Maridulu Budyari Gumal
Working together for good health and wellbeing

Place-based health interventions in NSW: A rapid review of evidence

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Healthy Urban Environments
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Table of contents

List of tables

List of figures

Introduction

This report describes a rapid review exercise on the place-based intervention approaches to improving the health and wellbeing outcomes of residents in the Australian state of New South Wales (NSW). The aim of this exercise is to inform the Cancer Institute NSW on their future policy and program developments in cancer prevention and screening. Specifically, it seeks to answer the following research questions:

1. What place-based interventions for health promotion and risk prevention and screening currently exist in NSW?
2. How effective have these interventions been in achieving their stated objectives?

The conducting of this rapid review follows an increasing recognition of the benefits of place-based interventions (Crimeen et al. 2017), which reflects the growing international understandings on the social determinants of health (AIHW 2020). Broadly, social determinants of health relate to the diversity of socioeconomic positions, conditions of employment, power and social support, which may differ from place to place. Further, social determinants of health may be enhanced or hindered by locationally specific factors including the availability of and access to infrastructure, policy and program coverage, environmental conditions to name a few. All these factors, therefore, may lead to a divergence of health outcomes. It is recognised that place-based interventions may be able to better respond to these socioeconomically and/or locationally-specific factors by implementing customised programs that address these specificities.

As such, place-based approaches may be intervention programs and policies that are locationally specific. Locations may not be limited in scale, so that programs may be applied to suburbs, neighbourhoods, whole (or part of) cities, or even broader regions. In that sense, ‘place’ is not, and cannot be, always easily defined by boundaries—even though administratively it often is—but rather as spaces that have been imbued with social meanings (Cresswell 2004; see also Liu & Freestone 2016, McEntyre et al. 2021). Some place-based approaches may be focused on specific socioeconomic groups—for example, Indigenous Australians, recent migrants, lower-income families—that are identified to experience additional challenges due to socioeconomic, historical, and/or broader structural factors, with interventions designed to address specific social determinants of health that these groups may additionally experience. Such interventions may then be implemented across multiple locations with similar experiences.

In this rapid review, ‘place-based’ is defined broadly to encompass these broad definitions. Final inclusions were determined by papers that self-described as having undertaken a place-based approach, or their descriptions fit the locationally-specific and/or socioeconomic group-specific definitions described above. This was so lessons may be learnt from a broad range of approaches to address place-based issues concerning different social determinants of health.

Reflecting this growing global recognition, the body of literature on place-based interventions has also increased commensurably. Yet, there is still limited knowledge—and broader transfers of knowledge—on whether and how these interventions achieved their stated objectives in changing health outcomes (Crimeen et al. 2017). This rapid review aims to address this gap in the context of the Australian state of NSW and place-based, health-related intervention programs.

Objectives

To facilitate the exercise's aim and in answering the research questions, this rapid review of literature has the following five objectives to uncover:

- the key objectives of place-based, health-related intervention programs,
- the processes to achieving these objectives,
- the barriers encountered throughout the life of the programs (including design, planning, implementation, and monitoring),
- the outcomes achieved (intended and unintended), and
- the lessons learnt.

Methods

A mixed method approach was adopted, comprising a rapid systematic review and semi-structured interviews.

Rapid systematic review

Eligibility criteria

The following study characteristics were used as criteria for eligibility for inclusion in the final set of studies synthesised via a rapid systematic review process:

1. **Publication year**: studies published in and since 2013 (last 10 years)
2. **Publication type**: studies published as peer-reviewed articles, postgraduate theses and reports by major credible organisations (governmental, research institutes, peak bodies)
3. **Publication language**: studies published in English
4. **Study type**: primary and secondary studies, any design including place-based, health-related intervention programs
5. **Study topic**: the main focus of the study is on summarising key objectives, processes, barriers, outcomes and lessons learnt of place-based, health-related intervention programs
6. **Study geographical focus**: the Australian state of NSW

An iterative process was considered during the actual review process to refine the above criteria:

Scaling up: Where fewer than 5 studies eligible for inclusion in the review were identified using the combined eligibility criteria 1-5, we considered including relevant studies from other Australian jurisdictions.

Scaling down: Where 20 or more studies eligible for inclusion in the review were identified using the combined eligibility criteria 1-5, we only included peer-reviewed articles and selected one most representative and detailed study per intervention program.

Search terms

A list of search terms was co-developed with the Cancer Institute NSW, and included terms that concerned the tools and/or intervention approaches, as well as the intervention setting.

Tools/interventions

- Place-based
- Place-specific
- Place-oriented
- Intervention*
- Program*
- Initiative*
- Health promotion
- Risk reduction
- Risk prevention
- Risk screening
- Regional program*
- Regional initiative*
- Region* program*
- Region* initiative*
- Health action zone
- Neighbourhood renewal
- Community renewal
- Neighbourhood based
- Community based
- Community wellbeing

Setting/population

- NSW
- New South Wales

The option to expand the search to include Australia and all other Australian states, if fewer than 20 papers fit the inclusion criteria, was not required as the minimal number was reached in the initial searches.

Information sources

1. Scopus
2. Web of Science
3. Medline (via Web of Science)
4. Embase (OVID)
5. CINAHL (EBSCOhost)
6. BASE
7. Cochrane Library
8. ProQuest
9. WorldWideScience
10. Google Scholar
11. Health Infonet https://healthinfonet.ecu.edu.au/
12. Analysis & Policy Observatory (APO) [manual search by HY]
13. From the studies included from the above searches, forward (citing studies) and backward (cited studies) reference searches using the Scopus platform were conducted. The "related studies" function in Google Scholar to find similar studies to those initially included was also used.

Literature search and study records

The study records found from the searches in online databases were exported as bibliographic files or, for APO, have their metadata (by HY: FirstAuthor, Year, Title, PublicationType, Abstract, URL) recorded in a Microsoft Excel spreadsheet. After removing duplicates, title and abstracts were independently screened by two reviewers to identify relevant studies using the inclusion/exclusion criteria described in the earlier section of this protocol. Full papers were then retrieved for studies deemed potentially relevant.

Two reviewers (EL, ML) independently performed screening of full papers by using the same criteria as for the titles and abstracts. The titles and abstracts of an initial shortlist of papers (n=67) were also reviewed by representatives of the Cancer Institute NSW, which provided the research team an initial inclusion list for full-text reviewing (n=18 papers). Additional papers were included following the initial data extraction, the exclusion of initially included papers (see Table 5), and stakeholder interviewees' recommendations.

Resulting included studies were used to perform additional searches for missed papers (forward and backward reference screening and related papers in Google Scholar, 441 unique hits). For the additional references, titles were scanned first, then duplicates removed, abstracts and finally full papers assessed for inclusion.

All data was extracted by EL, and checked by ML, using a data extraction table created in Microsoft Word and pre-tested with two included papers.

Data items

We recorded the following study characteristics: study title, author(s), year of publication, publication type, geographic scope (i.e. which area(s) of NSW), intervention type, study approach, funding source(s) of intervention, declaration of conflicts of interest, intervention objective(s), intervention process(es), barriers encountered, outcomes anticipated/achieved, and lessons learnt.

Table 1 presents the extracted variables and their descriptions (also used in Table 4 in the Results section, and Table 6 in the Discussion section).

Table 1: List of the main study variables extracted and coded for the included studies, with relevant values.

Study variables	Description
FirstAuthor_Yr	Key (ID) of the paper is created by concatenating the surname of the first author and the year published
Title	Title of paper
PublicationType	Type of publication, including SJR journal ranking quartile of the corresponding publication year where relevant
GeogFocus	Main geographic area(s) addressed in the article
InterventionCat	Type of intervention program (see Table 2 below for category descriptions)
StudyApproach	Approach and method(s) undertaken to studying/evaluating the intervention program
ProgFunding	Funding source of intervention program declared in the article
ConfOfInterest	Conflicts of interest declared in the article
ProgObjectives	Stated objective(s) of the intervention program discussed
Processes	Description of the intervention process(es)
Barriers	Barriers encountered in designing/implementing the intervention program
Outcomes	Intended and achieved outcomes of the intervention program
Lessons	Main lessons learnt of intervention program

Outcomes and prioritisation

During the study selection process, we prioritised peer-reviewed studies based on a diversity of intervention types (Table 2, overpage). Studies with relevance to a partnership approach, has a strong equity focus (i.e. focussing on higher needs communities), and higher feasibility for application in cancer screening and prevention were also prioritised. Where multiple papers that report on the same study were long-listed, only one paper (prioritising the paper that covers all aspects of the study, e.g. a final report, over papers that report on individual aspects) was considered.

Risk of bias in individual studies

Given the expected diversity of included study types, no formal assessment of Risk of Bias was possible.

Table 2: Intervention categories and descriptions

Categories	Description
Access	Improving access to services/support, e.g. community transport, e-health
Co-production / Government facilitation	Government-facilitated community programs, e.g. peer support programs
Cultural healing / knowledge	Indigenous culture/Country-centred approaches to program implementation and/or information dissemination
Education / Community engagement	Health literacy and community engagement activities, e.g. multilingual information dissemination
Integrated care / practices	Multi-method approach to designing/implementing customised care packages
Screening	Improving access to screening opportunities, e.g. community drop-off sites, postal services

Semi-structured interviews

Four semi-structured interviews were conducted with key stakeholders who have recent experience in conducting place-based, health-related interventions in NSW. A shortlist of potential interviewees was suggested by the Cancer Institute NSW, supplemented with desktop research based on some of the studies included in the rapid review exercise. To retain anonymity of potential participants approached, the research team selected the final list of 10 invitees and sent out the initial invitation. Participants who did not respond to the initial invitation were sent one reminder one week later; further non-response after another week was then marked as a 'no response'. Table 3 shows the list of stakeholders invited, their organisational representation, professional role, and response to the invitation.

Table 3: Description of stakeholder interview invitees and participants

Pseudonym	Organisation type	Role	Outcome
NGO1	Major charity	Executive manager	Declined
NGO2	Community organisation	Executive manager	Interviewed
NGO3	Aboriginal health service	Chief Executive Officer	No response
NGO4	Aboriginal health service	Chief Executive Officer	No response
Govt1	NSW Government agency	Health Promotion Officer	Interviewed
Govt2	NSW Government agency	Project Officer	Interviewed
Govt3	NSW Government agency	Health Promotion Officer	Interviewed
Acad1	University	Academic researcher	Deceased
Acad2	University	Academic researcher	No response
Peak1	NSW peak body	Director	Declined

The interviews were conducted during August and September 2022 via video-conferencing (Zoom), and were recorded with participant consent. The interview schedule is included as Appendix 1. Interviewees were asked to comment on the most recent intervention program they were professionally involved in. The auto-transcription function was used as the primary basis of note-making, and were then collectively and inductively analysed based on the following objectives:

- To gain more insights into place-based interventions currently underway or in the planning phases,

- To seek their professional reflections on past programs regarding the impacts of and challenges encountered by these interventions, and
- To seek recommendations on further literature and policy documents for inclusion in the rapid review exercise.

This study has ethics approval from the UNSW Sydney Human Research Ethics Advisory Panel G: Health, Medical, Community and Social, approval number HC220419.

Results

The final study list includes 20 papers that fulfilled our inclusion criteria and is presented in Table 4 below. These papers represent a mix of academic and grey literature written in English, that described and critically reflected on place-based intervention programs in NSW that had a health focus.

Overview of included studies

The included papers represent a mix of academic and grey literature. These include six research reports, and 14 journal articles. As a proxy reflection of their quality, the Scimago Journal Ranking[1] (SJR) Quartile that corresponds to the journal and publication year of the article is included as an indicator. Notably, those in the first quartile (Q1) are considered journals of the highest quality in that particular field, and those in the lowest quartile (Q4) considered of lesser quality in that particular field. The rankings are updated annually based on the papers published in the corresponding year.

Figure 1: Types of included papers

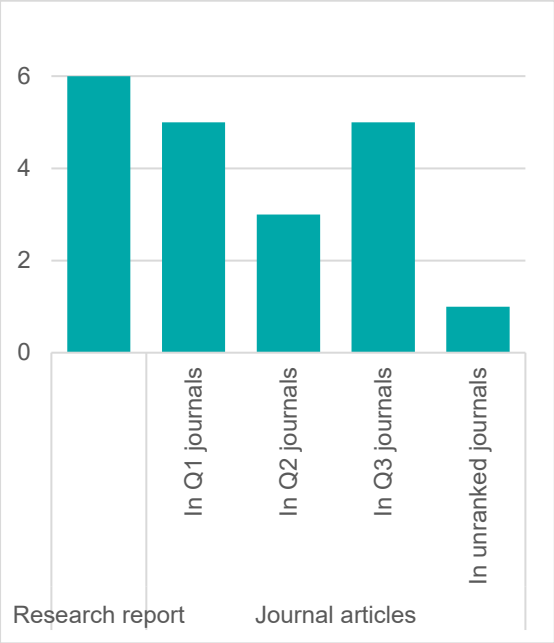
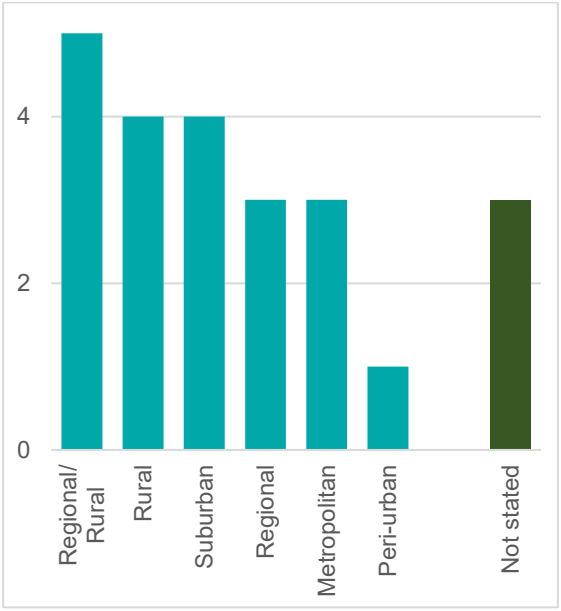


Figure 2: Geographic foci of included papers



Of the 14 journal articles included, five were from Q1 journals, three from Q2 journals, five from Q3 journals, and one from a journal that is not part of the SJR ranking system (Figure 1). The majority of the included journal articles (n=9) were published in journals that focused on the subject areas of 'Health Policy', 'Health (social science)', 'Public Health, Environmental and Occupational Health', and 'Health Informatics'. Four of the five remaining journal articles were published in more specialist subject areas—'Endocrinology', 'Endocrinology, Diabetes and Metabolism' (Taing_2017, Vita_2016), 'Internal Medicine' (Taing_2017), 'Medicine (miscellaneous)' (Taing_2017), 'Nursing (miscellaneous)'

[1] https://www.scimagojr.com/journalrank.php

(Stuhlmiller_2015), 'Psychiatry and Mental Health' (Singer_2015)—while the remaining one (Giles_2019) was published in a journal not recognised in the SJR system.

The case studies reported in all included papers were focused on the state of NSW. There was, however, a diversity in terms of the scale of the geographic focus. There were five papers that focused on both regional and rural NSW, with another four focussing on rural NSW only. Programs that targeted suburban Sydney (n=4; Abbott_2017, Lloyd_2019, MHC NSW_2020, Ndwiga_2021), regional NSW only (n=2; Bovill_2017, Tweed Shire Coucil_2021) and metropolitan Sydney (n=3; MHC NSW_2020, Taking_2017, Vita_2016) were also reported in more than one paper. One paper reported on case studies in the peri-urban, just outside of metropolitan Sydney (Giles_2019). There was also one paper that had multiple geographic foci, with case studies from across metropolitan, suburban and regional/rural Australia (MHC NSW_2020). Of particular note was that no specific geographic scale was reported in three papers (Figure 2). These included a state-wide program that focussed on a specific socio-economic group (Peiris_2019), another state-wide program that did not specify the case study in focus (King_2022), and a rapid review that informed the design of a state-wide program (Leung_2016).

In terms of the type(s) of intervention programs discussed, a diversity was covered in the included papers. These intervention types reflect the categorisation noted above in Table 2. Among the included papers, the most common intervention type discussed concerned Education and community engagement (n=7). This was followed closely by those concerning indigenous cultural health and knowledge (n=5). There were three papers each on co-production / government facilitation, and on improving access to health services, while two papers each on screening and on integrated care / practice models were also included (Figure 3). Among these, two studies corresponded with more than one intervention type: Giles_2019 in having an Indigenous-centric approach as well as community engagement approach, while Stuhlmiller_2015 reported on an intervention that aimed at improving access to an integrated practice.

Figure 3: Intervention types of include papers

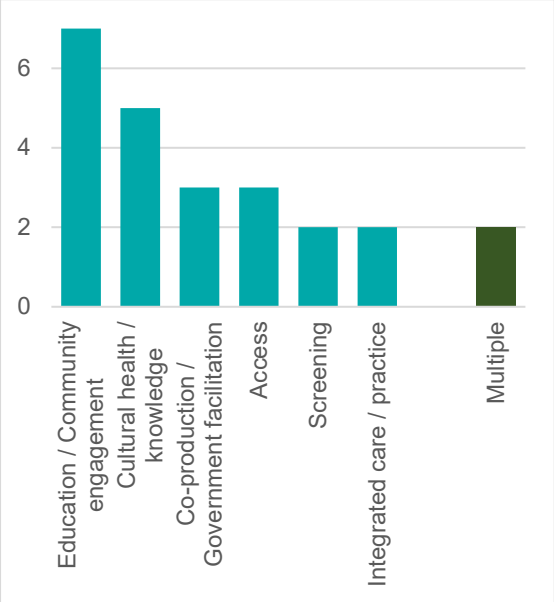
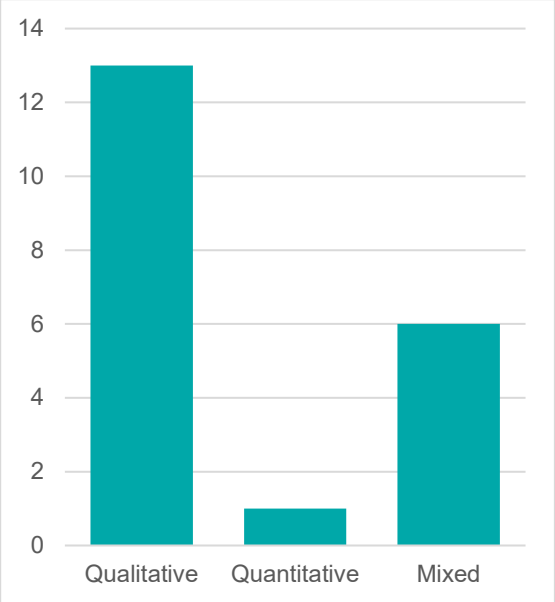


Figure 4: Study approaches of included papers



Of the included papers, most studies followed a qualitative only approach to reflecting on and/or evaluating the intervention programs (n=13), with less than half as many that followed a mixed-method approach (n=6). Only one of the included papers reported on a study that followed a quantitative only approach to evaluating the program outcomes (Vita_2016) (Figure 4).

Of the included papers, the highest number of studies reported on programs that fully or primarily received funding from the NSW state government or one of its agencies (n=8). Funding from federal government agencies only were reported in four papers, while three papers reported funding from peak bodies. Academic institutions provided funding support to two studies. Only one study reported having received funding from a philanthropic organisation. Studies reported in four included papers noted the programs received funding from multiple sources, while no funding information was provided in five included papers (Figure 5).

Figure 5: Program funding of included papers

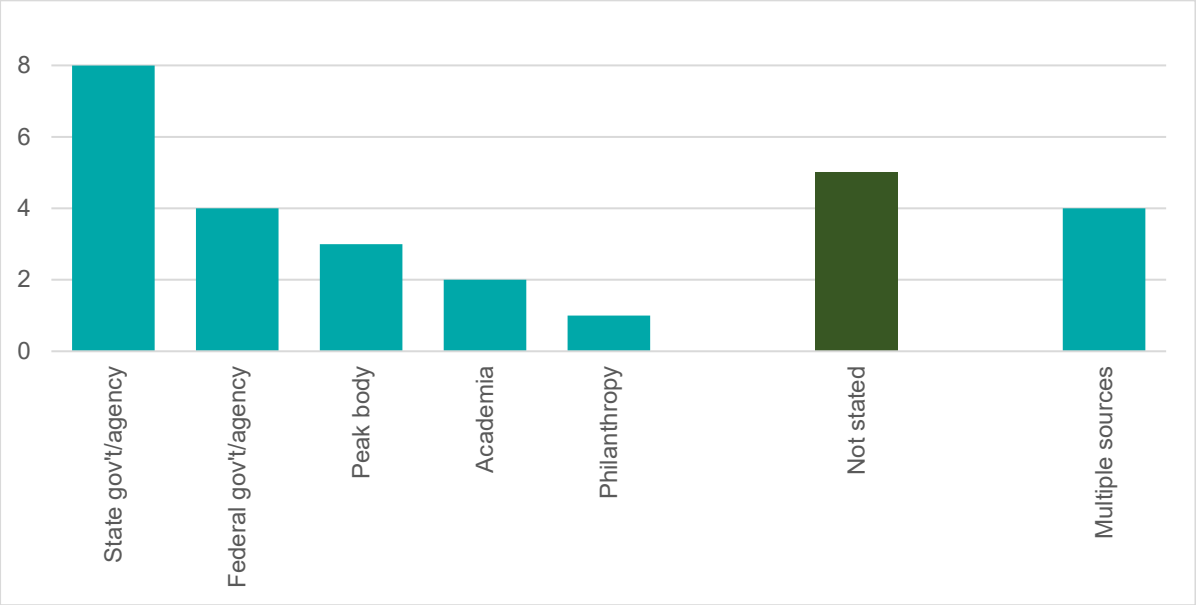


Table 4: Main characteristics of the included studies

FirstAuthor_Yr	Title	PublicationType	GeogFocus	InterventionCat	StudyApproach	ProgFunding; ConfOfInterest
Abbott_2017	Supporting the mental health and wellbeing of the residents of Airds – during and beyond housing renewal	Research report	Airds; Suburb	Integrated care/ practice	Qualitative; Stakeholder interviews and focus groups	No funding statement; No conflict of interest statement
Bovill_2017	Collective and negotiated design for a clinical trial addressing smoking cessation supports for Aboriginal and Torres Strait Islander mothers in NSW, SA and Qld – developing a pilot study	Journal article [Q3[a,c]]	Aboriginal Community-Controlled Health Services; Regional	Education / Community engagement	Qualitative; Community engagement and capacity building	University of Newcastle, Faculty of Health and Medicine, Centre for Brain and Mental Health Research and Hunter Cancer Research Alliance; Statement declaring no conflicts of interest.
Bulloch_2019	Aboriginal Health and Wellbeing Services: Putting community-driven, strengths-based approaches into practice	Research report	East Arnhem Land, Nowra and the Wreck Bay Aboriginal Community; Regional/rural	Cultural healing / knowledge	Qualitative; Case studies and stakeholder interviews	No funding statement; No conflict of interest statement
Giles_2019	Working towards a tobacco-free	Journal article [Q n/a]	Centre Coast, NSW;	Cultural healing / knowledge	Mixed;	Central Coast Local Health

FirstAuthor_Yr	Title	PublicationType	GeogFocus	InterventionCat	StudyApproach	ProgFunding; ConfOfInterest
	Aboriginal community through an arts-based intervention		Peri-urban	Education / Community engagement	Focus groups, post-workshop evaluation	District Health Promotion Service No conflict of interest statement
Gwynn_2015	Aboriginal and Torres Strait Islander community governance of health research: Turning principles into practice	Journal article [Q3[c]]	NSW; Rural	Cultural healing / knowledge	Qualitative; Ethnographic	No funding statement; No conflict of interest statement
Handley_2021	Lessons from the development and delivery of a rural suicide prevention program	Journal article [Q3[c]]	Hunter New England region; Rural	Education / Community engagement	Qualitative; Interviews	Australian Department of Health and Ageing, Hunter New England Central Coast Primary Health Network; Statement declaring no conflicts of interest.
King_2022	Integrating shade provision into the healthy built environment agenda: the approach taken in NSW, Australia	Journal article [Q1[a,c]]	NSW; Not stated	Co-production / Government facilitation	Qualitative; Ethnographic	No funding statement; Statement declaring no conflicts of interest. Three authors note their

FirstAuthor_Yr	Title	PublicationType	GeogFocus	InterventionCat	StudyApproach	ProgFunding; ConfOfInterest
						membership of the Shade Working Group, subject of this paper.*
Leung_2016	Are libraries effective settings for accessing health information?	Research report	Not stated; Not stated	Education / Community engagement	Qualitative; Rapid review	NSW Ministry of Health; No conflict of interest statement
Lloyd_2019	Can Get Health in Canterbury Project Outcome Evaluation	Research report	Canterbury; Suburb	Access	Mixed; Document analysis, online surveys, interviews	No funding statement, but notes Sydney Local Health District and Central Eastern Sydney Primary Health Network in text; No conflict of interest statement
Longman_2013	The role of social isolation in frequent and/or avoidable hospitalisation: rural community-based service providers' perspectives	Journal article [Q2[a]]	Not stated; Rural	Access	Qualitative; Stakeholder interviews	The Institute of Rural Clinical Services and Teaching; Statement declaring no conflicts of interest.
MHC NSW_2020	Journey of Wellbeing: A preliminary	Research report	NSW;	Cultural healing / knowledge	Qualitative; Case studies	No funding statement;

FirstAuthor_Yr	Title	PublicationType	GeogFocus	InterventionCat	StudyApproach	ProgFunding; ConfOfInterest
	Aboriginal Model of Care based on documented examples of best practice across NSW		Metropolitan, Suburban, Regional/Rural			No conflict of interest statement
Ndwiga_2021	Using Community Based Research Frameworks to Develop and Implement a Church-Based Program to Prevent Diabetes and Its Complications for Samoan Communities in South Western Sydney	Journal article [Q2[c]]	South western Sydney; Suburb	Education / Community engagement	Qualitative; Community-based participatory research, semi-structured interviews, reference group meeting minutes	South Western Sydney Local Health District's Diabetes Obesity Metabolism Translational Research Unit, South Western Sydney Primary Health Network, WentWest Limited, Wentworth Health Care Limited and the Western Sydney University's Translational Health Research Institute; Statement declaring no conflicts of interest.
Peiris_2019	Community-Based Chronic Disease	Journal article [Q2[d]]	Not stated; Not stated	Screening	Mixed; Health and administrative	No funding statement;

FirstAuthor_Yr	Title	PublicationType	GeogFocus	InterventionCat	StudyApproach	ProgFunding; ConfOfInterest
	Prevention and Management for Aboriginal People in New South Wales, Australia: Mixed Methods Evaluation of the 1 Deadly Step Program				records analyses, client satisfaction survey, service provider interviews	Statement declaring no conflicts of interest.
Ramsden_2021	Collaborative care: Primary health workforce and service delivery in Western New South Wales—A case study	Journal article [Q3[c]]	Tottenham, Trundle, Tullamore and Trangie; Rural	Co-production / Government facilitation	Qualitative; Descriptive case studies, synthesised field observations, health needs assessments	Australian Government Department of Health; Statement declaring no conflicts of interest.
Singer_2015	"You didn't just consult community, you involved us": transformation of a 'top-down' Aboriginal mental health project into a 'bottom-up' community-driven process	Journal article [Q3]	Northern NSW; Regional/Rural	Education / Community engagement	Qualitative; Principle-application	Australian Government e-Mental Health in Practice (eMHPrac) national project; Statement declaring no conflicts of interest.
Stuhlmiller_2015	Developing a student-led health and wellbeing clinic in an underserved	Journal article [Q1]	West Tamworth; Regional/Rural	Access Integrated care/ practice	Qualitative; Community-based action research	Health Workforce Australia Clinical Training Fund;

FirstAuthor_Yr	Title	PublicationType	GeogFocus	InterventionCat	StudyApproach	ProgFunding; ConfOfInterest
	community: collaborative learning, health outcomes and cost savings					Statement declaring no conflicts of interest.
Taing_2017	Primary analysis of the Mandarin-speaking sub-study within the Sydney diabetes prevention program	Journal article [Q1]	Greater Sydney; Metropolitan	Cultural healing / knowledge	Mixed; Statistical analysis, interview, CATI survey	Australian Better Health Initiative, NSW Ministry of Health; Statement declaring no conflicts of interest.
Tweed Shire Council_2021	Streets as shared spaces grant: Evaluation report	Research report	Murwillumbah; Regional	Education / Community engagement	Mixed; Post-installation survey, observation, interviews	Streets as Shared Spaces program – Category 1: Quick Response Demonstration Project; No conflict of interest statement
Vita_2016	Type 2 diabetes prevention in the community: 12-Month outcomes from the Sydney Diabetes Prevention Program	Journal article [Q1]	Greater Sydney; Metropolitan	Screening	Quantitative; Real world implementation, lifestyle modification cohort study	Australian Better Health Initiative, NSW Ministry of Health; Statement declaring no conflicts of interest.
Welsby_2014	Process evaluation of an up-scaled	Journal article [Q1]	NSW; Regional/Rural	Co-production / Government facilitation	Mixed;	National Partnership Agreement on

FirstAuthor_Yr	Title	PublicationType	GeogFocus	InterventionCat	StudyApproach	ProgFunding; ConfOfInterest
	community based child obesity treatment program: NSW Go4Fun®				Pre-post measures, questionnaire	Preventive Health (NPAPH), Australian Government; Statement declaring no conflicts of interest.

Note: For journal articles, their SJR Quartile—for the subject areas of (a) 'Health Policy', (b) 'Health (social science)', (c) 'Public Health, Environmental and Occupational Health' or (d) 'Health Informatics', except Giles_2019, where the journal is not recognised in the SJR system; Singer_2015 for 'Psychiatry and mental Health'; Stuhlmiller_2015 for 'Nursing (miscellaneous)'; Taing_2017 for 'Endocrinology', 'Endocrinology, Diabetes and Metabolism', 'Internal Medicine', 'Medicine (miscellaneous)'; Vita_2016 for 'Endocrinology, Diabetes and Metabolism'—is included as a proxy to indicate quality of the publication, where journals noted as Q1 are recognised as journals of the highest quality in its respective field(s).
Note: * The Cancer Institute NSW—the funder of this rapid review—also belongs to this group and was a co-author organisation on the paper.

Overview of excluded studies

Table 5 lists the five studies excluded from this review at the full-text screening stage, alongside the reasons for exclusion. Four studies were excluded because they comprised extended abstracts only that did not include much information on the intervention program in focus (Davis_2018, Lawrence_2017, Perkins_2017, Ratcliff_2018). The other paper was excluded because it is a study on assessing unmet needs and was not a reflection or evaluation of an existing intervention program (NCOSS_2016). Despite being excluded, some of these papers may still provide useful insights that are relevant to those interested in designing future intervention programs to fill identified gaps (e.g. NCOSS_2016).

Table 5: Table of excluded studies at the full-text screening stage, with reasons.

FirstAuthor_Yr	Paper title	Reason for exclusion
Davis_2018	A new culturally informed and innovative commissioning approach to boost access and primary health care performance for Indigenous communities of rural and remote New South Wales and Queensland	Extended abstract only / not full paper
Lawrence_2017	Dilly Wanderer initiatives – Wollondilly Health Alliance	Extended abstract only / not full paper
NCOSS_2016	'Staying Alive': Transport to treatment for people living with a chronic disease	Focused on assessing unmet needs only
Perkins_2017	Integrated mental healthcare in Australia: rural pact and city partnership	Extended abstract only / not full paper
Ratcliff_2018	Housing and Health as partners in a place-based hub	Extended abstract only / not full paper

Quality, risk of bias and confidence in cumulative evidence

Authors of eight studies did not provide statements outlining potential conflicts of interests (or competing interests) or lack of such conflicts. Authors of 12 studies provided statements declaring the absence of conflicts on interests. Of these, for one paper (King_2022), three co-authors noted their roles as chair and members of the working group that was the subject of the paper; the Cancer Institute NSW—the funder of this rapid review—was also a co-author organisation of King_2022.

Rapid review limitations

Our literature search may not be fully comprehensive, and some relevant papers may have been missed. We also only included studies that focused on the Australian state of NSW, published in English, and those published within the last 10 years.

Discussions

The purpose of this project—which combines a rapid systematic review with stakeholder interviews—was to assess the place-based approaches to health-related intervention programs in the Australian state of NSW. It focuses on the following five objectives:

- the key objectives of place-based, health-related intervention programs,
- the processes to achieving these objectives,
- the barriers encountered throughout the life of the programs (including design, planning, implementation, and monitoring),
- the outcomes achieved (intended and unintended), and
- the lessons learnt.

We detail the findings from the rapid systematic review and stakeholder interviews of each of these objectives below.

Intervention objectives

The stakeholders interviewed revealed that health and planning professionals were often aware of a range of local issues that influenced social determinants of health within their respective geographic regions. When relevant funding opportunities arise, intervention programs may be formed to help address some of these issues. The program objectives, however, may be adjusted to fit the broader intentions and conditions of the funding programs. As such, project objectives often aligned more with (or were restricted by) the conditions imposed by the broader funding schemes.

From the rapid review exercise, the objectives of the included studies can be broadly categorised as follows:

- *To design and deliver a service (intervention) (n=13)*. This was by far the most common stated objective across all included papers. These included studies that engaged with the local community and an intervention was developed in response (e.g. Ndwiga_2021), as well as studies that adapted an existing program for local application (e.g. Tweed Shire Council_2021). These studies were also more likely to report on the type and extent of outcomes achieved through the conducting of post-implementation evaluations or critical reflections.
- *To assess needs (n=3*; Abbott_2017, Leung_2016, Longman_2013). These papers typically reported on projects that set about assessing local needs, generally without the accompaniment of a fully designed/developed intervention to addressing these needs. Recommendations on program developments were sometimes included (e.g. Leung_2016).
- *To develop a new framework for later implementation (n=2*; Bovill_2017, MHC NSW _2020). These programs generally expanded on previously identified needs. In place of designing and developing interventions for implementation, these papers described the processes of developing frameworks that may be flexibly adopted so they may be implemented later to suit specific local contexts.
- *To assess alignment to broader strategies (n=1*; Gwynn_2015). This paper set out to describe how two existing programs align with two existing governance structures and guidelines, to provide guidance on how policies may be operationalised for place-specific contexts.
- *To evaluate the effectiveness of an implemented program (n=1*; Peiris_2019). This was the only included paper that set out to evaluate the outcomes of an implemented,

place-based program. It described the mixed approach to keeping the community engaged, and the approaches to evaluating the outcomes of the program.

This diversity of intervention objectives described here are by no means representative of all current and recent health-related place-based intervention programs in NSW, but nonetheless can provide an indication of the likely aims of these funded intervention programs.

Intervention processes

There was a similar diversity of processes introduced to achieving the intervention objectives stated above. This diversity was largely related to the mix of intervention objectives, so that the processes for identifying needs may be different to those in delivering an intervention, though overlaps were also observed.

From the rapid review exercise, these processes can be broadly categorised as follows:

- *Establishing a clear communication and engagement strategy (n=16)*. Almost all included papers highlighted the establishment of clear communication and engagement strategies as part of their processes to achieving the intervention objectives. These included direct communications and engagements with community members and/or stakeholders to identify needs and appropriate approaches, recruitment activities, and dissemination of results, to name a few. The variety of activities included were wide, from printed materials (flyers, posters, billboards, reports), electronic communications (e-newsletters, social media posts), competition and reward programs, classes (art, exercise, sport), to other in-person activities such as involving local business in using and maintaining parklets (e.g. Tweed Shire Council_2021).
- *Providing opportunities for capacity building (n=7)*. Related to community engagement, seven of the included papers mentioned building up the capacity of the local community as one of the processes of their intervention delivery. This involved engaging community members (in employed and/or voluntary capacities) in recruitment, implementation and/or dissemination activities. Both Stuhlmiller_2015 and Vita_2016 discussed training up and employing local community members as nurses to deliver health care services. The involvement of the local community through capacity building were noted as beneficial on two fronts: it can facilitate program sustainability by having both local buy-in and also in retaining the economic benefits of local employment; and by establishing and maintaining rapport, which is related to the next process detailed below.
- *Developing relationships and building trust (n=4*; Bovill_2017, Handley_2021, Lloyd_2019, MHC NSW_2020). Four included papers discussed the importance of developing relationships (with community, stakeholders, and partners) and building up trust as part of the intervention processes. The latter—in establishing and maintaining trust—can help ensure the longevity of the programs, by encouraging community members to participate in the interventions, in relaying important information (of themselves to the health services so that they get the appropriate support, or of the services to the community). Developing relationships with the broader community and stakeholders, demonstrating that the delivery partners can be trusted to deliver quality services that meet local needs, can also help in the establishment of future programs or extending of existing programs, in meeting further needs.
- *Developing a protocol for evaluation (n=3*; Gwynn_2015, Peiris_2019, Ndwiga_2021). Only three of the included papers mentioned the development of an evaluation

protocol (and/or conducting a program evaluation) as part of the intervention processes. It was, however, noted as important to develop and implement an evaluative process early so that adjustments may be identified and implemented (Peiris_2019).

- *Developing a pilot program (n=1*; Ndwiga_2021). Only one paper noted the development of a pilot program as part of their intervention processes. This intervention also involved some of the other processes mentioned—namely communication and engagement strategies, building up trust, and evaluation—in delivering the intervention and assessing whether and to what extent the program objectives were achieved.

It was noted in the included papers that engagement, capacity building, and establishing trust are particularly important processes for interventions that involve Indigenous Australian communities. These processes would allow for the design of culturally-appropriate interventions and delivery mechanisms; the establishing of trust especially would help address the level of distrust some Indigenous people may have towards authorities and services given bad past experiences (e.g. Abbott_2017).

Partnership approach

More than half of the included papers (n=12) described projects taking a partnership and/or collaborative approach to intervention delivery. Descriptions primarily focused on the number and types of partnerships, as well as the outcomes achieved. There is little information among the included papers on decisions and discussions around which organisations to partner with, and how the partnerships were established.

When asked during the interviews, stakeholders provided some further insights into these partnership and collaborative approaches. All stakeholders interviewed noted that their intervention programs were most usually designed with their existing network of partners rather than new collaborations being formed to address the identified issue. On the rare occasion where a new partner may benefit the intervention program, they were typically drawn from each individual partner's extended collaboration network. The collaboration networks may be at an inter-institution level (i.e. existing, formal collaborations between two or more organisations, such as between a government agency and a local community organisation), or at the individual level such as stemming from previous collaborations (e.g. between stakeholders in similar roles across different organisations). Interventions, therefore, were more likely to have extended existing networks and partnerships than establish new collaborations. This links back to one of the processes described above—developing relationships and building trust—as an exercise to testing out potential successful working relationships for future delivery.

Barriers encountered

Most included papers highlighted a number of barriers that limited the implementation of their respective intervention programs; only three papers (Gwynn_2015, MHC NSW_2020, Singer_2015) did not explicitly specify any barriers encountered. Of those that did, the vast majority stated multiple barriers, many of which were contextually-specific to the particular programs and/or timeframe being discussed such as locational challenges or the onset of the COVID-19 pandemic. Many of these barriers—most notably funding and resourcing

limitations, and the relatively short delivery timeframes—were echoed by stakeholders interviewed.

From the rapid review exercise, these barriers can be broadly categorised as follows:

- *Funding and resourcing (n=9)*. Limited funding and resourcing was explicitly mentioned in nine of the included papers as a barrier to intervention implementation. This restricted the breadth and scale of the intervention, constraining the types of community members who may be eligible to participate, as well as the duration of the programs (see further details below). According to the stakeholders interviewed, in addition to the limited funding, there were often requirements of in-kind contributions from program partners (usually various government agencies). Such in-kind contributions ranged from administration and management support, the use of community or even private facilities, to the procurement of materials. Tweed Shire Council_2021, for example, noted that the program needed local businesses to get on board in maintaining the temporary parklets and garden spaces at their own expense. The limited funding available also meant that many of these intervention programs were run as pilots. There were hopes of further funding support with the demonstration of successful outcomes, but those were noted as hard to achieve given the relatively short durations of pilots (further details below).
- *Relatively short timeframes for achieving outcomes (n=5)*. Five of the included papers highlighted the relatively short timeframes of intervention programs as a major barrier to achieving outcomes. This was especially the case when improvements in health outcomes may take time to materialise, which may be beyond the scope of the intervention itself (e.g. Lloyd_2019). Further, all stakeholders interviewed reflected on the relatively short timeframes of pilot studies. Notably, most pilot programs only run for up to 12 months, which is a very short amount of time to genuinely engage with communities to understand the issues and local contexts, design appropriate responses, bring in additional partners (where relevant), and conduct evaluations on whether and how program objectives were achieved.
- *Accounting of outcomes (n=4*; Leung_2016, Lloyd_2019, Ndwiga_2021, Welsby_2014). Related to the barrier of short program timeframes, four of the included papers highlighted opportunities (or lack thereof) for the accounting of outcomes as a barrier to sustaining intervention programs. This was often because changes to health outcomes took time to materialise. Many studies also noted that the short timeframe, or the funding guidelines, simply did not provide any scope for evaluations. As highlighted in the previous section, only three included studies mentioned the development and/or conduction of evaluation as part of their interventions. As such, the accounting of outcomes was often limited to observed changes in attendance and usage. While changes in health outcomes may also be observed, these may not be directly attributed to the interventions in the absence of proper assessments and evaluations (e.g. Ndwiga_2021).
- *Accessing hard-to-engage individuals and communities (n=4*, Abbott_2017, Handley_2021, Ndwiga_2021, Welsby_2014). Three of the included papers highlighted that participation of intervention programs was likely limited to those who were already interested in the issue, and those who were hard-to-engage remained largely non-participatory. This was especially the case for self-recruited programs compared to those referred by health professionals (Ndwiga_2021). Other factors, such as cultural backgrounds and practices, may also see hard-to-engage individuals and communities not willing to participate despite the involvement of translated program materials and/or other community members as recruitment and retention strategies (e.g. Handley_2021). Other literature highlights perceptions of shame

attached to help-seeking may be more prevalent among particular cultural groups (e.g. Sangar & Howe 2021). Experiences of mental illness may also prevent particular individuals from wanting to engage (e.g. Doblytė 2020). Abbott_2017 highlighted that, especially among Indigenous Australian communities, distrust of authorities as an outcome of poor past experiences as a notable example.

- *Establishing and maintaining community buy-in (n=3*; Taing_2017, Tweed Shire Council_2021, Vita_2016). Three included papers discussed the difficulties experienced in establishing and maintaining community buy-in as challenges of placed-based intervention programs. This was particularly challenging for programs that were designed to have on-going rather than one-off engagements with participants. In their study, Taing_2017 noted that less than half completed the 12-month program in full, with attrition experienced along the way and in different aspects of the program.
- *Other external and broader structural issues (n=2*; Abbott_2017, Bulloch_2019). These involve challenges that were outside the scope of the intervention programs themselves, but nonetheless impacted on the willingness and/or experiences of communities in participating in the interventions. The two papers highlighted intergenerational life disadvantages (Abbott_2017) as well as racism (both past and present; Abbott_2017, Bulloch_2019) as notable examples of these external and structural issues.
- *A lack of physical access to services (n=1*; Longman_2013). In rural settings, large geographical distances remain a major barrier to service accessibility. The introduction of ambulatory services (the focus of Longman_2013) was only able to partially address this issue.
- *High staff turnover (n=1*; Handley_2021). This was especially related to the common barrier of limited funding, or inconsistent funding, which led to staff leaving when cycles of funding completed. This issue was exacerbated by the rural setting of the case reported in Handley_2021, where the recruitment and maintaining of staff across industries and sectors was a known major barrier across different industries and sectors.
- *Insufficient staff training (n=1*; Leung_2016). This is related to the barrier of insufficient resourcing, and limited the intervention's capacity to deliver appropriate service and support.
- *Technological troubleshooting (n=1*; Peiris_2019). This was quite specific to the case discussed in Peiris_2019, which incorporated the development of two apps and an online staff portal aimed at facilitating client information collation and tracking program progress. The paper discussed the capacity (or willingness) of participants to download and engage with the app, linked with the timeliness of prototype development, being a barrier to implementation.

Anticipated and achieved outcomes

Given the barriers described above, most studies and stakeholders interviewed were only able to report on observed rather than assessed changes and outcomes. These included increased awareness of the health issue and/or program (linked with the prevalent community engagement approach undertaken), increased use of local facilities and/or infrastructures (linked to processes in removing physical and other barriers, e.g. financial), increased employment (paid and/or voluntary) of local community members (linked to capacity building processes), and the expansion of pre-existing services (linked also to capacity building, as well as community engagement). There was little reporting of changes

to health outcomes (notably with the exception of Vita_2016, through analysis of administrative and medical records). It was also highlighted throughout many of the included papers that any changes reported may not be understood as directly resulting from the interventions in the absence of any built-in assessments and evaluations, given the relatively short timeframes of the programs.

Lessons learnt

It was uncommon for the included papers to explicitly state lessons learnt on the designing, implementation, and operation of the intervention programs. These may, however, be drawn from descriptions throughout the main texts, especially in the conclusions and recommendations sections of the included papers. Much like the barriers described above, many of the lessons related to the specific contexts of each intervention program, often in response to the barriers and challenges encountered, as well as the processes they implemented. Broader level lessons, however, may be summarised as below. These lessons distilled from the included papers largely resonated with those highlighted by the stakeholders interviewed.

Many of the included papers highlighted the importance of *early and regular communication and engagement* with the community. This was not only important in identifying the issues from a local context and perspective, it was also important in informing the community of the intention and potential processes of the intervention, easing any anxieties they may have, facilitating early and deeper buy-ins (e.g. Abbott_2017, Ramsden_2021, Singer_2015). Early and regular engagements would also facilitate the community's involvement in the design and implementation of appropriate responses that are suitable to that local context. One interviewed stakeholder reflected that, while the intention of the intervention was not to increase local medical presence but improve healthy lifestyle habits, it was through early engagement that they were able to identify the departure of the local General Practitioner several years prior, and that the local community would visit the General Practitioner for both medical needs as well as other health-related advice in the absence of other similar services. The need to travel to nearby towns for such support meant that uptake of any lifestyle-oriented intervention was lower, because there was not a local medical professional who they could seek additional information or advice. An unanticipated outcome of this intervention was, then, to advocate (successfully, with support from Medicare) for the funding of a local General Practice service.

Lessons concerning early and regular engagement were also related to *the identification of culturally specific practices and responses*. While the presence of particular cultural groups may be known, these were often harder-to-engage individuals and communities due to language, financial, and other socioeconomic factors. Early and regular engagements, in showing the intervention program's commitment to the community and place, may help gain the community's trust and potentially reach harder-to-engage individuals and groups. As several included papers highlighted (e.g. Handley_2021, Taing_2017), additional resourcing may be required to design alternative engagement activities that specifically target hard-to-reach communities. This may include the use of more informal means of engagement (e.g. Bulloch_2019), such as by working collaboratively with local community leaders.

As highlighted in the previous sections, funding and resource limitations presented as major challenges that constrained the scope and impact of the intervention programs. As such, several included papers highlighted the importance of *appropriate funding and resourcing support*, noting especially the participants that such intervention programs often target were

more likely of socioeconomically disadvantaged backgrounds and/or in areas that were already limited in resourcing (including infrastructures, e.g. Abbott_2017, Welsby_2014). Programs also need to show commitment to longer periods that may, as noted above, facilitate more local buy-in, but more importantly reflect a realistic timeline for intended outcomes to emerge and be bedded in. *Building up local capacity* to deliver the interventions, especially by employing local community members, may assist in the delivery of appropriate services and support (e.g. Ndwiga_2021), as well as help build an economic case in sustaining them beyond the initial funding period.

An overview of the objectives, processes, barriers, and outcomes of included studies is provided in Table 6.

Table 6: Summary of objectives, processes, barriers, and outcomes of included studies

FirstAuthor_Yr	ProgObjectives	Processes	Barriers	Outcomes	Lessons
Abbott_2017	To assess mental health and wellbeing needs before and during housing renewal, and how needs may be best supported.	Regular and clear communication and community consultation. Develop trusting relationship between residents and housing workers. Customised/ individualised support. Link with external/partner services and life improvement opportunities, e.g. education and employment. Funding support programs and facilitating volunteering.	Pre-existing health (especially mental health) conditions could become more at risk due to loss of services, support or disrupted care, including from periodic changes to support eligibility (esp. for non-citizens). Intergenerational life disadvantage and lack of self-efficacy are noted to have ongoing negative impacts on mental health, and limit intervention avenues and outcomes. Distrust of authority (e.g. past trauma). Poor accessibility to services and support, including real and perceived lack of affordability, poor transport connectivity, and long waiting lists.	Improved access to facilities/infrastructure. Improved community reputation of service and providers. Decreased stigma Improved community optimism.	Pre-existing structural drivers (e.g. entrenched socio-economics, chronic health problems) may be hidden and remain unaddressed. Deep-seated drivers could (re)occur when support funding ceases or tapers following conclusion of housing renewal. Children and elderly particularly impacted, especially in loss of peer groups and social network dispersal. Cultural and language competency (of support services) remain major barriers for identification of needs and referral. Normalisation of disadvantage and poor health require long-term remediation.
Bovill_2017	To develop an intervention and	Partnerships with Aboriginal	Limited access due to funding changes/cuts.	Capacity building through employment	Local communities and services engaged

FirstAuthor_Yr	ProgObjectives	Processes	Barriers	Outcomes	Lessons
	partnership framework to target smoking cessation during pregnancy.	organisations and communities, including capacity building. Negotiate and develop a pilot study involving counselling and expedited use of nicotine replacement therapy following culturally competent care guide.		(research, service delivery), community education, and webinar training.	early on, which facilitate buy-in and engaged contributions and co-design of program methods and materials. This facilitated a sense of ownership and assisted in overcoming low participating and loss to follow up.
Bulloch_2019	To deliver local and culturally appropriate (physical and mental) health services.	Bottom-up approach to program design, guided by mix of western and Indigenous governance and self-determination. Notable engagement and involvement of local community members (paid staff and volunteers) in service delivery to enhance community buy-in and service penetration. Employ outreach and regular/	Racism and ethnocentrism remain issues that prevent appropriate engagement. Supporting self-determination within westernised governance structures can be challenging. Desires to facilitate self-determination may not work easily within bureaucratic strictures of funding guidelines. Relationship and capacity building take time, including for people who are already in the	Recognise non-clinical determinants of health, and work in partnership with other organisations to build trust with community members. Trust-building may require stretching resources to cover tasks outside of funding scope. This often relied on goodwill of staff/ partners/community.	Recognise diversity within and among Aboriginal and Torres Strait Islander peoples, and develop appropriate support with local inputs. Responses must work with and complement local histories, cultures and contexts. Recognise the value/ benefit of informal arrangements (flexibility, innovation, community-/place-specific). Difficulty juggling prescribed (top-down) KPIs and what

FirstAuthor_Yr	ProgObjectives	Processes	Barriers	Outcomes	Lessons
		committed presence to build trust.	community (e.g. from different mob). This does not always align with the outcomes-delivery approach of shorter-term programs. Reliance on external funding that does not offer flexibility in service delivery. Grants often attract heavy administration (application, management, reporting). May need to run pilots unfunded to demonstrate success in order to attract funding.		community deems important (bottom-up).
Giles_2019	To facilitate smoking cessation through art-based interventions.	Art workshops and competitions centralised around the theme of smoking cessation.	Widespread social acceptance of smoking within Aboriginal communities. Practical smoking cessation support was not offered together with the art-based interventions. Low participation by local Aboriginal organisations due to	No data on smoking cessation. Artworks being used in social media and follow-up campaigns.	Art-based interventions are effective means of engagement, but has limited impacts on assessing outcomes.

FirstAuthor_Yr	ProgObjectives	Processes	Barriers	Outcomes	Lessons
			competing priorities and lack of resourcing.		
Gwynn_2015	To assess the current governance structures and procedures of two Aboriginal rural health services to support community engagement and research governance, and test their alignment with the NHMRC's 'Values and ethics' guidelines and 'Roadmap II Action Areas'.	Health promotion in schools and communities concerning children's healthy food consumption, physical activities, and knowledge about diabetes. Capacity building through local employment. Adaption of longitudinal health survey to local context/needs	Not stated.	Not stated.	The continued development of guidance on governance structures and processes, based on a growing evidence base, is needed across different geographic levels. Greater coherence across practical guides needed.
Handley_2021	To provide suicide prevention in rural NSW through community and clinical education	Short and focussed skills training program with flexible components that cater to specific cohorts (e.g. farmers, Aboriginal people). Referral to professional services to extend risk minimisation.	Inconsistent funding, and change to funding remit necessitated changes in target and delivery. High staff turnover, related to inconsistent funding cycles. Under-representation of hard-to-reach cohorts. Likely 'preaching to the converted', i.e. those already have interest	Reduced suicide-related stigma, and improved suicide prevention literacy. Attendance and participation not necessarily reaching target audience (e.g. mainly female participation while suicide fatalities are higher among males).	Short and targeted program minimises direct and opportunity costs for participants. Periodic refresher courses may be required. Short funding cycles impeded staff retention, impacting service delivery as well as relationship development and continuity.

FirstAuthor_Yr	ProgObjectives	Processes	Barriers	Outcomes	Lessons
			in mental health and are less at risk. Difficulty in referring to appropriate further support in under-resourced situations.		Alternative recruitment approaches needed for hard-to-reach cohorts, e.g. via partnership with engaged groups.
King_2022	To raise awareness of skin cancer prevention through education (esp. via quality shade). To provide advocacy and advice concerning skin cancer prevention. To gather new evidence on progress and outcomes of the NSW Skin Cancer Prevention Strategy (2012).	A specialist Working Group consisting of representatives from academia, government, non-government, and professional organisations. Engagement with professional networks (e.g. Australian Institute of Landscape Architects). Submissions to public consultations, conference and other presentations, publications, and guest lectures at universities. Incentivise promotion through recognitions, e.g. AILA ShadeSmart awards.	Shade audits have been conducted as part of the Strategy, but shade availability and quality remain lesser known. Further research required to assess audit outcomes and develop comprehensive dataset and action tool to influence design and implementation.	Notable increase in recognition of shade in skin cancer prevention in recent public and professional documents (e.g. NSW Draft urban design guide).	SWG achieved collaborative partnerships across disciplines, professions and sectors through opportunistic and strategic engagements. The value of reiterating key messages across stakeholder groups. A practitioner-focused approach to influence practice and implementation.

FirstAuthor_Yr	ProgObjectives	Processes	Barriers	Outcomes	Lessons
Leung_2016	To assess public libraries as an effective delivery of health promotion and education to the community. To uncover which library features/ settings may be key enablers	PRISMA rapid review using two search engines (Google Scholar, World Catalogue)	Library staff may not be trained to provide health education/ advice, can only perform facilitative role in information-sourcing. Limited evidence on role(s) of public libraries in health education and promotion, esp. ones that present causal evidence. Public libraries may be perceived as providing little privacy, and discourage seeking of information/assistance.	Social and public infrastructures are important sources of information (health and other) for communities. Information may be delivered via active (e.g. facilitated by staff), passive (e.g. printed pamphlets) means or combination. Partnerships with relevant organisations may facilitate more targeted delivery (e.g. information to specific physical/ environmental setting.	Public libraries increasingly incorporate functions other than knowledge/ information discovery, e.g. host public service activities (e.g. health and wellbeing classes) in response to changing community needs. Alternative community settings (e.g. sports clubs) should also be considered for targeted health education and promotion delivery (e.g. skin cancer prevention at outdoor sports clubs).
Lloyd_2019	To improve access to comprehensive primary health care services. To increase healthy literacy at individual and community levels To work with stakeholders in addressing local	Engage and involve targeted community groups to identify, plan and design health interventions. Build local capacity by promoting leadership and skills. Fund bilingual workers to enhance	Change/improvements to inequities and capacity building not usually immediate/ directly causal, and often not quantifiable.	Increased partner organisational capacity via training, information and resource support to service providers. Administrative and research support to stakeholders to further health equity agenda and organisational capacities, including via joint projects.	Bottom-up approach to identify and respond to local/social determinants of health. Advantages/benefits of improving comprehensive system capital (e.g. via capacity building, partnerships and collaborations) to multiply effects.

FirstAuthor_Yr	ProgObjectives	Processes	Barriers	Outcomes	Lessons
	social determinants of health. Focus on priority areas (child, family and women's health, mental health, capacity and workforce building, chronic disease prevention and management) and groups (Arabic, Bangladeshi, Chinese, refugees and asylum seekers).	planning and implementation. Close and sustained engagement with community leaders and community groups.			Strong governance and commitment to project monitoring, evaluation and improvements.
Longman_2013	To uncover link(s) between social isolation in rural NSW and avoidable hospitalisation for older patients with ambulatory care-sensitive conditions.	Community-based health and community service providers reflecting on factors impacting frequent/ avoidable hospital admissions, and intervention/support services introduced.	Some previously existing services that can reduce social isolation have been reduced or cut (e.g. change in funding). This reduces opportunities for identifying concerns, or for referrals. Geographic distance of rural-dwelling older patients also contributes to social isolation.	Social isolation contributes to avoidable hospitalisation in several ways: lack of monitoring of conditions, lack of self-care, seeking social connections, and being in a safe (physically, psychologically, emotionally) environment. Social isolation can lead to sedentary lifestyle that can worsen pre-existing	Living alone and being geographically/socially distanced from family and friends contributed greatly to anxiety, self-care, and the detection and monitoring of ill-health. Social isolation reflects continued structural and societal changes, resulting in family dispersion, geographic dislocation, and reduced opportunities for family contact.

FirstAuthor_Yr	ProgObjectives	Processes	Barriers	Outcomes	Lessons
				conditions and/or further deteriorate physical and mental health.	
MHC NSW_2020	To consolidate and promote best practices in social and emotional wellbeing by Aboriginal Service Providers across NSW, focussing on storytelling, empowerment, and choice.	Consult with a selection of Aboriginal Service Providers to distil best practices in social and emotional wellbeing models of care. Emphasis on collaborations to extend limited resources and efficiency.	Not stated.	Not stated.	Ensure community engagement and cultural safety through 'soft-entry' approaches (informal, friendly, familiar environments). Employ longer-term, holistic view on engagement, in contrast to the conventional crisis management model.
Ndwiga_2021	To develop a culturally tailored and church-based lifestyle intervention for preventing diabetes.	Establish a community reference group to guide research project, comprised of community leaders and other community members across age groups and sociocultural statuses. Co-develop a culturally tailored pilot program through community consultation with	Participation was self-recruited; difficult-to-engage individuals remain largely excluded. Difficult to track causal outcomes from a community message program, relying on participant recall.	Community consultations and genuine engagements enabled the establishment of trust and respect, likely leading to sustained partnership and program uptake. Involvement of community leaders in delivering the co-designed messages further enhanced trust and uptake. Program delivery via peers has further	Significant input from community reference group in co-developing healthy lifestyle and diabetes management messages to ensure cultural appropriateness and receptiveness. Significant community input in identifying community leaders and appropriate pilot testing sites.

FirstAuthor_Yr	ProgObjectives	Processes	Barriers	Outcomes	Lessons
		Samoans with experiences of type 2 diabetes. Identify community leaders (e.g. church pastors) for delivering co-developed healthy lifestyle and diabetes management messages.		benefits of capacity building and sustainability. Pilot study already showing benefits of lifestyle intervention.	Research team served facilitation role to address bottom-up community health concerns. Also enhanced sense of community ownership.
Peiris_2019	To evaluate the *1 Deadly Step* program that aim to promote prevention, early detection and evidence-based management of chronic diseases among Aboriginal people in culturally safe, innovative and community-based ways.	Develop a client-facing screening app. Develop web-based administration and service provider portals for data collection. Develop web-based reporting tool for data aggregation. Design program logic to evaluate the *1 Deadly Step* program.	Timeliness of prototype app meant not all participants received their health reports before concluding their visits. Also associated with technical errors with connecting to printing. The nominated follow-up process was resource intensive and inflexible. Clients not part of the same ACCHS needed additional assistance to nominate their preferred primary health care provider. Technical limitation of the apps and web-	Majority of clients reported screening app easy to use. Interviewees reflected on ease of use of the administration and service provider web-based portals, though integration to routine service provision was noted as lacking (e.g. use by staff was inconsistent).	App requires further updating to improve user-friendliness, to account for testing time (and possible need for reruns), and that not all screening tests are mandatory. Implementation of the *1 Deadly Step* program relied heavily on in-kind support of staff and local organisations, which can impact longer term sustainability. Program was implemented across several sites, which allows for cross-site comparisons and

FirstAuthor_Yr	ProgObjectives	Processes	Barriers	Outcomes	Lessons
			based portals and alignment with existing hospital and other medical record systems, e.g. unable to download and import reports from apps to existing systems.		learnings, but not usually exercised in practice.
Ramsden_2021	To design placed-based approach to co-designing health services with community to improve access to quality and sustainable health services. To apply and test co-developed collaborative care framework. To investigate factors in attracting and retaining primary health workers in rural areas.	Working group of subject experts, community and workforce representatives, co-developed a collaborative care framework based on community development principles. Obtain Medicare Benefits Scheme status to improve access by lower socioeconomic individuals.	Change (in governance, implementation, operation, and evaluation) takes time to be embedded and for outcomes to emerge. More government support needed in funding services and recruiting and sustaining employment packages.	Too early (second year of implementation at time of writing) for outcomes on workforce sustainability to be realised.	Community engagement crucial in identifying and addressing local health service gaps. Leadership and commitment at state agency level necessary for sustaining local service presence. Benefit of dedicated project manager to facilitate government and industry/ stakeholder groups liaison. Having staff that can work across general and specialist care services (including via telehealth) to reduce administrative and other duplications.

FirstAuthor_Yr	ProgObjectives	Processes	Barriers	Outcomes	Lessons
					Identify key resources for investment, including integration of public and private primary care services.
Singer_2015	To apply ten principles (identified via literature review) to transform a top-down e-mental health strategy into a bottom-up approach.	Apply a community-based participatory research protocol for genuinely engaging with Aboriginal and Torres Strait Islander Peoples. Ensure widespread community involvement across all stages of the project via advisory groups, learning circles, and community forums.	Not stated	The design and implementation of the first Indigenous online therapy program. The introduction of culturally appropriate training for e-technology application. The introduction of post-training supervision.	Establishing and maintaining rapport through on-going conversations over time. Sufficient budget to support capacity building. Develop and support community ownership.
Stuhlmiller_2015	To improve access to integrated and primary health care (including via e-health) of disadvantaged Australians living in rural NSW. To increase health literacy. To optimise and promote self-health.	Establish student-led clinic in underserved rural NSW as part of nursing clinical training program, via the New England 4G Framework of Guided Self-Health. Increase health literacy, equity and access to services via community	Long lead-in required for appropriate and effective engagement, and to understand place- and community-specific health-related issues.	Clinic grew substantially over the course of its first year, expanding days of operation, number of care receivers and health promotion activity participants. Service expanded to align with strong Aboriginal presence in the community and to further build local	Increased self-health and access to lower cost primary care services improved community's willingness to access appropriate care early, circumventing need for more substantial and costly treatment later on. This presents significant cost savings to governments by

FirstAuthor_Yr	ProgObjectives	Processes	Barriers	Outcomes	Lessons
	To increase medical/ clinical student learning and capacity building in under-served areas.	driven, student-led, person-centred approach, including engaging and training community members student clinicians.		capacity through an Aboriginal nurse practitioner. Updating of self-health promotion literature for local context.	diverting presentations to already stressed local emergency departments. Engagement of community members as care providers enabled broader collaborations and community acceptance, as well as capacity building.
Taing_2017	To provide lifestyle modification intervention for increasing exercises, dietary fibre and fat consumption, and reduce body weight. To specifically target intervention at Mandarin-speaking Chinese (50-65) with Australian Diabetes Risk score ≥15.	Engagement of bilingual lifestyle officers to develop and deliver culturally appropriate program and resources for lifestyle modification interventions. Engage with Mandarin-speaking GPs for periodic monitoring over 12 months.	Less than half (47%) completed full program. Limited recruitment success, leading to smaller than anticipated sampling.	Significant improvements in waist circumference reduction, lowering total cholesterol and increased physical activities; low to no improvements in other anthropometric and metabolic outcomes. Notable differences (less favourable) in outcomes between Mandarin-speaking and English-speaking cohorts.	More intensive resourcing (esp. face-to-face) may be required for CALD groups, designed with community input.
Tweed Shire Council_2021	To activate public streetscapes in the Murwillumbah CBD through the	NSW Government funding enabled engagement of local businesses to design and	Other activation programs cancelled due to COVID-19 physical distancing	Notable increases in pedestrians who lingered/dwelled at activated zones than just passing through	Difficulty in balancing installing new parklets/ street furniture to promote physical/ social

FirstAuthor_Yr	ProgObjectives	Processes	Barriers	Outcomes	Lessons
	installation of two temporary parklets. To encourage take-up of active transport by removing car spaces and installing street furniture.	construct the parklets and street furniture. Engagement of local businesses to use parklets and maintain planter boxes.	rules in place at the time. Dependent on pilot funding, leading to short turnaround and short intervention timeframe. Reliance on community and local business to upkeep/maintain some elements (e.g. planter boxes).	Very high community and local business support for interventions to be made permanent. Notable increases in sense of safety. Improved opportunities for social interactions, celebration of cultural diversity.	interactions with the removal of parking spaces., especially in absence of alternative (parking spots, public transport options).
Vita_2016	To measure the impacts of lifestyle modifications (nutrition, physical activities) on peopled aged 50-64 at high risk of developing type 2 diabetes, to inform policy and practice. To increase moderate to vigorous physical activities, reduce total daily fat and saturated fat intake increase daily fibre intake, reduce body weight.	Cohort screened and recruited via primary health care settings, with intervention program delivered by trained Lifestyle Officers with backgrounds in nursing, dietary science, exercise physiology, and psychology via a health coaching (individual and group) approach over 12 months.	Difficulties in keeping participants engaged throughout study/ follow-up period. Australia's primary care system has limited capacity to identify and refer suitable participants; system under stress. Participant-skew: women, non-smoker and better educated individuals more likely to participate.	Notable achievements in reducing risk markers rather than reducing diabetes incidences. Intervention had higher effects on dietary changes than on physical activities, which may be linked to the absence of supervised exercise classes. Changes in lifestyle relied primarily on self-reporting. Program was delivered in English only and lacked diverse participation	Need for more targeted recruitment to engage and involve less often engaged groups, e.g. men, lower socioeconomic groups, those who visit primary health care less frequently. Longer follow-up to ascertain sustained impacts.

FirstAuthor_Yr	ProgObjectives	Processes	Barriers	Outcomes	Lessons
Welsby_2014	To promote healthy eating, physical activity and healthy weight for children 0-18 years.	Deliver programmatic activities that target childhood obesity through partnerships at Local Health District level. Primarily targeted children/families from low SES backgrounds. Provides face-to-face training to local program facilitators. Involves range of health professionals (vary/adjust based on local needs).	The bi-weekly commitment over 20 weeks was noted as a barrier to continued participation/initial sign-up. Particular cultural groups less likely to complete programs; need more culturally sensitive engagement and implementation partnerships. Timeframe too short to evaluate real health outcomes.	Program largely achieved intended outcome of reaching disadvantaged/ disengaged communities.	Advertise free programs (incl. promotional items) broadly and facilitate toll-free contacts to encourage participation. Promoting consistency in location to facilitate longer-term bedding in. Utilise local networks and engage local communities to ensure buy-in and participation.

Conclusions and recommendations

This project combined a rapid review of 20 academic papers and grey literature on place-based, health-focussed intervention programs in the Australian state of NSW, with insights from four stakeholders with recent professional experiences in such place-based interventions. It aimed to provide the Cancer Institute NSW information on how place-based interventions were formed, with what intentions and anticipated outcomes, as well as to reveal barriers that restricted and/or prevented the better achievements of outcomes. The information will assist the Cancer Institute NSW improve its design and implementation of future place-based intervention programs on cancer prevention and screening.

This review revealed that, while place-based, health-focused interventions in NSW comprised many different forms and have varied aims and objectives—ranging from improving access to health services, to increasing community engagement, and enhancing health literacy—common approaches and challenges were also experienced and encountered. In this final chapter, we review these common approaches and challenges, to suggest potential pathways for improving the design and implementation of future place-based health interventions in NSW.

Ensuring appropriate resourcing and implementation timeframe

One of the most commonly encountered challenges reported in the papers reviewed and reflected by stakeholders interviewed have been the limited resources made available to the intervention programs. This was especially the case regarding the amount of funding available. Several papers and stakeholders discussed the significant amount of in-kind support that is often required from project partners—usually various government agencies but sometimes also the private and non-profit sectors as well as community members themselves—in order for the intervention to be fully realised as designed.

Limited resourcing restricted intervention programs in several ways: it often confined the scope of the interventions, both in terms of their reach (who can benefit; the narrow breadth of health benefits) and the timeframe during which the interventions may be in place (for how long people may benefit). With the generally lower socioeconomic statuses of the communities that these interventions were often targeted at, limited resourcing (especially when it concerns (co)payments from program participants) may limit community members' willingness to participate, therefore the interventions' reach and ultimately sustainability in the longer term.

Further, both reviewed papers and stakeholders interviewed discussed that funding for interventions was often in the form of pilot programs, with the typical timeframe being 12 months on average. This is a very short amount of time for engaging with the community to identify (and likely also to prioritise) local challenges, devise appropriate place-based responses, implement the interventions, and assess outcomes. This was especially when changes to health outcomes may take time to emerge. This is particularly reflected in the general lack of outcomes assessments reported in the reviewed papers, as the conducting of assessments was usually not plausible within the short timeframe.

Recommendation: Collaborating with other agencies to ensure sufficient resourcing and to realise co-benefits

One potential means to overcoming this may be for several government agencies to collaborate on co-funding programs that can sustain interventions at a reasonable scope and timeframe. Such collaborations may be possible to realise several health co-benefits concurrently. For example, changes in lifestyles may not only assist in cancer prevention but also lower the risks of other diseases such as diabetes and mental illnesses. Some of these co-benefits were already mentioned in several papers reviewed and, therefore, can and should be more formally accounted for and taken to scale. Co-benefits may also be more than health-focussed: Tweed Shire Council_2021 noted that activating town centres by removing parking and installing parklets not only nominally increased the physical activities of community members, it also had flow-on economic benefits to local businesses with increased patronages.

Collaborations may also involve funding from industry partners and local service providers. Both Stuhlmiller_2015 and Vita_2016 spoke of the benefit of training up and employing local community members in intervention implementation and service delivery. Not only can local capacity be built up, the economic benefits are also retained within the community, which helps the longer-term sustainability of the interventions. It may also take lessons from studies from other disciplines (e.g. Liu et al. 2017), where suggestions of a business case as part of the deliverables of pilot programs may be taken on board, so that successful elements may be taken forward to deliver the intended outcomes in longer terms and/or broader scales. To this end, additional support may be needed to connect intervention teams with those with the relevant skills and expertise to draw up feasible business cases.

Enhancing and expanding partnerships with proven success

While little information on how delivery partnerships were formed could be obtained from the reviewed papers, the stakeholders interviewed provided some insights. Notably, they highlighted the current partnership approaches to intervention implementations more likely extended and expanded existing collaborations across government agencies, industry and the non-profit sector, rather than establish new ones. Partly this reflects the challenge of time limitation already discussed, that applications to funding opportunities may have relatively short turnaround, and there may be little time and resources available for new partnerships to form. Stakeholders did, however, note the benefit of working within existing networks, in knowing how (or how not) to work with partners, and in recognising their respective expertise, strengths and limitations. These can ensure that the co-designed interventions can be delivered successfully and as intended.

A danger, however, may be that it restricts innovations in program (co)design, in employing different approaches to addressing the same or similar social determinants of health, and the potential to achieving outcomes differently, or maybe even in achieving broader, more in-depth outcomes.

Recommendation: Flexibility in funding arrangements to enhance collaborations and innovations

One potential means to overcoming this may be to ensure that there is sufficient lead-in time to funding applications. In addition to extending the application timeframe, this may involve

having a set schedule (e.g. annual, bi-annual) so discussions about new collaborations may be held in anticipation.

Funding arrangements may also be relaxed, so there is flexibility in including new partners and/or in establishing new partnerships as the interventions progress. It may also allow unanticipated issues—and new approaches to addressing them—to be identified so intended outcomes may be more fully realised. Many of the reviewed papers, for example, discussed encountering unanticipated challenges, notably in recruiting harder-to-engage individuals because of cultural practices, distrust of outsiders and/or authorities, or alternative approaches to seeking advice and services. While top-down guidance on the achievement of outcomes is necessary, there must also be flexibility to allow for the design of place-based approaches to achieving such outcomes to ensure uptake and sustainability, and their suitability for the communities of interest. Again, borrowing from outside of health, a previous housing renewal program (Liu et al. 2012) highlighted how outcomes (e.g. improved educational outcomes, increased local work opportunities, improved individual and community health) may be set broadly within the remit of the funding program. While a partnership approach was suggested as an implementation mechanism, the details of ‘who with’ and ‘in what ways’ were left to each of the local coordination teams to design and implement. Importantly, such flexibility extended to how the overall pool of funding could be spent so long as the new local partnerships formed corresponded with the broader level outcomes.

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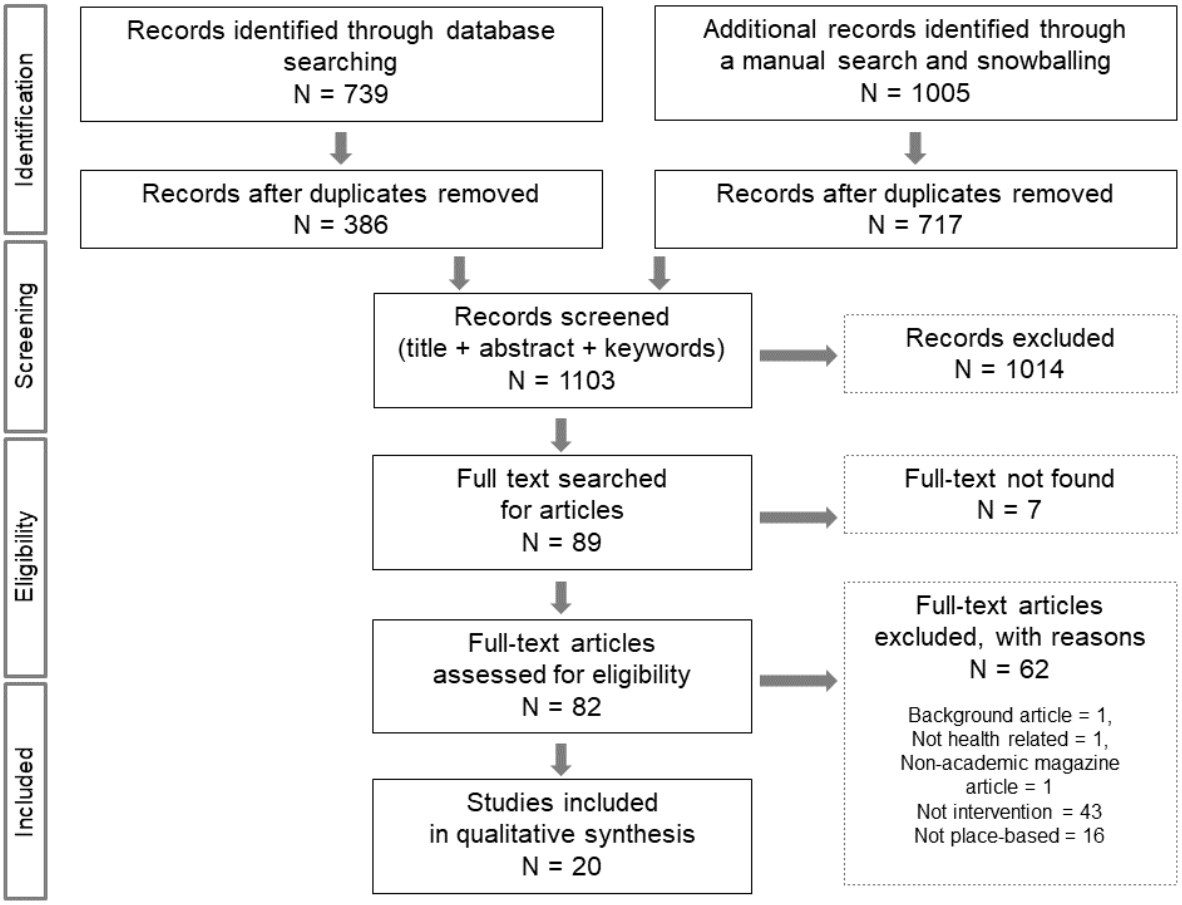
Appendices

Figure A1: PRISMA diagram of literature searches and selection



Appendix 1: Interview schedule with stakeholders

1. Please provide a brief overview of your role in relation to place-based intervention programs. [*Prompt experience in field*]
2. Can you please describe the objectives of [intervention program]? (Prompt health related aspects of the intervention?)
3. What prompted the introduction of that program?
4. What was the process in designing that program?
    a. Did you seek guidance or information? Where/who from?
    b. Does it follow an existing model?
        i. How did you/your team/organisation decide on this model over others?
        ii. What aspects of that model did you need to adjust to suit the local settings?
5. Did you encounter any barriers or challenges in the (i) design, (ii) planning, (iii) implementation, and/or (iv) monitoring of the program?
    a. How did you go about addressing these? Were all of them able to be resolved? What challenges remained unresolved? Why?
6. What are the outcomes that the program was looking to achieve?
    a. Were these achieved to plan/schedule?
    b. What could not be achieved?
    c. Were there any (additional) outcomes that you did not anticipate? What were they?
7. What have been the main lessons learnt from this program?
    a. What would you have done differently? Why?