



Australian Government

Department of Infrastructure, Transport,  
Regional Development and Local Government



ROAD SAFETY GRANT REPORT  
2008-01

# Aboriginal People Travelling Well: Issues of safety, transport and health

October 2008

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**No. 2008-01**

**Aboriginal People Travelling Well:  
Issues of safety, transport and health**

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**October 2008**

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## DOCUMENT RETRIEVAL INFORMATION

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Report No.	Publication date	No. of pages	ISBN
2008-01	October 2008	120	978-0-642-25583-9

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### Publication title

Aboriginal People Travelling Well: Issues of safety, transport and health

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### Funding organisation [Available from]

Department of Infrastructure, Transport, Regional  
Development and Local Government  
GPO Box 594, Canberra, ACT, 2601  
Website: [www.infrastructure.gov.au](http://www.infrastructure.gov.au)

### Reference No.

October 2008 / INFRA-08298

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### Abstract

The starting point for this project was the proposition that safe and sufficient transport should be accessible to everyone, and that a lack of safety can be a consequence of insufficient or inadequate transport. The study themes and approach were informed by a series of forums held in 2005, 2006 and 2007, involving representatives of Aboriginal organisations and officers of government agencies. Consultations with focus groups and personal interviews were conducted, and case studies recorded, in several Aboriginal communities (Adelaide and the far west coast region of South Australia). Literature reviews were conducted in the areas of driver licensing, seatbelt and restraint use, and the transport issues related to Aboriginal health and disability.

The availability of safe and sufficient transport has diverse implications for safety, health and welfare. Recommendations were made in relation to improving driver licensing, seatbelt and restraint use, provision of public transport and programs to address the problems of drink driving and driving while affected by drugs.

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### Keywords

Indigenous road safety, safe transport, indigenous driver licensing, restraint use.

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### Notes

- (1) Road safety grant reports are disseminated in the interest of information exchange.
  - (2) The views expressed are those of the author(s) and do not necessarily represent those of the Australian Government or the Department of Infrastructure, Transport, Regional Development and Local Government.
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# EXECUTIVE SUMMARY

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## Background

Mobility is a basic human need, and transport is the way that it is achieved. Walking is the oldest form of transport, but in modern societies other forms of transport predominate – chiefly motorised land transport. The starting point for the work reported in this document is the proposition that safe and sufficient transport should be accessible to everyone.

The sufficiency of the transport available to an individual or to a community depends on their needs (e.g. when and where they need to travel) in relation to the transport options available to them. The options available are partly related to personal or family resources (financial and other), but transport availability depends greatly on community infrastructure, such as roads, and on publicly available transport systems, such as buses, trains and scheduled air services. Some transport needs can be increased or reduced by the geographic placement of services or jobs.

Lack of safety can be a consequence of insufficient or inadequate transport. For example, given a need to travel – for work, education, medical services, family or cultural reasons, or recreation – and limited transport options, a person might travel in an unsafe way rather than not travel. As discussed in this report, the ways in which the adequacy of transport can interact with safety are diverse.

Transport safety has many facets, including in the case of road transport, safe vehicles, roads and drivers. In focusing on the nature and consequences of insufficient or inadequate transport, we offer an additional perspective, with the aim of enabling new approaches to prevention.

About 25,000 people who live in South Australia identify as being Aboriginal. The circumstances and demographic characteristics of this small part of the total population provide reasons to expect that their transport needs, and the availability of transport options to them, differ from the general population. For example, much larger proportions of Aboriginal people than others live in rural and remote areas, and are young. While the general principles of safe and sufficient transport apply to the whole population, these and other distinct characteristics of the Aboriginal population of South Australia provide the basis for the focus of this project on Aboriginal people.

## Methods

This project required multiple methods, predominantly qualitative. The project has been conducted as action research, and has caused or enabled certain changes, as described below. Ethical conduct of research is essential; ensuring that this was achieved occupied a considerable part of the time available for the project. The main aspects of the method are summarised here.

### Aboriginal People Travelling Well (APTW) forums

The study themes and approach were informed by a series of forums held during 2005 and 2006. The forums were convened by the study team, under the title 'Aboriginal People Travelling Well'. Participants in the APTW Forums were mainly representatives of Aboriginal organisations, officers of government agencies and researchers. A key result of the forums was identification of a set of twelve issues related to the safety and sufficiency of transport for Aboriginal people in South Australia.

## **Literature reviews**

We searched for and reviewed existing literature, both formally published work and 'grey' literature. The latter is particularly important for a project such as this one, because much of the relevant work has been done on a small scale and out of the mainstream of research and publication. As such, the findings often have not been published, or not in prominent ways. Limits on the time and other resources available to this project constrained the scope of the literature reviews. Four topics were selected for attention, informed by the discussions of the APTW Forums. The topics are:

- Driver licensing
- Seat restraints and compliance with restraint laws
- Transport issues relating to Aboriginal health, and
- Transport issues relating to Aboriginal disability.

## **Focus groups**

Semi-structured consultations with focus groups were conducted in several Aboriginal communities, both in suburban Adelaide and in the Far West Coast region of South Australia.

## **Personal interviews and case studies**

According to the study plan, focus groups were to be complemented by individual structured interviews. An interview questionnaire was developed and its use was approved by ethics committees. However, this mode of data collection did not prove to be successful in the field, in the types of settings relevant to this project. Case studies were obtained by means of unstructured interviews with individuals; this mode of data collection was successful.

## **Ensuring ethical research practice**

All research should be conducted in accordance with ethical principles, guidelines and laws. Special issues and obligations apply to research involving Aboriginal people. This project involved focus groups and interviews with Aboriginal people. Ensuring ethical acceptability of the method required a lengthy process involving seeking clearances from two ethics committees. The process commenced soon after funding was received. Final clearance of the method and instruments for fieldwork was obtained in May 2007, more than two-thirds of the way through the initially agreed project time-line. Even more time was required to develop relationships with Aboriginal community groups within which understanding of the project, and trust concerning the way it would be conducted, were sufficient to allow field work to commence. This process commenced before the funding application was made.

## **Action research**

Research that results in change in the course of the research can be described as action research. This project caused or contributed to changes relevant to the subject of the research. These are described below and in the report. Actions arose in two main ways. The first was that the research processes – particularly the APTW Forums and the extensive consultation undertaken in the course of the project – initiated or strengthened connections between individuals and agencies which, in several instances, resulted in outcomes such as the initiation or change of a program. The second was that some issues and problems that emerged during focus groups and interviews were amenable



to action by study team members. The relationships developed with Aboriginal communities, which allowed field work to be undertaken, also created an obligation to offer assistance with such issues.

## Findings and results

### Findings

The findings of this project are based on primary research in a small number of communities, supplemented by other information from the reviewed literature and from consultations and forums, involving people with wide experience. While it is likely that some broad themes reported here are applicable more generally, caution must be exercised in making this assumption. The following themes emerged in this project and are likely to apply in many settings:

- Access to safe transport for Aboriginal people is restricted by their economic circumstances.
- The poor health of Aboriginal people generates high levels of need for safe access to a wide range of health and disability services.
- Aboriginal culture drives a need to belong to a place and to meet the obligations to that place. Since the obligations often require a person to go to a place far from where they live, this generates a need for long distance travel often over roads that are of a lower standard and, because of economic circumstances, in vehicles not suited for this sort of travel.
- Responsibility to family and kin, especially when an important person dies, generates a need for large numbers of Aboriginal people to travel at times of high stress.
- Access to a drivers licence is not straight forward. Problems with literacy and language often present barriers, as does access to vehicles and instruction. These barriers to licensing generate increased risk of Aboriginal people driving while unlicensed and this offence is one of those most often charged by police.

In addition to these broad findings, many more specific experiences, concerns, suggestions or recommendations were reported, emerged in discussions, or were raised at APTW Forums. These are the subject of most of the Results section of the report, and are the basis for most of the Recommendations below.

### Results of action research

The project caused, enabled or prompted numerous changes intended to improve the safety or sufficiency of transport for Aboriginal people in South Australia. Some of these are listed and described in the report (section 3.5.1).

At least some of these have potential for use as models, which could be applied in other parts of South Australia or elsewhere in Australia, perhaps with modifications. Some might also have applicability to other segments of the population (e.g. the model for facilitating driver training and licensing might be applicable to some migrant groups).

A relatively intangible, but important, result of the project is the emergence of a functioning network for information sharing, problem identification and problem solution. This network is operating largely by telephone and email and, hence, it is not much limited by geographical distance. This network has been enabled by several aspects of the project.

The first is the creation and strengthening of communication and collegiality between the numerous 'players', who (variously) have relevant knowledge, needs and potential solutions. The APTW Forums were the foundation for this.

The second has been a willingness to cast a net widely across conventional institutional and conceptual boundaries when framing issues, obtaining information and advice and when seeking solutions. The location of the project in a university setting may have facilitated the participation of government agencies; a formal governmental inter-sectoral process might have raised problems to do with institutional boundaries and responsibility in a way that this project did not.

A third is that the project has valued small-scale problem-solving as well as the identification of large and structural issues. This is important in at least two ways. The positive changes resulting from solving even small problems have value in themselves and for the direct beneficiaries. They also have value for the overall APTW process, encouraging participants to become and remain engaged because of the positive, 'can do', character of the project.

Some outcomes take the form of changes in the practices of government agencies. A strength of such changes is their potential to persist, because they are based on government-funded programs. For example, tailoring existing driver road accident awareness and preparedness programs to be relevant to Aboriginal people living remotely, and delivered in a whole of community rather than an age-targeted setting.

At the time of writing – that is, at the end of the period of APTW activity enabled by the funding under which this project has been undertaken – there is an accelerating flow of approaches from government agencies, non-government organisations and community groups, who are aware of the project, with interest in acting on particular issues raised in this report. This can be seen as a process which goes beyond the APTW project, and has potential to persist – though there is a risk that this relatively new and small process could peter out without some level of further facilitation and encouragement.

## **Conclusions**

### **Safety and sufficiency of transport for Aboriginal people**

The availability of safe and sufficient transport has diverse implications for safety, health and welfare. Among many examples in the report are the necessity of transport to access health services, education and employment, and to enable the maintenance of family and community connections. Less direct connections include heightened social pressures for residents of isolated communities who lack transport that would enable them to leave when they want to, and the potential of barriers to obtaining a drivers licence to increase the likelihood of negative interactions with the justice system.

Transport deficiencies are experienced by Aboriginal residents of suburban Adelaide, as well as by residents of remote communities. The limitations experienced by residents of remote communities tend to be more obvious, and often have substantial consequences for health and wellbeing.

Family relationships and kinship are strong and influential aspects of the life of most Aboriginal people, whether they live in urban or non-urban places. Travel necessitated by such relationships is common and often complicated by insufficient transport. Examples are travel required to attend funerals and to visit and support sick or disabled relatives. Transport problems are more likely for residents of remote areas.

Some barriers to transport access are due to lack of knowledge about services and systems rather than to inadequate services per se. For example, we were told of a practice of calling a taxi to transport a sick person to hospital, because of fear that ambulance charges would be high. In fact, programs exist which would have provided free transport by ambulance.

Situations of poverty impact on the ability to drive legally and to maintain and register cars. Unpaid fines and defected cars can all lead to the loss of a drivers licence.

The absolute size of the Aboriginal population of South Australia is not very large. While a large proportion lives in rural and remote regions, most of the people live in a relatively small number of discrete communities, facilitating service provision. In contrast, urban-dwelling Aboriginal people are more interspersed with the non-Aboriginal population, though with regional concentrations (e.g. near Port Adelaide).

**The research process**

A diverse range of agencies was found to be involved – or had potential to become involved – in solving problems of insufficient transport for Aboriginal South Australians. At the start of the project, we found many of these agencies to be operating in isolation. The project provided opportunities for representatives of these agencies to meet and share knowledge and experiences. In many instances, a strong willingness was evident to work together in new ways. During the course of the project a number of such initiatives was put into effect, often quickly and at little cost. Some further issues identified in the project are amenable to similar solutions. Other issues, however, are related to structural factors of disadvantage, remoteness, disability and so on, and these will require more substantial responses.

**Future research**

The scope of this project was, perforce, limited to a few communities in one state. A wider range of localities should be studied.

Future research will enrich the understanding of the similarities and differences in different localities and communities. It will spell out in more detail the relationship between broad factors such as economic wellbeing, and health, and the ability of Aboriginal people to move safely to meet their cultural and family obligations, and for reasons of work, education, health and recreation.

**RECOMMENDATIONS**

The consultative and qualitative methods used in this project resulted in many issues being raised by individuals or organisations which are, or can be seen to imply, recommendations. These are presented as Recommendations 1 to 17 below. The project as a whole also prompted the formulation of a broader recommendation (Recommendation 18).

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## ACKNOWLEDGEMENTS

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The authors acknowledge the funding support provided by the Australian Government, through the Department of Infrastructure, Transport, Regional Development and Local Government. The project was initially supported through a Seeding Grant from the Flinders University–Industry Collaborative Research Scheme (UICRG), and is an in-kind project endorsed and supported by the Cooperative Research Centre for Aboriginal Health (CRCAH), and the Aboriginal Health Council of South Australia (AHCSA).

Many persons have been helpful and generous in providing their time to explore the issues in this report, especially those who have contributed to the Aboriginal People Travelling Well forum series, Aboriginal community members from Yalata, Ceduna and the suburbs of Adelaide, and agency representatives. In particular, thanks go to:

Roxanne Adams	Alan Everest	Lorraine Haseldine
Bobby Agius	Jordan Falla	Geoff Hawkins
Anne Amos	Ben Farewell	Ben Haythorpe
Brian Axleby	Helen Farinola	Clayton Helps
Dr Trevor Bailey	Grant Feidler	Joy Helps
Tony Barrett	Louise Flood and the	Dr Stephen Helps
Trevor Bromley	congregations of St Barts	Paul Henrys
Janice Braun	and St Matthews	Susan Henrys
Mary Buckskin	Anglican Churches	Peter Heylen
Sue Castledine	Allan Foster	Dora Hunter
Pastor Peter Chambers	Trudy Foster	Tania King
and congregation	Deb Frank	Francesca Kinnane
Alwin Chong	Michael Frost	Det Insp Trevor Lovegrove
Cyril Coaby	Dr Liz Furler	Tony Lindsay
Angela Commane	Julie Galanos	Sharon Meagher
Danny Curtis	Pierre Gebert	Lorraine Merrick
Rhiannon Dawes	Adrienne Gillam	Maree McColm
Lionel Dodd	Leah Glover	Wallace McKittrick
Peter Dodson	Sherree Goldsworthy	Kathy Meier
Bernadette Donaldson	Cameron Gordon	Debra Miller
Avis Dunnett	Elaine Gordon	Hayden Miller
Tim Dunning	Paul Gregory	Peter Miller

Gwyn Elson	Peter Hall	Carolyn Modra
Alvis Morrison	Rev Alex Rodgers	Nora Varcoe
Helen Murray	and congregation	Kingsley Varcoe
Lindsay Nash	Rosemary Ryan	Ass. Prof. Malcolm Vick
Petra Nisi	Don Saltmarsh	Irene Wanganeen
Jade Norwood	Senior Sergeant Graham	Klynton Wanganeen
Lindsay Osborn	(Shades) Schaedel	Lisa Warner
Westley (Mally) Owen	Leonie Scott	Judith Welgraven
Allie Paerata	George Shearer	Caroline Wilson
Chari-lee Peel	Chandra Sluggett	Maxine Wilson
Lauren Peel	Alexander Stengue	May Wilson
Jenny Pilgrim	Terry Stewart	Rachelle Wingard
Braddon Queama	Kerry Symons	Bonnie Wizer
Brian Queama	Philip Treloar	Bob Wright
Bob Ramsay	Garry Trowbridge	Lindsay Wyatt

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## ABBREVIATIONS

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AARD	Aboriginal Affairs and Reconciliation Division (formerly DAARE)
ABS	Australian Bureau of Statistics
ACE	Adult Community Education project
ACS	Automated Coding System
ADAC	Aboriginal Drug and Alcohol Council (South Australia)
AHCSA	Aboriginal Health Council of South Australia
AIHW	Australian Institute of Health and Welfare
APOSS	Aboriginal Prisoners and Offenders Support Service
APTW	Aboriginal People Travelling Well
APY Lands	Anangu Pitjantjatjara Yankunytjatjara Lands
ATSB	Australian Transport Safety Bureau
CDEP	Community Development Employment Program
CHD	Coronary Heart Disease
CKD	Chronic Kidney Disease
CVD	Cardio Vascular Disease
CRCAH	Cooperative Centre for Aboriginal Health
DAARE	Department of Aboriginal Affairs and Reconciliation (now AARD)
DTEI	Department of Transport, Energy and Infrastructure (SA)
FFP	Flexible Funding Pool
GP	General Practitioner
HACC	Home and Community Care
ICD-10	International Classification of Diseases
MAP	Mobile Assistance Patrol
NPY	Ngaanyatjarra Pitjantjatjara Yankunytjatjara Womens Council
OIPC	Office of Indigenous Policy Coordination
PATS	Patient Assisted Travel Scheme
RFDS	Royal Flying Doctor Service
SAPOL	South Australia Police
SRA	Shared Responsibility Agreement
TAFE	Technical and Further Education
WHO	World Health Organisation



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# 1 INTRODUCTION

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## 1.1 Background

Key indicators of advantage (health, education, employment and housing) identify Aboriginal people as being amongst the most disadvantaged people in Australia today. The underlying societal and institutional causes of this physical and emotional disadvantage are complex, and are historically based in the dispossession and exclusion experienced by Aboriginal people at the time of colonisation, and in ongoing social, political and economic disadvantage (ABS/AIHW 2005). A recent study confirmed the link between transport and social exclusion, another factor of disadvantage (Church A, Frost M et al. 2000). In terms of social capital, transport sits within the structures that provide access for people to a range of resources that enable or empower them to engage in decision making and to contribute to the development of policy (Serageldin I and Grootaert C 2001). Building on the Declaration of Alma-Ata (World Health Organisation 1978) and the Ottawa Charter for Health Promotion (World Health Organisation 1986), the World Health Organisation (WHO) states in the Jakarta Declaration that:

“The prerequisites for health are peace, shelter, education, social security, social relations, food, income, the empowerment of women, a stable eco-system, sustainable resource use, social justice, respect for human rights, and equity. Above all, poverty is the greatest threat to health.”  
(World Health Organisation 1997)

To date the extant literature takes a fragmented view of the needs for safe transport systems for Aboriginal people in particular. Internet searches uncovered a huge number of sites referring to Aboriginal transport needs. A formal literature search revealed many articles dealing with individual aspects of Aboriginal transport needs and safety but there were no systematic analyses that brought together a coherent view of the issues. This report pulls together the fragmented literature and through interviews and focus groups with Aboriginal people in different settings, starts to develop a coherent view of issues and possible responses. It is supported by separate detailed literature reviews on Aboriginal health and disability and transport safety issues.

The safety and wellbeing of many Aboriginal people is adversely affected on a daily basis by lack of access to transport that is suitable for their needs, timely in delivery, and safe for the conditions. Notions of injury and safety differ between cultural groups, and it is important to understand that the Aboriginal concept of safety is not only the right to be at no risk of a physical injury, but also to live with a feeling of safety (National Public Health Partnership 2005).

Approximately 25,000 Aboriginal people live in South Australia in a wide range of geographic settings. Almost half live in urban settings mainly in metropolitan Adelaide. The remainder live in rural and remote areas with 6,500 living in remote areas including the Anangu Pitjantjatjara lands of the north west of the state and the unincorporated areas of the north and north east of the state. Almost 60 percent of Aboriginal people are less than 25 years of age and compared with their non-Indigenous counterparts, there are very few Aboriginal people over the age of 55 years. This is due to premature death from diabetes, kidney and cardiovascular disease, accidents and violence (Hels YLM and Harrison JE 2004; ABS/AIHW 2005).

### 1.1.1 Health and disability major factors in transport needs

Health or perhaps more accurately lack of health is an important driver of Aboriginal peoples need for transport. It is important to understand the Aboriginal view of health.

'Aboriginal health is not just the physical well being of an individual but also the social, emotional and cultural well being of the whole community in which each individual is able to achieve their full potential thereby bringing about the total well being of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life.' (NAHSWP 1989)

Therefore, negative impacts on health are not restricted to physical disease and injury but encompass a range of issues that relate to the overall ability to meet cultural and social responsibilities. The need for treatment of disease, injury and disability often conflict with the need to support family and to attend to responsibilities to land and family, including attendance at the relatively numerous funerals that cast a shadow over Aboriginal South Australians.

The geographic distribution of Aboriginal people further increases the need for Aboriginal people to move about South Australia. Many Aboriginal people in urban regions have cultural ties to land and family living in distant places. Illness, injury and death are key factors in the need to travel urgently, often over large distances and often while suffering the impact of poor health.

Renal dialysis for example requires inpatient treatment several times a week. This treatment is offered in a limited number of centres. As kidney disease is prevalent among Aboriginal South Australians, many are faced with frequent trips to dialysis centres. A spatial analysis of Aboriginal health issues (South Australian Aboriginal Health Partnership 2006) shows that Aboriginal people with advanced kidney disease tend to move to be within reach of dialysis centres. This results in whole families moving and generates a large number of "return to country" visits both for the patient and their supportive family.

There are higher risks associated with rural and remote living, particularly in regard to driving at higher speeds over longer distances, often over poorer road conditions (Edmonston C, Dwyer J et al. 2002), including unsealed road surfaces (Cercarelli, R 1994). Many discrete communities do not have year round road access due to weather or environmental conditions (Bailie R, Siciliano F et al. 2002).

Disability issues are less well understood. Research concerning Aboriginal disability is limited and there is every chance that the true impact of disability is far greater than that measured by currently available data.

There is a dearth of systematic literature on Aboriginal disability. Aboriginal disability policy and services operate in the shadow of mainstream services and ideas in a system that diversifies responses across a wide range of departments and agencies.

Aboriginal concepts of disability appear to be poorly understood by policy makers and service providers. There has been little research published on Aboriginal disability possibly because the small numbers of Aboriginal people involved with medical disability has limited the study of this issue. However, while numbers are small in relative terms the prevalence is much greater and more complex than in non-Aboriginal society. There is a great need to study Aboriginal disability in a systematic and culturally sensitive manner in order to determine what services are needed.

The lack of good information about Aboriginal disability in general has an impact on the understanding of transport issues for Aboriginal people with a disability and their families. We could find no literature that systematically addresses Aboriginal disability needs and issues of access and transport. Issues of access to services are raised for all disabled people and it is clear that the population distribution and economic and social well being of Aboriginal people generates specific critical needs.

Nevertheless, it is important that services are delivered in a manner that does not increase the costs to families by requiring a great deal of travel. Disability needs are less common than general health needs, so safe transport systems will either need to piggyback on the health system arrangements or will need to be especially arranged for individuals and their families.

### **1.1.2 Interaction between health issues and transport systems**

The travel patterns of Aboriginal people are, by necessity, very different from those of the non – Aboriginal majority for which transport systems in South Australia have been developed.

It is not only the need for people to travel that generates problems for Aboriginal people. For example, in remote areas the adequacy of the road infrastructure is a factor in the range of resources that can be delivered to a community, and subsequently maintained (Bailie R, Siciliano F et al. 2002). It has been shown that unsealed roads leading into communities contribute significantly to dust nuisance, with eye conditions, skin disorders and respiratory infections being consequences to health (Bailie R, Siciliano F et al. 2002). Tasks such as routine testing of water samples for bacterial contamination become problematic due to lack of refrigerated transport to testing facilities.

In rural and remote areas, infrequent or non-existent public transport to major centres may prevent access to tertiary and specialist health services, or inhibit regular treatment and assessment. In this situation, many Aboriginal people go without health services that the majority of Australians see as a right, and those who are assisted to travel to treatment are often left in the major centre with no means of return to country. Relatives who travel to support persons needing treatment receive no support, further exacerbating the impact of poverty on families.

This presents a number of problems, among them vulnerability to influences outside their regular life, isolation from relatives and community at a time of emotional as well as physical need, isolation in terms of language barriers between Aboriginal groups, and between Aboriginal people and administrative institutions.

### **1.1.3 Access to transport increasing risks to Aboriginal people**

Access to transport is not only a problem in rural and remote areas. In all areas it is a dominant factor for many Aboriginal people, effectively determining the extent to which participation in employment, social engagements, cultural events and responsibilities and day-to-day business of life is possible. Isolation from family and community, inability to fulfil cultural obligations, limitation of education and employment opportunities, and restricted access to services such as primary and specialist health care can result (ANCD 2000; ABS/AIHW 2005).

Difficulty in obtaining a drivers licence can prompt inappropriate behaviour, including driving unlicensed, driving under-aged, and involvement in road traffic accidents due to lack of experience. Barriers may include language differences, reading and writing difficulties, distrust of police officers (in areas where licensing is overseen by local police), and apprehension about dealing with agencies (government licensing authorities). Conditions of poverty restrict access to safe private vehicles, often leading to use of lower standard cars and overcrowding (Watson M, Elliott P et al. 1997).

Kinship obligations may also influence an Aboriginal person's decision to drive unlicensed. Pressures to drive come from a variety of sources, in some cases from people to whom it is culturally inappropriate to refuse, and for attendance at events that it is culturally important to attend. Time restrictions may also influence people to drive whether licensed or not.

For urban dwelling Aboriginal people, emotional distress and depression may result from being unable to travel at particular times to traditional country, and lack of means of travel may influence people to use unsafe or illegal means in order to fulfil cultural obligations (unlicensed drivers, unregistered and unsafe vehicles).

Supporting efforts that might make travel more accessible, whether through provision of public or community transport, subsidised health travel, or increased accessibility to driver education and

training, will assist Aboriginal people in making their own choices and strengthen their ability to avoid cycles of behaviour that result in negative outcomes.

#### **1.1.4 Transport safety**

Many issues are involved in reliably reporting on road injury and death for Aboriginal people, and there are a range of factors influencing road safety outcomes, for example:

- shortcomings in data collection and identification of victim continues to be a major obstacle in reliable reporting of Aboriginal injury and death (Moller 1996; Brice 2000; Helps and Harrison 2004; ATSB 2006; Helps and Harrison 2006),
- While acknowledged to be an undercount, it is known that Aboriginal people are about three times more likely to be fatally injured in motor vehicle accidents than non-Aboriginal people (Helps and Harrison 2004; The Honourable Jim Lloyd MP Minister for Local Government Territories and Roads 2006; The Honourable Jim Lloyd MP Minister for Local Government Territories and Roads 2006),
- It is also known that Aboriginal people are hospitalised for motor vehicle injury at least one and a half times the rate of non-Aboriginal people (Helps and Harrison 2006),
- Over 60% of Aboriginal vehicle occupant fatalities overall are for those people not wearing a seat restraint (The Honourable Jim Lloyd MP Minister for Local Government Territories and Roads 2006). A large proportion of motor vehicle fatalities in the Northern Territory (1998–2001) for Indigenous people were for those not wearing seatbelts (ATSB 2006). Overcrowding and not wearing seatbelts are major issues in Western Australia (Williams S and Maisey G 1991; Edmonston, Dwyer et al. 2002; Office of Road Safety WA 2007) and for the whole of Australia (ATSB 2004),
- Although high for both population groups, alcohol involvement in fatal accidents in the Northern Territory (1998–2001), and in Western Australia and South Australia, was much higher for Indigenous people than for non-Indigenous people, whether drivers, motorcycle riders, or pedestrians (Brice 2000; ATSB 2006; Office of Road Safety WA 2007),
- A high proportion of Aboriginal fatalities are for unlicensed drivers, who lack education and training on road safety and safe driving practice (Macaulay, Thomas et al. 2003),
- Speeding and road quality, particularly in rural areas are acknowledged risk factors (Williams S and Maisey G 1991; Edmonston, Dwyer et al. 2002; Treacy, Jones et al. 2002),
- Unsuitable, un-roadworthy vehicles and remote living are established risk factors for Aboriginal road injury (Cercarelli, RL, Ryan et al. 2000; Treacy, Jones et al. 2002),
- More remote areas (Watson M, Elliott P et al. 1997; Treacy PJ, Jones K et al. 2002),
- The severity of road accident outcomes increase with the ageing and deterioration of the condition of the vehicle (Paine 2000), and
- Indigenous populations have also been identified as being at greater risk of mortality and hospitalisation than the rest of the population, particularly in rural and remote areas, and therefore in need of further investigation and intervention (Edmonston C, Dwyer J et al. 2002).

In 2000, a critical review and research report came to the conclusion that literature pertaining to Indigenous injury from road trauma was underdeveloped, and that there was little available material from a social health perspective (Brice 2000). Lack of research has previously been pointed out in

other reports seeking to describe Indigenous road trauma (Moller J 1996; Watson M, Elliott P et al. 1997; R & M Consultants 1999).

There are published reports and some grey literature that offer valuable and detailed insight into aspects such as road safety, injury and death statistics, and transport accessibility issues that impinge on the wellbeing of Aboriginal communities. It is important to consider more fully the range of underlying factors that relate to the availability of safe and sufficient transport. It is much more difficult to directly measure the effect on individuals who suffer from interpersonal violence because they cannot physically transport themselves out of their situation, or the effect on children for whom access to regular schooling is affected by distance, or the ability of families to prosper when fresh food choices are severely restricted due to lack of heavy transport access to their area for delivery of consumables. Lack of integrated and up-to-date evidence hinders progress in the provision of equitable access to safe transport for Aboriginal people in many settings and geographical situations.

### **1.1.5 Issues of policy and policy fragmentation**

Perhaps the most striking feature of government policy literature relevant to Aboriginal travelling, safety and health is the way in which each document seems to be prepared with little or no consideration of documents in other sectors. In addition, while Aboriginal people are mentioned in many key documents on transport, public transport, health and social welfare, the outcomes for the non-Indigenous majority swamp effective outcomes for Aboriginal people. In some sectors a broad policy document that raises the needs of Aboriginal people, leads to implementation documents with no significant consideration of Aboriginal needs. Like the literature, policy responses to Aboriginal needs remain fragmented. The true needs of the 25,000 Aboriginal people in South Australia remain poorly considered and individual Aboriginal people and their families are left to sort their way through a complex maze of systems that are designed for other people.

## **1.2 The purpose of this research**

This research attempts to reduce the fragmentation of evidence about transport and transport safety issues for Aboriginal people and to start to bring about a synthesis and framework for future analysis. It is only a start to the work that needs to be done. Not all Aboriginal community settings could be accessed with the project resources available, but connections with Aboriginal people with a remarkable knowledge about the circumstance of people living in other settings has strengthened our findings. The systematic interviews and focus groups as well as information from key elders and leaders of Aboriginal programs and services has allowed us to develop a foundation of an integrated approach to increasing the opportunity for Aboriginal adults and children to travel well.

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## **2 METHOD**

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### **2.1 Overview**

This research is primarily qualitative in nature, using multiple methods and triangulating findings from a number of sources. It describes the issues of travelling well as seen by Aboriginal people living in South Australia. The resources available have permitted information to be gathered from community members and key organisations in Ceduna, Yalata, Port Adelaide and Gilles Plains. The methods used were approved by the Aboriginal Health Research Ethics Committee, the Flinders University Social and Behavioural Ethics Committee and Yunggoorendi First Nations Centre (Flinders University).

It is clear that we have not been able to cover all of the types of location that are necessary for a comprehensive study. In particular direct information from remote areas and major country towns is limited. However our aim was not to conduct a comprehensive study of all areas, but to develop a framework for an integrated view of issues of Aboriginal people travelling well and from the limited information gathered, to form a foundation for further research and to identify issues where it may be possible to meet some of the unmet need.

### **2.2 Research methods**

#### **2.2.1 The Aboriginal People Travelling Well forums**

The research process was supported by a reference committee who were closely involved in determining the content of the interviews and the selection of stimulus materials for the focus groups. This group provided important links to key informants who had particular expertise and knowledge about relevant issues.

A major goal of the project has been to identify shortfalls in access to safe and sufficient transport for Aboriginal people, and to develop working partnerships between Aboriginal communities and service providers to implement and evaluate local, sustainable strategies for safer transport options. We have worked with a philosophy of identifying gaps in services and overlaps between service providers, and linking agencies to other service providers in order to realise the potential of services to their clients. We did not seek to establish new services per se, rather, to more fully utilise existing services, and perhaps to suggest ways of value adding to enhance working models. We also made a point of identifying and building on previous research or community consultations in the area, and learning from successful interstate models that may be transferable to local situations.

Preliminary contacts and relationship building with agencies, organisations and communities began in March 2005. We began a discussion forum and partnership building exercise with representatives from agencies and organisations with an interest in this area. We adopted the name 'Aboriginal People Travelling Well' for our project and team name, and for the title of the forum meetings.

At the first forum (3<sup>rd</sup> March, 2005), we established common goals and barriers among the groups. The inaugural participants were representatives from the (then) Department of Aboriginal Affairs and Reconciliation (DAARE), now known as the Aboriginal Affairs and Reconciliation Division (AARD), the Indigenous Coordination Centre, Adelaide and the Patpa Warra Yunti Regional Council (A list of these participants appears in Appendix A).

The inaugural discussion centred on what the invited agencies and organisations had experienced in terms of difficulty in accessing suitable transport for clients, what would make a difference, and what would be needed to make change. There was support for further exploration of issues around access to safe and sufficient transport, and we were encouraged to continue to develop a research model.

A seeding grant from Flinders University (University/Industry Cooperative Research Grant, \$4,725) in April 2005 assisted us in continuing these meetings, which has developed into a spasmodic forum series, and has funded some limited travel to collect case studies and information from further afield, the Far West Coast in particular.

The second forum (14<sup>th</sup> April, 2005) drew more agencies and groups, and was hosted by the Adelaide Indigenous Coordination Centre, with a video conferencing link to include participants meeting in Ceduna. Nine specific themes were identified for further investigation and action (a full list of themes to date is described in section 3.1).

The third forum (9<sup>th</sup> June, 2005), explored solutions in respect to the nine themes and aimed to identify likely industry partners to support actions.

Further meetings were convened on the 18<sup>th</sup> July and the 25<sup>th</sup> August 2005, and new participants and organisations or agencies were involved on both occasions. On August 16<sup>th</sup> 2005, Helen Farinola (ARC SA) and Yvonne Helps (APTW) jointly addressed the Working Together Ceduna Inter-Agency meeting, at which local church groups, school principals, government and non-government service providers, Indigenous Coordination centre representatives, police and key community members gather. Underpinning this group are the following commitments: “That there are two focuses of this group: short-term immediate responses to community needs; and longer term vision and growth of the community in Ceduna and surrounding areas...”(McCallum S 2005). It was at this meeting that feedback on the Yalata bus service (result of a Shared Responsibility Agreement (SRA)) was reported. Positive outcomes included the Health services reporting that clients were making it to appointments, and SAPOL reported that “offending has decreased and the risks in travelling have also decreased.”(McCallum S 2005) Anecdotal evidence was also offered that there seemed to be a decrease in notification to the Child Youth and Family Services (CYFS) on families needing to return to homes in Yalata (see description of the Yalata bus service from 2005 to 2007, Section 3.2.4).

The 27<sup>th</sup> October 2005 forum was hosted at the Adelaide DAARE office. We continued to explore a total of 11 themes identified by the group in meetings on the 15<sup>th</sup> December 2005 and the 25<sup>th</sup> May 2006.

The research group applied to the ATSB for a research grant, and were awarded the funds that supported this current project in the second half of 2006. In light of the many themes identified and time and funding constraints, it was decided that four main themes would be explored through four stand-alone literature reviews and in this report:

- Transport issues related to Aboriginal disability
- Transport issues related to Aboriginal health
- Transport issues related to Aboriginal seat restraint non-compliance, and
- Transport issues related to Aboriginal driver licensing issues

On 29<sup>th</sup> June 2006, APTW hosted a joint forum with the SA Indigenous Road Safety Taskforce. The taskforce consists of:

- A representative from Department for Transport, Energy & Infrastructure

- A representative from SA Police
- A representative from the Department for Aboriginal Affairs & Reconciliation
- A member of a SA Aboriginal community
- A representative from the Aboriginal Health Council SA

The taskforce undertakes to:

- Provide a forum for the identification of road safety issues associated with Aboriginal road safety and for the exchange of relevant information;
- Monitor and evaluate research and initiatives from other States and Territories;
- Recommend strategies for addressing Aboriginal road safety issues in South Australia; and
- Respond to requests from the Road Safety Ministerial and Advisory Councils for advice on Aboriginal road safety issues.

On July 18<sup>th</sup> 2006, APTW convened a Road Safety Resources meeting, hosted by SA Metro Fire Service (SAMFS) at their Adelaide city station. The purpose of this meeting was to identify road safety and related educational materials from a range of agencies, which might be drawn on for use or adaptation for use in Aboriginal communities. A follow-up meeting for this purpose was held on August 18<sup>th</sup> 2006, hosted by the Department for Transport, Energy and Infrastructure (DTEI) at their Norwood premises.

On December 5<sup>th</sup> 2006, APTW hosted a seminar by Associate Professor Malcolm Vick from James Cook University, on the Qld Indigenous Driver Licensing Program (Vick M 2006), which was based on a conference paper delivered in Melbourne in September of that year (Vick M 2006). A discussion forum of representatives from DTEI, SAPOL, TAFE SA, Commonwealth DoHA, AARD, OIPC followed. Associate Professor Vick became aware of the APTW project through the Australian Indigenous *HealthInfoNet Indigenous Road Safety Website*, an online resource funded by the Australian Government and state and territory government road safety organisations in the Northern Territory, South Australia, Queensland, Western Australia and New South Wales. The website is produced by Edith Cowan University, Western Australia, and includes a 'yarning place', an electronic network within this resource, to enable information sharing on specific topics relating to Indigenous health. The Australian Indigenous *HealthInfoNet* describes its function:

"The Australian Indigenous *HealthInfoNet* is an innovative web resource that makes knowledge and information on Indigenous health easily accessible to inform practice and policy.

Our web resource is a 'one-stop info-shop' for people interested in improving the health of Indigenous Australians. We provide quality, up-to-date knowledge and information about many aspects of Indigenous health, and support 'yarning places' (electronic networks) that encourage information-sharing and collaboration among people working in health and related sectors." (Australian Indigenous *HealthInfonet* 2007)

In response to the interest and discussion generated by the December seminar, a further meeting was held on April 26<sup>th</sup> 2007, with presentations from Judith Welgraven of TAFE SA (Welgraven J 2007), and Associate Professor Malcolm Vick (Vick M 2007). Once again, there was a fruitful exchange of information and experiences between attendees from DTEI, SAPOL, TAFE SA and other agencies.

A full list of forum participants and those who participate or follow our progress through electronic mail outs appear in Appendix B. Letters of support from Aboriginal communities, agencies, and organisations appear in Appendix C.



### **2.2.2 Literature reviews**

The Aboriginal forum guiding this project identified a number of important issues. These are detailed in the results. As a result of the regular forum discussions it was decided to undertake detailed literature reviews on a number of key topics. Literature on direct safety risks including the nature of Aboriginal road traffic related injury, seatbelt use and child restraint use, the impact of health and health care on travel needs and patterns and the impact of disability on travel needs and patterns.

The literature reviews are detailed and the method and results have been written up in full in separate documents. The strategy of the literature searches was to identify information that dealt directly with the specific issues. With the exception of formal literature on road related injury data and articles on the use of restraints, there were very few articles in refereed journals or books that covered the major issues directly and in depth. When the informal literature was searched, there were very large numbers of articles, policy documents and fragments relating to Aboriginal transport needs and safety issues. Formal literature searches covered the health literature through Medline, the broader published literature through Ingenta, and searches of Aboriginal literature sites such as that operated by Edith Cowan University. Google was used to identify the scope of the literature and to provide a basis for understanding how to filter the huge number of pieces of information available in the informal and service and policy literature.

A systematic approach was developed to select subsets of the literature that provide a meaningful coverage of major issues. It is also likely that relevant literature may be missed because transport or access is not directly discussed but there is other information that has an impact of these matters contained in the text.

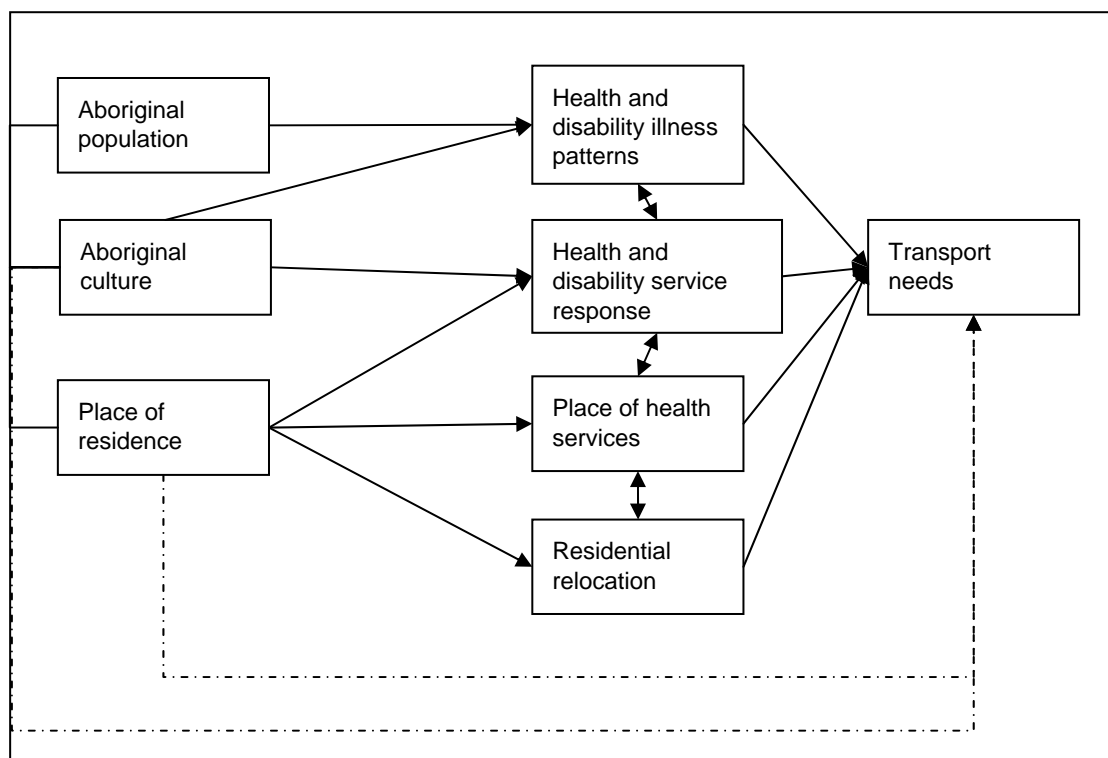
A simplified causal model is presented in Figure 1. It identifies factors that influence transport needs and the interactions between them. This literature review focuses on key literature on each of the major causal components. The direct effects shown as dotted lines are the subject of a separate literature review also generated by this project.

Our focus on health and disability presents us with some interesting issues of definition. The Aboriginal view of health is focus on social and emotional well being as well as illnesses and diseases. Western medical literature is divided into two parts, that which deal with wellness and prevention and the other much larger literature that focuses on specific diseases and their cures. This review will cover the range of ideas drawing each approach to understand the way in which health influences transport. Disability is even less well defined and the notion of disability in Aboriginal culture is poorly covered in the literature.

Figure 1 shows that the size and nature of the Aboriginal population in concert with culture and belief systems and place of residence form the basic foundation for Aboriginal health. This foundation then forms a distribution of health and disease, interacts with services and the way in which they are delivered and where they are delivered to influence Aboriginal mobility and the need to access services. The whole process influences the need for safe travel. There are of course direct influences that are not linked with health, but given the Aboriginal view of health and wellbeing, even these may well not be as separate as the diagram suggests.

The figure should be seen in the context of alienation, disempowerment and conflict that has been wrought by European civilisation. These are the influences which are all pervasive, touching each of the factors detailed.

**Figure 1: Health and transport needs**



The literature was reviewed under the following headings and the findings synthesised to identify transport issues related to health.

Aboriginal population of South Australia

Aboriginal place of residence

Aboriginal cultural factors

Aboriginal health and disability needs

Health and disability services and treatment responses for Aboriginal people

The geographic distribution of services

Aboriginal mobility

This model allowed a systematic approach to the literature, including searching for literature that did not directly address transport and transport safety in depth, but was still relevant to better understanding needs and impacts of a range of factors.

In this report, the key findings from the detailed literature reviews are interwoven with the information collected from subjects during the project to form a triangulated analysis. This triangulation increases validity of the analysis by identifying common agreed themes and areas where tension exists and further understanding is required.

### **2.2.3 Project data collection**

#### **Overview**

The approach taken has an action research focus. Aboriginal communities and their needs are far from homogenous. It was therefore necessary to match information gathering techniques to the type of community and its preferred method of information exchange. The ethics committees approved a number of different research instruments and these were used according to the needs and opportunities with each group. While this increases the difficulty of making close comparisons of different areas and groups, it would be incorrect to force such different groups into a single method that would be more appropriate for some places and people and less appropriate for others. Our approach involved identifying the way in which each community wanted to communicate and using a mix of instruments to gather the richest possible set of information.

As an action research process, the project not only gathered information, but also interacted with both the information and informants to assess possibilities for change. Aboriginal people have for a long time complained about researchers taking away information and giving nothing back. Opportunities to give information back and to build links and opportunities for change were taken wherever they were within the resources of the project. This not only resulted in some interesting and fruitful actions being undertaken, but also enriched feedback about what works and what is acceptable. For the technical or medical researchers such processes may be seen as contaminating the evidence and weakening the study. For action researchers however, the opportunities for being a participant observer in change processes enrich and strengthen the validity of conclusions.

Information collections included focus groups, personal interview and case studies, key informant interviews and structured questionnaires. Of these the structured questionnaires were least useful. These instruments focused on getting information about individuals, but it became clear that participants were much more accepting of groups and individual discussions about the issues. These revealed many individual examples and cases, but the focus was not on the individual but on the issue. Most of the information was gathered from people who had a leadership or spokesperson role who could tell the stories of a range of people. For the individual, shyness and shame are often barriers to telling personal stories. In some places language difficulties and the cultural distance between researchers and possible subjects were barriers. To gain trust and open communication at the grass roots individual level would take much more time and resources than were available for this project. The mix of methods used was culturally sensitive, ethical and respected the preferred communication strategies of the groups and individuals involved.

#### ***Aboriginal People Travelling Well Timeline***

Although the APTW grant for this project commenced in September of 2006, much preparatory work was done, and several other sources of funding were sought at different time. A brief list of notable milestones in the life of the project is in Appendix D.

### **2.2.4 Focus groups**

Focus groups were conducted using a set of standard stimulus materials (see Appendix E) and discussion followed the issues raised. The same introduction and explanation was read out to each focus group. Each focus group was taped with the consent of the group and the tape transcribed. The transcribed material was analysed by the interviewer to identify key issues and possible ways of responding to them. The analysis was checked by another member of the research team against the transcript and where it was important to understand nuances by listening to the tapes. The summary

of the group was then sent back to the group for checking and approval as an accurate summary of the group. The tapes and transcripts have been placed in secure storage.

**Table 1: Recruitment method and sample size for focus groups**

Location	Contact agency	Number in focus group	Status of persons e.g. health workers, elders, community members
Ceduna	District Council, Families SA, Co-ordination Centre, Ceduna District Health Service	2 males, 4 females	Non-Aboriginal health and other government workers
Gilles Plains Zebra Finch Men's Group	Aboriginal Outreach Service, SA Department of Health	14 males	Elders and younger men
Port Adelaide Burka Meyunna (Western Region Elders Group)	Kura Yerlo Incorporated	4 males, 6 females	9 Elders and 1 younger family member

### ***Personal interviews/case studies***

Personal experiences of Aboriginal people involving issues around transport were gathered in taped conversations, with written, informed consent. The content was evaluated qualitatively, searching for matching themes or new issues. Some interviews are presented as case studies throughout the report. In addition, in each location, people who held key roles in the community, whether they were Aboriginal or non-Aboriginal, were identified and personal interviews conducted. Often these subjects had long-term involvement with relevant issues and provided interesting insights into the differences in different places.

**Table 2: Recruitment method and sample size for individual interviews**

Location	Contact agency	Number of interviews	Status of persons interviewed e.g. health workers, elders, community members
Ceduna	Private contact Families SA	2	Male Elder Female Aboriginal government worker
Gilles Plains Zebra Finch Men's Group	Aboriginal Outreach Service, SA Department of Health	1	Male Elder
Port Adelaide	Kura Yerlo Inc	1	Male Elder
Yalata	Tullawon Health Service Inc. Yalata Community Inc.	5 1	Male and female clinic staff Male worker

### ***Questionnaires***

A questionnaire schedule was developed specially for this project (see Appendix F). This method of data collection could not be implemented as intended, as participants preferred to relate stories and personal experiences in response to the questions. Rather, the questions served as prompts that elicited information, usually specific to the questionnaire item, but related in more personal terms. As taping of each questionnaire was always part of the method, we were able to use all data. This

resulted in a much richer collection of information than the set responses would have afforded, and information from the questionnaires completed have been used throughout this report in the form of vignettes. It had been anticipated that results may have been comparable to similar items from the National Aboriginal and Torres Strait Islander Social Survey (ABS 2004), but further collection using this method was not pursued due to time constraints and the relatively better success of the personal interview method.

**Table 3: Recruitment method and sample size for individual questionnaires**

<b>Location</b>	<b>Contact agency</b>	<b>Number of questionnaires</b>	<b>Status of persons interviewed e.g. health workers, elders, community members</b>
Gilles Plains Zebra Finch Men's Group	Aboriginal Outreach Service, SA Department of Health	3	Male Elders

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## 3 RESULTS AND DISCUSSION

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### 3.1 Key informants

The research was guided by information from a key informant group. These were mainly Aboriginal leaders who met several times to guide the project and make connections with the communities. Some important issues and potential solutions were identified at forums early in the project. These were:

#### (1) Transportation issues in Anangu Pitjantjatjara lands

Private transport is difficult due to the short life of vehicles travelling long distances on rough roads and high cost of fuel. There is a need for quality second-hand vehicles at reasonable prices especially heavy-duty people movers, 4WDs. Purchase could involve a cooperative.

Gaps in public transport between communities, towns and services in rural and remote regions need to be identified and addressed.

#### (2) Car pooling across government agencies and ban on clients in cars in some agencies

Staff from multiple agencies and their clients often travel separately to the same (distant) location at the same time. Some agencies ban clients travelling in their cars. Co-ordinating and pooling agency travel would reduce costs and promote communication. Allowing clients to travel with staff would also enhance client attendance.

#### (3) Exploitation in some regions by operators of taxi services

In areas where there is a lack of public transport, exploitation by some taxi operators has been alleged, for example; accessing the key cards of clients inappropriately, and charging for a return trip where clients need to travel one way.

#### (4) Lack of co-ordinated transport to a safe home place on release from prison

On release from prison, many Aboriginal people do not have transport available to deliver them to a safe place, leaving them vulnerable to influences that may lead them to re-offend. Co-ordination of release information would allow time for a safe (usually home) destination to be identified, for family and community members to be notified, and for suitable transport and possibly an escort (language, country considerations) to be arranged.

#### (5) Cessation of discounted monthly travel passes

In the past, monthly travel passes for public transport services were available at a considerable discount, but this system no longer exists. Multi-trip tickets are available, but only cover 10 occasions, and can easily be used up in a few days. A return to monthly passes would enhance mobility for urban travellers, and if available at a reasonable discount, may decrease infringements for ticket non-compliance.

#### (6) Hospital and medical centre outpatient transport and discharged patient transport

Clients often need to travel to Adelaide from rural and remote areas for specialist medical services, but may not attend due to lack of transport. Sometimes clients are transported to Adelaide, but fail to attend appointments due to unfamiliarity with the city or other distractions. Services transport funds are wasted, specialists' lists are disrupted, and clients do not receive care, which can result in serious health consequences. When appointments are missed, the client

is 'lost' to the system, and may be vulnerable and at risk, as well as having no means of return to home. Provision of a database to co-ordinate care and transport would assist.

#### **(7) Yalata to Ceduna and return travel**

People often find a way into Ceduna, but do not have return travel. This may be to access health or other services, to shop, etc. Often, those without means of return travel stay at the Transitional Camp, or drift to other camps outside town.

The Yalata Shared Responsibility Agreement was trialled from April 19<sup>th</sup> for six months and provided a community bus twice daily, two days a week, with travel behaviour moderated by the community. Yalata community payday has been adjusted to Thursday, with bus days being Friday and Tuesday, allowing same day or over weekend trips to be planned and budgeted for. This pilot project could be adapted for other communities.

#### **(8) Yalata and Oak Valley**

Royal Flying Doctor Service evacuates clients situated in these two remote communities who need to be hospitalised to Pt Augusta hospital. While a large hospital may provide the most appropriate acute medical care, other supports are lacking. The potential consequences include: additional distress for clients already in poor health, isolation from family and community support, communication problems because of language differences, apprehension about hospitalisation and treatment, vulnerability on discharge with no return transport arranged, and associated risks of negative influences prevalent in a large regional centre.

There is a need for a Step Down type of facility and possibly a linked bus and hostel system co-ordinated to link client and family supports.

#### **(9) Driver licensing barriers and solutions**

Difficulty in obtaining a drivers licence can prompt inappropriate behaviour, including driving unlicensed, driving under-aged, involvement in road traffic accidents due to lack of experience. Barriers to obtaining a licence include language and literacy difficulties, distrust of police officers (in areas where licensing is overseen by SAPOL), apprehension about dealing with agencies (for example; Dept Road Transport) and limited access to instructors and legal supervisors for learner drivers. Pressures to drive unlicensed come from a variety of sources, in some cases from people to whom it is culturally inappropriate to refuse, or to attend important events.

There is a need to develop a system that encourages Aboriginal people to get a licence and that removes the barriers. Some initiatives exist in Port Adelaide and Victor Harbour.

#### **(10) Child restraints for hospital and medical centre outpatient transport and discharged patient transport**

Some people from remote areas are not familiar with child seat restraints even though their use is mandatory. Children, parents and drivers can become distressed as the journey is repeatedly interrupted in an attempt to keep everyone safely buckled up.

It was apparent that recognition of the safety value of child car restraints, consequences of crashes, availability and affordability of the restraints, and accredited installation to ensure correct usage were all critical issues, and that there was a need for action particularly in the more remote communities.

#### **(11) Provision and maintenance of roads in communities and homelands**

Roads to some communities are poor, impacting on ability to travel and the delivery of goods and services. There is a need to develop a coordinated approach for homelands areas in particular with cooperation between DAARE (now AARD), Department of Transport and the communities.

## 12) Disability and access to transport

Access to assessment and rehabilitation services for Aboriginal people with a disability is poor. There is a need for adequate transport to meet the needs of people with a disability, and for local delivery of disability services.

## 3.2 The communities

### 3.2.1 South Australia

The Indigenous population in South Australia is young in contrast to the rest of the population, with 56% of Indigenous people aged 24 years and under, compared to 31% of non-Indigenous people in that age group, and only 3% of Indigenous elders (65 years plus) compared to 15% of non-Indigenous elders (Table 4). There is a large and growing proportion of young people whose health, wellbeing and special needs should be considered in the context of ageing well. This young cohort will also increase the need for driver education and licensing services over the next decade or more.

**Table 4: Indigenous population by age group in South Australia, 2006 Census (ABS 2007)**

Age group	Indigenous count	Proportion of total	Non-Indigenous count	Proportion of total
0–14	9,292	36.4%	258,585	18.2%
15–24	5,029	19.7%	186,801	13.2%
25–44	6,841	26.8%	381,420	26.9%
45–64	3,487	13.6%	375,175	26.4%
65+	907	3.5%	217,480	15.3%
<b>Total</b>	<b>25,557</b>	<b>100%</b>	<b>1,419,461</b>	<b>100%</b>

Fertility rates for Indigenous women are higher in South Australia than for anywhere else in the country, and fertility is higher there at younger ages in the Indigenous population, with nearly three quarters of all Indigenous babies being born to women under thirty years of age (ABS 2006). The younger age structure of the Indigenous population in South Australia is also partly due to the high mortality rate, with life expectancy (for those born between 1996 and 2001) being 59.4 years for Indigenous males, and 64.8 years for Indigenous females (ABS 2006). Non-Indigenous males and females born in the same period can reasonably expect to exceed those expectancies by a further seventeen years (ABS 2006).

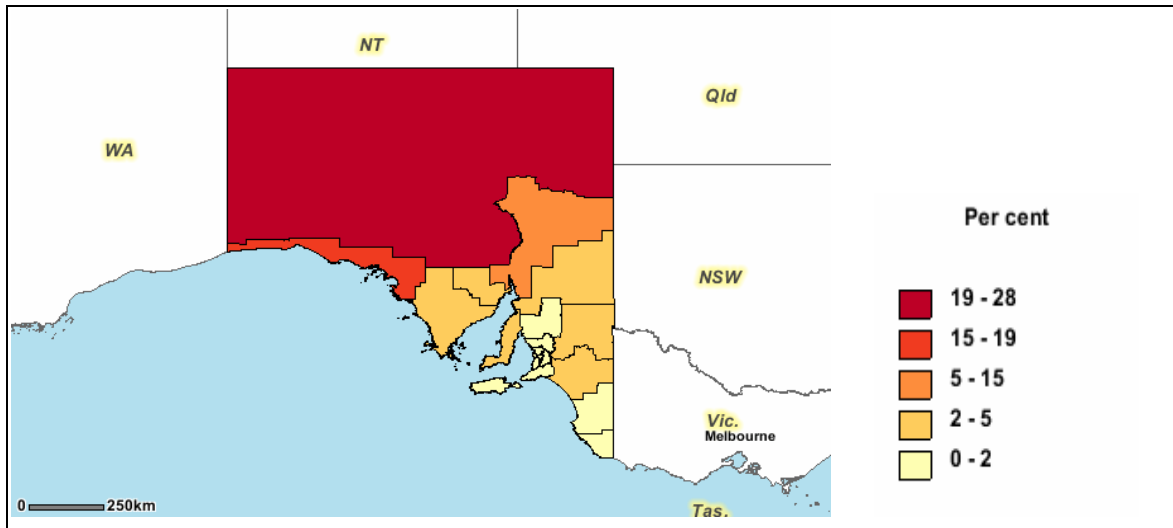
This indicates that there will be a surge in the young Indigenous population, with increasing demand for health services (considering poor health outcomes for Indigenous people generally), and likewise an increase in the numbers of young people becoming of eligible age to become licensed to drive.

The distribution of Indigenous people across the state is depicted in the chart below (Figure 2), showing much higher proportions of Indigenous people living in rural, remote and very remote



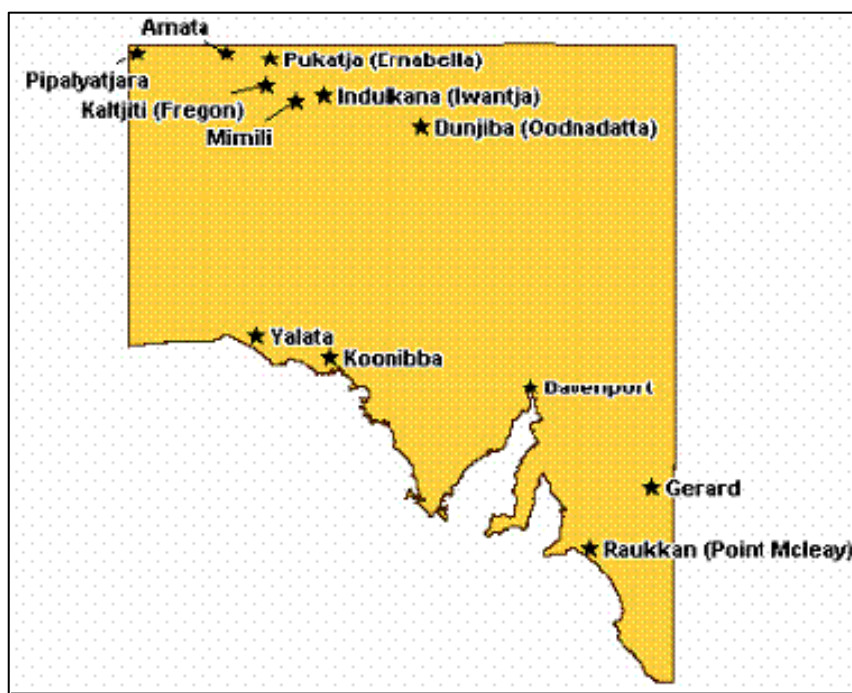
areas of the state than in the urban and metropolitan areas, which are mainly located in the south to south eastern portion of the state.

**Figure 2: Indigenous population distribution in South Australian Statistical Sub Division (SSD) (ABS 2007)**



Of the 91 discrete Indigenous communities in South Australia, there are twelve major ‘hub’ communities, all in remote to very remote areas (Figure 3). Seven of the most remote communities lie in the APY Lands in the far north and northwest edge of the state, bordering the Northern Territory and Western Australia.

**Figure 3: Major ‘hub’ Indigenous discrete communities in South Australia (Baillie, Siciliano et al. 2002)**

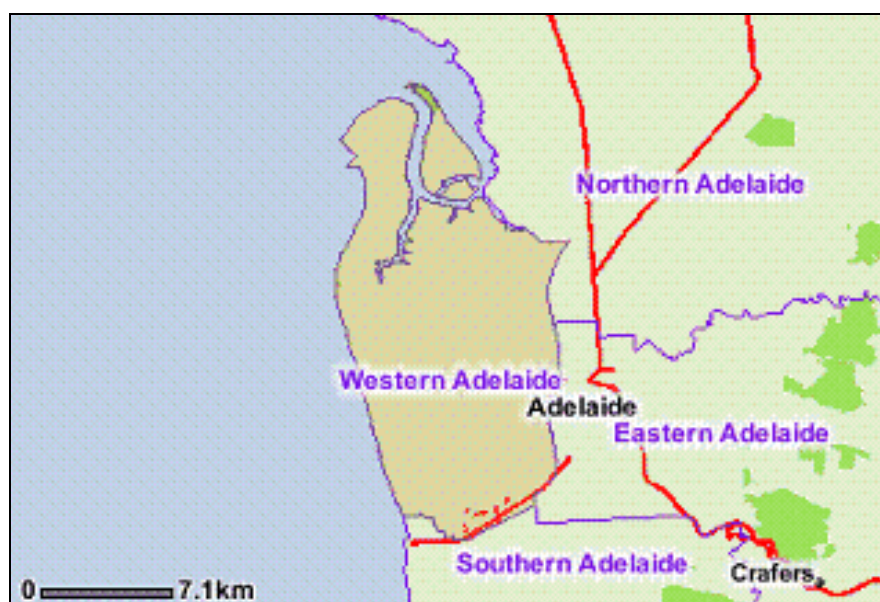


### 3.2.2 Western Adelaide

#### *Demographics of the area*

The Western Adelaide Statistical Sub Division covers 159.5 square km, and includes the council areas of Pt Adelaide and Enfield, West Torrens, and Charles Sturt (Figure 4).

**Figure 4: Boundaries of Western Adelaide Statistical Sub Division (SSD) (ABS 2007)**



In Western Adelaide in the 2006 Census, 2,934 persons identified themselves as being Aboriginal, Torres Strait Islander, or Aboriginal and Torres Strait Islander, referred to in total as Indigenous (ABS 2007). This equates to 1.4% of the total population in the Western Adelaide Statistical Sub Division. Of all reported Aboriginal and Torres Strait Islanders in this area, 4.3% of people (n=125) spoke a traditional language, down from 5.7% of people in the 2001 Census (ABS 2002). The age structure of the Indigenous population in this area is different in all but the 25–44 years age group, with higher proportions of Indigenous than other people aged 15–24 years, and low proportions of Indigenous than other people aged 65 years (Table 5).

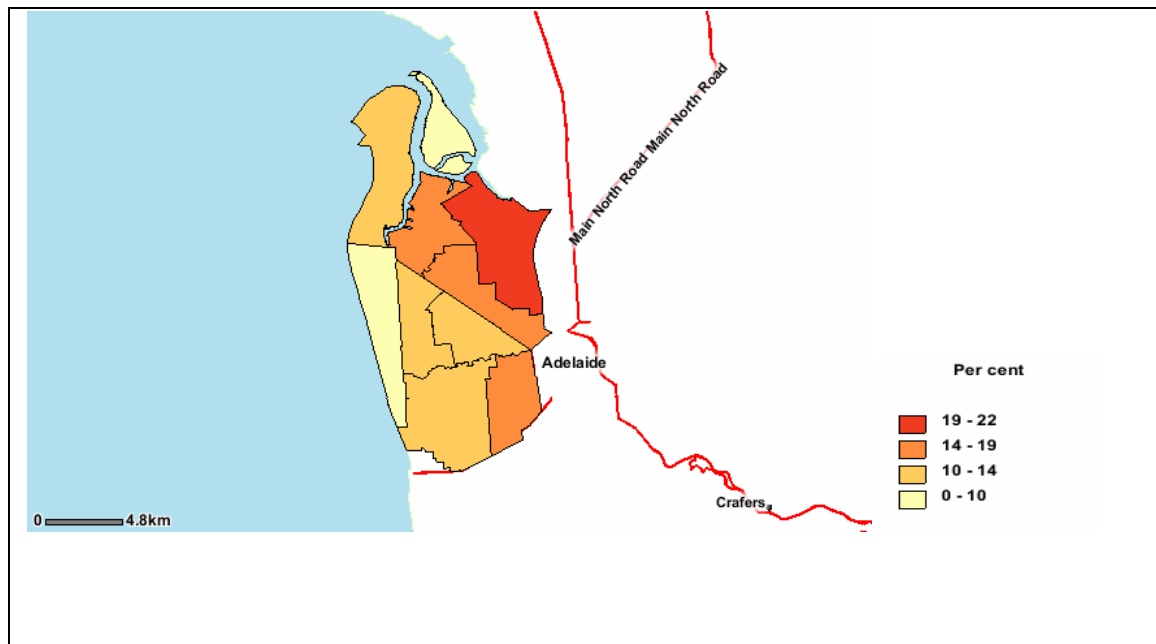
**Table 5: Indigenous population by age group in Western Adelaide, 2006 Census (ABS 2007)**

Age group	Indigenous count	Proportion of total	Non-Indigenous count	Proportion of total
0–14	970	33.1	31,917	15.8
15–24	625	21.3	25,708	12.7
25–44	769	26.2	56,348	27.9
45–64	450	15.3	50,692	25.1
65+	120	4.1	37,637	18.6
Total	2,934	100	202,302	100

The median weekly household income was \$656 with an average household size of 2.9 persons for Indigenous households, and \$786 with an average household size of 2.3 persons for non-Indigenous households (ABS 2007). However, median monthly housing loan repayments were higher for Indigenous households (\$1,192) than for non-Indigenous households (\$1,083) (ABS 2007).

In the Western Adelaide area, the proportion of all households reporting no vehicle ownership varied from 0–10% to 19–22% (Figure 5).

**Figure 5: Dwellings with no motor vehicles in Western Adelaide (ABS 2007)**



A train line that runs from Outer Harbour, through the Largs, Semaphore, Port Adelaide, Woodville and Croydon areas, to the city of Adelaide, services the Western Adelaide area. A network of public bus routes also services the area. Commercial taxis are available.

During the project, bus services were reduced in this area. A daily service changed its route to exclude a major arterial road, resulting in a substantial walk for some regular users to access the service. A circle route service ceased to operate on the weekend, and was reduced to an hourly rather than a 30 minute service.

#### *Background to the group*

The Western Region Elders Forum, Burka Meyunna (meaning elder people by the sea), is a service run by Kura Yerlo Centre, which provides services and facilities to the Aboriginal community on the west side of Adelaide. Kura Yerlo Centre is located on the esplanade at Largs Bay, but the Elders group meets in St Pauls Anglican church hall referred to as Tira Appendi (to protect and shelter), a safe Nunga friendly place, at Pt Adelaide. A number of the group are collected from their homes and brought to the hall in the Kura Yerlo mini bus. On the first visit (12<sup>th</sup> April, 2007) time was spent listening to the group doing their usual catch-up with each other, talking with the workers from Kura Yerlo who run the Elders program (thanks to Sue Castledine, Trudy Foster and Lisa Warner), and talking about what the project was about and who the researchers were. The level of friendship, support and respect within the group for its members was obvious and genuine. It was agreed that a taped focus group would be scheduled.

#### *What we heard*

On the day (10<sup>th</sup> May, 2007), ten members of the Elders group took part in a focus group, four men and six women. One of the women was the carer for her mother who attended the group, and the group accepted her as a participant, although being much younger. The focus group was conducted as described in the methods section of this report. Below is a summary of the main themes of their discussion.

#### *Long distance bus travel*

- Several people used buses to travel to places as far away as Port Augusta, Ceduna or Geelong,
- Good, comfortable seating was a high priority,
- Seatbelts might be worn if fitted to the bus, but not if comfort was affected,
- Onboard toilets were important,
- A major issue was travelling for long periods in confined spaces. Some buses were large and there was room to move or raise the legs, other buses were small and cramped, and affected the condition in which people arrived (swollen limbs),
- Seat allocation without explanation raised questions about whether individuals may be targeted for attention, and
- Racism in the form of a non-Aboriginal passenger turning their back on an Aboriginal person seated next to them had been observed.

#### *Suburban bus travel*

- Difficulty in boarding and departing buses was an issue, with age and infirmity being key aspects, especially when using a walking frame or wheeling a shopping cart,
- Drivers not using the tilt mode to allow easier boarding for Aboriginal people, but using tilt mode as a matter of course for white passengers,
- Concerns for personal safety, particularly at night,
- Concern about reports of people being touched inappropriately on buses, regardless of age or time of day, and
- Reports of people being held up at bus stops with syringes

#### *Taxi travel*

- People coming down from the far north are still being taken advantage of in terms of their often lesser grasp of English, their lack of knowledge about how far or how long a journey should take in the suburbs, and what the fare should reasonably cost. Drivers picking them up from the bus station go the long way round and charge exorbitant fares,
- Recent cases of rapes by taxi drivers is a large concern,
- They don't go the quickest way, and don't like you to tell them which route to take,
- Mistrust of non-English speaking drivers is a large concern, particularly for women, who can feel intimidated at their size and appearance,
- Many taxi drivers will not assist with getting luggage from the boot, which is difficult for older people or those with mobility problems, and

- Taxis are preferable to the bus where mobility is a concern, particularly the use of walking frames.

#### *Seat restraints*

- Not popular, might be worn if fitted on long distance bus travel, but not at the expense of comfort, and
- Interest in how one could gain an exemption from wearing a seatbelt.

#### *Walking*

- Walking at night was something that the women avoided as much as possible, because they felt unsafe and at risk of physical assault,
- Activities were discontinued at night (such as visiting the pokies) because of concerns for personal safety, and
- One participant had been confronted by a robber (in daylight) and had threatened the offender with his walking stick in order to get him to back down.

#### *Train travel*

- Not many participants were regular train users,
- One male participant liked the convenience of the train (close, easy to get on and off), and felt safer on the train than on the bus, and
- One female participant said that safety travelling on the train was not the issue, but safety waiting at the station and getting off at stations, particularly at night.

#### *Driver licensing*

- Driving themselves in private cars was not an activity mentioned by any of the group, and
- One participant had previously been licensed, and wanted to know how to go about getting a current licence.

#### *Ambulance use*

- Some people are calling taxis instead of the ambulance in emergencies, because they are afraid of the cost, and could be risking their health by delaying medical attention, and
- There is a lack of knowledge about how much the service costs for non-members, what discounts might be available for seniors or special circumstances, and how much membership is.

#### *Children and travel*

- Not safe for children to travel unaccompanied, concern about being at risk even travelling to school on buses
- *Other issues*
- Concerns over personal safety within the home (intruders),
- Concern over repercussions of acting in self-defence, and
- Would like more information about travel assistance and eligibility for benefits such as Seniors cards, Gold cards, transport vouchers

## Discussion

Comfort was mentioned on seven different occasions, and safety on six. Cost of travel was mentioned in relation to using the ambulance service, and in relation to taxi usage (most used vouchers or were reimbursed, otherwise not affordable), and overcharging by some drivers. Travel type was influenced by accessibility and infirmity; taxi travel was heavily favoured.

## Conclusion

The information here provides detail on many topics specific to the Western suburbs of Adelaide, and to the older age group. Several forum themes (cost of transport, accessible transport for disabled people, exploitation by taxi drivers, seat restraint non-compliance were repeated by this group.

### 3.2.3 Northern area

#### *Demographics of the area*

The Northern Adelaide Statistical Sub Division covers 672.2 square km (Figure 6).

**Figure 6: Boundaries of the Northern Adelaide Statistical Sub Division (SSD)(ABS 2007)**



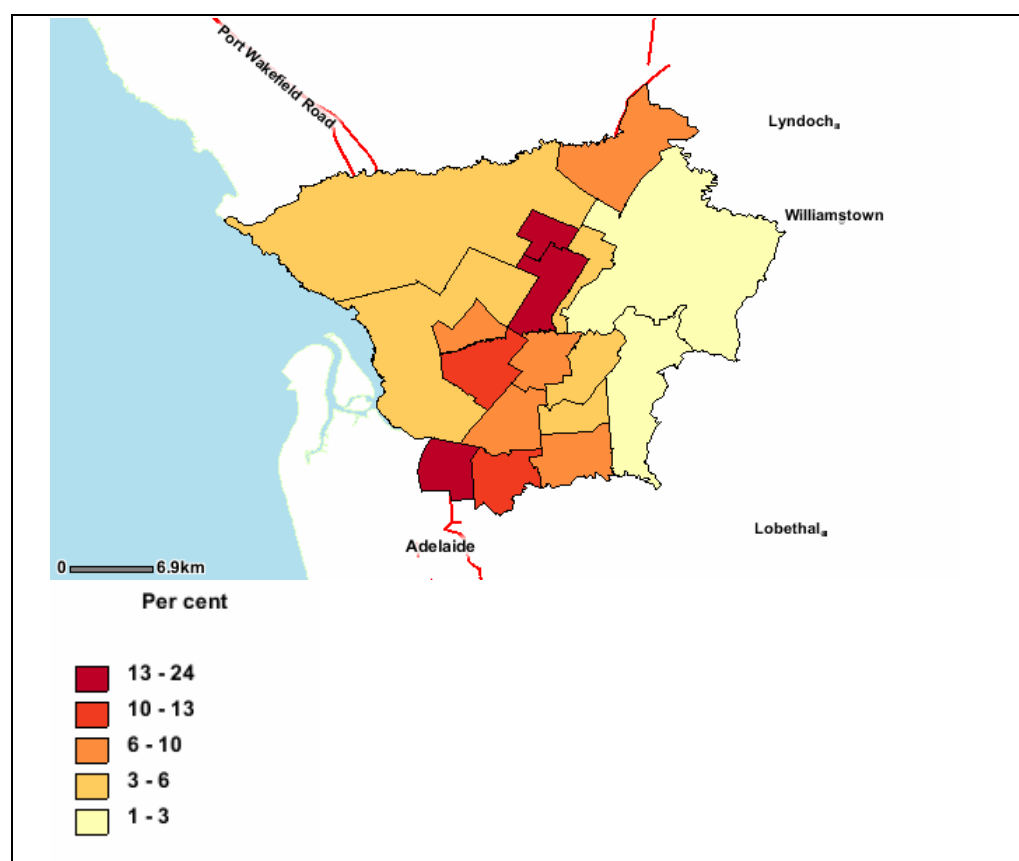
In Northern Adelaide in the 2006 Census, 5,788 persons identified themselves as being Aboriginal, Torres Strait Islander, or Aboriginal and Torres Strait Islander, referred to in total as Indigenous (Table 6). This equates to 1.6% of the total population in the Northern Adelaide Statistical Sub Division. Of all reported Aboriginal and Torres Strait Islander people living in this area, 3.7% of people (n=216) spoke a traditional language, down from 5.1% in the 2001 Census(ABS 2002). Children 0–14 years comprised 41% of the Indigenous population, which is twice the proportion in the non-Indigenous population in the area, while there was less than 3% of Indigenous people aged 65 and over, compared to 13% of non-people in that age group.

**Table 6: Indigenous population by age group in Northern Adelaide, 2006 Census (ABS 2007)**

Age group	Indigenous count	Proportion of total	Non-Indigenous count	Proportion of total
0–14	2,362	40.8	69,441	20.0
15–24	1,189	20.5	49,027	14.1
25–44	1,434	24.8	98,854	28.4
45–64	668	11.5	85,787	24.7
65+	134	2.3	44,801	12.9
<b>Total</b>	<b>5,788</b>	<b>100</b>	<b>347,909</b>	<b>100</b>

In the entire northern Adelaide area, the proportion of occupied dwellings that reported no vehicles was low. The outer lying areas had the highest car presence, while the inner areas where public transport is more frequent, and more varied; car presence is lower (Figure 7).

**Figure 7: Dwellings with no motor vehicles in Northern Adelaide (ABS 2007)**



In 2006, 47% of Indigenous households, and 42% of other households in this area in private dwellings had a family income of less than \$800 per week (ABS 2007).

The Northern Adelaide area is serviced by a train line that runs from the far and outer northern areas (Gawler, Elizabeth, Salisbury), to the city of Adelaide. A network of public bus routes also services the area. Commercial taxis are available.

### *Background to the group*

The Zebra Finch Men's Group is run by the Aboriginal Outreach Service, located at Gilles Plains in the northern suburbs of Adelaide. Peter Hodgson co-ordinated the group during part of this project, employed by the South Australian Department of Health. Here is how the group describes itself:

"The Zebra Finch Men's group was established in June 2006 with 11 members of the Aboriginal community here in Adelaide. The focus of the group is to promote Safe Families and Healthy Men; the group is made up from elders whose main role is to pass on their life experiences and knowledge to our younger members. The elders do this by leading by example and sharing cultural and community values, the group now has over 20 members.... The Zebra Finch is a bird that provides for family and the community, the group will be promoting Aboriginal mens roles within the family and community, encouraging good role models for the next generations!!" (Zebra Finch Men's Group 2007)

Three of the Zebra Finch group are also members of the Western Elders Group, and had participated in a focus group in the Western area of Adelaide. It was on their recommendation that the Zebra Finch group decided to host a focus group on their transport experiences. The members were making spears, nulla nullas, clapping sticks and other pieces handcrafted from different wood they had gathered; tea tree, three types of gum, mallee, mulga. The skilled men gave advice and mentored those less knowledgeable.

All sorts of tools were used to achieve the desired result; knives, tommy axes, meat cleavers. When the pieces are finished, they are available for sale, and the proceeds go toward projects that the group support. After the focus group concluded, the group asked for a return visit in order to allow time for questionnaires, and feedback from the day.

### *What we heard*

On the day (6<sup>th</sup> June, 2007), 14 men took part in the focus group. One was under eighteen, some were young men, and most were middle to older age. Below is a summary of the main points that arose.

### *Funeral travel*

The first issue to be raised was the difficulties that Aboriginal people face when a funeral is announced. It was also brought up later in the discussion. For this group, when people pass away in country areas, it is difficult to go from city to country, country back to city. It is often the case that a lot of people want to go to the country to attend a funeral, but it's just not practical, it's tough for those without (their own) transport.

As these events are unexpected and cannot reasonably be planned for economically, people go to Social Security to get an advance on their next cheque, which puts them further behind the next fortnight. It was felt that Social Security should have some sort of ability to assist with funeral transport costs, without the recipient having to forgo the full amount of their pension, which is pretty much budgeted for in day-to-day living expenses.

It was mentioned that the health services should have some ability to assist with travel. Not said, but I felt that this may relate to the health conditions common within the group, such as diabetes and chronic heart disease, as well as mobility issues for some.



The need for enquiries to be made across agencies to establish what assistance might be available for travel in relation to funerals, and where gaps may be bridged. Information needs to be organised and made available to Aboriginal people.

#### *Concession travel*

Restricted income made local and interstate bus travel hard to afford. One person talked about borrowing money from others because his income was barely enough to cover bills and food. Apart from the cost, that participant found buying tickets was also difficult due to problems working out the timetable, and not knowing where to buy a ticket. Information about who is eligible for travel concessions, and what types of travel they cover would be helpful. The process of how to apply, or where to get assistance to apply is also needed.

There was confusion over what happens when a concession (age or disability pension) card is about to, or has, expired. One person usually carried a pension card, but left it at home because it had expired, and a replacement had not been issued. Consequently the participant was charged full price for an interstate bus ticket. It was felt that there should be some way Centrelink could avoid people being left without valid cards, and that this should be investigated.

In regard to being eligible for travel concessions, it was suggested that there should be an 'Aboriginal' card that could be used for travel discounts, health services other benefits. The issue of having difficulty in establishing identity and Aboriginal heritage would be dealt with in one card, instead of having to carry different cards for different agencies. Other forms of identification are not always practical (many people don't have a drivers licence or birth certificate), and many people don't have a birth certificate or may not have ever been registered. Some Aboriginal people do not have the outward appearance of being Aboriginal, and find this a barrier in accessing services to which they are entitled. Not all members of the group favoured the card idea, as it sounded too much like an identity card.

#### *The agency bus*

Members of the group are regularly transported around to different groups and activities in a minibus driven by a worker from The Parks Community Centre. The bus has an automatic transmission that is operated by pushing buttons. On several occasions going down a three lane road that is used by heavy transport (Port Road) the motor has either jumped out of gear altogether, leaving the bus unpowered, or sometimes jammed in third gear. This has made the passengers vulnerable to an accident, and it was feared that other vehicles that would be unaware of the difficulty would ram them from behind.

The outer door handle was broken and took 3 months to be fixed. Members of the group are not vandals; they respect the equipment they get to use.

#### *Discussion*

No one mentioned using a train, taxis and private cars were not mentioned.

#### *Conclusion*

The main issue that dominated was that travel is unaffordable when it matters, which is usually to attend funerals. People were in general not expecting travel at no cost, but looking more to be able to afford and plan their travel where concessions were available. Where funerals were concerned, it was felt that there should be some access to transport without charge, possibly because it would benefit groups of people and not just individuals. The issues around the roadworthiness and safety of the agency bus highlight that Aboriginal people do not always have safe and sufficient travel options, but must make do with what is available, even if it is substandard.

### 3.2.4 Ceduna

#### *European history of the area*

Matthew Flinders explored the site on which Ceduna township is situated, and the area began to be settled during the 1840s. The town was surveyed in 1901 and was known as Murat Bay, after its location within the larger Denial Bay. It was not until 1921 that the name was changed to Ceduna, derived from an Aboriginal word ‘chedoona’, commonly taken to mean ‘a place to sit down and rest’ (Sydney Morning Herald 2004). Ceduna lies on the Eyre Highway, 781km north west of Adelaide, and 1,900km east of Perth (Ceduna District Council 2006). Expansion and prosperity was aided by the extension of the rail line from Port Lincoln. There is an abundance of fresh fish of many types, and the region is famous for its oysters.

The median weekly (all) household income was in the range \$700 – \$799 with the average household size of 3.6 persons. This reflects a weekly per capita household income that is slightly higher than in the Northern metropolitan region (ABS 2002).

#### *Aboriginal history of the area*

“Anangu people of Western desert language groups (Pitjantjatjara / Yankunytjatjara) are the traditional owners of the coastal lands, undulating plains and the deserts regions surrounding the Nullarbor. Wirangu occupied the land east of the Head of Bight and the Mirning clans occupied the coast west to Eucla. Kokata, Antakarinja and Ngalea occupied lands to the north and northeast. Radiocarbon dating of cooking hearths and stone implements provides evidence for human settlement on the Nullarbor Plains 40,000 years ago. Early Anangu settlers mined a band of minerals found between the limestone formations to extract and trade a hard and brittle chert that was used to make cutting tools. Today, Anangu are widely dispersed and many live in local population centres. Anangu living on the traditional lands and remote communities practice traditional custom and their spiritual beliefs remain strong. In the summer, family groups move north to attend traditional ceremonies. Game meat (kuka) remains an important food in the diet of local people and Anangu hunt kangaroos (malu), bush turkey (kilpara) and wombat (wadu). Anangu artists produce a unique paintings and carvings.” (Yalata Community 2006)

#### *Creation of the Anangu Landscape*

“Wanampi, the rainbow serpent, carved out the Head of Bight landscape after a journey from the red desert country, hundreds of kilometres north. Wanampi carved out the rolling hills and subterranean caves as he was chased from waterholes by goanna men from the north. The landscape is marked with Wanampi’s passage south and the men from local clans stand at Wati Tjutaku (place of all the men) looking down on the serpent escaping across the Nullarbor Plain. The goanna men speared the serpent hiding in a rock hole at Pedinia Lake two hundred kilometres north. The serpents shaped the lake and his blood spilled to form a large red claypan as he writhed to escape and go underground from his attackers. The Plain is dotted with sites where Wanampi pushed out of the ground to see the goanna men still in pursuit.” (Yalata Community 2006)

#### *Demographics of the area*

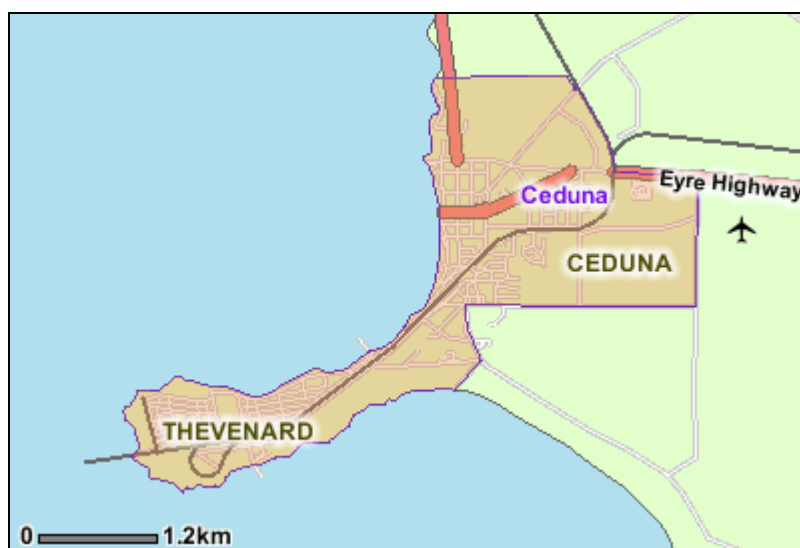
Ceduna is a major regional centre, with a high volume of tourists passing through via the Eyre Highway to access the Head of the Bight for whale watching, and to cross the Nullarbor Plain to reach Perth. The area around Ceduna is a mixture of grain farms, bush and mallee, and the spectacular coastline ranges from low sandy beaches to rugged outcrops and cliffs (Ceduna District Council 2006).

**Figure 8: Ceduna foreshore, Murat Bay**



The town of Ceduna covers 6.9square km, and has a large area bounded by sea Figure 9).

**Figure 9: Boundaries of Ceduna, Far West Coast (ABS 2007)**



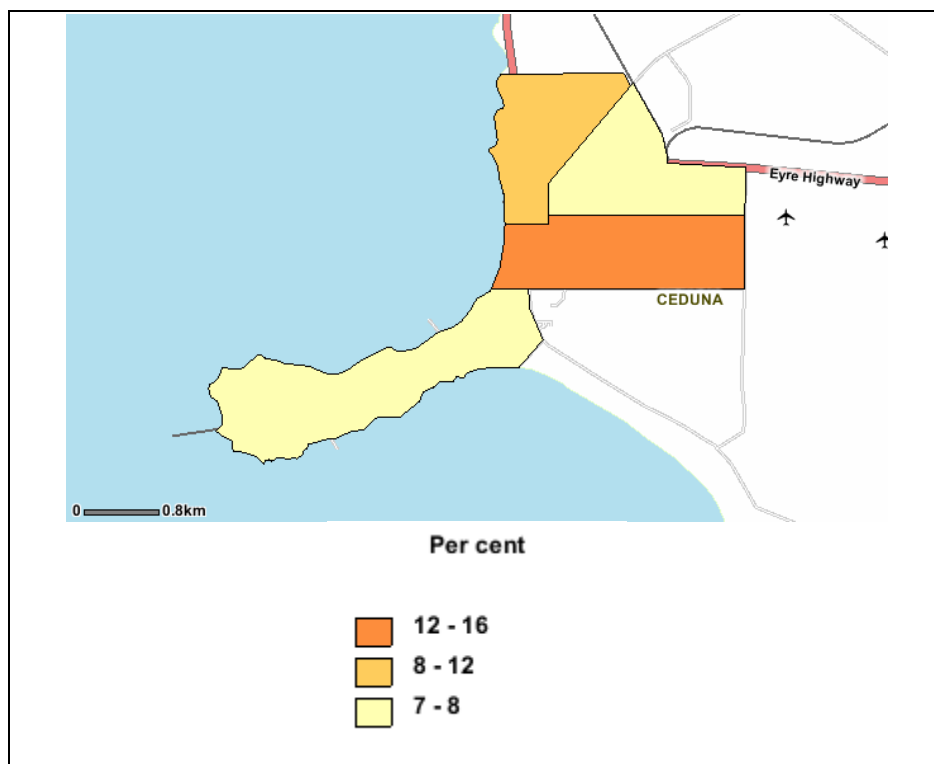
In the 2006 Census, the community of Ceduna was reported as having an Indigenous community of 521 people out of a total population of 2,305 resident persons (ABS 2007). The population can fluctuate depending on the season and on social and cultural pressures, and demands on the health services and commercial outlets located there. Of the total Aboriginal population in Ceduna, 57% were under 25 years of age (ABS 2007). Ceduna has the highest ratio of Aboriginal to non-Aboriginal residents in the state (Irvine T 2000).

**Table 7: Indigenous population by age group in Ceduna, 2006 Census (ABS 2007)**

Age group	Indigenous count	Proportion of total	Non-Indigenous count	Proportion of total
0–14	197	37.8	323	18.1
15–24	98	18.8	196	11.0
25–44	139	26.7	448	25.1
45–64	73	14.0	544	30.5
65+	14	2.7	273	15.3
<b>Total</b>	<b>521</b>	<b>100</b>	<b>1,784</b>	<b>100</b>

Car ownership in Ceduna was lowest in the commercial centre (12–16% of dwellings with no vehicle), and highest in Thevenard (7–8% of dwellings with no vehicle), which is harder to access from the commercial centre of town (2001 Census, this data unavailable for 2006 Census Figure 10).

**Figure 10: Dwellings with no motor vehicles in Ceduna in 2001 (ABS 2002)**



An airport for light aircraft operates from the outskirts of the town; Ceduna to Adelaide is a one and a half hour flight in a Saab 340 aeroplane. A private passenger bus service operates from Ceduna to Adelaide via Pt Augusta and Pt Pirie, an eleven-hour journey. Two rental companies have cars and four wheel drive vehicles available, and a taxi operates. In cases of medical emergency travel, the Royal Flying Doctor Service (RFDS) operates from bases in Pt Augusta (468km distant) and Adelaide (781km distant). There are also restricted conditions of hire for the council owned

community bus, and there are two private local bus operators. There is no public transport system or passenger rail service.

#### *What we heard*

Information in Ceduna was gathered through a focus group of non-Aboriginal service providers from the state government and local government, and two personal interviews from Aboriginal community members.

#### *Lack of private transport, emergency health travel, agency vehicles*

When an urgent need to travel arises, there is a scarcity of private vehicles. Many people would have to seek out a relative with a car and licence, not always easy to do in an emergency. Agency workers are constrained by policies and insurance liabilities when using their own vehicles, and the number of available agency vehicles does not meet the current demand. Ceduna Koonibba Aboriginal Health Service has pickups available for antenatal and immunisation appointments, but not for general appointments, because at present there is no GP. For people living in Koonibba, there is a clinic worker, and a community bus and a health service vehicle for access to health appointments in Ceduna. Whether living in Ceduna or Koonibba, transport requests are made by telephone – not everyone has access all the time to a telephone.

*“We had a child that broke his arm in two places and to try an get.....cause I can’t put a child in my car and take him to the hospital, so to try and track down a relative and also a relative who has a drivers licence and has a car to take the child to hospital is also an issue.”*

So the health service couldn’t help out there?

*“They don’t like to do anything after 4pm on a Friday”.*

So when you said you couldn’t put the child in your car to take to the hospital. Why?

*“Duty of care, work policy conditions...getting permission from the parents.. The risk for me would have been putting the child in my own car and having an accident on the way.”*

*“Duty of care is I can’t put children in my car without permission from the parents.”*

In one of the personal interviews, it was noted that at times agency workers transported clients, but were reprimanded for it because “we’re not a taxi service”. In the same interview, it was explained that the health services liaised with the Step Down service to provide transport to appointments for clients, but that Step Down only operated during business hours. This is often problematic when bus and ‘plane services arrive and depart outside normal business hours. The Aboriginal Health Service operates a client pickup service Monday–Friday 9am–5pm for medical appointments, to pharmacy and return home and for bus or plane arrivals and departures if medical related (Step Down [Ceduna] has no involvement with this service). Some people who needed to travel to specialist appointments away from home were too frightened to go, because there was no provision for travel and accommodation for carer support, and no money to arrange it themselves. The doctor can authorize a patient escort, but often have to keep in mind that people often want to take advantage of being in town with family. The Patient Assisted Travel Scheme (PATS) provides bus fares airfares or fuel vouchers to a limited value for travel for patient and carer (authorised by the referring medical officer). Arrangements are made with Step Down in Pt Augusta or Adelaide to provide pickups or taxi vouchers for patients to travel to their appointment and return to the airport or bus depot. There is no ‘plane or bus service from Ceduna to Pt Lincoln; private cars are the only means of access to specialist services there. PATS also has its limitations:

*"I reckon through our own health service or somewhere like that, they should have a service that helps people go away for specialist appointments, ya know. It's ok to give people PATS assistance but what if they don't have a car or they've never been to Adelaide before or they've never been to Port Lincoln. They get lost or they don't talk up at their appointments and so nobody knows why they're at their appointments. Some people are so shy and non-people have a way of talking to Indigenous people that makes them feel like sheep, ya know, belittling people or I've heard comments come out of white peoples' mouths – ohhh well, they don't mind doing this when they're drunk so why don't they do that when they're sober. It's a real put down to a lot of Aboriginal people."*

*"Delivery of service included the employment of drivers and they did all the pick ups of Aboriginal people within the townships of Ceduna and Thevenard. There was a homeland set-up and families within those homelands had community vehicles that could bring people to and from those communities to hospital. The (HACC bus) pick up service was more for the elderly. The health service had a bus with a disability lift on the back and could be used for people in wheelchairs. This bus not only took people to the doctor but it was also used to take them shopping and make sure the old people were down the street when they wanted to be down the street. The bus service also catered for a range of different other services, e.g. day trips to Streaky Bay, Jervois Bay, to Smokey Bay. The day trips they did for the Aboriginal people was a credit to the service, the way that the Health Council supported the health services throughout SA is a step forward for this state. I think the delivery of service had the support of the council that had given all our health services across SA... I can only speak up to 2000 of what the council (AHCSA) achieved."*

The cost of vehicle registration and high fuel prices were raised:

*"I would like to see the Government put incentives out into rural areas by reducing registrations. I think we pay enough money for fuel. Have some incentive for people to pay their car regos over a 12 month basis but you get a reduction in the fee. In the courts we see so many Aboriginal people being booked for driving unlicensed, unregistered vehicles and disqualified for not having a licence. It's because they don't have jobs or the money to register their cars. Once you pay the rent, buy food, clothe your kids, ya don't have much money left to register your car. It's the last thing on your list for a lot of people. It's really sad because a lot of people are getting hefty fines and some are getting jailed because it's a recurring event that's popping up in every court session every 6 weeks."*

*"The farmers get reduced prices in fuel, why can't community people in remote areas get reduced prices? You go to Yalata and Oak Valley, they're paying almost up to \$2 at one stage and these people are only on CDEP or pensions and by the time they fuel their car up, do a bit of shopping and go back, they've got no money left. So incentives certainly wouldn't go astray especially to Indigenous communities, fuel rebates...."*

*Public transport, walking, youth sporting and social activities*

The residential area of Thevenard grew up around the port of the same name, which has bulk handling capabilities for gypsum, grain and fertiliser (State Library of South Australia). Today, as well as its industries, it is a highly desirable housing area, with panoramic views of Murat Bay, overlooking Goat Island and St Peters Island (Ceduna Tourism). With no public transport between Thevenard and the town centre of Ceduna, walking (3km) is the only option for many, including those with young children who need to access the main street for daily essentials. One focus group participant said:

*"...regarding young people and children. I live in Thevenard and if I walk from Thevenard to the start of the main street it takes me 45 mins and I'm a fast walker. If someone has children and they're going to do the shopping...that makes it a lot more difficult."*

Children end up walking around the streets when there are no organised activities, and there are little means of getting them home safely.

*“...but I just think the biggest transport problem is Ceduna and Thevenard and trying to get kids home like trying to get kids home and get them around to have interactive activities. Just getting them home safely because they end up walking the streets and getting into trouble.”*

In a sense, providing activities to relieve boredom and to engage youth in social activity can have negative effects for agency workers:

*“In Ceduna and Thevenard we do try to organise youth activities, the major problem is that any activity that is held at night time, we have a duty of care to youth to get them home. With discos where we call on Families SA, bus seats 8. As you can imagine trying to transport 50–60 kids in an 8 seater vehicle is a little bit hard. Council does have a bus, it’s on its last legs. The rigmarole – paperwork – required to hire the bus is quite astronomical. Finding a driver is also another problem, so this eliminates us from doing a lot of after dark activities. The youth centre works on daylight saving so if its daylight saving, we’re open until 7pm. At the moment it’s open ‘til 6pm – have duty of care. We believe that if we close at 6pm, Thevenard kids have time to walk home. A lot hang around at the skate park for up to 45 minutes, by the time they get home its dark.”*

#### *Seatbelts a low priority*

The highest priority for most people was to get where they needed to, by whatever means were available. Seatbelts and seat restraints were a low priority.

#### *Mobile Assistance Patrol (MAP) and Sobering-Up Unit*

The focus group expressed concerns about the MAP not having a regular and safe place to house people they were picking up. The Sobering-Up Unit is the obvious and appropriate destination for most MAP clients, but this service is currently (from May 2007) only funded to operate from 6pm to midnight, Thursday and Friday (see Table 8).

**Table 8: Operating history of the Ceduna Sobering-Up Unit**

Funding period	Number of days	Days of operation
May 2007 onwards	2	Thursday and Friday
July 2006 to April 2007	5	Tuesday to Saturday
November 2005 to June 2006	5	Tuesday to Saturday
July 2005 to November 2005	2	Thursday and Friday

The MAP service, initiated by the Aboriginal Sobriety Group, patrols the main streets and hotels of Ceduna, offering assistance to Aboriginal people under the influence of alcohol or other substances, assisting vulnerable youth with transport home, integrates with sobering up shelters, and offers referrals to other appropriate services. There are currently no safe houses nor womens refuges in Ceduna. A report stated that in Ceduna the service:

“keeps young people out of the lock-up and has lowered the incidence of substance abuse-related call-outs to police and St Johns volunteers” (Blagg H and Valuri G 2003)

The same report goes on to identify barriers to MAP operating:

“Inadequate and uncertain funding is the major barrier to effectiveness for patrols in South Australia”. (Blagg H and Valuri G 2003)

In one of the personal interviews the demand on the MAP and Sobering-Up services was illustrated:

*“They’ve got a MAP bus but that only works after 4pm and on certain days when the Sobering-Up Unit is open, that will pick up intoxicated people and then there’s a lack of where to drop them when they’re intoxicated because the Sobering-Up Unit only takes 5–6 people. When that’s full you can’t take them to town camp because they close the gates at a certain time and they don’t like taking drunks in there. The police station don’t like having them. A lack of facilities...then they drop them off at family houses and they call the police cause they make noise, then the neighbours complain to housing trust, then the housing trust are sending families eviction notices and it’s a vicious circle going around and around...It’s crazy.”*

It was observed that the MAP bus was only utilised from about 4pm to midnight, and it was suggested that it could be shared to provide transport for youth community programs during the day. This had been discussed previously with the community, but Aboriginal parents were not happy for their children to ride in the MAP bus, because of the stigma. It was suggested that a magnetic Youth Bus sign could be used to cover the MAP logo while in use for youth activities. Parents had not responded to this suggestion, and the service providers agreed to follow this up as a solution to transporting children to and from activities. Recently, a bus was needed to transport people to a funeral – the MAP bus was refused because of the stigma attached.

#### *Community buses and funding*

In the past, there had been some funding available from regional councils to support community buses. At present, funding is limited mainly to Shared Responsibility Agreements (SRAs), or Flexible Funding Pools (FFPs), which are not always easy for communities to negotiate.

#### *The traumatic impact of road deaths*

A former Aboriginal police aide who had been a pioneer in that field, and who had enjoyed bringing police education and a different perspective particularly to Aboriginal children, told of trauma from attending horrific road accident scenes. The effect on him was such that he resigned from his position.

*“I got out because there was too many accidents. I just saw too many people unnecessarily getting killed. Too many drunks, think they can jump in the car and drive and think that nothing is going to happen to them.”*

*“That was the saddest part, that’s why I got out. One of my mates, I saw his son grow up. Then I had to ring him up and tell him that his son got killed and that, that really hit me and he wasn’t a Nunga fella. He was a little white fella ya know. That was a turning point – when you see things like that. Then his father wanted to come and look at the car. The car was squashed. We was given gloves, squeezers and a little plastic bag and there were too many blow flies around the car. We had orders to take all the meat off the car...When you see things like that, ya gotta do things like that....that was a turning point for me but as for the job itself, talking to people on the streets, going to domestic disputes, going to disputes at the pub, stopping people on the road, I was proud to wear the uniform. It was that particular accident that got to me. I gave the sergeant my badge & he said think about it. I had counselling.”*

#### *Conclusion*

There is little private transport for Aboriginal people living in Ceduna/Thevenard, and no local public transport. Walking remains the most accessible means of travel between Ceduna and Thevenard (3km) for most people. High priorities for local and distance travel are health and specialist appointments, (local appointments utilise health service pickup vehicles), and sporting and social outlets for Aboriginal children and youth. Existing services are stretched, and gaps are



clearly identified. The referring medical officer determines if an escort is required. PATS services do not recognise and include the need for family and carers to travel with Aboriginal patients as part of their treatment and recovery process. Vehicles for service agencies are not to be used for client transport (medical only), and cannot be shared between agencies, and there are not enough vehicles to meet current demand. Often, the ways in which vehicles might be best used to connect Aboriginal people with care is not seen as appropriate in the agency view, whilst being culturally sensitive and embracing. The MAP bus and the Sobering-Up Unit are both respected services, and there is a growing need to fund the operation of the Sobering-Up Unit to enable it to accommodate clients seven days a week, to compliment the MAP service and respond to community need. Community transport is not organised and structured, but there is a strong consensus that it is needed, and needs to be set up with ongoing funding.

**Recommendation 1. That a central point be established to assess Mobile Assistance Patrol (MAP) clients, to enable informed decisions to be made on where to transport them (e.g. home, Sobering-Up Unit, Town Camp, hospital).**

### **3.2.5 Yalata**

#### *European history of the area*

Edward John Eyre was the first European overland explorer, making an eight month expedition from Streaky Bay to Albany in 1840/1841. Many other explorers, all seeking resources and grazing land, followed Eyre. Whaling and sealing activities are recorded as early as 1805, and continued until the Southern Right Whale was declared a protected species in 1935. Commercial fishing developed to underpin the economy and growth of the region. Yalata Station was a pastoral lease taken up in 1858 by William Swan and Robert Barr-Smith, ruins of the station can still be seen near Fowlers Bay. The Overland Telegraph commenced construction in 1874, and in 1941 the service track associated with it was developed into the Eyre Highway (Director of National Parks (Australian Government Department of the Environment & Heritage) 2005). The South Australian Government purchased the Yalata lease in 1951 in preparation for removal of Aboriginal people from Ooldea soak, where the mission was becoming unviable. The Lutheran Church purchased the lease in 1954 and managed the area as a mission, until 1975 when the land was sold back to the government (Brady M 2004).

#### *Aboriginal history of the area*

Aboriginal occupation of the land in this region goes back 20,000years, and most probably much further than that. The original groups who populated the Nullarbor region were the Mirning, Wirangu, Kokata, Ngalea, Pindini and Antakarinja peoples, who are acknowledged as ancestors to current Aboriginal people known as Anangu (Director of National Parks (Australian Government Department of the Environment & Heritage) 2005). These groups are commonly referred to as the Western Desert Bloc.

In the normal seasonal pattern, Aboriginal people from the Western Desert Bloc who suffered drought conditions further out came to settle at Ooldea soak. In the 1940s and 1950s they were displaced by a number of factors. Chiefly, the overuse of the soak resources there when the Indian Pacific Railway siding was built, and later to make way for atomic testing at Maralinga, and the opening of the Woomera Rocket Testing Range (Director of National Parks (Australian Government Department of the Environment & Heritage) 2005). The Lutheran mission was closed down in 1952, at which time most people remaining in Ooldea gravitated to Yalata (Director of National Parks (Australian Government Department of the Environment & Heritage) 2005).

To enable British atomic weapons testing to proceed at Maralinga and Emu Field, and to allow the construction of the Woomera Rocket Testing Range, thousands of Maralinga Tjarutja, Pitjantjatjara and Kokatha people were forcibly removed. The testing occurred in 1956 and 1957.

The implications of this were immediate, and are ongoing for descendants today. Removal from homelands and cultural sites, and the declaration of these as Prohibited zones has dispossessed Aboriginal people of their heritage and lifestyle, and denied them the ability to maintain living and custodial links to their land. When the Maralinga land was 'repatriated' and handed back in 1985, thirty years of isolation had passed. In 1995, remaining Maralinga Tjarutja people (including some who had been resettled in Yalata), formed a community on the regained land. It is called Oak Valley, about 315km from Yalata, via Ooldea.

Yalata began as the South Australian Governments solution to rehousing the people of Ooldea in 1951, and was first managed by the United Aborigines Mission. In 1954, Yalata was sold to the Lutheran Church, and became Yalata Lutheran Mission (current church, Figures 11 and 12).

**Figure 11: Good Shepherd Lutheran Church, Yalata**



**Figure 12: Church when it's hot**



The Lutheran church sold the land back to the government, and management of Yalata was passed to the community under the Aboriginal Lands Trust Act of 1966 (Commissioner Elliott Johnston 1990). Therefore, Yalata Aboriginal community is a created settlement, the result of people being forcibly removed from traditional lands around Ooldea, Maralinga and Emu in the 1940s and 1950s (Director of National Parks (Australian Government Department of the Environment & Heritage) 2005). They didn't choose to live together. The Yalata community consider themselves southern Anangu (people), and speak a southern dialect of Pitjantjatjara as their first language.

“In 1996, the Yalata Reserve was proclaimed an Indigenous Protected Area (IPA) being an area of distinct character having significant ecological and cultural value. The reserve holds the largest expanse of untouched coastal mallee in the south hemisphere. Under agreements between Commonwealth and State Government agencies, Yalata Community Incorporated (YCI) is committed to conserving the unique coastal and inland landscapes on the Yalata IPA.” (Yalata Community 2006)

### *Demographics of the area*

Yalata community is situated on Nyangatja Yalatanya Nganampa Manta (Yalata Aboriginal Lands), approximately 200km west of Ceduna, on the Far West Coast of South Australia. The area is a 458,000 hectare lease, running from the mallee to the sea. In parts the Eyre Highway intersects it, and sections of the old unsealed highway run through it and are still used to access hunting (wombat, kangaroo, goat) areas. A portion of the 5,400 km Dog Fence, built about sixty years ago to protect sheep country from dingoes, also runs across Yalata land, running right to the cliffs overlooking the Great Australian Bight.

**Figure 13: Yalata Aboriginal Lands**



**Figure14: Sign 4km from Yalata community**



All visitors seeking access to the area, for whale watching or fishing, require permits. Permit proceeds assist in management of the arid coastal area and access is restricted to protect the people and the land (Figures 13 and 14). The remote lease, managed by the Yalata Community Incorporated–Yalata Land Management, runs down to the Great Australian Bight (Figure 15).

**Figure 15: Boundaries of Yalata lease, Far West Coast**



In the 2006 Census, the size of the residential community on Yalata land was reported as being 6.6 square km, and having a total Indigenous population of 84 people (ABS 2007). The population in Yalata is fluid, and can fluctuate from a core community of around 100 people, to up to 450 people depending on the season and on social and cultural pressures, and demands on the health service located there. Of the total Aboriginal population, 56% were under 24 years of age, and only 11% were reported as being between 45 and 64 years of age (Table 9). Of the 84 Indigenous people resident at the Census, 77 spoke a traditional language, with 4 people not speaking any English (ABS 2007).

**Table 9: Population by age group in Yalata, Far West Coast, 2006 Census (ABS 2007)**

Age group	Indigenous count	Proportion of total	Non-Indigenous count	Proportion of total
0–14	26	31.0	3	16.7
15–24	21	25.0	0	0.0
25–44	28	33.3	15	83.3
45–64	9	10.7	0	0.0
65+	0	0.0	0	0.0
<b>Total</b>	<b>84</b>	<b>100</b>	<b>18</b>	<b>100</b>

Car ownership data was not available for the 2006 Census. Data from the 2001 Census indicated that around one third of dwellings in Yalata at that time did not have car ownership (ABS 2002). This could be interpreted in many ways and is not easy to compare to more urban areas. It is

uncertain whether the response includes registered vehicles or all vehicles. During our visit we observed several vehicles used for hunting that were not roadworthy. It is unknown how these were reported in the Census. There is also a matter of licensing. Our interviewees told us that there were very few people at Yalata who had a valid drivers licence as some of those who had qualified were currently suspended. What is clear is that household sizes were large estimated by the Census as 5 persons per household and the number of vehicles available for private use on the road was small compared with the number of persons requiring transport.

The small population of Yalata means that income figures available for the other areas are not reported in the same way as for other areas with the exception of broad averages. Of the 21 households included in the 2006 Census, 15 had an average weekly income of between \$150 and \$999 with 2–6 persons per household (ABS 2007).

There is no train service, no commercial flights, no public bus service. The Eyre Highway is the only road access, with Ceduna 220km to the east being the nearest regional centre, and the nearest available fuel is 70km away at Nundroo. The interstate bus service between Adelaide and Perth via Ceduna ceased to operate in October of 2005. A 1.2km airstrip with lighting is in good condition. Private vehicle, a once weekly community bus to Ceduna run by the CDEP (Community Development Employment Program), the Tullawon Health Service Ambulance and the Royal Flying Doctor Service are the only available means of transport in Yalata (Figures 16 and 17).

**Figure 16: Tullawon Health Service**



**Figure 17: Tullawon Ambulance Service**



### *What we heard*

Information was collected in Yalata by individual interviews. This was the preference of the local community and fitted in with other commitments of the Community Board who were engaged in detailed negotiations with a consultant and several government agencies who over the last three years has worked to assist Yalata from the status of being declared a community in crisis to appoint where successful change of status is now imminent.

### *Health travel*

A major theme of the interviews was travel for health care. Many of the people living in Yalata require health service that cannot be provided locally. A GP service and some additional hospital services are sited in Ceduna some 200 km away but the majority of specialist and inpatient care service are in Port Augusta (approximately 500 km) and Adelaide (approximately 800 km). Emergency medical evacuation is provided by the RFDS, but return travel is by road.

A typical journey for medical care or hospitalisation in Adelaide involved leaving Yalata around 3pm, travelling to Ceduna by Health service car, boarding a bus at 6 pm travelling to Port Augusta arriving at midnight, stopping for an hour and then proceeding to Adelaide arriving at 5.30 or 6 a.m. the next morning. The support services in Adelaide are not available out of hours so the patient must get a taxi. The appointment may be any time during the day and the return trip, again overnight, with an hour stopover in Pt Augusta around midnight and requiring staff to travel from Yalata to Ceduna for the pick up. Trips to Port Augusta use the same services and involve arriving at midnight and leaving at midnight. There are no organised after hours support services while patients wait for the bus.

Travel is a major disincentive to obtaining the necessary specialist medical care and inpatient treatment. Many people at Yalata have poor English skills and are not familiar with the Adelaide or Port Augusta environs, and different social expectations in the cities. As a result appointments are missed and if this occurs, Commonwealth government travel support, the PATS scheme, benefits are withheld. There is no provision for accompanied travel.

Patients who are already stressed by worry about illness and who may be quite ill, are subjected to very difficult and uncomfortable travel with a high risk that connection to the appointments will not be made. The Tullawon Health Service absorbs high travel costs as a result of unpaid PATS benefits, staff time on travel to Ceduna, which often requires an overnight stay for staff in Ceduna so that Occupational Health and Safety requirements are met in terms of maximum hours worked in a day (The return trip is just over four hours and occurs at the end of a working day).

Tullawon is considering establishing an Adelaide office to enhance connections to Adelaide services and provide a familiar face to pick up patients from the bus. The community bus also tries to assist with patient travel on Fridays.

Examples of the effect of inefficient or inadequate travel for health care:

“Sometimes bus travel can prove degrading: for example, recently an elderly wheelchair bound woman travelling to Port Augusta for an eye appointment had to crawl onto the bus, in front of tourists, due to the lack of wheelchair facilities on the bus.”

“One of our patients who recently was diagnosed with a tongue malignancy required review by a number of specialists including a neurosurgeon, a dental surgeon, a dermatologist, and an ear nose and throat surgeon. Attempts to try and get better co-ordination of specialist visits, to reduce the number of uncomfortable trips by the patient and to reduce overall costs, proved difficult. It was estimated that health service nursing staff spent the equivalent of two days work completing the transport arrangements and the documentation required for cost reimbursement. Recently this patient needed to be transported to Port Augusta for dental surgery following her operation; because



dental work is not covered by PATS she was not eligible for accommodation assistance and had to sleep in the Accident and Emergency department of the Port Augusta Hospital.

Another recent case involved a six-year-old child who required major reconstructive facial surgery in Adelaide for a congenital disorder. Before the surgery, the child had eighteen outpatient visits in Adelaide that needed to be organized. When the time for surgery arrived, the family was staying in another town several hundred km from Yalata. The health staff attempted to organise transport at a distance, and the child was sent unescorted on an aircraft to Adelaide, while the rest of the family (two parents and two young children) had to travel by bus. Numerous phone calls, involving a considerable amount of time, were made by health staff to ensure that the family was accommodated in the hospital. A considerable proportion of the costs were not reimbursed, and as the surgery was delayed several times this added to the financial burden borne by the health service and the family. Excerpt from submission advocating improvements to the PATS system.

In yet another case:

“A young child was recently admitted to a hospital in Adelaide with a life-threatening illness, which required admission to the Intensive Care Unit and emergency neurosurgery. The young mother, a sole parent, wanted family support with her during the time of crisis but despite a considerable amount of time spent by health staff making phone calls, the PATS scheme was unable to accommodate family support.” Excerpt from submission advocating improvements to the PATS system.

#### *Travel for cultural reasons*

Many of the residents of Yalata have strong traditional ties to land and family. This requires travel into the large area to the north of Yalata including Oak Valley and Maralinga and for some into the southern parts of the Anangu Pitjantjatjara lands. There are strong association as far as Coober Pedy in the east and well into Western Australia. This travel requires strong vehicles in good condition, but there are few if any of these owned by the residents of Yalata. If a southern Anangu does not meet cultural responsibilities it can have a major impact on health and wellbeing of the individual and their family. There have been several incidents where community distress has occurred as a result of competition for vehicles to undertake cultural business. At times a very large proportion of the population needs to move for ceremonial or cultural reasons. One of the most frequent reasons for such travel is to attend funerals and the “sorry” camps that follow a funeral. These are important for maintaining cultural continuity. On other occasions a large number of people not usually resident at Yalata will arrive for a funeral or other cultural reasons. This can result in an influx of vehicles into Yalata and an increased risk of petrol sniffing.

There is a need to facilitate cultural travel in a safe and a secure manner. The nature and timing of this sort of travel means that it presents a considerable logistical problem as a vehicle can be away for several weeks. Community organisation vehicles or health service vehicles cannot therefore fill the gap. There is no easy solution but further work needs to be undertaken to consider such options as pool vehicle for a wider region.

#### *Public transport*

There is no public transport in Yalata. The Perth bus stopped running in 2005. Cheaper airfares meant that interstate travellers no longer used bus travel. This left Yalata without a regular, publicly accessible connection to the outside.

### *Yalata bus Shared Responsibility Agreement (SRA)*

Yalata remote Aboriginal community of around 430 people had been declared a 'Community in Crisis' in 2004. This was the culmination of many decades of instability and forced change in the community, which itself originated from the dispossession of several different Aboriginal groups from their homelands, and relocation by the government to the created community of Yalata.

In March 2005, a Shared Responsibility Agreement (SRA) was developed between the Yalata community and the Commonwealth of Australia (through the Office of Indigenous Policy Coordination (OIPC)) and the South Australian Government (through the Children Youth and Family Services (CYFS) and the South Australian Police (SAPOL)) to provide transport in the form of a community bus. The service was operate twice weekly to and from Ceduna, the nearest regional centre. The service commenced on the 19<sup>th</sup> of April 2005, for a trial period of six months.

No regular public or private transport existed previous to this. Travel between the community and Ceduna, and the outlying communities of Oak Valley and Koonibba, and further afield to Pt Augusta and Adelaide (primarily for hospital visits) was a haphazard and uncertain affair. People took their chances of a ride out of the community in private cars that might be considered unroadworthy for the harsh conditions, perhaps without windscreens, seatbelts, fully functioning braking systems, and unreliable engines. They may be unregistered, and there may not be enough petrol in the tank for the full journey. Added to this, the driver might not be suitably experienced or in a good state to drive, and in fact may not have a licence. It would also be unusual for any seat to remain vacant, and overcrowding would often be the case. Even if the driver were competent and in fit condition, the distraction of passengers whose behaviour was likely to deteriorate over a long journey was a major concern. There was often no return plan, again chance playing a big part in finding a ride at the right time. Lack of planning and choice often resulted in people exiting the community at short notice, often leaving children at school to come home to an empty house and no meal. People stranded in Ceduna with no ride home created other difficulties, and led to people to engage in risky behaviours, which they probably would not choose to consider if they had another choice. Some of these choices might be to go with someone they don't know who offers them food, drink, a ride or shelter, as they are seen to be vulnerable, especially if they are particularly young, or female. Others would drift to the Town Camp (18 Tank) on the edge of town, or would be continually moved on by the local constabulary, who are under pressure to curb violence and keep order for the town residents, for whom the scenes were all too familiar and unpleasant. Access to alcohol for people who normally reside in a 'dry' community usually had negative consequences for the individual and the residents, with violence and assaults resulting all too regularly. Those who were able to stay with relatives in town put pressure on already burdened households, with relatives obliged to accommodate and provide hospitality at short or no notice for unexpected guests. The Sobering-Up Unit in Ceduna, managed by Lourdes Ordasi from Ceduna Koonibba Aboriginal Health Service (up until September 2007), was also put under pressure at these times, especially as it was, at that time, only a partial service, running 2 days a week. Don Saltmarsh, the contracted bus operator for the duration of the SRA, was also a mechanic, and a member of the Ceduna Road Safety Committee.

Mr Don Saltmarsh operated the charter bus in 2006, funded by the Flexible Funding Pool (ICC), and that funding ceased in December of that year. It ran once a week on a Thursday, to Ceduna and back. The charter bus charged a \$20 full fare and a \$10 fare for pensioners and children for the return trip. It was a one-year contract.

From January to the middle of June 2007, there was no service. A community bus is now being used. It operates on Fridays and cost \$10 per return trip. The bus is a smaller capacity than the charter bus and it has been filling up (24 seats).



*“There were way too many people to come back to Yalata one day, we nearly had riots. That’s why we’ve got to get a ticket system going, like a receipt. The driver didn’t know what to do, didn’t know who to pick to kick off. Some people still get stranded in Ceduna.”*

Advertisements for a bus driving position have been put up everywhere, as currently only the CDEP manager and the Administrative officer have a bus licence. If a driver can be employed the service will run two days a week. Some passengers could go down on Friday for the football (Ceduna, Penong) and come back on Tuesday morning (200 odd km to go and play football). They considered ceasing the Friday bus and doing a run down on Saturday morning so they can play football, but the current driver works full time during the week and has family responsibilities, and so won’t be able to drive a bus on Saturdays.

*We’re trying to get some CDEP drivers, to drive it (the community bus), but we’re having problems with people not having their licence. I’ve only got three people in CDEP that have got a licence at all.*

How many of your CDEP clients do you think could get employment if they had a licence?

*We’ve got people keen to drive the bus, but they have to have their licence (unencumbered) for a year before they can do that. I’ve got about half a dozen licences back from the courts through grovelling, just so people can be driving here (in the community) legally. That’s something I’m very strict on, no licence – no drive. Most people just lost their licence through not paying fines. That’s easy to get back. You just get people on regular payments, once they’ve been doing that for a couple of months, I twist a few arms, and...*

So you go through the court system and advocate for them?

*Yes. What sort of fines? Oh, a lot of them, alcohol in a public place...*

*So, not necessarily involved with a car, more personal? Not normally, more personal. Offensive behaviour, drinking in a public place. If they don’t pay the fines, they can take their licence away. The ones who’ve been disqualified, I can’t do nothing.*

Is it hard for people out here to get their car registered, or do they get a licence and rely on someone else having a car? *They have cars, they just can’t (legally) drive them! Some other family member drives them around. A lot of fines have been from driving unregistered cars, that does seem to be a big problem.*

The bus also presents difficult management issues. Smoking is banned on the bus and many passengers do not like this policy, which is required by South Australian law. Many of those who go to Ceduna consume excessive amounts of alcohol and on occasion attempt to smuggle alcohol onto the bus, which is a breach of the dry community policy at Yalata. The bus trip from Ceduna is slower because of the frequent toilet stops required after a day drinking.

The bus, however, represents an important link to the outside world for an isolated community. It enables people to maintain their language, culture and lifestyle in Yalata Community while maintaining links and access to the wider community.

**Footnote:** Three weeks after gathering this data, the bus service ceased due to a violent incident amongst passengers. Some weeks after the incident, a bus driver from outside the community was employed. The service resumed w/c 17/09/07, retaining the Friday schedule.

### *Licensing*

It is estimated that only 12 of current Aboriginal residents of Yalata have a drivers licence. Only the CDEP coordinator and an administrative officer have a bus drivers licence. The barriers to obtaining

a licence include, lack of literacy, lack of access to vehicles, lack of a pool of people who can provide driver training.

Currently, a minimum of 50 hours supervised driving in a range of specified circumstances is required to attain a P licence. Recent revisions of provisional licensing may lead to an increase in required supervised driving hours, which would increase the barriers to Yalata residents obtaining a licence. Insurance of vehicles to be driven by young inexperienced drivers, especially learners, are very high meaning that there is considerable financial risk in mentoring a learner driver. The critical mass of drivers to support training is not available.

A real life example of barriers to gaining 50 supervised hours of driving:

A student in her final year of secondary education at an urban residential Aboriginal school is struggling to accrue the supervised driving hours and undergo the test to obtain her P licence. She is trying to achieve this by the end of the school year, as well as successfully complete her academic studies. Why is it difficult for this student?

The student is studying in Adelaide, to give her an advantage when she returns to her community, which is on Aboriginal leasehold lands approximately 1,000km west of Adelaide. She has no family in Adelaide able to support her driving or to provide a vehicle, and the conditions in her home community would not afford the range of driving experiences necessary to complete the competencies. For example, there are no curbs to move off from, no hills to move off from, no 90° angle parking, no real opportunity for reverse parallel parking, no roundabouts, and certainly no traffic lights. It is also unlikely that she would be able to find a willing person who has held an unconditional licence for two years without disqualification, who would pass the criteria for being a supervising driver.

**A sad footnote:** at the time of writing, this student learnt of the death of her young niece in a car roll over. She was preparing to travel back to her community for the funeral.

One young mother who had no licence drove her children in an emergency and as a consequence has an extended prohibition from driving.

Licence suspension due to driving under the influence or driving without a licence contributes to low effective licence numbers. There is a perverse cycle. Lack of people who can drive make it difficult for a car owner to opt out of driving when under the influence of alcohol. Some who are not licensed to drive protect those under the influence by driving resulting in longer term suspension of licence. This cycle undermines cooperation with the licensing system.

There is a great deal of confusion about licensing. It appears that in some remote areas where the land is Aboriginal land, people can drive without a licence. This is similar to unlicensed drivers driving on a farm or station property. The different status of land tenure seems to vary what is possible. In Yalata where the land is leasehold, the roads are public roads and full licensing is required. This is seen by some of the community as inconsistent and unfair.

A new mine is planned in the area near Yalata and some residents would like to seek employment. They are unlikely to succeed without a drivers licence and preferably a heavy-duty vehicle licence. This requires a period of light vehicle experience before moving on to a heavier vehicle and the opportunity to practice on a heavy vehicle. There is a need to develop a system to support driver training including light, heavy and heavy passenger vehicles.

#### *Vehicle availability*

Private vehicle ownership is low. There are few cars and some of those are old and in a poor state of repair. Light vehicles which are generally unsuitable for travelling long distances and in rough

terrain are cheaper to purchase but do not provide reliable long term transport. The nearest fuel and repair depot is at Nundroo more than 50 km away.

Vehicle availability is also reduced by the pattern of use of available vehicles. Just about any vehicle is used off road to hunt wombats and the consequences for the vehicle are disastrous. This reduces the pool for other travel.

#### *Petrol and diesel vehicles*

The Community Board and the health centre discourage petrol vehicles on Yalata. This is to reduce the opportunity for petrol sniffing.

#### *Conclusion*

Travelling well in Yalata is not easy. Barriers to licensing, ownership of appropriate vehicles and large distances to service combine to place residents at risk. The risk occurs directly through the nature of travel and vehicle combinations and indirectly through the impact on access to health services and cultural events.

### **3.3 Factors that shape the need to travel**

Travel patterns are shaped by a number of different factors. Many of these factors are beyond individual control. Basic human rights dictate that people should be free to travel safely to meet their needs for cultural fulfilment, health and wellbeing.

#### **3.3.1 Demography**

##### ***Population***

At the 2001 census it was estimated that there were 22,003 Aboriginal and 778 Torres Strait Islander people living in South Australia (ABS 2002). By 2006 this had increased to 24,080 Aboriginal people and 1,045 Torres Strait Islander people (ABS 2007). The increase is partly due to improved identification and enumeration of Indigenous people and high mortality rates, but also represents a resurgence of the Aboriginal and Torres Strait Islander population.

If the growth is projected forward the estimated Aboriginal population of South Australia in 2007 is approximately 26,000 and growing at about 1000 persons per year a growth rate in excess of 3% per annum. The Aboriginal population in South Australia in 2007 is approximately 26,000, with almost 60 % under the age of 25 years.

##### ***Aboriginal place of residence***

Approximately half of the Aboriginal population in SA (12,500) live in the greater metropolitan area and the balance of the population is split evenly between rural centres and the remote areas of the State.

#### **3.3.2 Impact of demography**

In most areas and at state level, Aboriginal people form a minority of less than 2% of the population. South Australia has a mainstream population that is rapidly ageing and the young Aboriginal populations' needs contrast sharply to those of the majority. Consequently Aboriginal needs including travel needs are underestimated, poorly understood and buried by mainstream needs and claims.

Aboriginal social cohesion is supported by a group of Aboriginal adults. These are the surviving elders and young to middle aged adults. The demographic structure of Aboriginal society means that there are large numbers of dependent people. These are the coming generation of young Aboriginal people, and the sick and infirm. It is important to ensure that young people are provided with the opportunity for education, employment and safe travel. The core support group needs assistance to remove barriers to the progress of young people. McCoy also notes the importance of connection to land and culture. His focus is on the impact on the young of dislocation and interruption of extended family ties.

“It is not uncommon today, in the desert and other places, to hear a young Aboriginal person say, ‘I’ve got nobody’, or ‘nobody boss for me’. One interpretation of such statements is that they reflect, ‘the rhetoric of personal distinctiveness and autonomy’ ((Martin D F 1993) p30) however, some adults in the Kutjunga region would interpret them differently. They would say, ‘he wants someone to look after him and care for him’. And while they link the cause of the anger and the feelings of hurt to the absence of a parent, or whoever who was responsible for caring for that young person, their understanding is that they are hearing a ‘cry for help’. They would then argue that a new holding experience needed to be introduced for this young person.” (McCoy BF 2004)

Both Commonwealth and State government policy has shifted toward mainstreaming services including health services and transport services with complementary specialist services ((Commonwealth of Australia and the State of South Australia 2005)Pg 7). This has generated a system where the Aboriginal voice is less likely to be heard, especially where there is no distinct geographic Aboriginal community. It is easy for a major policy to include recognition of the needs of Aboriginal people, but much harder to ensure that the minority voice of Aboriginal people is heard when the broad policy is translated into action.

In areas where Aboriginal people are in the majority, or at least form a significant minority, there have been some interventions targeted to address the poor health and social status of Aboriginal people. This has occurred in the Anangu Pitjantjatjara Yankunytjatjara Lands and at Yalata, which was declared a Community in Crisis in 2004, and is one of the pilot areas for the trial of the Coalition of Australian Government (COAG) initiative commenced in 2002.

### **3.3.3 Culture**

Aboriginal culture is rich and varied. In more traditional areas the ancient culture is lived every day and is the source of health. In other places, especially where there is a mix of Aboriginal peoples from a variety of places and a strong influence of white culture, there are many different cultures, and often, different views about culture in one community. Nevertheless, Aboriginal commitment to social and family responsibility, reciprocal gift giving, the importance of place and heritage is an essential foundation that influences health and the need to travel.

At the heart of the Aboriginal culture is the need to meet traditional responsibilities and to be in the right place for health and community connection.

“Since 2002, WDNWPT emphasised that this cumulative experience was best described through a migrant prism of ‘dislocation’ rather than muffled ‘relocation’. It is a schism, an abrupt and profound separation from all that was familiar and sustaining, all that went before. Yanangu describe how ‘dislocation’ strikes at the very core of their identity, disrupting linked values of family and relatedness (walytja), country (ngurra) and Dreaming (tjukurrpa), the basis of Yanangu well-being. The enforced disconnection of individuals and family is central:” ((Rivalland P 2006) Pg 13)

“Yanangu consistently describes the entangled, debilitating sadness, insecurity and loneliness brought on by being so far from country and family. It is culturally inappropriate and unwise to always remain in one place, especially in another Aboriginal persons country where social, spiritual and nutritional activities are lacking, e.g. hunting. With the frustration and emptiness of boredom, reduced networks and lost opportunities, individuals can wait endlessly for visits or even a familiar face: ((Rivalland P 2006)Pg 13)

“... All those sorrowful people, they’re living in town with too much worry, getting sick at (name of hostel), living in one place, not going to Kintore and their families not seeing them. Sitting outside, they’re looking for their family, becoming lonelier and lonelier. They then just go back inside their room and think, “My family isn’t coming from Kintore.” 12 ((Rivalland P 2006)Pg 13)

“...Because it was another place. Many of their family died, like young brother, sister, auntie and many old women and many others. Staying too long, we lost our grandmothers and grandfathers. All those first people died in Papunya, in another place.” ((Rivalland P 2006)Pg 14))

“Alongside strengthening family relationships, including non-WDNWPT staff and transport in trips such as hunting had several intended outcomes. It is important in remote areas to ensure that vehicles are reliable, particularly through extremes of weather when carrying children and those with chronic illness. However such trips also assisted the development of necessary personal relationships required to provide secure cross-cultural care, especially when staff are out of their personal and institutional safety-zones in remote communities. Yanangu regards this as part of their relationship responsibility to make others ‘understand’ (kulini): “Us two went everywhere together ... All of us went for pura (bush tucker) – we were always eating it, by the bucket-full! I finally took her to see my outstation, to show her so she’d understand. “((Rivalland P 2006)Pg 44)

Yanangu emphasised that to remain healthy, all family members must sustain fundamental relationships with ngurra, walytja and tjukurpa. Alongside simple visits, there is a need to be present for funerals, a major opportunity for both renewing acquaintances, being with family and ensuring that vexed issues arising from ritual ‘Sorry Business’ are handled appropriately.” ((Rivalland P 2006)Pg 37)

The impact of culture is not just limited to more traditional people or the remote regions. While many less traditional Aboriginal people live different lifestyles, the underlying importance of family connection and connection to place is profound.

In our interviews and focus groups the strength of commitment to culture was evident even among Aboriginal people who live in the metropolitan areas. In the more remote areas the expression of need was more along the traditional lines found in the literature. In towns and urban areas the focus of discussion was more on the need to support family and this meant extended family in far-flung areas of Australia. The travel needs were quite different to those in non-Aboriginal society. The need to attend funerals and to be with family at critical times is paramount. The need to return to country to support those who live there and to care for land is also strong. Cultural commitment often means long distance travel, at times of stress, to places where roads are more hostile to vehicles. This occurs among a community where underlying poverty dictates that transporting large numbers of people must be done in older vehicles not well suited to rough roads or to carrying large numbers of people in difficult terrain.

### **3.3.4 Location**

Location of residence is an important factor in shaping transport needs. In each location a mix of needs for access to services, access to family and community, and access to lands interacts with poverty and mainstream transport options. In many cases the most frequent travel needs of Aboriginal people are quite different from the needs of the majority population making transport

more difficult and often more expensive. There are a number of issues that are common across all of the communities studied and some which are particular to individual communities or types of community. A note on Emergency Services:

The Yalata police station and an adjacent abandoned house were destroyed by fire a month after our field trip there, causing approximately \$500,000 worth of damage to the police station alone; fortunately there were no injuries (Milnes M 2007). Fire investigation is underway to determine the cause of the blazes. A single volunteer, whose determined efforts limited damage to the two structures, operated the community fire truck. The nearest trained CFS crew, Far West Brigade, were called to respond from Nundroo, some 70km distant. As the incident involved structures, the protocol is to respond a unit with CABA (Controlled Atmosphere Breathing Apparatus) equipment and personnel trained and certificated to that performance level. The protocol was followed, and Ceduna Brigade responded, reaching Nundroo before a stop call was placed on their attendance, meaning that they headed the fire appliance back to Ceduna without attending the fire scene. The consequences of this incident were limited to property damage. Had the home or the police station been manned, or indeed, had an offender been in detention there at the time, tragedy would likely be the outcome. Whilst there are many issues surrounding the cause of the fire, remoteness from essential services is a key point. The capacity of remote communities to take on training to accredited standards and to maintain and support functional volunteer CFS brigades are also important issues. It is vital to be aware that fire and road accident response on the Far West Coast from Ceduna to the Western Australian border, some 482km, is provided by volunteer CFS members, supported and directed by a small core of Regional Officers (CFS salaried staff). The SA CFS provides a modest amount of funding to the Eucla Brigade over the Western Australian border to provide joint response where appropriate. Volunteers turn out to incidents including grass and bush fires, structure fires, storm and flood damage, vehicle accidents, hazardous materials spills and industrial incidents. Often work time is affected in responding to community needs, particularly when long distances are involved. In addition to operational fire fighters, many other volunteers are involved in supporting the CFS and its duties; auxiliary staff in logistics, radio operation, administration and catering. Cadets are trained and mentored to become fire fighters on reaching 18 years of age. Fund raising and promotion of the Service are also part of the role. A previous house fire in March 2006 destroyed a home, the damage was estimated at \$200,000.

### ***Common themes in four locations***

This project studied four locations. The following common themes emerged:

- Mainstream transport systems were set up according to non-Aboriginal culture and needs and therefore were rarely ideal for Aboriginal travel. The urban transport hub system means that people not undertaking mainstream direct travel find it difficult to reach their destination in a timely and efficient manner. Urban transport policy is firmly focussed on majority commuter systems and does not adequately address the needs of other groups. We were unable to find any reference to Aboriginal transport needs in publicly accessible transport policy documents. In the country, long trips at inconvenient times make travel difficult. Travel is generally to Adelaide. If travel is from country town to country town (say, Coober Pedy to Ceduna) connections are difficult.
- Access to transport by private vehicle was limited by low income, language and literacy barriers to gaining a licence, lack of access to vehicles and supervision to meet new licensing experience provisions and the wide range of travel demand in communities with low vehicle ownership. Even where car ownership is possible, the ongoing cost of registration, fuel and maintenance is prohibitive.

- Aboriginal people need public transport more because of lack of access to private transport. In areas where they are available, taxis are often used regardless of the cost to allow groups of people to move efficiently without the difficulties of using public transport and the shame generated by racism. This further erodes disposable income. Racism presents a barrier to the use of public transport both in terms of the drivers of transport and the general public acceptance of Aboriginal people.
- Most Aboriginal people need to undertake long distance travel to meet family and cultural responsibilities. Access to efficient and economical country travel for groups of people is poor, resulting in unsafe travel in vehicles not suitable for the trip, overcrowding, excessive loads on vehicle owners and those with licences and a temptation to ignore lack of a current licence.

### ***Major differences across four locations***

Some issues arose only on one or two communities. It was particularly noticeable that in remote areas there were specific issues relating to remoteness. It might be anticipated that these issues would occur in many remote areas.

- Lack of access to transport of any kind.
- Poor scheduling and timing of long distance services.
- Reduction of public land transport services as non-Aboriginal land travel in remote areas is replaced by air services.
- Excessive wear and tear on vehicles and difficulty with accessing repair services because of cost and distance.
- Inconsistent requirements for a drivers licence depending on the status of land ownership and the classification of road crossing Aboriginal lands.
- The need to control petrol powered vehicles in areas with petrol sniffing histories and the expense of substituting diesel vehicles in the absence of the availability of “non-sniffable” petrol (Opal).
- Lack of a critical mass of licensed drivers and suitable vehicles to meet requirement for longer hours of supervised drivers during the learner period. Appropriate insurance cover for young and inexperienced drivers is an issue.
- Systemic pressures to drive while under the influence of alcohol or unlicensed related to high levels of stress and disorder from time to time.

### **3.3.5 Health**

The Aboriginal view of health is holistic. Lack of health is indicated not only by the presence of disease but also disruption and stress in Aboriginal society. A Joint ABS AIHW report, “The Health and Welfare of Australia’s Aboriginal and Torres Strait Islander Peoples 2005” paints a picture of this broad need across Australia (ABS/AIHW 2005).

High levels of poverty, social disruption, violence and injury are demonstrated and are detailed in the separate literature review on health (Moller J 2007 ). Of particular interest for this study is that about 30% of Aboriginal people report difficulties with transport and a higher than expected rate of hospitalisation for transport related injuries. Many more hospitalisations occur than expected with the greatest differentials being for kidney disease, endocrine and metabolic disease (including

diabetes), diseases of the skin, infectious and parasitic diseases, respiratory system disease, injury and poisoning, circulatory disease including heart disease), mental and behavioural disorders and complications of pregnancy.

Aboriginal peoples perceptions of their own health as reported in the National Aboriginal and Torres Strait Islander Social Survey 2002 (ABS 2004) are described:

“ people were more likely to report fair or poor health than non-people at all ages, with the exception of those aged 18–24 years (graph 7.2). The proportion of Indigenous people reporting fair or poor health increased with age, from 8% of people aged 18–24 years to 56% of people aged 65 years or over. Indigenous Australians living in remote areas were less likely to report fair or poor health (22%) than those in non-remote areas (27%).” (ABS/AIHW 2005) pg 92)

In 2005 The South Australian Aboriginal Health partnership published data on a wide range of health indicators of Aboriginal health and mapped them for the Indigenous geographic regions of South Australia (South Australian Aboriginal Health Partnership 2006). This study compared the health indicators in each region with the State Aboriginal average which for the first time showed the large variations in Aboriginal health in different regions. The document is extensive and would provide a sound basis for detailed planning. The main findings were:

- Aboriginal people in rural and remote areas had significantly different patterns of disease than their counterparts living in more densely settled areas. In general their risks were higher and in remote areas, diseases associated with poor environmental conditions (e.g. infectious and parasitic disease) were more prevalent.
- It was notable that chronic health problems, which required intensive specialist treatment caused Aboriginal people to relocate forming clusters, near treatment centres. This was especially the case for renal disease and mental health and alcohol problems.
- CDEP played an important role in providing income to Aboriginal families, without CDEP, the number of persons dependent on each income was greatly increased
- Very different patterns of health were shown for different areas. There is a need to respond to health needs locally and to understand the cause of the patterns of disease and to provide a wide range of inputs including income, improved access to treatment and environmental improvements.

From the National and State data it is clear that there are some health problems that form a very heavy burden on Aboriginal society in South Australia. The literature on these problems has been sifted and the dynamics of each of the following issues assessed in the detailed literature review (Helps and Moller 2007).

- Renal disease
- Heart disease
- Violence and suicide
- Youth and child health
- Injury

The burden of disease and death on Aboriginal people generate an imperative to travel. Travel may be for diagnosis, treatment, to be with a relative who has had to relocate to receive ongoing treatment, to meet obligations to family and land generated by poor health and relocation or all too often to attend a funeral and its repercussions.



Renal disease, for example, often requires relocation of one person for treatment but it is necessary to move a section of the family support system as well. Heart disease requires careful management with frequent specialist involvement yet health service data show that Aboriginal people are underserved in terms of advanced procedures and it is likely that lack of access to diagnosis and treatment contributes to this.

Violence requires relocation to separate parties in a dispute, and to obtain safety for individuals, most often for women and children. Depression and suicide are common and the availability of transport for people at risk and support persons to ensure that the risk can be properly managed is essential. Too often the supportive response is too late because travel arrangements are too difficult.

The Aboriginal population is young in comparison to the non-Aboriginal population. A whole new generation of young Aboriginal people require support and preventive health care to ensure that they do not develop the chronic disease burden of the previous generation. This requires access to services and programs that address disadvantages. These cannot be delivered without a mix of locally delivered services and ready access to more advanced services located further away. Transporting children safely requires support for carers and family members who must accompany children and the availability of safe transport systems.

Injury data shows that Aboriginal people experience a much higher rate of injury hospitalisation and death than non-Aboriginal people (Helps YLM and Harrison JE 2004; Helps YLM and Harrison JE 2006). Transport injury is one of the major causes of serious injury and death. Indigenous populations have also been identified as being at greater risk of mortality and hospitalisation than the rest of the population, particularly in rural and remote areas, and therefore in need of further investigation and intervention (Edmonston, Dwyer et al. 2002; Macaulay, Thomas et al. 2003). The health system is however difficult for Aboriginal people:

“Traditionally, Australian and many other ‘developed nation’ health services have relied on the individual delivering himself to the system and largely delivering himself up to the system.”(Boustany J 1999)

As practitioners we need to recognise the unspoken paradigms of our culture and how our conditioned expectations and beliefs, however unconscious, do effect our interactions and make us sometimes inaccessible to cultures of a different understanding. We are a product and reflection of western culture, and even the physical spaces we occupy, which we expect to confer a sense of safety, expertise, and technological science, clash directly with the Indigenous sense of healing.

Hospitals and large buildings are seen as a threat; bad experiences of the past are associated with large buildings, for example police investigations, community welfare taking children away((Boustany J 1999)Pg 2).

Being able to access services is a problem that frustrates many Aboriginal and non-Aboriginal people alike. Service delivery systems based on perceived efficiency of operation models are often electronically based or telephone systems that do not allow immediate access to an operator. This can be particularly frustrating for disabled or older persons.

A comment about agencies being more accessible and helpful:

*“Government departments need to be more accessible and friendly – they should advertise it more (services) and explain it in a way that Aboriginal people understand quickly. Written, TV, over the ‘phone. ‘Push a number’ ‘phone services entirely border on the inhumane!”*

Aboriginal people experience high levels of need but are faced with a system that is often distant and which has unrealistic expectations based on the dominant health culture. For example:

A Torres Strait Islander man living in the northern suburbs asked about travel assistance in regard to accessing a dentist. A disability pensioner in his early forties and very quietly spoken, he explained

that he avoided walking out in public because of shyness and lack of confidence, and was apprehensive about going to new places on his own, mainly because he could not read. He also felt that because of his height, large build and dark skin, that people might look at him and find him intimidating, when in fact he was feeling extremely vulnerable and felt he was being stared at. His lack of literacy left him unable to navigate new locations, and prevented him from using the public bus transport system, because the signs on the buses and bus stops meant nothing to him, and maps and timetables were an impenetrable maze. Despite his agoraphobia, he was moved to ask about how to get someone to help him go to a dentist. He had been enduring erupting or impacted wisdom teeth, to the point that his diet and wellbeing were affected through pain when eating. In the past, he had resorted to extracting other teeth using pointy nosed pliers for an instrument, when pain from other teeth became too intense. At this point in time he said:

*“I know that if I don’t get help with my teeth this time, it will hurt my mind as well as my body. I know I have to fix my teeth to have my mind well.”*

As a direct result of inclusion in a men’s activity group (made possible by transport to and from the location in an agency bus), over the course of some 12 months he became confident enough to pursue his social worker for help, resulting in two dental visits. Continuity of care was disrupted through a change of social worker, but again, he pursued further appointments through the Department. When he could go no further, he was able to seek advice and assistance from elders in the group who were familiar with the system and could advocate with him.

### **3.3.6 Disability**

There is a dearth of systematic literature on Aboriginal disability. Aboriginal disability policy and services operate in the shadow of mainstream services and ideas in a system which diversifies responses across a wide range of departments and agencies.

Aboriginal concepts of disability appear to be poorly understood by policy makers and service providers. There has been little research published on Aboriginal disability, possibly due to the relatively small numbers of Aboriginal people identified as having a disability has limited the study of this issue. However, while numbers are small in relative terms the prevalence appears to be much greater and more complex than in non-Aboriginal society. There is a great need to study Aboriginal disability in a systematic and culturally sensitive manner in order to determine what services are needed.

The lack of good information about Aboriginal disability in general has an impact on the understanding of transport issues for Aboriginal people with a disability and their families. We could find no literature that systematically studies Aboriginal disability needs and issues of access and transport. Issues of access to services are raised for all disabled people and it is clear that the population distribution and economic and social well being of Aboriginal people generates specific critical needs.

The numbers of Aboriginal people with a disability are clearly underestimated due to lack of culturally appropriate systems to identify need. It is clear however that there are more than a thousand Aboriginal people with impairment or disability as defined by a health based definition and at least 10,000 who can be identified as being affected by broader social and educational disabilities.

While transport systems are only one barrier to access to services for assessment and support, they can be a focus of attention. A person with a disability requires proper assessment and support. This can only be done if the services are easily accessible. Where a disability exists there are significant pressure on families and caregivers in meeting the direct load generated by the disability. There are

multiple assessment meetings with a range of professions, meeting the different needs for daily living and adjusting to different education and support system.

It is important that services are delivered in a manner that does not increase the costs to families by requiring a great deal of travel. Disability needs are less common than general health needs, so safe transport systems will either need to piggyback on the health system arrangements or will need to be especially arranged for individuals and their families.

### **3.4 Factors that shape the safety of travel and the nature of risk**

#### **3.4.1 Road conditions**

In rural and remote areas road conditions have an impact on safety and cost of travel. Poor roads damage vehicles and vehicles that are designed for such roads are more expensive to purchase and maintain. The cost to people living in remote areas is very high.

Road conditions contribute to crashes and in particular rollovers, where the likelihood of injury and death is increased. Difficulty in accessing treatment also increases the likelihood of adverse outcomes of serious injuries (Croser JL 2003). A particular reference to the stretch of the Eyre Highway between Ceduna and Yalata was made in the press in 1997, following publication of a report centred on Yalata community (Watson, Elliott et al. 1997). *The Advertiser*, 26<sup>th</sup> July, 1997.

#### **“Eyre Highway 'a danger' to Aborigines”**

A 200km stretch of the Eyre Hwy, on the States West Coast, has been designated a major danger for Aborigines.

More Aborigines per head of their regional population are injured in road accidents along the highway than anywhere else in Australia.

This was found in a study (Watson M, Elliott P et al. 1997) which showed Aborigines accounted for a "disturbingly high" percentage of casualties and deaths between Ceduna and the alcohol-free Aboriginal community of Yalata, the Aboriginal Drug and Alcohol Council said.

The study, by the Transport Departments office of road safety, centred on admissions to hospital, where patients were asked for personal details.

This method was preferred to police statistics, which do not differentiate between racial origins.

The departments report shows 41 Aborigines were killed on SA roads between 1990 and 1994. This was 4 per cent of all road deaths, yet the Aboriginal population is about 1.4 per cent.

More than 70 per cent of Aboriginal casualties lived in rural areas, compared with just 40 per cent of non-Aboriginal casualties, and most were from the northern and Eyre Peninsula regions.

The council next week will complete a 10-month study which will make a series of recommendations on the incidence of Aboriginal death and injuries on the roads.

The councils education and training officer, Mr Paul Elliott, said a Transport Department steering committee had singled out the Murat Bay district, between Ceduna and Yalata because it had a disproportionately high number of deaths and injuries.

Mr Elliott said a later survey he conducted with the Yalata community found the accidents were usually caused by a combination of alcohol and the long distance travelled.

Both Ceduna Council and the police Major Crash Investigation Section have been asked to contribute suggestions to reducing the accident rate.

The council has been pro-active in helping the transient Aboriginal community establishing dry areas and campsites in and around the town.

Mr Elliott said his reports recommendations would include:

MORE police breath testing of drivers along the highway.

A FREE bus service operating between Yalata and Ceduna.

AN EDUCATION campaign because government media-based campaigns were not reaching the communities. (Holder Rick 1997)

On occasions roads are cut by weather conditions. The most travelled are repaired first, leaving more remote areas on less travelled routes vulnerable for longer periods. The following vignette reflects the impact of loss of connection through transport failure:

Around Christmas, most of the non-Aboriginal people had gone on leave. There was a nurse and a couple of other support people left in the community. The weather turned bad with very heavy rain. The roads and the airstrip were closed. The weekly food truck could not get through and even the mail 'plane could not land. The community was cut off. Fregon is a six to seven hour drive from Alice Springs and the food and other goods are delivered through Marla.

Two problems emerged. The food started to run out and the absence of the mail 'plane meant that some people had no money to buy even the supplies that were available because they were paid by cheque and the mail had not arrived. No benefit cheque equals no food.

There were communications through the radio and telephone links but the roads were washed out. The community became very unsettled. Many knocked on doors trying to get food and there was a risk of violence. Some families who had money and had purchased the last of the food resorted to strong-arm tactics.

As the roads started to dry out one man drove the thirteen-hour return trip to Alice Springs to get the mail, especially the benefit cheques so that the ability to purchase food was restored as soon as supplies arrived.

Road transport is a vital link for Aboriginal communities and for individual and groups that are attending to cultural tasks and family business. Lack of access to vehicles appropriate to road conditions and the road conditions themselves place many Aboriginal people at risk.

Risk is generated by the combination of road conditions, the vehicles that are available and the nature of the circumstances of travel. Modifying the risk can be addressed by changing any or all of these.

In remote areas there is often no local government to look after local roads. The Aboriginal Affairs and Reconciliation Division (AARD) and Transport authorities work together to identify problem areas and maintain roads. However maintaining long stretches of remote roads is expensive and more investment is required to develop a consistently higher standard.

The issue of appropriate vehicles relates to the economic circumstances of Aboriginal people and the lack of appropriate mass transport systems in remote areas. There is a need to address both of these.

The third aspect is that risk on poor roads in inappropriate vehicles is exacerbated when travel is done in an emergency or when the travellers are under stress. Lack of appropriate support for transport in emergencies generates high risk and in turn can lead to a cycle of repeated crises.

**Recommendation 2. Increased attention should be paid to the condition of unsealed road surfaces especially in homeland areas and routes commonly used by Aboriginal people for cultural and family travel.**

### **3.4.2 Availability and accessibility of transport services**

Public transport is generally planned for the majority population. This means funding of services around the capital city hub and central business district. Our interviews have suggested that Aboriginal people are not well served by this pattern of service. In urban areas travel for health and family reasons often occur in directions that are not well served by public transport. In rural areas, public transport is infrequent and often at inconvenient times. In remote area public transport is often unavailable.

The lack of public transport suitable for the needs of Aboriginal people excludes them from the subsidies enjoyed by the majority of the population. Hence one of the poorest and most disadvantaged groups is further disadvantaged. The following vignette tells a story that illustrates the impact of transport failure on an Aboriginal man:

A male Elder had a specialist appointment to attend. He had planned his time in advance, pre-booking a taxi the previous day, allowing extra time for the trip. On the day he was more than punctual, he was ready early and waiting outside to make it easier for the taxi to locate him. Even when a period of time elapsed without the taxi arriving, he found a 'phone box and tried to contact the company. When these efforts were frustrated by the automated system, he committed to catching a bus, which involved another walk. As the events unfolded, and his careful planning went for nothing, his anxiety about missing the appointment increased. By the time he sighted the cab, travelling away from him, he was in a state of some distress. He ran down the middle of the road, to catch the taxi as it waited at the railway crossing.

*"You see, that to me, if I saw someone running down the road to the train, the railway line like that, I'd be laughing at a person like that, running down the street, waving a bloody hat and a bloody bag all the time."*

*"I had this return (cab) voucher, you see. Naturally, I saw the doctor he gave me something, put something in my arm. I don't remember what. Anyway, they said, 'now, you can't go home by yourself, you have to have someone with you to take you all the way home, and after that we'd like somebody to be with you. This dose they give you works for quite a while. Anyway, I didn't feel too bad at all."*

He remained calm when told he wasn't to travel unaccompanied, and arranged an escort for himself. When he felt better, he pursued the matter, but his distrust of Yellow Cabs since this experience has had an effect on him. I very much got the sense that it would be a personal affront for him if he had not arrived in time, and if his specialist were to think that he had not kept the appointment and not notified him, when he had done all that he could to be there.

While the experience in this vignette could occur to anyone, the impact on an Aboriginal person is different. The man was already aware of the attitude of health systems that "Aboriginal people are unreliable and don't keep appointments". The failure of the arranged transport therefore had a higher emotional impact and led to anxiety and long term feeling of resentment and personal failure. It is not easy being part of a race that has a stereotypical image and a fear of being discriminated against. Information from focus groups and individual conversation revealed feelings of

discrimination and racial antipathy in both directions with Aboriginal people holding racial stereotypes of taxi drivers and believing that the drivers held similar stereotypes about Aboriginal people. Much needs to be done to develop better communication and trust to a level where racial stereotyping is eroded.

An observation from an elder living in the Western suburbs about reasons why people don't access public transport, based on his previous work experience in a government agency:

"People often can't access water or cleaning facilities (homeless or transient people), and feel that their clothing is not good enough, or that their hygiene is lacking – prevents them from using public buses. It's a shame job for them – non-Aboriginal people in that situation too. They often can't understand money for taxis – can't judge how much and are scared of not having enough."

Lack of appropriate public transport also increases the risks to Aboriginal people. Long distance travel in buses for health care places patients at risk and acts as a barrier to receiving appropriate health care. These risks can be direct. One interviewee expressed concern:

"I worry about the people in the community with asthma. It is not safe for them on the long bus trip. What if they have an asthma attack? Does the driver know what to do?"

Other risks come because of waiting for transport after hours, stopovers late at night and having little knowledge about the trip or the destination.

Even when support for transport and a vehicle is available, there are important barriers. The community bus experience at Yalata (see page 38) illustrates the problem.

In Ceduna, buses were available in the town but were operated by different agencies. Funding tied the bus to use for a specific project, but the bus was not fully utilised for this purpose and issues of insurance on excursions remains a block to wider use. This occurs in urban areas. The fragmentation of services to Aboriginal people across multiple agencies is a major barrier to the effective use of available resources. Often delegation has not been made to those who oversee the booking of transport to negotiate the most effective use of that transport.

An excerpt from the response to a letter from Reverend Peter McDonald, Minister Uniting Care Wesley, Adelaide, to the Office of the Minister for Families, Community Services and Indigenous Affairs: Minister Assisting the Prime Minister for Indigenous Affairs, the Hon Mal Brough MP. Mr Jacob Pilot, Mr Brough's advisor, responded to the letter in August 2007.

"The Federal Government reported that Yalata had, over the last three years, "moved from crisis to a point where the community's capacity to develop and manage solutions is evident." It listed the following as **examples of how the State and Federal Government – in partnership with the community – had "moved to upgrade community infrastructure and services addressing family violence"** (our emphasis):

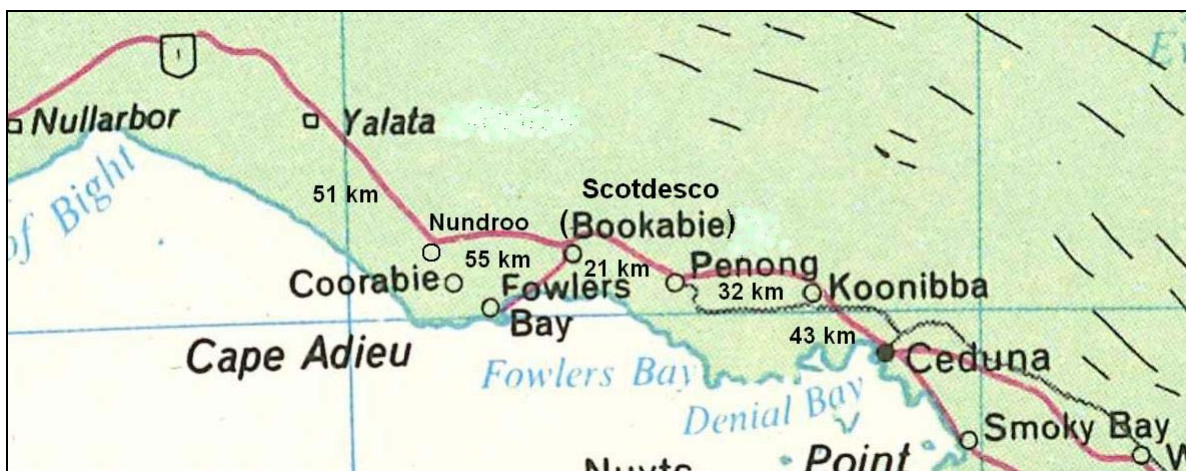
- The provision of extra police
- additional security lighting for recreational facilities
- substance misuse programs
- programs for youth
- establishment of a Family Well-being program
- **regular transport to and from Ceduna to access a range of services, including medical and legal services;** (our emphasis) and
- the appointment of experts to work with residents to develop a Community Safety Plan, which is now underway." (Pilot J 2007)

Clearly, the transport issue has not been addressed in an ongoing and sustainable manner.

**Recommendation 3. That a passenger service with a regional community focus be established to provide regular and reliable transport to and from Ceduna for outlying communities, between which there is a natural pattern of movement unmet by any current service.**

The map below shows the proximity of these communities to each other and relative distance from Ceduna. A more inclusive regional service would have the potential to operate more frequently than once per week, would service the broader community, and may be more sustainable over time than a service targeted at one specific community. A whole-of-government approach to developing the infrastructure, and providing funding, administration and maintenance is necessary. A recent tender to provide public transport in the APY Lands was recently awarded, the service scheduled to commence in October 2007. A similar approach could be adopted for the Far West Coast communities, perhaps also including the remote community of Oak Valley.

**Figure 18: Relative approximate distances in km between communities from Yalata and Ceduna (Feodoroff JS 1975), adapted 2007.**



**Recommendation 4. Agencies servicing a local area should consider their transport requirements cooperatively with a view to making reciprocal use of buses for group transport, and shared travel with clients in agency vehicles.**

**Recommendation 5. Racial sensitivity training is required for bus, train and taxi operators, followed up with quality assurance measures to assure that a standard of non-racist behaviour by operators and drivers is understood and adequately maintained.**

### **3.4.3 Health**

Emergency travel for health reasons is supported by mainstream emergency services. Since 2004, Ambulance SA has enabled people of Aboriginal or Torres Strait Islander descent to have their fee for service reduced or waived, where financial hardship exists. Where Indigenous people have the financial capacity to pay the fee, they are expected to do so (Solito T 2004). The Royal Flying Doctor Service (RFDS) is provided without charge to the patient. Our literature search showed that a problem exists with other emergencies. The families and support systems of people transferred in a health emergency often do not have the ability to travel to join the patient. This results in family distress and has an impact on the patient.

“A lot of patients...they get agitated especially if they are very unwell and you take the family member down because they don't want to go on their own. ...Sometimes they can't get on the plane, there's only a certain amount of people on that thing, but still they don't want to go you know. The family doesn't know what's going on and then they want to travel to get to the city by the time the patient arrives. We helped get one family member down with them because when you are going down querying cancer, querying something you know. (Aboriginal Health Worker” ((Stamp G, Miller D et al. 2006)Pg 2)

In cases where the safety of a person or a family is at risk such as during domestic violence, there is no easy system for moving those at risk to safe or neutral ground.

Transport for people suffering a mental health crisis is also difficult. Lack of access to private transport often rules out this as a means of taking a person for treatment and it is necessary to use police, ambulance or RFDS services. This requires more restraint and sedation and can exacerbate the situation.

The risk of emergency travel is generated by the frequency of crisis events, acute stress and its interaction with available resources. The risk is not usually felt as much by the person experiencing the crisis because services for these individuals are often available. Lack of availability of transport for relatives, and supportive carers lead to rushed and a poorly prepared trip, in vehicles that are not ready for such a trip and where the driver may be highly stressed. Lack of licensed drivers can also mean long periods at the wheel with fatigue risks and the temptation to drive unlicensed.

Emergency travel and even planned health travel can also be problematic for children of adults who need to travel. Children are often not catered for in adult treatment facilities. There is fear that arranging formal care for a child may result in a risk that the child will be taken into care more permanently and the tragedy of the "stolen generation" repeated. Aboriginal communities already live under a high degree of stress and finding appropriate informal care can be difficult.

A mother from Yalata required inpatient treatment in Port Augusta. Her eight-year-old daughter needed to be looked after for a few days and nights. The mother would have preferred to take her child with her to the hospital so she could see her and be sure she was OK, but this was not possible because there was no system for funding the child's travel and the hospital system did not cater for children accompanying adult patients. At the particular point in time, it was hard for the mother to ask for informal care from family and community members in Yalata. The idea of emergency foster care or other government assisted care brought up fears of a system that had taken children away and in any case there was no fostering system available locally. The visit to hospital was deferred.

A risk management strategy will include improving prevention to lower the number and level of crisis of emergency events, the provision of transport services for relatives and support carers who need to travel and the provision of support where children need to be left behind. This will require a radical rethink of the PATS scheme so that it caters for the cultural needs of Aboriginal people and their families.

Aboriginal people with chronic condition such as renal disease often have no option but to travel away from their families in order to access treatment. An evaluation of the cost of dialysis equipment and specialist health services (including day areas for supporting family) in key regional and remote areas might be compared to the repeat costs of travel, medical service and accommodation costs of renal patients, as well as taking into account the effect on daily wellbeing and recovery of separation from family and country:



“I now want to make a statement about people, I mean about renal patients. I want to make a message, give a message to anyone who listens to this and support us with it, with the idea. We’re talking about a statement and that is – “People on dialysis need to get back out there to their communities for cultural reasons, to be there with the family, to be there with the other relations, and make themselves happy. All the renal patients should have this chance to go out and have a visit”. So we need to know that. We don’t have any hope for us, for ourselves, we are supposed to have a dialysis machine out in the community. That way people can be happy, in their country and with their family. That’s a message I wanted to give, that’s my personal message, I don’t know what the other people think. If nobody’s going to say something about (ABS/AIHW 2005) their own lives they should say. But, I am talking, also for myself and for those people, for those renal patients this is the message I am giving.” Smithy Zimran Tjampitjinpa (1958–2001) from (Rivalland 2006)Pg 2

Until specialist services are provided in rural and remote areas, addressing transport to existing services will remain a priority.

**Recommendation 6. The Patient Assisted Travel Scheme (PATS) should be reviewed with the aim to increase the availability of support for carers and companions during health related travel, to simplify the procedures and paperwork necessary to make the service more accessible for clients in need, and to reduce the workload for remote health workers.**

**Recommendation 7. Alternatives to long distance bus travel to attend health appointments should be actively pursued. Scheduling of specialist appointments to a particular day or week of month for people from a particular region would allow for organisation of group transport, and increase the economic feasibility of air transport.**

**Recommendation 8. There is a need for increased hostel accommodation in all centres where Aboriginal people from distant areas are treated. It is recommended that all advanced level hospitals in urban and country areas have access to an Aboriginal accommodation program, coordinated with a single desk booking system.**

### ***Funerals***

Travelling to funerals was an important theme in all communities studied and in the literature. Aboriginal people have in the last 200 years experienced disease and death brought by settlers, the separation of children from their families, land and culture and an ongoing incidence of death and disease that is far greater than other Australians and which does not compare favourably with other Indigenous people across the world.

The death of any Aboriginal person occurs in this context and has a major impact on the wider community, not just one or two families. The death of an elder marks a loss of knowledge and the passing of important knowledge. The funeral is a place where grieving is undertaken and where arrangements are made for future spiritual well being by meeting cultural obligations and ensuring that cultural roles are passed correctly to others. Funerals, especially among transitional Aboriginal people can involve a range of lengthy ceremonies and ‘sorry’ business.

Many people need to travel to funerals. Mass travel at a time of such stress among people who may have few economic reserves generates a risk. It is not uncommon to hear of incidents where two or three people are killed while travelling to or from a funeral, generating a further cycle of loss and grief. As discussed above, travel can be in areas with poor roads and in unsuitable and overcrowded vehicles.

One male elder from the Western suburbs spoke about the difficulties he encountered around getting to funerals, particularly of those for family members. He related that he can usually go

everywhere and anywhere he needed to around his home base. His difficulty was in attending funerals, primarily due to financial constraints. For example:

Recently this elder had three funerals to attend on the Far West Coast, where he had spent most of his adult life.

*Because of my financial situation, I was unable to attend, but I sent my condolences, which were read out during the ceremony.*

If not for financial constraints, would you have attended those three funerals?

*I would go. Oh, definitely. They are my grandchildren.*

So that must cause you a lot of grief and frustration?

*Oh, a lot of grief, and I was only discussing that this morning, that it's been getting me down, it's been increasing, not decreasing, with those young people dying.*

So not only are there issues about family funerals, it's about your young grandchildren, that you're so sad because they're dying, and on top of it you're not able to go? And that's because it's a financial constraint?

*Yes, exactly. A financial constraint more than anything else. It's the number one problem in attending funerals. Even for a wedding, you're very restricted because of finances. In some cases, family will help me out, but that's not too often.*

And sometimes it would be you helping the family out? *Yes, Yes.*

Does that impact on your own wellbeing and perhaps on your role in the family or community?

*Oh, no, in my family and my community, my family and friends know very well that if I can get there, I will get there. If I don't get there they know I have a very good reason for not being there. Because I've attended a lot of funerals in the past (and weddings and occasions), so long as I'm able to I go. But if there's some setback, they will know I'm unable to attend.*

Common locations for family funerals would include Ceduna (a long, full days travel from Adelaide), half a days solid travel to Pt Augusta or Pt Lincoln, and at least two hours travel to parts of the Riverland. While finance is the number one constraint to travel, the costs of accommodation and food as well as fuel are heavy burdens.

An extended funeral may result in a vehicle being away from its home community for some time, sometimes making it difficult for those who are left at home to undertake their daily routines. A funeral causes a strong direct effect with a number of ripple effect that can be long lasting.

An aspect of funeral travel not often considered:

You were telling me before that in the past, you personally would take the deceased person back to their community if they'd been in hospital here or somewhere away from home? "Yes, yes."

Is that something that still needs to be done?

*"I think if you're sick, remote communities can access the PATS program, but families have complained to me that it's increasingly difficult (sick travel and transportation of deceased persons). People are not very receptive in that area...."*

*"You know, in the past, before dialysis was available out in remote areas, people were told that they would die if they went back to their lands and didn't have treatment. Well, they quit the dialysis and went back so they **could** die in their land – their spirit had to be there..."*

So if someone dies in a hospital in Adelaide, and they come from, say, the (APY) Lands, how are they taken back to their community for the funeral?

*“Well, in some cases – like my granddaughter – was taken back by her family. But in Ceduna – I can only speak for Ceduna – the bloke who runs the funeral business there, he is very helpful. Really nice bloke, he’s always been like that. He can, say, arrange it (transportation), get it done without too much bother or problem for people. I can’t say the same for other areas.”*

There would be a substantial cost (for transportation)?

*“There would be a substantial cost, but I think that there are ways and means of helping out, you can get in touch with different organisations. But I think in the main that families are obliged to pay the cost. That’s what it boils down to. It’s a big burden (the costs associated with funerals). I know when this other relative died that they asked me to help out, and the best I could do was to try and help out with that (costs). But it seems to be that Aboriginal families understand that where there’s a funeral on and all that sort of sadness, they get together and rake up some money for meals so people can have a meal and go home (after). Nothing sumptuous, but that’s the way they are.”*

**Note:** While there is no legal technicality that prohibits the conveyance of deceased persons in private vehicles, it is understandable that this situation is not desirable, and has long term consequences on the emotional and spiritual wellbeing of all involved.

It is difficult for many Aboriginal people to attend funerals due to poverty. The social welfare system is cumbersome in dealing with immediate needs of this nature; travel costs can be high compared to meagre economic reserves. There is a need to develop a support system for funeral travel that lowers the risk to those who need to participate. Transport needs to be supportive of group travel in vehicles that are suited to the road conditions utilising drivers that are less closely involved in the event.

**Recommendation 9. Travel to funerals in rural and remote areas should have priority access to the pools of agency travel options recommended in Recommendation 4 when available, and emergency funding for transport where no support is available.**

### **3.4.4 Disability**

Aboriginal disability is poorly understood and documented. In the 2002 National Aboriginal and Torres Strait Islander Social Survey, 41% of remote living, and 38% of non-remote living Indigenous South Australians aged 15 years and over reported having a disability or long-term health condition (ABS 2004). About 29% of people living remotely had physical disabilities, about 20% had problems with sight, hearing and speech, and just under 10% reported intellectual disabilities (ABS 2004). Those living in non-remote areas were also most affected by physical incapacities (22%), sight, hearing and speech deficits (17%) and intellectual disabilities (6%) (ABS 2004). While the Survey gives a self reported indication of the size of disability in the South Australian Indigenous community, it is just that – an indication. The Survey sampled Indigenous people in remote and non-remote locations in all jurisdictions of Australia, with results available by state and territory. The estimates are therefore subject to sampling variability, as not all people in the Indigenous population aged 15 years and over were interviewed. Self-reporting may also include instances of under reporting, where a particular topic is particularly sensitive (for example, alcohol, substance and tobacco use) (ABS 2004). However, this indication is the best existing indication of the state of disability in the Indigenous population.

Observations made during this study revealed that people with disabilities are not connected well to the disability treatment and support systems, Aboriginal people with an impairment that requires

assistance with travel are not uncommon, but there appears to be no systematic data on their needs and the distribution of needs. It appears that there are increased needs in rural and remote areas.

**Recommendation 10. That a systematic survey be undertaken to determine the size and pattern of disability among Aboriginal people in South Australia to improve understanding of the Aboriginal definition and view of disability, to develop culturally appropriate assessment tools, and to document the ways in which access to safe and sufficient transport can improve outcomes for disabled Aboriginal people.**

### **3.4.5 Vehicles**

While this study has not conducted a survey of vehicles available to Aboriginal people, our observations are that vehicles tend to be older, relatively poorly maintained and not suitable for the type of travel to be undertaken. In the country and remote areas in particular access to sturdy well maintained vehicle suitable for unsealed roads are necessary, but are too costly. Maintenance and repair costs are high and there is a lack of mechanical skills in many places.

Aboriginal people often prefer to travel in groups, making buses the preferred vehicle. We have already dealt with the problems of using buses effectively and efficiently across agencies. An additional issue is the need for buses that are capable of reliable travel across unsealed roads.

Risk is generated by a chronic shortage of appropriate vehicle to meet the needs of Aboriginal people. Safer vehicles are more costly and therefore are harder to fund. Vehicle suitable for unsealed roads are even more costly and require extensive and careful maintenance. There is a need to increase the skill of Aboriginal people in vehicle maintenance.

In all locations there was evidence of poorly maintained and damaged vehicles being a common mode of transport. This was particularly so in country areas where vehicles might be used for hunting and reduced to broken wrecks when they hit a hidden obstruction. It will be necessary to develop ways of ensuring that vehicle for safe transport are kept safe and roadworthy and that vehicle for off road high-risk pursuits should be set up especially for the task.

A combined strategy of improving access to better vehicles, instruction and experience with maintenance, access to drivers licences and appropriate solutions for vehicles that are needed for traditional pursuits is required to lower risk.

**Recommendation 11. Mechanical training programs should be developed to increase the number of Aboriginal people who can undertake repairs of vehicles to increase vehicle safety, increase employment opportunities and increase community awareness of road transport safety.**

**Recommendation 12. A system of cooperative not-for-profit wholesale purchase and mechanical checking of second hand vehicles is needed to make vehicle purchase more affordable and to ensure that vehicles are roadworthy and suitable for local conditions (may be an extension of Recommendation 11).**

### **3.4.6 Licensing and driver training**

Pressures to drive come from a variety of sources, in some cases from people to whom it is culturally inappropriate to refuse, and for attendance at events that it is culturally important to attend. Kinship obligations and time restrictions may also influence an Aboriginal persons decision to drive unlicensed. In one Far West Coast location, a man was unable to transport elderly and disabled community members to the beach – 28km but over half an hour away on a road that

reduced to 4wd conditions – because he had no licence, and no suitable vehicle. This environment and part of Anangu life was now closed off to the elderly and disabled.

**Figure 19: Remoteness of Yalata beach**



**Figure 20: Yalata beach**



Barriers may include language differences, reading and writing difficulties, distrust of police officers (in areas where licensing is overseen by local police), cost of testing and licences, and apprehension about dealing with agencies (government licensing authorities). Affordable, appropriate and accessible licensing and driver training have also been identified as barriers to access to safe transport in rural and urban areas of New South Wales (Mid North Coast Aboriginal Health Partnership 2001; Western Sydney Area Health Service Centre for Public Health 2003).

Place of residence also has an effect on travel. Many Aboriginal people experience transport problems such as unavailability of public transport in remote areas (ABS 2004). This is significant, as proportionally more Aboriginal Australians live in the more remote regions than other Australians (ABS 2002). Difficulties with written language and comprehension are known barriers to vehicle licensing, and low-income status makes multiple test attempts (which attract a fee) impractical. Low accessibility to culturally appropriate driver education and training for Aboriginal

communities in rural to remote areas in South Australia has previously been identified through community consultation (Watson, Elliott et al. 1997).

A significant proportion of Aboriginal contacts with the criminal justice system are for driving related offences, and unpaid fines for those and other car related issues (non-registration). A higher proportion of Aboriginal people with these problems result in detention than non-Aboriginal people, through lack of ability to pay fines, lack of ability to gain a licence, lack of ability to negotiate terms through the court system. Licensing has many benefits to the individual and to the wider community, including:

- has been obtained after education and training to improve safety on the roads,
- is a 'rite of passage' that is recognised by the wider community (increases self esteem),
- means of photographic identification,
- reduces contact with the criminal justice system and the risk of incarceration (costly for both the individual and the wider community),
- increases opportunities for employment and career advancement, and
- has the potential to strengthen family and community capacity through ability to support each other in moving about

**Recommendation 13. Driver licensing for Aboriginal people should address literacy and language barriers and learning styles, as well as the need for improved access to instruction, including practical driving supervision to attain a provisional licence. Similar approaches to heavy vehicle and bus licensing accreditation will improve employment opportunities.**

Although not all Aboriginal areas have a legal requirement for licensing, all roads from Lands lead to public roads, and therefore travel outside communities to regional centres and service areas must be done using licensed drivers. Any form of driving carries responsibility for passenger safety, if not for licensing and registration, and driver education and licensing process is a key element in the acquisition of knowledge and skills with which to travel safely.

**Recommendation 14. That as part of promoting driver education and training, a map be produced that details the boundaries of Aboriginal areas and public roads where a drivers licence is required, as well as signposting and education on the responsibilities of driving.**

### **3.4.7 Restraint use**

In the Northern Territory, fatalities for unrestrained occupants of cars was 68% for Indigenous people, and 46% for non-Indigenous people in the period 1996–99 (ATSB 2004). An interview study of crash involved and control drivers in Auckland, New Zealand showed that a greater than ten fold increase in injury was correlated to seatbelt non-compliance at time of crash, even after adjusting for numerous potential confounders (Blows, Ivers et al. 2005). The same study also found that habitual non-seatbelt users were likely to be unrestrained in crash involvement.

Studies have shown the efficacy of front facing child restraints in providing vital protection in frontal, and in side impact collision situations when correctly fitted (Bilston, Brown et al. 2005), using best anchorage methods, and the child correctly restrained (Krahn D, Barker R et al. 2007). Other studies have highlighted the dangers and risk of injury and death through child seat restraint misuse, invalid installation, and inappropriate size of child in relation to restraint device (Lalande, Legault et al. 2003).

It was learnt that transporting parents with infants and children who had travelled down for treatment from homelands and remote areas was problematic for the service because of a lack of familiarity with, and distrust of seat restraints. Commonly, the children had never been restrained before, and being often already distraught, fatigued from lengthy travel and showing anxiety from their exposure to the healthcare system, refuse to be restrained. The driver would seat them safely and depart, the child would cry and become distressed, the parent would unbuckle them and comfort them on their lap, the bus driver would have to stop, and the process would start all over again (Wanganeen Irene 2005). It was apparent that recognition of the safety value of child car restraints, availability and affordability of the units, and accredited installation to ensure correct usage were all critical issues, and that there was a need for action particularly in the more remote communities.

**Recommendation 15. A long-term initiative should be established to increase the use of seat restraints among Aboriginal people, including education that takes into account the needs of people who rarely travel in vehicles, provision of seat restraint advice, hire and installation, and provision and use of restraints in buses.**

### **3.4.8 Substance use**

Alcohol use is a major risk factor for road injury and death. Among Aboriginal people alcohol use varies markedly from person to person and community to community. There is a significant problem with a proportion of the Aboriginal population experiencing alcohol addiction and or binge drinking. This in turn generates a significant hazard with driving. Even where a community has declared itself dry, there can be outbreaks of sly grog running or a pattern of binge drinking when residents of dry communities travel to places where alcohol is available. In urban area there is no prospect of declaring a dry community, this is only possible where Aboriginal communities own or operate their own land. Our interviewing in Ceduna and Yalata provided an insight into the importance of alcohol as a risk to safety. Yalata is a dry community. Ceduna is an Australian country town. The people of Yalata who wish to drink travel to Ceduna, which has one of the highest turnover bottle departments in South Australia. A pattern of binge drinking can be observed with both local and visiting Aboriginal people purchasing large quantities of alcohol. Many others do not drink at all. The streets of Ceduna are declared a dry zone so alcohol is consumed in the bush or around camps out of the town. This generates a problem with heavy drinkers moving between the point of purchase and the drinking places. It creates a pattern of alcohol affected driving, pressure on non-drinkers to transport groups of people badly affected by alcohol, and sometimes violent. Pedestrians are at risk when they are under the influence of alcohol and even when sober, from riskily driven vehicles. A Mobile Assistance Patrol system and a Sobering-Up Unit operate in Ceduna. This reduces the risk to some extent. This pattern can be seen in many Indigenous communities throughout the world. It is generated by system that has dispossessed Indigenous people and failed to generate a sense of purpose. Alcohol is an escape. The dominant society continues to profit from the sale of alcohol. As one interviewee said:

“They want you until the money runs out. Once it is gone you are thrown on the scrap heap and run out of town”.

Alcohol use is not just the problem of rural and remote areas. There is considerable tension between the drinkers and the non-drinkers about how alcohol should be managed.

Risk is generated by combining alcohol use with car use, by the reduction of the pool of drivers due to suspension as a result of offences committed while under the influence of alcohol and by the long term damage done as a result of violence, and physiological damage from chronic alcohol abuse. It is beyond the scope of this paper to address the issue of alcohol management. Yet it is clear from our informants that many of the solutions for safer travel lie in reaching a far better approach to reducing acute and chronic alcohol problems.

From the information obtained in this study, it will be important to provide good access to driver licensing and training to the coming generation and developing a code of conduct that supports road safety laws including alcohol consumption limits. At present some Aboriginal people appear to believe that it is not possible to conform to the law and to drive licensed and sober. This group has to some extent become the public face of Aboriginal driving and if availability of roadworthy vehicle and barriers to driver licensing are not removed this is likely to remain so.

Unfortunately those who sell alcohol are happy to claim the profits from alcohol sale while speaking out about how irresponsible some Aboriginal drivers are. Solving the problem will require joint responsibility and not blaming the victim.

In addition to alcohol issues, illegal drugs are also a problem in communities, with remote communities reported as being more affected than non-remote communities. In the 2002 National Aboriginal and Torres Strait Islander Social Survey, 58% of Indigenous people in South Australia living in remote communities reported alcohol, and 56% reported illegal drugs as being problems in their area, compared to people in non-remote neighbourhoods 24% affected by alcohol problems (24%), and illegal drug problems (26%) (ABS 2004). A combination of driving while drink and/or drug affected is a potentially lethal combination, for the immediate community as well as the individual. Legislation introduced in South Australia in 2007 now allows police to undertake driver drug testing in addition to alcohol testing.

**Recommendation 16. It is recommended that a joint program between road safety authorities, drug and alcohol agencies and licensing authorities develops, with Aboriginal people, strategies to reduce the likelihood of driving under the influence of drugs and alcohol.**

## 3.5 Actions

### 3.5.1 Actions generated by the research process

The APTW project is conceived as being action research in the following context:

"action research aims to contribute both to the practical concerns of people in an immediate problematic situation and to the goals of social science by joint collaboration within a mutually acceptable ethical framework" (Rapoport R 1970)

A major goal of the project has been to identify shortfalls in access to safe and sufficient transport for Aboriginal people, and to develop working partnerships between Aboriginal communities and service providers to implement and evaluate local, sustainable strategies for safer transport options. We have worked with a philosophy of identifying gaps in services and overlaps between service providers, and linking agencies to other service providers in order to realise the potential of services to their clients. We did not seek to establish new services per se, rather, to more fully utilise existing services, and perhaps to suggest ways of value adding to enhance working models. We also made a point of identifying and building on previous research or community consultations in the area, and learning from successful interstate models that may be transferable to local situations.

That is, our relationship with the people (agencies, individuals and communities) is one in which we regard it as being our responsibility to take steps to resolve problems that come to light in the course of our research activities, and to encourage other participating organisations to do so. The change making projects or actions arising are themselves situated within a sub community created by the individuals, agencies and Aboriginal communities involved (Senge P and Scharmer O 2006). The research project became a catalyst for Action, stimulating a number of positive responses. Not all actions that have occurred during this research project are strictly concerned with road safety and



directly enabling travel. Coincidental and complimentary actions and relationships have developed that enhance overall wellbeing and assist in the empowerment of individuals and communities.

#### *Forum series*

The forum series drew together and linked representatives and agencies and organisations from a diverse range of areas (see lists of participants in Appendices A, B and C). The discussions emanating from these meetings guided the research process, and along the way and information gained the actions resulting from consultations were reflected back to the participants, who became an informal reference group. Many of the forum participants have actively assisted in this project outside of the forums, through personal meetings, telephone and email communication, and through providing access to documents and data.

#### *Special Forums*

Two special driver licensing forums were convened in response to specific issues of Indigenous licensing barrier, solutions and improved outcomes put forward by TAFE SA, SAPOL, DTEI and community groups seeking to assist young clients in gaining licences. Associate Professor Malcolm Vick from James Cook University was a guest speaker at both, and Ms Judith Welgraven of Regional TAFE SA at the second.

Two special meetings were convened to pursue identification of existing road accident awareness, road safety, first aid response and other related material. Agencies including SAMFS, ARC SA, SA CFS, DTEI freely offered materials and confirmed their commitment to work together where possible to enhance the delivery of such education and information to Aboriginal communities in particular.

#### *3<sup>rd</sup> Indigenous Road Safety Forum*

Three members of the research team participated in the ATSB Forum, held in Broome in September 2006. Associate Professor James Harrison provided expert advice on road accident statistics and epidemiology, Ms Kim O'Donnell co-presented a workshop with Mr Colin Edmonston of CARRSQ, and Mrs Yvonne Helps co-presented a workshop with Dr Emma Hawkes of the WA Dept of Premier and Cabinet.

#### *National Indigenous Working Group – Taskforce representation*

As an action of the proceedings and recommendations of the 3<sup>rd</sup> Indigenous Road Safety Forum, Yvonne Helps prepared a review an existing educational video for Aboriginal people on seat restraints, baby capsules and child restraints. This resulted in the formation of a Taskforce made up of members of the National Indigenous Working Group, and including Mrs Helps. The Taskforce mandate is to evaluate the first video and a further video resource, develop recommendations for updating both, identify actions and costs involved, and to secure funding to implement the changes to ensure that up to date legislation and equipment is effectively conveyed to Aboriginal audiences and distributed free of charge via the ATSB website. Several telephone conferences involving several jurisdictions have occurred, and progress is being made.

#### *South Australian Transport Subsidy Scheme*

Members of the Northern focus group had asked for information about travel subsidies for which they might be eligible. The Transport Subsidy Scheme was found on the DTEI website, a medium not familiar or accessible to many older, infirm, or disabled people. The scheme requires a medical practitioner to verify certain conditions, and offers subsidised taxi travel vouchers for clients with certain specified impairments, such as being permanently unable to negotiate steps of a specified height, or being unable to walk distances of 100 metres. As the Northern group meet in the Aboriginal Outreach Health Services premises, the doctor there was contacted and copies of the

application form were supplied to the clinic. The scheme and conditions were described to the group, and forms were available for them to read. Individuals were then able to request an assessment from the doctor if they wished.

#### *SA Ambulance and Australian Red Cross SA*

From the focus group held in the Western suburbs (see Section 3.2.1), it was apparent that there was a lack of knowledge about services available through SA Ambulance, and in particular, confusion or misinformation about the charges that apply, about conditions under which a client might be exempt from charge, and about whether some people were in fact paying subscriptions when they might qualify for an exemption (if this were the case, the money allocated to ambulance subscription might better be used to enhance their everyday condition). It was also apparent that many Aboriginal people who are older or infirm live alone, and may not have daily contact with anyone. Ms Tober Solito (Manager, Customer Service Centre, SA Ambulance Service) has committed to giving talks to all interested Aboriginal groups and agencies on services, costs and benefits and to provide written consumer information. Likewise, Ms Helen Farinola (General Manager, Services, Australian Red Cross SA), has committed to providing information on the Telecross Service (a daily telephone call at an agreed time to check on the wellbeing of the client, and to maintain social contact) and other services that might be appropriate to different Aboriginal groups. It is likely that SA Ambulance and Red Cross will co-present their services to groups where possible, as an interagency initiative.

#### *Australian Red Cross SA and Tullawon Health Service*

The Mile End Safety store has committed to donating a number of ex-hire child car restraints and booster seats to the Health Service by the end of 2007. The equipment will be able to be used for the next three to four years under current standards. The Health Service is ideally placed to oversee the distribution and use of these safety products in the community. Seat restraint pamphlets produced by DTEI in conjunction with ARC SA have been distributed to the Health Service, as well as similar pamphlets and posters in Pitjantjatjara language which were a part of a previous safety campaign emanating from DTEI (the Aboriginal Seatbelt Campaign).

#### *Australian Red Cross SA and Ceduna Town Camp*

Ceduna Town Camp (also known as Wangka Wilurrara Accommodation Centre) provides safe, secure temporary accommodation for Aboriginal families or individuals who are in transition between communities and permanent accommodation. Alcohol, drugs and violence are prohibited, and the centre is staffed 24 hours, 7 days a week (Community Information Strategies Australia 2007). The camp manager contacted us with an urgent request for a baby capsule to transport a new resident and infant to health and other appointments. The same day, Red Cross was able to supply an ex-hire capsule, anchor bolt and extension strap to suit the people mover vehicle used by the camp staff..

#### *Aboriginal Employment Program and Wiltja Residential College*

In response to the vignette in Section 3.2.4 regarding the difficulties faced by young people attempting to progress from their Learner licence to the Probationary licence: Through the Aboriginal Employment Program (Department of Further Education, Employment, Science and Technology), this student is eligible to access up to eight lessons with a qualified driving instructor, in a driving school vehicle. If she were to book a total of eight, two hour lessons, this would equate to 16 hours of supervised driving, which could be recorded in her log book. This training opportunity recognises that gaining a drivers licence is a crucial point in the transition from school to the workforce. The College and the AEP are now more aware of potential clients, and available programs.

*Malcolm Vick, Judith Welgraven*

APTW facilitated Associate Professor Malcolm Vick in networking with South Australian agencies involved in Aboriginal driver education and licensing. He gave presentations to forums in December 2006 and April 2007. Ms Judith Welgraven of Regional TAFE SA gave a presentation on the South Australian Aboriginal driver education model at the April 2007 forum.

#### *TAFE SA*

APTW wrote a briefing paper on driver licensing issues to support a TAFE funding application to increase the number of Lecturers qualified to conduct Aboriginal driver education courses.

#### *Tullawon Health Service (Yalata) and St Johns Uniting Church, Prospect*

APTW linked the Aboriginal health service at Yalata with a suburban Adelaide parish that was keen to establish links with a remote community. The church has begun supplying the clinic with specific items such as baby clothes, suitcases, pyjamas. Woollen beanies (mukata) in Nunga colours (red, yellow, black) knitted by the church ladies were particularly popular, in sizes from babies to adults.

#### *Tullawon Health Service (Yalata) and The Wrigley Company*

Mr Lindsay Osborn (Tullawon Health Service), had commented that sugar-free chewing gum would assist in oral hygiene for the Yalata children in particular, and would also assist in relief of temporary earache. Temperature and pressure changes can trigger earache. For example, when a child plays outdoors in cold conditions and then enters a warm room, and the physical action of chewing relieves the symptoms (ACT Government 2002). This may also prevent the condition worsening, and helps maintain the opening of the eustachian tube that equilibrates pressure between the interior and exterior of the ear drum (University of Illinois 2007). To explore the concept, the Wrigley Company was approached. Ms Carol McCormick (Consumer Affairs, The Wrigley Company), was able to supply 150 individual packs and other products for the community, a package of about 3kg that was posted to the Health Service (correspondence appears in Appendix G). The gum was distributed during Indigenous Childrens Day activities in the community, and proved very popular. Mr Osborne noted that the wrapping from the gum did not pose a litter problem.

#### *Ceduna Area School*

The SA Aboriginal Seatbelt Campaign video and resource kit were supplied to the school for use in their Pitjantjatjara language course; the film and written materials are duplicated in Pitjantjatjara and in English.

#### *Metropolitan Fire Service RAAP and Ceduna Area School*

The SA MFS Road Accident Awareness Program was delivered to Ceduna Area School in August 2007. It is likely that the program will be presented as a community activity in Yalata at a later date.

#### *Yalata Anangu School and car safety*

The SA Aboriginal Seatbelt Campaign video and resource kit was supplied to the school for use in their Pitjantjatjara language course; the film and written materials are duplicated in Pitjantjatjara and in English. The Corrugations to Highways video and resource kit was also supplied. Up to date brochures on child car restraints, buying and fitting advice, current laws and purchase discount cards from ARC SA and DTEI were also distributed to the School and Tullawon Health Service.

### *Yalata Anangu School and St Johns Uniting Church, Prospect*

The school (DECS) will administrate the swimming pool when it is opened (anticipated for late October 2007). In preparation for the anticipated numbers of children who will want to swim, the suburban parish is collecting board shorts and t-shirts and rash vests so that there is swimming clothing available for the opening. Sandals and shoes are also being collected, as well as Bible picture story books and Nativity scenes, which were also requested.

### *Yalata Anangu School and the Kensington and Norwood Anglican Team Ministry (St Bartholomew and St Matthew)*

The congregations of St Bartholomew and St Matthew Anglican churches collected over \$1,300 to enable the school to choose and order Nativity scenes and/or picture Bible stories for use in the classrooms.

### *Yalata Anangu School, Australian Red Cross and the Royal Life Saving Society of Australia (RLSSA)*

ARC SA has liaised with the school and offered to work with them in the delivery of first aid training to help equip them for the opening of the swimming pool, in conjunction with services that may be available through the RLSSA.

### *APTW and the Premiers Thinkers in Residence Program*

In October 2007, the project provided the basis for a session in a state conference on Mobility, Health and Equity, convened by the SA Motor Accident Commission and led by Professor Ilona Kickbusch (WHO, Geneva) in her capacity of Thinker in Residence. Advice based on the findings and recommendations of the project will be included in a report by Professor Kickbusch to the Premier, and has good potential to influence policy. The Professor is recommending to the Premier and Cabinet that driver education and licensing be added to the State Strategic Plan as a key strategy to improve mobility, to establish identity, and to provide improved employment opportunities for Aboriginal people.

### *APTW and the Cooperative Research Centre for Aboriginal Health*

A summary of the project was presented to Parliament in Canberra in the CRCAH inaugural Parliamentary Showcase on Aboriginal Health Research in March 2008. The CRCAH supported the project throughout, and aided in the transfer of research results in printing a community focussed version of this report.

## **3.5.2 Actions that are required**

### ***Implementing the recommendations***

A number of recommendations have been made in the discussion section of this report. While individual sectors or agencies will have responsibility for the issues identified in these recommendations, it should be recognised that the solutions can only be achieved with a whole of government approach.

There are often barriers to action for one sector due to the need to develop changes in another sector or barriers generated by difficulties in coordination Commonwealth and State government change. This has been recognised by the Coalition of Australian Governments (COAG) process. COAG has initiated a program of work on Indigenous well-being in Australia. In November 2006 a framework for cooperation between the Commonwealth and the South Australian Government was signed. It included the following provision:

- “1. The Commonwealth of Australia and the State of South Australia (the governments) are committed to achieving better outcomes for Indigenous people in South Australia.
2. This agreement provides an overarching framework for the governments to work together in a spirit of close cooperation.
3. The agreement has the principal aim of improving and streamlining service delivery so that appropriate services are accessible to Indigenous Australians, their families and communities.
4. This agreement sets out strategic approaches for joint and innovative action by the governments in partnership with Indigenous people and communities.
5. The governments are committed to:
  - working jointly on service planning and delivery and investment in Indigenous communities
  - engaging Indigenous people and communities in policy, planning and service delivery partnerships
  - ensuring that services provided by mainstream agencies are appropriate and meet the needs of Indigenous people
  - reviewing opportunities for better data collection in relation to expenditure on Indigenous affairs.
6. This agreement builds on existing arrangements and bilateral agreements (Commonwealth of Australia and the State of South Australia 2005).”

The sort of cooperation described in the agreement will be necessary to implement the recommendations of this report. Neither transport nor travel are specifically mentioned in the detailed agreement, but the priority areas include, among others, safety, housing and infrastructure, health and economic development and service delivery (Commonwealth of Australia and the State of South Australia 2005). Delivering on these priorities will require an improvement in the accessibility and appropriateness of transport systems and the cooperation of many sectors.

**Recommendation 17. It is recommended that relevant government agencies become actively involved with the COAG processes on Indigenous affairs with a view to raising the profile of transport and transport safety issues and seeking implementation of the recommendations of this report.**

### ***Future research***

There is a need for more research in this field. This report scratches the surface of factors which promote or erode the ability of Aboriginal people to travelling. The scope of this project was, perforce, limited to a few communities in one State. A wider range of localities needs to be studied. More detailed exploration of how the findings can be embedded in policy and service developments is required. The report has shown that undertaking this sort of research takes quite a long time. This work could only be undertaken with a twelve month grant because of the relationships built up before the grant was sought and even an extension was required to ensure that sufficient time was available to build communication with the respondent communities. Research of this type must be undertaken with the full involvement of Aboriginal leaders and communities. This requires the development of trust and a common view of what the research seeks to achieve. Ethics approval can be lengthy and the demands of meeting Aboriginal cultural needs and the strict methodological requirements of an academic institution present a situation of trying to live in two worlds at once.

The process of developing a working relationship with the leadership in each community is vital and requires the researchers to show commitment to a longer ongoing relationship.

Future research will enrich the understanding of the similarities and difference in different localities and communities. It will spell out in more detail the relationship between broad factors such as economic wellbeing, and health, and the ability of Aboriginal people to move safely to meet their cultural and family obligations.

**Recommendation 18. That the methods used in the study be further refined to research the travel and transport needs of Aboriginal people over a wider range of communities and localities, with a view to identifying ways of increasing access to safe means of travel for cultural, family, health, education and economic purposes.**

### 3.6 Generalising findings from this report

It is important to consider whether the findings of this study can be generalised more widely. The communities studied were selected because they were expected to have differences. They are not fully representative of all of the types of Aboriginal communities in South Australia and certainly not the whole of Australia. Nevertheless a number of common themes arose that may be expected to occur in many if not all communities. These are:

- Access to safe transport for Aboriginal people is restricted by their economic circumstances.
- The poor health of Aboriginal people generates high levels of need for safe access to a wide range of health and disability services.
- Aboriginal culture drives a need to belong to a place and to meet the obligations to that place. This generates a need for long distance travel often over roads that are of a lower standard and because of economic circumstances in vehicle not suited for this sort of travel.
- Responsibility to family and kin, especially when an important person dies generates a need for large numbers of Aboriginal people to travel at times of high stress.
- Access to a drivers licence is not straight forward. Problems with literacy and language present an upfront barrier. Access to vehicles and instruction present a problem for the increasingly arduous learning process. These barriers to licensing generate increased risk of Aboriginal people driving while unlicensed and in some cases to a licensed driver driving under the influence of alcohol.

In addition, it was clear that no two communities were the same. Responding to the issues raised therefore requires that the travelling needs of each community should be considered carefully and in detail. Each community will have its own set of needs that will change as the community changes. Good planning of Aboriginal travel and travel safety requires a continuous process of development and review. This paper has shown the link between demographic mix, poverty, health and disability needs, type of location, and the type of services provided for mainstream society interact to generate patterns of travel and needs for different type of travel services.

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## APPENDIXES

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## **APPENDIX A: REPRESENTATIVES AT THE INAUGURAL ABORIGINAL PEOPLE TRAVELLING WELL FORUM, MARCH 3<sup>RD</sup> 2005.**

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Professor Charlotte de Crespigny School of Nursing and Midwifery, Flinders University

Mr John Gregory Director, Policy and Planning, Dept Aboriginal Affairs and Reconciliation, Dept of Premier and Cabinet

Associate Professor James Harrison Director, Research Centre for Injury Studies, Flinders University

Mrs Yvonne Helps Research Officer Research Centre for Injury Studies, Flinders University

Dr Inge Kowanko Head, Flinders Aboriginal Health Research Unit, Flinders University

Ms Kira Kudinoff Manager, Indigenous Coordination Centre, Adelaide

Ms Sharon Meagher Senior Policy and Planning Officer, Department of Aboriginal Affairs and Reconciliation

Ms Lorraine Merrick Deputy Manager, Indigenous Coordination Centre, Adelaide

Ms Kim O'Donnell Research Associate, Aboriginal Health Research Unit, Flinders University

Mr Tauto Sansbury Chairperson, Patpa Warra Yunti Regional Council

Ms Chandra Sluggett A/g Senior Officer, Regional Council Support Unit, Indigenous Coordination Centre, Adelaide

Mr Klynton Wanganeen, Patpa Warra Yunti Regional Council

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## **APPENDIX B: ATTENDEES OF ONE OR MORE FORUMS, INCLUDING ELECTRONIC CONTACTS:**

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Mr Anthony Ah Kit, Project Officer Aboriginal Health Division, SA Department of Health

Ms Jude Allen, A/Director, Community Renewal Unit Dept of Families and Communities

Dr Trevor Bailey, Senior Project Officer Transport SA (DTEI) and Chair of the Aboriginal Road Safety Taskforce SA

Ms Margaret Brown, National Chairperson Health Consumers of Rural and Remote Australia

Mr Alwin Chong, Senior Research & Ethics Officer Aboriginal Health Council South Australia (AHCSA)

Ms Angela Commene, former Service Development Project Officer ARC SA

Ms Sapna Dogra, Coordinator Information and Monitoring Unit, Aboriginal Legal Rights Movement (ALRM)

Ms Bernadette Donaldson, (former) Car Restraint Coordinator Australian Red Cross SA

Mr Tim Dunning, Project Officer Aboriginal Lands District

Ms Helen Farinola, Service Development Manager Australian Red Cross SA

Mr Allan Foster, District Officer Community Education Community Safety Dept, South Australian Metropolitan Fire Service (SAMFS)

Dr Liz Furler, Executive Director, Medical Management TRACsa, Motor Accident Commission

Mr Pierre Gebert, Snr Project Manager Driver and Vehicle Licensing

Mr Robert Gillespie, A/Field Operations Manager Aboriginal Legal Rights Movement (ALRM)

Ms Sherree Goldsworthy, former Director Driver and Vehicle Licensing DTEI (currently Director Security and Legislation DTEI)

Mr John Gregory, Director, Policy and Planning, DAARE, Dept of Premier and Cabinet

Mr Geoff Hawkins, Admin Officer Aboriginal Drug and Alcohol Council (SA) Inc (ADAC)

Mr Ben Haythorpe, Education Consultant Dept for Transport, Energy and Infrastructure (DTEI)

Ms Kira Kudinoff, former Manager – Indigenous Coordination Centre, Adelaide (currently Snr Manager, Whole of Government Stream FACSIA)

Ms Sue Lacey, Community Renewal Unit, Indigenous Services Parks Department for Families and Communities

Mr Tony Lindsay, Aboriginal Prisoners Offenders Support Service

Inspector Trevor Lovegrove, Officer in Charge Operations Section, Traffic Support Branch SAPOL

Senior Sergeant Gerry Mangan, Officer in Charge Traffic Training and Promotions Section, SAPOL

Ms Sharon Meagher, former Senior Policy and Planning Officer, DAARE, Dept of Premier and Cabinet (currently Lecturer, Aboriginal and Social Sciences, UniSA)

Ms Petra Nisi, DAARE, Dept of Premier and Cabinet

Ms Fevronia Plomaritis, Acting Indigenous Coordination Centre Manager, Adelaide

Ms Kerry Symons, Executive Director Australian Red Cross SA

Mr Bob Ramsay, Acting Deputy ICC Manager Ceduna ICC (currently General Manager Maralinga Tjarutja)

Mr Tauto Sansbury, Former Chairperson, Patpa Warra Yunti Regional Council

Chandra Sluggett, A/g Senior Officer, Regional Council Support Unit, Indigenous Coordination Centre, Adelaide

Ms Tania Toth, Policy Officer Social Inclusion Unit, Dept of Premier and Cabinet

Associate Professor Malcom Vick, School of Education, James Cook University Qld

Ms Irene Wanganeen, Coordinator Adelaide Step Down Service, Dept Health

Mr Klynton Wanganeen, former (currently Statewide Program Leader, Aboriginal Education TAFE)

Mr Les Wanganeen, Aboriginal Justice Officer Port Adelaide Magistrates Court

Ms Judith Welgraven, Snr Program Manager, Aboriginal Education, Regional TAFE

Ms Natalie Williams, Aboriginal Liaison Officer Queen Elizabeth Hospital

Ms Jo Willmot, Indigenous Services Parks Dept Families and Communities

Ms Rachelle Wingard, Solution Broker, Whole of Government, Dept of Health and Ageing

Ms Bonnie Wizer, Aboriginal Justice Officer Adelaide Magistrates Court

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## APPENDIX C: LETTERS OF SUPPORT

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30.01.07

To whom it may concern

Kura Yerlo Incorporated is aware and strongly supports the "Aboriginal People Travelling Well Project".

Kura Yerlo believes that this project will provide benefits, improve the safety and quality of life to Aboriginal individuals and communities.

Kura Yerlo looks forward to working in partnership. Please do not hesitate to contact me on 08 84497367 if you require any further information.

Yours sincerely

A handwritten signature in blue ink, appearing to read "Tania King".

Tania King  
CEO  
Kura Yerlo Incorporated

Address: 208 Lady Gowrie Drive Largs Bay SA 5016  
PH: 84497367  
FX: 83417006  
Email: [kycmngt@arooma.com.au](mailto:kycmngt@arooma.com.au)





South Australia  
207 - 217 Wakefield Street  
Adelaide SA 5000  
GPO Box 2295 Adelaide SA 5001  
T (08) 8 00 4500  
F (08) 8 00 4500  
E [redcross@sa.redcross.org.au](mailto:redcross@sa.redcross.org.au)  
[www.redcross.org.au](http://www.redcross.org.au)  
ABN 50 159 561 034 011

13 December 2005

To whom it may concern

Australian Red Cross, South Australia (ARC, SA) positively supports Flinders University and the work they are undertaking with Indigenous communities in South Australia.

In partnership with Flinders University and SA Fire and Emergency Services Commission (SAFECOM), ARC, SA has been working with Munda and Wanna Mar Inc, an Aboriginal Homeland Community located approximately 30 kilometres south-east of Ceduna in rural South Australia. The focus of this partnership model is to assist the community to build capacity and in turn improve the safety and quality of life of community members.

ARC, SA has enjoyed positive working relationships with Flinders University and SAFECOM and looks forward to continuing this partnership with the view to improving the capacity of vulnerable communities in South Australia.

Please do not hesitate to contact me on 8100 4646 if you require any further information.

Yours sincerely

Kerry Symons  
Executive Director

Red Cross is here



## Munda & Wanna Mar Inc

P O Box 219, Ceduna SA 5690  
Phone/Fax 08 8625 7119  
ABN # 15 133 113 677



8<sup>th</sup> December 2005

To Whom it May Concern:

Munda and Wanna Mar Inc. is a small Aboriginal homeland community located approximately 30 Kilometres South - East of Ceduna in the vicinity of Smoky Bay. The Incorporation was established to provide housing and infrastructure to operate as a working farm to help improve the social and economic base of the community.

Munda and Wanna Mar Inc. would like to work in partnership with SA Fire and Emergency Commission (SAFECOM), Flinders University and Australian Red Cross to assist us to build capacity with the view to making our community a safer place to live and work.

We understand the support provided by Flinders University will be guided by the SA Aboriginal Health Council Ethics Commission and the Flinders University Social and Behavioural Ethics Committee to ensure the process is ethical and respectful.

We look forward to positive working relationships with SAFECOM, Australian Red Cross and Flinders University.

Yours sincerely

Debra Haseldine  
(Chairperson)





Government of South Australia  
Southern Adelaide Health Service

Population & Primary Health Care  
Aboriginal Health

Level 3A, St Mark's Hospital Building  
Boleyn Park, Malvern  
Laffer Drive, Bedford Park SA 5042

Tel: (08) 8231 7801  
Fax: (08) 8231 7871

8<sup>th</sup> February 2007

To Whom It May Concern:

At the Southern Adelaide Health Service (SAHS) Senior Aboriginal Managers meeting held on the 30<sup>th</sup> January 2007 members agreed to support the Aboriginal People Travelling Well (APTW) Project.

The Managers believe the results of this project will provide a comprehensive understanding of transport issues for Aboriginal people in South Australia. It is hoped that with this understanding, strategic decision making in and across departments and service agencies can occur that lead to supportive partnerships with service agencies towards solutions which can be actioned by communities in urban, rural and remote locations.

The SAHS Senior Managers look forward to working with the APTW Research Team. Please do not hesitate to contact me at the address above, should you need further information.

Yours sincerely,

**Zell Dodd (Ms)**  
Director for Aboriginal Health Services  
Population & Primary Health Care  
Southern Adelaide Health Service



Government of South Australia  
Department of Health

Ms Sonia Waters  
Acting Director of Strategic Policy & Monitoring  
Aboriginal Health Division  
Level 9 Citi Centre Building  
Adelaide SA 5000

Aboriginal Health Division  
111 Rundle Street  
Adelaide SA 5000  
PO Box 287, Rundle Mall  
Adelaide SA 5000  
DX 243  
Tel: 08 8226 6044  
Fax: 08 8226 6000  
APN: 37 628 356 500  
[www.health.sa.gov.au](http://www.health.sa.gov.au)

22<sup>nd</sup> of March 2007

To Whom It May Concern

I met with Kim O'Donnell on the 1<sup>st</sup> February 2007 to discuss the Aboriginal People Travelling Well (APTW) project. This project will provide an understanding of the barriers that prevent remote, rural and urban Aboriginal people from traveling safely in South Australia. With this knowledge, it is anticipated that supportive partnerships with service agencies and other departments can occur towards better policy decisions that lead to practical solutions to enable Aboriginal people to travel safely.

The Aboriginal Health Division looks forward to working with the APTW research team. Please do not hesitate to contact me if you require further information.

Yours sincerely

**Sonia Waters**  
Acting Director of Strategic Policy & Monitoring  
Aboriginal Health Division



107 Wakefield Street  
Adelaide SA 5000  
GPO BOX 94  
Adelaide SA 5001  
Tel: +61 8 8204 3800  
Fax: +61 8 8204 3838  
www.mfs.sa.gov.au  
A/N 26 637 553 30

If calling please ask for:  
Allan Foster

Telephone: 8204 3547  
Fax: 8204 3781  
Email: [foster.allan@sa.gov.au](mailto:foster.allan@sa.gov.au)

Reference:  
Participation and support Aboriginal People Travelling Well research group (APTW, Flinders University)

30 May 2008

Ms Kim O'Donnell  
Flinders University Aboriginal Health Research Unit

Dear Kim

As discussed at our meeting at Red Cross House (24/05/08) I wish to offer this organisation's support to this project.

Community safety achieved through capacity building and community engagement is a logical way of reducing risk to that community. Clearly our primary interest for involvement is in the reduction of fires and vehicle accidents in both metropolitan and regional areas.

The South Australian Metropolitan Fire Service Community Safety Department can provide physical and intellectual resources to support existing programs and those to be developed.

Looking forward to our next meeting.

Yours faithfully

A handwritten signature in blue ink, appearing to read "Allan Foster".

Allan Foster  
District Officer  
Community Safety Department





**Aboriginal Health Council of SA Inc.**  
78 Fullarton Road  
Mawson SA 5067  
PO Box 787, Kent Town SA 5087  
Tel: (08) 5132 6700  
Fax: (08) 5132 6799  
Email: [ahcsa@ahcsa.org.au](mailto:ahcsa@ahcsa.org.au)  
Website: [www.ahcsa.org.au](http://www.ahcsa.org.au)  
ABN 61 267 024 542

To whom it may concern

The Aboriginal Health Council of SA Inc (AHCSA) is aware of the *'Aboriginal People Travelling Well Project'* and strongly supports this project.

The ethics and community consultation processes have been conducted in accordance with AHCSA's principles and values and we firmly believe this project will bring practical benefits to the participating Aboriginal communities.

Yours sincerely

**Mary Buckskin**  
Acting Chief Executive Officer

19 December 2005





If calling please ask for:  
Peter Heylen

Telephone:  
0418 836 532

Reference:  
leph0557pjh

13 December 2005

To whom it may concern

Attention: Dear Sir/Madame

**Re: Funding application by Flinders University**

Munda and Wanna Mar Inc. is a small Aboriginal homeland community located approximately 30 kilometres South-east of Ceduna in the vicinity of Smoky Bay. The Incorporation was established to provide housing and infrastructure to operate as a working farm to help improve the social and economic base of the community.

Munda and Wanna Mar Inc. has indicated it would like to work in partnership with SA Fire and Emergency Commission (SAFECOM), Flinders University and Australian Red Cross. The aim of this partnership is to assist the community build capacity with the view to making the community a safer place to live and work.

It is SAFECOM's understanding that for Flinders University to be part of this partnership the University needs to access funding from outside the University budget. SAFECOM also understands the University's input will be guided by the SA Aboriginal Health Council Ethics Commission and the Flinders University Social and Behavioural Ethics Committee to ensure the process is ethical and respectful.

As such SAFECOM is supportive of any applications the University may make to secure the funding necessary for it to be a contributing partner in this venture.

SAFECOM is eager to progress these matters and looks forward to positive working relationships with Flinders University and Red Cross Australia with the aim of building the capacity of Munda and Wanna Mar.

Yours sincerely



Mick Ayre  
Manager Risk and Prevention  
SA Fire and Emergency Commission



**SA FIRE & EMERGENCY  
SERVICES COMMISSION**

ABN 85 437 883 949

80 Weymouth Street  
ADELAIDE 5000

RCK 2706 GPO  
ADELAIDE 5001

DX 208

Telephone:  
(08) 6433 4350

Facsimile:  
(08) 6433 4051



ABORIGINAL HEALTH  
RESEARCH ETHICS COMMITTEE

Mrs Yvonne Helps  
Research Centre for Injury Studies (RCIS)  
Flinders University  
GPO Box 2100  
Adelaide SA  
5001

2<sup>nd</sup> February 2007

Dear Yvonne

Thank you for submitting your research project, *Aboriginal people travelling well*, on the 26<sup>th</sup> October 2006 for ethical consideration.

At our last meeting your application was assessed and I am pleased to inform you that this proposal has met with support and that the committee has decided that your application be recommended.

In accordance with the NH&MRC guidelines, *National Statement on Ethical Conduct in Research Involving Humans*, we require at regular periods, at least annually, reports from principle researchers.

If you require any further information please do not hesitate to contact the Executive Officer or myself.

We wish you well with the project and look forward to receiving a copy of your report.

Sincerely yours

DR TAMARA MACKINNON  
CHAIRPERSON  
Ref: Proposal/Agreement/21 January/07



Aboriginal Health Council  
(Inc) 50151010

AHREC is a sub-committee of A-HCSA

18 Fullarton Road, Norwood SA 5067 PO Box 787 Kent Town SA 5067  
Tel: (08) 8132 5700 Fax: (08) 8132 6755 Email: ahrec@ahc.org.au Website: www.ahc.org.au





FLINDERS UNIVERSITY  
ADELAIDE • AUSTRALIA

Social and Behavioural Research Ethics Committee  
Office of Research

GPO Box 2100  
Adelaide 5001 Australia

Telephone: (+61 8) 8201 5962  
Facsimile: (+61 8) 8201 2035  
Email: sandy.huxtable@flinders.edu.au

SBRE 3711

13 December 2006

Ms Kim O'Donnell  
Flinders Aboriginal Health Research Unit

Dear Ms O'Donnell

**Project 3711      Aboriginal People Travelling Well**

Further to my letter dated 28 November 2006, I am pleased to inform you that approval of the above project has been confirmed following receipt of the additional information you submitted on 8 December 2006. Approval is valid for the period of time requested or three years, whichever is the least, and is given on the basis of information provided in the application, its attachments and the information subsequently provided.

In accordance with the undertaking you provided in the application, please inform the Social and Behavioural Research Ethics Committee, giving reasons, if the research project is discontinued before the expected date of completion and report anything which might warrant review of ethical approval of the protocol. Such matters include:

- serious or unexpected adverse effects on participants;
- proposed changes in the protocol; and
- unforeseen events that might affect continued ethical acceptability of the project.

I draw to your attention the requirement of the *National Statement on Ethical Conduct in Research Involving Humans* that you submit an annual progress and/or final report to SBREC. If a report is not received beforehand, a reminder notice will be issued in twelve months' time. A copy of the report pro forma is available from the SBREC website  
<http://www.flinders.edu.au/research/Office/ethics/socialbehavioural.html>.

Yours sincerely

Sandy Huxtable  
Secretary  
Social and Behavioural Research Ethics Committee

cc: Mrs Yvonne Helpe, Research Centre for Injury Studies  
A/Prof James Harrison, Research Centre for Injury Studies  
Dr Inge Kowanko, Flinders Aboriginal Health Research Unit  
Prof Charlotte de Crespigny, School of Nursing and Midwifery

Location: Sturt House, Bedford Park, 5008 Adelaide.

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## APPENDIX D: APTW PROJECT TIMELINE

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February 2005, first meeting of research team and establishment of research project, 'Aboriginal People Travelling Well'

February 2005 Applied for grant in ATSB funding round – unsuccessful on this occasion, but encouraged to resubmit in the following year

June 2005 Applied for Flinders University University/Industry Cooperative Research Grant, awarded seeding grant (\$4,725)

March 2005 Preliminary contacts with agencies, organisations and communities

March 2005 Inaugural APTW forum

April, 2005 Second forum

June 2005 Third forum

July 2005 Fourth forum

August 2005 Fifth forum

August 2005 Addressed the Working Together Ceduna Inter-Agency meeting jointly with ARC SA

October 2005 Sixth forum

November 2005 Joint visit to Munda and Wanna Mar community, APTW, ARC SA, SAFECOM

December 2005 Seventh Forum

February 2006 Applied for grant in ATSB funding round, awarded project grant

May 2006 Eighth forum

May 2006 Meeting with ARC SA

June 2006, APTW hosted a joint forum with the SA Indigenous Road Safety Taskforce

July Meeting ARC SA Emergency Services Manager, APTW, SAFECOM

July 2006 Road Safety Resources meeting

August 2006 APTW meeting with Red Cross

August 2006 Follow-up Road Safety Resources meeting

September 2006 signed off on ATSB funding (\$23,294)

September 2006 Joint presentation with ARC SA, SAFECOM at ARC Emergency Response Meeting

October 2006 The 3<sup>rd</sup> Indigenous Road Safety Forum workshop presentations, Broome WA

November 2006 Request for clarification of some points in Ethics application to Flinders University SBREC

November 2006 CRCAH Symposium APTW project presentation

December 2006 Formal Ethics approval from Flinders University SBREC

December 2006 Qld Indigenous Driver Licensing Program seminar (Malcolm Vick)

January 2007 Reviewed SA Aboriginal Seatbelt Campaign video and resources with ARC SA for currency and accuracy

February 2007 Formal Ethics approval from the Aboriginal Health Research Ethics Committee (AHREC)

February 2007 APTW, ARC SA meeting

February 2007 TAFE Learner Driver education observation in Moonta

March 2007 First Indigenous Road Safety Taskforce teleconference – Aboriginal road safety education resources

March 2007 Kura Yerlo Learner Driver education observation at Largs Bay

April 2007 Ethics approval for modification of items in questionnaire from the Aboriginal Health Research Ethics Committee (AHREC)

April 2007 Community meeting Western suburbs

April 2007 Second Indigenous Road Safety Taskforce teleconference – Aboriginal road safety education resources

April 2007 Indigenous Licensing forum (presentations from Judith Welgraven and Malcolm Vick)

May 2007 Ethics approval for modification of items in questionnaire from Flinders University SBREC

May 2007 Applied to ATSB for extension of project

May 2007 Third Indigenous Road Safety Taskforce teleconference – Aboriginal road safety education resources

May 2007 Focus group, Western suburbs

May 2007 ATSB extends project timeline to end September 2007

June 2007 Focus group, Northern suburbs

June 2007 Follow-up, Northern suburbs

July 2007 APTW members visit Yalata community

August 2007 APTW, ARC SA meeting – supply of baby capsules and child seat restraints for Ceduna and outlying areas

August 2007 Follow-up, Western suburbs

August 2007 Follow-up meeting, supply of baby capsules and child seat restraints for Ceduna and outlying areas and provision of other ARC programs

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## APPENDIX E: INTRODUCTION TO FOCUS GROUP

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Hello, I'd like to start by thanking you all for meeting here today, on Kurna (or appropriate) land, and I respectfully acknowledge the living cultural and heritage beliefs of the Kurna people. My name is XX, I work at Flinders University, where I'm part of a research group called Aboriginal People Travelling Well. We are interested in your experiences, and in particular, in how being able to travel safely affects your day to day lives.

We are gathering information about transport safety for Aboriginal people in several areas of South Australia, and would like to hear about your experiences where you live.

I have some general questions to help focus the discussion, but please feel free to comment on anything you feel strongly about. I'm anticipating this discussion may go for an hour to an hour and a half. Can everyone stay for at least an hour?

In order to accurately record and understand this information when I go back to work, I would like to tape record it. The tape will be kept securely in my workplace, and will not be made available to anyone outside of the research team. We have a consent form so that you can show that you are happy to join in this discussion and be recorded on tape. We also have an information sheet for you to take home so that you can refer back to our project, it has contact names and 'phone numbers if you would like to talk again with us. If you would like to say your name when you start to talk, that would be great. If you would like to say something but not say your name, that is okay too. Is that alright with everyone?

We would like to emphasise that we are here to talk with and listen to you about transport issues. Sometimes other things come up that might have a legal implication, or that might not be appropriate to discuss with us, because we don't have the right skills to help you. You don't need to tell us about those things. Sometimes group discussions can bring up issues that we may not have expected, or may stir up uncomfortable emotions. If this happens, or if you would like to stop participating at any time, please raise your hand. There is no shame or embarrassment if you choose not to continue. I would like to follow you up after the session if you do leave, in case there are things that are still bothering you. We have a list of support services that we will leave with you in case you feel you need to talk to someone in your local area about a particular issue. This is so that you have the best service for you. Perhaps you may feel you want to talk to your local health worker, or maybe someone from your local church.

We have a list of places in your local area that you might want to contact if something from today continues to bother you. We will give everyone a copy.

As I said, at times group discussions can draw out lots of issues. In light of this, I need to ask the group to respect the confidentiality of personal views, and not to disclose personal information outside of our discussion today. Can everyone agree to that? I'd like to say to you all that I also give you my confidentiality, the information from today is only to be used in the context of this research, as we have discussed.

Thanks for continuing, lets make a start.

**Prompts (focus on safe travel, attitudes and beliefs around use of seat restraints).**

**A focus group is an evolving discussion based on a theme, or focus, introduced by the moderator. It elicits attitudes toward a concept, action or behaviour in an interactive group setting, where individuals are free to talk with other group members.**

**To get through the set of prompts in one hour, allow no more than about 15 minutes response time for each. Use your judgement about skipping a prompt if you feel it is being covered in the flow of the discussion, or if the group wants to pursue a different issue within the theme that they feel strongly about.**

**At the end of the response time for the last prompt, make a wrap up comment drawing together threads from the discussion to round off the session. Finish with the opportunity for questions from the group (remind them that they can contact us, details on the information sheet), and thanks. This may take a further 10–15 minutes. The health services referral sheet for the area should be handed out to everyone before they leave.**

When people travel or move about from one place to another, various things can affect their safety. To get things going today, I'd like to hear about what sorts of things concern you. (perhaps offer a person example if the silence is too long)

And what sort of things concern you about the safety of children when they travel?

Young children rely on older people to look out for them. What can older kids and adults do to improve the safety of youngsters when they travel?

What sort of things could be done to improve your own safety when you travel?

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## APPENDIX F: QUESTIONNAIRE

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Aboriginal People Travelling Well  
Community questionnaire

### Aboriginal People Travelling Well project

#### Getting around

Please take about 45 minutes with me to go through this questionnaire on your experience of transport use. The Aboriginal People Travelling Well team welcomes your involvement and your answers will be kept confidential. I will mark down your answers, and we will tape our conversation to help me with some of the responses. Thank you for your participation.

#### Some details to help us

#### Section 1

1. Are you

☐

Male

☐

Female

2. How old are you?

3. In which community/town/suburb do you live?

4. People often have a preference about how they like to be identified. Some people like to say 'I'm an Aboriginal man or woman', or 'I'm Torres Strait Islander'. Some people like to be identified by the traditional name of their family group, such as Narungga, Kurna or Pitjantjatjara for example. How do you prefer to be identified?

☐

Aboriginal

☐

Torres Strait  
Islander

☐

Aboriginal and  
Torres Strait  
Islander

☐

Indigenous

Another name?

## Ability to go where you want to

## Section 2

5. What places do you normally want to go to?

- ☐ School
 ☐ Health centre
 ☐ Shops
 ☐ List relatives
 ☐ List other

6. How often are you prevented from getting to the places you want or need to go?

- ☐ Never
 ☐ Hardly ever
 ☐ Sometimes
 ☐ Often
 ☐ Almost always

7. What places are difficult for you to go, and why?

- ☐ School
 ☐ Health centre
 ☐ Shops
 ☐ List relatives
 ☐ List other

8. How do you normally get to each of the places you mentioned?

- ☐ Walk
 ☐ Bicycle
 ☐ Private vehicle (types)
 ☐ Public transport (types)
 ☐ Charter transport (types)
 ☐ Train
 ☐ Specify other

Write or say the place in relation to the type of transport

Open response for each place mentioned

9. How far is it, or how long does it take to travel to the places you mentioned?

Open response in km or other measure used by respondent



**10. If you sometimes don't go to the places you mentioned, is it your choice, or what things make it too difficult for you?**

- ☐ School      ☐ Health centre      ☐ Shops      ☐ List relatives      ☐ List other

Open response

**11. What would be the reason you want or need to go to the main place (specify) you mentioned?**

Open response

**12. How do you get to the main place (specify) you mentioned?**

Open response for each place mentioned

**13. How far or how long does it take to travel to the place (specify) you mentioned?**

Open response in km or other measure used by respondent



## Walking

## Section 3

14. Do you have to walk to somewhere because other transport is not available to you?

- ☐ Never
 ☐ Hardly ever
 ☐ Sometimes
 ☐ Often
 ☐ Almost always

15. What are the places you sometimes have to walk to?

- ☐ School
 ☐ Health centre
 ☐ Shops
 ☐ Other

16. How far or how long does it take to walk to the place (specify) you mentioned?

- ☐ Usually less than 1km (short trips)  
☐ Usually between 1-5km  
☐ Usually between 5-20km  
☐ Usually 20-50km  
☐ Usually further than 50km (long trips)  
☐ Specify other

Open response in km or other measure used by respondent

17. If you don't walk to places you want to go, is it your choice, or are there things that prevent you (pick up to 3 choices)?

- ☐ Distance
 ☐ Health reason
 ☐ No/poor footpath
 ☐ Weather (e.g. usually too hot/humid/cold/raining)
 ☐ Feel vulnerable to others
 ☐ Takes too long

## Motor vehicles

## Section 4

18. About how often have you travelled in a motor vehicle (anything powered by a motor) since this time last year?

☐

Never

☐

A few times

☐

About once a month

☐

About weekly

☐

About daily

19. How many vehicles do you have access to?

Open response

20. What sort of motor vehicle do you travel in most? Starting from 1, we will mark the transport you used most, with 2 for the next and so on. If there are items in the list that don't apply to you, we will leave that box blank.

☐

Car/small 4WD/station wagon

☐

Big 4WD/van/people mover

☐

Ute

☐

Bus

☐

Truck

☐

Motorcycle

☐

Specify other

**21. Who is in charge (decides how and when it is used) of the motor vehicle in which you travel most often? Starting from 1, we will mark most frequent, with 2 for the next and so on. If there are items in the list that don't apply to you, we will leave that box blank.**

- ☐ You
- ☐ Your husband/wife
- ☐ Another relative, including a child or a parent
- ☐ Friend, neighbour, other private local transport
- ☐ Commercial provider (taxi, bus operator)
- ☐ Government agency
- ☐ Specify other

**22. Do you have access to a private vehicle when you want to go somewhere?**

- ☐ Never      ☐ Hardly ever      ☐ Sometimes      ☐ Often      ☐ Almost always

**23. Who owns the vehicle that you have access to?**

- ☐ Male family member      ☐ Female family member      ☐ Clinic/health agency      ☐ School      ☐ Council      ☐ List other

24. How often are you the driver of motor vehicles in which you travel?

- ☐ Never
 ☐ Hardly ever
 ☐ Sometimes
 ☐ Often
 ☐ Almost always

25. When you travel in a motor vehicle, how many people (apart from you) are usually on board?

- ☐ 2
 ☐ more than 2
 ☐ all seats are full
 ☐ as many people as will fit
 ☐ Varies a lot

26. When you travel in a motor vehicle, how often do you wear a seat belt?

- ☐ Never
 ☐ Hardly ever
 ☐ Sometimes
 ☐ Often
 ☐ Almost always

27. When you travel in a motor vehicle with children, how often do they use a baby or child restraint?

- ☐ Never
 ☐ Hardly ever
 ☐ Sometimes
 ☐ Often
 ☐ Almost always

28. When you have travelled in a motor vehicle since this time last year, how far have you usually travelled? Starting from 1, we will mark the distance you travelled most often, with 2 for the next and so on. If there are distances in the list you didn't travel, we will leave that box blank.

- ☐ Usually less than 5km (short trips)  
☐ Usually between 5-20km  
☐ Usually 20-50km  
☐ Usually further than 50km (long trips)  
☐ Specify other

### Decisions you had to make to get where you wanted to go Section 5

29. Sometimes people go places in ways that they don't like because other options are not available. Since this time last year did you go places in any of the following ways because other options were not available to you?

(a) Walked a long way/further than was comfortable

0 times      1 time      2-5 times      More than 5 times

(b) Walked or waited where I didn't feel safe

0 times      1 time      2-5 times      More than 5 times

(c) Went in a vehicle though I didn't feel safe with the driver's driving

0 times      1 time      2-5 times      More than 5 times

(d) Went in a vehicle with a driver who'd been drinking

0 times      1 time      2-5 times      More than 5 times

(e) Had to beg a lift from a family member or friend

0 times      1 time      2-5 times      More than 5 times

(f) Hitchhiked

0 times      1 time      2-5 times      More than 5 times

(g) Travelled in a vehicle that I wasn't sure could make the trip without breaking down

0 times      1 time      2-5 times      More than 5 times

(h) Travelled in a vehicle that I didn't feel safe in

0 times      1 time      2-5 times      More than 5 times

(i) Travelled in a bus where other people's behaviour was a problem

0 times      1 time      2-5 times      More than 5 times

(j) Travelled at a time that wasn't good for me

0 times      1 time      2-5 times      More than 5 times

(k) Specify another reason

0 times      1 time      2-5 times      More than 5 times

30. If you had to do any of the above things to get where you wanted or needed to go, what was the main problem with what you did? Starting from 1, we will mark what bothered you most, with 2 for the next and so on. If something in the list didn't bother you, we will leave that box blank.

- ☐ Felt vulnerable/that I might be attacked
- ☐ Didn't like begging for a lift
- ☐ Worried I might be in a crash
- ☐ Couldn't be sure when I would arrive
- ☐ Had to allow a long time for the trip
- ☐ Specify other

31. What things do you want or need to do often (at least once a week) that is a problem because of lack of good transport?

Open response

32. What do you think could be done that would make it easier to move about to do these things?

Open response

### Not making it to where you wanted to go

### Section 6

33. Sometimes people don't get to a place that they want to need or go because of lack of transport. It might be that there is no transport available, or it's not affordable, not at the right time, or not an acceptable type of transport.

Since this time last year did lack of transport stop you from getting to any of the following things?

**(a) Family/community events**

0 times      1 time      2-5 times      More than 5 times

**(b) Health appointments**

0 times      1 time      2-5 times      More than 5 times

**(c) Work/employment**

0 times      1 time      2-5 times      More than 5 times

**(d) School/education**

0 times      1 time      2-5 times      More than 5 times

**(e) Entertainment (e.g. party, movie, club)**

0 times      1 time      2-5 times      More than 5 times

**(f) Sports activity**

0 times      1 time      2-5 times      More than 5 times

**(g) Shopping**

0 times      1 time      2-5 times      More than 5 times

**(h) Specify another reason**

0 times      1 time      2-5 times      More than 5 times

34. What was the most important thing that you couldn't do in the past year due to lack of transport?

Open response

35. What do you think could be done that would let you get to this sort of thing in the future?

Open response

### Driver's licence

### Section 7

36. Do you have a current driver's licence

☐

Yes

☐

No

37. Have you ever had a driver's licence?

☐

Yes

☐

No

38. Can you tell me how easy or difficult you felt it was to get your driver's licence?

☐

Very easy

☐

Easy

☐

Neutral

☐

Difficult

☐

Very difficult

39. Can you tell me how and where you got your driver's licence?

Open response

40. If you haven't got one, can you tell me what put you off getting a driver's licence?

Open response





### Additional Feedback

### Section 8

41. Is there a particular travel situation you would like to tell me about?

Open response

42. Would you like someone to contact you with any results or feedback from this questionnaire?

☐

Yes

☐

No

### Personal Information

### Section 9

Providing the following information is optional, but we will need it if you answered yes to the last question.

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Telephone: \_\_\_\_\_

***Thank you for taking the time to fill out our questionnaire.***

***Your input is greatly appreciated.***

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## APPENDIX G: CORRESPONDENCE WITH THE WRIGLEY COMPANY

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Dear Carol,

Thanks for your time earlier today. I am involved in a research project that is investigating the impact of lack of access to safe and sufficient transport, and the effect that has on Aboriginal communities in urban, rural and remote areas of South Australia. From the 17–19th of July members of our team will visit Yalata, a remote Aboriginal community that lies 2.5 hours (by car) west of Ceduna, towards the WA border.

This community is isolated, and has no regular or reliable means of access to shops and services, the closest of which are in Ceduna. We are being hosted by Mr Lindsay Osborn, the director of Tullawon Health Service (Yalata), and he has told me of his concern for the dental care of the young people and children. Toothpaste and toothbrushes are not popular and not plentiful, and he believes that if we could introduce the young people to sugar free gum, this would be a positive and practical dental health intervention. To this end, I am appealing to you to consider a donation of sugar free product to enable us to test this idea. I know that any contribution would be most appreciated, even if it is not immediate, but in the future.

If I can assist your decision with further information, please contact me via e-mail, or on the number listed below.

Yours sincerely,

Yvonne Helps

Dear Yvonne

We have sent a post parcel bag and padded bag, with approx 150 individual packs, I slipped 3 bottles also for your team to use as treats perhaps to children.

I trust this small donation will make a difference.

Wishing you well

Carol McCormick

Consumer Affairs

The Wrigley Company