Community Connections
Vulnerability and Resilience in the Blue Mountains

Project Report

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Executive Summary

The Community Connections research sought to identify the needs of vulnerable community members and inform strategies to address their social inclusion and safety requirements.

In emergency situations most people are assisted by family, neighbours and friends. For others assistance may be much harder to find. Within the NSW Blue Mountains, the October 2013 fires highlighted that knowledge of vulnerable individuals and their needs is fragmented across the community and across multiple agencies and service providers. The impetus for the research stemmed from initial investigations revealing that vulnerable residents within the Blue Mountains may not be actively engaged or consulted by relevant authorities prior to, or during, emergency situations.

'Community resilience' refers to the ability of a community to deal with and rebound after a disaster or challenge. Measuring community connectedness is key to evaluating social capacity and we consider that social capacity is key to gauging community resilience. Building the community resilience of identified vulnerable residents needs to occur in ways which strengthen existing wider community resilience and recognises the social capital of the local area.

Ethical approval for conducting the research was provided by Charles Sturt University. Through focus groups, survey and interviews within a participatory action framework, the project drew together information from State and Federal reports, academic research, local support groups, community centres and community members, specifically focusing on the needs of vulnerable populations within the Blue Mountains.

The survey was completed by 1103 residents of the Blue Mountains. The statistical analysis software program SPSS was used to generate upper level summary statistics by demographic group (for example, age, gender, living arrangements). These results were tested against 2011 Census data to check whether the sample was representative of the Blue Mountains population. Weightings for gender and age were added to reflect the population described in the 2011 Census. The analysis can be seen as indicating trends for age groups and chronic illness/disability in relation to need for assistance and connections within the community.

Interview and focus group data was transcribed and transcripts entered into NVivo 10. Key word queries were run in NVivo and comments from participants relating to key areas noted.

Through an examination of the level of engagement of vulnerable community members with local services e.g. Neighbourhood Centres and emergency service organisations, we sought to develop strategies for increasing the community connectedness of the most vulnerable within the Blue Mountains community generally, and in times of public emergency.

The Community Connections research was conducted through a partnership between Charles Sturt University, Blue Mountains City Council, Katoomba Neighbourhood Centre Inc and Springwood Neighbourhood Centre Co-operative Ltd.

Aim

This report is designed to inform strategies for increasing community resilience, community connection and planning for the needs of vulnerable community members and, as a flow on, for increasing community resilience during times of natural disaster or public emergency.

By focusing on community connections, our aim is to inform the local day to day requirement for supporting residents ageing in place in the community, those with a disability and/or chronic debilitating illness, people living with chronic mental health issues and as an extension, to prepare for disaster situations in the Blue Mountains Local Government Area (LGA).

The guiding research question was:

> What are the needs of vulnerable community members within the Blue Mountains and how can they be better connected and supported in their community environment? This includes connection and safety at home, in the immediate locality and in disaster situations such as bushfires, storms and extended power outages.

Key Findings

A component of community resilience is the measure of a community's ability to account for those who lack resources to sufficiently cope on a daily basis, and to provide assistance where needed. Community resilience measures must account for the differences in household resources and capacity to manage in times of disaster.

By virtue of their knowledge and contact with vulnerable people, we found that local community organisations are well placed to provide assistance and support to vulnerable households and individuals. The contingency is that the engagement of local community organisations depends heavily on the availability of resources and funding. Outlined in the next section are a number of key findings, followed by another section detailing our recommendations.

Community involvement

The Community Connections survey included five questions on broader community involvement from measures of social capital. Attending festivals and community events was engaged in by the majority of respondents, as was sharing a meal with friends at least once a month. Just over half the survey respondents said they volunteered, which is more than double the 23 per cent indicated in the 2011 census. Involvement in some kind of association was also high, at 70 per cent.

Contact with others

Most people see family monthly (30 per cent), weekly (37 per cent) or daily (20 per cent) and 4.3 per cent said they never see family. The majority of respondents see friends on a weekly basis with only 1.6 per cent saying never. Most attend social events weekly (44 per cent) or monthly (40 per cent) with 5.7 per cent saying never. Most talk with people in the street on a weekly basis, though 3.2 per cent never. The majority chat with people while shopping on a weekly basis, with 7 per cent saying never.

Interviewees frequently mentioned walking around the neighbourhood as a common way in which people got to know others in the area, especially when walking a dog. Being out on the streets was an important contributor to neighbourliness. Not being able to walk can result in isolation and a lack of knowledge of the neighbourhood and fewer connections with neighbours.

Neighbourhood connection

Neighbourhood connection was based on a group of questions in the survey and interviews related to how the neighbourhood is perceived. The highest scoring questions were related to feeling safe and the neighbourhood being perceived as clean, tidy and friendly. The lowest rating was attributed to support availability, followed by neighbours helping each other.

How connected people feel to their neighbourhood is an important direct measure of social participation. When examined statistically it was evident that there is consistency across age groups for feeling connected. Most people feel connected to their neighbourhood, regardless of their age.

Most survey respondents and interview participants considered their neighbourhood to be friendly and regardless of age, the majority felt safe.

Age

In the Blue Mountains 15.7 per cent of the population are over 65 years of age, and 6.7 per cent of the population are over 75 years of age. Survey results confirm that people over 65 years are more likely to require assistance with daily tasks, though not all are vulnerable. Many have good connections and family involvement. There were some differences, based on age, as to who would provide help – people aged between 40 and 65 years, and those over 75 years, are more likely to be helped by family while, interestingly, people aged 65 to 75 years are more likely to receive help from neighbours.

Differences related to age were evident in how often people saw neighbours, family and friends. People over 65 years were more likely to see family weekly or monthly, while younger people were more likely to see family daily. Not surprisingly, we found that people over 75 years tend to go to social events less

frequently than younger age groups. For many, family live out of the area sometimes more than 100kms away.

People older than 65 years appear to make more effort socially. Most people talk in the street either daily or weekly, but people over 65 years are more likely to talk daily. Talking daily increases with age. Some in the over 65 year age groups are more vulnerable due to chronic illness and social isolation and are less connected.

Chronic condition

The proportion of survey respondents who indicated they had a chronic illness or disability was 19 per cent. Analysis clearly showed that people with a chronic condition are more likely to require help. We consider this to be because at the very time when people's needs are increasing, their physical contact with friends and family are decreasing. Results demonstrated that people over 65 years made a more conscious effort to socialise, perhaps making up for the deficit of less contact with existing friends and family, while those with a chronic condition found it more difficult to socialise.

Having a chronic condition appears to affect the likelihood of neighbours being considered a source of assistance. For those over 65 years with a chronic condition, neighbours were not considered a high source of assistance. Focus groups with people with chronic conditions indicated that relationships with neighbours are more difficult for them.

Regardless of age, people with a chronic condition attend social gatherings less frequently. People under 65 years with a chronic condition tend to chat with people while shopping less frequently and are less likely to report a strong feeling of connection to their community or a strong feeling that neighbours help. People with a chronic condition felt less safe than their healthy peers.

Living alone

In the Blue Mountains 25.6 per cent of households are lone person households and 3,101 are older (over 65 years) lone person households. Most survey respondents lived with someone, primarily a spouse or partner, while 28.2 per cent lived alone. Those living alone were more likely to feel that there was not enough support available to them. Of people who live alone, those who require assistance are more likely to receive help from neighbours and family if they are over 65 years, and more likely to receive help from friends if they are under 65 years.

People younger than 65 years and living alone go to social events slightly more frequently than those who live with others. For people over 65 years, those who live alone are more likely to report never attending social events.

Living alone was significantly correlated to feeling disconnected from the neighbourhood for people over 65 years. In addition, they felt it less likely that support was available to them and were not as likely to consider the neighbourhood as clean and tidy.

Living alone with a chronic condition

For people with a chronic condition, those living with others are more likely to see friends daily; those who live alone are more likely to see friends monthly.

Of significance, for people living alone with a chronic condition, it was found that they:

- attend social gatherings less frequently
- talk in the street less frequently
- are less likely to talk daily with someone, and are more likely to never talk with someone while shopping
- are less likely to feel connected to the neighbourhood
- are more likely to feel ambivalent about neighbours helping each other out
- are less likely to strongly agree that the neighbourhood is clean and tidy
- are more likely not to feel safe in the neighbourhood.

People with a chronic condition and those who live alone are more likely to feel that no support with daily activities is available.

It is not only willingness to act which is important in the face of disaster – differences in the capacity and varying abilities of individual and/or households to access resources needs to be taken into account when considering daily resilience and when planning for response and recovery.

Recommendations

The recommendations in this report include strategies to better connect community members and organisations in order to inform planning for vulnerable and ageing populations both in day to day life and in times of emergencies. The recommendations are designed to draw out the importance of the connections that can be developed from within the community to enable shared responsibility through better planning for vulnerable residents and the ensuing effective response in times of disaster.

Recommendation 1: Maintain key connections

That Council, emergency services, and local community services, continue to network and partner in ways which recognise and utilise the capability of each organisation within the community, through adopting strategies which promote a paradigm shift from a top-down approach to emergency planning, response and recovery to being inclusive of community at every level. This would be evidenced through a re-visioning of the community as active agents in the emergency management process through:

- a genuine integration of local community service providers, especially Neighbourhood Centres and peak bodies, into all levels of disaster management processes within the Blue Mountains

- initiating new partnerships, such as local community services representation on the Local Emergency Management Committee

- fostering the continuation of existing partnerships, such as the Disaster and Resilience Working Group, including a commitment from Blue Mountains City Council (BMCC), Nepean Blue Mountains Local Health District (NBMLHD) and Family and Community Services (FACS) to have their disaster and welfare representatives attend regularly as core members of the Blue Mountains Disaster and Preparedness committee

- the implementation of inclusive language, such as the use of full titles rather than acronyms, in all multiagency communications

- the explanation of policies and procedures previously understood as a known within a particular service

- the inclusion of as many as practicable service providers in multiagency emergency management training and preparedness activities, such as table top and scenario based training

- resourcing of emergency and community services to undertake community engagement and education around readiness and preparedness in high season, when the messages most resonate with the community.

Recommendation 2: Shared responsibility

In order to promote a shared understanding of the responsibility we each have towards ourselves, our neighbours and our community we need to:

- clarify roles and responsibilities of all residents and services during periods of natural disaster and emergency

- reframe the current thinking around individual responsibility for preparedness and readiness, to ensure that those who are unable to implement plans or engage in such activities are supported by neighbours and, when appropriate, the service system

- involve community groups and individuals in local risk assessment

- use various community development strategies to ensure household awareness and generate a sense of shared responsibility within neighbourhoods, e.g. Heads Up For Fire (HUFF), Know your Neighbour, Meet your Street, More than a Fire Plan

- identify and develop community leaders who can be supported to develop awareness and promote participation by residents

- provide information, training and education to community members in local neighbourhoods regarding how to support their vulnerable neighbours

- address the issue of transport for the more vulnerable and isolated within our communities, especially in relation to emergency meetings and evacuations

- advocate for change in policy to ensure that in times of declared natural disaster or emergency, Blue Mountains community members with pets can access public transport without fear of penalty

- ensure local government, via its community services section, continues to work with vulnerable people groups.

Recommendation 3: Recognise the role of community organisations

The Community Connections research demonstrates that vulnerable people typically relate to various community services and Non Government Organisations (NGOs) in the first instance, rather than friends, neighbours or family. It is therefore imperative that existing community services and NGOs are maintained and resourced appropriately within the Local Government Area. To support enhanced approaches to accessing and supporting vulnerable people within the community, Neighbourhood Centres need greater recognition as trust builders with vulnerable residents through:

- a commitment in policy and strategic direction from community organisations to build stronger links and integration across a range of community groups and services to strengthen a collective and sustainable capacity to respond to the needs of vulnerable residents in daily living and in periods of natural disaster and emergency

- a wider net cast to ensure that vulnerable individuals who are not currently connected with a community service are nevertheless reached

- more specific advertising and marketing of services targeting vulnerable residents

- assisting local community and NGO services to build capacity and develop skills within neighbourhoods and neighbours to support spontaneous community participation and reduce an overreliance on government agencies and services

- working on innovative strategies with Council to provide incentive and support for local communities/neighbourhoods/streets engaging in community focussed self-help initiatives that enhance civic responsibility

- functional partnership models with mainstream service providers such as health, to ensure that vulnerable people within our community are referred appropriately to community focussed services able to promote community connection and social inclusion.

Recommendation 4: Ageing in community

The new Aged Care Reforms and Disability Reforms developed by both the State and Federal Government focus on enablement and reablement of the person. Whilst these reforms emphasise the importance of older people and people with a disability to make their own informed decisions, it also depends on the belief system that aged residents (some of whom are most vulnerable) will be able to access the services available to them independently and effectively negotiate new systems such as the My Aged Care Website. This approach, whilst plausible in theory, will create a number of issues for our most vulnerable- namely the potential loss of local community connection and engagement with local service providers as their essential point of contact. As they will not, under new funding models, have the local sector supported positions provided, such as those of the support workers in Neighbourhood Centres or the Aged and Disability Service Officer positions in Council, to assist them. Therefore we need to consider this issue in any forward planning. It is essential therefore, to utilise appropriate methods of communication which are accessible and local to the over 75s, regarding the various services available to them for social support and community engagement; relying on the My Aged Care Website may work well for future generations, but not so well with the existing generation of aged residents.

Due to a larger than National average ageing population, the Blue Mountains needs to move fast and continue working towards an Ageing Strategy, and as such:

- resources for must be identified and developed to support people over 75, because their community connections are less viable as they age

- it is essential to utilise appropriate methods of communication which are accessible and relevant to the over 75's, regarding the various services available to them for social support and community engagement; relying on the My Aged Care Website may work well for future generations, but not so well with the existing generation of aged residents

- health, and providers of specific health care services to the aged within the community, must begin formal partnerships and dialogues with general community services such as Neighbourhood Centres, to ensure that all possible opportunities are provided for the aged to link in with their communities and improve their social connections.

Recommendation 5: Formal strategy for vulnerable people

Due to the identified issues of younger people living with a disability and chronic illness, the Blue Mountains needs to review the potential for a formal strategy to address these needs within the community, and as such:

- Council needs to consider developing a strategy that can better address the needs of the vulnerable, and those living with a disability or chronic illness

- Council may consider providing consultation with, and programs in partnership with, services that assist the 40-65 age group who have a disability and/or chronic illness, in keeping with the Disability Inclusion plan

- providers of specific services to this group within the community must begin formal partnerships and dialogues with general community services, such as Neighbourhood Centres, as policy, to ensure that all possible opportunities for the 40 to 65 age group to connect with their communities and improve the social connections are afforded them.

Recommendation 6: Enhance community connections and resilience of vulnerable people

Age, disability, chronic illness, ethnicity and socio-economic conditions are all factors contributing to the social marginalisation of vulnerable people and community groups. We need to recognise the existing strengths and capacities of vulnerable people, and acknowledge, through providing assistance, their self-identified needs. These may be as diverse as irrational fears, worry over lack of finances to meet emergency disaster needs and transport for daily living. Recommendations to enhance the community connections and resilience of vulnerable people are:

- the provision of community based programs which aim to integrate, or at the very least encourage, inclusion in wider community activities; the community sector requires resourcing to meet these needs as personnel, equipment and location are resource intensive

- re-envisage vulnerable community members from socially marginalised people to contributors to social and cultural diversity, with unique strengths and abilities e.g. some may have time available to volunteer as well as knowledge of who else is vulnerable and in need

- local Neighbourhood Centres and similar NGOs are best placed to advocate on behalf of vulnerable community members and groups. They must be sufficiently resourced otherwise the voice of the marginalised and vulnerable will fade rather than strengthen.

Recommendation 7: Vulnerable persons register

As recommended by the 2009 Victorian Bushfires Royal Commission, some form of accounting for the location and needs of vulnerable members of the community needs to be initiated, and this would require:

- a centralised vulnerable persons register within the Blue Mountains
- maintenance and review by the appropriate agencies i.e. the Ministry of Policing and Emergency Service, Blue Mountains City Council, Local Emergency Management Committee
- resourcing to support such an initiative and appointment of an appropriate agency or service to manage this function across the Blue Mountains Local Government Area
- strong administration and coordination of the register
- clear development and delineation of responsibilities between agencies, specific to the actions to be taken by individual agencies to assist persons on the vulnerability register
- clear identification of the resources that would be deployed or made available by specific agencies in the event of activation of a Vulnerable Persons Register in a natural disaster or emergency.

Please see the full report for detailed results and discussion of findings and recommendations. The full report will be located on the Institute for Land, Water and Society website (ILWS) http://www.csu.edu. au/research/ilws/home

Introduction

> The Victorian Bushfires Royal Commission uses the expression "shared responsibility" to mean increased responsibility for all. It recommends that state agencies and municipal councils adopt increased or improved protective, emergency management and advisory roles. In turn, communities, individuals and households need to take greater responsibility for their own safety and to act on advice and other cues given to them before and on the day of a bushfire. (National Strategy For Disaster Resilience, 2011, p2)

The National Disaster Resilience Strategy (2011) set out the agenda for shared responsibility in disasters and the need to draw on all sectors of society to take responsibility in times of disaster- including all levels of government, business, the non-government sector and individuals. For individuals this involves 'taking their share of responsibility for preventing, preparing for, responding to and recovering from disasters'. Their ability to do this is enhanced by drawing on guidance, resources and policies of government and other sources such as community organisations. The National Disaster Resilience Strategy further states that:

> The disaster resilience of people and households is significantly increased by active planning and preparation for protecting life and property, based on an awareness of the threats relevant to their locality. It is also increased by knowing and being involved in local community disaster or emergency management arrangements, and for many being involved as a volunteer.

The community sector, including non-government organisations, is recognised as having a valuable part to play in strengthening disaster resilience through the support they are able to offer in helping communities to cope with, and recover from, a disaster. Community organisations typically have a pool of volunteers to draw on and are usually aware of and working with some of the most vulnerable members of their community. As communities begin to work out ways to determine how resilient they are and what are the key factors in community resilience, they are also confronted with the need to recognise those who are unable to adequately support themselves in a disaster. The Community Connections project set out to examine these issues within the context of the Blue Mountains.

The Blue Mountains are located on the rim of the Sydney basin in the region identified as Greater Western Sydney, NSW. Stretching over 75 kilometres, the City of Blue Mountains encompasses 78,691 people, living in 33,348 dwellings scattered across 25 separate hamlets. As the City straddles the mountain ridge in a ribbon development serviced by one major arterial road and one main railway corridor, older, vulnerable and at risk members of the community face specific challenges due to the topography of the region, the known natural disaster risk (bushfire, earthquake, severe weather storms), problems created by the ribbon development of hamlets, demographic profile, and variable public infrastructure.

The focus of the Community Connections research project involved investigating the fabric of social connectedness and organisational links and knowledge of the community in day to day life, in addition to mapping social support and planning for the vulnerable in the event of disaster. The impetus for the research stemmed from initial investigations revealing that the vulnerable residents of the Blue Mountains may not be actively engaged or consulted by relevant authorities prior to or during, emergency situations. Anecdotal evidence suggested there may be a lack of appreciation for the needs of the vulnerable and at risk and their needs during potential extended periods of isolation (such as caused by road closures and the halt of public transport due to natural disaster), lack of power during major outages and situations arising from lack of connection to the wider community who may be able offer support in times of crises. Knowledge of individuals and their needs is fragmented across the community and across multiple agencies and service providers.

The Community Connections research aimed to consider how to determine the resilience of the Blue Mountains community and to identify the needs of vulnerable community members in order to inform appropriate strategies to address these needs. There are a number of contributors to vulnerability recognised in existing models and literature including living alone, low income and unemployment (Sherrieb et al. 2010; Phillips et al. 2010). Other contributing factors are ageing, living with dementia, disability and or chronic debilitating illness and chronic mental health issues. In addition, a lack of social support increases overall vulnerability.

The overarching purpose of the research is to feed the findings into the development of strategies for increasing the connectedness of the most vulnerable within the community, both generally and in times of public emergency.

Guiding research question

What are the needs of identified vulnerable community members within the Blue Mountains to be connected and supported in their community environment? This includes connection and safety at home, in the immediate locality and in disaster situations such as bushfires, storms and extended power outages.

Background Context to Community Connections

According to the 2011 census, the Blue Mountains has a high proportion of people over 65 years of age. More than 11,700 individuals are over 65 years representing, 15.6 per cent of the population compared with 14.7 per cent for NSW and 14 per cent for Australia. In addition there are 3100 lone older person households representing 10.6 per cent of the Blue Mountains population compared with 9.2 per cent for NSW and 8.8 per cent for Australia. Measuring community connectedness is key to evaluating social capacity and social capacity is a key element of gauging community resilience (National Strategy For Disaster Resilience 2011). The importance of community based approaches for building social capacity has been explored in the United Kingdom (Burnell 2013). The relationship between community engagement and social outcomes has been assessed in Milton et al. (2012).

The *National Strategy for Disaster Resilience* (2011) emphasises the need to develop disaster resilient communities. The common characteristics of disaster resilient communities are reported to be functioning well while under stress, successful adaptation, self-reliance, and social capacity (p.4).

> Resilient communities share the importance of social support systems, such as neighbourhoods, family and kinship networks, social cohesion, mutual interest groups, and mutual self-help groups (National Strategy for Disaster Resilience, 2011, p. 4).

In the Community Connections project we explored these characteristics as a means of gauging the social capacity of the Blue Mountains community.

Population characteristics

Older people are most likely to age in their own home. According to the Productivity Commission report *Trends in Aged Care Services: some implications* (2008), 89 per cent of people over the age of 65 years live in a private dwelling. There is a growing need for services that are accessible by this population, as well as improved community connectedness to provide as a factor for increasing the resilience of people over 65 years of age. The Productivity Commission also reports that the need for assistance increases with age with around 25 per cent of those aged 65 years needing assistance, 40 per cent of those aged 70-74 years and over 80 per cent of those aged over 80 years requiring some kind of assistance (pp.10-11).

Needs for assistance can include self-care, social inclusion, mobility, communication, cognitive or emotional tasks and health care, paperwork, transport, housework, meals, and property maintenance. There can be considerable variation in needs within and between age groups in the over 65's depending on health and chronic conditions, level of isolation, social exclusion, community engagement and living circumstances. While most live in secure housing, a proportion are renting and can be subject to variation in their living circumstances beyond their control. In the Blue Mountains the majority of people over 65, 75 per cent, own their own or are paying off homes. There are 16.2 per cent of households in rental accommodation and 1.9 per cent in social housing (ABS 2011).

Economic factors also play a part in the needs of the ageing and other vulnerable populations. In the Blue Mountains 19.1 per cent of households are living on $600 or less per week (ABS 2011). This represents a significant proportion of people requiring community resources to make up for what they are unable to afford or access for themselves. There is also an increase in diversity of living arrangements, lifestyles, family circumstances and cultural, social and religious practices that need to be taken into account when considering vulnerable community groups within the population.

Figure 1: Index of Relative Socio-Economic Disadvantage for Blue Mountains
Source: *NBMLHD Healthcare Services Plan 2012-2022*
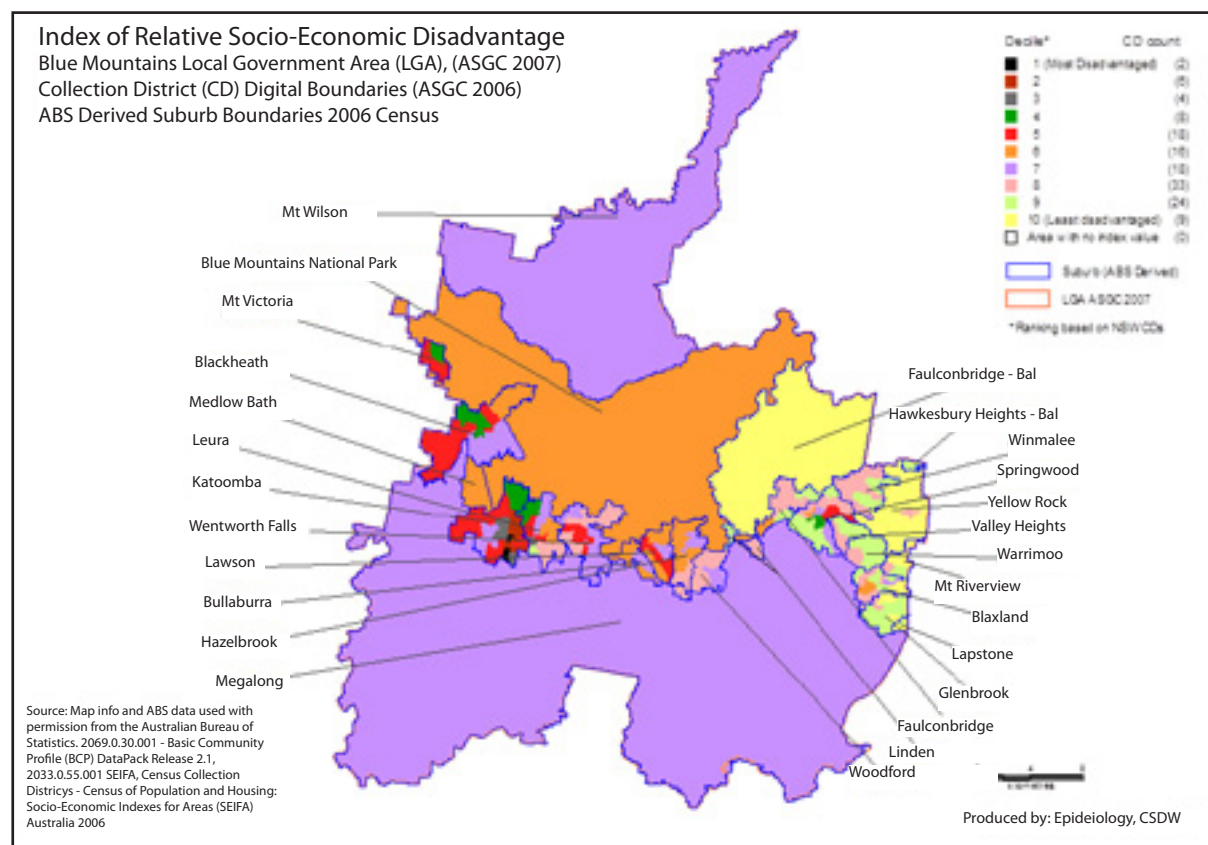
Figure 1 shows the unequal distribution of disadvantage among the areas in the NBMLHD. There are notable pockets of socio-economic differences within the LGA, particularly in the upper mountains around Katoomba, Blackheath and into the Megalong Valley.

The proportion of people living alone is increasing and living alone has been shown to raise the risk of social isolation, with those living alone less likely to attend cultural, leisure or sporting events or to engage in voluntary work (Living Alone, ABS Australian Social Trends 4102.0 December 2009). Amongst those over 65 years, a higher proportion of time is spent alone rather than in contact with others.

> *Living alone becomes more common as people age, particularly for women, who tend to outlive their husbands. People living alone may be at risk of social isolation, which can have a negative impact on people's mental and physical wellbeing. While people generally value some time alone, people who spend a lot of time alone may become socially isolated. The Australian Government's social inclusion agenda recognises the importance of all people having the opportunity to be engaged in society, in ways such as being involved in their local community, connecting with their family and friends and having access to services they need.* (Living Alone, ABS Australian Social Trends 4102.0 December 2009, p.1)

While women are more likely to seek contact with others, only 26 per cent of women over 65 years living alone had face to face contact with others on a daily basis. Among men aged 65 years and over, the proportion who had daily contact was about the same regardless of whether they lived alone or with others (around 18 per cent) (Living Alone, ABS Australian Social Trends 4102.0 December 2009, p.2).

Living alone can result in higher social vulnerability and in the Blue Mountains 10.6 per cent of households are lone person households. Living alone and low social participation are significant risk factors for later disability onset, and even more so for males. Men who live alone can alleviate their risk of disability by being socially active and by satisfactory social relations (Lund, Nilsson, and Arvlund, 2010).

Personal vulnerability through frailty or cognitive deficits can be increased with the addition of social vulnerability. The level of community engagement impacts on social vulnerability. The amount of connection to the community is related to the level of social vulnerability. The less connection groups or individuals have to the broader community, whether through state or local organisations, the greater

their social vulnerability and therefore the greater their personal vulnerability. Someone who is frail aged and isolated is more vulnerable in this sense than someone who is frail aged but has family and neighbours looking out for them regularly. Emergency preparedness planning needs to take into account the age-related needs of older adults with regards to the personal and social resources available to them (Tuohy & Stephens 2011).

Community resilience

'Community' within the context of this project is focused on local or geographic community where physical proximity is important in providing immediate assistance when needed. In emergency situations it is important to have assistance nearby in a physical sense so that a response can be mobilised quickly. By 'community' then we mean the Blue Mountains Local Government Area, unless specifically referring to the variety of communities defined by other characteristics such as interest groups, ethnicity or particular values.

Community resilience refers to the ability of a community to deal with and rebound after a disaster or challenge:

> Community resilience is largely neglected in planning and in operations, though in practice community engagement in recovery, a measure of resilience, tends to happen spontaneously. In this sense resilience may be inherent or at least developed in situ after a disaster. However, resilience can also be planned for and developed before a disaster strikes. (Coles and Buckle 2004, 6)

McAslan proposes the following definition of a resilient community:

> … a resilient community recognises that its people, homes, infrastructure and services may be affected by some disruptive events, but it has the innate ability to cope during such events and to recover afterwards. A resilient community must ensure that its critical infrastructure and warning systems are sufficiently robust to minimise the harm to its people, property and the environment. (McAslan 2011, 7)

The framework McAslan discusses involves three sets of capital (physical, procedural and social) that can be used by communities in times of need. Physical enablers include physiological needs of air, water, food and shelter and safety needs of personal security, health, well-being, and protection against accidents and illness (9). Procedural enablers encompass operational strategies, policies and plans. Social enablers noted are community cohesion and motivation (McAslan 2011, 11). Community networks are of particular importance here and include the community organisations connected to community members and networked within the community through programs, staff and volunteer activities.

Norris et al. (2008) reviewed the literature on community resilience and identified four primary sets of networked resources: Economic Development, Social Capital, Information and Communication, and Community Competence (p. 136). Economic development denotes economic growth as well as resource distribution and stability of income. Extensive interdependencies mean that 'economic resilience depends not only on the capacities of individual businesses but on the capacities of all the entities that depend on them and on which they depend' (Norris et al. 2008, 136; Rose 2004).

Embedded in social capital are the resources invested in social networks. This includes social support and the 'social interactions that provide individuals with actual assistance and embed them into a web of social relationships perceived to be loving, caring, and readily available in times of need' (Norris et al. 2008, p. 138). Community bonds, roots and commitments are central to social capital, extending helping behaviours beyond individuals and family to neighbours and the broader community. A sense of community, attachment to place and citizen participation are also dimensions of social capital.

Sense of community is considered to encompass high concern for community issues, respect for and service to others, sense of connection, and needs fulfillment, and is assumed to be a dimension of community capacity and an attribute of resilient communities (Norris et al. 2008, p. 139). Attachment to place is about emotional attachment to the neighbourhood or locale. Citizen participation is the involvement of community members in local associations and volunteer activities.

Information and communication essentially refers to common meanings and understandings 'and the provision of opportunities for members to articulate needs, views, and attitudes' (Norris et al. 2008, p. 140) and includes systems infrastructure and communal narratives encompassing shared meanings and purposes.

The final area, social competence refers to the ability of communities 'to learn about their risks and options and work together flexibly and creatively to solve problems' (Norris et al. 2008, p. 141). It has been argued that the capacity to acquire trusted and accurate information, to reflect on that information critically, and to solve emerging problems is far more important for community resilience than a detailed security plan that will rarely foresee all contingencies (Longstaff, 2005).

The framework put forward by Norris et al. (2008) covers many dimensions of community and potential resilience and has been highly influential in the development of discussion and measures around community resilience. Zautra, Hall and Murray (2008) discuss the value of developing indicators and bringing these together in an integrative resilience framework to understand what constitutes a healthy and strong community in a dynamic environment. The fundamentals of community resilience they outline will be used to draw together results and other data in the Findings section following presentation of results.

As with McAslan social capital is central to community resilience for Norris et al.. Research on social capital includes understanding the involvement of residents in the community, their social networks and connections and the way the local area or neighbourhood is viewed (Sherrieb et al. 2010, Putnam 2000). It is evident that social participation, social support and community bonds contribute to resilience and health (Sherrieb et al. 2010, Janssen et al. 2011, O'Sullivan et al. 2013).

The Community Connections research focuses on social connection and networks within neighbourhoods and community, and therefore encompasses the essential areas of community resilience as outlined by Norris (2008). The following excerpt illustrates the importance of community organisations such as Neighbourhood Centres in times of natural disaster:

During the devastating natural disasters in late 2010 and early 2011, Neighbourhood Centres in impacted communities played a vital role in the local disaster management response. Very quickly, centres became the place where people gravitated to in the spontaneous outpouring of community support for impacted householders. Centres undertook many roles including:

- use as Community Recovery Centres
- developing and distributing information on local support services
- organising counselling referrals, information and support services
- participating in feedback sessions related to local recovery efforts
- coordinating the distribution of goods and financial donations
- providing household goods, food, fuel or third party payment vouchers
- liaising with regional councils and other key stakeholders regarding post support strategies and future planning activities

The role of Neighbourhood Centres in the recovery process has been an important part of Queensland's recovery and is an excellent example of the flexibility resourcefulness and community connectedness of these Centres.
Increasingly Neighbourhood Centres are becoming 'multi-service hubs' within the broader human service system. They actively promote community engagement and connectedness. Service delivery is flexible and culturally inclusive providing a range of community activities that best meet the identified needs of vulnerable individuals and families.
Neighbourhood Centre Initiative Review Date: August 2011 Department of Communities, Queensland Government, p. 6.

Research approach

There are many factors that can be utilised for the measurement of community resilience, including economic, structural and social features of a community. In the Community Connections project the focus is on social connectedness factors, and in particular how connected people are within their immediate neighbourhood and then within the broader community.

The research approach would not have been possible without the full cooperation of all research partners, for example accessing particularly vulnerable community members was made possible through entry into various Neighbourhood Centre Programs. Ross and Berkes (2014) consider participatory approaches that build adaptive capacity and community resilience as assisting a community to explore what makes it resilient, its resource use and the development of community-based planning approaches informed by resilience. Participatory research means full community participation in all phases of research (see Figure 2).

Figure 2: Participatory research to explore and build community resilience
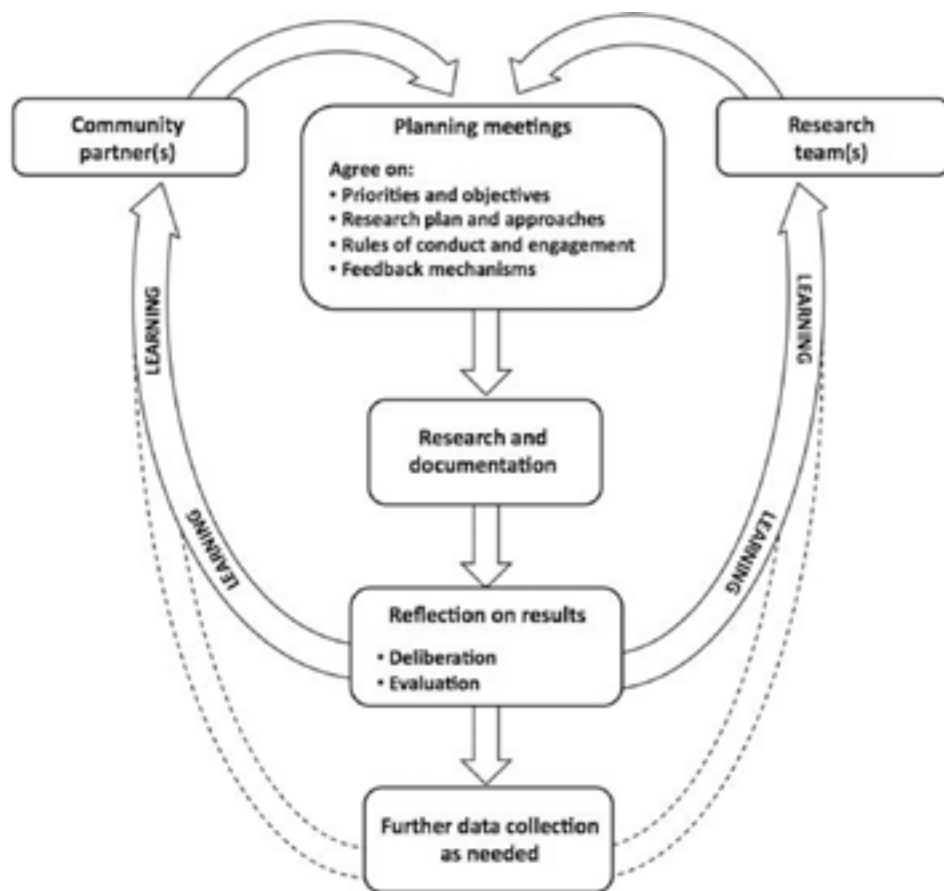
 (Ross and Berkel 2014, p. 795).

The partnership for this project involved academic researchers and community members (through their representatives) participating in a planning process to agree on the purposes and processes of the research for mutual benefit, reflect on findings, and prepare the documentation together (often in several iterations), both parties learning from the process (Ross and Berkes 2014, p. 795). The involvement of the partners, Springwood and Katoomba Neighbourhood Centres and the Blue Mountains City Council, at all levels of the research process, has meant that the Charles Sturt University researchers were able to attend meetings at various levels of community organisation engagement in the disaster recovery process in 2014 in the Blue Mountains.

The Community Connections project draws together information through the use of questions from social capital and neighbourhood and network connection measures as well as data available from the 2011 census to provide a comprehensive picture of community resilience including areas of population vulnerability.

The project employed four main data gathering tools. The first was a literature review incorporating

data from the 2011 census and related surveys . The second was a survey mailed by the Blue Mountains City Council. The third round of data collection consisted of focus groups with vulnerable community members, and lastly individual interviews were conducted in the community to include the voices and personal experiences of community members.

Survey

The Community Connections survey was sent to all council ratepayers with properties in the Blue Mountains. It was necessary to either complete the hard copy and return it by post or complete the survey online on council's website page 'Have Your Say'. Access to the survey was further promoted by advertising and articles in the local paper and inclusion in the BMCC circular, 'News from the Hill'. The survey was also available in hard copy form from neighbourhood centres and the local libraries.

The survey consisted of five groups of questions. The first set were demographic questions including postcode, age, indigenous or non-indigenous, living arrangements, fluency in English, and whether respondents had a chronic illness or disability. The second set of questions was adapted from social capital surveys developed for the US Social Capital Benchmark Survey (reported in Putnam, Feldstein and Cohen 2003). The third section consisted of one question regarding who was most likely to provide help if needed. This question was created by Community Connections and not related to other surveys. The fourth section asked respondents about their local area connections. Neighbourhood questions in the fifth section were concerned with how people feel about their neighbourhood and their connection to it. These were based on the HILDA Self Questionnaire 14, v1 R08102 - W14DR1, B11, page 6. Not all HILDA questions were asked and the questions chosen were slightly reworded

The full Community Connections survey is located in Appendix 1.

Interviews

Ten interviews were held with 11 participants (one couple were interviewed together). Interviews were held in Neighbourhood Centres (Springwood and Katoomba) and one was held in the Springwood Library. One interview was held at MacDonalds in Blaxland. It was not possible to make a recording in this location. The remainder were held in people's homes at times convenient to them. All participants were offered the opportunity to be interviewed in a centre or other location that was suitable for them. Interview questions are provided as Appendix 2. The interviews were recorded, transcribed by an outsourced company and later coded for major themes.

Focus groups

Three focus groups were held in Katoomba. All were over 65 years of age or suffering from a mental illness or disability. There were eight people in two of the focus groups and four in the third focus group.

Focus groups lasted a maximum of one hour and were recorded. Recordings were transcribed verbatim. Focus group discussions followed the schedule of questions for interviews and it was ensured that each participant was able to respond to each question. As with the individual interviews, the focus groups were transcribed and analysed for major themes.

Approach to data analysis

The survey instrument was sent to 30,000 ratepayers in the Blue Mountains. Ratepayers were invited to return the survey to Council by mail, or to complete the survey online. The survey closed on 1 September 2014, yielding a total sample of 1103 respondents.

The data was prepared for analysis, the survey results summarised and a contingency table analysis of selected variables performed, testing for significant differences across questions about community connection for different demographic groups.

In summary, the data was cleaned to remove partial responses and responses from outside the Blue Mountains Local Government Area and then imported into the statistical analysis software program SPSS.

SPSS was used to generate upper level summary statistics by demographic group (for example, age, gender, living arrangements). These results were tested against 2011 Census data to check whether the sample was representative of the Blue Mountains population. The data was found to be biased in terms of age and gender, so the data was weighted to reflect the population described in the 2011 Census.

Once the data was weighted, new summary tables were compiled. These were used to select variables to compare using contingency table analysis and chi-square tests of statistical difference. Groups tested for differences included age (40-65, 65-75, 75+), people with a chronic condition/no chronic condition, people who live alone by age (<65, >65) and people who live alone with a chronic condition/no chronic condition. Separate tests were performed for each group for each question relating to different aspects of community connection. Significance is at 0.01 (allowing for 1 per cent error) throughout results unless otherwise stated. The analysis can be seen as indicating trends for age groups and chronic illness/disability in relation to need for assistance and connections within the community.

Interview and focus group data was transcribed and transcripts entered into NVivo 10. All transcripts have been read and key words extracted. Key word queries were run in NVivo to extract comments from participants relating to neighbours and neighbourhood, and other key areas noted in the transcripts such as walking. The frequency of comments from different participants can be taken into account in the analysis.

Results

In this chapter we detail the results of the survey, interviews and focus groups. Data was entered into SPSS for statistical analysis including descriptive demographics and analysis of correspondence between items using chi square tests. Once data was cleaned 1072 surveys were analysed.

The survey was returned either online or by post. The majority were returned by post with 27 per cent returned online. In the 40-65 years 62 per cent returned the survey online and 38 per cent in hard copy. The 65-75 year age group returned 23 per cent online and 77 per cent, the highest number in hard copy. In the over 75 years age group, 92 per cent returned surveys in hard copy and 8 per cent completed the survey online. The younger age group 25-40 years clearly preferred the online method returning 71 per cent online and 29 per cent in hard copy. Two respondents in the 18-25 years age group returned the survey online.

Figure 3: Age groups and means of survey completion
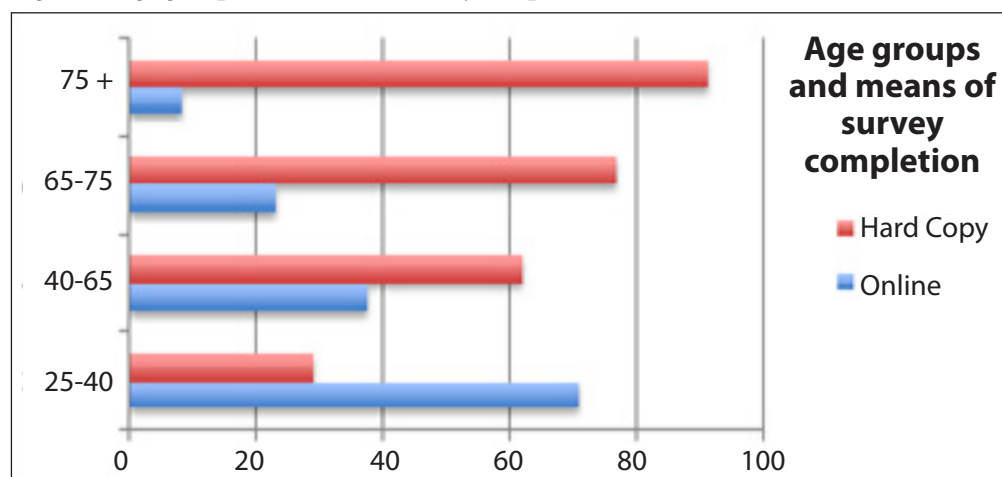
Survey returns by postcode

The survey was returned from across the Blue Mountains region of 25 hamlets which is represented by 12 postcodes as shown in Table 1. The distribution of responses by postcode was similar to that of the census and weighting for distribution was not required.

The dominant postcodes were Springwood and Katoomba representing approximately 19 per cent each, followed by Blaxland with 13.5 per cent. The postcode was not given on 6.5 per cent of returned surveys. The smallest returns of between 2 per cent and 3 per cent were from the Mt Victoria and Bullaburra postcodes. All other postcodes had returns of between 4 per cent and 9 per cent.

Table 1: Surveys returned by postcode and proportions

Postcode	Villages	Frequency	Percent
2773	Glenbrook/Lapstone	62	5.4
2774	Blaxland/Warrimoo	130	13.5
2776	Faulconbridge	41	4.5
2777	Springwood/Winmalee/Yellow Rock	206	18.7
2778	Woodford/Linden	38	3.3
2779	Hazelbrook	70	6.8
2780	Katoomba/Medlow Bath/Leura	204	19.8
2782	Wentworth Falls	90	6.3
2783	Lawson	50	4.4
2784	Bullaburra	18	2.2
2785	Blackheath/Megalong	72	5.2
2786	Mount Victoria/Mount Wilson/Bell	24	3.2
No response		67	6.25
Total		1072	

The total number of surveys returned was 1103. For 6.25 per cent of surveys a postcode was not given but data was included. Several respondents gave postcodes that were not of the Blue Mountains. Data for these was excluded from the analysis. Once data was cleaned and responses that did not include gender or age excluded, 1072 surveys remained for analysis.

Gender and age

Two thirds of respondents were women and one third were male. Numbers are shown in Table 2. Weightings were applied for gender and age as proportions were significantly different from the 2011 census figures for the area. Two respondents gave their gender as other. The data was included in the analysis but was insufficient to create a subcategory.

Table 2: Gender

Male	Female	Other
353	717	2

The age group with the highest representation overall was 40-65 years with 38 per cent of respondents in this age group as shown in Figure 3. The 65-75 year age group represented 33 per cent and the over 75 years age group 22 per cent. Less than 1 per cent of respondents did not give a response for age. These were excluded as age is vital to the outcomes of the analysis. The 18-25 year age group was also excluded as there were only two responses.

When combined, the 65-75 and 75+ age groups account for 55 per cent of respondents, a higher proportion than the general population which is 15.6 per cent. Age weightings were applied for statistical analysis.

Figure 4: Age group proportions
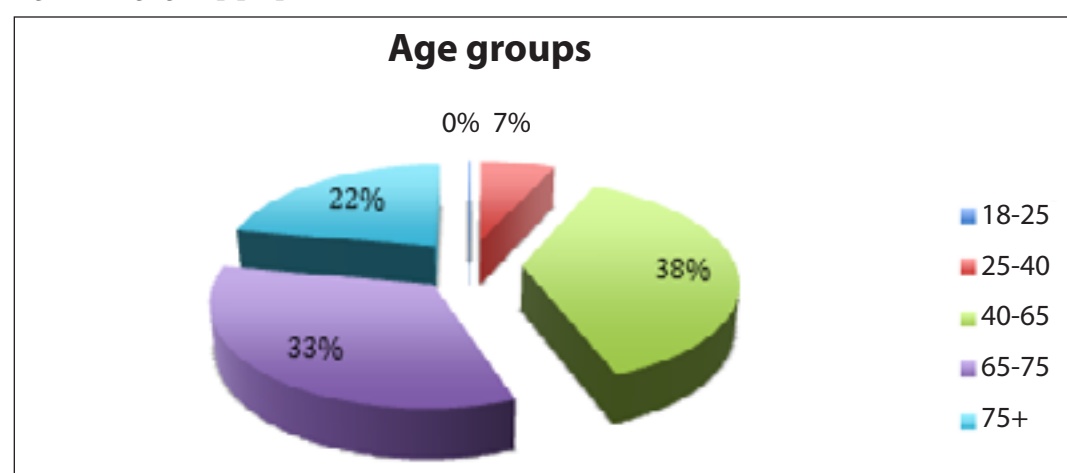
Five respondents stated that they were Aboriginal and one Torres Strait Island. The majority, 88.7 per cent, stated they were non-Indigenous with 10.8 per cent not answering the question. The data for Indigenous respondents was included in the analysis but was insufficient to create a subcategory.

Ten interviews were held with 11 participants (one couple were interviewed together). Four interviewees were male and seven were female. Four were in the 40-65 year age group, four were in the 65-75 age group and three were in the 75 and over age group. Three participants identified as Aboriginal and three as having a chronic illness (one in the 40-65 year age group and the other two over 75 years).

Two of the Aboriginal participants were receiving services from the Healthy for Life team from the Medicare Local. This was an important source of support for them as was the Aboriginal Cultural Resource Centre, which helps with transport to shops and other activities and also provides some social events. Another male participant lived alone and relied on community lunches provided by churches and Neighbourhood Centres for socialising and for meals.

Figure 5 illustrates the distribution of survey responses by postcode, age, gender and living arrangements. For the Katoomba postcode there were a high number of females who live alone who responded to the survey. Of those who said they lived alone, 22 per cent gave their postcode as Katoomba followed by 15 per cent as Springwood.

Figure 5: Survey respondents' age, gender, postcode and living arrangements

Source: Prepared by Spatial Data Analysis Network, Charles Sturt University 2014

Living arrangements

Most respondents lived with someone, primarily a spouse or partner while 28.2 per cent lived alone. All living arrangements are shown in Figure 6. Most of those living with children were in the 40-65 year age group (53 per cent of 52), as were those living with parents (7 of a total of 11). Those living with others were in all age groups as were those living alone, though the highest percentage of those living alone (39 per cent) were in the 65-75 year age group, followed by the over 75s (33 per cent) and then the 40-65 year age group (28 per cent). Of those who said they lived alone 75 per cent were female and 37 per cent said they had a chronic condition.

Figure 6: Living arrangements proportions
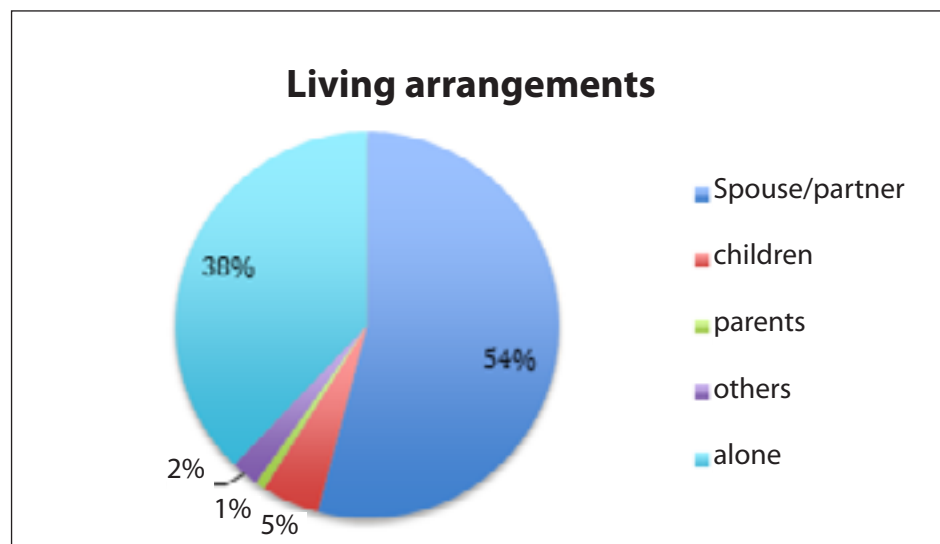
Those living alone were a significant group of respondents and living alone can be a risk factor in times of disaster. An analysis was conducted in which those living alone was compared with all other categories as 'those living with others'. The analysis indicated that males are more likely to report having a chronic condition and that those who live alone are more likely to report a chronic condition.

For both males and females, those that live alone are more likely to report a chronic condition. For people who live with others, more males than females report having a chronic condition.

Chronic illness or disability (chronic condition)

The survey included a question which stated, 'Do you have a chronic illness or disability that limits your everyday activities?' The proportion of survey respondents who ticked 'yes' to the question was 19 per cent, a higher proportion than the 4.5 per cent identified in the census indicating that there are potentially more people in the community who might need help in an emergency than the census data would suggest.

The Australian census measures those who report a need for assistance due to a 'profound or severe core activity limitation' and it is likely that there is a higher level of chronic illness and disability effecting daily life in the community. The 2011 census identified 4.5 per cent of the Blue Mountains population people as in need of assistance (compared to 4.4 per cent for Greater Sydney). As a percentage of each age group the proportion reaches above 5 per cent for the 65-69 year age group climbing to 46.9 per cent for the over 85 year age group. Just over half of the total number identified as in need of assistance in the 2011 census are over 65 years.

The Community Connections survey has captured a surprising number of responses from those <65 years who state that they have a chronic illness or disability that limits their everyday activities. The proportion includes a broader group than the census measures and was not high enough to require weightings.

Those living alone included 55 per cent of those reporting a chronic illness. Of those who said they had a chronic condition 36 per cent were over 75 years of age. Of those who are over 75 years and have a chronic illness, 64 per cent lived alone. The proportion living alone with a chronic illness aged between 65 and 75 years was 59 per cent with 44 per cent in the 65-75 year age group living alone while of those aged 40-65 who reported having a chronic illness 46 per cent live alone.

Of the eleven interview participants six lived with a spouse or partner and four lived alone. One said he lived with his daughter but it was unclear how much time she spent there. He was over 80 years and had a walker and seemed to spend a lot of time alone.

Three focus group participants lived with a spouse or partner and seven lived alone, while one lived with a parent and one lived with others.

Community involvement

The survey included five questions on broader community involvement from measures of social capital. Attending festivals and community events was engaged in by 77 per cent of respondents. Sharing a meal with friends at least once a month was engaged in by 75 per cent of respondents. Just over half the respondents (52 per cent) said they volunteered, a higher percentage than 23 per cent indicated in the 2011 census. Involvement in some kind of association was also high with 70 per cent indicating some involvement.

Table 3: Community involvement

	Yes per cent	No per cent
B1 Attend festivals	79.7	19.1
B2 Volunteer	50	49.6
B3 Go out	72.9	26.5
B4 Local Assoc	67.3	31.9
B5 Share Meal	74.8	23.4

Between 19 per cent and 26 per cent of respondents did not regularly engage in activities such as attending festivals, going out for entertainment or sharing a meal with friends while 32-49 per cent did not belong to local associations or volunteer. Those over 75 years were less likely to engage in all activities. Of those in the 25-40 year age group 90 per cent attend festivals.

Eight interviewees said that they attended local festivals and events, volunteered and went out regularly. Nine were involved in local groups or associations and four said they shared a meal with friends at least monthly while six did not though some attended community lunches.

Five of the focus group participants said they volunteered and six belonged to local associations. Eight said they attended local festivals and only five said they went out regularly and seven shared a meal with others at least once a month.

Assistance provided

Over one third of respondents, 37.5 per cent, said they provided assistance with household tasks such as putting bins on the street to people in their neighbourhood, indicating that helping others located nearby is fairly common. There were 9.6 per cent who said they required assistance with household tasks such as putting bins on the street. While 19 per cent said that they had a chronic illness of some kind only a small number say they need help. This could indicate that those with chronic illness prefer to try to do everything for themselves as much as possible.

Three interviewees said they required assistance and six that they provided assistance to others. Five focus group participants said they required assistance with daily tasks and three said they provided assistance to others.

The need for help clearly increases with age. The survey showed that people aged 65-75 and 75+ are statistically more likely to require assistance.

When assistance with household tasks is considered by age and chronic illness or disability a more complex picture emerges. It becomes apparent that having a chronic illness or disability has a significant effect on the need for help at all ages.

The main findings here are that:

People >65 are more likely to require help with or without a chronic condition. Those with a chronic condition are more likely to require help than those who are over 65 years with no chronic condition. For people <65, those with a chronic condition are more likely to require help.

Living circumstances has no effect on the need for help with those >65 years more likely to require help whether they live with others including a spouse or partner or live alone.

Figure 7: Assistance with household tasks by age group
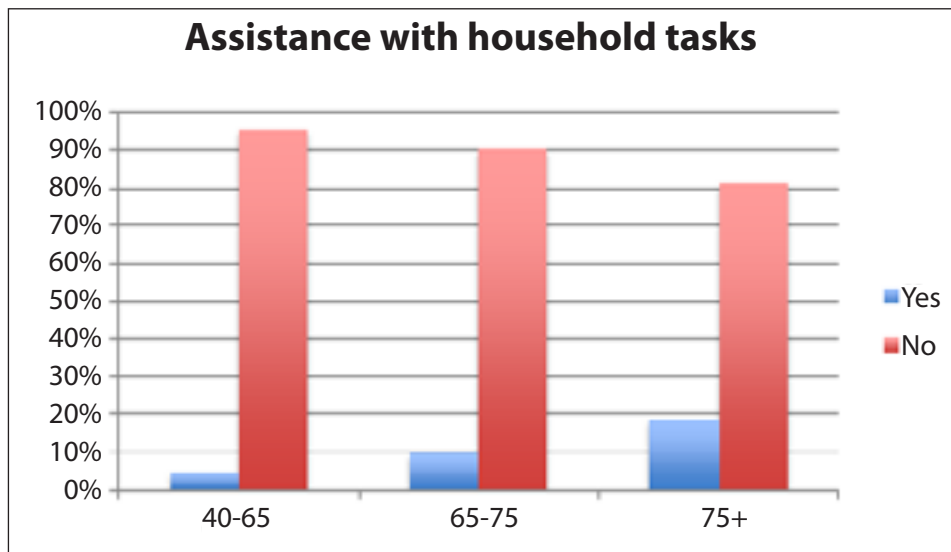
Figure 8: Assistance with household tasks by age and chronic condition
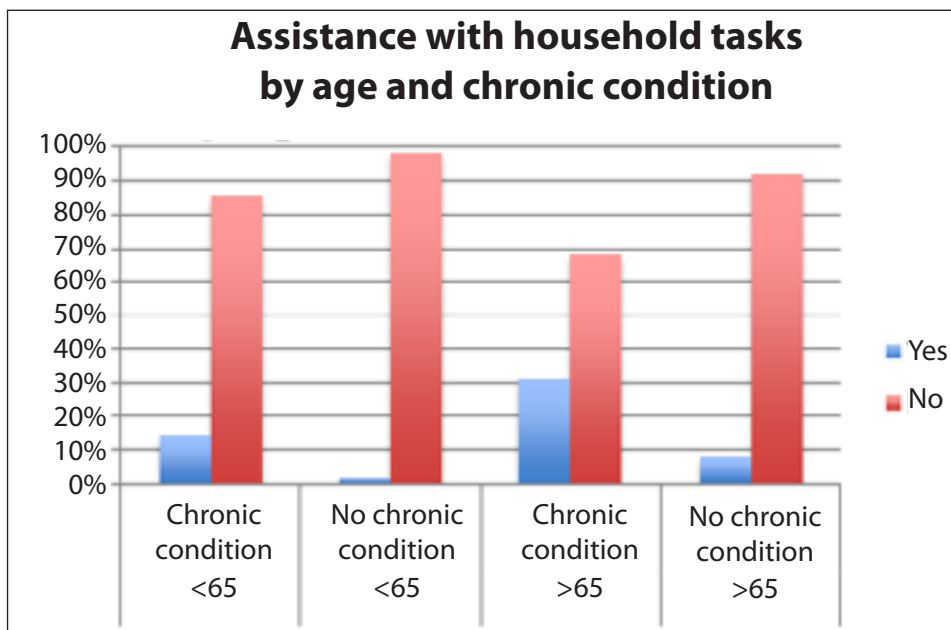
Who is most likely to provide help

Help is most commonly available from family for 44 per cent, followed by neighbours for 33 per cent and then friends for 17 per cent. For 6 per cent of respondents there is reportedly no one to help them. The question was not answered by 7.8 per cent of respondents.

People aged 65-75 years are statistically more likely to receive help from neighbours than people aged 40-65 years or 75+ years who were more likely to receive help from family.

Of the community interviewees who responded to the question, five said a family member would help them and four said a friend would help.

Most (eight) focus group participants said a family member would help them if they needed it. This included parents, siblings, and children.

> … *my four brothers and sisters are supportive. My sisters would help us out if we were in crisis.* (FG2P1)

My brother and sister in law, my worker. (FG3P3)

I probably couldn't rely on my neighbours but my family and friends I could. (FG3P2)

I've got a friend who used to be next door neighbour, but he would, he would definitely help me, you know, and also the guy in the flat, he would do anything, you know, if I had an accident and, oh you know, there'd been a situation in my life, you know, for what—needed help, and he's more than happy to help me, you know, he's a really caring person, and also my ex-wife, if I lock myself out or lock the keys inside she says, 'Oh,' you know, 'crash in the lounge room, we've got a nice big lounge,' you know? (FG3P1)

Figure 9: Assistance provided
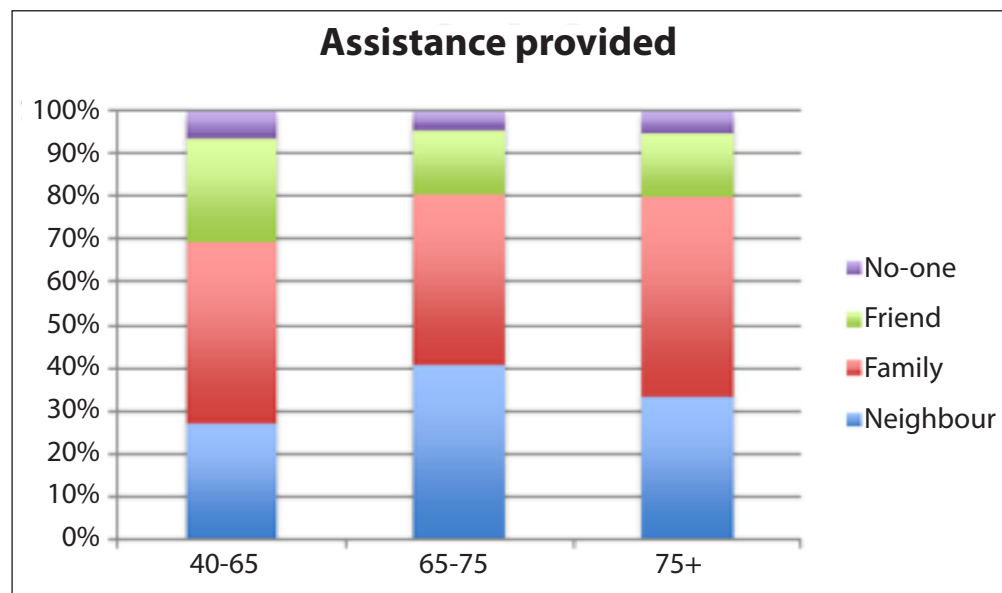
For others where family members are not available:

> *You have to chase round like neighbouring centre, neighbourhood centre or some other places, ask if they can help you, be there, you know, interpreter, tell something to somebody, you know, use their telephone, something like that.* (FG1P3)

> *Got a friend who we thought would help us out and he's let us down a few times and, but we've got another friend. Because we don't have a car, we need a car sometimes for the lawn mower to get fixed.* (FG2P1)

> *I have a lot, because I went through this big thing a couple of weeks ago I had quite a few people helping me… was helping me with another worker. I used to have the SMOPS team - Senior Mental Health, it's in the hospital. Where a nurse used to come out and see me every now and again and talk to me. She was going to arrange for me to have, go, they arrange to, somebody had a coffee with me once a month to let me air my feelings sometimes. Because I had no one to do that with.* (FG2P3)

> *Well I'm sort of lonely in that my mother and my father have both passed away within the last three years.* (FG2P5)

> *I had to go … up there and I had nobody to take care of my little dog, so I knocked on …'s door but I saw his car wasn't there. And I knocked on …'s door, the only two people I could rely on. And she wasn't there either, so I had to ring up the vet …* (FG2P4)

Some wanted to be seen as providing help not just needing it:

> *I'm perfectly well able to ring people that I know if I feel I want to talk or I need to talk, or maybe I'm concerned about them because I'm just as much a helper as someone who sometimes might need help.* (FG1P2)

> *I can feel that, having a car I can help others. You know. That's why there's a car. So that I can have someone next to me or I can have a whole pile in the back. And I sort of know a few of the guys around town and we get around, you know, in the car. It's good, you know.* (FG2P5)

The analysis indicated that having a chronic condition can affect the likelihood of neighbours being considered a source of assistance for those under 65 years. For people with no chronic condition, those >65 are statistically more likely to receive help from neighbours, those <65 are statistically more likely to be helped by family or friends.

Of people who live alone, those that require assistance are more likely to receive help from neighbours and family if they are over 65, and more likely to receive help from friends if they are under 65. The importance of friends here is different to the sample average, that is, it is unique to those that live alone.

For people with a chronic condition, people who live with others are more likely to receive help from family and neighbours, while people who live alone are more likely to receive help from friends. People who live alone are more likely to not receive help.

Figure 10: Living alone and assistance provided
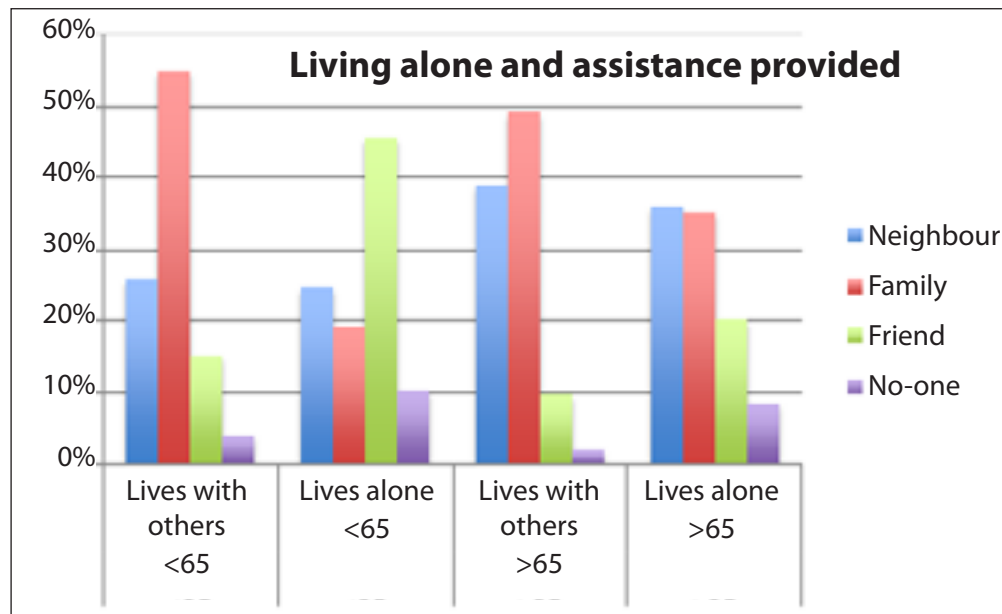
Contact with others

Contact with others on a weekly basis is highest overall in all areas. Most people see family monthly (30 per cent), weekly (37 per cent) or daily (20 per cent) and 4.3 per cent said they never see family. The majority of respondents see friends on a weekly basis (63 per cent) with only 1.6 per cent saying never. Most attend social events weekly (44 per cent) or monthly (40 per cent) with 5.7 per cent saying never. Most talk with people in the street on a weekly basis (50 per cent) though significant numbers, 28 per cent, do so on a daily basis and 3.2 per cent never. The majority chat with people while shopping on a weekly basis (58 per cent) though 18 per cent do so on a daily basis and 18 per cent on a monthly basis with7 per cent saying never.

Table 4: Contact with others, proportions and total responses

	Daily per cent	Weekly per cent	Monthly per cent	Yearly per cent	Never per cent	No response per cent
D1 Family members	22.2	33.9	26.4	12.3	4	1.1
D2 Friends	16	69.2	18	4.1	1.3	1.5
D3 Attend social events	1.9	39.2	41.5	10.9	4	2.6
D4 Talk in the street	22.6	48.7	19.1	5.5	2.9	1.3
D5 Chat while shopping	14.3	51.9	19.1	4.7	8.2	1.8

Most frequent contact was *weekly contact* with friends and chatting while shopping for over 50 per cent of respondents, indicating the importance of community connection through public places and through networks of friends. Talking in the street was the next highest form of contact, also weekly for over 48 per cent of respondents.

The most frequent *daily contact* was talking in the street followed by talking with family members and then chatting while shopping.

Table 5: The most common response for each question and for each time interval.

	Daily	Weekly	Monthly	Yearly	Never
D1 Family members					
D2 Friends		✔			
D3 Attend social events		✔ ✔	✔	✔	
D4 Talk in the street	✔	✔			
D5 Chat while shopping		✔			✔

Figure 11: Contact frequency – number of responses
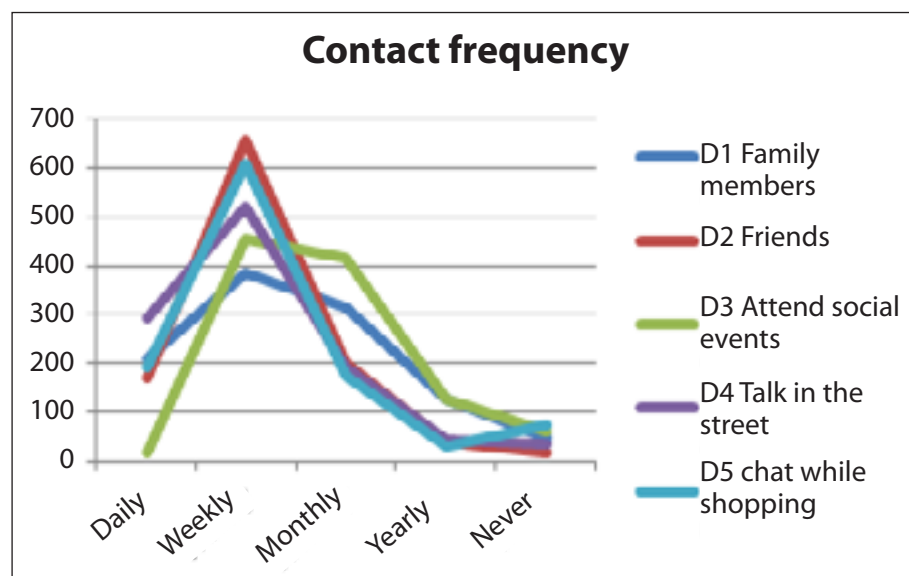
Those interviewed who had regular and numerous contacts were able to talk at length about their experiences and contacts whereas those who had few contacts had very little to say and did not talk as much about their experiences.

Seeing family members

When data for seeing family members was analysed for age effects it is was evident that people aged 40-65 years are statistically more likely to see family daily than older people.

In addition, people aged 65-75 years and 75+ years are statistically more likely to see family weekly or monthly than younger people. Those over 65 years see family less often than those under 65 years.

The correspondence between age and those who have a chronic illness or disability indicates that for people with no chronic condition, those <65 are statistically more likely to see family daily. For people <65, those with a chronic condition are less likely to see family daily or weekly than those with no chronic condition.

Figure 12: Seeing family members by age group
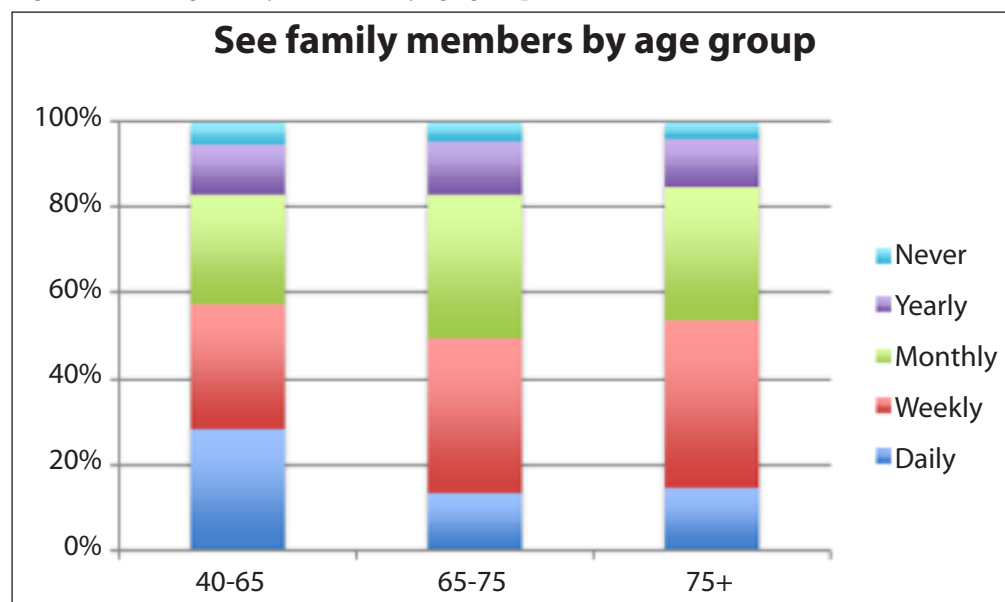
Another difference for those with chronic illness or disability is that those <65 are less likely to see friends daily or weekly than those with no chronic condition.

People who live alone see family less frequently than those who live with others regardless of age. Of people who live alone, those with a chronic condition are more likely to see family less frequently than those without a chronic condition.

Of people who live alone, those with a chronic condition are more likely to see friends less frequently (monthly or never, rather than weekly) than those without a chronic condition. For people who live alone, those with a chronic condition are less likely than those without to see family daily or weekly. They are more likely to see family monthly or never (sig. at 0.05).

Six interviewees said they saw family monthly, two weekly, one yearly and one never. Seven saw friends weekly and three monthly, one attended social events daily, one weekly, three monthly and one yearly. Five talked in the street on a weekly basis and one daily. Four said they chatted while shopping weekly and two said monthly.

All interview participants had family and friends that were not in the area. For two participants, contact with family was rare or only occasional while for others it was weekly or monthly. Most had children who would help them out if they needed it but were sometimes far away.

Three focus group participants said they never see family members and three that they saw family yearly, one monthly, three weekly and two daily. Eight had weekly contact with friends, one daily, one monthly and two never. Seven indicated they attended social events weekly, two monthly, one yearly and two never.

> *I would have to say the biggest ones that listen to us was of course our once a week conversation with (wife's) parents down there in Melbourne.* (FG1P1)

> *I've got family in the western Sydney area, but it's not a close relationship. Like even though it's only an hour drive away we might see them once a year on Christmas day lunch, and that's it and all that.* (FG1P4)

See friends

On average, people in all groups are most likely to see friends weekly. There are, however, some differences across groups:

For people with a chronic condition, people who live with others are more likely to see friends daily than those that live alone who are more likely to see friends monthly.

For people with no chronic condition, people who live alone are slightly more likely to see friends weekly than those that live with others.

For people who live with others, those with a chronic condition are more likely than those without to see

friends less frequently, yearly or not at all.

Figure 13: Seeing friends by living situation and chronic condition
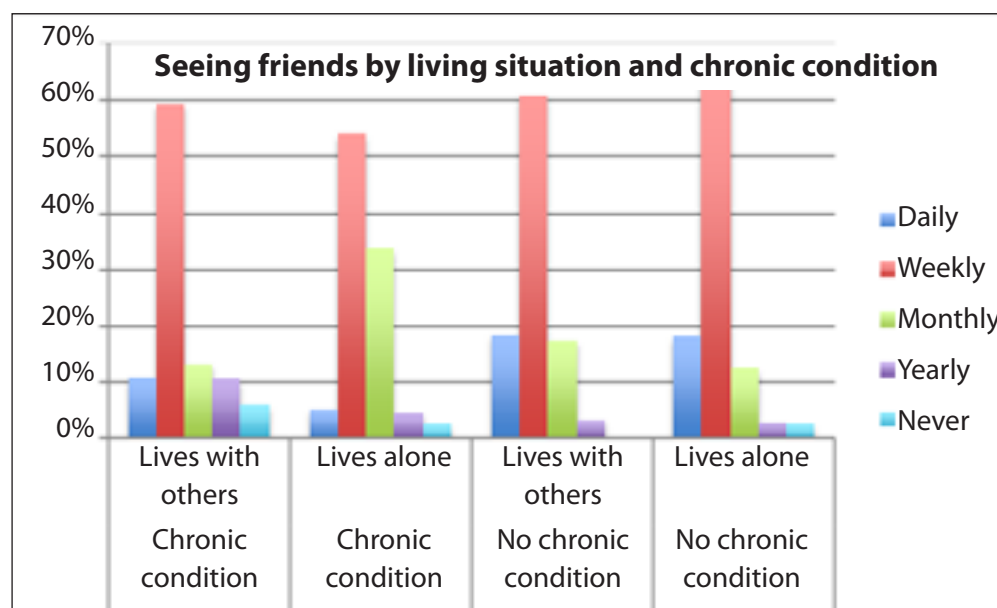
Focus group participants revealed when asked about contact with friends that it can be quite difficult for them:

> It can obviously be an issue for me getting to know people in the first place because of the issue of where I have struggled with my hearing in the past, which can be socially quite isolating. The blindness isn't so much an issue because I've been blind most of my life, but the hearing getting worse and worse has been an issue from that point of view. (FG1P2)

> Not really, they're more private people, you know, they're, everybody work, everybody go to programmes. … Because sometime if you were to come into friends, it will be lot of problems coming behind, you know, their own, you know. (FG1P3)

> No, not much, not much of the time. (FG1P2)

> Not many people. There's only one person and their hearing is going down, so, and that's me. (FG1P4)

> Well one friend doesn't like watching movies, he doesn't like drinking, he doesn't like this, he doesn't like … The other friend's got a gambling problem so I can't go to the clubs or pubs with her. (FG3P2)

Attend social gatherings by age and chronic illness or disability

Statistical significance was found between those who have chronic conditions and those who do not for attending social gatherings.

For people with no chronic condition, people >65 are less likely than people <65 to go to social gatherings monthly (more likely to go out weekly).

Results demonstrate that regardless of age, people with a chronic condition attend social gatherings less frequently.

There is also some difference in attending social events for those who live alone. For people <65, those that live alone go to social events slightly more frequently than those that live with others. For people >65, those that live alone are more likely to report never attending social events (sig at 0.20).

Of people who live alone, those with a chronic condition are more likely to attend social gatherings less frequently (monthly rather than weekly) than those without a chronic condition.

Figure 14: Attend social gatherings by age and chronic condition
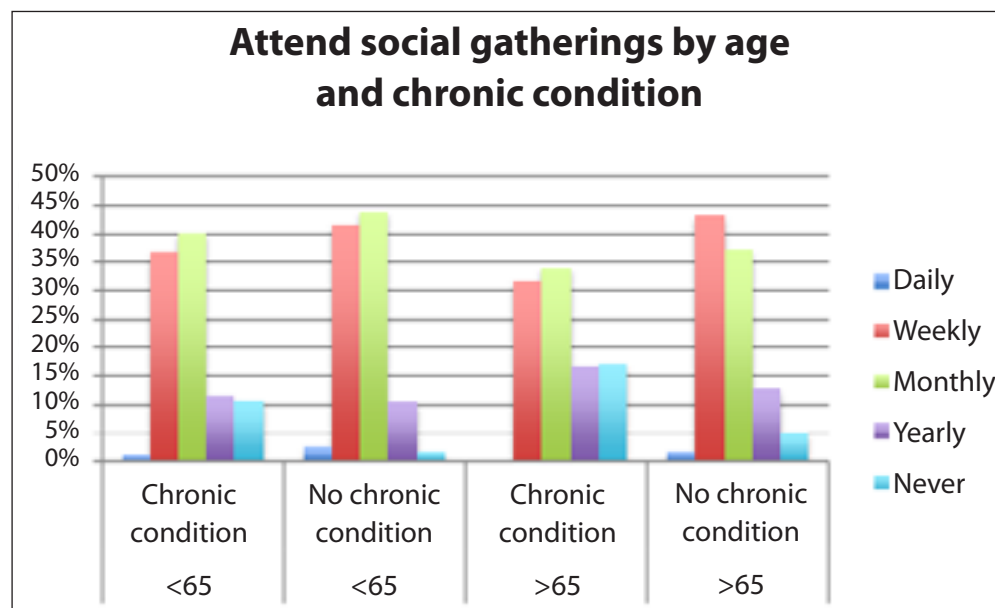
Frequency of talking in the street

Statistical significance was evident for age and frequency of talking in the street, indicating that age and talking in the street are statistically related. While most people talk in the street either daily or weekly, incidence of talking daily increases with age, and weekly and monthly incidence of talking in the street decrease with age. A clear increase in proportions of those talking in the street daily can be seen in Figure 15.

Figure 15: Talking in the street by age
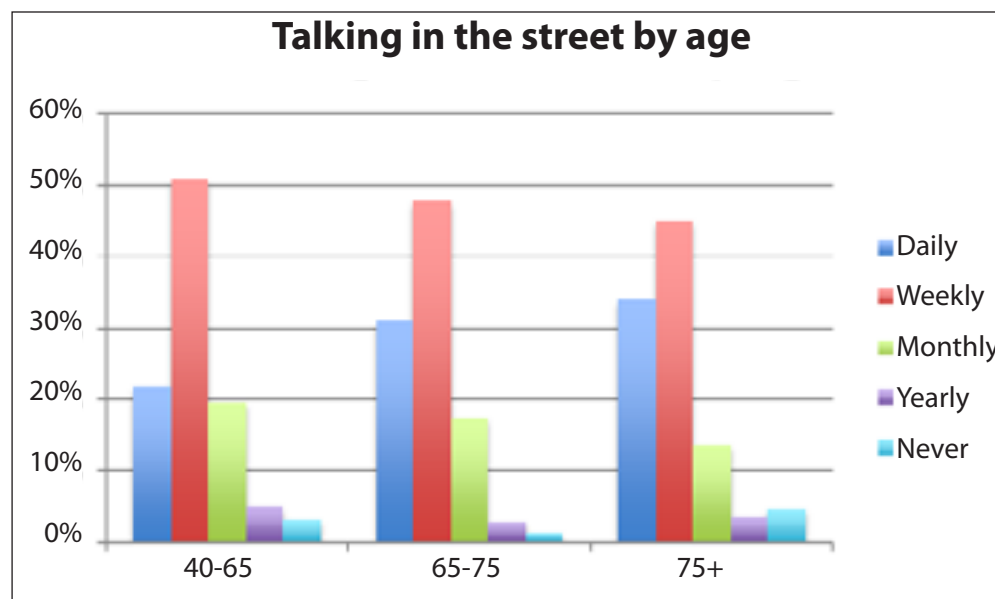
There were also differences for those with a chronic condition and their frequency of contact with others in the street.

For people with no chronic condition, people >65 are significantly more likely than people <65 to talk daily with people on the street. People <65 with a chronic condition talk with people in the street less frequently than those with no chronic condition.

Most people talk with people in their street weekly - people >65 talk more frequently than those <65. Of people who live alone, those with a chronic condition talk in the street less frequently (weekly rather than daily) than those without a chronic condition.

Figure 16: Talking in the street by age and chronic condition
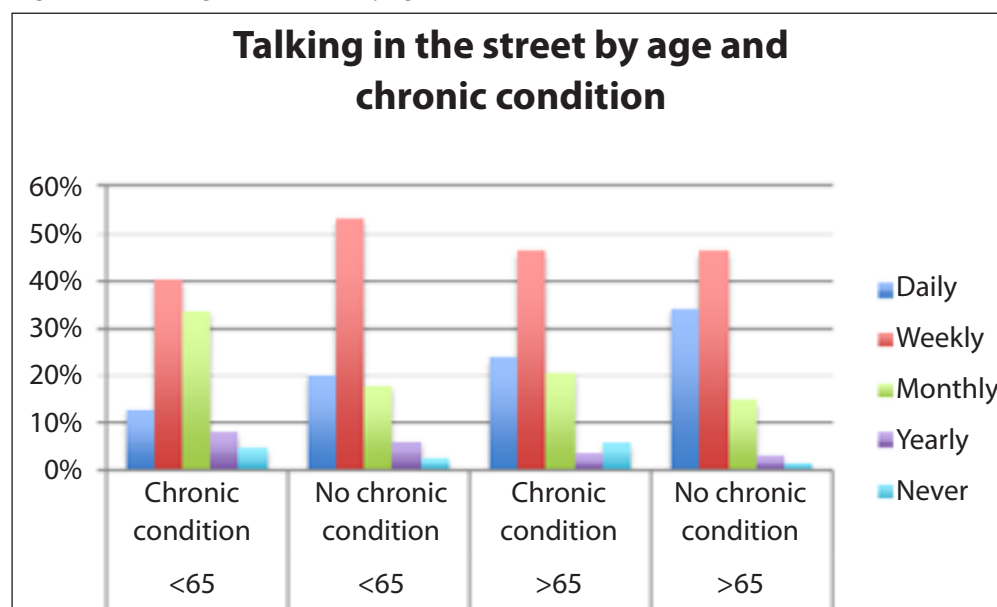
People in all groups are most likely to talk weekly with people in their street. People with a chronic condition and those that live alone do so less frequently.

For people who live with others, those with a chronic condition are less likely than those without to talk daily or weekly with people in the street.

For people who live alone, those with a chronic condition are less likely than those without to talk daily with people in the street. For people with no chronic condition, people who live alone are less likely than those that live with others to talk with people in their street, including not at all.

One man in his 80s who had limited mobility, indicated in an interview that the idea of neighbourhood did not match his current experience. He did not see his own neighbourhood as living up to this ideal:

> *Neighbourhood is if they come out and talk to you. That's the neighbourhood. But you don't see anyone, I only see L… I hardly see anyone in this complex. They all keep to themselves. I like a bit of seclusion myself.* (Interview 7)

Talking in the street was a daily occurrence for four focus group participants, weekly for three, it was monthly for one, yearly for one and never for one.

> *Only very immediate neighbours. I live in a sort of a unit above a shop and I have contact with the other people in the unit, yeah, and I have contact with other people like … and like that sort of thing.* (FG1P4)

> *Only one of the neighbours we have coffee with now and then. Yeah, there's this girl who walks her dog and she talks to me every time I see her walking past. That's about once a week or something. I bump in to her and we talk for about half an hour when she's walking her dog.* (FG2P1)

> *I just don't know people, I just keep to myself. I know a lady next door in the house, because I'm in the block of units. Only to say hello, good morning, small chat to the neighbours and you just keep to yourself. You don't want to get too involved with them.* (FG2P2)

> Most of the people in the block of flats either have mental illnesses or they're elderly. There's not a lot of connection between a lot of them. But I do talk now to a lady downstairs. (FG2P5)

> *I have good contact with one of the guys in one of the flats; there's six flats there in a sort of group, so yeah we talk about things and they ask how I'm going on and what I've been doing and what my interests are …* (FG3P1)

> *Well I sort of get on all right with my neighbours, you know, I say hi to them, I talk to one of them, you know, and yeah that's about it.* (FG3P2)

One way of connecting with the neighbourhood that was frequently mentioned by interviewees was walking. Walking around the neighbourhood was a commonly mentioned way in which people got to

know others in the area. Walking was mentioned in eight interviews and walking dogs was mentioned by five interviewees. Being out on the streets was an important contributor to neighbourliness:

> *A lot of people walk to the shops. A lot of the older people just walk around the neighbourhood together so there's lots of people and lots of kids in this neighbourhood and they're often riding their bikes or their scooters or their skateboards around the place.* (Interview 6)

> *I talk to people in the street, I walk my little dog. And now I get to know people that walk their dogs too.* (FG2P5)

> *Yeah, one or two might; they walk their dogs and I—what I normally say is, 'Hi Doggie,' and they actually—like, say, 'Hi, I'm …,' and I introduce myself and she sits down and we get talking. And anytime when I'm in Katoomba at one of the cafes and she sees me she always says hi and … It's good to have at least somebody to talk to.* (FG3P3)

In some cases walkers were able to observe when something was not right in the neighbourhood:

> *With the dog, you'd be surprised at the things you learn in the neighbourhood. There was a break-in the house across the road from us which backs on to the golf course, and the front door was open and it was our dog that went in there and sort of …* (Interview 2)

People may not know each other very well but can have some idea where they live:

> *I don't know their names but because we walk the dogs around the neighbourhood we know where people live and we know to say hello but we don't actually know their names.* (Interview 6)

It can be a source of comfort to know that others are walking around in the area noticing what is going on:

> *There's a couple who live over in the corner there who are probably a bit younger than me who walk their dog, and they were also very conscious and asked us if we needed something.* (Interview 3)

Not being able to walk can result in isolation and a lack of knowledge of the neighbourhood and fewer connections with neighbours:

> *With my legs cracked up I can't do much. I can walk with the walker a bit out there and maybe to the mailbox but if I want to walk further I think I could but I don't want to press it. Gotta be careful what you do.* (Interview 7)

Chatting while shopping

It was evident that chatting while shopping was not related to age and that the majority in all age groups considered this a weekly activity as indicated in figure 17. Being able to access shopping villages is an important social activity.

Figure 17: Chatting while shopping by age
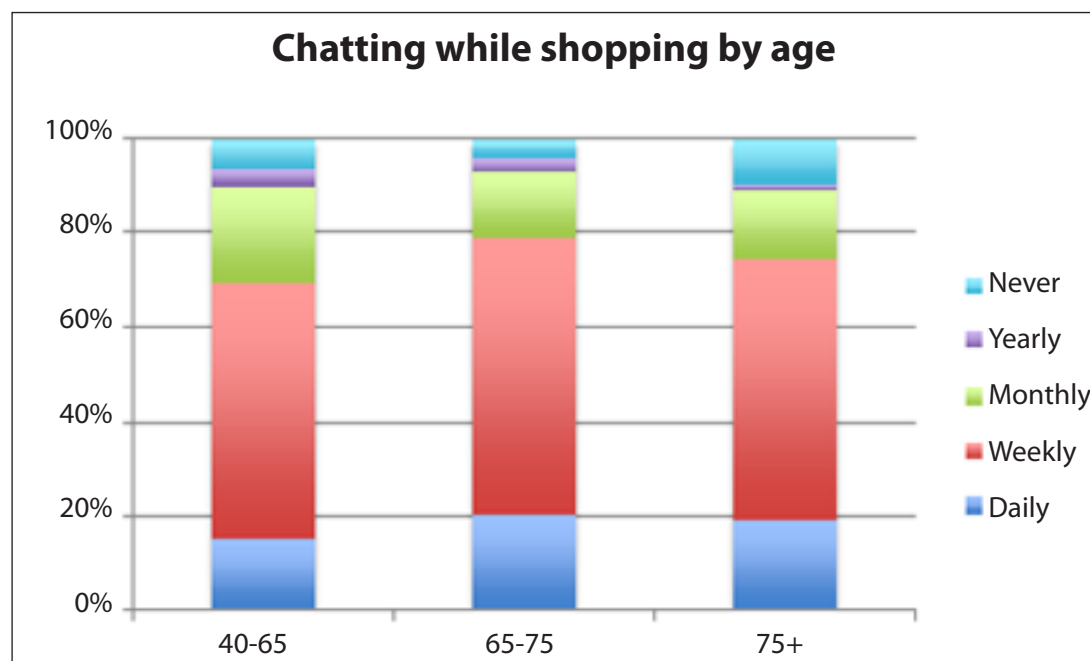
There were some apparent differences for chatting while shopping for those with a chronic condition. For people with no chronic condition, people >65 are significantly more likely than people <65 to chat with people while shopping. People <65 with a chronic condition chat with people while shopping less frequently than those with no chronic condition.

For people <65, those that live alone are more likely to talk while shopping daily than those who live with others (small proportional differences). Of people who live alone, those with a chronic condition are less likely than those without to talk to people while shopping daily. They are more likely to talk weekly.

People in all groups are most likely to talk weekly to someone while shopping. People with a chronic condition and those that live alone do so less frequently.

For people who live with others, those with a chronic condition talk with someone while shopping less frequently than those with no chronic condition.

For people who live alone, those with a chronic condition are less likely to talk daily with someone while shopping - and are more likely to never talk with someone while shopping.

For people with a chronic condition, people who live alone are more likely to talk weekly with someone while shopping - or never (sig. at 0.05).

Chatting while shopping occurred daily for three focus group participants and weekly for four with one saying monthly and four saying never.

One focus group participant found going to Katoomba important:

> *I'm always bumping into someone in Katoomba, when I'm out and about shopping would know me for the last 30 years I've been here, so I bump into a lot of people in Katoomba Street, I mean virtually every time I'm out and about shopping there's always someone knows me and says g'day in that regards and all that.* (FG1P1)

> *I go to the library at least once a week. I know the librarians and I know people, you know, in the shops, I know them very well.* (FG2P5)

> *Oh just up the street, you usually run into somebody you know because I've been there about 15 years now and we have a bit of a chat and it's good, it just or just go up, you know, just for a bit of a stroll.* (FG3P1)

> *If my legs can handle it, fine I'll catch the bus, otherwise, 'Anyone going near Katoomba?' … And I just like rock up and have a look around the shops and have a coffee and whatever and that's when I kind of meet people.* (FG3P3)

Neighbourhood connection

Neighbourhood connection was based on a group of questions in the survey related to how the neighbourhood is perceived. The highest scoring questions were related to feeling safe, the neighbourhood as clean and tidy and as friendly. The lowest rating was support availability followed by neighbours helping each other. Figure 18 shows the ratings for each question.

The percentages for each rating are shown in table 6.

Table 6: Feeling connected responses by rating

	1 per cent	2 per cent	3 per cent	4 per cent	5 per cent	No response per cent
E1 Feel connected	4	13	30	30	21	0.9
E2 Neighbours help	7	16	28	29	19	2.0
E3 Clean and tidy	2	6	21	47	25	0.9
E4 Friendly	2	8	22	41	26	1.6
E5 Support avail	16	16	31	22	14	4.1
E6 Feel safe	1	3	15	45	26	1.2
E7 Access info	3	6	20	39	31	1.5

Figure 18: Neighbourhood connection levels for each question – number of responses

Neighbourhood levels of connection by numbers of response
- E1 Feel connected
- E2 Neighbours help
- E3 Clean and tidy
- E4 Friendly
- E5 Support avail
- E5 Feel safe
- E7 Access info
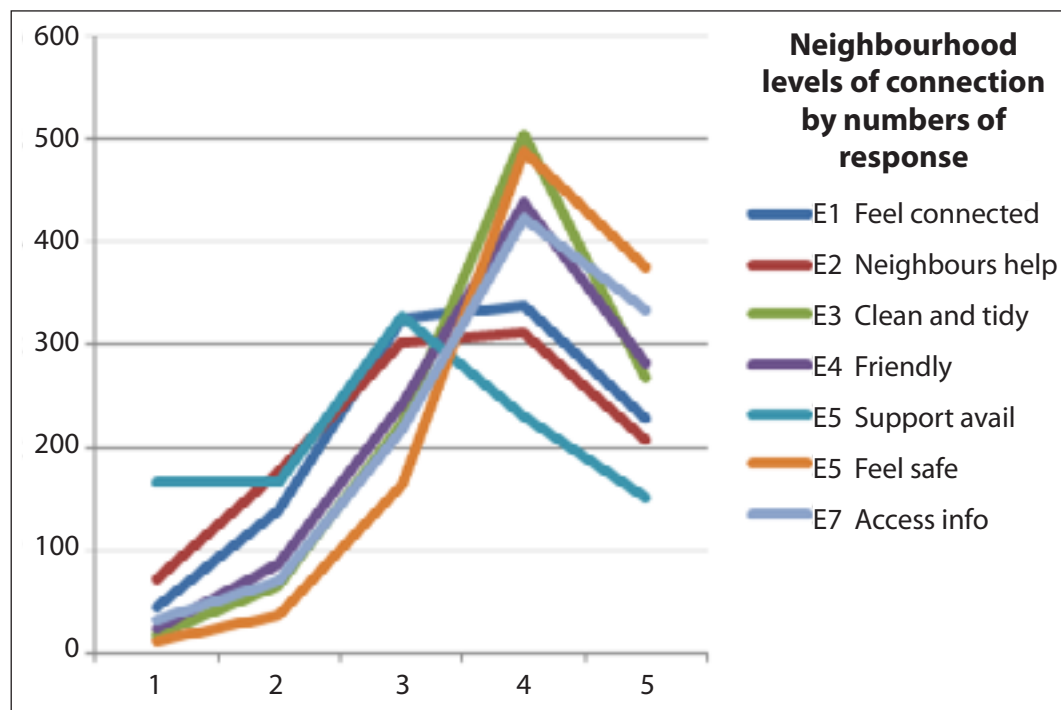
Figure 19: Feeling connected by age

Feel connected by age
- Not at all
- 2
- 3
- 4
- 5 Very much
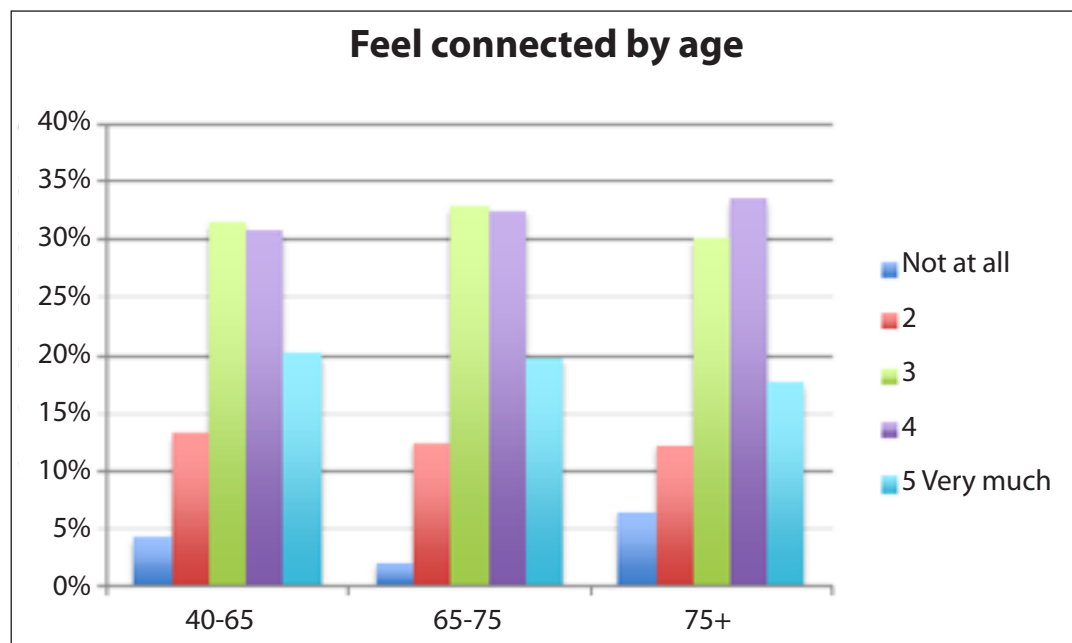
Feeling connected to your neighbourhood by age group

How connected people feel to their neighbourhood is an important direct measure of social participation.

When examined statistically it was evident that there is consistency across age groups for feeling connected. Most people feel connected to their neighbourhood, regardless of their age. Age and feeling connected to the neighbourhood are independent.

Interviewees described neighbourhood:

> *It's a community where you can feel safe and know that you can help people if they need help and call on them to help you if you need help.* (interview 6)

> *It's the place where I live. It's my place of safety, it's where my shops are and people I know, and all my friends live.* (Interview 10)

> *We know everyone around the place. The people are there, we know them, we can contact them when we like but we don't have to contact them every day. They're friendly.* (Interview 9)

One focus group participant noted:

> *I think you associate it, like a friendly neighbourhood is strongly associated with a higher wellbeing, higher state of happiness in the community, and also potentially more economic.* (FG1P4)

For those with a chronic condition the situation is different. For people <65, those with a chronic condition are less likely to report a strong feeling of connection than those with no chronic condition. As can be seen in Figure 20 there is a distinctly higher proportion of people with a chronic condition who are under 65 years giving a rating of 3 than for those without a chronic condition and those over 65 years with or without a chronic condition.

Figure 20: Chronic condition and feeling connected by age

The situation is also different for those who live alone. For people <65, people who live with others are more likely to feel connected to their neighbourhood than those that live alone. For people >65, those that live alone are more likely than those that live with others to feel negative about their connection to the neighbourhood (sig. at 0.20).

Of people who live alone, those with a chronic condition are less likely to feel connected to the neighbourhood than those without.

People in all groups are more likely to feel either positive or neutral about being connected to the community. People with a chronic condition are most likely to feel neutral, and those who live alone are most likely to feel negative.

For people who live with others, those with a chronic condition are more likely to feel neutral or negative about community connection those with no chronic condition (sig. at 0.10).
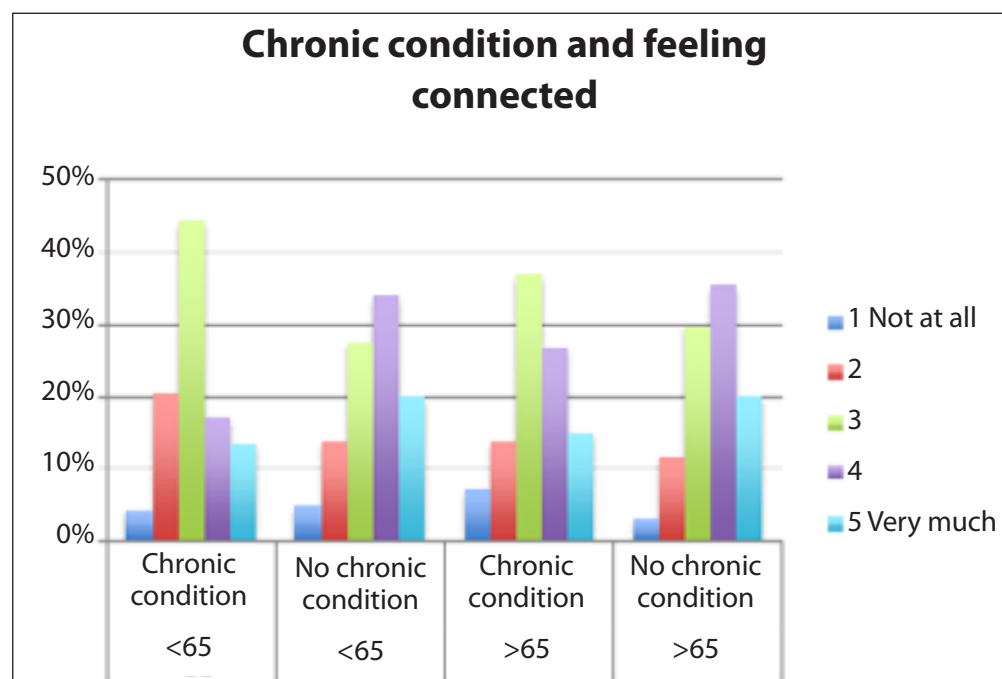
For people who live alone, those with a chronic condition are more likely to feel neutral and less likely to feel positive about community connection than those with no chronic condition (sig. at 0.05).

For people with a chronic condition, people who live alone are more likely to be neutral or negative and less likely to feel positive about community connection than those who live with others (sig. at 0.05).

For people with no chronic condition, people who live with others are more likely to feel very connected with their community than those who live alone.

Neighbours in your area help each other out

Neighbours helping each other has been considered an important indicator of interconnection within neighbourhoods (Norris et al. 2008). The survey shows that most (27.6 per cent) rated this at 3, 46.9 per cent high at 4 or 5, however for 23.5 per cent helping each other was rated low as 1 or 2. Figure 21 shows

the ratings for neighbours help by age group indicating that for all age groups most consider neighbours help each other.

Figure 21: Neighbours help each other by age
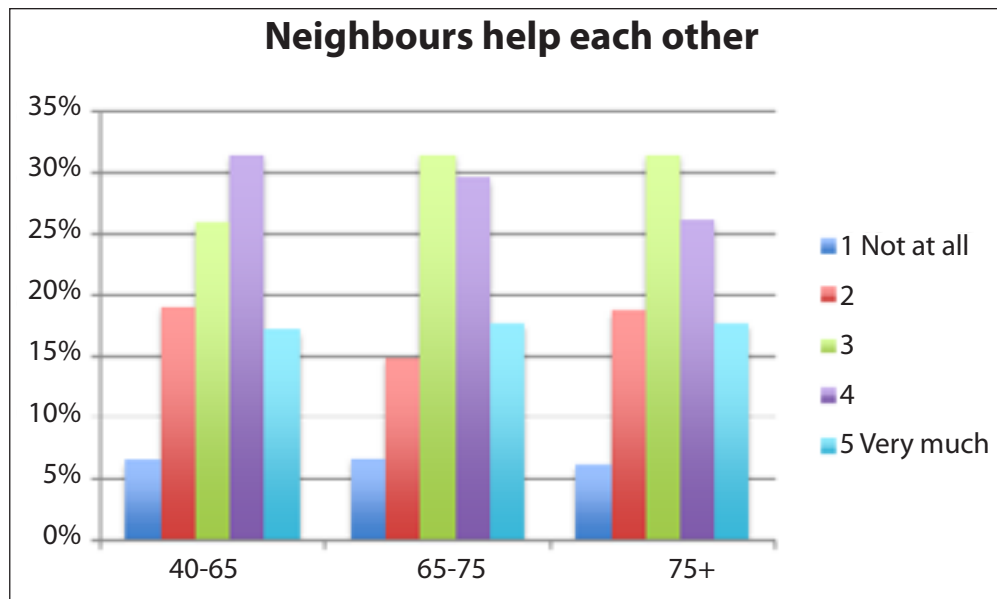
Most respondents felt fairly strongly that neighbours help each other out. How old a person is does not relate to their feeling about the help neighbours provide. Those who gave a lower rating are more likely to have a chronic condition as analysis shown in Figure 22 indicates.

Figure 22: Neighbours help each other and chronic condition
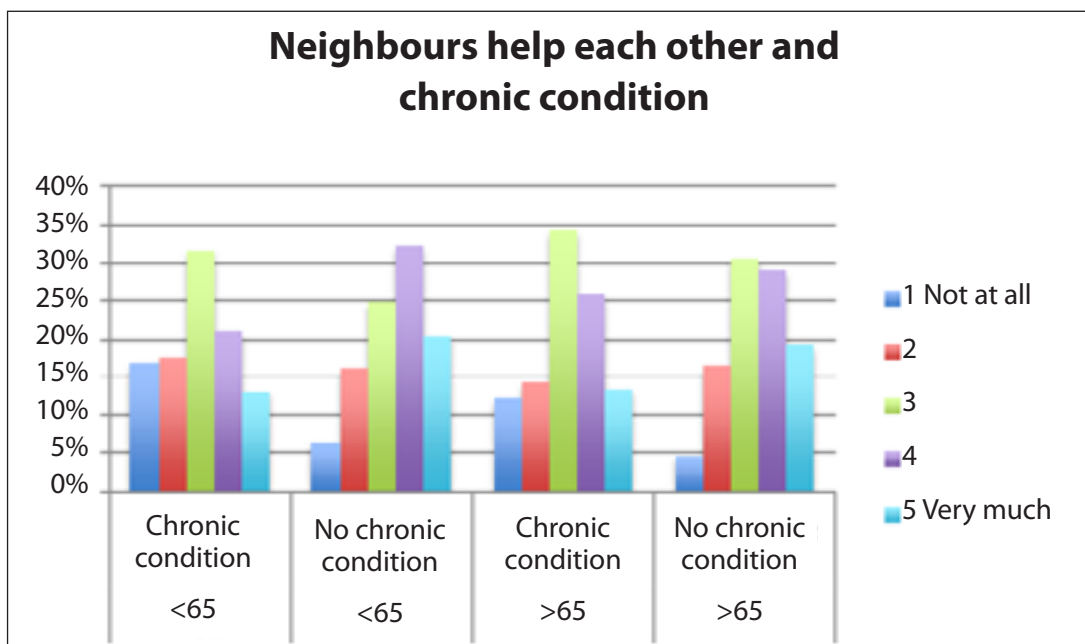
It is evident that ratings of 1 and 2 appear more frequently for those who report having a chronic condition. For people <65, those with a chronic condition are less likely to report a strong feeling that neighbours help than those with no chronic condition.

Most people who live with others feel positive about neighbours helping each other. People <65 who live alone, however, are more likely to report feeling negative or neutral. Of people who live alone, those with a chronic condition are more likely to feel ambivalent about whether neighbours help each other out.

People who live with others with no chronic condition are most likely to feel neighbours help other. People who live alone with a chronic condition are the only group to report more negative than positive responses.

For people who live with others, those with a chronic condition are more likely than those with no chronic condition to feel that neighbours do not help each other.

For people who live alone, those with a chronic condition are more likely than those without to feel neutral and less likely to feel positive that neighbours help each other (sig. at 0.10).

For people with a chronic condition, people who live with others are much more polarised in their feelings that neighbours help each other than those who live alone. Those who live alone are more likely to feel neutral or negative.

Neighbourhood as clean and tidy

The neighbourhood being considered clean and tidy is an indication that people feel good about their neighbourhood. Overall, those surveyed considered their neighbourhood to be clean and tidy. In the survey 75 per cent gave a positive rating of 4 or 5 and 22 per cent a neutral rating of 3. For 8 per cent the neighbourhood rated low at only 1 or 2 for clean and tidy.

Figure 23: Neighbourhood as clean and tidy
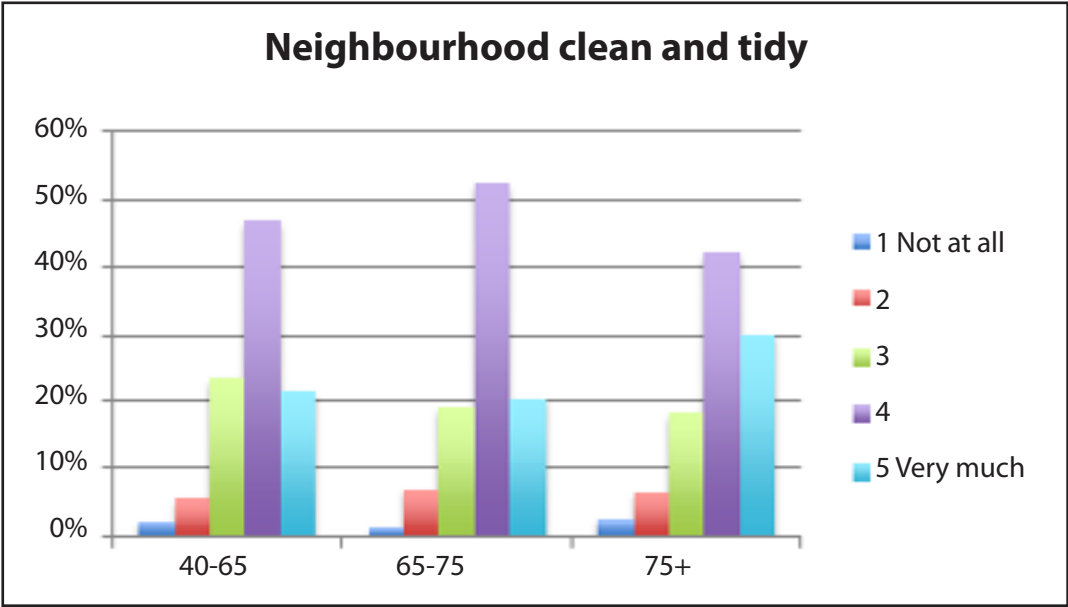
The experience of the neighbourhood as clean and tidy is also effected by having a chronic condition. Statistical analysis showed that for people with a chronic condition, people <65 are less likely than people >65 to feel that the neighbourhood is very clean and tidy (more likely to be neutral). For people <65, those with a chronic condition are less likely than people without to feel that the neighbourhood is very clean and tidy (more likely to be neutral).

Most people in all groups report feeling that their neighbourhood is clean and tidy. Those <65 who live alone have a larger proportion of people who feel neutral. Of people who live alone, those with a chronic condition are less likely to strongly agree that the neighbourhood is clean and tidy.

Neighbourhood as friendly and safe

Most also considered their neighbourhood as friendly, with 41 per cent rating friendliness at 4 and 26 per cent rating it at 5. Feeling safe was also rated highly and independent of age with all ages rating it similarly.

Figure 24: Feeling safe in the neighbourhood by age
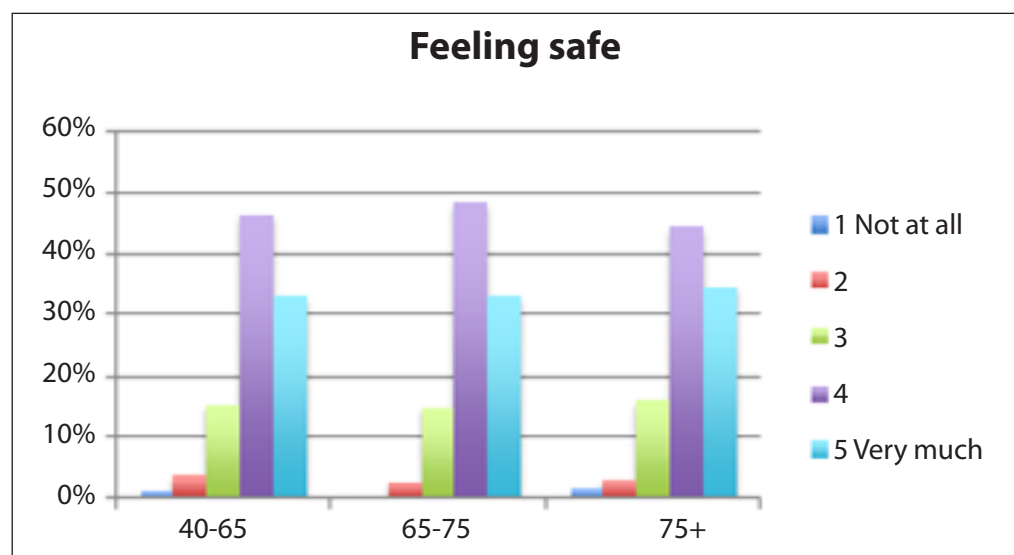
Feeling safe

Feeling safe was influenced by having a chronic condition. Analysis indicated that for people <65, those with a chronic condition are less likely than people without to feel very safe (more likely to be neutral). More people with a chronic condition gave a rating of 3 for feeling safe.

Most people in all age groups report feeling safe in their neighbourhood. Those <65 who live alone have a larger proportion of people who feel neutral. Of people who live alone, those with a chronic condition are more likely not to feel safe in the neighbourhood.

The extent to which people felt support with daily activities was available to them also rated similarly for all age groups though the highest proportion of ratings was at 3 indicating that this area rated lower than questions of feeling safe and connected.

Figure 25: Support available by age
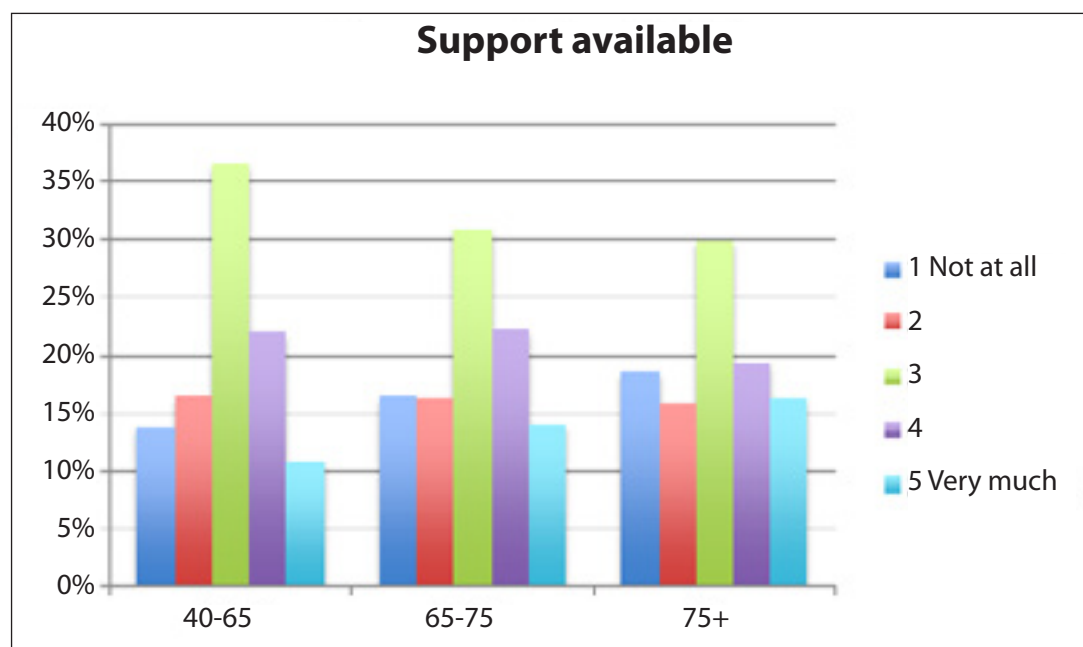
Support available

A higher proportion of those aged 40-65 gave a rating of 3 while a higher proportion of those over 75 years gave a rating of 5. None of these results were statistically significant however.

Feeling support was available was distinctly different for those with a chronic illness who were more likely to give a rating of 1 or 2 for this question.

Figure 26: Support available and chronic condition

Figure 26 shows that for people <65, those with a chronic condition are less likely than people without to feel supported (more likely to provide a negative response).

People who live alone are also less likely to feel that support is available to them. For people <65, people who live alone are significantly less likely to feel support is available than those that live with others. For people >65, people who live alone are significantly less likely to feel support is available than those that live with others (sig. at 0.05).

Overall, people who live alone are less likely to feel support is available to them than people with other living arrangements. Of people who live alone, those with a chronic condition are less likely to feel support is available to them than those without. People with a chronic condition and those that live alone are more likely to feel that no support with daily activities is available.

For people who live alone, more people say they feel support is not available than those who do. The intensity of the negative responses is higher for those with no chronic condition (sig. at 0.05).

For people with a chronic condition, both those that live alone and those that live with others feel negative about whether support is available. Those that live with others are slightly more likely to provide a positive response (sig. at 0.05).

For people with no chronic condition, those that live alone are most likely to say they feel support is not available.

Summary of Survey Results

It is clear from survey respondents that the majority of people feel connected to their community, feel safe and that their neighbourhood is clean and tidy and friendly. Most people are able to go out, share meals and visit with friends and family. It is also evident that people are prepared to help others including neighbours and that there is generally a good level of connection with neighbours. It is not clear, however, what can be reasonably expected of neighbours in a disaster and what help people would be able to provide others or would be expected to provide for others.

Most respondents were engaging in activities such as local festivals, going out for entertainment and sharing meals with friends. Around 50 per cent were also involved in some kind of volunteer activity and over 67 per cent belonged to local associations. Between 19 per cent and 26 per cent of respondents did not regularly engage in activities such as attending festivals, going out for entertainment or sharing a meal with friends while 32 per cent-49 per cent did not belong to local associations or volunteer. Of those in the 25-40 year age group 90 per cent attend festivals and this proportion decreased with every age group. Those over 75 years were less likely to engage in all activities.

For at least half of respondents, weekly contact is most common with neighbours, friends and family. Those with no chronic condition, who live with others are more likely to feel very connected with their community.

There is a strong proportion of survey respondents who indicate that they are not as well connected for a variety of reasons. There were three particular areas where vulnerability was evident with requiring help and where people felt less connected, safe and supported. The main criteria that we analysed statistically were age, chronic condition and living alone. The significance from the analysis for each of these areas will be discussed in the following.

Age

It is confirmed by survey results that people aged 65-75 and 75+ are more likely to require assistance with daily tasks. It was also apparent that there were differences in who would provide help that were based on age. People aged 40-65 and 75+ are more likely to be helped by family than people 65-75 years who are more likely to receive help from neighbours. People aged 40-65 years are more likely to receive help from friends than older people and to see family daily than older people.

Differences related to age were evident in how often people see neighbours, family and friends. People aged 65-75 and 75+ are more likely to see family weekly or monthly than younger people who are more likely to see family daily. Not surprisingly we found that people 75+ tend to go to social events less frequently than younger age groups. Those over 65 years see family weekly or monthly, which is less often than those under 65 years who are more likely to see family daily or weekly.

People >65 appear to make more effort socially. They are more likely to go to social gatherings weekly rather than monthly. Most people talk in the street either daily or weekly but people over 65 years are more likely to talk daily. Talking daily increases with age.

There is consistency across age groups for feeling connected, that neighbours help each other, the neighbourhood is clean and tidy, the neighbourhood is friendly, people feel support is available to them when they need it, the neighbourhood is safe and they are able to access information when they need it.

Chronic condition

Analysis clearly showed that people with a chronic condition and people >65 are more likely to require help. Those <65 years who have a chronic condition are less likely than people >65 to feel that the neighbourhood is very clean and tidy (more likely to be neutral) and are less likely to see family daily or weekly, or to see friends daily or weekly.

The analysis indicated that having a chronic condition can affect the likelihood of neighbours being considered a source of assistance for those under 65 years. For people with no chronic condition, those >65 are statistically more likely to receive help from neighbours, those <65 are statistically more likely to be helped by family or friends.

Regardless of age, people with a chronic condition attend social gatherings less frequently. For people with no chronic condition, people >65 are significantly more likely than people <65 to chat with people while shopping. People <65 with a chronic condition chat with people while shopping less frequently

than those with no chronic condition.

For people <65, those with a chronic condition are less likely to report a strong feeling of connection or a strong feeling that neighbours help than those with no chronic condit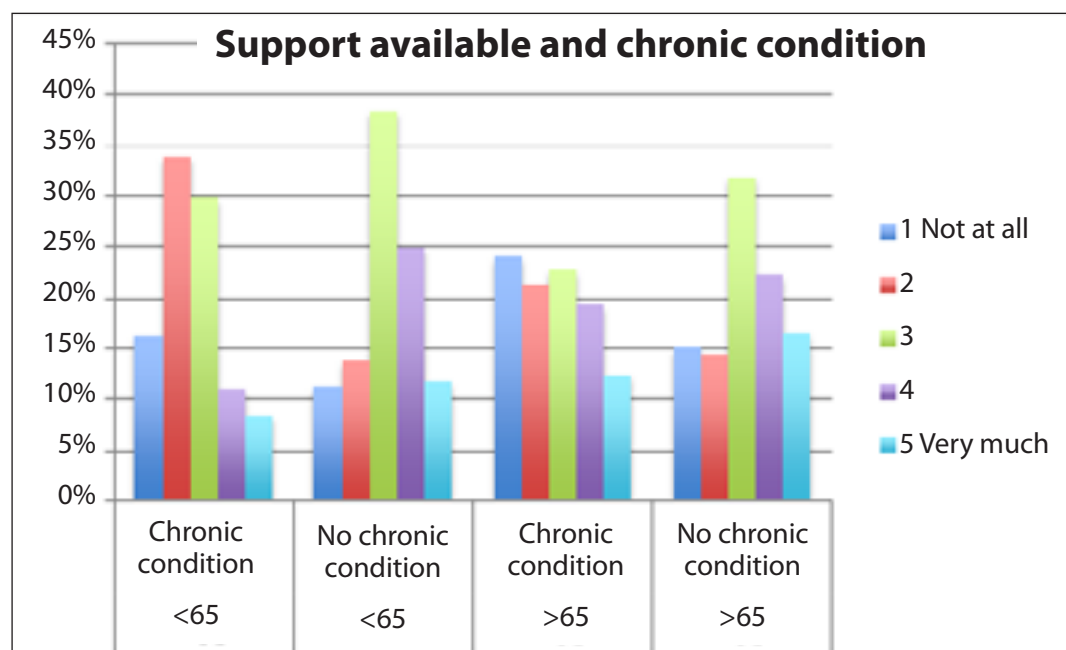ion. Feeling safe was influenced by having a chronic condition. Analysis indicated that for people <65, those with a chronic condition are less likely than people without to feel very safe (more likely to be neutral).

For people with a chronic condition, both those that live alone and those that live with others feel negative about whether support is available. Those that live with others are slightly more likely to provide a positive response (sig. at 0.05).

Living alone

Of people who live alone, those that require assistance are more likely to receive help from neighbours and family if they are over 65 years, and more likely to receive help from friends if they are under 65 years. The importance of friends here is different to the sample average, that is, it is unique to those that live alone.

People who live alone are slightly more likely to see friends weekly than those that live with others. For people <65, those that live alone go to social events slightly more frequently than those that live with others. For people >65, those that live alone are more likely to report never attending social events (sig at 0.20).

For people >65, those that live alone are more likely than those that live with others to feel negative about their connection to the neighbourhood (sig. at 0.20), about neighbours helping each other. People <65 who live alone are more likely to report feeling negative or neutral about neighbours helping each other and to feel neutral about whether their neighbourhood is clean and tidy and how safe they feel in their neighbourhood.

People who live alone are also less likely to feel that support is available to them. For people <65, people who live alone are significantly less likely to feel support is available than those that live with others. For people >65, people who live alone are significantly less likely to feel support is available than those that live with others (sig. at 0.05).

Live alone and chronic condition

For people with a chronic condition, people who live with others are more likely to see friends daily than those that live alone who are more likely to see friends monthly.

Of people who live alone, those with a chronic condition:

- attend social gatherings less frequently (monthly rather than weekly)
- talk in the street less frequently (weekly rather than daily)
- are less likely to talk daily with someone while shopping - and are more likely to never talk with someone while shopping
- are less likely to feel connected to the neighbourhood than those without
- are more likely to feel ambivalent about whether neighbours help each other out
- are less likely to strongly agree that the neighbourhood is clean and tidy
- are more likely not to feel safe in the neighbourhood

People with a chronic condition and those that live alone are more likely to feel that no support with daily activities is available.

Findings: Determining Community Resilience

In this section, while still introducing a few results, we draw on comparisons with the 2011 Census and a number of relevant community research projects, NSW State Government data, to integrate previous understandings in order to construct an holistic approach to describe the community resilience of the Blue Mountains. We have structured this section with headings derived from Zautra, Hall and Murray (2008).

Zautra, Hall and Murray (2008) highlight six fundamentals of neighborhood resilience. According to Zautra, Hall and Murray, resilient communities have:

1. neighbours who trust one another

2. neighbours who interact on a regular basis

3. residents who own their houses and stay for awhile

4. residents who have a sense of community and cohesion

5.residents who work together for the common good and are involved in community events and affairs

6. formal and informal civic places for gathering

Neighbours that trust one another

The extent to which people trust their neighbours is often linked to crime rates as well as the composition of neighbourhoods. Influences on neighbourhood connection include people who work out of the area, people with connections that are widespread and do not include neighbourhood connections, the extent to which values are shared, discrimination and poverty. Where people have most of their links out of the area, and/or work out of the area there may be fewer connections in the local area.

Our analysis does not encompass the extent to which Blue Mountains residents have their connections out of the area in which they live. We are able to consider crime rates from New South Wales police statistics and we can show from the Community Connections Survey the extent to which people consider their neighbourhood is clean and tidy, safe, and friendly.

The Blue Mountains is a relatively safe community with low rates of crime, including assault. Most crimes in the Blue Mountains have decreased in the last two years or are stable. The highest crime rate is for 'malicious damage to property' and Blue Mountains has a state ranking of 55 (of 143) for this. All other rankings are higher indicating that Blue Mountains has a lower rate of other crimes compared to other jurisdictions (Draft Blue Mountains Crime Prevention Plan 2014-2017, p.5). For assaults, Blue Mountains is ranked 89 of 143.

> In comparison to other local government areas across NSW, the Blue Mountains local government area has a relatively low crime rate and while "malicious damage" is the highest recorded crime it is, in part the result of an active community that report incidents of graffiti. (Draft BM C P Plan p.5)

Incidents of malicious damage are concentrated in the Katoomba, Springwood, Blaxland and Glenbrook town centres. These town centres are the larger commercial areas in the Blue Mountains and 'higher concentration of malicious damage is expected' (p.10).

Neighbourhoods were rated high for being clean and tidy and feeling safe in the Community Connections Survey, indicating that people feel good in their neighbourhood and perceive it positively. Overall over 70 per cent of those surveyed, gave their neighbourhood a high rating for clean and tidy and feeling safe. For 8 per cent the neighbourhood rated low for clean and tidy and 4 per cent gave a rating of 1 or 2 for feeling safe.

A comparatively low crime rate and a stable population combined with survey data indicates a high level of trust. On the question of how safe they felt, 71 per cent of the respondents gave a felt very safe. The majority (67 per cent) also felt their neighbourhood was friendly.

In the interviews there was some consideration of what neighbourhood meant to them. For most the neighbourhood was the local streets and the connections formed within that, where friends might also live. It is a place to feel safe, to access conveniences and to talk to people. Contact is not necessarily daily or regular, though it is generally 'safe' and 'friendly'. It is where you know people are there if you need them.

Neighbours that interact on a regular basis

The Community Connections survey included a set of question to indicate interaction with neighbours. People were asked how often they had contact with neighbours, family, friends and others.

A high percentage of respondents indicated that they talked on a regular basis with people in their street, with 27 per cent indicating they talked on a daily basis and 48 per cent weekly. A total of 7 per cent indicated they speak yearly with people in their street or never. The remaining 18 per cent talk on a monthly basis.

The most frequent daily contact for all participants was talking in the street followed by talking with family members and then chatting while shopping. The most frequent contact for over 60 per cent of respondents was for weekly contact with friends and chatting while shopping, indicating the importance of community connection through public places and through networks of friends.

The respondents who said they never have contact ranged from 6.6 per cent for chatting while shopping, 5.8 per cent for attend social events and 5 per cent for contact with family to 3.3 per cent for talking in the street and 1.6 per cent for seeing friends. While these are relatively small numbers it is important to recognise that there are people who lack these opportunities for contact.

On the question of who would help if needed, 33 per cent indicated a neighbor where 45 per cent indicated family and 18 per cent friends and 9 per cent said they had no one to help. In response to the question 'neighbours in your area help each other out' almost 50 per cent gave a high rating and 28 per cent gave a neutral rating.

The most frequent daily contact was talking in the street followed by talking with family members and then chatting while shopping.

It is evident that for some contact is less frequent. Those who live alone and those with a chronic condition are less likely to talk in the street daily and those under 65 years with a chronic condition are less likely to talk in the street daily or weekly.

Residents who own their houses and stay for a while

The 2011 census shows that the Blue Mountains, with a population of approximately 78,000, has a stable population with changes of only 100 - 800 people between 2002 and 2012. Most residents own their home (42 per cent), 39 per cent have a mortgage and 19 per cent are renting.

Nearly 80 per cent of households have broadband internet connection while 4514 or 15.4 per cent had no connection. There are 324 visitor only households in the Blue Mountains as reported in the 2011 census.

Rental accommodation can be less stable with less reliable maintenance of properties (Carr, Penny and Tennant, Maria (2010) A Better Lease on life: Improving Australian Tenancy Law, National Shelter Inc and National Association of Tenant Organisations). Increased costs of home ownership and rents have increased the levels of housing stress experienced.

- With 19 per cent of the Blue Mountains population renting there is a need to consider how many might be experiencing housing stress and therefore vulnerable to forced homelessness. A report by Homelessness NSW in 2010 concluded that 'being female, older, and single is to be at housing risk' (McFerran 2010).

- A high percentage of renters were experiencing rental stress according to the 2011 census. Blue Mountains had 35 per cent of renters experiencing rental stress overall, compared with 25 per cent in Greater Sydney, the highest proportions being in the middle and upper mountains (http://atlas.id.com.au/blue-mountains/maps/vacant-dwellings#MapNo=10064&SexKey=4& datatype=1&themtype=1&topicAlias=rental-stress&year=2011). Proportions ranged from the lowest of 19.0 per cent in Glenbrook Township to the highest of 46.1 per cent in Katoomba Township. Lawson and Blackheath also had proportions over 40 per cent of renters experiencing rental stress.

- In 2011, 9.4 per cent of Blue Mountains City's households with a mortgage were experiencing mortgage stress compared to 11.6 per cent in Greater Sydney. Mortgage stress varied across the Blue Mountains with proportions ranging from a low of 5.1 per cent in Glenbrook - Lapstone to a high of 21.3 per cent in Mount Victoria. Katoomba and Blackheath also had 16 per cent of those with mortgages experiencing mortgage stress.

- The Blue Mountains has over 7100 lone person households (24.5 per cent compared to 23.1 per cent for NSW and 23.1 per cent for Australia) and over 3100 of these are lone older person (over 65 yrs) households (10.6 per cent compared to 9.2 per cent for NSW and 8.8 per cent for Australia) with Leura having the highest proportion of these.

- In addition there are 2300 (7.8 per cent) households with no car. Having no car can make many things very difficult in the Blue Mountains depending on income level and location. Train services are hourly but many households are some distance from stations and bus services are infrequent and not in all areas. Carless households can experience greater isolation and can be vulnerable in times of disaster (Jeekel 2014).

Vulnerabilities to consider in the community include people with chronic illness or disability that affects their daily lives, people living alone, households without a car, single parents, low income households, and those experiencing housing stress. Those in rental accommodation are often the most vulnerable such as adults with complex needs, Aboriginal people, those escaping from domestic violence and youth, many of whom are also on low incomes.

Residents who have a sense of community and cohesion

The State of the City Report 2008-2012 conducted by the Blue Mountains City Council reported that over 90 per cent of 757 residents who completed a survey had a medium to high sense of belonging in their community. The question was 'I feel I belong to the community I live in'. Responses were on a scale of low, medium and high. Over 80 per cent reported a high sense of belonging and only 3.5 per cent reported a low sense of belonging.

For connectedness the question was 'I have someone in my area outside my immediate family to turn to in a time of crisis.' High level agreement was indicated for 82.6 per cent of respondents in 2009. Low agreement was indicated by 10.5 per cent.

There are a range of population differences in income and lifestyle in the Blue Mountains. Of a total of 3,861 (5.1 per cent) who stated that they spoke a language other than English at home, only 0.4 per cent of the population, 333 people, stated that they did not speak English well. There is a need to consider however, how people from other countries relate to their communities and neighbourhoods.

Other household differences include single parent families. There are 3080 single parent families in the Blue Mountains and 5611 (19.1 per cent, 19.6 per cent for NSW and 19.1 per cent for Australia) low income households with an income of less than $600 per week.

In the Community Connections Survey neighbourhood connection was based on a group of questions related to how the neighbourhood is perceived by the respondent. The highest scoring questions were related to feeling safe, the neighbourhood as clean and tidy and as friendly. The lowest rating was support availability followed by neighbours helping each other. How connected people feel to their neighbourhood is an important direct measure. Feeling connected was rated neutrally for 32 per cent of respondents, and high 55 per cent. Seventeen percent feel relatively lacking in connection.

Neighbours helping each other has been considered an important indicator of connection. The survey shows that most (59 per cent) rated this as neutral or high and 20 per cent as high. For 24 per cent helping each other was rated low.

While for most the neighbourhood rates highly on a number of dimensions, for some it is not friendly and is not experienced as offering help and support. Availability of support was rated low for 32 per cent of respondents. Scaling responses from those who said they had a chronic illness or disability separately from the remaining responses indicates the differences in experience for those who may have difficulty managing their daily lives. A third group based on focus group participants shows an even larger difference for a group of people who are affected by mental illness and disability.

Another question that showed a strong contrast was neighbours helping each other. As with feeling connected, those who said they had a chronic illness or disability rated the experience lower than those who did not. Focus group participants rated the experience even lower.

Figure 27: Connected to the neighbourhood, chronic illness or disability and focus group participants
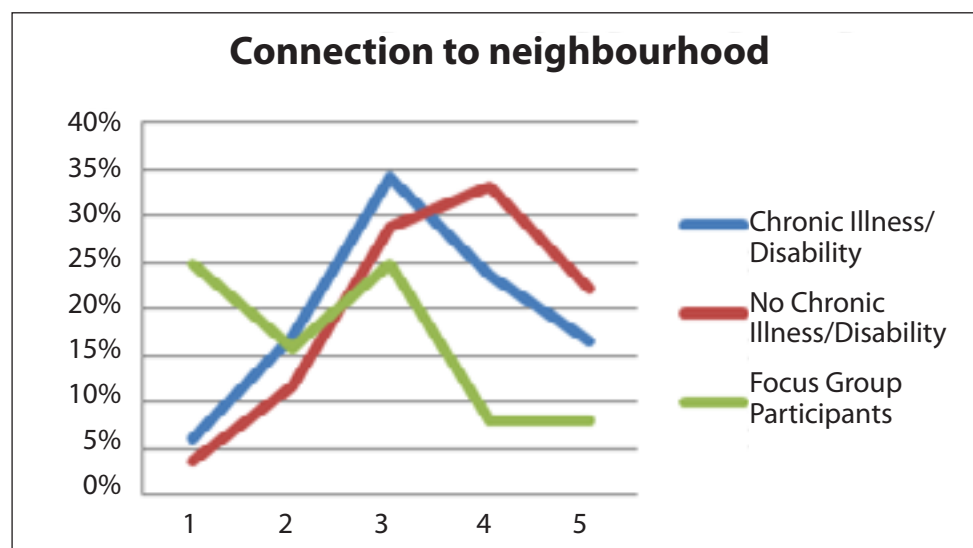
Figure 28: Neighbours help, chronic illness or disability and focus group participants
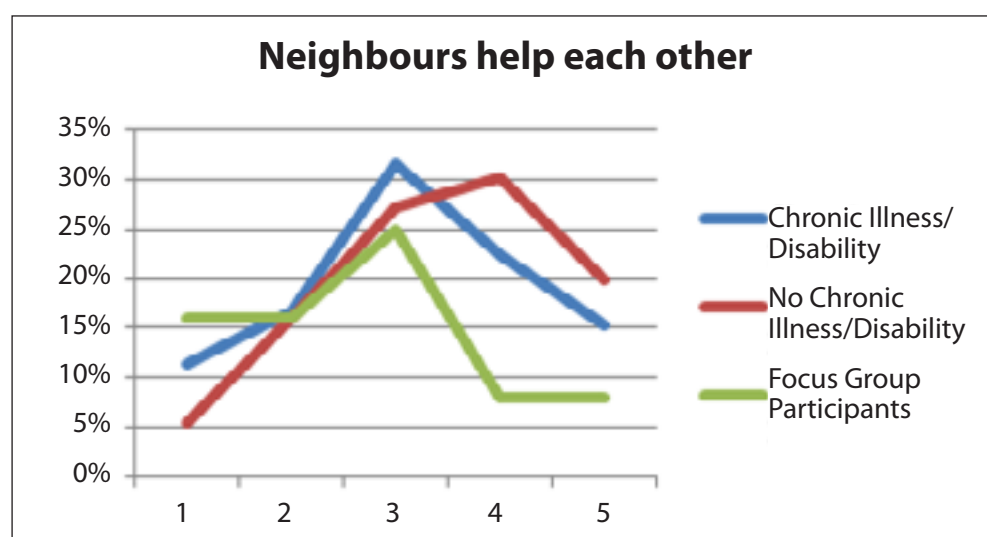
For those who feel little connection or experience of neighbours helping each other it may be difficult to feel a sense of community and cohesion with the broader community.

Residents who are involved in community events and affairs

The Blue Mountains has a high proportion of volunteering according to the 2011 census. Volunteering was at 14,289 (23.4 per cent of adult population compared with 15.1 per cent in Greater Sydney). Unpaid care was reported in the census at 7,886 (12.9 per cent compared to 10.8 per cent for Greater Sydney). The provision of unpaid assistance has increased from 2006 by 931.

From the Community Connections Survey the most common activity was attending festivals and community events which 846 (77 per cent) respondents said they engaged in. This was followed by sharing a meal with friends at least once a month and this was the case for 75 per cent of respondents. Just over half the respondents (52 per cent) said they volunteered, a higher percentage than 23 per cent indicated in the 2011 census. Involvement in some kind of association was also high with 70 per cent indicating some involvement.

Around 25 per cent of respondents did not regularly engage in these community activities. Those over 75 years were less likely to engage in all activities.

Over one third of respondents to the survey, 37.5 per cent, said they provided assistance with household tasks such as putting bins on the street to people in their neighbourhood indicating that helping others nearby is fairly common. There were 106 or 9.6 per cent who said they required assistance with household tasks such as putting bins on the street. While 19 per cent said that they had a chronic illness of some

kind only a small number say they need help. This could indicate that those with chronic illness prefer and try to do everything for themselves as much as possible. It could indicate that people may be less willing to say they need help than that they provide help to others.

Help is most commonly available from family (44 per cent) followed by neighbours (33 per cent) and then friends (17 per cent). For 62 respondents (6 per cent) there is reportedly no one to help them. The question was not answered by 50 respondents.

It appears that most do feel connected to their community and are involved in community activities. It is important to identify those for whom this is not likely to be the case. Our survey has indicated that for people with a chronic condition and people who live alone there are significant differences in how connected they feel and what help is available to them. It is important to find ways to identify those who do require assistance in unusual circumstances.

Formal and informal civic places for gathering

The Blue Mountains has a number of civic places though these are in the major centres of Springwood and Katoomba. Places are needed in each township for people to gather and be reassured in times of crisis or emergency where seating, shelter and water are available. Identified safe places may be ovals where there is no shelter or water, while there are locations within each township where temporary shelter could be arranged with more safety and comfort. Arrangements would need to be made with existing facilities such as council, bowling clubs, churches, schools and the health service to enable them to provide for disaster events.

Similarly, transport for those who are unable to transport themselves and for their animals needs to be considered. This is unlikely to be large numbers of people in any event and there are many transport options available from community transport to vehicles owned by council and the health service that could be redirected for use in emergencies. Some flexibility is required with community resources such as these in times of disaster.

Discussion and Recommendations

In undertaking this research we were acutely aware of the conspicuousness of some of the issues we were investigating. For instance, it is already clear to many within the community sector that the needs of vulnerable individuals and groups need to be addressed and that there should be an holistic and integrated approach to building the community connections necessary to do this. It is the 'how' that forms the challenge. It is likely that most readers will be able to describe and explain the problem, however pragmatic solutions are difficult to articulate due to their complexity and associated resourcing needs.

Resourcing is an issue in which complex systems and organisations are being forced, in the new economic arena, to compete for funding. In the struggle to retain local community services and thus essential support for people and programs, the most viable approach is to collaborate and generate a collegial approach and engage in formal resources partnerships to effect sustainable change. Current agreements and consortiums being established such as the Blue Mountains Lithgow Integrated Neighbourhood Network (BLINN), a consortium comprising all Blue Mountains and Lithgow LGA Neighbourhood Centres including the Mountains Outreach Community Service, are exemplary examples of this idea in action.

As in many other work settings, networking, collective approaches and strong partnerships are highly prized within the community sector, but paradoxically it is individual achievements that are officially recognised. This is possibly because we live in a world system which evaluates programs and activities by converting the benefits of life-changing participatory experience into numbers, percentages and a sequential linear flow of measurable 'outcomes'.

Into this highly complex mix, add the question of how to best support and benefit the most vulnerable among us. What we have generated in this final section is a description of what most in the community sector will already be familiar with, and accordingly our contribution is written with building long term resilience and sustainability in mind. We have endeavoured to outline a strategy for the way forward in developing a sustainable, resilient community which nurtures and supports itself and specifically protects and develops its vulnerable members, both in times of ordinary living and flowing on into emergency situations. The recommendations which follow are designed to strengthen existing community connections and initiate others.

We begin this section with a brief background of emergency management in its historical context, move towards community service involvement and shared responsibility, and then close with a focus on the vulnerable within the community. The relevant recommendations are attached to each section.

The emergency management context

In order to place the issue of caring for the vulnerable into perspective we briefly touch on the formal origins of emergency management. This is necessary as the federally mandated emergency management arrangements in Australia have a flow-on effect right down to the grass roots level of a community.

Emergency management originates from civil defence strategies and practices established during World War II and the Cold War (Manock 2001). Following the impact of crises in the late 1960s such as the Tasmanian bushfires, and in the early 1970s the Granville train crash and Cyclone Tracy, Australia turned its attention to improving prevention and planning for disaster. The establishment of comprehensive community-based recovery management facilities and services following the 2003 Canberra bushfires and Cyclone Larry in Queensland in 2006, demonstrates the importance that recovery management now receives from emergency services and local government authorities (Eyre 2004; Gordon 2004). More recently the 2009 Victorian Bushfires Royal Commission, the 2011 Queensland Floods Commission of Inquiry and the 2011 Keelty report on the Perth Bushfires, *A shared responsibility*, have highlighted various issues relating to shared responsibility and community sector participation in emergency management.

Emergency management activities across Australia are not always consistent and there are still many areas for improvement (Childs, Morris & Ingham 2004; Paton & Johnson 2004). One area for improvement lies with continuing to encourage the paradigm shift from a focus on the emergency services as 'rescuers' and residents passively waiting to be 'rescued', towards embracing the 2011 National Strategy for Disaster Resilience (NSDR) focus on 'shared responsibility'. This paradigm shift is massive and ongoing, as with its paramilitary origins emergency services operate from a hierarchical model which is at odds with the participatory action model of the community sector, where community engagement depends upon a collegial approach to decision making.

Morphing from the rigid structure of command and control to become inclusive of community engagement and equally valuing NGO participation in all levels of disaster planning, prevention, response

and recovery, is challenging for emergency service organisations, be they career or volunteer based. The emergency services engagement with community should be taken seriously, as Sewell comments, "I believe we have moved into a very dangerous place when 'consultation' is used as a disguise rather than a genuine interest in engaging the needs of any community, particularly when the outcomes are potentially fatal" (Sewell, 2007). Our future relies on a paradigm shift involving societal change. Each of us must take individual responsibility for personal safety and protection of ourselves and our households. The Community Connections research endeavours to extend this individual responsibility to encompass our friends and neighbours within the immediate locality within which we live.

Within the Blue Mountains there is a growing appreciation of the connection between emergency services and NGO's since the 2013 bushfires. The value of this connection as a resilience-builder in daily living needs to be recognised, as the current climate of rather short contracts and funding limited to recovery processes with an 'end date' fails to recognise the integrated nature of such connections in building resilience during daily living and the flow-on effect into disaster resilience.

In various programs and survival brochures we are encouraged to consider how we would survive without power, water, food or transport for an extended length of time, when designing our personal emergency plans. The glaring gap in the continuum is the silent voice of the vulnerable, those requiring assistance with daily living and those reliant on support for daily and/or weekly essential activities. These are the community members most at risk of having no help with evacuation in times of disaster, no resources for transport and no access to crisis communications, warnings and evacuation advice.

Neighbourhoods

It is perhaps not surprising that people over 65 years have more contact with neighbours. They are no longer involved in the work force full time and are likely to have more time for chatting with people. Many people under 65 years would be in the workforce, including most of those with a chronic condition and therefore are likely to have less opportunity to engage with neighbours and other aspects of community. They may shop out of the area, shopping in areas close to work or on the way home that are convenient. This would give them less opportunity for chatting with people while shopping an important opportunity for engagement with local community.

Those who are under 65 years and have a chronic condition could feel less connected to their community because they are having to spend a lot of time out of the area reducing opportunities for engagement within their neighbourhood. How neighbours relate to those who have a chronic condition is unclear though it may be that people relate more easily to those over 65 years who are reasonably able to look after themselves than to those who have a chronic condition at any age.

One of the concerns that was raised through talking with people in interviews and focus groups was the burden that could potentially be placed on neighbours in times of emergency. What can reasonably be expected from neighbours who have their own household and needs to consider in an emergency? To what extent are neighbours likely to be able to deal with households where there are frail aged people or those with a chronic condition who may also have animals that need to be considered? Neighbours can reasonably be expected to be aware of who is around them and to provide assistance where the effect on them is minimal such as in a power outage or heat wage. Where evacuation is required however, it could potentially be quite difficult for neighbours to cope with the needs of a household other than their own, especially where a person with vulnerabilities is concerned.

How people who have a chronic condition relate to their neighbourhoods and how neighbours relate to them requires further exploration. Many people with chronic conditions may wish to avoid imposing on neighbours and/or fiercely defend their independence not wanting to suggest that they cannot manage for themselves. Women who live alone may similarly feel they want to avoid asking neighbours for help as they fear being seen as unable to manage for themselves. Finding the balance in neighbourly relations is not always as easy as might be expected. Most described neighbours as friendly with each other but 'not living in each other's pockets'. Neighbours need to know how to most appropriately support others within their own means and to feel assured that they are not left with responsibility for others beyond their capacities.

Our research revealed that some people had an unnecessarily frightening and solitary experience during the 2013 Blue Mountains bushfires. Various vulnerable community members told how they could not find the means to travel to emergency community meetings, did not have the funds for transport to evacuate, were either unable to access suitable accessible transport options to evacuate with multiple pets, or restricted from travelling on public transport if they had pets and wished to pre-emptively evacuate. They expressed little or no constructive knowledge of how to interpret the complex warning

system whereby residents were provided information with instructions to select the option which best fitted their circumstance. These communications were generally beyond the reach of the most vulnerable and only increased their anxiety.

There needs to be a re-visioning of the community as it is the community who is at the heart of disaster and risk management decision making. The community is usually the first responder to its own dilemmas, and has often developed its own coping mechanisms built on local knowledge and the utilisation of local resources. We need to move from an event-centered mindset when we conceptualise a disaster, and instead move towards embracing a process approach that acknowledges that resilience is built through daily living and community connectedness. It is this connectedness that provides the solid foundation for community resilience in the face of disaster. This is a sustainable approach to building a resilient community as it captures and enacts the lessons learned from a disaster, rather than waiting for the next 'event' to occur – by which time integrated networks and connections between the Council, emergency services and local community services, have long been forgotten.

Recommendation 1: Maintain key connections

That Council, emergency services, and local community services, continue to network and partner in ways which recognise and utilise the capability of each organisation within the community, through adopting strategies which promote a paradigm shift from a top-down approach to emergency planning, response and recovery to being inclusive of community at every level. This would be evidenced through a re-visioning of the community as active agents in the emergency management process through:

- a genuine integration of local community service providers, especially Neighbourhood Centres and peak bodies, into all levels of disaster management processes within the Blue Mountains

- initiating new partnerships, such as local community services representation on the Local Emergency Management Committee

- fostering the continuation of existing partnerships, such as the Disaster and Resilience Working Group, including a commitment from BMCC and Family and Community Services to have their disaster and welfare representatives attend regularly as core members of the Blue Mountains Disaster and Preparedness committee

- the implementation of inclusive language, such as the use of full titles rather than acronyms, in all multiagency communications
- the explanation of policies and procedures previously understood as a known within a particular service
- the inclusion of as many as practicable service providers in multiagency emergency management training and preparedness activities, such as table top and scenario based training

- resourcing of emergency and community services to undertake community engagement and education around readiness and preparedness in high season, when the messages most resonate with the community.

Recommendation 2: Shared responsibility

In order to promote a shared understanding of the responsibility we each have towards ourselves, our neighbours and our community we need to:

- clarify roles and responsibilities of all residents and services during periods of natural disaster and emergency

- reframe the current thinking around individual responsibility for preparedness and readiness, to ensure that those who are unable to implement plans or engage in such activities are supported by neighbours and, when appropriate, the service system

- involve community groups and individuals in local risk assessment

- use various community development strategies to ensure household awareness and generate a sense of shared responsibility within neighbourhoods, e.g. Heads Up For Fire (HUFF), Know your Neighbour, Meet your Street

- identify and develop community leaders who can be supported to develop awareness and promote participation by residents

- provide information, training and education to community members in local neighbourhoods regarding how to support their vulnerable neighbours

- address the issue of transport for the more vulnerable and isolated within our communities, especially in relation to emergency meetings and evacuations

- advocate for change in policy to ensure that in times of declared natural disaster or emergency, Blue Mountains community members with pets can access public transport without fear of penalty

- ensure local government, via its community services section, continues to work with vulnerable people groups.

Recommendation 3: Recognise the role of community organisations

The Community Connections research demonstrates that vulnerable people typically relate to various community services and NGOs in the first instance, rather than friends, neighbours or family. It is therefore imperative that existing community services and NGO's are maintained and resourced appropriately within the Local Government Area. To support enhanced approaches to accessing and supporting vulnerable people within the community, Neighbourhood Centres need greater recognition as trust builders with vulnerable residents through:

- a commitment in policy and strategic direction from community organisations to build stronger links and integration across a range of community groups and services to strengthen a collective and sustainable capacity to respond to the needs of vulnerable residents in daily living and in periods of natural disaster and emergency

- a wider net cast to ensure that vulnerable individuals who are not currently connected with a community service are nevertheless reached

- more specific advertising and marketing of services targeting vulnerable residents

- assisting local community and NGO services to build capacity and develop skills within neighbourhoods and neighbours to support spontaneous community participation and reduce an overreliance on government agencies and services

- working on innovative strategies with Council to provide incentive and support for local communities/neighbourhoods/streets engaging in community focussed self-help initiatives that enhance civic responsibility

- functional partnership models with mainstream service providers such as health, to ensure that vulnerable people within our community are referred appropriately to community focussed services able to promote community connection and social inclusion.

Recommendation 4: Ageing in community

The new Aged Care Reforms and Disability Reforms developed by both the State and Federal Government focus on enablement of the person. Whilst these reforms emphasise the importance of older people and people with a disability to make their own informed decisions, it also depends on the belief system that aged residents (some of whom are most vulnerable) will be able to access the services available to them independently via the My Aged Care Website. This approach, whilst plausible in theory, will create a number of issues for our most vulnerable- namely a loss of community connection as they won't have the local sector supported positions provided, such as those of the support workers in Neighbourhood Centres or the Aged and Disability Service Officer positions in Council, to help them negotiate internet access issues. Therefore we need to consider this issue in any forward planning. It is essential, therefore, to utilise appropriate methods of communication which are accessible and local to the over 75's, regarding the various services available to them for social support and community engagement; relying on the My Aged Care Website may work well for future generations, but not so well with the existing generation of aged residents.

Due to a larger than National average ageing population, the Blue Mountains needs to move fast and continue working towards an Ageing Strategy, and as such:

- resources for must be identified and developed to support people over 75, because their

community connections are less viable as they age

- it is essential to utilise appropriate methods of communication which are accessible and relevant to the over 75's, regarding the various services available to them for social support and community engagement; relying on the My Aged Care Website may work well for future generations, but not so well with the existing generation of aged residents

- health, and providers of specific health care services to the aged within the community, must begin formal partnerships and dialogues with general community services such as Neighbourhood Centres, to ensure that all possible opportunities are provided for the aged to link in with their communities and improve their social connections.

Recommendation 5: Formal strategy for vulnerable people

Due to the identified issues of younger people living with a disability and chronic illness, the Blue Mountains needs to review the potential for a formal strategy to address these needs within the community, and as such:

- Council needs to consider developing a strategy that can better address the needs of the vulnerable, and those living with a disability or chronic illness

- Council needs to provide consultation with, and programs in partnership with, services that assist the 40-65 age group who have a disability and/or chronic illness, in keeping with the Disability Inclusion plan

- providers of specific services to this group within the community must begin formal partnerships and dialogues with general community services, such as Neighbourhood Centres, as policy, to ensure that all possible opportunities for the 40 to 65 age group to connect with their communities and improve the social connections are afforded them.

Recommendation 6: Enhance community connections and resilience of vulnerable people

Age, disability, chronic illness, ethnicity and socio-economic conditions are all factors contributing to the social marginalisation of vulnerable people and community groups. We need to recognise the existing strengths and capacities of vulnerable people, and acknowledge, through providing assistance, their self-identified needs. These may be as diverse as irrational fears, worry over lack of finances to meet emergency disaster needs and transport for daily living. Recommendations to enhance the community connections and resilience of vulnerable people are:

- the provision of community based programs which aim to integrate, or at the very least encourage, inclusion in wider community activities; the community sector requires resourcing to meet these needs as personnel, equipment and location are resource intensive

- re-envisage vulnerable community members from socially marginalised people to contributors to social and cultural diversity, with unique strengths and abilities e.g. some may have time available to volunteer as well as knowledge of who else is vulnerable and in need

- local Neighbourhood Centres and similar NGOs are best placed to advocate on behalf of vulnerable community members and groups. They must be sufficiently resourced otherwise the voice of the marginalised and vulnerable will fade rather than strengthen.

Recommendation 7: Vulnerable persons register

As recommended by the 2009 Victorian Bushfires Royal Commission, some form of accounting for the location and needs of vulnerable members of the community needs to be initiated, and this would require:

- a centralised vulnerable persons register within the Blue Mountains
- maintenance and review by the appropriate agencies i.e. the Ministry of Policing and Emergency Service, Blue Mountains City Council, Local Emergency Management Committee
- resourcing to support such an initiative and appointment of an appropriate agency or service to manage this function across the Blue Mountains Local Government Area

- strong administration and coordination of the register
- clear development and delineation of responsibilities between agencies, specific to the actions to be taken by individual agencies to assist persons on the vulnerability register
- clear identification of the resources that would be deployed or made available by specific agencies in the event of activation of a Vulnerable Persons Register in a natural disaster or emergency.

Future research possibilities

Measuring community resilience is complex due to the dynamic nature of communities and the difficulties of measuring factors which do not easily lend themselves to metrics. The Bushfire and Natural Hazards Institute aim to publish the 'Australian Natural Disaster Resilient Index' within the next three years. This could inform further research regarding marginalised and vulnerability mapping within the Blue Mountains.

Other areas for research include:

The female to male ratios in the emergency services when compared with the community services could be investigated further as a factor to improve shared responsibility.

Managing relations between neighbours and how to relate to the vulnerable is an area for further investigation that could help to strengthen community resilience.

Differences between males and females regarding dealing with chronic conditions and isolation were uncovered in the Community Connections research, and these require further investigation. It was not possible within the scope of the project to pursue and outline the differences evident in the research.

Strategies to improve engagement between various service agencies and community need to be explored.

Investigating the optimum population levels at which organisations lose contact with people could assist with understanding the optimum level at which communities are able to function most effectively through their networks. The meaning and implications of shared responsibility requires exploration and consideration at a community and household level.

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Appendices

Appendix 1: Community Connections survey

Connected Communities Project
invitation to participate

This research is intended to identify community connections in the Blue Mountains.

We would like ALL community members to participate in this survey.

Are you connected to your community?

Do you assist someone in your street or neighbourhood with household tasks and/or daily activities?

Do you need assistance with household tasks and/or daily activities?

Your contribution to this research is very much appreciated. It is important to receive your feedback so that we can be more informed about community connection and support needs.

The survey will take less than 10 minutes to complete.

Thank you!

Are you interested in participating further in the Community Connections Project?

Are you interested in volunteering with your local Neighbourhood Centre?

If you are over 65 years old and interested in being further involved in the research by participating in a focus group and/or interview about your community connections at the Springwood or Katoomba Neighbourhood Centre, please contact:

- Katoomba Neighbourhood Centre **4784 1117**; or
- Springwood Neighbourhood Centre **4751 3033**

If you would like to be part of an Older People's Advisory Committee of Council, please contact:

- Blue Mountains City Council Aged and Disability Services Officer **4780 5546**

Please return this survey to Council as soon as possible by posting to Locked Bag 1005 Katoomba 2780 or by dropping the survey into one of the Library Branches, Neighbourhood Centres or Council's Customer Service Counter at Springwood or Katoomba. Or alternatively if you would prefer to complete the survey online, below is the link to the survey on Blue Mountains Have Your Say. The survey closes Monday 1 September 2014.

http://bluemountainshaveyoursay.com.au/connected-communities-project

Springwood Neighbourhood Centre Co-operative Ltd

blue mountains City Council

KNC *Connecting our Community*
KATOOMBA NEIGHBOURHOOD CENTR

Charles Sturt University

Survey Questions *(please tick or circle your answer as required)*

A1. Your gender: ☐ Male ☐ Female ☐ Other **A2.** Your postcode: [ ]

A3. Your age *(please tick one box)*: ☐ 18-25 ☐ 25-40 ☐ 40-65 ☐ 65-75 ☐ 75+

A4. Do you identify as: ☐ Aboriginal ☐ Torres Strait Islander ☐ Non-Indigenous

A5. Your current living arrangements are best described as living with:
☐ Spouse/partner ☐ Children ☐ Parents ☐ Others ☐ Alone

A6. Is speaking English difficult for you? ☐ Yes ☐ No

A7. Do you have a chronic illness or disability that limits your everyday activities? ☐ Yes ☐ No

B. Connections in your local area *(please tick "Yes" or "No")*	Yes	No
Do you attend local festivals or other community activities?	☐	☐
Do you volunteer?	☐	☐
Do you go out for entertainment at least once a month, e.g. cinema, theatre or restaurant?	☐	☐
Are you involved in any local associations, clubs, religious or other group?	☐	☐
Do you share a meal with friends at least once a month?	☐	☐
Do you require assistance with household tasks, such as putting bins on the street?	☐	☐
Do you provide assistance to people in your neighbourhood with household tasks such as putting bins on the street?	☐	☐

C. If you require help who is most likely to provide it? ☐ Neighbour ☐ Family ☐ Friend ☐ No one

D. How often do you ... ?	Daily	Weekly	Monthly	Yearly	Never
see family members	☐	☐	☐	☐	☐
see friends	☐	☐	☐	☐	☐
attend social gatherings	☐	☐	☐	☐	☐
talk with people in your street	☐	☐	☐	☐	☐
chat with someone while shopping	☐	☐	☐	☐	☐

E. To what extent do you feel *(please circle a number for each)*:	Not at all				Very much
connected to your neighbourhood	1	2	3	4	5
neighbours in your area help each other out	1	2	3	4	5
your neighbourhood is clean and tidy	1	2	3	4	5
your neighbourhood is friendly	1	2	3	4	5
support with daily activities is available to you	1	2	3	4	5
safe in your neighbourhood, and	1	2	3	4	5
able to access information on services you need	1	2	3	4	5

Please return this survey to Council as soon as possible by posting to Locked Bag 1005 Katoomba 2780 or by dropping the survey into one of the Library Branches, Neighbourhood Centres or Council's Customer Service Counter at Springwood or Katoomba. Or alternatively if you would prefer to complete the survey online, below is the link to the survey on Blue Mountains Have Your Say. The survey closes Monday 1 September 2014.

http://bluemountainshaveyoursay.com.au/connected-communities-project

Appendix 2: Interview and focus group questions

Focus group and interview questions

Interviews involved discussion of the following questions;

What kind of contact with people do you have in the local neighbourhood and more broadly across the Blue Mountains?

What does neighbourhood mean to you?

Do you have people who you feel really listen to you and appreciate you?

Do you have concerns about how you manage at home? What kind of support do you feel you need and whether you have that support and who provides it or should provide it?

If you had a fall or were ill, who would look after you?

Can you tell me about your experience last year when the fires were on?

How did you first hear about the fires? Where were you, were you alone?

What did you feel when you first heard?

And the next few days, did your feeling change? (prompt: fear; unworried?)

What did you do? (prompt: phoned someone; bought food; packed a bag?)

When did you feel safe again?

What would have helped you cope better?