AusHSI Australian Centre for Health Services Innovation

QUT

The Senior Settlement Worker Health Pilot Project (#healthPAC)

Final Report December 2023

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Prepared on behalf of
CentacareFNQ

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Executive Summary

Background

The Senior Settlement Worker - Health Pilot Project (#heathPAC) was created as a means of addressing the growing need for complex casework support among culturally and linguistically diverse (CALD) clients in Cairns, while integrating community voice and health and wellbeing into CentacareFNQ's Multicultural Services. It aims to deliver culturally appropriate health promotion, advocacy, and capacity building activities to meet CALD client needs across health and local government sectors in the region.

A key part of the project is a Senior Settlement Worker, leveraging on the knowledge, skills, and expertise of Centacare's Multicultural Team and community leaders. The team is highly trusted in the provision of settlement support, and they engage closely with communities to identify needs and develop effective strength-based programs that are community driven through to being community led.

#healthPAC is a strengths-based approach that empowers self-advocacy of clients via linguistic brokerage and system navigation in collaborative partnerships with health services. It also provides capacity building opportunities for CentacareFNQ staff, health providers and other services about meaningful health and wellbeing engagement with CALD and refugee communities.

The Australian Centre for Health Services Innovation (AusHSI) was engaged by CentacareFNQ to independently evaluate the Senior Settlement Worker - Health Pilot Project in 2023.

This evaluation examines the implementation, effectiveness, and sustainability of #healthPAC to deliver health promotion and education for CALD clients; build capacity of CentacareFNQ staff and other organisations to work with CALD clients/communities; and advocate for culturally appropriate health and wellbeing support of CALD communities in Cairns.

The evaluation employed a mixed-methods approach using an established evaluation framework. A comprehensive approach captured information about the project, process, and context in which #healthPAC is delivered, using both objective and subjective measures of impact. Data sources included:

- Qualitative project and reporting data routinely collected by #healthPAC including meeting minutes, reports, resources developed, and administrative records
- Qualitative documentation collected as part of the Cairns 6 (C6) establishment and community consultation process
- Quantitative information from the project's client casework database
- Qualitative case studies on selected casework clients
- Individual and group qualitative interviews with #healthPAC stakeholders in community, health, education, and project roles
- Written feedback from health, social, community and education partner services and stakeholders

To address recall bias, selection bias, or other limitations, data from multiple sources have been analysed and compared (where appropriate) to inform findings.

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Key findings

This evaluation clearly demonstrates the benefits of the #healthPAC pilot project across client, community, provider, organisational, and system level outcomes. #healthPAC's ongoing engagement with community leaders, health providers and service partners, culturally appropriate tailoring of health promotion/education, and ability to overcome access barriers for CALD clients had strong impacts on the reach, appropriateness, and effectiveness of the project within these communities. Providing holistic, culturally appropriate education and access to healthcare has also improved CALD client's health literacy and knowledge, increased their awareness of local health system navigation and access rights, and increased their engagement with mainstream services. Moreover, it would appear that #healthPAC is contributing positivity to system-level advocacy in Cairns and beyond, while also playing a key role in supporting a local ecosystem driving service improvement for multicultural communities.

Moving forward, there is a clear need to better define and communicate the roles, responsibilities, and scope of the project at all levels of implementation. Ideally this should include consideration of internal team composition and funding, as well as how #healthPAC should be integrated into the existing refugee health service system in a complimentary way. Such work will be crucial for long-term project sustainability within Centacare and the broader service system.

Key findings and recommendations from the report are consolidated in the table below.

Client level benefits and learnings
#healthPAC demonstrated good reach of health promotion and education across CALD clients and communities in the region, including those who have previously been hard to reach.
While #healthPAC was able to provide a range of casework activities for clients, its main role was in supporting clients to plan, book and attend healthcare appointments.
#healthPAC played a key role in supporting CALD clients with multiple complexities, who required frequent engagement to access services across varied settings.
A relatively high requirement for language support and repeat casework encounters were observed for #healthPAC, suggesting complexities in both clients and the local service environment.
#healthPAC increased access to health services in the region by breaking down barriers for clients and offering more appropriate types of care. They did this by providing language assistance and interpreters; supporting clients with transportation; going out to communities; making learning social and group-based; adapting existing services; working to build trust over extended periods; sourcing low-cost services; and 'doing it together with clients' to build confidence.
Outcomes suggest effectiveness of the project to: increase client health knowledge; increase client health literacy and understanding of the health system; reduce health education stigmas; increase the capacity of clients to access services, including re-engagement with previously declined services; build connections between clients and services; assist with health service navigation and continuity of care for clients.
Service and provider benefits and learnings
The #healthPAC team was integral to the project's success. Key factors include: bi-cultural workers, understanding of both clinical and refugee local service contexts, responsive communication, compassion and dedication, a funded co-ordination role, existing trust and connection in the community.

CentacareFNQ settlement staff working on the #healthPAC project gained capacity and confidence to provide non-clinical health information and system navigation support to clients and advocate for culturally appropriate care.
Pre-existing positive, trusting relationships that CentacareFNQ/#healthPAC staff had established with local providers and CALD communities were a key driving factor in project implementation and success.
#healthPAC built connections and relationships, and expanded reach of health and social services. It played a pivotal role in linking key health and organisational stakeholders in the sector.
Health and community service providers experienced better reach and engagement with CALD community members as #healthPAC had already built trust.
#healthPAC worked successfully with a number of multidisciplinary services and providers to deliver culturally appropriate health promotion and programs and increase their cultural capacity.
Tensions were observed resulting from unclear/miscommunicated project scope and difficulties for external stakeholders in understanding the senior settlement worker's role within the existing service setting.
Investing in partnerships in the system, clarifying roles and project scope, demonstrating value to the health service, and better integrating with clinical services will be key for sustainability of the project.
Community and system benefits and learnings
The successful establishment of the Cairns 6 (C6), with representation from the six current Humanitarian Settlement Program cohorts was a key outcome of #healthPAC.
Having a funded position to coordinate the C6 group (#healthPAC coordinator) was integral to its success and should be continued. Providing remuneration for members of the C6 was also perceived to be highly important.
Expanding and sustaining the C6 should be a key focus of ongoing work in the region as it will benefit community, local services, and state-wide advocacy by responding to needs and improving CALD service delivery.
Listening to community and delivering contextualised activities or support to meet identified needs was a key philosophy of the project, and part of its success.
#healthPAC made a significant contribution to ensuring that the voice of CALD and refugee communities was included in consultations, networks, committees, and academic research at the local, state, and national level.
#healthPAC helped to create a platform for broader system change related to multicultural health in the region. The project has been integral in driving advocacy for change in other services and helps emphasise the value of listening to community to improve service delivery.
Tensions were observed resulting from unclear/miscommunicated project scope and difficulties for external stakeholders in understanding the specialist case worker's role within the existing service setting.
Investing in partnerships in the system, clarifying roles and project scope, demonstrating value to the health service, and better integrating with clinical services will be key for sustainability of the project.

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Glossary of terms

Acronym or abbreviation	Full name
#healthPAC	Senior Settlement Worker - Health Pilot Project
AusHSI	Australian Centre for Health Services Innovation
CALD	Cultural and Linguistically Diverse
C6	Cairns 6
GP	General Practitioner
FNQ	Far North Queensland
QPASTT	Queensland Program of Assistance to Survivors of Torture and Trauma

Background

Historically, refugees and migrants have struggled to access mainstream health services in Australia due to social, language, knowledge, cultural, and systemic challenges[1]. The COVID-19 pandemic further highlighted the disparities in healthcare access and outcomes experienced by these vulnerable groups[2]. It also highlighted weaknesses in how health services and government engage with culturally and linguistically diverse communities nationally[3]. If healthcare and social services are to play a key role in reducing the health disparities experienced by Culturally and Linguistically Diverse (CALD) communities, they must evolve their practices to better meet the needs of these diverse communities.

Fortunately, local initiatives during the pandemic demonstrated how this could be achieved by inviting community voice into the decision-making process and successfully supporting CALD community engagement with service delivery across multiple sectors[4]. This included engaging with community leaders to advise on community identified priorities, co-creating and co-disseminating resources, and valuing cultural knowledge and expertise. Work that adopts this culturally appropriate, strengths-based approach with communities should play a key role in addressing ongoing inequities across the country.

CentacareFNQ

CentacareFNQ provides social services to Cairns and the wider Far North Queensland region, particularly to people who are vulnerable, disadvantaged or marginalised within the community. The Multicultural Services team is the lead provider of refugee and migrant services in the region. This includes settlement support, community engagement, and employment and training. As part of this, federally funded settlement casework is provided to eligible migrants residing in Australia less than five years.

During the COVID-19 pandemic in 2020, health emerged as an important determinant of successful settlement and so became the focus of CentacareFNQ's work in the region to ensure communities remained connected and safe. During this time, there was a unique opportunity and a regional willingness from all health and intersectional service partners to work closely with CALD communities to support health and wellbeing initiatives. CentacareFNQ led successful regional engagement with local CALD communities and responded to their needs through a range of regional and state-wide initiatives which took a partnership approach with community including Queensland's CALD COVID-19 Health Engagement project[4]. The legacy of this response is evident in the agency's continued support of place-based work with refugee and migrant communities.

Since the pandemic however, CentacareFNQ has seen a significant increase in the need for case management support which falls outside the scope of funded service allocation (i.e. those residing in Australia for more than five years). This includes an increase in older clients, and those presenting with complex physical and mental health needs, such as family and domestic violence. Referral to mainstream health services for many of these clients is challenging as such services are not fully equipped with the level of intercultural knowledge and capacity required to meet their unique and diverse needs[5]. As such, clients are often referred back to CentacareFNQ for ongoing support. This challenge has been amplified by an increased need from additional migrant groups for service navigation including Pasifika, Sikh and Indian communities, and South East Asian Women on Partner Visas.

Unaddressed, this increase in demand creates significant burden on emergency and crisis services, CentacareFNQ, and community leaders who are already stretched for capacity. Although CentacareFNQ has provided considerable advocacy around this growing gap, no consistent funding for service provision has been forthcoming, and a long-term strategic approach for the region is lacking. Consequently, all support delivered out of scope remains unfunded in the region and there is grave concern around sustainability of supports available.

The Senior Settlement Worker Health Pilot Project (#healthPAC)

The Senior Settlement Worker - Health Pilot Project (#heathPAC) was proposed as a means of addressing some of the burden associated with out-of-scope work and sought community partnerships within existing funded services to improve health outcomes for individuals and families. #healthPAC models a strengths-based approach when assessing supportive needs. It aims to empower clients to identify their own journey of care with nominated referral pathways. A key part of the project is a Senior Settlement Worker dedicated to advocacy, health promotion and capacity building within the health and wellbeing space, leveraging on the knowledge, skills, and expertise of Centacare's Multicultural Team and Community Leaders. The overall aim is to support clients to build confidence in service access through strong, trusting relationships with settlement services, primary care, and the hospital system.

The project sits within CentacareFNQ's Settlement team, consisting of qualified social and bicultural workers, caseworkers, assistant case workers and community engagement workers. The team is highly trusted in the provision of settlement support, and they engage closely with communities to identify needs and develop effective strength-based programs that are community driven through to being community led.

Project principles

The project was created as a means of integrating community voice and health and wellbeing into CentacareFNQ's Multicultural Services. Project #healthPAC is underpinned by the principle that health is not the absence of illness but rather a **state of well-being** influenced by spirit, mind, and body. It is also a strengths-based approach that places consideration of **cultural determinants of health, trauma informed and person-centered care** and **cultural safety** at its core.

Project activities

#healthPAC aims to deliver culturally appropriate health promotion, advocacy, and capacity building activities to meet CALD client needs across health and local government sectors in Cairns.

Advocacy – Across health and government sectors. Participation in networks, advisory groups, and forums. Sharing case studies and CALD data. Focus on regional issues. Empower self-advocacy of clients via linguistic brokerage and system navigation in collaborative partnerships with health services.

Health Promotion – Within local CALD communities. In partnership with local providers, programs, and services. Support communities with culturally appropriate activities and resources that are community driven, designed, and endorsed.

Capacity Building – of CentacareFNQ service providers, health providers and other services. How to engage meaningfully about health and wellbeing with CALD and refugee communities, and to be culturally responsive. Increase referrals from settlement services to appropriate health services. Build clinician confidence and support the shaping of flexible systems with community for best care of vulnerable CALD clients.

Evaluation study design

The evaluation used a pragmatic mixed methods design comprising retrospectively and prospectively collected quantitative and qualitative data. It incorporated perceptions of the implementation process from a range of stakeholders to evaluate the effectiveness of implementing the #healthPAC project. The evaluation sought to answer a set of questions designed to determine how successfully the project had been able to meet its aim to deliver culturally appropriate health promotion/education, advocacy, and casework capacity building to support CALD needs across health and government sectors in Cairns.

Objectives

The objectives of the evaluation were to:

1. Evaluate the implementation, effectiveness, and sustainability of the #healthPAC project to deliver culturally appropriate health promotion and education to CALD clients and communities in Cairns
2. Evaluate the implementation, effectiveness, and sustainability of the #healthPAC project to empower and build capacity of Centacare staff, community services, and health providers for best care of CALD clients in Cairns
3. Evaluate the implementation, effectiveness, and sustainability of the #healthPAC project to deliver advocacy for culturally appropriate health and wellbeing support of CALD communities in Cairns

Methodology

Evaluation framework

Evaluation of #healthPAC is based on an integration of the Implementation Outcomes and RE-AIM Frameworks[6]. Both are widely cited and rigorously developed implementation evaluation frameworks developed to assist in the translation of research into practice, policy, and public health impact. They provide measurable outcomes to move beyond effectiveness and consider the implementation processes and program elements that underpin success and sustainability.

RE-AIM[7] comprises five dimensions related to health behaviour interventions: Reach (and Representativeness) into the target population, Effectiveness of the project, Adoption by target settings and groups, Implementation, and Maintenance or sustainability over time. The Implementation Outcomes Framework[8] provides a way of measuring and understanding the precursors to achieving success in each of these dimensions. Namely the appropriateness, acceptability and feasibly of the project and its implementation. A description of each dimension with respect to implementation precursors in the context of the current evaluation is provided in Table 1. The dimensions of the RE-AIM Framework and outcomes of the Implementation Outcomes Framework are well matched to the needs of this evaluation and could be informed by available data.

Table 1. Description of RE-AIM Framework dimensions and implementation outcomes

RE-AIM dimension	Description of RE-AIM measure	Description of implementation precursor measures
Reach	The absolute number, proportion, and representativeness of individuals (CALD community members) who were engaged or served by the project and reasons why or why not	Acceptability/satisfaction of clients with #healthPAC Appropriateness of #healthPAC to address client needs
Effectiveness	The impact of the project on important client and service level outcomes e.g. service provider knowledge and capacity, appropriate referrals, client service navigation, client health knowledge	
Adoption	The absolute number, proportion, and representativeness of service settings, groups and communities who took part in the project's activities/events, and why or why not	Acceptability/satisfaction of service providers with #healthPAC Appropriateness/compatibility of #healthPAC within provider services and settings Feasibility of delivering #healthPAC within services settings
Implementation	The fidelity to the project's key principles and components. Barriers, enablers, and experiences of implementation.	Acceptability/satisfaction of service providers with #healthPAC Appropriateness/compatibility of #healthPAC within provider services and settings Feasibility of delivering #healthPAC within services and settings
Maintenance	At the setting level, the extent to which #healthPAC becomes part of the routine organisational practices and policies. The likelihood that #healthPAC will be sustained in the medium to long term.	Acceptability/satisfaction of organisations with #healthPAC Appropriateness/compatibility of #healthPAC with organisation Feasibility of delivering #healthPAC within organisation

Data sources and collection processes

The evaluation took a pragmatic approach using a combination of existing data and data captured specifically for this purpose. All data for the evaluation was collected by either AusHSI researchers or #healthPAC project team members/partners as outlined in Table 2 below. Descriptions of this process and the agreed data collection matrix can be found in the #healthPAC Pilot Project: Evaluation Plan. An overview of the data types, sources and collectors can be found in Table 2. Project data for this evaluation was considered for the period from 1st February 2023 to November 30th 2023. All prospective data, including interviews, emails, and discussion groups, was collected between August and November 2023.

Qualitative and quantitative data were triangulated to increase rigor. This triangulation of data from multiple sources helps to mitigate some of the biases involved with single data sources, provides a more holistic perspective on the program, and allows for increased trustworthiness and validity of the findings[9].

Table 2. Description of data used in the evaluation

Data source	Data collector
Qualitative	
Semi-structured interviews and focus groups with #healthPAC decision makers and implementors	AusHSI evaluator
Semi-structured interviews and focus groups with health, social, community and education partner services/stakeholders	AusHSI evaluator
Written feedback and emails from health, social, community and education partner services/stakeholders	#healthPAC project team; AusHSI evaluator
Documentation from Cairns 6 meetings	#healthPAC project team
Case studies on selected clients	#healthPAC project team
Documents: resources developed	#healthPAC project team
Quantitative	
#healthPAC casework database	#healthPAC project team
Qualitative & Quantitative	
Documents: #healthPAC project administrative, reporting, and organisational records*	#healthPAC project team

**includes advocacy and educational activities, project reporting, meeting minutes*

Data collection tools and participants

A semi-structured interview guide (Appendix 1) was developed by AusHSI and used to facilitate group and individual discussions. An AusHSI evaluator conducted virtual interviews and focus groups with key organisational level stakeholders such as administration, leadership, policy, and service delivery staff, project coordinators, and reference group participants. These were conducted in English, digitally recorded, and transcribed.

Table 3 provides a full list of organisational level stakeholders interviewed for the evaluation. In total, AusHSI conducted six interviews/focus groups with a total of 13 participants and received written feedback from a further four participants (total 17 participants). Participants came from a diverse range of partner organisations, as well as health services and education. As part of our ethical commitment to protect the privacy of individual interview participants, interviewees are not named by agency, organisation, or specific role within the report. Rather, those who contributed quotes to the report have been designated aliases P1-P8 in no particular order, which reflects participants across all 6 interviews. This is important as there is a risk that interview participants may be identifiable to each other due to relationships within the #healthPAC project and CALD community.

No #healthPAC clients were interviewed for this project. The impact of the project on clients was only considered from the perspective/options of project staff/partners and via any feedback which was already received by the project team through routine implementation of activities e.g. asking participants at an event to provide feedback at its completion.

Table 3. Characteristics of the 17 evaluation participants

Interviews and discussion groups			
Interview number	**Individual vs group**	**Number of participants**	**Type of organisation or group**
1	Group	6	CentacareFNQ & #healthPAC project team
2	Individual	1	Specialist refugee health provider
3	Group	3	Specialist refugee health provider
4	Individual	1	Mainstream health provider & health education provider
5	Individual	1	Education provider
6	Individual	1	Mainstream health provider & health education provider

Written feedback	
Participant number	**Type of organisation or group**
1	Specialist refugee health provider
2	Mainstream health service
3	Mainstream health service
4	Mainstream health service

Data analysis

The research team at AusHSI led data analysis for the evaluation. The analysis was conducted using de-identified aggregate and individual level outcome data. A broad mixed-methods approach was applied. For quantitative indicators, descriptive statistics such as counts, percentages and means were used to calculate and present the relevant results and outcome measures.

For all types of qualitative data (including interviews, discussion groups, written feedback, project administrational and organisational data), a rapid analysis approach[10] was used to synthesise raw data and derive common findings across all sources. The evaluation questions and integrated outcomes framework guided data analysis, however no predetermined expectations or themes were applied. For qualitative data relating to the Implementation outcome, we applied a systematic assessment of multi-level contextual factors important for program implementation and sustainability. The valence of factors influencing the program were rated as being a barrier, a facilitator, or having a neutral impact on implementation. Methods used to maintain trustworthiness and rigour of the qualitative analysis included double coding by researchers experienced in qualitative research and implementation science.

Ethical requirements

The evaluation was approved by QUT's University Human Research Ethics Committee (approval number 7812).

Methodological limitations

Overall, the AusHSI team assessed the data as being sufficient to inform a robust evaluation of #healthPAC. #healthPAC staff have generally been rigorous in their data collection. However, some limitations should be noted. #healthPAC nominated internal and external stakeholders for AusHSI to approach for qualitative interviews and feedback. Hence, it is possible that the stakeholders who shared their opinions and experiences about the project differ from those who did not participate in this evaluation.

Further, some interview participants, for a variety of reasons, may have shared information that they believed to be more socially acceptable than their true beliefs. AusHSI limited opportunity for these biases to affect data collection and analysis by devoting time to developing a good working relationship with the partners and engaging with all key stakeholders in regular communication. Further, when possible, AusHSI ensured a broad range of stakeholders was engaged as participants.

Also, without a randomised controlled trial, attribution of outcomes is often difficult in complex partnership and social service delivery interventions such as #healthPAC. However, both quantitative and qualitative data have been used and triangulated where possible to increase confidence in findings while acknowledging limitations.

Results

The evaluation was designed to determine how successfully #healthPAC was able to achieve its three stated objectives by considering the outcomes of reach, effectiveness, adoption, implementation, and maintenance. As with any real-world health or social services evaluation assessing a broad range of activities and outcomes, limitations in the robustness of the data mean that it is not possible to make causative attributions. To increase robustness, quantitative and qualitative data have been used to undertake the evaluation while acknowledging the limitations mentioned above.

Current data for the project provides only a partial picture to assess whether #healthPAC meets its objectives. The expert opinions of #healthPAC staff, staff from other stakeholder organisations, and available administrative and program data (supported by relevant literature), are the principal sources for most of the key findings.

Client-level outcomes

The following section details findings related to #healthPAC outcomes at the level of the individual client. It seeks to understand the **reach** and **effectiveness** of the project to build capacity of individuals to access health services, as well as deliver culturally appropriate health promotion and education to CALD clients and communities in Cairns (Evaluation Question 1). It also includes an analysis of the **implementation** of #healthPAC to understand 'what has' and 'what has not' worked in terms of the delivery model along with its appropriateness and ability to effectively address client needs. This section draws on qualitative data captured from project reports, case studies, email correspondence and stakeholder interviews. Quotes from these sources are used where appropriate to support findings (*indicated as such*). Quantitative sources in this section include the project's casework database and project reports.

#healthPAC delivered a range of activities which had direct impact on CALD communities. These can be categorised as client casework, bespoke community information sessions and programs, and resource development and dissemination.

Client casework

One of the key aims of #healthPAC is to deliver specialised health casework services for CALD clients with complex health needs. It models a strengths-based approach when triaging supportive needs, aiming to empower clients in their identified person-centred and shared plan of care with nominated referral pathways. The casework service is led by a specialised case worker, employed specifically for #healthPAC, and with experience in both health and multicultural service delivery in the region. The specialised case worker is supported by settlement case workers and community engagement workers from CentacareFNQ's Multicultural Team, many of whom are bi-lingual. This is important given that the specialist case worker does not come from a refugee background or speak any of the languages of settled CALD communities. The specialist case worker also supported the Multicultural Team to build capacity in leading client referrals and service navigation.

What did casework service delivery look like?

The casework team provided a range of services to 45 different CALD clients (Figure 1) across 230 encounters. While these varied from client to client, broad categories of service activity could be observed. A list of these activities and specific examples are provided in Table 4.

Importantly, the cultural backgrounds of #healthPAC casework clients reflect those of the recently settled Cairns refugee community at the time of the project, suggesting good representative reach into groups at need. For example, the largest number of new arrivals to the region came from Congolese backgrounds in 2023, while far fewer came from Myanmar. The comparatively lower number of Bhutanese and Ukrainian clients likely reflects their status as longer settled cohorts.

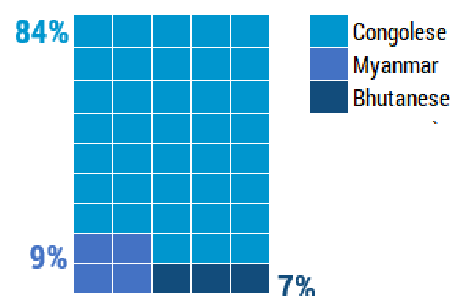

Figure 1. Ethnicity of #healthPAC clients. Each box is one client.

Table 4. Description and categorisation of #healthPAC case work activity

Case work activity	Example tasks
Assist clients with booking appointments	Assist the client to book or rebook health care appointments; support understanding and completion of paperwork related to bookings
Assist clients with social care and non-health services	Assist with access to, and navigation of, social care and non-health services as needed e.g. real estate, schools, citizenship. Communicate client needs to services.
Coordinating care with other services	Work with other services to provide person-centred, culturally appropriate, coordinated care for clients as needed. This has occurred via case conference and joint consultations; and supporting clients while in emergency care of the health service.
Client follow-up (general)	Follow up with clients before or after participation in health promotion activity (Breast Screen, My Health for Life); confirm needs for support
Client follow-up (wellbeing check)	Perform home visits or phone-based wellbeing checks for clients as required
Perform intake for My Health for Life program	Perform intake for culturally adapted chronic disease prevention program, My Health for Life
Prepare clients to attend appointments	Work with clients, families, and services to establish access plans for appointments; negotiate access for clients; develop transport plans for clients; remind clients about appointments
Provide health advocacy	Provide health advocacy support for individual clients as needed
Provide health education resources	Provide in-language health resources to clients
Refer, correspond and/or follow-up with external health services	Refer clients to other services; liaise with external health services to follow-up on referrals and/or ensure the needs of the client are met
Support clients to attend appointments	Telehealth, phone or in-person attendance with clients at appointments; provide transport; help navigate and understand appointment; provide interpreter or bi-cultural support

Most of the casework delivery was performed either in-person (n=107 encounters) or over the phone (n=99 encounters) (Figure 2). The specialist case worker was involved in every client encounter, except for the intake of five clients to the My Health for Life program (n=225, 98% of all encounters).

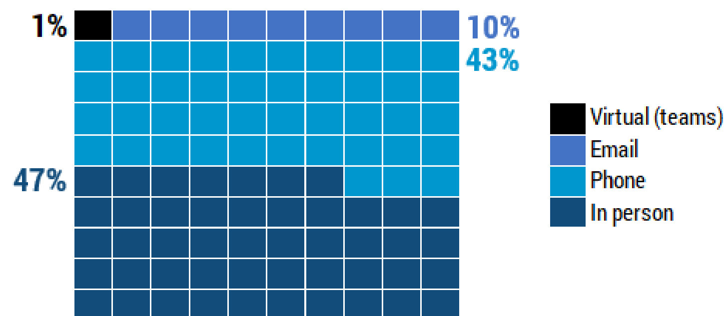

Figure 2. Proportion of casework service activity delivered by phone, in-person, email, and virtual means

Language support was utilised for more than half of all casework encounters (Figure 3). This included the use of CentacareFNQ's own bi-cultural staff when required. This is comparatively more language support than was required for a similar model of CALD casework implemented in Brisbane (where 33% of encounters involved interpreters)[11]. Such a finding could suggest both poorer English language skills in this regional cohort, and/or deficiencies in interpreter access and use by Cairns mainstream health service providers. To assist with these needs for language support, an additional staff member not directly funded by the #healthPAC project (e.g. from CentacareFNQ, QPASST, or My Health for Life) was involved in the delivery of 27% of client encounters. Besides language support, the addition of these staff was also used as an opportunity to model the importance of bi-cultural support in the region and acted as a capacity building opportunity for local services the project engaged with. Additionally, in partnership with the Specialist Case Worker, the CentacareFNQ staff were able to build their own capacity in providing casework support and understanding client needs and appropriate referral pathways.

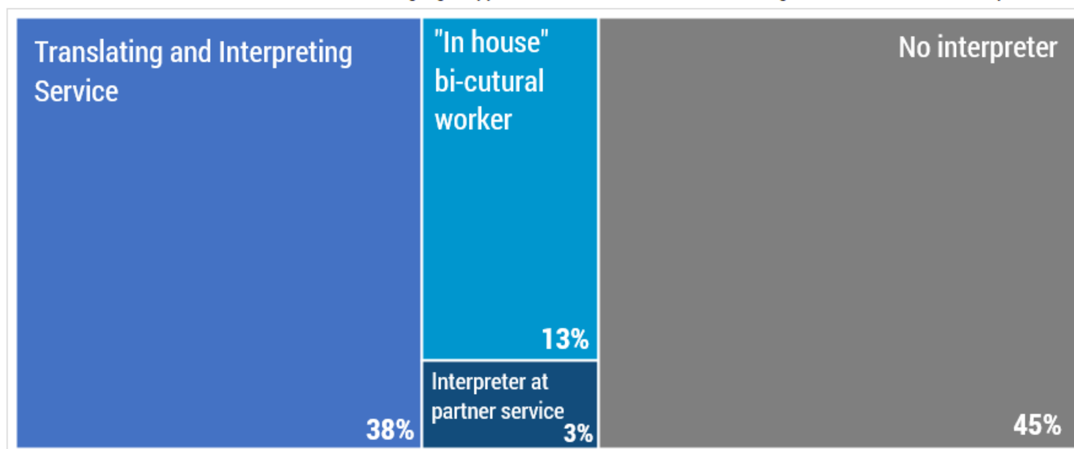

Figure 3. Proportion of casework encounters which utilised language support

What were the most frequently delivered casework activities?

Overall, half of all encounters (n=117) were related to helping clients plan, book or attend healthcare appointments. One-quarter of casework load was related to client follow-up (n=54), while most of the remainder (n=57, 25%) involved communicating and collaborating with external health services and professionals.

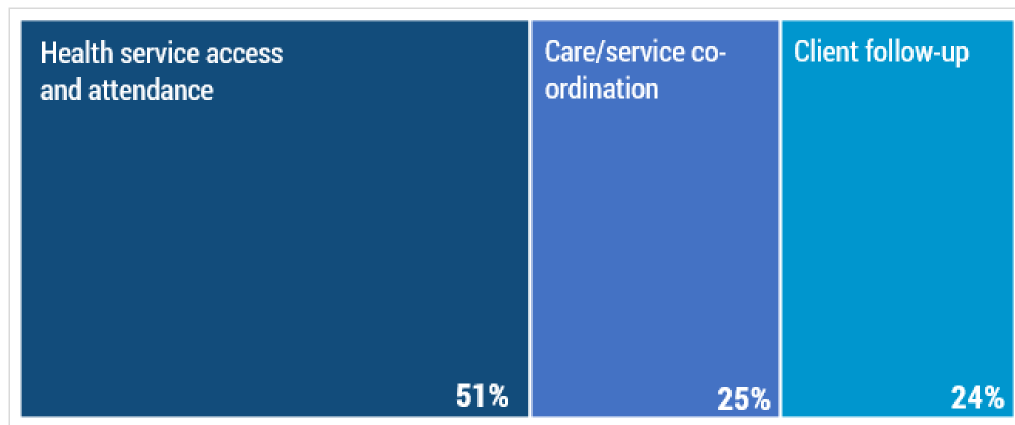

Figure 4. Proportion of casework dedicated to high-level categories of activity

A review of all individual encounters in the casework database (n=230) highlighted that the largest proportion of the project's casework activity was related to supporting clients to attend appointments (one-third, Table 5). These were mostly appointments with general practitioners, imaging services, and pathology services, but also included some with allied health providers and at the local hospital. For 13% of these encounters, #healthPAC also provided the clients with transport to attend the service. Overall, this constitutes a slightly higher proportion of casework dedicated to appointment support than that observed in the Brisbane-based multicultural support project[11]. Once again, such disparities most likely reflect differences in client complexity or system-level challenges in the Cairns region. For example, despite not having Translating and Interpreting Service (TIS) support for clients, Cairns local pathology and imaging services mandate an interpreter or support with language capacity as an access requirement. Consequently, much of this language and access support has fallen to #healthPAC, who provide bi-lingual caseworkers or use their own TIS at appointments for client access. This system-level policy is likely impacting the amount of client support required in the region, however without this language support, service access would be much more challenging for CALD clients.

Besides enabling increased service access in the first instance, #healthPAC's support to attend appointments was also part of a capacity building approach focused on 'doing it together'. Attending with a trusted #healthPAC team member encouraged greater confidence and relationship building with the external health provider, which it was hoped would translate into the ability to better engage with the service independently in the future. This type of casework also built the capacity of the health provider involved (e.g. GP, physiotherapist) to better understand the needs and preferences of CALD clients.

Table 5. Proportion of total casework load spent delivering each type of activity

Casework activity	Total service encounters	Proportion of total casework load
Support clients to attend appointments	79	34%
Corresponding and/or follow-up with external health services	29	13%
Client follow-up (wellbeing check)	28	12%
Client follow-up (general)	26	11%
Assist clients with booking appointments	23	10%
Prepare clients to attend appointments	15	7%
Perform intake for My Health for Life program	12	5%
Coordinating care with other services	9	4%
Assist clients with social care and non-health services	7	3%
Provide health advocacy	1	<1%
Provide health education resources	1	<1%
All activities	**230**	**100%**

How did clients engage with #healthPAC casework?

Engagement of local clients with #healthPAC casework has grown over time. New clients are regularly enrolled in the service and the casework activity has been particularly busy since August (Figure 5). This increase in activity aligns with the arrival of the largest and most complex cohort of families the region has ever settled. September was #healthPAC's busiest casework month, with 50 recorded encounters from 21 different clients, 14 of whom were new. On average #healthPAC supported 10 unique clients each month across 23 encounters and enrolled 4-5 new clients. The unplanned absence of the Specialist Case Worker in June is clear, with no casework service activity provided to clients at the time. Given that trust and continuity of care are so important in this population, establishing contingency plans for emergent leave should be a priority of future service delivery. It must be noted though that the #healthPAC team were able to successfully coordinate and deliver a bespoke health promotion session in the absence of the Specialist Case Worker (see below).

Two-thirds of all clients (n=29) engaged #healthPAC for **support to attend appointments** (Table 6). Other casework activities that were commonly provided included referral and correspondence with external health services (33% of all clients) and general follow-up (31% of all clients).

Figure 5. Counts of individual casework encounters, unique clients, and new clients each month of the #healthPAC pilot

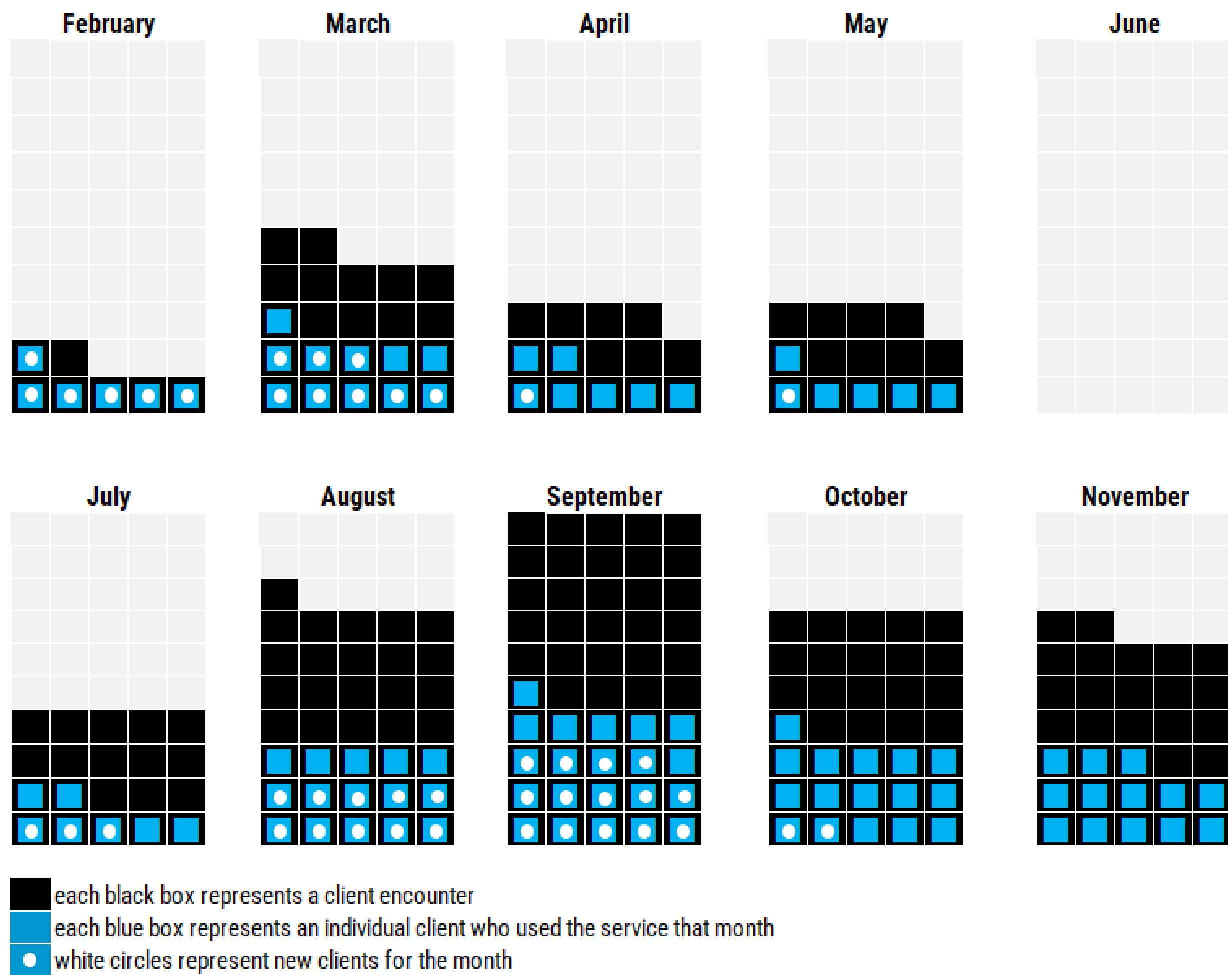

Table 6. Proportion of clients who engaged with each #healthPAC casework activity

Casework activity	Number of clients who required this activity	Proportion of clients who required this activity
Support clients to attend appointments	29	64%
Corresponding and/or follow-up with external health services	15	33%
Client follow-up (general)	14	31%
Perform intake for My Health for Life program	12	27%
Assist clients with booking appointments	11	24%
Client follow-up (wellbeing check)	8	18%
Prepare clients to attend appointments	8	18%
Coordinating care with other services	6	13%
Assist clients with social care and non-health services	4	9%
Provide health advocacy	1	2%
Provide health education resources	1	2%

The median number of visits across all clients was two, however the frequency of client engagement with the #healthPAC casework team varied greatly. While one-third of clients only recorded one interaction, others recorded many more. In fact, seven clients (15%) made up 60% off all encounters recorded by #healthPAC between February and November. The most frequent of these attendees had 43 encounters over a period of 9 months. The profile of activities required by this group of frequent attendees did not however differ from the broader group, except for an increased proportion of wellbeing checks. Overall, the number of encounters per client was more than twice that observed in the Brisbane casework pilot[11].

While it could be argued that this highly frequent engagement with #healthPAC casework suggests that the project is not supporting these community members to build confidence in accessing services independently, particular caveats must be considered. This group of clients were some of the most vulnerable in the community: generally women who had experiences of torture or trauma pre-settlement and minimal language capability and health literacy. In addition, many had complexities related to single parenting of multiple children, relationship breakdowns, family and domestic violence, housing, chronic pain, and substance abuse. Consequently, they needed to navigate large challenges in many unfamiliar settings and spaces, requiring multiple contacts with the #healthPAC team to break these down into smaller, more manageable tasks. These more frequent contacts also provided multiple opportunities for capacity building at different levels and in different scenarios.

Trust building is also a key requirement underpinning service access within this group. However, trust building could not be done with a one touch approach due to the multiple complexities present. Consequently, #healthPAC employed an approach to take up every opportunity to do things together, to build trust and confidence in referral pathways. Not only does this approach explain the high frequency of casework recorded, but ‘doing it together’ was also critical to breaking down the barriers that this group had placed for themselves about access. By fostering trust, providing ongoing support, and addressing systemic failures, #healthPAC aimed to empower this group to eventually access services independently, despite the complexities they may face.

Finally, this data reflects not only those most vulnerable clients reaching out for support to #healthPAC, but also local services reaching out to better support these clients. For example, as the project progressed, and services were initially engaged with this group of frequent attenders, they would reach out for further support to deliver culturally safe services. The strategy employed by #healthPAC was to use a trust building model to gently support one-on-one direct communication between these clients and services over an extended period.

What were the impacts of #healthPAC casework on complex clients?

Case studies were provided to the evaluation team to demonstrate the impact of #healthPAC casework on selected complex clients with frequent service engagement. However, due to the potentially identifying nature of these case studies, the evaluators have chosen to summarise the key findings and recommendations from the case studies in broad terms which demonstrate the acceptability, appropriateness, and effectiveness of the project on building capacity of clients.

Client A: newly arrived via the humanitarian settlement program, referred to #healthPAC to support health service access for complex health needs

What did #healthPAC do?: #healthPAC was engaged to support the client within the emergency department of the hospital. The caseworker used personal connection, laughter, in-language communication, and compassion to support the client in a triggering environment while building a trusting relationship. They also responded to observed client needs in a gentle way, offering information about culturally appropriate services without pressuring referral.

What was the outcome?: The client was successfully supported while at the hospital. They also continued to be supported by #healthPAC for ongoing mainstream service access and later requested, unprompted, referral to a culturally appropriate health provider where this had previously been declined. These outcomes suggest appropriateness of the first contact/approach for building trust and effectiveness of the program to provide service access where other approaches may have failed.

"…as we waited, I felt a shift in energy. I looked beside me to catch a stream of tears. In that very raw and human moment, I listened, I leaned in and offered my hand and after some time gently spoke about the QPASTT (culturally sensitive and trauma-informed counselling) service. I did not mention referral again and whilst supporting Client A in the following days they asked further about QPASTT and for a referral to the service. The initial offers of QPASTT referral by other services had been declined" [#healthPAC caseworker]

Client B: had been in Australia for 5 years, self-referred to #healthPAC for support with health service access for chronic pain

What did #healthPAC do?: Helped the client access low-cost, timely and culturally appropriate support for their pain. The client was invited and participated in #healthPAC's bespoke pain clinic held in partnership with North Queensland Persistent Pain Management Service. Provided support to seek GP referral pathways to support chronic pain. Sought funding to cover gap fee of private allied health services.

What was the outcome?: Client independently attended appointments with GP and continues to do so. With the cost barrier removed, attended previously declined allied health services. Leant how to use community support to attend appointments. Accepted previously declined referral to QPASTT. These outcomes suggest effectiveness of the program to provide service access where other approaches may have failed and to build capacity of the client to self-access services in the future. The appropriateness of #healthPAC to meet the client's needs was reflected in frequent casework encounters to facilitate access to previously declined or inaccessible services.

Bespoke community education and health promotion programs

#healthPAC also aimed to deliver strength-based education and health promotion to CALD communities in Cairns to broaden their understanding of Australian health service access (including supports in their own language) and increase health literacy, and knowledge about health and well-being. As CentacareFNQ is not a health service provider, they partnered with local health services and organisations to develop and deliver culturally tailored workshops, programs, and events for community which targeted identified needs.

#healthPAC delivered tailored sessions in partnership with services

Between February and November #healthPAC partnered with 12 different groups and organisations to deliver eight community events to more than 400 CALD community members (Table 7). This suggests considerable reach of the project, including to those communities which are often less engaged, such as seasonal workers (see case study box). Many of these sessions were designed to meet a community need or challenge. For example, long waiting lists and difficulties with service access for the Northern Queensland Persistent Pain Management Service were creating considerable issues for many CALD clients with persistent pain, often secondary to trauma. In response, #healthPAC was able to use their networks of connection to engage with the psychologists in that service and bring them to CentacareFNQ to deliver a bespoke workshop for CALD clients. How this event delivered against appropriateness and effectiveness outcomes is described in more detail in the case study below.

Case study of bespoke community education: Healthy Living with PALM

What did #healthPAC do and how did they tailor the service to be appropriate for clients?: brought the experts to a hard-to-reach community (Rainforest Lodge, Tolga), split into groups by gender; provided language support from local workers and CentacareFNQ staff; encouraged question asking and discussion; taught practical nutrition tips relevant to them and their work; provided information and resources for further health service contacts; provided catering (BBQ).

What was the outcome?: Effectively engaged a large number of hard-to-reach CALD community members. Has built increased interest of this group to received further tailored education.

Case study of bespoke community education: Queensland Health Pain Clinic

What did #healthPAC do and how did they tailor the service to be appropriate for clients?: brought the health experts to community; provided language support; encouraged sharing of stories and experiences in a non-threatening way to stimulate discussion; taught skills for dealing with pain; provided resources for further health service contacts, emphasised holistic approach to health and wellbeing; provided catering and gift (heat pack).

What was the outcome?: Participants provided positive feedback including gain in knowledge about medications, the role of a GP, and healthy behaviours, as well as skills in deep breathing and relaxation.

Table 7. List of #healthPAC community education and events delivered with external partners

Health or community partner	Topic/s	Month delivered	Number of attendees
St Francis Xavier School (staff)	The Refugee Journey - global, national, and regional context; role of settlement services; trauma informed practice	January	30
Pacific Labour Facility, Cairns Sexual Health Service, Queensland Police Service; Cairns Regional Domestic Violence Service	Oral health, skin health, healthy living (nutrition and exercise), mental health and wellbeing, how to seek help in own language, sexual health, alcohol-related topics, domestic violence services/support, medical review	February (2 sessions)	130 and 120
TAFE, Cairns Regional Domestic Violence Service, True Relationships and Reproductive Health - Health in My Language (HIML)	Health implications, current statistics and domestic and family violence services to help support friends, relatives, or themself in referral support	March	16
Breast Screen Queensland	Breast health information and opportunity of breast screen afterwards	March, May, and October	41
Mareeba Hospital Midwives, Cairns Sexual Health Service	The Refugee Journey - global, national, and regional context and role of settlement services; Cairns Sexual Health Service outreach initiatives with seasonal workers	April	12
True Relationships and Reproductive Health (HIML); Elder's Group	Bowel screen education	May	20
Queensland Health Pain Clinic	Understanding and managing persistent pain	June	26 (+ caregiver)
Hearing Australia; Elders Group	Hearing education and opportunity of hearing screen afterwards	June	20
Cairns African Association, Queensland Program of Assistance for Survivors of Torture and Trauma, True Relationships and Reproductive Health, Cairns Sexual Health Service	Healthy Relationships in Community		Planned for Feb 2024

#healthPAC delivered tailored health programs in partnership with other services

#healthPAC also sought opportunities to partner with those running established programs and support them to provide health promotion activities to CALD clients over a longer period. This included a sexual health and relationships unit for Year 12 students with English as an additional language or dialect at Trinity Bay State High School and a chronic disease prevention program with Health and Wellbeing Queensland (Table 8). Both of these programs were delivered in a format specifically designed for CALD attendees. While the school-based unit had been running previous to the establishment of #healthPAC, the piloting of My Health for Life in Cairns was a direct outcome of the project's delivery.

Table 8. List of #healthPAC health promotion programs delivered with external partners

Main health or community partner	Other services or partners engaged	Topic/s	Duration	Number of attendees
Trinity Bay State High School	True Relationships and Reproductive Health, Cairns Sexual Health Service, Lives Lived Well, Services Australia	Sexual health, consent, safe sex practices, gender and sexuality, pregnancy and contraception	1.5 hours per week over 10 weeks (July- September)	25
Health and Wellbeing Queensland (My Health for Life)	Ethnic Communities Council of Queensland chronic disease team	Chronic disease risk, health barriers, goal setting, lifestyle change	6 sessions over 4 months (August- November)	19 (varied attendance by session 9-14)

Case study: sexuality and relationships unit at Trinity Bay State High School

What did #healthPAC do and how did they tailor the service to be appropriate for clients?: partnered with a sexual health provider that had experience working with CALD clients; added value to an existing culturally tailored health promotion program; used networks to link in new services with program such as Lives Lived Well; went to community; utilised existing language support; encouraged question asking in non-threatening way (including anonymously); established a longer-term relationship with the students.

What was the outcome?: Student's feedback reflected positive experiences with the program. They particularly liked being able to ask questions and have them answered by experts. When asked about something they had learnt most cited safe sex practices.

"I liked everything we talked about in this sex class. I enjoyed talking about healthy relationships as well as consent." [feedback from Year 12 student]

"I liked how we were answering the questions." [feedback from Year 12 student]

My Health for Life

As part of the project, #healthPAC was able to capitalise on an emergent opportunity to collaborate on a trial adapting [My Health for Life] for the Cairns CALD community. This is an evidence-based, funded, and established program run out of Brisbane to participants across the state. It uses a health coach to deliver health information and behaviour change to support healthier choices. #healthPAC partnered with Health and Wellbeing Queensland and the Ethnic Communities Council of Queensland (ECCQ) chronic disease team, who are experts in delivering this type of service, to expand the program to Cairns. In doing so they were able to offer a free, 6-week program to #healthPAC clients who were at risk for chronic disease such as diabetes, cardiovascular disease, stroke, or kidney disease. The My Health for Life team travelled to Cairns to facilitate the initial session and health assessment with clients face-to-face, and then helped to support four online sessions and one face-to-face session over a four-month period (Table 9). All sessions were delivered with two members of the ECCQ team and four of the Cairns Multicultural Service/CentacareFNQ service team.

Table 9. Details about the delivery and uptake of the #healthPAC My Health for Life CALD program trial

Session	Modality	Topic	Number of attendees
Health check/intake	F2F via #healthPAC	Screening your risk of developing a chronic disease - questionnaire	19
Session 1	Face to face	Introduction to program, understand your risk and focusing on areas you can make changes. Pre-program evaluation	9
Session 2	Online	Understanding risks and prevention of chronic disease	13
Session 3	Online	Planning for success and physical activity	14
Session 4	Online	Engaging support and nutrition	12
Session 5	Online	Adjusting for change, alcohol, and smoking, sleeping, living and coping well	11
Session 6	Face to face	Maintaining healthy habits and program feedback review. Program maintenance evaluation	8

A total of 19 clients were enrolled in the program: 12 females and 7 males ranging in age from 21 to 61 years (mean age: 48 years). They spoke Burmese (37%), Kinyarwanda (16%), Nepali (26%) and Swahili (21%) as their primary languages. On average participants attended 3-4 out of the six available sessions, with two clients attending all six. Four clients dropped out due to work commitments or relocation. Despite potential concerns that using a hybrid model "*reduced face-to-face interaction that can be encouraging to participants*" [email feedback], this delivery format appeared to be an appropriate means of program delivery with good online attendance numbers and engagement with the program reported to be strong.

Case study: My Health for Life program

What did #healthPAC do and how did they tailor the service to be appropriate for clients?: adapted an established mainstream program to CALD community; brought experts to community; tailored content to community; provided sessions in Easy English with group language support from qualified workers in Kinyarwanda, Swahili, Nepali (CentacareFNQ) and Burmese (ECCQ).

"Having bi-lingual staff available on the ground made the process of delivery run smoothly and allowed the participants to grasp the information in a language they are comfortable with, enhancing outcomes." [email feedback from provider]

What was the outcome?: Built both client capacity and #healthPAC/CentacareFNQ team capacity in chronic disease prevention; expanded reach of an existing program into a new region; positive experience for providers, partners and clients.

"It has been such a great experience being able to support CentacareFNQ under the #healthPAC initiative and be able to connect with communities up north." [email feedback from provider]

Resource development and dissemination

As part of its aim to build capacity of individuals to access health services and deliver culturally appropriate health promotion and education to CALD clients and communities in Cairns, #healthPAC was involved in the development and dissemination of tailored health resources. The project developed two sets of locally relevant health information flyers (Figures 6 & 7):

1. Healthy Breast 5 – encouraging breast cancer screening, in Easy English and Kinyarwanda
2. 5 Handy Health Points – highlighting oral health, skin health, food, sleep, exercise, mental health, and the importance of medical review, in Easy English and Samoan

All flyers contained a QR code which, if scanned, directed readers to simple YouTube videos produced by CentacareFNQ, in English and language, with further information and directions about how to access health services. Delivering information in multiple formats such as this is a key communication strategy for CALD communities[4]. These resources also capitalised on another known strategy of using images and videos of local community champions and trusted bi-cultural workers to share messaging. Since their creation, these resources have been shared across the state by the Refugee Health Network, enabling greater reach of #healthPAC beyond Cairns. It is planned for the newly formed Cairns 6 group to identify new topics for resource creation and dissemination to meet community needs.

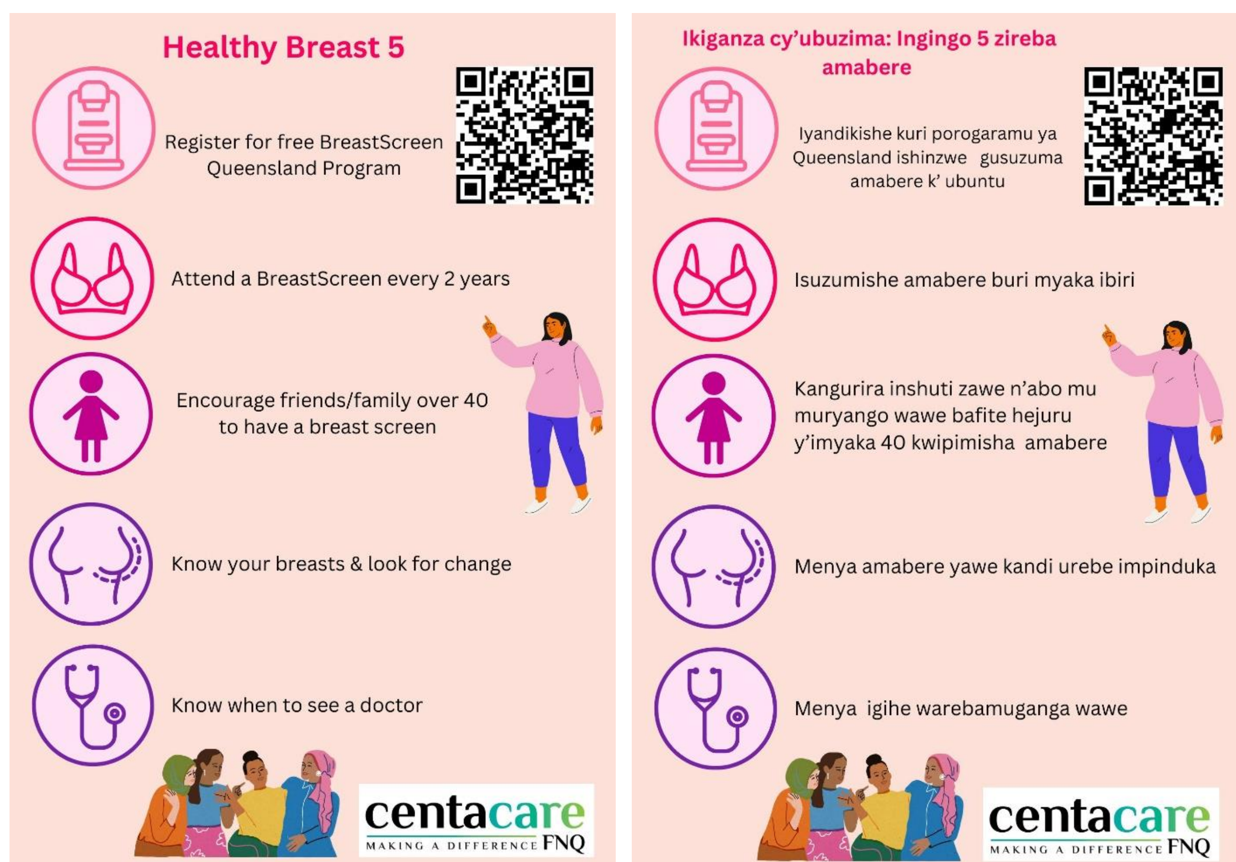

Figure 6. Breast health resources developed by #healthPAC

Figure 7. General health resources developed by #healthPAC

Types of positive outcomes noted for CALD clients

Based on analysis of interviews and feedback from stakeholders, project documentation, and the casework database, a range of positive outcomes were observed to have occurred for clients who engaged with #healthPAC activities. These outcomes included:

- An increase in education and understanding of health topics
- An increase in health literacy and understanding of the health system, including rights to have medical information in their language: *"they have confidence after doing this multiple times with #healthPAC support to ask for this." [P1, interview]*
- High engagement of clients with culturally adapted sessions and services (community buy-in): *"You know, the hype around Covid and vaccines is gone. But we are still having community wanting information sessions on health. You know, prior to Covid, no one wanted information sessions. The girls couldn't even get ten people to attend sessions. Now, you know, we're trying to break (sessions) into four groups to manage the influx of people that are occurring." [P1, interview]*
- Connection with other community members via groups and education sessions: "*He's [client] gone along and he's really engaged and really interested. And I think [it helps] connecting with others to talk about some of these topics." [P3, interview]*
- Decreased stigma around learning about health (even sexual health)
- Capacity building of community leaders and C6 to assist with health service access
- Increased capacity of clients to access other services, including re-engagement with previously declined services: "*Clients who were not engaging with services, who had declined initial offer of services such as QPASTT, after time spent together in accessing other services and supports, with regular wellbeing check ins, did later ask further about QPASTT and consent to referral and continue to engage currently." [P1, interview]* and help to access low-cost services: *"building knowledge that these options actually exist and how to make connections." [P1, interview]*

- Increased awareness and uptake of what is available in the region e.g. My Health for Life, Breast Screen: *"The C6 could see the improvement, in terms of information sharing and uptake of people in breast screening and things like that." [P4, interview]*

- Clients are less likely to fall through the cracks, especially while waiting for health appointments (e.g #healthPAC can help with understanding letters or referrals, and give reminders): "*We've also seen some others that were falling through the gaps. And it was getting connected to the appropriate area or ensuring that health professionals were aware of the complexity and having the client's voice at the center of them sharing a little bit of what they're hoping for [that was effective]." [P3, interview]*

- CentacareFNQ felt able to provide patient-centred care and advocacy in a proactive manner: *"having someone stepping through or linking to appropriate people just really ensured that people had their health needs met." [P3, interview]*

- Otherwise cost prohibitive services i.e.: allied health can be accessed via links to other funded projects/programs which support gap fees.

Lessons from implementation of #healthPAC related to client outcomes

Considering the implementation of #healthPAC at the client level, key factors should be highlighted which contribute to its acceptability, appropriateness, reach and effectiveness to deliver culturally appropriate health promotion and education to CALD clients and communities in Cairns. The evaluation suggests that the success of #healthPAC at this level was related to its ability to (a) break down barriers to increase access and reach of health information and services and (b) walk alongside clients in long-term navigation of the system.

What worked: decreasing barriers for CALD communities to increase access and reach to health information and services

> *"All these things that could potentially be barriers if they went there…it reduced a lot of barriers for people to get that that help that they need." [P3, interview]*

#healthPAC demonstrated some important strategies that can be used to reduce barriers for CALD communities. Many of these have been highlighted in other research into CALD community engagement[3,4,12].

1. **Providing language support, bi-lingual staff, and interpreters** for clients in whatever modality or capacity was required. This includes both internal and external service delivery. Not only does this support make clients more comfortable, but it also ensures better understanding and many would not be able to access services at all without it:

    > *"CALD community members with little English language proficiency would be unable to easily access our services without support from a trusted settlement worker." [P10, email]*

    > *"Having bi-lingual staff available on the ground made the process of delivery run smoothly and allowed the participants to grasp the information in a language they are comfortable with, enhancing outcomes" [P11, email]*

2. Creating and disseminating **in-language tailored health information** resources for community

3. **Supporting clients with transportation** to attend appointments or health promotion activities. This may be planning public transport or providing them with private travel.

4. Holding events in **common trusted locations** which are non-threatening such as the CentacareFNQ office

5. **Going out to community and groups** to deliver education to increase reach (especially of hard-to-reach groups) e.g seasonal workers, schools

6. Making health education and promotion a **social occasion**, using **group-based learning**, **gifts, and food**: "*it [breast screening] is offered in a supportive, relaxed group setting, with discussion over morning tea, that clients build trust with our service and staff." [P10, email]*

7. **Adapting existing services** for community or holding bespoke events for community "opening the service" e.g Breast Screen, My Health for Life: "*Our partnership enhances access to the free BreastScreen Queensland program by hosting the women onsite for their health education, offering morning tea and then an opportunity for those who want to have a screen to do so at that time, all in a supported environment. This process ensures informed consent and a real understanding of the process of screening." [P10, email]*

8. Providing services or education over an **extended period of time to build trust** with clients and support holistic needs e.g multiple touches in casework, school sexual health program

9. '**Doing it together'** to support initial service access while also building client confidence to navigate the health system themselves: "*Newly arrived refugee women would not be able to access breast screening without the coordination and support offered by Centacare. The process would be far too daunting." [P10, email]*

Provider and service-level outcomes

The following section details findings related to #healthPAC outcomes at the organisational and provider level. It seeks to understand the **adoption**, and **effectiveness** of the project to empower and build capacity of CentacareFNQ staff, community services, and health providers for best care of CALD clients in Cairns (Evaluation Question 2). It also includes an analysis of the **implementation** of #healthPAC to understand 'what has' and 'what has not' worked in terms of the delivery model along with its appropriateness and feasibility in the service setting. This section draws on qualitative data captured from project reports, case studies, email correspondence and stakeholder interviews. Quotes from these sources (*indicated as such*) are used where appropriate to support findings. Quantitative sources in this section include the project's casework database and project reports.

Internal capacity building ("It built people")

Analysis of interviews and project documentation suggests that #healthPAC successfully built the capacity of its own community engagement workers and case workers to provide best care for CALD clients in Cairns. Through supporting clients via casework and referrals alongside the specialist case worker, it upskilled settlement staff to be confident in providing non-clinical health information and system navigation to clients in a holistic and proactive manner. This is important for sustainability of the program and has positive impacts on CentacareFNQ as a service.

> *"What I didn't expect was how much capacity it would build in me, in management, and everybody else. It was about building us to be able to take on what the next challenges were and to be able to navigate systems. And yeah, I'm not scared to go into any health meeting anymore… It's the inherent skills that have been built in us, in the community." [P1, interview #healthPAC team]*

> *"What I have noticed is because our skill sets have been raised, we can advocate better around things we need and we know how to target that advocacy properly at the right people." [P1, interview #healthPAC team]*

A range of professional development activities focused of health and well-being and cultural care were also completed including:

- Mental Health and Personality Disorders in Family Law Matters
- Wesley Lifeforce Suicide Prevention (full day)
- Gwandalan Palliative Care Workshop (full day)
- Racism and Discrimination Determinants of Inequity (Webinar)
- Mental Health First Aid Training
- Dovetail Youth and Vaping Workshop

External provider engagement and capacity building

One key outcome of #healthPAC was capacity building of mainstream services to better engage with CALD clients and increase their own cultural capacity. For example, analysis of external stakeholder feedback suggested they had learnt about transport considerations for clients, how and when to use interpreters, and how to best communicate about appointments. This capacity building occurred while #healthPAC was advocating for the client when supporting appointments, via referrals and case conference, by co-hosting community education, and via resource sharing. For example, information sheets about the Translating and Interpreting Service and other resources were provided to two local optometrists who frequently receive referrals from CentacareFNQ to support recently settled refugee clients. Additionally, #healthPAC assisted North Queensland PHN with their development of a resource package for local GPs to encourage and help them support access and care for people from

migrant backgrounds. #healthPAC provided information for the package and reviewed the final resource. The resource has information about accessing interpreting services, culturally safe practice, clinical support available, billing options, and training opportunities, with further links and a service contact directory. Feedback suggests this type of resource is needed to support busy practitioners find key information easy and rapidly.

Figure 8. Resource package for GPs developed by #healthPAC

Overall, accounting for casework referrals, community education/promotion activities, health promotion programs, resource development and system-level collaboration, #healthPAC engaged with 31 different types of partners across multiple sectors (Table 10). Health partnerships were most common, however the project was cross-disciplinary engaging education, justice, social service, community, and industry partners. The partners marked with an * are those with more frequent or longer-term engagement with the project across multiple clients or activities. As previously mentioned, using multiple touchpoints for clients with services across several months was a deliberate strategy to build capacity of services that needed to understand the different culturally safe approaches required to support the diverse needs within Cairn's cultural groups.

"The biggest thing that we've proven is that we can work collaboratively with services and the partnerships that we've established. All of the deliveries that we've done. It has been a collaborative process." [P2, interview]

Table 10. Details of partners engaged by the #healthPAC project in service activities

External service, organisation, or group	Sector	How they were engaged in the #healthPAC project
BreastScreen Queensland	Health	Casework, community health promotion *
Cairns Base Hospital/ Cairns Hinterland Hospital and Health Service (e.g midwives, mental health, outpatients, emergency)	Health	Casework
Cairns Sexual Health Service	Health	Casework, community health promotion *
Child Health	Health	Casework
Hearing Australia	Health	Community health promotion
Lives Lived Well	Health	Health promotion program
Local dentist	Health	Casework
Local GPs	Health	Casework, resource development *
Local optometrists	Health	Casework
Local pathology providers	Health	Casework *
Local pharmacy	Health	Casework
Local physiotherapist	Health	Casework
Local podiatrist	Health	Casework
Local x-ray providers	Health	Casework *
Metro North Hospital and Health Service	Health	Casework
My Health for Life	Health	Casework, health promotion program *
Queensland Program of Assistance to Survivors of Torture	Health	Casework, community health promotion *
Refugee Health Network	Health	Casework, system-level activities *
Refugee Health Service	Health	Casework
Townsville Hospital and Health Service (pain clinic)	Health	Community health promotion
True Relationships and Reproductive Health	Health	Community health promotion *
World Wellness Group	Health	Casework
Cairns Regional Domestic Violence Service	Justice	Community health promotion *
Queensland Police Service	Justice	Community health promotion
Centrelink	Social services	Health promotion program
Settlement Service	Social services	Casework
Cairns African Association	Community	Community health promotion
Ethnic Communities Council of Queensland	Community	Health promotion program *
Pacific Australia Labour Mobility (PALM) scheme	Industry	Community health promotion *
Local schools	Education	Casework, community health promotion, health promotion program *
TAFE Queensland	Education	Community health promotion

Lessons from implementation of #healthPAC related to service-level outcomes

Considering implementation of #healthPAC at the service level, key factors should be highlighted which contribute to its acceptability, appropriateness, adoption and effectiveness to empower and build capacity of providers for best care of CALD clients in Cairns.

What worked: The #healthPAC team were a key part of project success

The #healthPAC team was one of the most important parts of the project's success. They were described as passionate, caring, and going above and beyond to deliver the project. Their good communication and responsiveness in dealing with partner services supported collaborative efforts. As already mentioned, their own experiences, language skills, cultural backgrounds and community connections were also used effectively throughout the project. As one stakeholder described: "*They [#healthPAC] have understanding, they have connection. They have people and they have the leadership qualities." [P6, interview].* It was suggested however that adding a male staff member to the all female team would probably have been beneficial in terms of engaging with particular groups or being able to broaden the scope and reach of program activities.

In particular, stakeholders highlighted the key role that having a funded project coordinator played, and how her professional and personal attributes contributed to success.

"I think that co-ordinator role is absolutely critical to having an outcome" [P4, interview]

Despite not working in a clinical role at the time, having a background in clinical nursing as well as refugee/community services was perceived as beneficial. This is because it allowed the coordinator to understand client and community needs, as well as having the ability to navigate the complexity of the health system.

"The advantage that was being able to be leveraged on her background and context is huge because it's really given them [#healthPAC] a good foundation for understanding health system and navigation." [P4, interview]

"With someone who is a nurse as well, yeah, that was really helpful too. And having those contacts in the different areas to be able to utilise" [P3, interveiew]

Her clinical background was also perceived to provide gravitas in interactions with health providers. However, holding this duality of experience was also a challenge, and sometimes created confusion with other services about her role and responsibility in the region. This confusion was compounded by the fact that she was previously the Refugee Health Nurse for Cairns Hospital and Health Service. This issue is explored later in this section of the report.

However, aside from the project coordinator, Centacare's team was not specifically funded to deliver #healthPAC services. Rather, the project was designed to be built into the existing service structure to allow staff to align #healthPAC with other CentacareFNQ duties. For example, enrollment in #healthPAC could be used to increase the frequency, intensity, or duration of contact with settlement clients or support opportunistic engagement of clients when attending pre-existing groups (e.g Centacare's elders' group). However, the need to balance #heathPAC with CentrecareFNQ's existing Multicultural Services created intense workloads at times of increased arrivals and could lead to staff burnout if not managed. There are also risks to project sustainability if Centacare work needs to be prioritised by these staff in the future. Consequently, three interview participants expressed a requirement to increase funding to provide additional workload dedicated to #healthPAC service activity beyond the coordination role.

"I think that was my biggest worry, yeah, it can build that capacity, but what's the point if they [staff] are broken at the end of it, you know. So that balancing, that's been hard. That was really the biggest challenge." [P1, interview]

What worked: The importance of existing relationships and trust

Pre-existing positive relationships between those working in health and social service organisations and CentacareFNQ/#healthPAC staff were a key driving factor in project implementation and success. This supported both initial engagement across services and ongoing partnership work such as referrals and health education delivery. The long-established reputation of CentacareFNQ and the project team as being 'on the ground' and connected to community was also a key enabler.

"The reputation of Centacare, the strong relationships and the wonderful work that Centacare has been doing previously. A lot of the work in community in those established networks with community leaders as well as clients" [P2, interview]]

"They have the ground, you know? They know people. They know the base of the people" [P6, interview]

"The last few years I've been very much in awe of what Cairns is being able to achieve through their on the ground community development and engagement approach." [P4, interview]

While external providers trusted Centacare's ability to understand community needs and provide relevant services, the community also trusted Centacare to support their needs. This reputation could then be leveraged to vouch for other services Centacare had partnered with through #healthPAC, increasing service engagement and uptake.

"We [external service] don't do a lot in the work in that space up here. It's really good having Centacare who do sort of vouching for us, you know…So having them as being that positive mouthpiece for us is really valuable because that's so important obviously in communities, you know, to have someone say, actually they're a good service, you know. Yeah, it's really valuable." [P8, interview]

The project also drew on the relationships and networks of project staff who were connected into the community to further increase trust, perform capacity building and role model behaviors to community. These themes about the importance of pre-existing relationships, community trust and cultural champions are evident in other CALD health service research[3,4,12].

What worked: Bridging and connecting "supporting others to engage with community"

#healthPAC's ability to bridge and connect across organisations and settings was a key enabler of reach, adoption, and effectiveness at the service level. The project played a connector role for staff and services working with CALD communities across the region, leading to increased engagement between services and several new organisational and individual level relationships.

"She's [the #healthPAC coordinator] been fantastic with connecting me with all these networks and all these people I didn't know…She is really good at connecting everyone up together. So that's been really invaluable" [P8, interview]

"I think I've seen a bit more of the engagement from different services, whether it's within Queensland Health or other services like True Sexual Health." [P3, interview]

"Definitely it's led to building a little relationship in that sense. Being able to see those little connections being built and finding out what everyone else is doing and

how we can support each other. So yeah, definitely those little partnerships get referrals." [P8, interview]

Furthermore, stakeholders from both within and beyond CentacareFNQ agreed that #healthPAC played a key role in facilitating a range of health, social and community services to work together more effectively and efficiently to provide education, resources, and support to CALD communities in a variety of settings (see Tables 7 and 8 previously). It was #healthPAC's coordination and organisation of these collaborative efforts that made it easier for services to come together and increase the likelihood that they would be attended and accepted by CALD communities.

"They [#healthPAC] were completely involved and engaged to make the program a success. They were bringing ladies, they were organising things, it was so wonderful. They make it easy for us. It was so great that I didn't have to worry about it." [P6, interview]

"#healthPAC support us, help support True and the Domestic Violence service to come together" [P6, interview]

Several interview participants also talked about how these connections across services and communities were creating an onward ripple effect of project outcomes in the region. For example, project benefits such as increased community engagement or decreased health stigma had been observed in services/activities not directly connected with #healthPAC. The Cairns 6 (C6, see next section) was also seen as key facilitator for spreading ripple effects through each of their own communities.

"Giving all this information to other stakeholders. We will work together in that way. #healthPAC is making differences in many services." [P7, interview]

What didn't work: unclear project scope and boundaries created tensions

Almost all participants interviewed spoke of a lack of clarity or misunderstanding about how the project was situated within the existing health service structure and what its scope comprised. Part of this challenge was due to the fact that a settlement service (CentacareFNQ) was now providing health-based services in a region which already had a refugee health nurse.

"And it was really confusing. What is #healthPAC's role? What is refugee health nurse's role? Who is advocating and helping these families to navigate? It then creates a blurry line." [P7, interview]

"Who's role is who? And who is better placed and where does one's boundaries stop? [P5, interview]

Some participants expressed how this could be perceived as threatening by the health service, particularly as the non-clinical nature and scope of #healthPAC were not articulated clearly to these stakeholders early on. This created tensions between the project and the health service which ultimately led to a lack of local health service buy-in.

"People thought that we [#healthPAC] had now stepped in and we would do all the health work. So, they did not understand what our role was. Many times, people in health in Cairns were not familiar with a health settlement model that wasn't clinical. So they [stakeholders and health service] felt threatened by a settlement health model that wasn't clinical because they had never seen it before." [P1, interview]

Consequently, opportunities to work in complementary ways to support CALD clients in the region were likely missed. For example, the #healthPAC team saw their role to be about providing clients with wrap around holistic care to support continued service engagement after the time-limited, referral-based services offered by the refugee health nurse. Additionally, #healthPAC's community engagement work could have been a much needed value-add for the health service.

> *"I feel that that's been a challenge, actually leveraging on that work and getting all the parties together to really think thoroughly about what is the value of having a health system navigation resource from a community's perspective, and how does that get embedded in the health system?" [P4, interview]*

Investing in partnerships in the system, clarifying roles, demonstrating value to the health service, and better integrating clinical and #healthPAC services will be key for sustainability of the project.

> *"You can't take it for granted that you will just integrate the approaches. You have to actually deliberately work at it and there has to be language that is developed and shared and people comfortable enough to trust the process." [P4, interview]*

Several participants also expressed a need to clearly define #healthPAC's framework and approach at the client, C6 and system levels. This should include considerations about how to balance case work and advocacy, and ensuring health and social determinants are an ongoing priority within settlement services.

> *"So, I think sustainability hinges on a really good understanding of what the foundations are for that approach." [P4, interview]*

> *"I think that they ended up doing a fair bit of work that was outside of what the project was meant to be. … ended up doing a fair bit of work in spaces that weren't expecting to go." [P8, interview]*

Community and system-level outcomes

The following section details findings related to #healthPAC outcomes at the broader community and system-level. It seeks to understand the **effectiveness** and **sustainability** of the project to deliver advocacy for culturally appropriate health and wellbeing support of CALD communities in Cairns (Evaluation Question 3). It also includes an analysis of the **implementation** of #healthPAC to understand 'what has' and 'what has not' worked within the broader system. This section draws on qualitative data captured from project reports, meeting minutes, email correspondence, written feedback, and stakeholder interviews. Quotes from these sources are used where appropriate to support findings (*indicated as such*). Quantitative sources in this section include project reports.

Establishment of Cairns 6 (C6)

Establishment of the Cairns 6 (C6) was a key outcome of #healthPAC to encourage reciprocal communication between community and services, as well as embed sustainable processes and systems into the project. The C6 is a health and wellbeing reference group based on the well-established G11 (in Brisbane) and GT (in Toowoomba), using the strengths, talents and wisdom existing within community. It aims to support community-led initiatives and community devised solutions to address inequities in access to health and social services, economic participation and health literacy while promoting cultural safety: *"the model is acting as a bridge to communities to amplify needs and voices" [P4, interview].*

Figure 9. Activities and progress of the C6 to date

#healthPAC engaged with leaders from the communities of the six current Humanitarian Settlement Program cohorts within Cairns to nominate advisors for the C6. These include representatives from:

1. the Bhutanese community
2. the Arakanese community
3. greater Myanmar communities (via Mahamuni Buddhist Society of Cairns)
4. the Congolese community
5. greater African communities (via Cairns African Association)
6. the Ukrainian community

The group was formally established in March 2023, creating Terms of Reference, a role description, and shared goals and purpose. Since then, the C6 has met a further three times under the guidance of two #healthPAC bi-cultural team members, who were in turn supported by the #healthPAC coordinator. At these meetings the C6 received presentations from local services, networks, and projects as well as input from the G11 in Brisbane. They then shared this information with their own communities.

> *"So that was really great for community leaders to work together, have channels to have that support…we would hear about some of those needs from community leaders. They'd talk about it but also find strategies together… how to link in to Queensland Health or whoever else might have been helpful." [P3, interview]*

The group has made good progress towards understanding community needs in the region and planning for ongoing community-led work in 2024 (Figure 9). Importantly, community-driven needs to expand the C6 are being addressed with additional representation from Pasifika, Islamic, and youth groups planned. The C6 has already contributed to Queensland Health service and policy discussions, including the Multicultural Health Engagement Project.

> *"We had this consultation [with C6] and the voices of those community members from Cairns were heard and put into the MHEP project, which is actually advice going to Queensland Health. So the fact that they were even at the roundtable discussion, I think that is really important and that's clearly something that has had an impact…certainly having the voices, the direct voices in that roundtable discussion was good" [P4, interview]*

In this way, the C6 contributes to advocacy work by ensuring that North Queensland has a seat at the table during state-wide discussions that may impact the region. The group also benefits Queensland Health by enabling more efficient and effective access to these CALD voices.

> *"If I'm wanting to hear from communities [it] would be very hard for a project worker to hear from regions without somebody like C6 to tap into and have the coordinator to organise them together, to then have a voice. Like it's such a benefit for Queensland Health on many different levels to have those regional community engagement groups." [P5, interview]*

Ongoing funding for the group has been secured by strategically including well-being and social determinants of health into its remit moving forward to access new funding streams. This means the C6 can be maintained as an ongoing meeting four times per year. This is an important outcome, as being able to provide remuneration for members of this group was perceived to be highly important by stakeholders. Additionally, having a funded position to coordinate this group (#healthPAC coordinator) was integral to its success and should be continued. Ensuring sustainability of the C6 should be a key focus of ongoing work in the region, as benefits to community and services will likely increase over time and require long-term investment for the most effective pay-off.

> *"…a long term strategy so that you can see it just grows and grows and gets more valued and respected and known, and then the members get more confidence so they can have more voice and make more of a difference" [P5, interview]*

> *"And I think it takes time. And it'd be such a shame if this stops now when this work has been put in." [P5, interview]*

Community consultation feedback document

A co-written community feedback document for dissemination to stakeholders in health and social services is a key output of the C6's work.

> *"The co-written Community Feedback Document is not mere words on paper – it is a call for action and attention for sincere culturally responsive engagement within local systems aligned to Queensland Health's Multicultural Communication Framework." [C6 members, written feedback for evaluation]*

This document highlights what is currently working well in communities in terms of health and well-being, as well as community devised solutions for the top two identified challenges in service access. The document will be shared formally with key stakeholders in January 2024, however key findings are summarised below.

While each community had unique feedback and challenges, some common themes were identified across multiple communities:

- Youth – need for role modelling, showcasing local achievements, mentorship, and low-cost activities.
- Mental health support – lack of knowledge about how to access services; need for leader suicide prevention training, a trained community support worker to support service access and intake, and culturally appropriate suicide prevention education
- Parents – need for education and training in modern parenting skills, boundary setting, dealing with technology, screen time, and e-safety
- Health system rights and access – lack of GPs in the region/GPs won't take new patients; more effective use of interpreters is required including consideration of dialects (particularly by government organisation), need to train bicultural community members to assist with interpreting

At the same time communities identified group-based, community-led, and partner-supported activities as working well in the region. For example, health workshops or programs with local partners using group learning in a culturally safe environment; bi-cultural workers in schools; a local coffee with a cop initiative; and community-wide engagement events.

Lessons from implementation of #healthPAC related to community level outcomes

Considering implementation of #healthPAC at the broader level, key factors should be highlighted which contribute to its appropriateness, adoption, and effectiveness to deliver advocacy for culturally appropriate health and wellbeing support of CALD communities in Cairns.

What worked well: listening and responding to community voice

A key philosophy of the project, and part of its success, was being able to listen to community and then deliver contextualised activities or support to meet identified needs. In doing so the project was able to be responsive to emerging needs. The C6 was just one example of how #healthPAC was able to listen and respond to community effectively. Other approaches included bespoke education sessions (e.g. My Health for Life, BreastScreen), tailored resources (Breast Health 5), and reaching out to requests from specific CALD groups (e.g. seasonal workers).

> *"Knowing some of the issues that might be present for people and also targeting who might be really relevant to come to certain workshops…hearing what the needs are and making sure that it's specific and targeted to those needs." [P3, interview]*

> *"Working with seasonal workers, it wasn't initially what we had in our cohort, but that's something that opened up, and that was just, again, through being responsive, through accessing our community partners and coming on board in that advocacy piece." [P2, interview]*

This was perceived to be a value-add for the services #healthPAC partnered with who may not have had connections into communities but could now more effectively deliver community-relevant care.

> *"Working within [external provider] programs in existing capacity, but then enhancing it to meet the needs based on what the communities themselves have been wanting." [P2, interview]*

System-level advocacy

#healthPAC made a significant contribution to ensuring that the voice of CALD and refugee communities was included in local, state, and national consultations and academic research. Team members from the project took part in seven different consultations, including three with a specific multicultural focus (Table 11). They also contributed as participants in three research studies and presented about the project at one local and one national conference.

Table 11. Participation of the #healthPAC project team in system-level advocacy: consultation and dissemination

Stakeholder or organisation	Project/event	Sector
Consultation		
Children's Health Queensland	Supporting Multicultural Children and Youth Project ECHO community of practice	Health
Ethnic Communities Council of Queensland	Queensland Women and Girl's Health Strategy	Health
National Disability Insurance Agency	National Disability Insurance Scheme CALD Strategy	Social Services
North Queensland Primary Health Network	Mental Health Stepped Care redesign workshops	Health
Queensland Alliance for Mental Health	Strategy Workshop	Health
Queensland Health and Refugee Health Network	Cairns Refugee Health Round Table	Health
Refugee Health Network	Multicultural Health Engagement Project	Health
Conferences and presentations		
Metro South Health	Multicultural Health Symposium	Health
The Forum of Australian Services for Survivors of Torture and Trauma	Australia and New Zealand Refugee Trauma Recovery in Resettlement Conference	Health/Social Services
Research project contributions		
James Cook University	Social Work and Dentistry collaborate across disciplines and sectors to develop innovative resources to build dental workforce capability and facilitate best practice in recognising and responding to domestic and sexual violence	Academia/Health
Queensland University of Technology	Pharmacogenomics	Academia/Health
University of Melbourne	Supporting Choice for Cervical Screening	Academia/Health

In addition to this, #healthPAC was involved in regular and ongoing participation in consumer and refugee networks and committees at the local and state level (Table 12). All of these activities support the importance of #healthPAC's role in delivering system-level advocacy for the needs of CALD communities in the region and beyond.

Table 12. Participation of the #healthPAC project team in system-level advocacy: networks and committees

Stakeholder or organisation	Group or network
Refugee Health Network Queensland	CALD Health Engagement Project Steering Group
Breast Screen Queensland	Cairns Consumer Reference Group
CentacareFNQ	Cairns Refugee Health Network
Refugee Health Network Queensland	Refugee Health Partnership Advisory Group
Refugee Health Network Queensland	Clinical Advisory Group
Multicultural Australia	Local Area Collaborative Cairns FNQ

#healthPAC's role and impact as part of the system

Interviewed stakeholders agreed on a need for #healthPAC within the broader system of care for multicultural communities in the region. However, the need to fit #healthPAC into the system in a complementary way with existing services was also highlighted. As too, was the project's ability to fulfil gaps in the current system and take on crucial roles not able to be supported within the scope of other services such as community development and advocacy.

"#healthPAC's been good at walking someone through the healthcare system and we've [external service] been able to step back a little bit more from doing that" [P3, interview]

"This project [#healthPAC] was certainly not to duplicate, not replace, not step on toes, but in fact the complete opposite. But to try and gently expose gaps" [P2, interview]

Importantly, stakeholders spoke of #healthPAC as creating a platform for broader system change related to multicultural health in the region. The project has been integral in driving advocacy for change in other services and helps emphasise the value of listening to community to improve service delivery. Two participants felt that #healthPAC had created an ecosystem to support other aligned projects in the region, helping with their success and efficiency.

"#healthPAC kind of pushed it a little bit, made them sort of get it off the ground. … it's helped get it there, inspire it to get it off the ground." [P8, interview]

"The project that I'm working on has been really enhanced with the #healthPAC…can't imagine how it could have gotten off the ground as much as I would have without the coordinator having done all that connection stuff." [P8, interview]

Key findings and recommendations

This evaluation clearly demonstrates the benefits of the #healthPAC pilot project across client, community, provider, organisational and system level outcomes. #healthPAC's ongoing engagement with community leaders, health providers and service partners, culturally appropriate tailoring of health promotion/education, and ability to overcome access barriers for CALD clients had strong impacts on the reach, appropriateness, and effectiveness of the project within these communities. Providing holistic, culturally appropriate education and access to healthcare has also improved CALD client's health literacy and knowledge, increased their awareness of local health system navigation and access rights, and increased their engagement with mainstream services. Moreover, it would appear that #healthPAC is contributing positivity to system-level advocacy in Cairns and beyond, while also playing a key role in supporting a local ecosystem driving service improvement for multicultural communities.

Importantly, #healthPAC has been able to successfully apply a client-centred, reciprocal engagement approach to its work. In doing so the project has adopted, translated, and built on lessons learnt from previous engagement work with refugee and CALD communities[4,3,12]. These key successful elements include: working collaboratively with communities and services; providing language support; establishing trust and building confidence via an ongoing relationship with clients across multiple service encounters; tailoring education and messaging to community; using trusted organisations and individuals; using community-based locations for events; supporting grass-roots community empowerment; and supporting community leaders with education and remuneration.

While implementation of the project was sometimes challenging and time consuming, those involved felt positively about their experiences. Moving forward however, there is a clear need to better define and communicate the roles, responsibilities, and scope of the project at all levels of implementation. Ideally this should include consideration of internal team composition and funding, as well as how #healthPAC should be integrated into the existing refugee health service system in a complimentary way. Such work will be crucial for long-term project sustainability within Centacare and the broader service system.

The below sections consolidate the findings discussed throughout the report.

Client level learnings

	Findings relevant to reach, appropriateness, effectiveness, and implementation
1	#healthPAC demonstrated good reach of health promotion and education across CALD clients and communities in the region, including those who have previously been hard to reach.
2	While #healthPAC was able to provide a range of casework activities for clients, its main role was in supporting clients to plan, book and attend healthcare appointments.
3	#healthPAC played a key role in supporting CALD clients with multiple complexities, who required frequent engagement to access services across varied settings.
4	A relatively high requirement for language support and repeat casework encounters were observed for #healthPAC, suggesting complexities in both clients and the local service environment.
5	#healthPAC increased access to health services in the region by breaking down barriers for clients and offering more appropriate types of care. They did this by providing language assistance and interpreters; supporting clients with transportation; going out to communities; making learning social and group-based; adapting existing services; working to build trust over extended periods; sourcing low-cost services; and 'doing it together with clients' to build confidence.
6	Outcomes suggest effectiveness of the project to: increase client health knowledge; increase client health literacy and understanding of the health system; reduce health education stigmas; increase the capacity of clients to access services, including re-engagement with previously declined services; build connections between clients and services; assist with health service navigation and continuity of care for clients.

Service and provider level learnings

	Findings relevant to adoption, appropriateness, effectiveness, and sustainability
1	The #healthPAC team was integral to the project's success. Key factors include: bi-cultural workers, understanding of both clinical and refugee local service contexts, responsive communication, compassion and dedication, a funded co-ordination role, existing trust and connection in the community.
2	CentacareFNQ settlement staff working on the #healthPAC project gained capacity and confidence to provide non-clinical health information and system navigation support to clients and advocate for culturally appropriate care.
3	Pre-existing positive, trusting relationships that CentacareFNQ/#healthPAC staff had established with local providers and CALD communities were a key driving factor in project implementation and success.
4	#healthPAC built connections and relationships, and expanded reach of health and social services. It played a pivotal role in linking key health and organisational stakeholders in the sector.
5	Health and community service providers experienced better reach and engagement with CALD community members as #healthPAC had already built trust.
6	#healthPAC worked successfully with a number of multidisciplinary services and providers to deliver culturally appropriate health promotion and programs and increase their cultural capacity.
7	Tensions resulting from unclear/miscommunicated project scope and difficulties for external stakeholders in understanding the senior settlement worker's role within the existing service setting were observed.
8	Investing in partnerships in the system, clarifying roles and project scope, demonstrating value to the health service, and better integrating with clinical services will be key for sustainability of the project.

Community and system level learnings

	Findings relevant to appropriateness, effectiveness, and sustainability
1	The successful establishment of the Cairns 6 (C6), with representation from the six current Humanitarian Settlement Program cohorts was a key outcome of #healthPAC.
2	Having a funded position to coordinate the C6 group (#healthPAC coordinator) was integral to its success and should be continued. Providing remuneration for members of the C6 was also perceived to be highly important.
3	Expanding and sustaining the C6 should be a key focus of ongoing work in the region as it will benefit community, local services, and state-wide advocacy by responding to needs and improving CALD service delivery.
4	Listening to community and delivering contextualised activities or support to meet identified needs was a key philosophy of the project, and part of its success.
5	#healthPAC made a significant contribution to ensuring that the voice of CALD and refugee communities was included in consultations, networks, committees, and academic research at the local, state, and national level.
6	#healthPAC helped to create a platform for broader system change related to multicultural health in the region. The project has been integral in driving advocacy for change in other services and helps emphasise the value of listening to community to improve service delivery
7	Tensions were observed resulting from unclear/miscommunicated project scope and difficulties for external stakeholders in understanding the specialist case worker's role within the existing service setting.
8	Investing in partnerships in the system, clarifying roles and project scope, demonstrating value to the health service, and better integrating with clinical services will be key for sustainability of the project.

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Appendices

Appendix 1

Discussion Guide

1. To start, I was hoping you could tell me a bit about your role here at [insert organisation] as it relates to healthPAC?

2. Can you describe your experience implementing or working with healthPAC?

   a. What works well in current implementation/activities? (consider internal context, external context and recipients)

   b. What are the challenges to current implementation/activities? (consider internal context, external context and recipients)

   c. How did you feel about being a part of healthPAC? (prompts: satisfaction, did you like it?)

3. How does healthPAC fit within your existing work? *(Probes: compatibility, duplication, workflows)*

4. In your opinion, what is the impact of healthPAC on CALD community members? *(prompts: access to information or services, knowledge, health)* Follow-up question: Why is healthPAC in particular important in achieving these outcomes?

5. In your opinion, what is the impact of healthPAC on CALD community leaders? *(prompts: knowledge, connection)*

6. In your opinion, what is the impact of healthPAC on community services and partnerships? *(prompts: consider positive and negative impacts)*

7. How much do you think healthPAC has enhanced social and service connections for CALD communities, health, and community services? (prompt: not at all, a little, a lot) Why?

8. What do you think are the key factors important for healthPAC's success or sustainability? (e.g. leadership/champions, funding, partnerships, organisational integration, adaption, demonstrate/share value, planning)

9. Can you suggest any ways in which that healthPAC could be improved?

10. Could this model of working be adoption in other services or settings?

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