

Committed to Participate Session 5: Communication

CACs and their 'Communities of Interest'

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The Directors of health service boards in Victoria are accountable for ensuring that their boards “meet the needs of the community” which is reflected in the Purpose and Roles of Community Advisory Committees (CACs).

The Victorian Department of Human Services (DHS) states their purpose as:

“CACs are established in Victoria to increase consumer, carer and community participation in public health services”. With two critical roles being:

1. To provide direction and leadership in relation to the integration of consumer, carer and community views into all levels of health service operations, planning and policy development; and
2. To advocate to the board on behalf of the community, consumers and carers.

The DHS website goes on to state, that amongst other things, the CACs:

- enables participation across the whole of the health service;
- advises the public health service on community issues and in relation to its communication with the communities it serves; and
- identifies and advises the public health services board on priority areas and issues requiring consumer and community participation.

These obligations are also reflected in its publication on community participation, *Doing it with us not for us* and again at the level of my health board, which has a Vision Statement which reads “In Partnership, Building a Healthy Community”.

You will have noted, repeated several times, the terms consumer, carer and the phrases ‘community views’, ‘community issues’ and ‘community participation’—the health service consumer and its carers can be readily identified and consulted, but how is this done for the community at large ?

The wider community is a large, amorphous body of people, which can be defined as “a diverse group of individuals in terms of gender, ethnicity, socio-economic status and levels of health”—so how can anyone, much less the monolithic health services, obtain their views and consult with them?

I am sure politicians would give their back teeth to be able to link to the total, wider community in one simple step, but of course there is no one body that represents them all, much less speaks on their behalf with a single voice. So how can health boards link to their community and carry out their responsibility for effective consultation?

Firstly, they must demonstrate key organisational features which encourage community participation (see box below).

Organisational Features which Encourage Community Participation

1. The organisation is open to change.
2. It has strong relationships with the wider community.
3. There is clear, two-way communication and information sharing between the organisation and its community.
4. Participation is most effective when it has full management support, at all levels.

This is where the CAC of each board has a vital role in establishing a strong relationship between its board and the community it serves and in fostering two-way communication between them.

If all sectors are to be reached, the CAC needs to adopt a 'population approach'—linking with and reaching out to multiple groups in the community but how can it do this? Could I suggest that this could be achieved by the CAC identifying 'communities of interest' in its area—a community of interest could be defined as:

"A group of people who share important characteristics, whether defined by geography, institutions, mutual interests, ethnicity or identity."

Examples would be ethnic and church groups; locality/geographic groups or community centres; sporting groups; tenants associations and housing advocacy groups; mental health and other health trusts; women's refuges and issues-based groups such as family planning, older people and youth groups.

So how could the CAC link into such groups. I suspect that if you canvassed their memberships, you would find that almost all members would have several 'communities of interest' to whom they relate; each of us personally could probably list several of our own, whether they be sports or social clubs; church or special interest groups; our own workplace and school-based groups.

In other words, there are already numerous links between their memberships and local 'communities of interest'—the trick is to use these links and to build on this liaison, to take advantage of these ready made communication channels. CAC members should be encouraged to use these contacts to consult on health issues that they see in their own community of interest. In this way, a mosaic of two-way communication lines is built up which, although not fully representative, is at least reasonably comprehensive.

CAC Membership and Structures

There are wider implications for this approach to local 'communities of interest' when health boards make their appointments to their CAC, they could ensure that a wide range of interests as is possible, are secured when selecting members. The CAC has the ability to set up its own subgroups which can narrow their focus onto key 'communities of interest'. They could be age specific, geographic or special interest based.

For example, Peninsula Health CAC has set up subgroups (called community advisory groups) that are seen as relevant to its area, at this time. They are a mixture of geographic, special interest groups and those that are age specific.

Peninsula Health CAC Subgroups

Geographic:

- Southern
- Western Port
- Frankston

Service related:

- Youth
- Older people
- Disability
- Mental health

Special Needs:

- Health promotion/population health
- Koori
- Cultural and linguistic

In this way, the CAC of every health board can act as a bridge between key groups in their community and the board to whom they link, through a 'community of interest' approach. The key is to identify the linkages already in place through its membership, and to put them to work. There is no need to throw our hands up in horror and say we can't consult because we can't identify our communities; the potential links are already in place, right in front of us!