

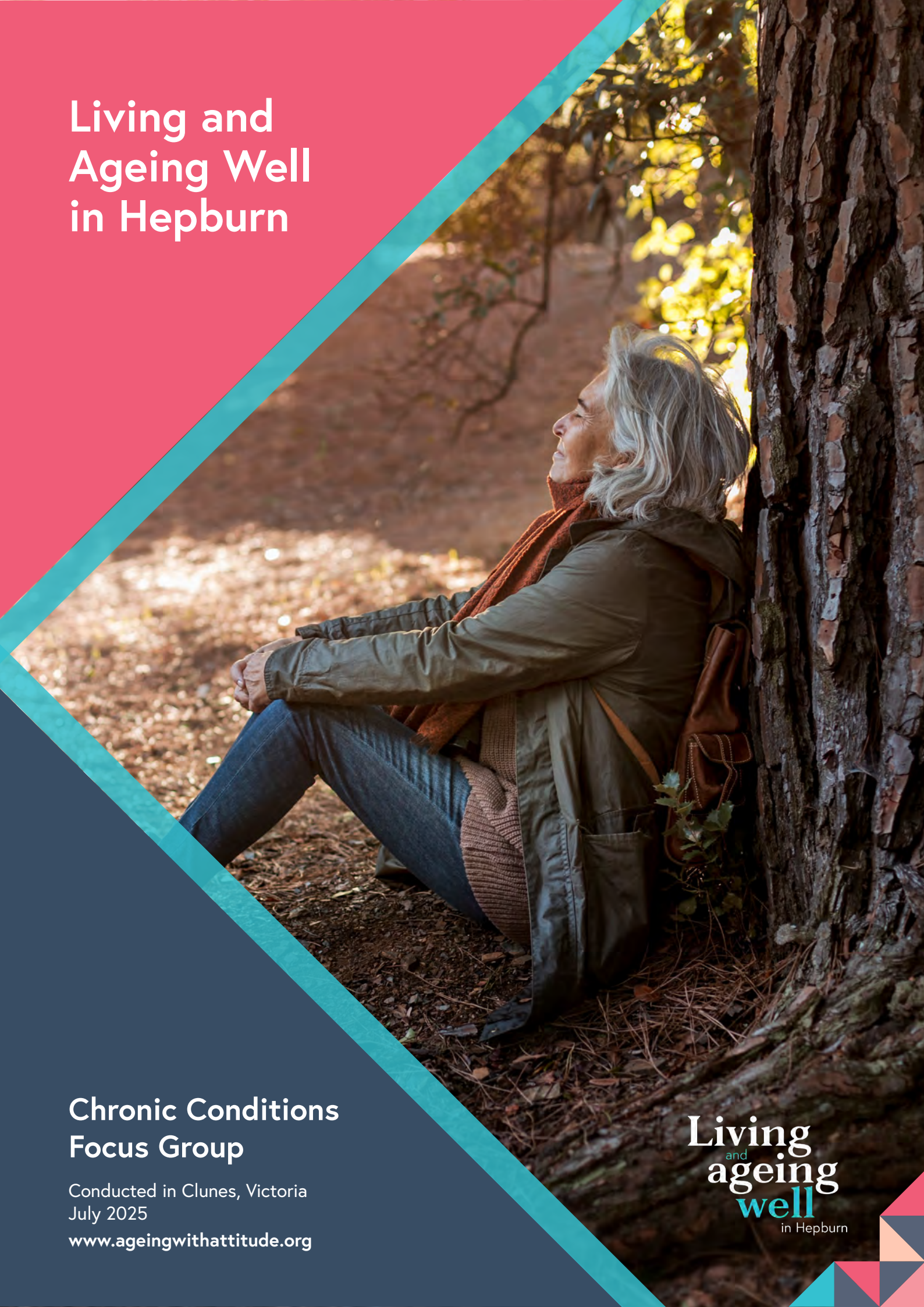
# Living and Ageing Well in Hepburn

## Chronic Conditions Focus Group

Conducted in Clunes, Victoria  
July 2025

[www.ageingwithattitude.org](http://www.ageingwithattitude.org)

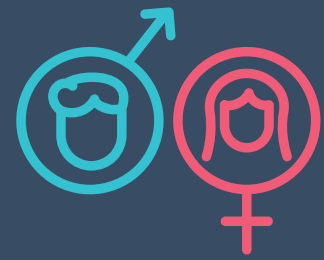
Living  
and  
ageing  
well  
in Hepburn



# Summary

Using the **RAND-36 Item Health Survey Instrument (SF-36)** and guided interview questions, **17 Clunes residents** (13 female, 4 male) living with chronic conditions voluntarily participated in a **five-month chronic conditions focus group** which aimed to explore the correlation between social connection and community engagement, with perceived health and well-being.

Before the program commenced, participants completed the RAND-36 questionnaire and shared insights into their experiences of managing chronic conditions, as well as the broader aspects of their daily lives.



## Participant information

Prior to commencing with the focus group, each participant was informed in writing the purpose of the focus group, their privacy and confidentiality will be protected, and each participant will remain unidentified including to other participants. All participants signed a participant agreement form.

The Rand 36-Item Short Form Survey Instrument (SF-36) was determined by the Chief Medical Officer of Western District Health Services (independent of the project) to be an appropriate tool for the purpose of this focus group.

During initial interviews, participants shared personal and often sensitive aspects of their lives. It was clear they valued the opportunity to be heard, with most expressing significant and meaningful stories. All but one male participant described the process as cathartic – appreciating the chance to speak openly, be listened to without judgement, and not feel directed or instructed.

Following the initial interview, which often involved the disclosure of sensitive personal experiences, two further interviews were conducted. These

subsequent conversations were less intense and carried less emotional weight, but they were notably reflective. Participants continued to be open in sharing their perspectives and experiences.

All participants expressed appreciation and gratitude for the opportunity to be involved, noting that they valued the experience more than they had anticipated. Additionally, they unanimously indicated a willingness to participate in future health and wellbeing focus group studies.

## Key findings from the RAND-36 Item Short Form Survey Instrument (SF-36)

Key findings from the interview discussions indicate that for female participants, engaging in structured conversations about their health and wellbeing – held for one hour on three occasions over five months – was impactful. These sessions encouraged reflection and a greater prioritisation of health and wellbeing. This outcome, however, was not observed to the same extent among male participants.

Participants comments and themes across the interviews were identified and are presented on pages 23 & 24 of this document.

NOTE: One participant was unable to participate in the final interview process; therefore, their data is incomplete.

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This study is funded by the Western Victoria Primary Health Network under the Australian Government's Primary Health Networks program.



# Introduction

The Chronic Conditions Focus Group aimed to explore the experiences of people over 45 years of age living with chronic conditions in a rural setting. The focus group consisted of 17 local people living with chronic conditions.

Over five months the group were monitored (interviews at approximately two monthly intervals) aiming to identify a correlation between social and physical activity to the participants perception of living and ageing well -overall wellbeing.

Activities and strategies were not prescribed; however, each participant engaged in discussions about their physical and emotional health and wellbeing at the commencement, midway and completion of the 5 months focus group duration. Each interview was allocated 60 minutes (180 minutes per participant in total). Some interviews ran over time.

The focus group is a product of the Living and Ageing Well in Hepburn project which is an initiative funded by the Western Victoria Primary Health Network and run in partnership by Clunes Neighbourhood House (project lead) and Central Highlands Rural Health.

Clunes Neighbourhood House and Central Highlands Rural Health thank the 17 participants for their time, courage and honesty.

# Methodology

## Participant recruitment

People over 45 years of age who have a chronic conditions diagnosis were invited to participate in this project. Initially there were 22 responses however at commencement of the project there were 17 participants.

## Data Collection

- Phase 1 (Commencement) was held at the local health service and consisted of interview styled questions and completion of the RAND-36 Short Form Survey (SF-36).
- Phase 2 (Midway) Individual interviews were held including 11 questions.
- Phase 3 (Final) Final interviews including 8 questions and the RAND-36 Item Short Form Survey Instrument (SF-36) was completed again.

## Data Analysis

The RAND-36 Item Short Form Survey Instrument (SF-36) has a scoring system which populates 8 specific domains – Physical functioning, Role limitations due to physical health, Role limitations due to emotional problems, Energy/Fatigue, Emotional well-being, Social functioning, Pain, General health. Questions populating these categories are listed as items. This scoring system has been used in accordance with the RAND-36 Item Short Form Survey Instrument (SF-36) scoring system instructions.

Interview responses and comments have been and reported as comments, themes and quantitative data.

Privacy and confidentiality of each participant is maintained through coding of participant identity, de-identification of comments, any comments that may identify participants have been excluded.

## Participant demographics: 17 Participants

AGE GROUPS	FEMALE (F) 13	MALE (M) 4	TOTAL (F & M)
45 – 59	5	1	6
60 – 69	2	1	3
70 – 79	4	1	5
80+	2	1	3

# Commencement Interview

Each participant attended a pre-focus group 1 hour duration interview.

The interview consisted of a discussion around the participant's perception of their current health status including diagnosis, wellbeing and social connectedness, health and wellbeing history, their current community engagement and social wellbeing, and whether financial constraints influence their ability to participate in activities within their community.

Participants also completed the Rand 36-item Short Form Survey Instrument questionnaire. Each question and answer were read to the participant. Participants were instructed there were no 'wrong' answers and should reflect the participant's perception.

## Participants chronic condition diagnosis:

- 2 non-insulin dependent diabetes
- 3 osteoporosis
- 8 osteoarthritis
- 6 cardiovascular conditions
- 3 experienced stroke or TIA
- 3 experienced cancer
- 4 COPD (Chronic Obstructive Pulmonary Disease – Lung disease)
- 12 reported mental health conditions
- 16 noted other physical ailments
- 7 described themselves as lonely or socially disconnected
- 11 considered themselves physically active



# Midway Interview

During this interview 10 questions were asked to each participant.

*Note: 1 participant was unable to attend their interview.*

**Q1. By comparison to when we had our first interview how is your:**

	BETTER	SAME	WORSE	UNANSWERED
Physical Health	5	7	4	1
Emotional Health	7	8	1	1

**Q2. Have there been changes in your health?**

YES	NO
11	5

**Q3. Have you had to cut down on activities due to your:**

	YES	NO	UNANSWERED
Physical Health	6	10	1
Emotional Health	0	16	1

**Q4. How is your overall wellbeing?**

BETTER	SAME	WORSE	UNANSWERED
7	7	2	1

**Q5. Did you find the discussion at the first session motivating to learn or do something different?**

YES	NO	UNANSWERED
7	7	1

## Midway Interview

**Q6. Have you made changes to how you participate within the community?**

YES	NO	UNANSWERED
9	7	1

**Q7. Have you faced barriers to participating or changing how you participate in the community:**

YES	NO	UNANSWERED
6	10	1

**Q8. Have your social activities changed?**

INCREASED	SAME	DECREASED	UNANSWERED
4	10	2	1

**Q9. Has there been a change in the support you have?**

INCREASED	SAME	DECREASED	UNANSWERED
4	10	2	1

**Q10. Participants were shown a video of a discussion with a dietitian.**

**Would you watch videos about health and well-being?**

**Would you watch these?**

YES	NO	UNANSWERED
14	2	1

**Q11. On reflection did the initial interview have an effect on you?**

YES	NO	UNANSWERED
15	1	1



# Quantitative Responses



# Final Interview

The RAND-36 Item Health Survey Instrument (SF-36) was conducted at the final interviews. Results are listed on pages 15-30.

## Group notable outcomes:

- Overall improvements in all 8 categories of the survey. Note - this does not indicate improvements for every participant. (see detailed demographic results or individual results for more detail).
- Significant improvement in the role limitations due to physical health responses
- Over 20% improvement in Role limitations due to emotional health responses

During the final interview participants were each asked to answer 8 questions.

*Note: 1 participant was unable to attend their interview.*

### Q1. Was it easy to participate in this group?

YES	NO
16	0

### Q2. Have you noticed any changes in your habits or choices over the last 5 months?

YES	NO
13	3

### Q3. Have there been changes in your:

	YES	NO
Health	14	2
Understanding of own health	9	7
Management of own health	8	8
Social connections	13	3
Physical Activity	8	8
Feeling of burden	16	0

**Q4. Has being a part of this group influenced any changes in question 3?**

YES	NO
13	3

**Q5. Has your support at home changed?**

YES	NO
9	7

**Q6. Have you been financially restricted from participating in activities:**

YES	NO
5	11

**Q7. Do you feel more aware of your well-being due to being in this group?**

YES	NO
14	2

**Q8. Would you consider being a part of another focus group around health and well-being?**

YES	NO
16	0

# Feedback

The following are participants comments offered during the final interviews.

**"Being able to talk to someone without judgement encourages me to improve my health and wellbeing and has been a huge benefit."**

**"Get past having meetings and into actions. If we had health checks during these meetings that would be of value."**

**"Being a part of this has come at the right time for me. I am aware of this and approach issues in a more positive way."**

**"Having someone with time to hear me has been more impactful than a 15 minute discussion with a doctor."**

**"Having a safe space and time to connect with an authentic person allowed me to open up."**

**"We live in an ageist society."**

**"Di (facilitator) has been supportive, friendly, genuinely interested, accessible. It's been a great experience."**

**"I would love to know what is identified out of this group and what that might lead to, especially in departmental eyes."**

**"I appreciate the safe and supportive space to speak and the reassurance of confidentiality."**

**"This is a good program. I'm pleased to participate. I hope it brings change."**

**"Is there a way of revisiting / following up in the future?"**

**"Good facilitator."**

**"Didn't need much from me just honesty."**

# Feedback

When asked about reflection of discussions during the interviews some of the comments included:

**"I'm more conscious of my health."**

"I prioritise my health and well-being more."

**"I reach out for support more now."**

"I've prioritised some area's but not all yet."

**"I'm proactive about my well-being now."**

"I got a jolt of reality about my health and well-being."

"I pay more attention to my health."

**"I've changed my job due to reflection around my health and well-being."**

"This reminded me to prioritise my health."

**"I'm more aware of my health."**

"I'm selective about my social connections. Quality over quantity."

**"I'm more aware of the health and well-being of others."**

# RAND-36 Item Short Form Survey Instrument (SF-36)

Data populated by the RAND-36 Short Form Survey Instrument (SF-36) scoring instructions show the following group percentages results.

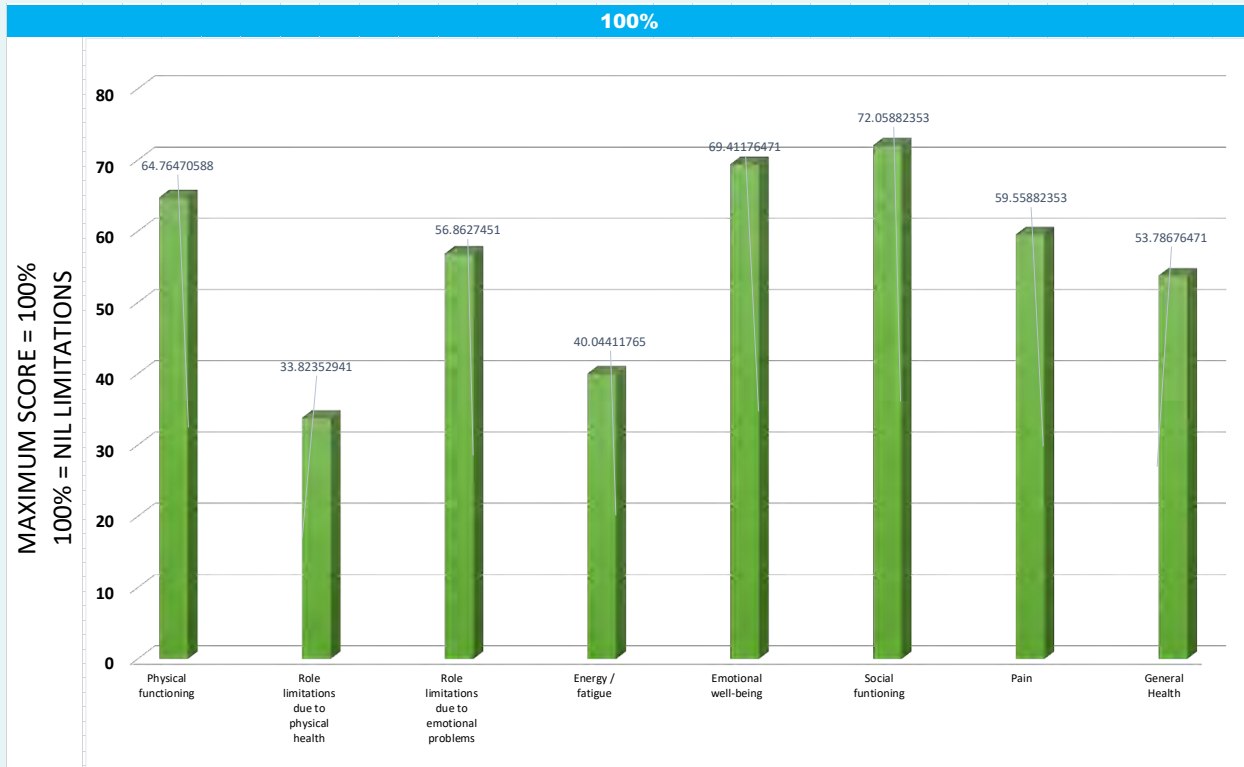
**Note:** 100% indicates nil limitations. Lesser numbers indicate the number of responses to limitations - not the level of limitation. Each category calculates over numerous questions.



# Results

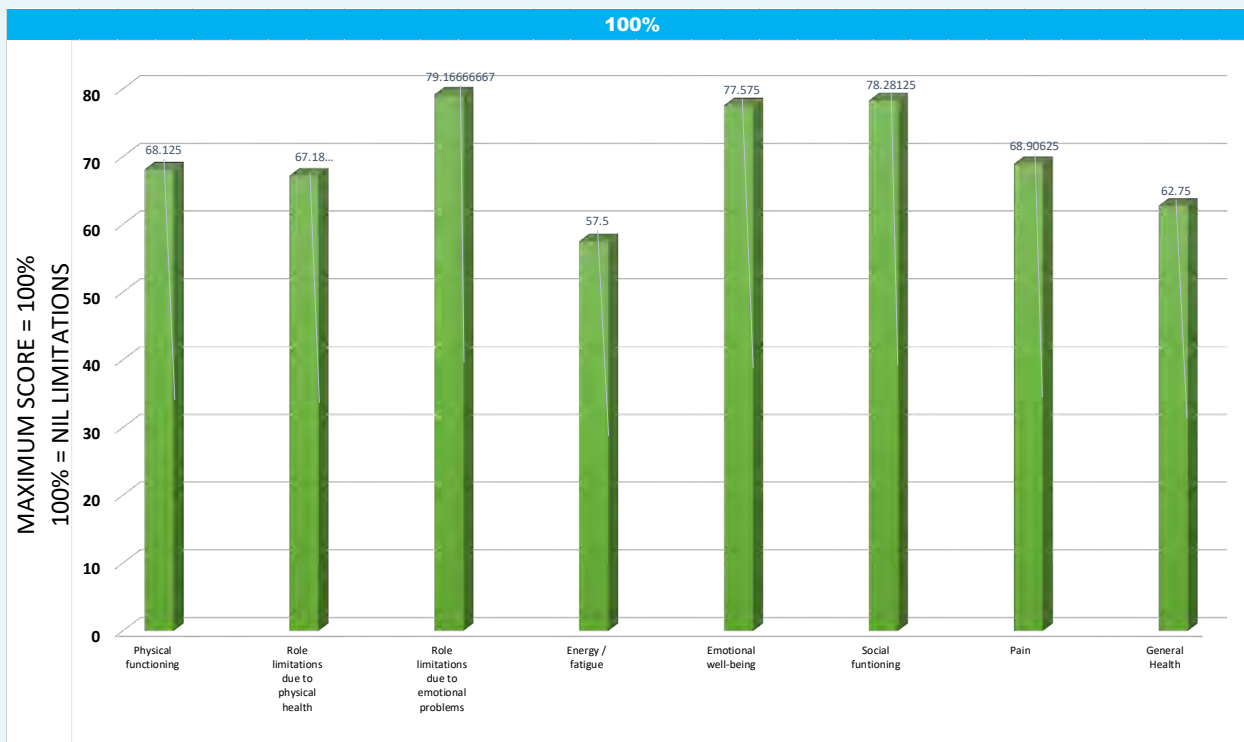
## COMMENCEMENT SURVEY RESULTS

8 Categories – Group Percentages – 100% Indicates NIL Limitations



## FINAL SURVEY RESULTS

8 Categories – Group Percentages – 100% Indicates NIL Limitations



# Group

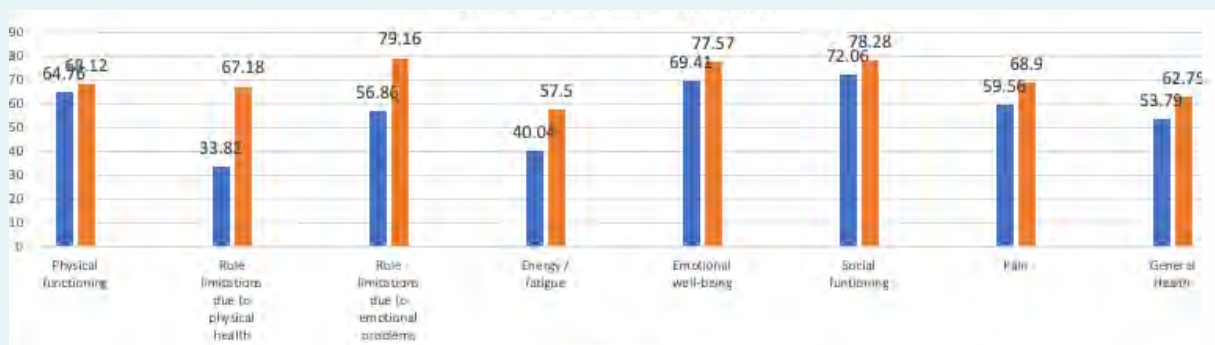
## PERCENTAGES COMMENCEMENT INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - GROUP PERCENTAGES			LEVEL OF FUNCTION	%
Physical functioning	10	items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12		64.76
Role limitations due to physical	1	Items 13 ,14, 15, 16		33.82
Role limitations due to emotior	3	items: 17, 18, 19		56.86
Energy / fatigue	4	Items: 23, 27, 29, 31		40.04
Emotional well-being	5	Items: 24, 25, 26, 28, 30		69.41
Social funtioning	2	Items: 20, 32		72.06
Pain	2	Items: 21, 22		59.56
General Health	5	Items: 1, 33, 34, 35, 36		53.53

## PERCENTAGES FINAL INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - GROUP PERCENTAGES			LEVEL OF FUNCTION	%
Physical functioning	10	items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12		68.125
Role limitations due to physical	1	Items 13 ,14, 15, 16		67.1875
Role limitations due to emotior	3	items: 17, 18, 19		79.16666667
Energy / fatigue	4	Items: 23, 27, 29, 31		57.5
Emotional well-being	5	Items: 24, 25, 26, 28, 30		77.575
Social funtioning	2	Items: 20, 32		78.28125
Pain	2	Items: 21, 22		68.90625
General Health	5	Items: 1, 33, 34, 35, 36		62.75

## PERCENTAGES COMPARISON ■ START ■ END



# Age Group 45 – 59

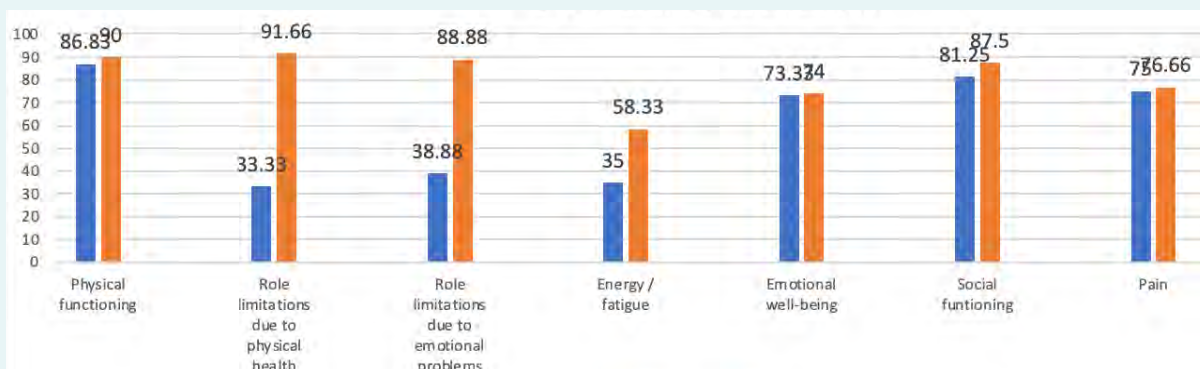
## PERCENTAGES COMMENCEMENT INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - AGE GROUP 45-59 PERCENTAGES			LEVEL OF FUNCTION
Physical functioning	10	items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	86.8333333
Role limitations due to physical health	1	Items 13, 14, 15, 16	33.3333333
Role limitations due to emotional problems	3	items: 17, 18, 19	38.8888889
Energy / fatigue	4	Items: 23, 27, 29, 31	35
Emotional well-being	5	Items: 24, 25, 26, 28, 30	73.3333333
Social functioning	2	Items: 20, 32	81.25
Pain	2	Items: 21, 22	75
General Health	5	Items: 1, 33, 34, 35, 36	60

## PERCENTAGES FINAL INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - 45-59 AGE GROUP PERCENTAGES			LEVEL OF FUNCTION	%
Physical functioning	10	items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12		90
Role limitations due to physical health	1	Items 13, 14, 15, 16		91.6666667
Role limitations due to emotional problems	3	items: 17, 18, 19		88.8888889
Energy / fatigue	4	Items: 23, 27, 29, 31		58.3333333
Emotional well-being	5	Items: 24, 25, 26, 28, 30		74
Social functioning	2	Items: 20, 32		87.5
Pain	2	Items: 21, 22		76.6666667
General Health	5	Items: 1, 33, 34, 35, 36		73.3333333

## PERCENTAGES COMPARISON



# Age Group 60 – 69

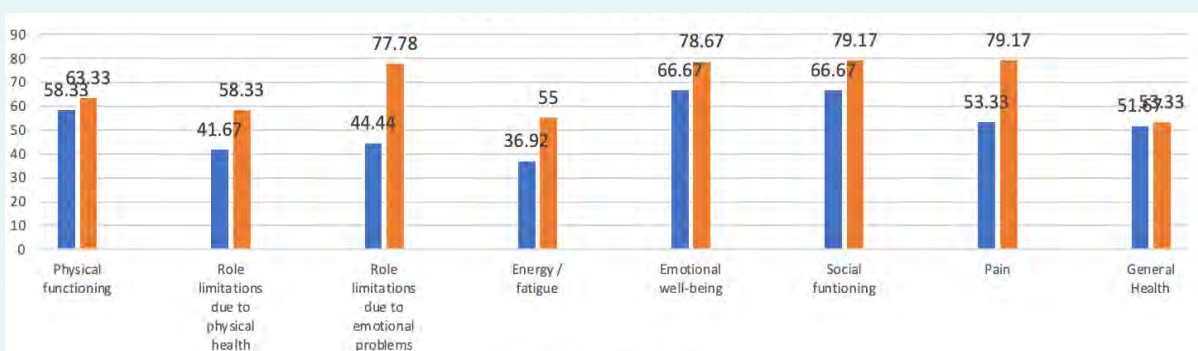
## PERCENTAGES COMMENCEMENT INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - 60-69 AGE GROUP % -		LEVEL OF FUNCTION
Physical functioning	10 items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	58.33
Role limitations due to physical health	1 Items 13 ,14, 15, 16	41.67
Role limitations due to emotional problems	3 items: 17, 18, 19	44.44
Energy / fatigue	4 Items: 23, 27, 29, 31	36.92
Emotional well-being	5 Items: 24, 25, 26, 28, 30	66.67
Social functioning	2 Items: 20, 32	66.67
Pain	2 Items: 21, 22	53.33
General Health	5 Items: 1, 33, 34, 35, 36	51.67

## PERCENTAGES FINAL INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - 60-69 AGE GROUP %		LEVEL OF FUNCTION	%
Physical functioning	10 items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12		63.33
Role limitations due to physical health	1 Items 13 ,14, 15, 16		58.33
Role limitations due to emotional problems	3 items: 17, 18, 19		77.78
Energy / fatigue	4 Items: 23, 27, 29, 31		55
Emotional well-being	5 Items: 24, 25, 26, 28, 30		78.67
Social functioning	2 Items: 20, 32		79.17
Pain	2 Items: 21, 22		79.17
General Health	5 Items: 1, 33, 34, 35, 36		53.33

## PERCENTAGES COMPARISON



## Results

# Age Group 70 – 79

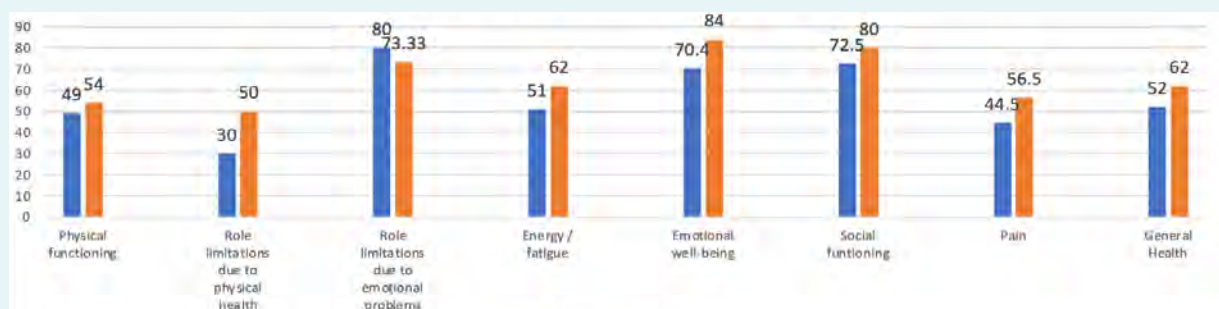
### PERCENTAGES COMMENCEMENT INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - 70 - 79 AGE GROUP %		LEVEL OF FUNCTION
Physical functioning	10 items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	49
Role limitations due to physical health	1 Items 13, 14, 15, 16	30
Role limitations due to emotional problems	3 items: 17, 18, 19	80
Energy / fatigue	4 Items: 23, 27, 29, 31	51
Emotional well-being	5 Items: 24, 25, 26, 28, 30	70.4
Social functioning	2 Items: 20, 32	72.5
Pain	2 Items: 21, 22	44.5
General Health	5 Items: 1, 33, 34, 35, 36	52

### PERCENTAGES FINAL INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - 70-79 AGE GROUP %		LEVEL OF FUNCTION	%
Physical functioning	10 items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12		54
Role limitations due to physical health	1 Items 13, 14, 15, 16		50
Role limitations due to emotional problems	3 items: 17, 18, 19		73.33
Energy / fatigue	4 Items: 23, 27, 29, 31		62
Emotional well-being	5 Items: 24, 25, 26, 28, 30		84
Social functioning	2 Items: 20, 32		80
Pain	2 Items: 21, 22		56.5
General Health	5 Items: 1, 33, 34, 35, 36		62

### PERCENTAGES COMPARISON



# Age Group 80+

## PERCENTAGES COMMENCEMENT INTERVIEW

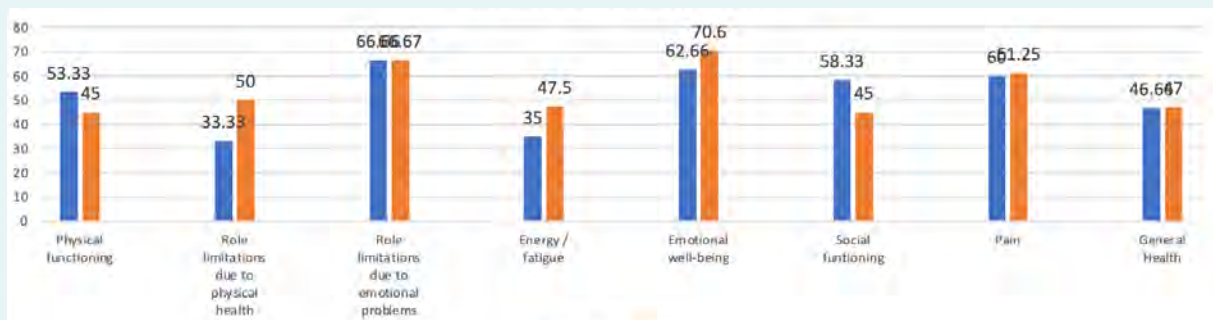
RAND 36 ITEMS 8 CATEGORIES - 80+ AGE GROUP %		LEVEL OF FUNCTION
Physical functioning	10 items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	53.3333
Role limitations due to physical health	1 Items 13, 14, 15, 16	33.3333
Role limitations due to emotional problems	3 items: 17, 18, 19	66.6667
Energy / fatigue	4 Items: 23, 27, 29, 31	35
Emotional well-being	5 Items: 24, 25, 26, 28, 30	62.6667
Social functioning	2 Items: 20, 32	58.3333
Pain	2 Items: 21, 22	60
General Health	5 Items: 1, 33, 34, 35, 36	46.6667

## PERCENTAGES FINAL INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - 80+ AGE GROUP %		LEVEL OF FUNCTION	%
Physical functioning	10 items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12		45
Role limitations due to physical health	1 Items 13, 14, 15, 16		50
Role limitations due to emotional problems	3 items: 17, 18, 19		66.67
Energy / fatigue	4 Items: 23, 27, 29, 31		47.5
Emotional well-being	5 Items: 24, 25, 26, 28, 30		70.6
Social functioning	2 Items: 20, 32		45
Pain	2 Items: 21, 22		61.25
General Health	5 Items: 1, 33, 34, 35, 36		47

## PERCENTAGES COMPARISON

■ START ■ END



# Gender – Female

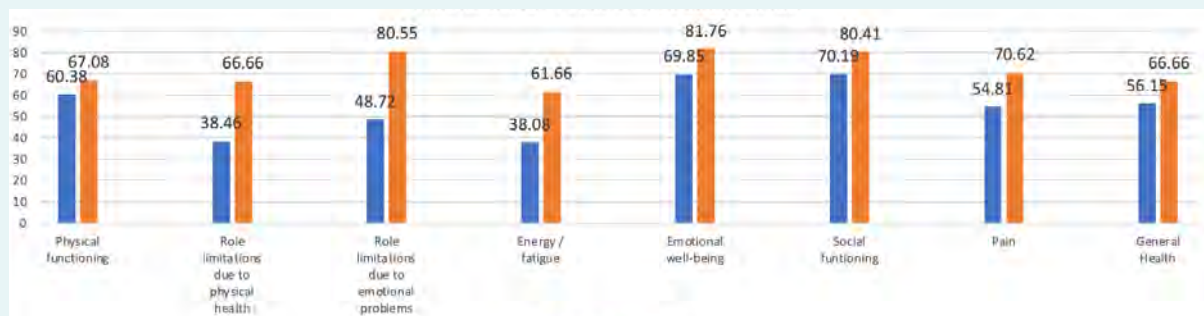
## PERCENTAGES COMMENCEMENT INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - GROUP PERCENTAGES			LEVEL OF FUNCTION	%
Physical functioning	10	items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12		60.38
Role limitations due to physical	1	Items 13 ,14, 15, 16		38.46
Role limitations due to emotior	3	items: 17, 18, 19		48.72
Energy / fatigue	4	Items: 23, 27, 29, 31		38.08
Emotional well-being	5	Items: 24, 25, 26, 28, 30		69.85
Social funtioning	2	Items: 20, 32		70.19
Pain	2	Items: 21, 22		54.81
General Health	5	Items: 1, 33, 34, 35, 36		56.15

## PERCENTAGES FINAL INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - GROUP PERCENTAGES			LEVEL OF FUNCTION	%
Physical functioning	10	items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12		67.08333333
Role limitations due to physical	1	Items 13 ,14, 15, 16		66.66666667
Role limitations due to emotior	3	items: 17, 18, 19		80.55555556
Energy / fatigue	4	Items: 23, 27, 29, 31		61.66666667
Emotional well-being	5	Items: 24, 25, 26, 28, 30		81.76666667
Social funtioning	2	Items: 20, 32		80.41666667
Pain	2	Items: 21, 22		70.625
General Health	5	Items: 1, 33, 34, 35, 36		66.66666667

## PERCENTAGES COMPARISON ■ START ■ END



# Female 45 – 59

## PERCENTAGES COMMENCEMENT INTERVIEW

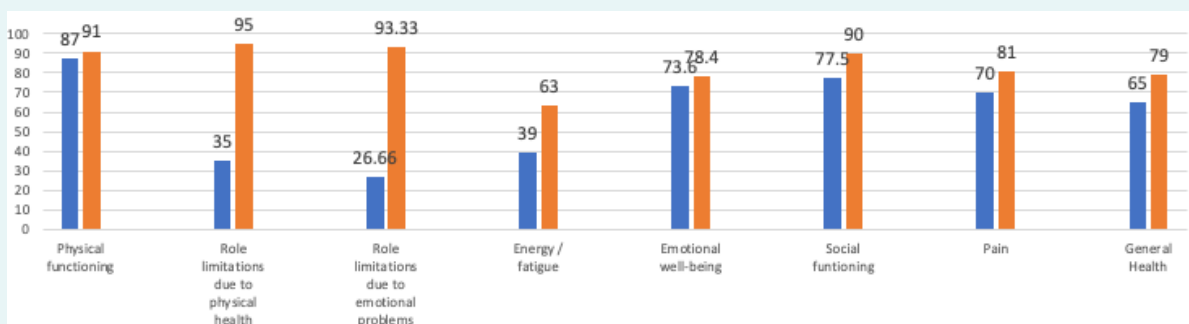
RAND 36 ITEMS 8 CATEGORIES - FEMALE AGE GROUP 45-59 %.			LEVEL OF FUNCTION
Physical functioning	10	items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	87
Role limitations due to physical health	1	Items 13, 14, 15, 16	35
Role limitations due to emotional problems	3	items: 17, 18, 19	26.6666667
Energy / fatigue	4	Items: 23, 27, 29, 31	39
Emotional well-being	5	Items: 24, 25, 26, 28, 30	73.6
Social functioning	2	Items: 20, 32	77.5
Pain	2	Items: 21, 22	70
General Health	5	Items: 1, 33, 34, 35, 36	65

## PERCENTAGES FINAL INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - FEMALE AGE GROUP 45-59 %			LEVEL OF FUNCTION	%
Physical functioning	10	items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12		91
Role limitations due to physical health	1	Items 13, 14, 15, 16		95
Role limitations due to emotional problems	3	items: 17, 18, 19		93.33333333
Energy / fatigue	4	Items: 23, 27, 29, 31		63
Emotional well-being	5	Items: 24, 25, 26, 28, 30		78.4
Social functioning	2	Items: 20, 32		90
Pain	2	Items: 21, 22		81
General Health	5	Items: 1, 33, 34, 35, 36		79

## PERCENTAGES COMPARISON

■ START ■ END



# Female 60 – 69

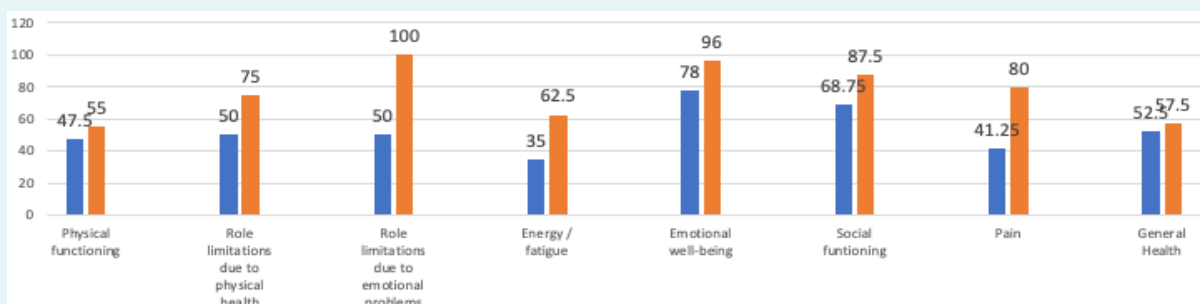
## PERCENTAGES COMMENCEMENT INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - FEMALE AGE GROUP 60-69 %			LEVEL OF FUNCTION
Physical functioning	10	items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	47.5
Role limitations due to physical health	1	Items 13, 14, 15, 16	50
Role limitations due to emotional problems	3	items: 17, 18, 19	50
Energy / fatigue	4	Items: 23, 27, 29, 31	35
Emotional well-being	5	Items: 24, 25, 26, 28, 30	78
Social functioning	2	Items: 20, 32	68.75
Pain	2	Items: 21, 22	41.25
General Health	5	Items: 1, 33, 34, 35, 36	52.5

## PERCENTAGES FINAL INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - FEMALE AGE GROUP 60-69 %			LEVEL OF FUNCTION
Physical functioning	10	items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	55
Role limitations due to physical health	1	Items 13, 14, 15, 16	75
Role limitations due to emotional problems	3	items: 17, 18, 19	100
Energy / fatigue	4	Items: 23, 27, 29, 31	62.5
Emotional well-being	5	Items: 24, 25, 26, 28, 30	96
Social functioning	2	Items: 20, 32	87.5
Pain	2	Items: 21, 22	80
General Health	5	Items: 1, 33, 34, 35, 36	57.5

## PERCENTAGES COMPARISON



# Female 70 – 79

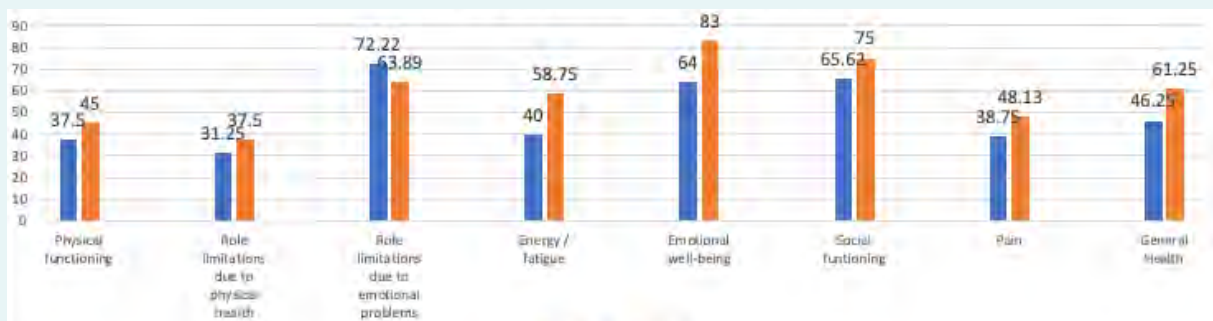
## PERCENTAGES COMMENCEMENT INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - FEMALE AGE GROUP 70-79 % LEVEL OF FUNCTION			
Physical functioning	10	items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	37.5
Role limitations due to physical health	1	Items 13, 14, 15, 16	31.25
Role limitations due to emotional problems	3	items: 17, 18, 19	72.2222
Energy / fatigue	4	Items: 23, 27, 29, 31	40
Emotional well-being	5	Items: 24, 25, 26, 28, 30	64
Social functioning	2	Items: 20, 32	65.625
Pain	2	Items: 21, 22	38.75
General Health	5	Items: 1, 33, 34, 35, 36	46.25

## PERCENTAGES FINAL INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - FEMALE AGE GROUP 70-79 % LEVEL OF FUNCTION				%
Physical functioning	10	items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12		45
Role limitations due to physical health	1	Items 13, 14, 15, 16		37.5
Role limitations due to emotional problems	3	items: 17, 18, 19		63.89
Energy / fatigue	4	Items: 23, 27, 29, 31		58.75
Emotional well-being	5	Items: 24, 25, 26, 28, 30		83
Social functioning	2	Items: 20, 32		75
Pain	2	Items: 21, 22		48.13
General Health	5	Items: 1, 33, 34, 35, 36		61.25

## PERCENTAGES COMPARISON ■ START ■ END



# Female 80+

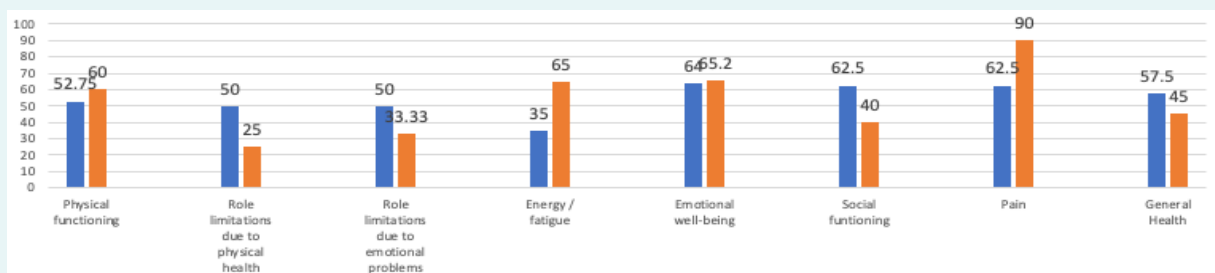
## PERCENTAGES COMMENCEMENT INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - 80+ AGE GROUP %		LEVEL OF FUNCTION
Physical functioning	10 items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	52.5
Role limitations due to physical health	1 Items 13, 14, 15, 16	50
Role limitations due to emotional problems	3 items: 17, 18, 19	50
Energy / fatigue	4 Items: 23, 27, 29, 31	35
Emotional well-being	5 Items: 24, 25, 26, 28, 30	64
Social functioning	2 Items: 20, 32	62.5
Pain	2 Items: 21, 22	62.5
General Health	5 Items: 1, 33, 34, 35, 36	57.5

## PERCENTAGES FINAL INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - 80+ AGE GROUP %		LEVEL OF FUNCTION	%
Physical functioning	10 items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12		60
Role limitations due to physical health	1 Items 13, 14, 15, 16		25
Role limitations due to emotional problems	3 items: 17, 18, 19		33.33
Energy / fatigue	4 Items: 23, 27, 29, 31		65
Emotional well-being	5 Items: 24, 25, 26, 28, 30		65.2
Social functioning	2 Items: 20, 32		40
Pain	2 Items: 21, 22		90
General Health	5 Items: 1, 33, 34, 35, 36		45

## PERCENTAGES COMPARISON ■ START ■ END



# Gender – Male

## PERCENTAGES COMMENCEMENT INTERVIEW

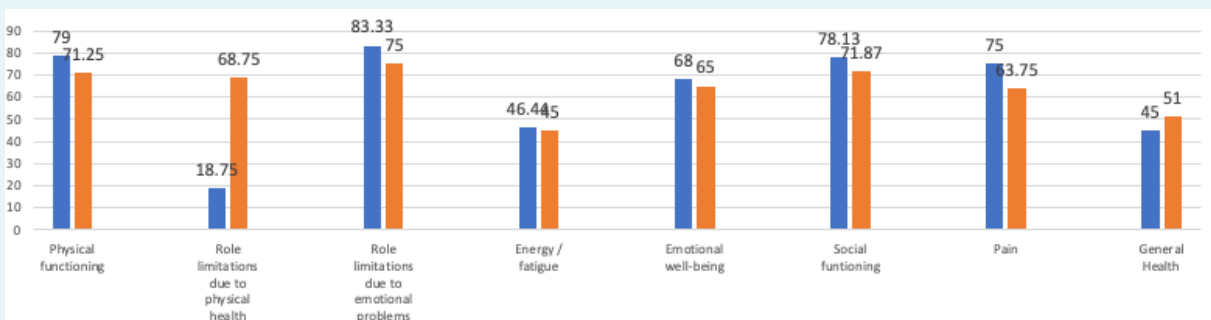
RAND 36 ITEMS 8 CATEGORIES - GROUP PERCENTAGES		LEVEL OF FUNCTION	%
Physical functioning	10	items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	79
Role limitations due to physical	1	Items 13 ,14, 15, 16	18.75
Role limitations due to emotior	3	items: 17, 18, 19	83.33
Energy / fatigue	4	Items: 23, 27, 29, 31	46.44
Emotional well-being	5	Items: 24, 25, 26, 28, 30	68
Social funtioning	2	Items: 20, 32	78.13
Pain	2	Items: 21, 22	75
General Health	5	Items: 1, 33, 34, 35, 36	45

## PERCENTAGES FINAL INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - GROUP PERCENTAGES		LEVEL OF FUNCTION	%
Physical functioning	10	items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	71.25
Role limitations due to physical	1	Items 13 ,14, 15, 16	68.75
Role limitations due to emotior	3	items: 17, 18, 19	75
Energy / fatigue	4	Items: 23, 27, 29, 31	45
Emotional well-being	5	Items: 24, 25, 26, 28, 30	65
Social funtioning	2	Items: 20, 32	71.875
Pain	2	Items: 21, 22	63.75
General Health	5	Items: 1, 33, 34, 35, 36	51

## PERCENTAGES COMPARISON

■ START ■ END



# Results

## Male 45 – 59

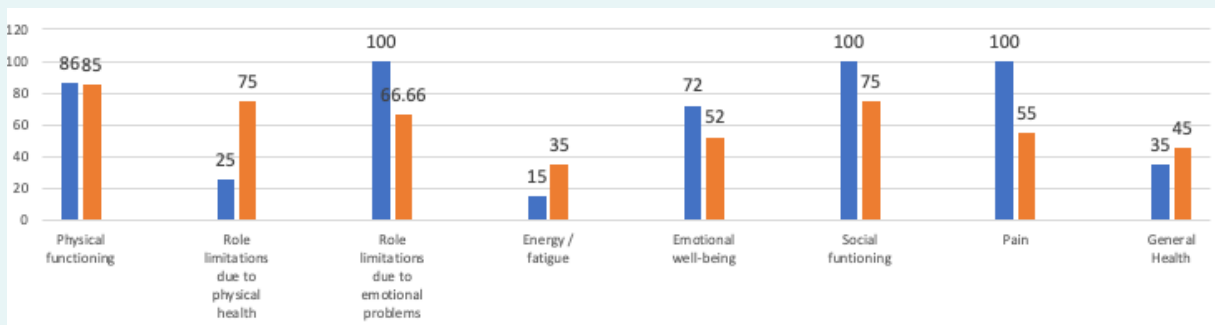
### PERCENTAGES COMMENCEMENT INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - MALE AGE GROUP 45-59 % - LEVE			LEVEL OF FUNCTION
Physical functioning	10	items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	86
Role limitations due to physical health	1	Items 13, 14, 15, 16	25
Role limitations due to emotional problems	3	items: 17, 18, 19	100
Energy / fatigue	4	Items: 23, 27, 29, 31	15
Emotional well-being	5	Items: 24, 25, 26, 28, 30	72
Social functioning	2	Items: 20, 32	100
Pain	2	Items: 21, 22	100
General Health	5	Items: 1, 33, 34, 35, 36	35

### PERCENTAGES FINAL INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - MALE 45-59 AGE GROUP %			LEVEL OF FUNCTION	%
Physical functioning	10	items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12		85
Role limitations due to physical health	1	Items 13, 14, 15, 16		75
Role limitations due to emotional problems	3	items: 17, 18, 19		66.66666667
Energy / fatigue	4	Items: 23, 27, 29, 31		35
Emotional well-being	5	Items: 24, 25, 26, 28, 30		52
Social functioning	2	Items: 20, 32		75
Pain	2	Items: 21, 22		55
General Health	5	Items: 1, 33, 34, 35, 36		45

### PERCENTAGES COMPARISON ■ START ■ END



# Male 60 – 69

## PERCENTAGES COMMENCEMENT INTERVIEW

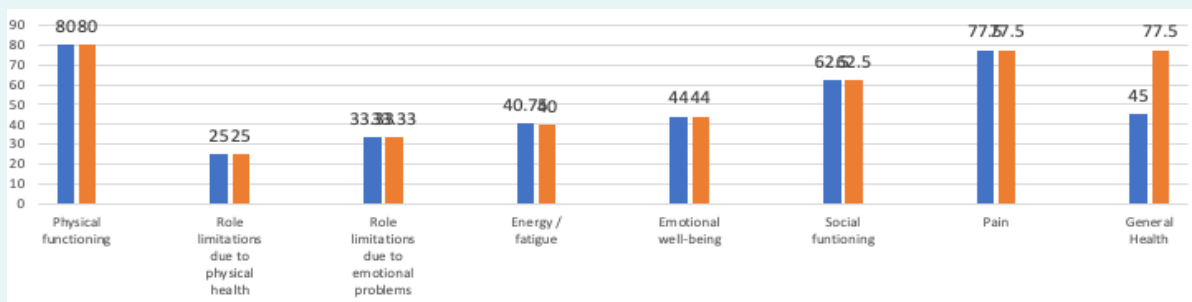
RAND 36 ITEMS 8 CATEGORIES - MALE 60-69 AGE GROUP % - LEVEL OF FUNCTION			
Physical functioning	10	items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	80
Role limitations due to physical health	1	Items 13, 14, 15, 16	25
Role limitations due to emotional problems	3	items: 17, 18, 19	33.33333333
Energy / fatigue	4	Items: 23, 27, 29, 31	40.75
Emotional well-being	5	Items: 24, 25, 26, 28, 30	44
Social functioning	2	Items: 20, 32	62.5
Pain	2	Items: 21, 22	77.5
General Health	5	Items: 1, 33, 34, 35, 36	45

## PERCENTAGES FINAL INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - MALE 60-69 AGE GROUP % LEVEL OF FUNCTION				%
Physical functioning	10	items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	80	80
Role limitations due to physical health	1	Items 13, 14, 15, 16	25	25
Role limitations due to emotional problems	3	items: 17, 18, 19	33.33	33.33
Energy / fatigue	4	Items: 23, 27, 29, 31	40	40
Emotional well-being	5	Items: 24, 25, 26, 28, 30	44	44
Social functioning	2	Items: 20, 32	62.5	62.5
Pain	2	Items: 21, 22	77.5	77.5
General Health	5	Items: 1, 33, 34, 35, 36	45	45

## PERCENTAGES COMPARISON

■ START ■ END



# Results

## Male 70 – 79

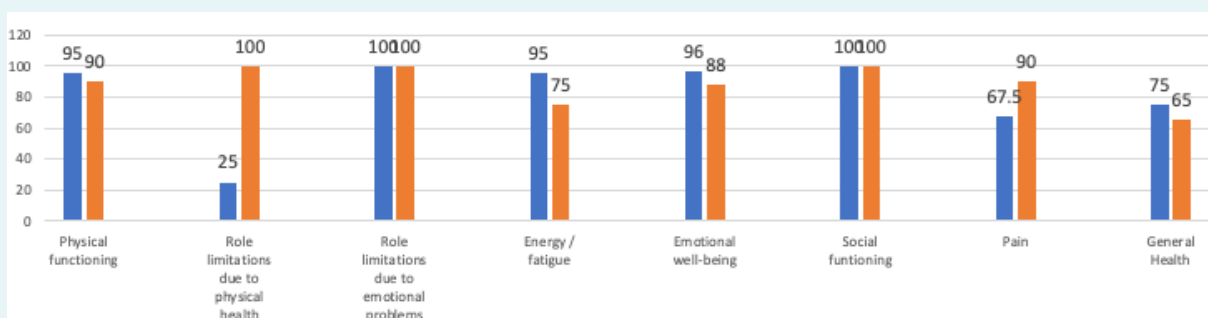
### PERCENTAGES COMMENCEMENT INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - 70 - 79 AGE GROUP %			LEVEL OF FUNCTION
Physical functioning	10	items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	95
Role limitations due to physical health	1	Items 13, 14, 15, 16	25
Role limitations due to emotional problems	3	items: 17, 18, 19	100
Energy / fatigue	4	Items: 23, 27, 29, 31	95
Emotional well-being	5	Items: 24, 25, 26, 28, 30	96
Social functioning	2	Items: 20, 32	100
Pain	2	Items: 21, 22	67.5
General Health	5	Items: 1, 33, 34, 35, 36	75

### PERCENTAGES FINAL INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - 70-79 AGE GROUP %			LEVEL OF FUNCTION	%
Physical functioning	10	items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12		90
Role limitations due to physical health	1	Items 13, 14, 15, 16		100
Role limitations due to emotional problems	3	items: 17, 18, 19		100
Energy / fatigue	4	Items: 23, 27, 29, 31		75
Emotional well-being	5	Items: 24, 25, 26, 28, 30		88
Social functioning	2	Items: 20, 32		100
Pain	2	Items: 21, 22		90
General Health	5	Items: 1, 33, 34, 35, 36		65

### PERCENTAGES COMPARISON ■ START ■ END



# Male 80+

## PERCENTAGES COMMENCEMENT INTERVIEW

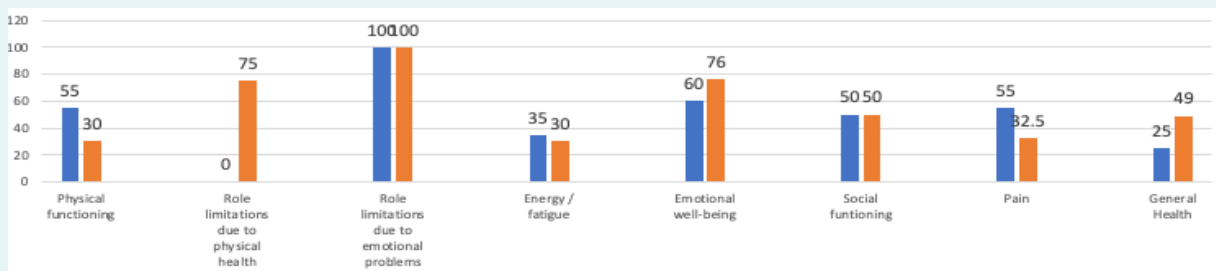
RAND 36 ITEMS 8 CATEGORIES - 80+ AGE GROUP %		LEVEL OF FUNCTION
Physical functioning	10 items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	55
Role limitations due to physical health	1 Items 13, 14, 15, 16	0
Role limitations due to emotional problems	3 items: 17, 18, 19	100
Energy / fatigue	4 Items: 23, 27, 29, 31	35
Emotional well-being	5 Items: 24, 25, 26, 28, 30	60
Social functioning	2 Items: 20, 32	50
Pain	2 Items: 21, 22	55
General Health	5 Items: 1, 33, 34, 35, 36	25

## PERCENTAGES FINAL INTERVIEW

RAND 36 ITEMS 8 CATEGORIES - 80+ AGE GROUP %		LEVEL OF FUNCTION	%
Physical functioning	10 items: 3, 4, 5, 6, 7, 8, 9, 10, 11, 12		30
Role limitations due to physical health	1 Items 13, 14, 15, 16		75
Role limitations due to emotional problems	3 items: 17, 18, 19		100
Energy / fatigue	4 Items: 23, 27, 29, 31		30
Emotional well-being	5 Items: 24, 25, 26, 28, 30		76
Social functioning	2 Items: 20, 32		50
Pain	2 Items: 21, 22		32.5
General Health	5 Items: 1, 33, 34, 35, 36		49

## PERCENTAGES COMPARISON

■ START ■ END



# Focus Group Findings and Case Studies





# Summary of Key Findings

Thematically significant, over 81% of participants reported being heard, with time and in a safe environment made a difference to their awareness, prioritising and actions around their own health and well-being. This was not through prescription or instruction. It was the opportunity to sound out to someone safe and reflect. Most reported not having this opportunity before.

**31%**

reported financial constraints impacting participation in social activities

**56%**

reported an improved understanding of their own health

**100%**

reported this process was a good reminder to take notice of their own health and well-being

**81%**

reported prioritising social connections – time and quality

**50%**

reported increases to their level or more purposeful physical activity.

The privilege of facilitating these interviews and the willingness of participants to the process and to disclose personal information and life stories can lead to challenges. The environment and topics regularly became emotional and intense during the initial interview. While managing privacy and confidentiality of all participants, future facilitators and program coordinators should consider engaging formal facilitator debriefing.

Please see case studies on the following pages.

# Building Resilience Through Connection and Reflection

During the focus group period, participant **LAWHAAF** (referred to as A) experienced a significant setback after sustaining a serious injury. While A was hospitalized and during recovery, a conflict arose with their primary family member (D), which caused considerable strain on family relationships.

At A's request, the final interview was conducted at their home. During this conversation, A shared the following:

- Since returning home from hospital, family relationships have deteriorated. A no longer receives visits or support from D, who has become increasingly hostile and accusatory.
- D involved other family members in negative discussions, making accusations that have influenced the family dynamic.
- While A was in hospital, D contacted the hospital to report that A was no longer of sound mind, questioning their capacity to make decisions or live independently.
- Following this, D ceased all visits and has negatively impacted A's relationships with other family members, including grandchildren.
- A no longer receives calls or visits from family members who were previously dependable, leaving A feeling isolated and betrayed.
- A strongly disputes claims of cognitive decline and reports significant emotional distress as a result of these family issues.

These challenges are difficult for anyone, but particularly for someone in the **80+ age group**, where assumptions about declining capacity are common and often accepted without question. A expressed feeling as though they had been "kicked while they were down."

Despite this distressing situation, the **RAND-36 survey** revealed something remarkable:

- **Role limitations due to emotional problems:** Score remained unchanged.
- **Emotional well-being:** Improved by **8%** compared to the previous survey.

When asked about this improvement, A shared that participating in the focus group interviews provided an opportunity to **be heard, reflect, and consider their own well-being**, which left them feeling "validated" and more empowered about their future. A reported that this process strengthened their **resilience and determination**, even in the face of family conflict and isolation.

This case highlights the profound value of **time, guided discussion, and reflection**. It demonstrates how structured conversations can enhance emotional well-being and resilience—an impact echoed in the stories of other participants.

# Finding Clarity and Reclaiming Energy Through Reflection

At the initial interview, IO reported being in generally good health but was experiencing persistent **emotional challenges, fatigue, and low energy levels**. Despite a strong understanding of their health and the role of exercise in supporting both physical and emotional well-being, IO had been struggling to recover from a lengthy illness. Efforts to find solutions through GP consultations, pharmacy support, and exercise therapy had not been successful.

During the first interview, IO described feeling heightened emotions while sharing their health journey and its impact on day-to-day life. IO also faced additional pressures in their role as a carer, with limited family support available locally.

Through the guided conversation and RAND-36 survey questions, IO experienced a shift in perspective. They later explained that having a safe, confidential space to speak openly about their challenges brought clarity, allowing them to better understand their needs and priorities.

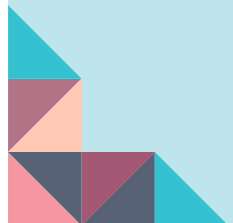
By the midway interview, IO reported feeling different—having made positive changes to priorities and expectations after reflecting on the first session.

**At the final interview, IO shared significant improvements in multiple areas of well-being:**

- Despite a sedentary work environment, IO introduced purposeful physical activity to their routine.
- They reported increased confidence and a stronger sense of purpose in managing emotional health.
- Fatigue levels decreased, and energy levels improved noticeably.

IO attributes these positive changes to the **three guided and trusted conversations**, which offered time for reflection, validation, and empowerment. They described feeling **heard, supported, and motivated to act**, leading to meaningful improvements in both emotional and physical health.

Importantly, because IO is in a **younger age group (45–59)**, the **early adoption of these lifestyle changes and coping strategies is likely to have long-term benefits**. By addressing these challenges now, IO is better positioned to maintain well-being over time, potentially reducing the likelihood of requiring significant **medical intervention in later years** compared to if these changes had not occurred.



# Unexpected but Powerful Outcomes from Guided Conversations

During the focus group interactions, several participants shared experiences that were both **unexpected and deeply significant**, demonstrating the power of reflection and structured discussion in shaping positive life changes.

## A Turning Point for Health and Well-being

One participant, aged **80+**, described experiencing a sudden "**jolt of realisation**" about their declining health while speaking during the initial interview. At the **midway interview**, this individual not only reported improvements in their health and well-being but also **appeared visibly healthier** to the facilitator.

When asked about the noticeable change, the participant explained:

"I realised I could no longer wait for improvement — I had to own it and do something about it. So I did."

They credited this transformation to the opportunity **to speak openly about the factors that were weighing them down**. The act of verbalising these challenges brought clarity, leading to an epiphany about where their health was heading and inspiring decisive action toward improvement.

## Reconnecting After a Decade of Distance

Another participant experienced an equally profound shift after the initial discussion. For over **10 years following the death of their son**, they had harboured resentment toward their spouse. This tension resulted in the couple living separately, and the relationship remained strained for many years.

During the first interview, the participant reflected on these long-standing feelings and, by the **midway interview**, reported a significant change in perspective:

- They realised they had been **too hard on their spouse**, acknowledging that both had suffered the same devastating loss.
- Since that realisation, the couple began spending more time together.
- The participant expressed **gratitude** for the support and social connection that emerged from this renewed relationship.



# Why These Outcomes Matter

These outcomes highlight the **value of providing time, safe spaces, and structured opportunities for reflection:**

- They demonstrate that **simple, guided conversations** can lead to significant emotional breakthroughs and behavioural changes, even in later life.
- Positive impacts were achieved **without medical intervention**, reducing potential future reliance on health services.
- In one case, improvements in social connection and emotional well-being not only enhanced quality of life but may also contribute to **better long-term health outcomes**.

Such results reinforce the importance of incorporating **reflective, person-centred approaches** in community health programs. They provide compelling evidence for **continued investment in early intervention and wellbeing-focused initiatives**.



# Conclusion

## The Value of Reflection and Connection in Community Well-being

This five-month focus group provided only a **snapshot** of what could be achieved with more time and resources, yet the findings are **clear and compelling**. Guided reflection – offered not as a mental health intervention but as a supportive conversation – enabled participants to gain **significant insight into their own health and well-being journeys**, resulting in measurable improvements and meaningful personal outcomes.

In today's context of **social fragmentation**, decreased extended family networks, and lingering effects of the pandemic, there is a growing demand for **community-based opportunities to reflect, connect, and plan for well-being**.

Furthermore, participants expressed the need for **guidance on where to turn when challenges are identified**, reinforcing the importance of having a **Community Connection Worker (or Link Worker)** to bridge gaps and support navigation to appropriate resources.

The evidence presented in this report strongly supports **continued investment in reflective, person-centred, and connection-focused initiatives** as an essential strategy for improving community health, well-being and resilience.



# Reflections

This Chronic Conditions Focus Group was part of a pioneering project exploring how people can live and age well in their homes for longer, by leveraging the social connections, supports and services available to them in their community. This study was specifically focused on a rural community, Clunes in Victoria.

## Context

It is well recognised that the health needs of rural and remote Australians are distinct from those in metropolitan areas, and that as a result of remoteness, health inequities do exist.

**What is less understood is how existing services and the attributes of a 'place' can combine to improve health outcomes for those living and ageing in those communities.**

Clunes is located in Hepburn Shire. Originally the first gold town in Victoria, this small community is primarily agricultural, with less than 2000 people living in the historic township and surrounding area. The median age is 51 years, with nearly two-thirds of the population experiencing one of Dr Frank Markel's five stages of ageing (independence, interdependence, dependence, crisis management and end of life.

On the Modified Monash Model, which is an Australian classification system that measures remoteness, Clunes has the equivalent service and infrastructure levels of a remote outback town. This is significant because the MMM is used to support the distribution of the health workforce, allocate funding for aged care, and determine pricing for services like the National Disability Insurance Scheme (NDIS).

Traditionally, in remote communities like Clunes, the services that form the foundations of a town's health and wellbeing ecosystem are anchor institutions like health services, the pharmacy and community organisations like Neighbourhood Houses. Anchor institutions are established, locally embedded organisations that are vital to a community's well being.

They are 'of the place', not just 'in the place', and use their resources and influence, including their purchasing, hiring and operational strategies, to create positive social and economic impacts.

## Proto-type

The Living and Ageing Well in Hepburn prototype was a two-year project launched in 2023. Funded by the Western Victoria Primary Health Network under the Australian Government's Primary Health Networks program the first 12 months focused on:

1. Understanding the needs of older people and the role they played in nurturing social connections, knowledge and agency in their community.
2. How organisations like Neighbourhood Houses could strengthen and underpin agency, supporting older people to play an active role in community life
3. How providers like the Health Service could link in and integrate with older people through these channels to raise awareness of early prevention and services as people aged >>



From the very beginning the project was unique. Central Highlands Rural Health opted to have Clunes Neighbourhood House take the project lead, recognising that Central Highlands Rural Health was a service provider whose organisational focus included Clunes, but extended more broadly across Hepburn Shire. Consequently, the only anchor organisation that was truly 'of the place' was Clunes Neighbourhood House.

This was an important decision because together, the partners believe that the outcomes achieved through this project, in particular in the second year, **highlighted how those 'of the place' can accelerate trust and outcomes through their relationship, local knowledge and experience.**

After the first year it was evident that the combination of community-led activities in a shared, age-friendly space provided older people with the agency and capacity to undertake activities that enriched their lives, both physically and emotionally, and would be sustained on an ongoing basis through the normal business of a Neighbourhood House. This was an exciting outcome, and one enabled by another anchor institution, the local council who leased the building to Clunes Neighbourhood House.

**But what we had not been able to fully quantify was whether this had a direct impact on early prevention and/or people's capacity to live longer in their homes as they aged; particularly people with chronic conditions. That became the focus of the second year of the project.**

### **Early Interventions and Chronic Condition Management**

Through a series of interventions aimed at people in the later stages of ageing (exercise, art therapy), educational strategies and this focus group, we sought to work out what was having the most direct impact on people's ability to live and age well.

During this last and final year of the project we sought to embed the way we were working, as partners, into business as usual. The Neighbourhood House had traditionally had representation on the Community Advisory Committee of Central Highlands Rural Health, but now the health service has a Memorandum of Understanding with Clunes Neighbourhood House, ensuring that the links between organisations are formalised and enduring, influencing how we work on a day to day basis, rather than just during a project.

However, our greatest impact was evident in the outcomes achieved by the project worker who not only implemented the Chronic Conditions Focus Group, also worked 'in place' at the Neighbourhood House, supporting them and community members to navigate complex queries that demonstrated the barriers to health and wellbeing that exist in remote communities.

**What we realised is that the project worker, once they had addressed the operational needs of the project, was in fact playing the role of a community-based connection or link worker – and the results were significant. >>**

## Way for the Future

In this Chronic Conditions Focus Group report we highlight the value of reflection and connection in community wellbeing. As you can see, these outcomes have been achieved because of the community based link worker.

As we conclude this project, we cannot reiterate this enough, but with one caveat. It is our belief that healthy literacy, early prevention and chronic conditions management can be significantly enhanced in remote communities if there is a community connection or link worker 'of the place' – preferably based at a Neighbourhood House (or similar anchor institution).

But here is our caveat. Ideally that worker would be part of the health service team, but accountable to shared objectives developed and managed by **both** institutions, and working part of that time, at the Neighbourhood House.

In the case of Clunes (with our learnings likely transferable to many other remote communities) this means Central Highlands Rural Health and Clunes Neighbourhood House.

**Why?** Because the solution is genuinely 'of the place', not just being done 'in place'. The result is a stronger, more connected and capable community that is better placed to look after its populations' health needs at every stage of ageing going forward.

**This prototype, particularly the second year, has given us the opportunity to demonstrate what is possible in remote communities where changes in health equities are not easy to shift. It shows how trusted institutions can think differently, and work together, to create results that ultimately influence not only the way services can work, but also peoples lives.**

Read just a few of the stories that have been realised as a result of approach in the last twelve months.

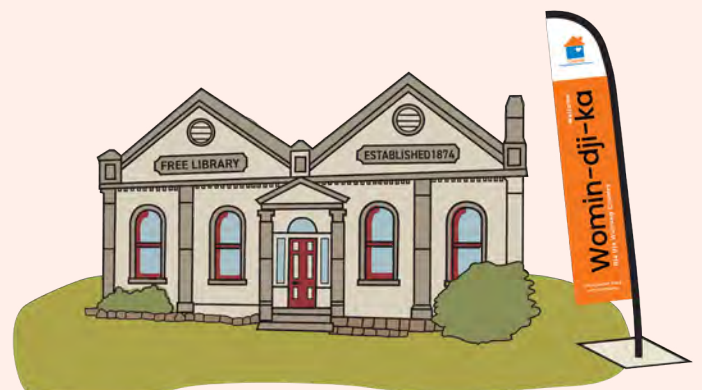
Imagine how many more could be added if this were to become a way of the future?

### Phil Catterson

Deputy Chief Executive Officer  
Central Highlands Rural Health

### Lana de Kort

Manager  
Clunes Neighbourhood House





**Entry Point:** Neighbourhood House  
**Link Work:** Central Highlands Rural Health  
**Pathway:** Community, Health and specialists

## Connection - Supporting Intergenerational Care

Requesting information about social activities. Program and information about local activities provided, but also referred to Living and Ageing Well Project Officer to provide 'warm introduction' to activities that would best fit needs. Evidence of complex factors contributing to needs.

John (not his real name) contacted our project seeking support for his 70-year-old mother, who had become socially isolated and was experiencing a decline in mobility. She had begun using a wheelchair of her own accord, without formal clinical assessment.

Her living situation was becoming increasingly untenable: unable to safely access the main house from her backyard unit, and now cohabitating in a home already under significant strain, shared with John, his wife, and their two children both of whom have neurodivergent needs - whom John and his wife care for full-time.

### Intervention:

We arranged a casual, low-pressure meeting at a local café to explore the situation further. This neutral, informal setting helped build rapport and made the mother feel more at ease. Through conversation, she was able to identify a 2 personal goals around regaining independence and re-engaging socially

From there, I provided:

- Tailored information on local activities aligned with her interests and capabilities
- Details on relevant allied health and community health services including exercise physiology mobility programs

- Advice on engaging a social worker to assist with navigating longer-term challenges, including housing and care coordination
- Information on accessing My Aged Care and the potential benefits of accessing supports

### Outcome:

This initial engagement marked the beginning of a positive shift. The mother felt heard and empowered to take steps toward improved health and community connection. John and his family gained clear pathways for support, helping reduce stress at home and easing tension. This case also highlighted the broader value of providing integrated, relational support that extends across generations.

### Key Themes:

- Early intervention and soft-entry engagement
- Holistic family support in complex care settings
- Connecting isolated individuals to both social and clinical supports
- Reducing carer strain through appropriate referrals and information >>

### Connection - Supporting Intergenerational Care

#### Living and Ageing Well in Hepburn, Project Officer - Link Worker Reflection

Working with John's family offered a window into the hidden complexities that often accompany intergenerational caring arrangements.

John's mother had been living in a bungalow in the backyard – a quiet semi-independent space, but as her mobility and confidence declined, she could no longer safely manage the short walk to the main house.

Out of necessity, she moved into the already stretched family home, where John and his wife are full-time carers for their two children with neurodivergent needs. What was once a functional arrangement shifted into a pressure cooker environment where everyone's needs competed for limited space, time and energy

From the project officer perspective, this case reveals how social isolation and physical decline can intensify under the radar, especially in households already under immense strain. John's mother's increasing disconnection from community, coupled with the family's 24/7 caring load, highlights the need for integrated, family-centred support – not just for individuals. It also reinforces how important it is to recognise carers and ageing family members as part of a shared ecosystem, not as separate service "types".

John's deep care for his mother, and the emotional burden he carries in trying to ensure her wellbeing while managing so much else is evident. After sitting down together and providing information pathways, and a calm space to explore their options, both John and his mother left the meeting with increased confidence and clarity. They gained practical tools and direction that helped them feel better

equipped to positively influence the next steps in their journey – a reminder that even one well timed conversation can shift momentum in a meaningful way.

Importantly, this case reinforced the need for the connector / link worker or Project Officer role to be filled by someone with a strong understanding of health, allied health, and community services. This knowledge ensures that families receive guidance that is not only compassionate, but also informed, realistic and appropriate to their complex needs.

In moments like these, having the right person in the room can mean the difference between continued overwhelm and a clear, hopeful path forward.

**Entry Point:** Project Brochure, Neighbourhood House

**Link Work:** Central Highlands Rural Health

**Pathway:** Community, Health and specialists

## Gentle Support - Reconnecting a Person with Health Services

Drop into Neighbourhood House when the doors were open. Over coffee it became apparent that it was more than a social visit. Referred to Living and Ageing Well Project Officer to see if they could help problem solve issues.

An 82-year-old woman was referred to the project seeking information about Power of Attorney (POA). Upon initial contact, however, it became apparent that her request was part of a much larger expression of intense psychological and emotional distress.

During the 90 minute phone call, the woman crying hysterically throughout, spoke at length about numerous concerns: allegations from her husband (who is living with dementia), fears around her son's legal authority as his POA, and feelings of persecution by government agencies including council and utility services.

### Intervention:

Despite the overwhelming and disorganised nature of the call, the woman demonstrated intelligence, clarity of memory, and strong verbal skills. However, her distress escalated quickly and sustained.

Using firm and respectful interruption, I was able to ask two critical questions:

- Was she safe in her home?  
→ She stated yes.
- Was she intending to harm herself?  
→ She emphatically stated no, citing strong spiritual, Celtic and

Indigenous values as protective factors, and affirming she still had "things to achieve."

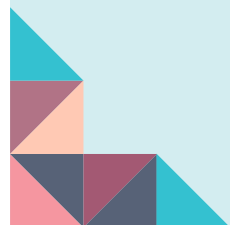
She denied having a mental health diagnosis, explaining that a past psychiatrist had misunderstood her spiritual beliefs.

As the conversation continued without resolution or clarity, despite attempts to redirect and define her needs, I asked directly what she required from the project. She eventually identified needing help with a Home Care Package application.

I explained this was not within my direct area of expertise, and offered to connect her with a health service social worker who could assist. She then disclosed she was already seeing a social worker/counsellor at the local health service and gave consent for me to contact them.

Despite efforts, I was unable to reach the counsellor directly, so I contacted the service manager. After discussing the situation and the intensity of the woman's emotional distress (separate from the content of her concerns), I was advised to contact the local mental health unit for further guidance and escalation. I followed this recommendation.

The next day, I spoke with the woman's counsellor, who confirmed she was scheduled to meet with her that day. The counsellor was able to provide context and reassurance around the situation, and I shared my concern over the woman's high distress level and social isolation. >>



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### Outcome:

The situation was appropriately handed over to the existing care team, ensuring continuity of care. My role in this case was:

- Providing calm, immediate emotional containment during
- Identifying risk and protective factors with sensitivity
- Making appropriate referrals and following professional guidance
- Ensuring consent was obtained for any external contact
- Practicing ethical boundaries while remaining supportive

### Key Themes:

- Crisis response and emotional de-escalation
- Recognising when issues exceed scope and require escalation
- Clear communication and consent-based collaboration
- Understanding the difference between content-driven distress and psychological risk
- Interagency collaboration to ensure client safety and wellbeing

## Living and Ageing Well in Hepburn, Project Officer - Link Worker Reflection

This case involved a distressed 82 year old woman with whom I had a 90 minute phone call. The woman was crying, highly emotional and expressed multiple overlapping concerns including fears that people were trying to take her property. It was immediately clear that she was in deep emotional distress, but it took time to gently but forcefully interrupt her to assess her safety. While reassured the woman was safe and not intending harm to anyone or self, the intensity of the call and the complexity of her distress remained heavy.

I was conscious that the neighbourhood house, who had taken the initial query, had obviously sensed some of this complexity, but without the training and supports that I may have in place.

This was one of the more personally distressing interactions I've experienced in this role. It was confronting to hear such vulnerability and confusion from someone who is elderly, isolated and clearly without enough immediate support. Although I was able to contact her health support team (with her consent) the following day, this call ended late and I had no available avenue to debrief or access support for myself.

This experience underscored the emotional labour involved in the role, and the need for a clear internal procedure to support staff following high intensity contact, especially when managers or clinical support staff are not available. Once again, this case reflects how critical it is that the connector or project officer is someone with a sound understanding of health and community services, but also that the organisation recognises the wellbeing needs of the worker behind the role.

**Entry Point:** Neighbourhood House  
**Link Work:** Central Highlands Rural Health  
**Pathway:** Community, Health and specialists

## Navigating Distress - Responding with Care, Boundaries and Coordination

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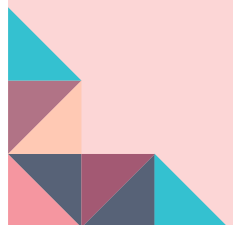
A person in their 70s had avoided healthcare services for over three years after a distressing experience with a general practitioner. During this time, they developed several health concerns, including chronic sinus infections and significant vision deterioration in one eye. Feeling increasingly unwell but disconnected from the health system, they visited the local neighbourhood house seeking advice, where they were referred to the project for further support.

### **Intervention:**

We arranged a private, one-on-one meeting in which trust was quickly established. The person shared that they often feel overwhelmed when given too much information at once, and that they have previously left conversations feeling shut down or unheard. This created anxiety about engaging with healthcare providers, particularly those who rushed consultations.

Together, we discussed options and I offered to source a GP at the local clinic and accompany them to their initial appointment - an offer they gratefully accepted. During the appointment:

- I gently explained to the GP that the person finds it difficult to process large amounts of information at once.
- The GP responded with sensitivity and adapted their communication style accordingly, providing reassurance and information at a manageable pace. The consultation confirmed the person had lost most of the vision in one eye, validating their decision to limit driving.
- A referral was made to an optometrist, and a treatment plan for chronic sinusitis was initiated. >>



## Navigating Distress - Responding with Care, Boundaries and Coordination

### Outcome:

Following this supported experience, the person expressed confidence to continue managing their healthcare independently. They express sincere gratitude for the help and sensitivity provided. During a follow-up conversation a few months later, they shared that:

- They are awaiting eye surgery.
- They feel capable of attending future GP appointments alone.
- They now feel more comfortable navigating health services and knows they can reach out for further assistance if needed.
- Key Themes: Trauma-informed, person-centred care
- Advocacy and respectful communication in clinical settings
- Empowering individuals to regain trust in health systems
- Strengthening independence through gentle, appropriate support
- They are now volunteering within community and remain connected to the Neighbourhood House

## Living and Ageing Well in Hepburn, Project Officer - Link Worker Reflection

This case involved a person who had completely disengaged from medical services following a negative experience with a GP approximately three years earlier. Over time their symptoms worsened, yet they remained disconnected from care until they reached out through the neighbourhood house. Their trust of the neighbourhood house accelerated our own trust.

We arranged to meet in a setting of their choice which was quiet, familiar and felt safe to them. During this conversation they shared that they have a condition (which they call a disability) that causes them to shut down when overwhelmed by information. As a result, they often left interactions appearing informed, but in reality, feeling confused and disengaged.

The person wanted to re-engage with a GP due to vision concerns and chronic sinus pain but was anxious about the communication barriers they'd experienced in the past. It was agreed I would organise a new GP and attend the appointment with them. I was able to explain the persons communication needs to the GP. The GP responded thoughtfully and adjusted their approach, which led to a constructive and respectful consultation. The person was diagnosed with near complete vision loss in one eye and acute sinus inflammation, and was referred to an optometrist for further investigation, and prescribed medication for their sinus inflammation.

In this case, I wasn't needed for long-term support, just to act as a bridge for that first step. It clearly demonstrated again how essential it is that the person in this role brings strong health and community services knowledge, along with the ability to translate between systems and people in a way that honours both.

# Living and ageing well

in Hepburn

