Assessing the Utility of HIA for Service Integration:

Health Impact Assessment of the Goodna Service Integration Project

~ a case study ~
Foreword

Health impact assessment (HIA) is a relatively young methodology and is evolving rapidly, but already its benefits are being recognised. In essence, it offers a path to understanding the potential health risks and benefits involved in any policy or program. It employs a rigorous methodology to achieve this, and is an approach that is sufficiently flexible to match both the resources and the responsibilities of decision-makers.

Recently, the Queensland Government has indicated its commitment to improving public health by the recognition of HIA within the *Smart State: Health 2020* directions paper. HIA can make a significant contribution to the achievement of health improvement, not least because of the values that underlie it. Similarly, establishment of the Community Engagement Division of the Department of the Premier and Cabinet demonstrates the need to address growing social, economic and environmental fragmentation by adopting a multisectoral approach. This approach has a strong emphasis on shared decision-making and engagement with community members.

This report sets out the results of the health impact assessment undertaken for a place-based model of service integration – the Goodna Service Integration Project being trialed in the Goodna community of South-East Queensland. Public Health Services undertook the study in collaboration with the Goodna Service Integration project team to investigate the impact of this model of service integration, and the usefulness of HIA methodology for Public Health Services.

Through the Environmental Health Unit, Public Health Services is continuing its developmental efforts in this field with the application of this methodology for state significant projects.

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Finally, special mention needs to be made of the assistance provided by Dr Geoff Woolcock of the University of Queensland (Ipswich Campus) for his support in this study. His participation on the steering group, sharing of information concerning the Goodna Service Integration Project and ongoing advice and guidance has been invaluable.

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Background

This report sets out the results of the health impact assessment for a place-based model of service integration – the Goodna Service Integration Project (SIP) being trialed in the Goodna community of South East Queensland. The West Moreton Public Health Unit, Queensland Health undertook the study in collaboration with the Goodna Service Integration Project Team to investigate the impact of this model of service integration on health inequalities in the community; and the usefulness of the adopted assessment methodology for Public Health Services.

International studies indicate that health impact assessment is a possible tool for addressing inequalities in health. Health Impact Assessment (HIA) has been defined as “…a combination of procedures or methods by which a policy, program or project may be judged as to the effects it may have on the health of a population”. However, there is a dearth of information concerning its validity in assessing the impact of human service integration on health differentials. In addition, a multi-departmental approach to improving health is reflected in the Smart State: Health 2020 Directions Statement – Queensland Health’s strategic vision for health in this state. Health impact assessment is identified in this document as an appropriate strategy to achieve this goal.

The HIA considered health impacts over the concluding phase of the SIP through 2002 into 2003 prior to its key learnings being transitioned to the West Moreton Regional Managers of Government Forum. By which stage the project had been operating for about two years. The assessment found that the project has the potential to promote and enhance the health and well-being of the Goodna-Gailes community. Further, the study showed that HIA has potential to be a valid methodology for assessing service integration initiatives within a community context.

Aims

The aims of the health impact assessment were to:

- assess the processes and impacts of a model of service integration on health determinants and health outcomes of the community targeted by the project
- identify and highlight the actual and potential impacts on health and health determinants to the steering group and stakeholders including decision and policy makers, service providers, and representatives of affected communities
- provide recommendations based on positive and negative health impacts that have arisen or may arise so that potential and actual negative effects can be avoided or reduced and the positive effects encouraged and enhanced
Executive Summary

- influence the service integration project processes so that it is responsive to health impact considerations.

**Method**

The assessment attempted to follow the methodological approach of the Merseyside Health Impact Assessment (HIA) model. This model allows the assessor to distinguish between procedures and methods for assessment with procedures providing the context for commissioning and implementing the HIA while the methods component being the actual process for carrying out the assessment. A steering group was central to the study’s development and implementation.

The steering group identified key informants for interviews and focus groups. During the process of conducting the interviews and focus groups other informants were suggested who could contribute to the assessment process.

Six in-depth interviews were held with community representatives, service provider organisations and project proponents. In addition, four focus groups were conducted with service consumer groups and a service provider group for a total of 21 participants.

It was agreed that health outcomes in terms of health impacts from the project should be based on the model of health determinants identified within the Merseyside model and assessed according to whether positive or negative impacts, their potential impact being definite, probable or speculative and whether in the short, medium and long terms.

The main points and themes from discussions were extracted for inclusion into the main elements characterising a place approach to service integration. These elements being:

- community participation and equity
- responsibility and accountability
- coordination and integration of service delivery
- flexible governance/partnerships.

**Key findings and main recommendations**

The findings were recorded in terms of positive and negative impacts of human service delivery on the target community. The recommendations came from the assessor and steering group giving due consideration to the health impacts that were identified by interviewees, key informants and focus groups and from literature on health and HIAs. Five sets of recommendations came out of the assessment and were grouped according to main health determinants. They are presented in Section 7 of the report. Unexpected findings were identified and discussed in relation to the HIA and to service integration. The main groupings of recommendation sets are based on health impacts relating to:
• personal/family circumstances
• social environment
• physical environment
• public services
• public policy

The assessment found that there are undoubtedly positive health benefits to be gained from the Goodna model of integration of human services. Benefits include:

• enhanced social supports
• promotion of community cohesion and reduction of social isolation for at-risk populations
• improved relationships between services and services and consumers
• partnership training programs to address issues of low education and unemployment with expected long-term outcomes
• increased effectiveness of programs as a consequence of extensive community consultation.

The assessment also suggests that broad negative health impacts will arise or continue. Although it is difficult to directly relate these points to the SIP, nonetheless they reflect aspects of the current human service delivery environment of the Goodna community.

It became clear that the findings indicated the importance of communication and relationship building as being necessary in providing services that are relevant and appropriate to local communities. It also became clear in developing the recommendations that there was a need to promote a health agenda in the community that was based around addressing the underlying causes of health inequalities. As part of this process it will be important for the project to promote economic development, and encourage social and community inclusion. Promotion of learning opportunities will also make a significant contribution to people’s self-belief and esteem and promotion of community cohesion.

During the course of the assessment it was noted that local people and service providers were extensively engaged in contributing to the SIP’s development. Through this focused, participatory approach adopted by the project’s proponents and enthusiastically endorsed by its project team, the community has developed a strong sense of ownership, which can only foster improved health and well being of its members.

**HIA and service integration**

As service integration does not focus explicitly on health as an outcome, extrapolation of service integration effects need to be considered for their impact on health determinants. In Section 2.4 a number of dimensions are identified as characterising a place approach to service integration and so it is
useful to locate the findings of the study within this framework and their implications for health inequalities:

**Community participation and equity:**

- the important role for representativeness of different communities and cultures in service planning
- each community will have unique needs determined by its population mix, history, and local issues
- service integration does not specifically address the underlying causes of health inequalities
- the impact of service access and delivery on quality of life
- identifying who misses out eg people not accessing services due to perceived barriers
- the need to communicate effectively with the community concerning services and how to access them
- the importance of relationship building for effective service delivery
- the need to match consumers needs with services provided.

**Responsibility and accountability:**

- the need for partner organisations to develop protocols for shared and agreed decision-making for priorities
- the importance of establishing an appropriate and inclusive transition phase from project to program and the roles of local community and other stakeholders in this
- key role of establishing protocols for prioritisation of needs and interactions between disparate services eg regarding intake and referral processes
- the central role played by project staff in driving the process.

**Coordination and integration of service delivery:**

- the importance of adequately identifying needs of consumer groups
- issues around service delivery and responsiveness
- the importance of good communication and relationships within and between services and the community.

**Flexible governance/partnerships:**

- unexpected key role of community members
- a range of issues around service delivery flexibility and cultural sensitivity
- the important role of relationships in establishing effective partnerships
- the need to address local community needs through the establishment of partnerships between a range of stakeholders.

The results of the study suggest that application of HIA methodologies to service integration initiatives can reflect good practice in addressing the social determinants of health and hence has relevance to Public Health Services. Some provisos are necessary such as the usage of quantifiable benchmarks.
and indicators around service access by at-risk populations during the course of the HIA. Long-term evaluation of projects using quantifiable indicators are necessary for enhancing the evaluation of service integration and assessment of the HIA methodologies and would further their applicability. HIA has the capacity to provide an added dimension to service integration through consideration of impacts on health determinants and subsequent health outcomes.
1 The Nature of Health Impact Assessment

1.1 Background to Health Impact Assessment (HIA)

The national and international literature has increasingly demonstrated awareness of the importance of public policy in addressing health inequalities\textsuperscript{1,2,3,4}. The World Health Organisation, for example, made making healthy public policy a cornerstone of its Ottawa Charter for Health Promotion\textsuperscript{5}. However, few reports made any attempt to evaluate the magnitude of the impact of public policies on health. More recently, this need has been articulated. In fact, a primary recommendation of the Acheson report\textsuperscript{6} (p30) was that:

“…as part of health impact assessment, all policies likely to have a direct or indirect effect on health should be evaluated in terms of their impact on health inequalities, and should be formulated in such a way that by favouring the less well off they will, wherever possible, reduce inequalities.”

The increasing awareness of the need to assess the impact of public policies and programs on public health has resulted in a need for evidence-based principles.

Health impact assessment (HIA) has been defined as “...a combination of procedures or methods by which a policy, program or project may by judged as to the effects it may have on the health of a population”\textsuperscript{7}. These policies and practices do not “…necessarily have health as its primary objective”\textsuperscript{8}.

In 1994 the need for HIA in Australia was strongly endorsed by the National Health and Medical Research Council (NHMRC) recommending its incorporation into environmental health frameworks\textsuperscript{9}. Up to the present time, Tasmania is the sole Australian State or Territory to have introduced

\textsuperscript{2} Canadian Public Health Association (1997) Health Impacts of Social and Economic Conditions: Implications for Public Policy. Ontario, Canada: Canadian Public Health Association, Board of Directors Discussion Paper. \\
\textsuperscript{3} National Health Strategy (1992) Enough to Make you Sick: How income and environment affect health. Canberra:NHS. \\
\textsuperscript{9} National Health and Medical Research Council (1994) National Framework for Environmental and Health Impact Assessment. Canberra: AGPS.}
legislation regarding formal HIA; in 1996 making it a requirement of environmental impact assessment processes\textsuperscript{10,11}.

As a concept HIA has a strong social justice basis emphasising the need to work towards sustainable development; be fair and equitable for all involved; encourage full participation of those people likely to be affected by the policy or practice; utilise both qualitative and quantitative evidence and to especially address the needs of disadvantaged and marginalised groups\textsuperscript{12,13}.

1.2 Terms and meanings used in HIA

**Community profile:** This is the process of establishing baseline information concerning the characteristics of the community in question.

**Community participation:** Means involving the community in an activity such as planning of projects or carrying out a HIA.

**Disadvantaged/vulnerable/marginalised groups:** These terms are applied to groups of people who, due to factors usually considered outside their control, do not have the same opportunities as other, more fortunate groups in society. For example, people who are unemployed, refugees and others who are socially excluded.

**Equity in health:** Inequity, as opposed to inequality, has a moral and ethical dimension, resulting from avoidable and unjust differentials in health status. Equity in health implies that ideally everyone should have a fair opportunity to attain their full health potential and, that no one should be disadvantaged from achieving this potential if it can be avoided. HIA is usually underpinned by an explicit value system and a focus on social justice in which equity plays a major role so that both health inequalities and inequities in health are explored and addressed wherever possible.

**Grey literature:** Generally unpublished documents for example, reports produced by agencies that have not been published in peer-review journals but none-the-less inform practice.

**Health:** A state of complete physical, mental and social well-being and not merely the absence of disease and infirmity.

**Health determinants:** This study included assessments and considered the impacts of the service integration project on the important determinants of health such as biological factors, personal/family circumstances and lifestyle, social environment, physical environment, public services, and public policy


\textsuperscript{11} National Public Health Partnership (2001b) *Health Impact Assessment Guidelines.* Canberra: Commonwealth Department of Health and Aged Care.

\textsuperscript{12} European Centre for Health Policy (1999) op cit

(see Table 1-1 below). The determinants model of health influences suggests that these determinants affect life expectancy, quality of life, and morbidity and mortality of communities within the reach of the project.14

**Health impact:** Is a change in health status (or in the determinants of health status) of an individual or group attributable to a project, program or policy within a boundary as agreed by a HIA project’s steering group. Studies have shown that developmental practices can cause health impacts by initiating significant changes in the health status of local communities.15,16 As a result a HIA study should include assessments of those factors that are known health status determinants.

**Health impact assessment:** A combination of procedures or methods by which a policy, program or project may be judged as to the effects it may have on the health of a population. That is, will (or does) a project affect quality of life issues beyond its intended meaning and as a result affect the health of that population.

**Health inequality and inequity:** Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups. Inequity, refers to the uneven distribution in health status that may be unnecessary and avoidable as well as unjust and unfair.

**Place management:** A target and time limited intervention to discrete local areas with chronic problems and/or high levels of disadvantage that are not amenable to action by individual agencies and require special funding and governance arrangements.17

**Qualitative and quantitative evidence:** Basically, quantitative evidence is based on what can be counted or measured objectively whilst qualitative evidence cannot be measured in the usual ways and may be more subjective, for example, encompassing people’s perceptions, opinions and views.

**Social determinants of health:** A somewhat loose term that generally refers to the social, cultural and economic factors in which people live, work and play that affect health.

**Stakeholders:** People concerned with, or affected by, the proposal or project.

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15 Mahoney, M. and Wright, J. (2002) op cit
Table 1-1: Determinants of health

<table>
<thead>
<tr>
<th>Categories of influences on health</th>
<th>Examples of specific influences</th>
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<tr>
<td>Biological factors</td>
<td>Age, sex, genetic factors</td>
</tr>
<tr>
<td>Personal/family circumstances and lifestyle</td>
<td>Family structure and functioning; primary, secondary, adult education; occupation; unemployment; income; risk taking behaviour; diet; smoking; alcohol; substance misuse; exercise; recreation; means of transport (cycle, car ownership). Mental health factors</td>
</tr>
<tr>
<td>Social environment</td>
<td>Culture; peer pressures; discrimination; social support (e.g. neighbourliness, social networks, isolation); social capital; community, cultural, spiritual participation</td>
</tr>
<tr>
<td>Physical environment</td>
<td>Housing conditions; working conditions; public safety; civic design; shops (location, range, quality); transport systems (road, rail); air; water; noise; smell; view; land use; developments; waste disposal; energy; local environmental features</td>
</tr>
<tr>
<td>Public services</td>
<td>Access to (e.g. location, disabled access, costs) and quality of primary, community, secondary health care, child care, social services, housing, leisure employment and social security services; public transport, policing, other health-relevant public services, non-statutory agencies and services</td>
</tr>
<tr>
<td>Public policy</td>
<td>Economic, social, environmental, health trends; local and national priorities, policies, programs, projects</td>
</tr>
</tbody>
</table>


1.3 Aims of the HIA

The HIA was conducted with regard to the model of service integration being trialed within the Goodna-Gailes region of South-East Queensland. It sought to assess the effects of the project on aspects of service delivery and on major influences (or determinants) of health of the population within the area. Following the approach of the Merseyside Guidelines for Health Impact Assessment\(^\text{18}\) the study based its approach upon the accepted understanding that a community’s health is not only determined by its health services, but also by a wide range of economic, social, psychological and environmental influences.

The main aims of the HIA were to:

- assess the processes and impacts of a model of service integration on health determinants and health outcomes of the community affected by the project
- identify and highlight the actual and potential impacts on health and health determinants to the steering group and stakeholders including decision and policy makers, service providers, and representatives of affected communities
- provide recommendations based on positive and negative health impacts that have arisen or may arise so that potential and actual negative effects can be avoided or reduced and the positive effects encouraged and enhanced
- influence the service integration project processes so that it is responsive to health impact considerations.

1.4 Benefits of the HIA to stakeholders

Benefits of the HIA will be accrued to the community and service provider organisations through different means.

1.4.1 Benefits to community stakeholders:

- enhanced partnerships through the encouragement of full participation of those likely to be affected by the project
- extension of the democratic process through greater involvement in decision making
- through identification of where partner organisations in the project can support local based initiatives health of the community can be enhanced
- identification of specific factors affected by the project will serve as a central focus for health in the ensuing community strategies
- ensuring social justice by targeting the needs of disadvantaged and marginalised groups
- highlighting health issues that are of concern to stakeholders so that the steering group can make appropriate recommendations for the ongoing sustainability of the project
- ensure community considerations are continuously taken into account through positively influencing the project processes
- support the local human service organisations (both government and non-government) to maintain and promote the well-being of the Goodna-Gailes community.

1.4.2 Benefits to service provider organisations:

- developing the local capacity to carry out future HIAs on programs and practices
- contribute to the evaluation of this model of service integration in the delivery of human services
• add to the knowledge base regarding HIAs for service integration endeavours
• preparation of practical recommendations which will encourage good practices in the delivery of human services
• inform decision-making and enhance quality within the management of operations
• increase organisations abilities to demonstrate a wider concern for the well-being of the community
• demonstrate wider economic and social benefits that will arise from the added value of service provision.

1.5 Why HIA and service integration?

Most HIAs have been based on land use projects and their impacts on social conditions. Little research has been conducted on the issues confronting HIA and service provision, especially a multiplicity of community-based services coming together for purposes of service efficiencies and more equitable service outcomes.

In 2001 Public Health Services (PHS), Queensland Health produced a report on the social determinants of health\(^\text{19}\) and the resultant health inequalities that occur as a consequence of inequitable life circumstances. As a strategy to address these inequalities the report identified HIA as an appropriate methodology applied at both the structural dimension and within the community context for identification of policies and practices that impact directly and/or indirectly on health and health differentials of populations. Further recognition and impetus for HIA was given in the pivotal Queensland Health document: *Smart State: Health 2020*\(^\text{20}\). Furthermore, integration of services has been recognised as an approach to furthering the goals of *Health 2020* through the *Integrated Strategy and Performance* (ISAP) framework currently being developed by Queensland Health\(^\text{21}\).

The aims of this study were to develop an understanding of HIA as a tool for policy development as applied to service integration in the Australian context. Through examination of the impact of a model of service integration being piloted in South East Queensland the study sought to answer questions relevant to the application of HIA to this model of service delivery for the purposes of future public health practices in addressing the social determinants of health. It attempts to identify the strengths and weaknesses, obstacles and limitations, opportunities, and lessons learnt from the

\(^{19}\) Queensland Health (2001a) *Social Determinants of Health – The Role of Public Health Services*. Brisbane: Public Health Services, Queensland Health.

\(^{20}\) Queensland Health (2002a) *Smart State: Health 2020: Directions statement*. Queensland Health, pp 44.

application of HIA to this model of human service delivery and from the findings to inform its utilisation as a best practice strategy for PHS.
2 The Goodna Service Integration Project

2.1 Background to the study

As previously mentioned HIA was originally identified by PHS as an appropriate methodology for addressing the social determinants of health. In fact it was a primary recommendation of an internal scoping paper that identified a range of activities that PHS could be engaged in to address the broader social environment and their impacts on health inequalities.

Little information was available in the international and national literature on the application of HIA methodologies to a multi-departmental approach to service delivery. PHS wished to trial this methodology within this context and in particular to gain some insight to its utility as a tool for assessing service integration initiatives.

During that time, in the West Moreton District a pilot project was being implemented of a model of service delivery focussing on integration of services within a place management framework. Approaches were made to the Goodna Service Integration Project (SIP) via its Measuring and Modelling Team for permission to apply HIA methods to their project. Approval was subsequently given. The HIA was seen by the SIP team to add value to the project’s development and sustainability and to its evaluation.

Consequently, this report needs to be considered in two dimensions: that of a health impact assessment of a model of human service integration. And, in addition, assessment of the applicability of HIA as a tool for public health practitioners in assessing service integration in general and as such represents good practice (see Appendix 6: Evaluation).

2.2 Background to the Goodna Service Integration Project

The Goodna SIP is a whole of government project “established to facilitate better integration of human services and the creation of a best practice, collaborative leadership model” in Goodna, South-East Queensland. Through identification of community aspirations and informed by national and international literature, the project aimed to contribute to enhanced community wellbeing through improved service delivery.

Membership of the overarching project team comprised representatives of local government, Commonwealth and State Government departments, and centres of learning (see Appendix 1 for a full list of SIP members). Formal endorsement and funding for the project was received in 2000. The project received the following funding (see Table 2-1 below).

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Table 2-1: Financial investment in the Goodna Service Integration Project

<table>
<thead>
<tr>
<th>Funding ($)</th>
<th>Source</th>
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<tbody>
<tr>
<td>240,000</td>
<td>Department of Families, Youth and Community Care (3yrs)</td>
</tr>
<tr>
<td>176,000</td>
<td>Department of Housing – Community Renewal (2yrs)</td>
</tr>
<tr>
<td>40,000</td>
<td>Ipswich City Council</td>
</tr>
<tr>
<td>60,000</td>
<td>University of Queensland (Ipswich)</td>
</tr>
<tr>
<td>32,000</td>
<td>Department of Employment and Training (2 yrs)</td>
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Three inter-related streams of work progressed the project:

- development of processes for measuring and modelling the wellbeing of community
- relationship building between stakeholders
- targeted theoretical and experiential learning activities about what does and doesn’t work regarding integrating services.

The aim of achieving a sustainable system of human service integration was guided by a set of principles or ideas.

2.3 Guiding principles

(See Appendix 2 for expansion of these principles)

Guiding Principle No.1 – community development through partnerships
Guiding Principle No.2 – collaborative leadership
Guiding Principle No.3 – development and delivery of human services
Guiding Principle No.4 – leadership, support and development
Guiding Principle No.5 – report and recommendations\(^\text{23}\)

2.4 Integration of services and community

Anyone who has worked as a frontline worker within human service delivery agencies or organisations would appreciate their highly specialised nature as they respond to the complex and multifaceted needs of the community and its members. The SIP, with its focus on interagency collaboration for purposes of providing improved service delivery has been confronted with many barriers including a range of professional perspectives, agency priorities, administrative arrangements, communication systems, service limitations and eligibility criteria, and funding considerations\(^\text{24,25,26,27,28}\).

\(^\text{23}\) SIP (2001) op cit.
In attempting to overcome these barriers for the provision of responsive and efficient service delivery a number of key elements have been identified in the literature as characterising a place approach to service integration including: 29,30

- community participation and equity
- responsibility and accountability
- coordination and integration of service delivery
- flexible governance/partnerships.

2.4.1 Community participation and equity

Equity is a fundamental objective. For service delivery to be responsive to community needs and to be equitable, appropriate and accessible, and for ensuring disadvantaged groups are involved in planning, implementation and evaluation of services community participation is essential. 31,32,33,34,35,36 Recognition is given to the fact that not all people and places are equal in terms of opportunities and outcomes.

Equity is also about how communities are targeted for service integration initiatives. How and by whom are some communities chosen over others and what indicators (both qualitative and quantitative) are employed? Also relevant are concerns whether targeting has been based on social need or economic opportunity.

2.4.2 Responsibility and accountability

To achieve improved service delivery a key element is allocation of responsibility and accountability to a designated institutional point – the place manager37,38,39. This presents a significant challenge to

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30 Walsh, P. (2001) op cit
government and non-government partnerships around determination of priorities and administrative procedures. Similarly, the appointment of a place manager is a potential cause of tension between partners if there is a perception of bias and/or lack of transparency in project management practice.

2.4.3 Coordination and integration of service delivery

Disadvantaged communities experience a complex array of interrelated problems (such as crime, health inequalities, and unemployment) and the development of clear, achievable and integrated area based strategies are seen as possible solutions\textsuperscript{40,41}. However, in order for this to occur it requires the diversity of government and non-government service providers which exhibit dissimilar philosophical and professional practices to develop shared goals, values and open communication. Furthermore, a clear understanding of the community’s history, structure and social relations is needed to more clearly identify any divisions between services, and for the development of more coordinated service delivery\textsuperscript{42,43,44}.

2.4.4 Flexible governance and partnerships

A reorientation of previously fragmented services into a collaborative governance structure is necessary for effective integration of services.\textsuperscript{45} A central issue for integrating diverse community services concerns power, control and authority\textsuperscript{46}. Service integration initiatives contend with historical patterns of contest, power and domination in an environment of struggle over scarce resources\textsuperscript{47}. Interagency cooperation can be compromised by geographical separateness; by agencies being governed by different levels of government with varying administrative arrangements; and from having different intake/assessment procedures often with incompatible eligibility criteria, funding arrangements and philosophies\textsuperscript{48,49,50,51}.

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\textsuperscript{38} OECD (1998) op cit
\textsuperscript{40} Fincher (1999) op cit
\textsuperscript{42} Adams and Hess (2001) op cit
\textsuperscript{43} Reitan, T. (1998) op cit
\textsuperscript{44} Reddell, T. (1999) \textit{Place Management: A mechanism for integration and coordination?} (Draft discussion paper). Policy Co-ordination Division, Department of the Premier and Cabinet, February 1999 p. 4.
\textsuperscript{45} Lowndes and Skelcher (1998) op cit p. 317.
\textsuperscript{47} OECD (1998) op cit.
If the establishment of a funding pool is necessary for project management purposes then issues of flexibility arise owing to the highly localised nature of the arrangements. To overcome these problems of fragmentation while contending with power and control issues requires a flexible approach to funding arrangements, the need to satisfy accountability requirements, and in facilitating the decision-making process for the delivery of services. Furthermore, a role for community needs to be incorporated to address issues of service responsiveness and sustainability.

In adopting a place approach to the delivery of human services the SIP has had to contend with this range of issues. And it is these new structural arrangements that need to be assessed for their impact on health and health inequalities of the Goodna community.

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51 Sullivan (2001) op cit
3 Methods and Procedures used in the HIA

3.1 Scoping procedure and methodological issues

The health impact assessment of the SIP followed the methodological approach suggested by the Merseyside model of HIA. This model distinguishes between procedures and methods for HIA (see Appendix 3: Stages in the HIA process). The procedures component refers to the commissioning and implementation frameworks for the HIA while the methods component indicates the system for carrying out the actual assessment. The methodology adopted in this assessment was discussed with the steering group and a number of important issues were raised concerning:

- selection of key informants and who to interview
- participants of focus groups
- the temporal and geographical boundaries of the study
- what kinds of ill health and well-being should be considered by the study
- the categories or determinants of health to be considered
- what the terms of reference for the assessment should be
- who will be affected, which communities
- ‘survey fatigue’ experienced by community members
- cultural diversity and associated issues
- who determines outcomes
- the applicability of the HIA methodology to service integration
- the need to be extremely careful in drawing causal references between the SIP and the health of the Goodna community.

The steering group identified key informants for initial discussions as well as helping identify major stakeholders and key informants for interviews and focus groups. During the process of conducting the interviews and focus groups other informants were suggested that it was felt could contribute to the assessment process. Consequently, a range of professionals, community workers, interest groups, and local residents were consulted and given the opportunity to express their views, concerns and opinions concerning service delivery and quality of life in the Goodna community.

Six in-depth interviews were held with community representatives, service provider organisations and project proponents. In addition, four focus groups were conducted with service consumer groups and a service provider group for a total of 21 participants. Tape recordings were made of these interviews and group discussions transcribed by a professional transcription service. Main points and themes of the discussions were extracted for inclusion into the matrix of predicted impacts.

Scott-Samuel, Birley, and Ardern (2001) op cit.

53 There are various models of HIA available but they exhibit commonalities with the Merseyside model in Appendix 3. For example, Queensland Health’s Environmental Health Unit is currently drafting a HIA framework to capture their evolving work in this field.
It was agreed that health outcomes in terms of health impacts from the project should be based on the model of health determinants identified within the Merseyside model\(^{54}\) (see Table 1-1) and assessed according to positive or negative impacts, their potential impact being definite, probable or speculative and whether in short, medium and long terms (see Appendix 4).

An ethics application was prepared and submitted to the West Moreton Health Service District – Human Research Ethics Committee for approval and subsequently granted.

### 3.2 Categories and influences on health

Generally the method followed in the assessment was based on the health categorisation construct suggested by the Merseyside model\(^{55}\) as outlined in Table 1-1. As illustrated in the table, the categories of influences on health include biological, personal/family circumstances and lifestyle, social environments, physical environment, public services and public policy.

The approach followed during the course of the study involved participants making qualitative assessments of the health impact of local human service delivery recognising that not many of these impacts could be tied directly to the influences of the SIP. In so doing, consideration was given to the specific influences within each category of health determinants as shown in Table 1-1. The model was adapted as necessary to the specific situations found in the field during the assessment process. See Appendix 4 for a copy of the assessment sheet.

### 3.3 Collection and qualitative and quantitative data sets

Evidence relating to health impacts was collected from a wide variety of sources including experts and key informants and comprised of both qualitative and quantitative data and information.

Qualitative and quantitative data and information used related to:

- the views, perceptions and opinions expressed by service consumers, service providers and project proponents at focus group sessions and key informant interviews on service delivery and quality of life issues
- published information from a range of state, national and international sources
- local information and data sets from which the community profile was developed
- literature reviews of HIA studies carried out nationally and internationally.

The steering group was informed that the assessment was concerned with collecting, collating and evaluating primarily qualitative data as indicated above and not involved in the collection of primary quantitative measured

\(^{54}\) Scott-Samuel, Birley and Ardern (2001) op cit.
\(^{55}\) Scott-Samuel, Birley and Ardern (2001) ibid.
data. The assessment included secondary data and information from a range of sources concerning health, demographic, economic, unemployment and social conditions.

3.4 Terms of reference

The terms of reference agreed by the steering group concerned the provision of overall advice, guidance and support on specific actions relating to progression of the assessment. Methods to be used in the assessment, boundaries of the study and what was to be excluded and included were:

- profile of the communities affected
- to use concurrent intermediate HIA methods substantiated with interviews with key informants on community issues
- conduct interviews and focus groups with stakeholders and key informants including service consumers, frontline workers from human service organisations and project proponents
- systematic review of evidence from data and information related to demographic, social, economic, environment and health within the target community
- literature searches to provide evidence of the likelihood of health impacts
- assess the impacts on service delivery and on health determinants during the course of the project. From this, assess and estimate the potential health impact of the project on the health status of the affected community
- identify and draw the potential health impacts to the attention of the steering group and disseminate information to all stakeholders, including decision and policy makers, community leaders, representatives and affected communities
- make recommendations by pointing to specific positive and negative aspects of the potential health impacts that may arise so that potential negative effects can be avoided or reduced and the positive impacts promoted and enhanced.
4 The Communities and Environment of Goodna-Gailes

4.1 Introduction

As part of the health impact assessment process, an initial interpretation of health risk across the target area was conducted by setting out the health profile of the community. This was achieved by using information collected from key informants (such as Centrelink and Queensland Health staff), Census data, and local Government, Community Renewal and other publications. These sources of information allowed a quick appraisal of the health profile across the community, which indicated existing comparative health problems and concerns of the region. The profiling enabled identification of the most vulnerable groups within the area (in health status terms). Members of these groups would be the most likely to be affected by the negative or adverse health impacts from the service integration initiatives.

4.2 Goodna-Gailes geographical, social, economic and employment profile

The Goodna-Gailes region is located within the city of Ipswich, mid-way between the central business districts of Brisbane and Ipswich and based on 2001 Census data, has a total population of approximately 8,527 people. The region for data collection purposes comprises thirteen collection districts. The area is situated in the Local Government Area of Ipswich and borders the western edge of the City of Brisbane. The lifestyle is urban, although vestiges of rural areas remain.

The Brisbane River crosses the northern boundary, as does the Brisbane – Ipswich railway and the multi-lane Ipswich Road. The rail and road linkages provide access to Ipswich City (in the West) and Brisbane City (to the East).

Demographic profiling based on 2001 Census data shows that the region differed from the Queensland population in a number of ways:

- the population was generally younger
- proportionally more Indigenous peoples
- high percentage of people born in non-English speaking countries
- high proportion of people who speak a language other than English at home
- lower educational achievement
- higher unemployment rates
- higher rates of low income
- higher proportion of single-parent families

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56 see Appendix 5: Map of Goodna-Gailes
57 Goodna-Gailes Collection Districts: 3,131,011; 3,131,201; 3,131,202; 3,131,203; 3,131,204; 3,131,205; 3,131,206; 3,131,207; 3,131,208; 3,131,209; 3,131,210; 3,131,211; 3,131,212
• higher proportion of households without a vehicle
• higher proportion of rented housing with most of these being public housing.

In summary, the Goodna-Gailes area is characterised by a young population, disadvantaged by income, employment and educational factors, has potential language barriers, and is ethnically diverse. Transport (or lack of) could be a major issue for disadvantaged members of the community. A high Aboriginal and Torres Strait Islander population in the area combined with well-documented health and socioeconomic disadvantage amongst Indigenous populations is a key aspect of this area.

4.3 Demographic and health profiles

The aim of this section is to provide a demographic and health profile of the area to help in consideration of the factors that influence health and well-being within Goodna-Gailes and identify those factors that service integration may influence over time.

The relationship between various key demographic factors and health issues is well documented. A NSW report identified health issues affecting specific populations. This report included overseas born people, Indigenous peoples and people from areas of socioeconomic disadvantage. Consistent with the findings of the 2001 Queensland Health report, a substantial health disadvantage was evident in Indigenous populations. Areas of socioeconomic disadvantage showed higher mortality rates (from all causes), higher infant deaths, higher prevalence of risk factor behaviours such as smoking, being overweight/obese, and harmful alcohol consumption.

The Queensland Health report on area health status identified deaths and hospitalisations from coronary heart disease as being major health issues for the broader West Moreton region of which Goodna-Gailes comprises the eastern sector. In addition, the region had significant incidents of Chronic Obstructive Pulmonary Disease (COPD), especially for women. The significant health problems are probably exacerbated by and associated with a higher prevalence of risk factors such as smoking, nutrition based behaviours and lack of physical activity.

Socioeconomic disadvantage is evident in the Indigenous community and could be expected to contribute to a wide range of issues including heart disease and deaths from injury and poisoning especially in young people and infants.

\[60\] National Health Strategy (1992) op cit
\[62\] Queensland Health (2001a) op cit
\[63\] New South Wales Department of Health (2000) op cit.
\[65\] Queensland Health (2001a) ibid
Measures to address the inequalities in health experienced by the region need to target risk factor behaviours and the wider social and economic conditions, which drive these health inequalities. Socioeconomic disadvantage and chronic diseases such as COPD and heart disease can physically limit the ability of community members to access health and community services.

4.4 Disadvantaged communities and groups

Health impacts are exacerbated for individuals, groups or communities that start from disadvantaged origins. Each particular group requires special understanding and respective responses. For example, specific arrangements must be made for access for people with disabilities.

The factors that impact negatively on the health of disadvantaged populations are complex and interrelated. They include the ‘upstream’ or structural factors of poverty, income inequality, education, housing, transport and discriminatory practices. They are also impacted on by the community context in which they occur including social network structures and community connectedness.

Disadvantaged groups disproportionately represented in the Goodna-Gailes region include single-parent families and young children, Indigenous peoples, people from culturally and linguistically diverse backgrounds (CALD), unemployed people, and young people.

Children and young people: Considering the number of children, young people, and in particular single-parent families that reside in the Goodna-Gailes region access to supportive community-based services is imperative. Queensland Health emphasises the importance of focussing on “building effective partnerships across health, education, social and economic sectors” to improve health of children and young people.

Indigenous peoples: The social disadvantage that affects the region further exacerbates issues for the Indigenous and CALD people’s living there. The significant Indigenous population residing in the Goodna-Gailes area suggests the need for services to be accessible by this group.

Culturally and linguistically diverse people: Goodna-Gailes has a comparatively high population of people from a wide variety of CALD backgrounds. Many are new communities or recent arrivals from such countries as Cambodia, Former Yugoslavia, the Middle East, and Pacific Island nations. Many have arrived as refugees and as a result of their refugee experience are at considerable social, economic, medical and mental health risk. Many experience low socioeconomic circumstances, English-language difficulties, high unemployment, mental health problems, social isolation, poor education and issues associated with social dislocation. Other

67 Queensland Health (2001a) op cit
key issues include inadequacy of local services and barriers affecting access to services (such as lack of information about mainstream service provision)\textsuperscript{69}. The complexity of issues identified within the community (and which are outside the traditional health jurisdiction) exemplifies the need for cross-sectoral strategies such as improved and integrated services. The community, especially the at-risk groups identified above, and other major stakeholders, need to be involved in the process of identification of need, and implementation and ongoing maintenance of policy initiatives. In addition, government policies need to be assessed for their (intentional or unintentional) impact or potential impact on the determinants of health. Programs need to have a community focus including enhancing the level of social connectedness through empowerment approaches, improving living and working conditions, and enhancing service delivery in the region through a more integrated model of service delivery\textsuperscript{70}.

\textsuperscript{69} Queensland Health (2001a) op cit pp. 43-44.
5 Key Informants and Evidence-based Materials

5.1 Overview

A list of key informants comprising experts, professionals, community and local residents was compiled with the assistance of the steering group. In addition, the ‘snowball’ sampling technique was utilised during meetings, interviews and focus groups to extend the participants lists by identifying other possible contacts that would be able to contribute further information about points of interest to be explored. During the process of the interviews and focus groups it was possible to collect information, brochures, videos, and pamphlets and so on relating to other activities that could be employed as evidence material for the assessment. The informants formed four main categories:

- residents of the affected community who accessed local services
- frontline workers from service provider organisations
- senior representatives of the Service Integration Project (ie project proponents)
- experts relating to health and socio-community issues.

5.2 Key informant interviews and focus groups

**Interviews:** One-to-one interviews were held with key informants employing qualitative methodologies of semi-structured and open-ended interviews. The semi-structured interviews that were carried out with consumers, providers and proponents were taped. A total of six interviews were carried out during the course of the study and from the recorded interviews transcriptions were made. Interviewees included project proponents (n=2), frontline workers (n=3) and a service consumer (n=1). The discussions with professionals (eg Centrelink) were more open-ended and unstructured. This was to allow free flowing exploration of the main points. In these cases notes were taken and in some instances statistical information was generated, constituting a record of the discussion.

**Focus groups:** Focus groups were held with residents of caravan parks (n=5 participants), a Ethnic Women’s Group (n=5 participants) and frontline service providers (n=6 participants). The group discussions were held at venues with which the participants were comfortable (eg Community Health setting, local library, and within the grounds of a caravan park). In all focus groups an assistant who had a connection with participants aided the researcher to promote trust and facilitate discussion.

All participants in both interview and focus groups were invited to contribute to the assessment of the health impacts of the project. They were asked to use their respective understanding of different aspects of existing human services in the Goodna-Gailes area and of issues relating to consumers quality of life based on the identified health determinants. They could also contribute from the perspective of their own organisational backgrounds (if relevant) and their
special areas of involvement. Issues around service integration that were explored included collaborative working relationships; service delivery and community involvement. In this way the study sought to explore the main elements of service integration as identified in the literature (see Section 2.4) and whether the project was having an impact on health determinants.

### 5.3 Interview questions

The questions for the semi-structured interviews consisted of two sections and were developed in consultation with the steering group and the Measuring and Modelling group. The sections were:

- **Section A**: concerned with aspects of service delivery including consumers involvement in identifying local need
- **Section B**: concerned with quality of life for community members.

Discussions generated by these two sections were designed to elicit comments around service delivery issues and issues associated with health determinants.

### 5.4 Instructions and ground rules

At the interviews and focus groups the participants were given an information sheet outlining the aims of the study, a document illustrating the social determinants of health, and in the case of interviews a consent form for signing. These messages were repeated verbally and assurances given about confidentiality and the freedom to withdraw at any time were reiterated. Ground rules were established for the focus groups to ensure the situation was respectful of people and promote an environment conducive to discussion.

### 5.5 Documentary evidence-based materials

Evidence-based material covering a wide range of issues was collected during the course of the study from a number of sources. The information contained within the material was used to identify and support impacts. Appendix 6 contains a list of key documented evidence-based materials received and used in the study.
6 Findings and Predicted Impacts

6.1 Introduction

This section provides a summary of the broad categories of positive benefits of the service integration project and a listing of the negative impacts. In collaboration with the steering group, the results of the discussions with the three groups of major stakeholders were collated and assessed for their being either positive or negative impacts, whether the potential impact was definite, probable or speculative, and whether the impact was a short-, medium-, or long-term issue.

The use of positive and negative categories enabled the assigning of potential impacts based on the judgement of steering group members. The aim being to propose ways to promote and record the beneficial health outcomes and also to monitor potential negative impacts with a view to reduce or mitigate their effects.

6.2 Overview of findings on positive impacts

The assessment found that there are undoubtedly positive health benefits to be gained from the Goodna model of human service integration, represented through the SIP. Positive benefits will flow directly from a planned holistic model of service delivery.

Social environment

Enhanced social supports as a consequence of activities by community centres, Goodna Community Health (eg the caravan park project) and Ipswich City Council (eg Support Link project) will impact positively on the health and well-being of people accessing such services\textsuperscript{71, 72}.

Physical environment

Community radio stations and the Goodna web site (www.Goodna.net)\textsuperscript{73} are important mediums for disseminating information concerning health matters and local community information. They can promote community cohesion and reduce social isolation for at-risk populations such as people from Non-English Speaking Backgrounds and provide information about health issues and local services.


\textsuperscript{73} The Goodna web site was launched in March 2003 following its recommendation at a community forum in early 2001. It includes data on local agencies, groups, clubs, and a ‘what’s happening section’ in which community members can have their say about their community.
Public services

Relationships between services have been enhanced by such initiatives as the Graduate Certificate course resulting in improved working arrangements as evidenced by the development of protocols establishing the ground rules for decision-making by partner agencies.

Cross-links have been established between services involved, reflecting the commitment to better communication, information sharing, collaborative resolution of issues and more flexible services.

Partnership training programs have been undertaken to address issues of low education and unemployment. For example, the Goodna Integrated Family Support (GIFS) program for families with students attending local schools are expected to have long-term outcomes for consumers including better employment opportunities and improved quality of life.

Relationships between services and consumers have been enhanced through:

- extensive community consultation such as the Health and Well-Being survey
- young people being involved in production of a suicide prevention video
- young people from Aboriginal and Torres Strait Islander backgrounds involvement in service integration project processes
- regular community consultation with community organisations, consumers, agencies and service management.

Goodna community health in partnership with caravan park residents have produced a video identifying health and well-being issues for people living in caravan parks, while improved relationships between community health ethnic health workers and local ethnic communities has implications for health service awareness and access. In the course of transition of the SIP to its ongoing management structure comprehensive consultation has been undertaken to ensure appropriateness of services and enhancement of local ownership.

It has been noted that effectiveness of programs is dependent upon active participation of community members and organisations in program development and implementation and in their on-going problem solving. This has been a characteristic of the Goodna project. Supportive relationships between service providers and consumers have positive implications for practical and social supports in the medium to long-term.

The assessment suggests that direct and immediate service delivery benefits will come from services working together better. Furthermore, positive health impacts will arise if the project partnership sets out to enhance the life

chances of disadvantaged community groups through addressing the underlying structural causes.

6.3 Overview of findings on negative impacts

The assessment suggests that broad negative health impacts will arise or continue as indicated below according to the relevant category of influence. Although it is difficult to directly relate these points to the SIP, none-the-less they reflect aspects of the current human service delivery environment of the Goodna community:

Social environment

- A lack of interpreter services in prisons impacts on family support mechanisms and linking for prisoners and their families.
- Negative health impacts that arise through continued differential access to services by people from Aboriginal and Torres Strait Islander backgrounds due to a shortage of Indigenous health workers in the area causing these populations to travel outside the immediate community for health care.

Physical environment

- Settings of human service agencies that are not user-friendly present as barriers to clients accessing services.

Public services

- Lack of cultural appropriateness of services impacts on people from culturally and linguistically diverse backgrounds access to services, data collection and resource allocation.
- Negative impact on health of people from CALD backgrounds and Aboriginal and Torres Strait Islander peoples that arise from lack of awareness of what services are available for physical and mental health issues and how services function.
- Lack of awareness of services by General Practitioner’s impacts on their ability to make appropriate referrals.
- Negative health impacts on people due to prolonged, formal and inflexible intake processes that are frequently replicated by referral agencies impacts on people’s access to services.
- Negative health impacts on health of people from refugee backgrounds due to sensitivity of information required at intake and the perception that confidential information will be circulated to other agencies.
- Lack of general practitioner’s (gp’s) that bulk bill, women gps, and gps not taking any new patients impacts on people’s access to health care.
- Poor local bus services affect people’s ability to access services, schools, food outlets and employment opportunities, which impacts on education, nutrition and income and as a result their health and wellbeing.
- Lack of accurate data on people residing in caravan parks impacts on allocation of resources by service provider organisations.
6. Findings and Predicted Impacts

- Indigenous projects that are ceased without explanation have negative consequences for relationships between service providers and consumers and for their health and well-being.

Public policy

- The need for diverse communities and diversity within communities to be reflected on projects and strategic groups through appropriate representation.
- The lack of a suite of community indicators to guide future development.

It became clear that the findings indicated the importance of communication and relationship building as being necessary in providing services that are relevant and appropriate to local communities. It also became clear in developing the recommendations that there was a need to promote a health agenda in the community that was based around addressing the underlying causes of health inequalities. As part of this process it will be important for the project to promote economic development, and encourage social and community inclusion. Promotion of learning opportunities will also make a significant contribution to people’s self-belief and esteem and promotion of community cohesion.

During the course of the assessment it was noted that local people and service providers were extensively engaged in contributing to the SIP’s development. Through this focused, participatory approach adopted by the project’s proponents and enthusiastically endorsed by its project team, the community has developed a strong sense of ownership, which can only foster improved health and well being of its members.

6.4 Unexpected findings and issues

During the course of the assessment a number of ‘unexpected’ findings and issues became apparent. They seem to reflect the interface between our theoretical understanding of factors that impact on health inequalities and service integration on one hand and the practice of working with communities and their specific issues on the other. Many of these findings seem to be issues that many disadvantaged communities with a high percentage of people from CALD backgrounds would experience and so may merely represent issues that a HIA methodology does not account for.

They have been grouped according to the categories of health influences used in the data matrix:

Personal/family circumstances

- Lack of respite facilities and services that are culturally appropriate.
Social environment

- The central role of the church for Pacific Islanders.
- Significant role played by key members of ethnic communities, including the local ethnic radio station.
- Schools need to be more supportive of children from disadvantaged backgrounds.
- The pivotal role played by caravan park managers in supporting residents.

Physical environment

- The need for accessible and quiet public telephones.

Public services

- Culture specific programs are needed to address the needs of specific ethnic groups.
- Antipathy held by some groups to government services that are historically based with subsequent reluctance to access these services.
- The need to establish relationships with Indigenous communities over time for effective consultation.
- At times what services can be provided are not what consumers need.
- Men’s issues not sufficiently addressed by local services.
- Long waiting times at Centrelink.
- The significance of the Professional Leadership Certificate Course for relationship building between management, frontline workers and community members.
- The pivotal role played by the service integration project officers.
- Inaccurate Census data owing to Census forms not being completed by caravan park residents.
- Inadequate data collected on community concerns such as health issues.
- Difficulty of services to respond quickly to short-term crises such as transport and accommodation needs.
- Service integration is developmental, takes time and commitment, requires different skills to service delivery and can add to the workers workload.
- There is a need for effective internal communication within services.
- The difficulty of service responsiveness to a community with a multiplicity of needs.
- The need by local government to coordinate planning activities such as ecological sustainability, infrastructure, public space, and community harmony with a desired direction.
- Consumers are subject to complex intake and/or referral processes that require divulging of sensitive and confidential information.
- The role of relationship building for effective integration.
- Billing and payment procedures are difficult to understand for people from CALD backgrounds.
- Young people needing a dedicated space for activities.
Public policy

- Development of a framework for decision-making around integration priorities.
- The lack of a suite of community indicators to guide future development.
- The need for diverse communities and diversity within communities to be recognised and appropriately represented on project and strategic groups.

The significance of these ‘unexpected’ findings and issues seemingly lies in their relationship to the applicability of HIA methodology to service integration and to the SIP’s priorities and processes. The inclusion of categories of health determinants that are informed by these unexpected findings will enable future service integration HIAs to be more robust in their approach. Furthermore, they can indicate gaps in identification of issues by the SIP and the SIP’s priorities.

6.5 Matrix of predicted health impacts

The impacts recorded in the assessment sheets were supplemented by carrying out a review of the literature on health impact assessments and also by examining the evidence collected and received during the assessment process. The tables therefore contained a comprehensive set of predicted health impacts that were identified by the HIA. The resultant matrix comprised of a collation data from the three main groups consulted. This information was linked to the relevant category of health determinant. These were discussed in the methods section of this report. The matrix records both positive and negative impacts, the potential impact being definite, probable or speculative and whether short, medium, or long-term issues.
7 Conclusion and Recommendations

This health impact assessment investigated the potential health impacts that have arisen and may still arise from the Goodna Service Integration Project model of human service integration and collaboration. The study utilised the views of a wide range of stakeholders and documentary evidence in compiling and evaluating the impacts. It identified and assessed how stakeholders experienced the processes and initiatives of the Goodna project in terms of how the project will impact on the health and health determinants of people and community groups of Goodna-Gailes. The recommendations made in this report will guide ongoing SIP management following its transition stage and other decision-makers on important essentials and concerns that are associated with the elemental aspects of the projects operation.

This final report has given full consideration to the impacts reported by stakeholders in their discussions, focus groups and interviews. The findings and recommendations highlight the main health impacts that are of concern to Goodna’s stakeholder communities. The findings will inform further development and ongoing implementation of the SIP. The SIP, as an example of a whole of government project designed to test and demonstrate how community and government and non-government agencies can work together for the benefit of the whole community has been recognised by the West Moreton Regional Managers of Government Forum as being core business of the group.

The recommendations arise out of the assessor’s consideration of the health impacts identified by interviewees, key informants and the focus groups. The recommendations have been grouped according to their relevant category of health influences adopted during the data collection phase. They have been categorised into sets and listed in tables below under the main headings of:

- personal/family circumstances
- social environment
- physical environment
- public services
- public policy.
Table 7-1: Recommendations Set: Health impacts relating to personal/family circumstances

<table>
<thead>
<tr>
<th>Health impacts relating to personal/family circumstances</th>
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</thead>
<tbody>
<tr>
<td>The recommendations are to reduce pressures of personal/family circumstances through:</td>
</tr>
<tr>
<td>7-1.1 undertaking to support work and career development for local people including continuing support of Graduate Certificate course, other training opportunities and supporting agencies in adopting a holistic approach to people’s health and well being</td>
</tr>
<tr>
<td>7-1.2 services to promote a sense of control for clients over their situation through building relationships and enhancing problem-solving skills to increase self-efficacy and establish support mechanisms</td>
</tr>
<tr>
<td>7-1.3 use the opportunity to support and develop community enterprises including provision of culturally appropriate respite facilities and services for people from CALD backgrounds</td>
</tr>
<tr>
<td>7-1.4 promote confidence of individuals in their personal/family good health.</td>
</tr>
</tbody>
</table>
Table 7-2: Recommendations Set: Health impacts relating to the Social Environment

<table>
<thead>
<tr>
<th>The recommendations are to:</th>
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</thead>
<tbody>
<tr>
<td><strong>7-2.1</strong> maintain engagement with and support of local community structures eg local ethnic radio station; support link project; caravan park project</td>
</tr>
<tr>
<td><strong>7-2.2</strong> recognise the importance of significant role played by key community members and institutions eg Managers of caravan parks; Pacific Islander churches and Ministers</td>
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<tr>
<td><strong>7-2.3</strong> maintain extensive community involvement, which has been a characteristic of the project</td>
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<tr>
<td><strong>7-2.4</strong> must engage and involve older people, people with disabilities, ethnic minority groups and young people in discussions about facilities that they need for active involvement in the community</td>
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<tr>
<td><strong>7-2.5</strong> involve and communicate with excluded communities eg ethnic minorities</td>
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<tr>
<td><strong>7-2.6</strong> provide social support for children and young people from disadvantaged backgrounds eg through schools</td>
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<tr>
<td><strong>7-2.7</strong> continue to develop new means of communicating with locals as represented by Goodna.com</td>
</tr>
<tr>
<td><strong>7-2.8</strong> understand the need for on-going involvement, active participation and not just consultation</td>
</tr>
<tr>
<td><strong>7-2.9</strong> continue to use open meetings with community members on the ground and more participatory appraisal methods</td>
</tr>
<tr>
<td><strong>7-2.10</strong> use more community/provider forums</td>
</tr>
<tr>
<td><strong>7-2.11</strong> promote cultural awareness of frontline workers including reception staff</td>
</tr>
<tr>
<td><strong>7-2.12</strong> promote availability and uptake of interpreter services</td>
</tr>
<tr>
<td><strong>7-2.13</strong> recognise the links between the social environment, health and crime and therefore engage in developing support programs for individuals and groups in the community</td>
</tr>
<tr>
<td><strong>7-2.14</strong> develop safe play areas for children, families and young people</td>
</tr>
<tr>
<td><strong>7-2.15</strong> request the use of high profile local policing around centres such as caravan parks.</td>
</tr>
</tbody>
</table>
Table 7-3: Recommendations Set: Health impacts relating to the Physical Environment

<table>
<thead>
<tr>
<th>Health impacts relating to the Physical Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>The recommendations are to:</td>
</tr>
<tr>
<td>7-3.1 maintain links with communication mediums such as local radio stations and Goodna.com as a vehicle for information dissemination about local activities</td>
</tr>
<tr>
<td>7-3.2 develop an efficient coordinated and sustainable green transport system</td>
</tr>
<tr>
<td>7-3.3 reassess the current transport plan, including local and wider travel needs</td>
</tr>
<tr>
<td>7-3.4 encourage creation of aesthetically pleasing buildings with greener landscapes. This will bring positive health benefits to consumers, workers, visitors and local residents and help reduce barriers to services, which will impact on support and receptivity for service organisations</td>
</tr>
<tr>
<td>7-3.5 promote well-lit footpaths and roadways to reduce health impacts from fear and crime and to promote health through increased incidental physical activity</td>
</tr>
<tr>
<td>7-3.6 respect the concerns for local centres to be safe and secure</td>
</tr>
<tr>
<td>7-3.7 provide sufficient quiet and accessible public telephones as needed</td>
</tr>
<tr>
<td>7-3.8 alleviate parking problems around Goodna-Gailes which limit access to shops and services.</td>
</tr>
</tbody>
</table>
Table 7-4: Recommendations Set: Health impacts relating to Public Services

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7-4.1</td>
<td>make partnerships between services central to service delivery and provision</td>
</tr>
<tr>
<td>7-4.2</td>
<td>consider a program of improving current/existing health premises/centres and providing extra community facilities in each of them that reflect community needs</td>
</tr>
<tr>
<td>7-4.3</td>
<td>engage and involve older people, people with disabilities, ethnic minority groups and young people in discussions about services that they need for active involvement</td>
</tr>
<tr>
<td>7-4.4</td>
<td>promote training for reception staff and frontline workers so that they are able to communicate with local ethnic groups</td>
</tr>
<tr>
<td>7-4.5</td>
<td>encourage services to adopt a holistic approach to addressing people’s needs and to provide services that are accessible and appropriate (eg intake processes)</td>
</tr>
<tr>
<td>7-4.6</td>
<td>continue to promote networks around health in a wider sense involving multi-agency and community networks</td>
</tr>
<tr>
<td>7-4.7</td>
<td>promote the establishment of meaningful relationships with Indigenous communities over time to better facilitate the consultation process</td>
</tr>
<tr>
<td>7-4.8</td>
<td>ensure the promised better services actually improve the lives of the affected community. This requires development of an appropriate evaluation plan for long-term assessment of the impact of service integration on health and health inequalities of the Goodna-Gailes community</td>
</tr>
<tr>
<td>7-4.9</td>
<td>provide a forum or other information dissemination activities to inform the community and other service providers about what services are available and how to access them</td>
</tr>
<tr>
<td>7.4.10</td>
<td>continue to provide information to the community about service integration initiatives in a format that suits local needs</td>
</tr>
<tr>
<td>7.4.11</td>
<td>build on the potential for 7 day 24 hour multi-purpose centres and provide weekend access to emergency relief and primary health care facilities and GPs</td>
</tr>
<tr>
<td>7.4.12</td>
<td>allow Community Health Centres and other government centres to be used for wider community purposes</td>
</tr>
<tr>
<td>7.4.13</td>
<td>ensure proper training to change attitude of all levels of staff to encourage access to services by all members of the community</td>
</tr>
<tr>
<td>7.4.14</td>
<td>continue to support greater communication between and within government and non-government service providers</td>
</tr>
<tr>
<td>7.4.15</td>
<td>continue to support the Caravan Park project, Goodna Family Support Program, Graduate Certificate course and other such programs</td>
</tr>
<tr>
<td>7.4.16</td>
<td>promote recruitment of Indigenous and ethnic workers into service organisations</td>
</tr>
<tr>
<td>7.4.17</td>
<td>promote training in refugee issues (including sensitivity of information; perceptions in which service providers may be held) for staff at all levels</td>
</tr>
<tr>
<td>7.4.18</td>
<td>support simplification of bureaucratic processes (eg intake and referral) within service provider organisations to streamline services and prevent duplication</td>
</tr>
<tr>
<td>7.4.19</td>
<td>promote the understanding that health is more than just the provision of reactive services but is based on addressing the underlying structural factors such as unemployment, transport, education, and so on</td>
</tr>
<tr>
<td>7.4.20</td>
<td>build on existing good practices by review/audit of what is currently happening and use external auditors to report consultations with local people regarding service integration</td>
</tr>
<tr>
<td>7.4.21</td>
<td>support accurate data collection and identification and usage of appropriate community social indicators</td>
</tr>
<tr>
<td>7.4.22</td>
<td>promote awareness of the need to address men’s health issues with local services.</td>
</tr>
</tbody>
</table>
Table 7-5: Recommendations Set: Health impacts relating to Public Policy

<table>
<thead>
<tr>
<th>Recommendations Set: Health impacts relating to Public Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>The recommendations are to:</td>
</tr>
<tr>
<td>7-5.1 ensure involvement of Aboriginal and Torres Strait Islander populations and representatives from culturally and linguistically diverse backgrounds in policy, program and project development at the very earliest stages to ensure they are culturally appropriate</td>
</tr>
<tr>
<td>7-5.2 continue to support the development of a suite of community social indicators to guide future development</td>
</tr>
<tr>
<td>7-5.3 support flexible funding arrangements between government departments to better resource local needs.</td>
</tr>
</tbody>
</table>

This study into the utilisation of HIA methodology for service integration has been characterised by multiple levels of complexity. Undertaking the HIA as well as addressing the overall effectiveness of this methodology for service integration for Public Health Services was always going to be a challenging task. Evaluation (see Appendix 7) of the HIA focussed on process and impact components only as outcome evaluation is dependent upon uptake of recommendations by the ongoing service integration project.

Health impact assessment provides an equity-based judgement of the impact of policies and practices on those structural factors that impact on or exacerbate health. The SIP model of service integration has obviously changed the way that governments and community-based agencies function in the Goodna region. However, health inequalities literature would suggest that to reduce health differentials that are a consequence of social circumstance, policy (and associated dollar investment) needs to be directed ‘upstream’ to those structural factors (such as unemployment) that exacerbate inequalities. The implications being that a cost/benefit analysis focusing on the most disadvantaged in the community needs to be considered in respect of service integration initiatives – prior to implementation. This has implications for sustainability as addressing the underlying structural factors, as opposed to addressing the service repercussions of social inequalities would have a greater positive impact on those in most need. This economic dimension needs to be incorporated into HIA methodology.

The lack of causal relationships between the SIP, services provided and assessment of impact has implications for relevance of HIA for service integration. Future HIAs of service integration will need to address this issue through pre- and post-testing of service integration interventions using quantifiable data. In addition, it will be necessary to allow appropriate time and effort to enable this form of assessment to be undertaken. Similarly, long term evaluation of the impact of the recommendations of the HIA and their uptake will be required to test the validity of the findings.
The SIP has prioritised time and resources to the task of relationship building between all major stakeholders to ensure integrated services be developed that respond to local needs and ultimately contribute to community well-being. However, as the study shows better communication of basic community needs and their relevance to community health and well-being is still required. Addressing of unmet need by the West Moreton Regional Managers Forum and community agencies represents a challenge in finding ways of further enhancing and sustaining these relationships.

The results of this study suggest that application of HIA methodologies to service integration have relevance to Public Health practice. The study has shown that HIA has the capability to identify factors, both good and bad that may not otherwise be identified. The methodology enables the findings to be incorporated into the planning and implementation phases of community-level service integration initiatives with subsequent implications for health and health inequalities. As result it has the capacity of changing the culture of whole-of-government service delivery so that policy makers always take health into consideration.
Appendices

Appendix 1: SIP Partners
Appendix 2: SIP guiding principles
Appendix 3: Stages in the HIA Process
Appendix 4: Health Impact Assessment Matrix for the Goodna Service Integration Project
Appendix 5: Map of Goodna-Gailes (with Collection Districts)
Appendix 6: List of evidence-based materials and documents
Appendix 7: Evaluation
Appendix 8: Potential criteria for selecting indicators
Appendix 1: SIP Partners

SIP Partners

Federal Government

- Centrelink
- Ipswich and Regional Area Consultative Committee

State Government

- Department of Corrective Services
- Disability Services Queensland
- Education Queensland
- Department of Employment and Training
- Department of Families
- Queensland Health
- Department of Housing
- Department of Industrial Relations
- Department of Innovation and Information Economy, Sport and Recreation Queensland
- Department of Local Government and Planning
- Queensland Police Service
- Queensland Treasury

Local Government

- Ipswich City Council

Learning Institutions

- University of Queensland (Ipswich Campus)
- Bremer Institute of TAFE
SIP Guiding Principles

Guiding Principle No.1 – Community development through partnerships

In line with social justice principles, consistent with existing Community Action Plans and in partnership between the general and business communities and government, the project supports the local community as it strives to meet its needs and aspirations.

Guiding Principle No.2 – Collaborative leadership

Through place management and collaborative leadership, the project identifies and promotes innovative preventative and remedial human service responses, which improves the government’s and the community’s capacity to develop and deliver appropriate services.

Guiding Principle No.3 – Development and delivery of human services

Best practice guides the development and delivery of integrated human services involving various stakeholders charged with issue identification and service delivery within an overall collaborative leadership framework and with a principal point of accountability. Through collaboration, consultation, conceptualisation, planning, resourcing, design and evaluation this process delivers integrated services which are more effective, efficient and flexible.

Guiding Principle No.4 – Leadership, support and development

The project team and project outcomes are supported by the provision of training and learning with a view to encouraging knowledge transfer and as a sense of pride and wellbeing in the community and the service deliverer. This support is through commitment in a peer learning environment and through academic pursuits, including a University of Queensland Graduate Certificate in Interprofessional Leadership.

Guiding Principle No.5 – Report and recommendations

The project team develops, trials, evaluates and recommends a preferred service integration model having application for service delivery across a range of places.
Appendix 3: Stages in the HIA Process

Stages in the HIA Process

Procedures

Apply screening criteria to select project or policy

Establish steering group

Agree terms of reference for assessment

Select assessor

Conduct assessment

Appraise the assessment

Negotiate favoured options

Implement and monitor

Evaluate and document

Methods

Policy analysis (if appropriate)

Profiling of communities

Interview stakeholders and key informants

Identify health determinants affected

Assess evidence

Establish priority impacts

Recommend and justify options for action

Collect evidence from previous reports

(Source: Scott-Samuel, Birley and Ardern, 2001:6)
## Health Impact Assessment Matrix for the Goodna Service Integration Project

<table>
<thead>
<tr>
<th>Category of influences</th>
<th>Predicted health impacts</th>
<th>Nature of impact (brief summary of impact)</th>
<th>Potential impact – is it definite (D), probable (P) or speculative (S)</th>
<th>Short (S), medium (M) or long-term (L)</th>
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</thead>
<tbody>
<tr>
<td><strong>BIOLOGICAL</strong></td>
<td></td>
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</tr>
<tr>
<td>Age</td>
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<tr>
<td>Gender</td>
<td></td>
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<tr>
<td>Genetic factors</td>
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</tr>
<tr>
<td><strong>PERSONAL/FAMILY CIRCUMSTANCES AND LIFESTYLE</strong></td>
<td></td>
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</tr>
<tr>
<td>Family structure and functioning</td>
<td></td>
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</tr>
<tr>
<td>Education</td>
<td></td>
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</tr>
<tr>
<td>Occupation</td>
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<tr>
<td>Income</td>
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<tr>
<td>Risk taking behaviour</td>
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<tr>
<td>Diet</td>
<td></td>
<td></td>
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<tr>
<td>Smoking</td>
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<tr>
<td>Alcohol</td>
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<tr>
<td>Substance use</td>
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<tr>
<td>Exercise</td>
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<tr>
<td>Recreation</td>
<td></td>
<td></td>
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<tr>
<td>Means of transport</td>
<td></td>
<td></td>
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<tr>
<td><strong>SOCIAL ENVIRONMENT</strong></td>
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</tr>
<tr>
<td>Culture</td>
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<tr>
<td>Peer pressures</td>
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<tr>
<td>Discrimination</td>
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<td></td>
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<tr>
<td>Social support</td>
<td></td>
<td></td>
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<tr>
<td>Social networks, isolation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community participation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PHYSICAL ENVIRONMENT</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental impacts and nuisances</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Working conditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport, communications and accessibility</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Public safety</td>
<td></td>
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</tr>
</tbody>
</table>
### PUBLIC SERVICES

| Access to and location of health care facilities |  |  |  |
| Quality of health care facilities |  |  |  |
| Child care |  |  |  |
| Social services |  |  |  |
| Housing and home services |  |  |  |
| Employment and social security |  |  |  |
| Public transport |  |  |  |
| Policing |  |  |  |
| NGOs agencies and services |  |  |  |

### PUBLIC POLICY

| Economic, social, environment and health trends |  |  |  |
| Local and national priorities |  |  |  |
| Policies |  |  |  |
| Programs |  |  |  |
| Projects |  |  |  |
Appendix 5: Map of Goodna-Gailes (with Collection Districts)

(Goodna Gailes Census Collection Districts: 3,131,011; 3,131,201; 3,131,202; 3,131,203; 3,131,204; 3,131,205; 3,131,206; 3,131,207; 3,131,208; 3,131,209; 3,131,210; 3,131,211; 3,131,212)
<table>
<thead>
<tr>
<th>Relevant HIA area</th>
<th>Reference</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community profile</td>
<td>Housing Queensland (1999) <em>Goodna &amp; Gailes Community Action Plan</em>. Community Renewal</td>
<td>Information on community characteristics</td>
</tr>
<tr>
<td>Identification of health impacts and services</td>
<td>Goodna and surrounds: Community Training Partnerships Stage 2 (2003)</td>
<td>Information on local training scheme - pamphlet</td>
</tr>
<tr>
<td>Community profile</td>
<td>Queensland Health (?) <em>Community Health Services</em>. Queensland Health.</td>
<td>Information on Community Health Services available at Goodna-Gailes</td>
</tr>
<tr>
<td>Identification of health impacts</td>
<td>Queensland Health (2001) <em>Social Determinants of Health: The role of Public Health Services</em>. Public Health Services, Queensland Health.</td>
<td>Information on social determinants of health</td>
</tr>
</tbody>
</table>
### Appendix 6: List of evidence-based materials and documents

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Community profile</td>
<td>OESR (2001) <em>Queensland Regional Profiles June 2001: Brisbane and Moreton Statistical Divisions</em></td>
<td>Regional information</td>
</tr>
<tr>
<td>Identification of service provision</td>
<td>West Moreton Health Service District (2002) <em>Family CARE for Young Parents Program</em>. A project funded by the Qld Government’s Community Renewal Program.</td>
<td>Program information</td>
</tr>
<tr>
<td>Community profile</td>
<td>Centrelink data on populations 2002 from personal discussion with Centrelink, Goodna staff</td>
<td>Information on population breakdown’s in Goodna</td>
</tr>
<tr>
<td>Background information</td>
<td>Goodna SIP newsletter. September 2002</td>
<td>Information on SIP activities</td>
</tr>
<tr>
<td>Background information</td>
<td>Goodna Service Integration Project (2002) <em>Overview Strategy</em>.</td>
<td>Information on SIP</td>
</tr>
<tr>
<td>Goodna and SIP background</td>
<td><em>This Place Called Goodna</em>.</td>
<td>A collection of useful information prepared for SIP partners</td>
</tr>
<tr>
<td>Community profile</td>
<td>Australian Bureau of Statistics – Census data for 2002 Census</td>
<td>Demographic information on Goodna community</td>
</tr>
</tbody>
</table>
Evaluation

1.1 Evaluation of the HIA

It is important to monitor and evaluate the effect of the HIA on the proposal or project and subsequent development and implementation. In assessing whether the HIA made a difference a good HIA will aim to monitor and evaluate its activities to enable those involved in the process to:

- improve the HIA processes
- modify future proposals or projects to realise health gains
- determine whether the recommendations were implemented
- assess the accuracy of predictions made during appraisal.

Types of evaluation include:

- **Process** – involving assessing how the HIA was conducted, who was involved, and how useful and valuable was the process.
- **Impact** – entailing following how far recommendations were adopted and implemented by the project proponents and if not, why not?
- **Outcome** – involving assessing whether the anticipated positive effects on health, well being and equity were in fact enhanced, and any negative effects minimised and if not, why not, and how could plans be further adapted?

1.1.1 Process evaluation

It is important to evaluate the processes of HIA to identify what went well and where it is possible to make improvement. These learning points should then be incorporated into the design and conduct of future HIAs.

Whilst a comprehensive overview of the HIA is provided in this report, every attempt has been made to validate the information with appropriate key informants but this has not been possible in every instance. As a consequence, some of the information may not be accurate, may have been incorrectly interpreted, or not be representative of all stakeholders. As the study relies heavily on information gleaned from discussions with many stakeholders the situation in respect to HIA is ongoing and new information is constantly being received.

Selection of appropriate participants for the focus groups and in-depth interviews may have biased the outcomes. Selection was based on advice from key sources with further selection influenced by people’s availability and their understanding of services from a consumer’s perspective, a frontline workers perspective or from service management. In this way it was intended to achieve input from the three main levels of stakeholders affected. However, the representativeness of participants needs to be questioned, especially service consumers.
Although input from people living in disadvantaged circumstances such as caravan parks could be said to represent people socioeconomically disadvantaged (and hence most in need of human services) a larger sample from consumers would have enhanced the validity of findings. Also, lack of input from Aboriginal and Torres Strait Islander consumers raises questions concerning experiences of service delivery by this group. Frontline workers, on the other hand were representative of services for major disadvantaged groups. Workers attended focus groups from Indigenous health, ethnic health, disability services, community health, rural health and Centrelink. In-depth interviews were held with frontline workers from Indigenous, ethnic, and men’s health services.

Steering group meetings were held monthly and were representative of a number of sectors and professions including community, health promotion, project proponents, community health, environmental health, education, youth and housing. This enabled regular input, advice and support from a range of expertise.

It was identified that there was a need for future studies to incorporate pre- and post-test of quantifiable data relating to service delivery such as intake and referral data. The lack of this information makes it difficult to identify empirically the impact of service integration on actual service delivery. Future studies will need to include this dimension.

### 1.1.2 Impact and outcome evaluation

HIAs are by nature speculative and therefore open to errors arising from the uncertainty concerning health effects following changes in policy or planning. They have however, a clearly defined objective that is to assess interventions that are not primarily designed to improve health.

As impact evaluation involves following how far the recommendations of the HIA are adopted and implemented by the project proponents then it is not possible to report on the impact evaluation at this stage. Similarly, for outcome evaluation as during this stage, trends in indicators and health outcomes, chosen to signal changes in health status, are tracked and analysed over time.

- In order to track trends in health status after implementation of recommendations, indicators must be chosen that reflect the determinants of health prioritised for amelioration during the appraisal. It is important to be explicit about the method of selecting the indicators. Possible criteria for selection are given in Appendix 775.

If the recommendations of this report are adopted and implemented then it will be necessary to audit the quality of the assessment and to provide information for future impact studies.

1.2 HIA and service integration

As outlined at the beginning of this report, there was a further remit to provide an overview of the HIA process and evaluate its usefulness and identify any problems and pitfalls in its application to service integration.

Increasing recognition of the effects of socioeconomic and physical environments on health may, at least superficially, make it difficult to question the philosophy of health impact assessment. Health impact assessment must bring added value to the decision-making process: it is not sufficient that it simply state the obvious. Kemp\textsuperscript{76} identifies a number of criteria for how HIA may enhance the policy/practice process, these being:

- identifying factors (harmful and favourable) that would not otherwise have been identified
- quantifying the magnitude of harmful and beneficial impacts more precisely than could otherwise have been done
- clarifying the nature of trade-offs in policy-making by better identification and description of the elements involved
- allowing better mitigation of harmful factors or enhancement of beneficial factors
- making the decision-making process more transparent and lead to more participation by stakeholders
- changing the culture so that policy makers always take health into consideration.

The utility of HIA methodology as a tool for assessing service integration needs to consider implicitly Kemp’s\textsuperscript{77} criteria. As service integration does not focus explicitly on health as an outcome, extrapolation of service integration effects need to be considered for their impacts on health determinants. In Section 2.4 of this report a number of dimensions were identified as characterising a place approach to service integration. It is against those characteristics that the usefulness of HIA for assessing service integration initiatives has been set. Within these dimensions the unexpected findings from the study have been included. As previously mentioned, these findings seem to represent the dynamic between theory and practice. HIA enables these elements to be identified and their relevance to health inequalities and future HIA undertaken for service integration considered.

In respect of the following criteria for service integration HIA has been useful in highlighting the following issues:

Community participation and equity

- The important role for representativeness of different communities/cultures in service planning.
- Each community will have unique needs determined by its population mix, history, needs and circumstances.
- Service integration does not specifically address the underlying causes of health inequalities.
- The impact of service access and delivery on quality of life.
- Identifying who misses out eg people not accessing services due to perceived barriers.
- Need to communicate effectively with the community concerning services and how to access them.
- The importance of relationship building for effective service delivery. and
- The need to match consumers needs with services provided.

Responsibility and accountability

- The need for partner organisations to develop protocols for shared and agreed decision-making for priorities.
- The importance of establishing an appropriate and inclusive transition phase from project to program and the roles of local community and other stakeholders in this.
- Key role of establishing protocols for prioritisation of needs and interactions between disparate services eg regarding intake and referral processes. and
- The key role played by project staff in driving the process.

Coordination and integration of service delivery

- The importance of adequately identifying needs of consumer groups.
- Issues around service delivery and responsiveness.
- The importance of good communication and relationships within and between services and the community eg the significant role of the Professional Leadership Certificate Course.

Flexible governance/partnerships

- Unexpected key role of community members.
- A range of issues around service delivery flexibility and cultural sensitivity.
- The important role of relationships in establishing effective partnerships.
- The need to address local community needs through the establishment of partnerships between a range of stakeholders.
1.3 Key learning points

The need to find a common language around practice linked HIA is of ever-increasing importance as is the need to build capacity of Public Health Service staff who can work in multi-disciplinary teams to undertake and evaluate HIAs at the local and systems level. This study is only the beginning of the process and from this it is possible to identify a number of key learning points.

Steering group

Membership of the steering group was multi-sectoral with representatives from the community, government departments and project proponents. Members were chosen for their local community knowledge, contacts and expertise in service delivery and in health issues. Meetings were called and resourced by the Project Officer.

**Key learning points:**

- send out details of meetings well in advance
- confirm details with attendees just prior to meetings
- appoint the Chair at first meeting (not the assessor/project officer)
- at first meeting introduce attendees to HIA to ensure a shared understanding of the methodology. This will enable those unfamiliar with the process to make informal contributions during the discussions
- give consideration to the time-scale of the project you are assessing to ensure that recommendations can be taken up at the planning stage or early enough into the implementation stage.

Advice and guidance

HIA as a methodology for addressing the social determinants of health by Public Health Services staff is still in its infancy within Queensland therefore access to expertise may be limited.

**Key learning points:**

- always seek advice from colleagues and peers who have undertaken assessments, have research skills, and have expertise in areas relevant to the appraisal
- ensure that language is compatible with readers, minimise or explain the use of acronyms or technical language
- be ready for criticism during the developmental stage of the HIA.

Scoping

This relates to deciding how to undertake a HIA in a given context.
Key learning points:

- establish a steering group. The group should be multi-disciplinary and provide advice, guidance and support. It should represent all major stakeholders including project proponents
- set up Terms of Reference (ToR) to define the boundaries of the HIA, budget available, deadlines, the scope of work, outputs involved and methods to be used. Included here is the determinants of health that the study wishes to explore (eg see Table 1-1).

Appraisal

As part of the HIA process it was agreed that focus groups and in-depth interviews would be the method adopted to consult with the stakeholders. This was also to be supported by other unpublished material or ‘grey material (eg videos).

Key learning points:

- focus groups
- recruit directly from the community affected
- provide the focus group with a brief outline of what HIA’s are and why their input is needed. It is also an opportunity to inform them of what will happen with their responses
- the number of participants in focus groups varies but is generally recommended to be no more than 12. This ensures that the group can be adequately managed
- be aware that focus groups may not represent the full view of the community and using outside agencies to take part in the focus groups may also enrich the discussions
- it is advisable that a person directly related to the project be present at the focus group. This will enable any technical and/or difficult questions to be answered
- have a facilitator and an observer in each focus group. The facilitator to chair and manage the group discussions and offer a summary of the points raised, whilst the observer will take notes
- there should also be a tape-recorder present, as this will enable the observer to double check any ambiguous statements made by participants. It is advisable for the recordings to be transcribed by a professional transcription service owing to the time involved (each hour of recording may take 6-8 hours to transcribe) and to use digital recording devices
- ideally an external facilitator should facilitate the discussion group but this requires payment. A good facilitator will ensure that all members contribute to the discussion and that, the subjects are covered without bias
- do not hold too many focus groups, as this will prove time consuming.
• Other methodological issues:
  • Adopt a mixed approach using all available data;
  • The health determinants for service integration assessments to be broader than that identified by the Merseyside model;
  • The methodological steps need to be flexible and not necessarily sequential owing to other items of information becoming available at various times during the course of the HIA;
  • Include a “Comments” section in the data matrix to enable complex issues to be qualified;
  • Incorporate a pre- and post-test of quantifiable data from services directly involved with the service integration endeavour; and
  • Clarify the health issues including who is most at risk and why; and will they benefit the most.

Recommendations

Recommendations need to be prioritised to enable project proponents to identify which options need the earliest attention.

Key learning points

• Read through your notes and/or listen to your tape recording (if you have made one) of the discussions several times, this should help formulate ideas and connecting issues.
• Try to distinguish between positives and negatives; the probability of impact; and whether the impacts are relevant in the short, medium or long-term.
• You may want to concentrate on reducing the negative impacts only, by just noting down the negative issues and identifying any connecting concerns.
Potential criteria for selecting indicators

Selection criteria:

- be worth measuring
- be measurable for diverse populations
- be understood by people who need to act
- galvanise action
- be relevant to policy and practice
- measurement over time will reflect results of action
- be feasible to collect and report
- comply with national processes of data collection.