

INITIAL DISCUSSIONS

BOARD AND CEO UPDATE

CAC members were asked what information would support their role on the Community Advisory Council. Members discussed Board and CEO updates to align more closely with strategic developments and previously discussed topics.

Members valued existing feedback loops and project updates, particularly clear explanations if recommendations/advice were not adopted. They also appreciated practical, community-facing updates that raise awareness of supports and show impact, reinforcing a preference for open, ongoing consultation and transparency.

CLINICAL COUNCIL UPDATE

Dr Kelly Dungey outlined the discussions at the Clinical Council on the Joint Regional Older Persons Strategy, focused on healthy ageing through prevention, health literacy and better use of midlife health checks. Clinical Council members called for practical, accessible and culturally appropriate resources on healthy ageing, dementia and frailty, and noted that some language may not connect across CALD communities.

They also raised concerns about fragmented care between hospitals, general practice and community services, and emphasised the need to better support ageing in place, strengthen care in residential aged care, and start earlier conversations about palliative care and advance care planning. Overall, the discussion reinforced the need for more connected, person-centred support for older people across the care continuum.

FEEDBACK LOOP

Bowel and cervical cancer screening

Earlier CAC feedback was used to improve bowel and cervical screening resources and pathways locally. Members supported clearer public messaging and practical education about the collection process for screening to dispel the myth that it is complicated and 'gross', and more flexible, inclusive options — especially for people facing sensory, physical or other access barriers.

They raised concerns about bowel cancer risk in younger people, noting that age-based messaging can create false reassurance, and called for better system coordination to reduce duplication of supply of screening kits to consumers. A letter with feedback on bowel cancer screening will be shared with the National Bowel Cancer Screening team as parts of the feedback are outside the GCPHN circle of influence.

DETAILS

Recent disasters highlighted major preparedness gaps for medically vulnerable people, particularly during prolonged outages and service disruptions. Connected and Prepared addresses these risks by offering a simple, practical planning approach for people who rely on medical devices, medications, mobility aids, carers or regular health services, helping them prepare for the health, support and access challenges they may face before, during and after an emergency.

KEY INSIGHTS

Importance of a practical, manageable planning tool

CAC members supported a focused, health-specific planning tool that is shorter and more manageable than the full Person-Centred Emergency Preparedness framework. They valued a practical approach that helps people identify supports, understand local risks and plan for likely needs during a disaster, but stressed that the tool must also be simple, portable, clearly structured and easy to update.

Need for clearer prompts, examples and more concrete detail

Participants said some parts of the plan were vague and would be hard to complete without clearer prompts, examples and suggested responses – either on the form or as part of the workshop. They particularly noted the needs of people living with disability, cognitive challenges, limited disaster experience or low confidence, and wanted more specific details such as medication storage, key contacts, and to include a place for the person's name and date the plan was completed.

Recognition that disasters affect support systems, not just individuals

Participants stressed that emergency planning cannot assume carers, family, neighbours or support workers will be available, as disasters may affect support networks at the same time. This creates particular risk for people who rely on daily assistance, highlighting the need to plan for disruption to both formal and informal supports. This needs to be part of the conversation, what are the alternatives, backup options.

Need to address communication and access barriers

Participants said emergency information and support can become inaccessible when power, phone, internet and reception fail, especially in isolated areas. They stressed that planning must assume people may be completely cut off and should include low-tech communication options, practical local knowledge and clear advice on staying informed when usual systems are unavailable. Practical advice can be included as part of workshop discussions.

Value of outreach, flexibility and community-based delivery

Participants said the resource should be delivered through trusted settings people already use, rather than expecting them to complete it alone. They supported flexible delivery through community groups, disability networks, online sessions and other existing forums, and stressed that the initiative should complement broader preparedness work rather than duplicate it.

NEXT STEPS

Refine the planning tool to ensure it is as simple, and easy to complete as possible for people living with disability, neurodivergence, low health literacy or limited disaster-planning experience; and to continue planning for flexible delivery through trusted community networks; strengthen links with broader emergency preparedness; and ensure training reflects realistic disaster scenarios, including outages, isolation, service disruption, unavailable supports and communication failures.

“It’s a useful tool. I think what came across today is that the topic overwhelms people because they know they are not prepared”

Anon. CAC Member

DETAILS

People living with mental health conditions often experience poorer physical health outcomes, including a reduced life expectancy and higher rates of co-existing illness, while physical inactivity remains a major preventable contributor to ill health in Australia. Evidence shows that movement can reduce symptoms of depression, anxiety and psychological distress and improve outcomes for people with chronic conditions. Although guidelines recommend regular weekly activity, the key message is that all movement counts, and even small amounts can support both mental and physical wellbeing.

Previous CAC consultation recommendations emphasised that messaging about movement should feel inclusive, practical and relatable. Rather than focusing only on gym-based exercise or sport, participants wanted everyday activities, home-based options and social connection highlighted, with diverse settings and body types reflected in campaign materials. There was also support for social prescribing approaches that help people connect with suitable community activities through trusted guidance and supported first steps, recognising that motivation, confidence and access are often strengthened when people are linked to others with similar goals and experiences.

KEY INSIGHTS

Movement should be framed sensitively, broadly and in context

Members agreed movement is important for mental wellbeing but said it must be introduced sensitively and as part of a broader conversation about wellbeing rather than as a directive. They wanted physical activity framed broadly and inclusively, using everyday, low-barrier options that feel relatable, adaptable and achievable for different people and circumstances.

Support needs to be practical, personalised and built around small steps

The main gap is not awareness of movement benefits (this is already known) but support to turn that knowledge into action. They wanted practical, tailored help that reflects a person's mental wellbeing, physical health and confidence and preferred a gradual approach that starts small, feels achievable and reinforces that every bit of movement helps.

Access, flexibility and the right fit are critical for engagement

Major barriers to community-based movement include time, cost, transport, location and limited suitable options, especially for working adults, parents and families with neurodivergent children. They emphasised that no single delivery model will suit everyone, and wanted a flexible mix of home-based, online, individual, group and community options that feel safe, welcoming and relevant to people's age, identity, needs and stage of readiness.



"I would like my GP or medical team to ease me into the conversation of how physical activity can improve my mental health not just to lose weight or stay physically healthy as advertised."

Anon. CAC Member

KEY INSIGHTS

People need supported connection, accountability and trusted navigation

Accountability and supported follow-through can make a significant difference and wanted more than simple referrals. Council members supported social prescribing approaches when backed by trusted guidance, reputable options, stronger provider knowledge and clearer pathways that help people stay engaged rather than being referred without practical support.

Movement support should be co-designed, specialist-informed and embedded in care

Movement support should be shaped through co-design and backed by partnerships between mental health, exercise and allied health providers so it is safe, tailored and realistic. They wanted varied options that respond to different ages, diagnoses, life stages and practical constraints, and stressed that movement should be meaningfully integrated, resourced and outcomes-focused within mental health care rather than added as an afterthought.

Better visibility and more suitable options are needed for priority groups

Participants said people often do not know what movement options are available, even when useful programs exist, and called for stronger local information pathways, including non-digital options. They also highlighted significant gaps in suitable activities for children, adolescents and neurodivergent people, particularly where programs are too narrow, costly or poorly matched to developmental, behavioural or sensory needs.

NEXT STEPS

Embed movement more deliberately within holistic, person-centred mental health care and gradually include it in commissioned services. This should be done flexibly, so services can consider how movement fits their model of care and the needs of the people they support, rather than through a one-size-fits-all approach.



Movement
is
Medicine