

Temporary Indigenous Mobility in Remote South Australia: Understanding the Challenges for Urban Based Health and Social Service Delivery

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Abstract

Remote dwelling Indigenous people in Australia frequently move between remote communities and urban centres for reasons such as access to health and social services, cultural and family obligations, or leisure and recreation. Short-term mobility challenges health and social service providers not only to deliver services to remote communities but to make sure that adequate services are available in places Indigenous people visit. This paper documents how service providers in two urban centres in remote South Australia respond to the challenges presented by temporary Indigenous visitors. The paper identifies a number of reasons why the existing health and social service sector is poorly set up to deal with the needs of temporary Indigenous visitors. Many service providers are aware that different groups of (temporary) Indigenous clients may require different services. However, they are limited in their capacity to change existing service strategies due to rigid funding structures and a lack of inter-agency collaboration and service coordination.

Keywords: Indigenous mobility, temporary migration, health and social services, remote, South Australia

1.0 Introduction

Indigenous people in Australia face a range of socioeconomic disadvantages compared to non-Indigenous Australians. They have lower life expectancies, suffer from poorer health conditions, and are more often affected by issues such as a lack of quality housing, education and employment (Altman, Biddle & Hunter, 2008; Thomson et al., 2010). Indigenous people in remote communities are particularly disadvantaged as a result of physical isolation, inadequate housing and public transport arrangements, a lack of economic opportunities, high rates of substance abuse, violence and anti-social behavior,

a lack of access to high-quality food, and a lack of accessible health and social services (Gruen, Weeramanthri, & Bailie, 2002; O’Dea, 2005; Vos et al., 2009).

A number of government strategies, including the ‘Closing the Gap’ initiative in 2008 or the Northern Territory Emergency Response in 2007, have recently been implemented that seek to improve the general health and living conditions of Indigenous Australians (Billings, 2010; Taylor & Carson, 2009). Health and social service agencies have increasingly started to address Indigenous disadvantage in various fields such as: primary health care (including specific Indigenous health care programs), mental health, alcohol and drug management, domestic violence and sexual assault counselling, child, adolescent and family services, disability assistance, housing services and homelessness assistance, and welfare and employment services.

Delivering such services to Indigenous people living in remote communities, however, has remained highly problematic, and there is ongoing concern that health care and social support services are severely under-resourced in remote communities (Robinson, d’Abbs, Bailie, & Togni, 2003; Smith & Elston, 2007). For example, health clinics in remote and sparsely populated regions are very costly to maintain and it is very difficult to recruit and retain professional service staff (Auer & Carson, 2010). Similarly, outreach services from urban centres (where health specialists based in urban centres visit remote communities on a ‘fly-in/fly-out’ or ‘drive-in/drive-out’ basis) are very costly and are only available on certain days of the week or month, leaving gaps in service provision in between visits (Guerin & Guerin, 2009). Moreover, outreach services beyond immediate primary health care, such as mental health programs and social services, are often just organised on an ad hoc basis and depend on time-limited project funds (Fuller et al., 2005; Gruen et al., 2002). A continuous supply of specialist health and social services in remote communities is therefore limited.

Another major problem in addressing the health and social service needs of people from remote Indigenous communities is the high rate of temporary and seasonal Indigenous mobility. Remote dwelling Indigenous people in Australia have been described in the literature as highly mobile as they frequently move between remote communities and urban centres. These movements can be caused by a variety of motivational factors, including service related reasons (e.g. the need to access better health, education or employment services), leisure motivated reasons (e.g. visiting family and friends, shopping, going to sporting events, or visiting entertainment facilities), cultural reasons (e.g. attending funerals), legal reasons (e.g. court appointments or short-term imprisonment), and safety related reasons (e.g. the need to escape violence and unpleasant living conditions in remote home communities) (Carson & Robinson, 2008; Long & Memmott, 2007; Prout & Yap, 2010). Short-term mobility can include planned and regular movements (e.g. people visiting family members for Christmas each year, or people coming into town for shopping on payday), as well as unplanned and irregular movements (such as people coming into town for a funeral or to escape domestic violence in their home communities).

Short-term mobility between remote communities and urban centres as a form of Indigenous ‘urban drift’ is not a recent phenomenon in Australia but has been observed for several decades (Carson & Taylor, 2009; Long et al., 2007). Yet such urban drift continues to be portrayed in the literature and the public media as problematic for urban based service providers. Despite well-known periods of seasonal Indigenous mobility, service providers often struggle to

predict the extent and nature of temporary Indigenous in-migration and fail to respond to fluctuating service demands (Carson et al., 2009).

This paper looks at the challenges for service provision in urban centres that remote dwelling Indigenous people occasionally visit. The paper draws on results from case studies in two urban centres in remote South Australia. It examines how service providers in these towns attempt to deal with challenges associated with temporary Indigenous mobility. The paper identifies a range of systemic weaknesses in the current structure of the health and service sector in remote Australia which seem to prevent individual service providers from improving service delivery to temporary visitor populations. The inflexible nature of the service system—caused by rigid funding programmes and an overall policy approach that fails to recognise the apparent diversity of Indigenous service populations—appears to be one of the main reasons why service providers struggle to respond to the needs of temporary Indigenous visitors.

1.1 Temporary Indigenous Mobility as a Challenge for Service Provision

Service providers in urban centres commonly perceive high rates of temporary Indigenous mobility as a problem (Prout, 2008; Taylor, Johns, Williams, & Steenkamp, 2011). Temporary visitors from remote Indigenous communities tend to be seen as causing a range of social problems in the places they visit, including overcrowding in houses, temporary homelessness, illegal camping, anti-social behaviour, and increased alcohol or drug abuse (Carson et al., 2009; Holmes & McRae-Williams, 2008). They are often seen as generating extra pressure for the local health and social service sector by diverting resources away from local residents.

One reason why service providers struggle to deal with temporary Indigenous mobility is that mobility patterns are frequently perceived as being dominated by highly unplanned and unpredictable movements, thus making it difficult to estimate and plan for fluctuating service demands. The size and composition of Indigenous visitor populations, the frequency of movements, as well as lengths of stay are not adequately captured by standard data sets such as the Australian population census (Prout, 2009; Taylor, 1998). As a result, service providers in urban centres tend to be ill-prepared to respond to the needs of an unknown service population that may be considerably larger in certain places and at certain times of the year than the usual resident population (Taylor, 1998; Warchivker, Tjapangati & Wakerman, 2000).

Service providers in urban centres appear to be well aware of regular seasonal peaks in remote-to-urban Indigenous migration. For example, known periods of high mobility include the time around Christmas and Easter, regional sporting carnivals, traditional periods of ceremonial activities, and seasonal climatic events such as the ‘wet season’ in the tropical north (from December to March) or the summer season in Central and South Australia (Carson & Taylor, 2011; Long et al., 2007; Northern Territory Treasury, 2008; Prout et al., 2010).

However, few service agencies seem to collect consistent internal data to measure service demand fluctuations caused by short-term Indigenous in-migration. Research in the Northern Territory (Northern Territory Treasury, 2008) has shown that existing agency data collections are largely incomplete and rarely comparable either between agencies or over time. They do not seem to capture key indicators of short-term Indigenous mobility well, such as the place of usual residence, reasons for travel, the size of the travel party, or intended length of stay. As a result, there appears to be a general lack of

evidence to develop an informed understanding of how many people move from remote communities to urban centres, at what point in time, for how long, and for what purpose. For example, a recent study in Darwin found that visitor estimates from service providers varied considerably across the service sector, ranging from a couple of hundred to a couple of thousand visitors for the same period of time (Carson et al., 2011).

One particular problem for service provision is that the mobile lifestyle of remote dwelling Indigenous people is sometimes incompatible with the inflexible and permanent nature of urban-based service facilities. Service providers in urban centres, particularly in the fields of health, education and housing, tend to cater primarily to permanent local service populations with single-locale sedentary lifestyles and struggle to adequately respond to service needs of ‘transient’ visitor populations (Prout, 2008). Prout’s (2008) study in Western Australia found that service providers considered the mobile lifestyle of Indigenous people as a major threat to continuity of care, as patients from remote communities unexpectedly disrupted treatment and decided to leave and move on. Short-term Indigenous mobility was seen as a problem in terms of post-care monitoring because transient people were difficult to track down once they had left urban centres (Prout, 2008).

Intercultural differences between people from remote Indigenous communities and people managing and working in the urban-based mainstream service sector (dominated by non-Indigenous Australians) are an additional challenge that complicates efficient service provision for Indigenous short-term visitors (Gruen et al., 2002; Prior, 2009). People from remote communities tend to have limited English language skills and struggle to understand practices that are common in the mainstream health sector (Gruen et al., 2002). For example, they often do not understand the need to make (and keep) scheduled appointments in the mainstream service sector (Prout, 2008), or they feel uncomfortable when they have to deal with non-Indigenous service staff (Maher, 1999). Providing culturally appropriate services for Indigenous clients has repeatedly been identified as a key priority in Indigenous health care, in particular when dealing with Indigenous people from remote and isolated communities (Gruen et al., 2002; Hayman, White, & Spurling, 2009; Maher, 1999; McLennan & Khavarpour, 2004). Strategies that have repeatedly been advocated in the literature include the employment of Indigenous staff as health and social workers, the use of interpreters, the provision of information in language, and regular cultural awareness training for service staff (Gruen et al., 2002; Hayman et al., 2009; Watson, Obersteller, Rennie, & Whitbread, 2001).

While it seems to be a common argument in the literature that temporary Indigenous mobility presents considerable challenges for urban-based service providers, few studies to date have looked at how service providers deal with the challenges caused by short-term Indigenous visitor populations. This paper documents how the health and social service sector in two regional service centres in remote South Australia attempts to manage the challenges of temporary Indigenous mobility for service delivery. Using qualitative in-depth interviews with health and social service providers, the research sought to address the following questions:

1. What do service providers perceive to be the main challenges for efficient service delivery to temporary Indigenous visitors?
2. What strategies have been employed by service providers to deal with these challenges?
3. How do service providers evaluate the effectiveness of these strategies?

2.0 Methods

The research was conducted in two regional centres of South Australia's remote Far North and Eyre Peninsula regions (see Figure 1). The Far North covers a vast area of almost 800,000 km² which accounts for around 80% of South Australia's landmass (RDA Far North SA, 2011). It has a population of approximately 28,670 people, the majority of whom are concentrated in the main regional centres Port Augusta, Coober Pedy, and Roxby Downs. Mining, energy, tourism, pastoralism and defence are the major economic sectors in the Far North. The Eyre Peninsula region includes the western areas of the state and extends from Whyalla to the Western Australian border. This region covers about 230,000 km² and has a population of approximately 57,500 people (RDA Whyalla and Eyre Peninsula, 2011). The main regional centres include Whyalla, Port Lincoln and Ceduna. The area relies primarily on mining and mineral processing, agriculture, aquaculture, fishing and tourism.



Figure 1. Far North and Eyre Peninsula regions in South Australia (created by authors).

The Far North and Eyre Peninsula have the highest proportion of Indigenous people in the South Australia. According to the last Australian census in 2006 (Australian Bureau of Statistics, 2007), about 9.4% of residents (or 7,900 people) were Indigenous (17.7% in the Far North, 4.9% on Eyre Peninsula), compared to only 1.7% for South Australia as a whole. About a third of Indigenous residents lives in remote and very remote desert communities located on traditional lands, including the Anangu Pitjantjatjara Yankunytjatjara Lands (APY Lands) in the Northwest of the state on the border to the Northern Territory, the Maralinga Tjarutja Lands in the Midwest, and the Yalata Lands on the West Coast (see Figure 2). According to the 2006 census data, the APY Lands are home to more than 2,000 Indigenous people, with the larger communities being Iwantja (population size 340), Pukatja (330), Amata (320), and Mimili (300). Other Indigenous communities in the area include Oak Valley (population size 105), Yalata (100), and Umoona near Coober Pedy (75). Due to high rates of Indigenous mobility, the number of

people residing in these remote Indigenous communities fluctuates considerably at certain times of the year, as illustrated by the following statement from the Oak Valley community websites.

“The local population ranges from 80-100. At times during special cultural activities the population has risen to 1,500 people, with visitors from neighbouring communities.” (Maralinga Tjarutja Administration, 2007)

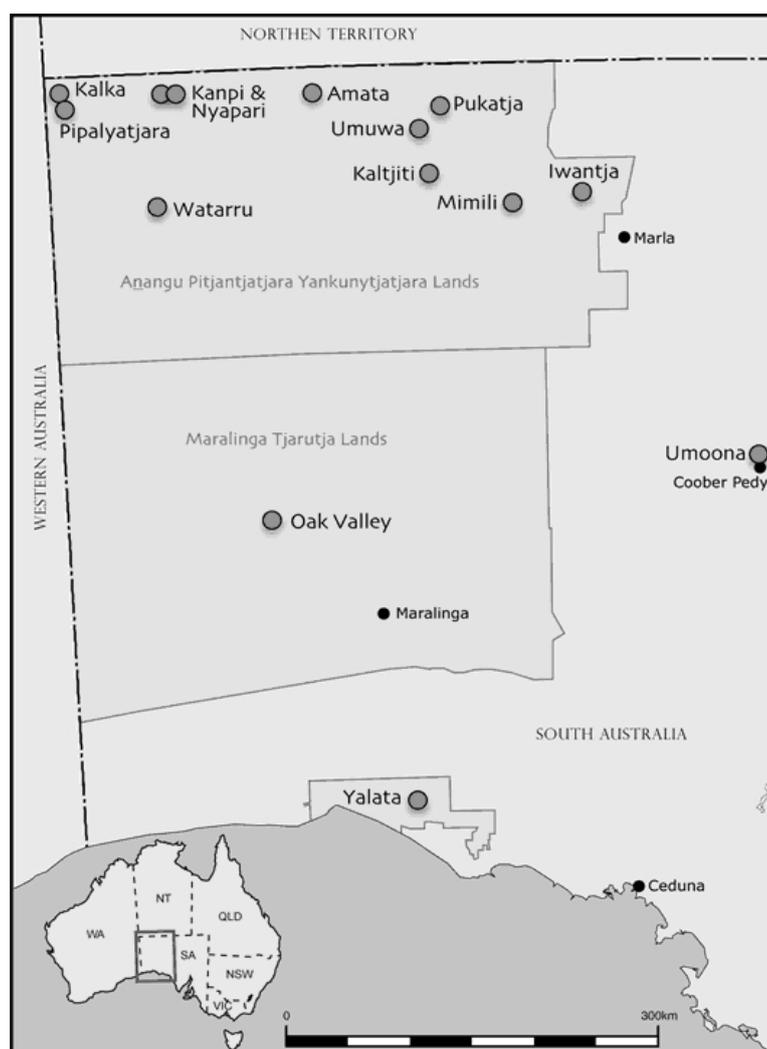


Figure 2. Map of Aboriginal Lands and communities in remote South Australia (Source: UnitingCare Wesley Adelaide, 2009, used with permission).

The research for this paper was based on in-depth interviews with health and social service providers in two regional centres in October and November 2010. The names of individual service providers and the two regional centres have been de-identified in this paper for reasons of confidentiality. They are referred to as Service Provider A/B/C and Regional Centre A/B. The two regional centres were chosen based on anecdotal evidence, such as media reports and statements from local service providers, suggesting that these towns were the main service centres for remote dwelling Indigenous people and therefore received high (albeit fluctuating) volumes of short-term Indigenous in-migrants. There is a relatively high concentration of service

providers in both regional centres. Available services include, for example, hospitals, Indigenous health care centres, mental health service agencies, governmental and non-governmental welfare agencies, housing and transitional accommodation services, employment services, alcohol and drug management services, family and child support services, and counselling services for domestic violence and sexual abuse.

Interview participants were identified from local service directories and through recommendations from local government members and representatives of the local Regional Development Australia (RDA) boards. In total, 27 out of 50 identified local service providers could be recruited for an in-depth interview, resulting in a response rate of 54%. Interview participants included managers and employees of service agencies operating in the following fields: primary health care; Indigenous health; housing and accommodation; child, youth and family services; alcohol and drug management; domestic violence; disability assistance; and non-government charity organisations. Interview participants represented a broad range of service agencies and generally reflected the composition of the local service sector. Hence, the relatively low response rate did not appear to have caused significant bias to the composition of the sample or the content of the interview data.

Interviews were semi-structured and followed a broad interview guideline that sought to obtain rich qualitative data. Interview participants were asked about their personal experiences in dealing with Indigenous visitors from remote communities and how they evaluated their role in providing services to this particular group of temporary service population. More specifically, service providers were asked about the type of challenges they have encountered when dealing with temporary Indigenous visitors, the type of strategies they have used to respond to such challenges, and how well these strategies appeared to be working. Interviews were audiotaped with the approval of participants and subsequently transcribed in the form of verbatim quotes and summary statements.

Interview transcripts were then reviewed and analysed independently by two researchers, using qualitative content analysis. The first step of analysis was based on an 'open coding' approach (Hoepfl, 1997), which focused on identifying the main themes and re-occurring patterns in the raw data. Starting from the three research questions, interview transcripts were analysed to identify participant responses that reflected 1) the perceived challenges of temporary Indigenous mobility for service providers, 2) the type of strategies that service providers have used to respond to challenges, and 3) how service providers evaluated the effectiveness of these strategies.

When reading through the transcripts, the researchers manually assigned descriptive codes to individual quotes and grouped them into meaningful conceptual categories. For example, as shown in Figure 3, codes identifying the perceived challenges of temporary Indigenous mobility for service provision included the high seasonality of movements, movements triggered by unforeseen events such as funerals, unpredictable family movements, and the prominence of non-health related movements. All these codes reflected concerns of service providers that short-term mobility would cause high levels of service demand at certain times of the year which were difficult to predict and exceeded existing service capacity. These codes were consequently grouped into one conceptual category labelled 'unpredictable movements – demand exceeding service capacity'.

The list of codes and conceptual data categories was gradually modified and extended as the analysis process proceeded. Through continuous re-

examination of codes and conceptual categories, the researchers sought to identify meaningful links and connections between individual data categories to build a more holistic understanding of the interview data. This process is also referred to as ‘axial coding’ (Hoepfl, 1997). For example, it was found that one commonly proposed strategy to control excessive short-term mobility was the improvement of outreach services (Figure 3, second column). However, the infrequent delivery of outreach services, limited funding for a broader range of services, and the lack of ability to address non-health related movements were identified as reasons why service providers thought that existing outreach services contributed little to control short-term mobility (Figure 3, third column).

Finally, all codes and categories, as well as the identified connections between them, were grouped according to the three research questions and a coding tree (a graphical outline of the various data codes and their connections) was developed to illustrate how the findings answered the study’s research questions (Figure 3).

3.0 Findings

3.1 Perceived Challenges for Service Provision

The findings confirmed previous observations in the literature (notably Taylor et al., 2011; Prout, 2008) that temporary Indigenous mobility was largely perceived as a problem by service providers. Most interview participants agreed that the frequency and unpredictability of movements between remote Indigenous communities and regional service centres were major challenges for service providers. The high seasonality of movements, for example as large numbers of temporary visitors moved into regional centres around Christmas and during the hot summer months, was identified as one of the main issues. Most service providers agreed that regional centres are not equipped to provide sufficient accommodation and support services during such peak seasons. As a result, visitors from remote communities often become temporarily homeless and sleep rough, or they cause overcrowding in the houses of friends and relatives.

Interestingly, few service providers seemed to collect client data to measure temporary Indigenous visitor patterns. Only seven out of 27 interview participants confirmed that their agencies did keep client records that could identify short-term visitors and ‘transient’ clients as such. However, many of them acknowledged that they did not specifically analyse such data to identify temporary visitor trends. As a result, estimates of visitor volumes were usually based on personal impressions and anecdotal reports rather than sound visitor statistics. Only two service providers (who provided accommodation services for temporary visitors) could give confident estimates of monthly visitor volumes. Yet even these providers indicated that they struggled to predict daily fluctuations of service demand.

“No [we never know how many people will come the next day]. Over a week we can average 16, 17 people on a Wednesday, Thursday night, but on a Sunday we might have 35. So it's a big change in number (...). It's a big job for our cook because she doesn't really know how many people would come.” (Service Provider A)

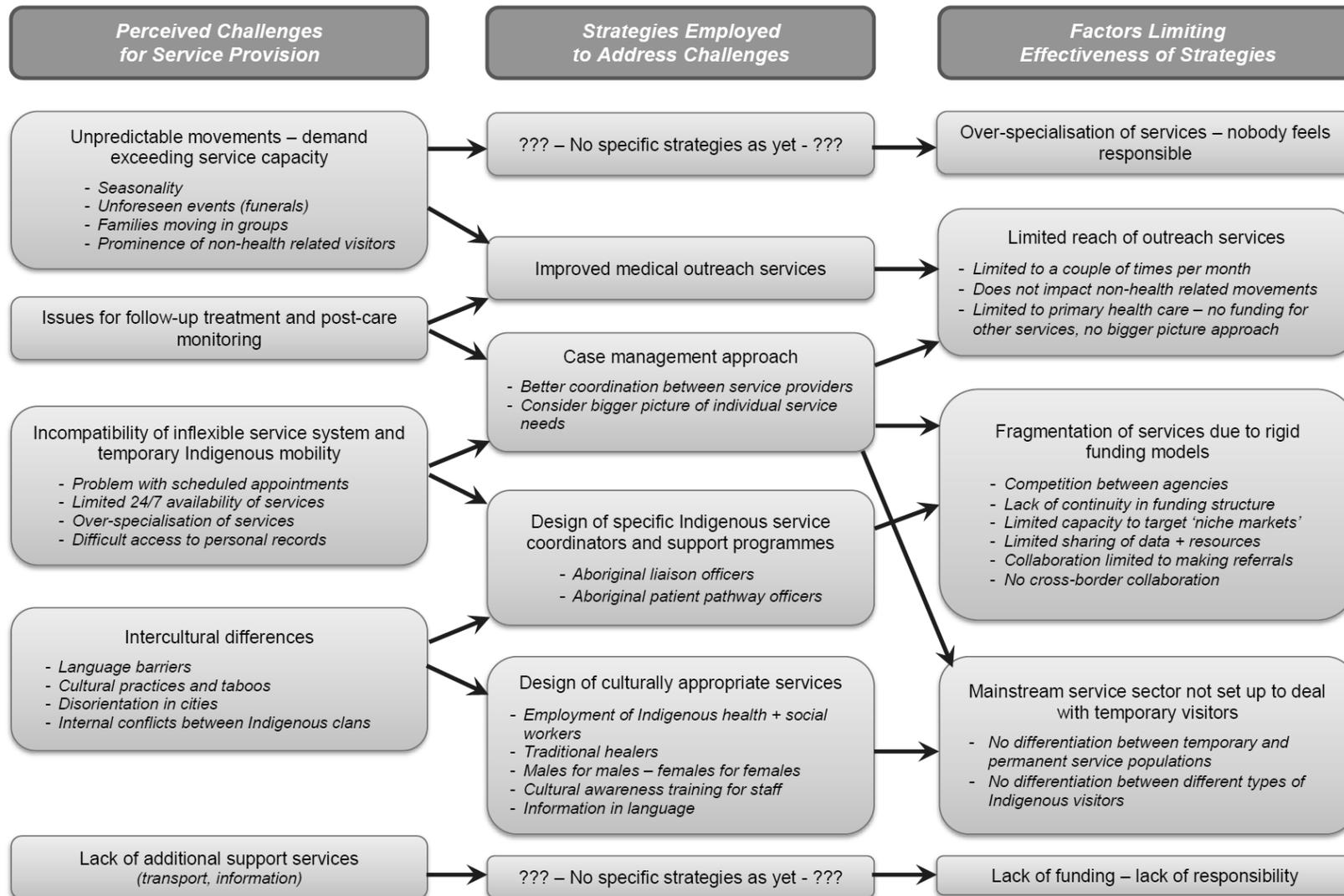


Figure 3. Data Coding Tree.

Service providers identified a range of additional scenarios where sudden increases in temporary visitors led to unexpected peaks in service demands that exceeded service capacity. Unforeseen events, including funerals and other cultural obligations, were critical situations when large numbers of temporary visitors come to regional centres and cause shortages to available accommodation and services. In particular, the cultural obligation to support family members who have gone to hospital or prison was seen as a problem. Large family groups frequently follow their relatives into town and wait until they are released from hospital or prison. Although service providers were well aware of such movement patterns there were no adequate strategies in place to measure, plan for and respond to service needs of those additional visitors who come to support family.

“[I]f you are an old fella and you go down to hospital, they [family members] all go then down to [Regional Centre A]. And because there is no place to stay they camp in the bush camp, they camp everywhere. So hospitalisation – you take one person and put in a hospital and his or her family will come back to be with that person.” (Service Provider B)

Another common scenario that service providers struggled to deal with was the prominence of non-health related visitors. Frequently, remote dwelling Indigenous people visit one of the regional centres for holiday and leisure related purposes. They seek to escape the summer heat in the desert, want to spend some time near the ocean and the beach, want to visit family, want to do shopping, or want to engage in certain leisure activities (including drinking and gambling) that are not available in remote communities. A lack of affordable temporary accommodation options for these people, as well as a lack of public transport and information services, can then lead to numerous problems as visitors get stranded in town. They have nowhere to stay, no transport back home to their communities, no information on what to do when they become stuck in town, and eventually run out of money and become homeless. Quite often, more family members then follow to look for their stranded relatives, and they might themselves become stuck in town due to a lack of transport and support services.

“And you would find too that (...) the men would come into town drinking and wouldn't come home for two weeks. So then the wife and the kids would come into town looking for them. But then they get into town and then they get stranded, you know, with no lift back to the community. So then that becomes another housing issue.” (Service Provider C)

Similar to Prout's (2008) findings, service providers in the health sector were concerned that the transient nature of temporary Indigenous visitors presented substantial challenges for post-care monitoring and follow-up treatment. Service providers often described visitors from remote communities as 'itinerants' who are difficult to trace for follow-up checks, as many of them do not immediately go back home to their communities but make a detour to visit family in other places and communities. Some service providers were particularly concerned that these 'itinerants' would engage in activities such as drinking or gambling and then forget to come back for their follow-up medical checks, or they forget to take their medication.

Another issue commonly associated with transience was the difficulty in obtaining personal and medical records from clients who were temporary visitors. For example, service providers criticised that visitors often did not bring their identification documents, Medicare (health insurance) or Centrelink (welfare) details, bank key cards, and prescribed medication because they left their communities at short notice (e.g. for a funeral or because a family member was rushed off to hospital) and did not have time to prepare their documents. In those cases, service providers had to go through a lot of extra paperwork to chase down the required details for delivering services.

Intercultural differences, including language barriers, the fear of having to go to a mainstream clinic and deal with ‘white’ service staff, and the perception that males should not be treated by females (or vice versa), were other challenges that service providers repeatedly encountered. Some interview participants mentioned that having to deal with different Indigenous family groups was sometimes problematic because of internal conflicts and rivalries between different families. Service providers had to make sure to keep clients from rivaling families separate to avoid fights and violent behaviour. This was particularly difficult for temporary accommodation providers (such as hostels, emergency shelters, town camps, etc.) where encounters between different Indigenous groups were more difficult to avoid.

Similar to Prout’s (2008) study, interview participants described the incompatibility of temporary Indigenous lifestyles with the inflexible and stationary nature of the mainstream service sector as a major challenge for service provision. In particular, a lack of understanding among Indigenous visitors about the structure and requirements within the mainstream service sector was repeatedly seen as a problem. For example, service providers struggled to communicate to Indigenous visitors the need to make appointments for medical services or that particular services were not available outside normal office hours.

“There are a lot of good services available around [Regional Centre A]. However, [the problem is] their chaotic lifestyle, living from relative to relative. They might have an appointment today, but there might have been an explosion in the house last night of drinking and stuff. They are not gonna keep that appointment today, but most of the mainstream places have appointments. So that’s where I don’t think is a flexibility for these people. Like it happened last night, and at 3 o’clock this afternoon they think ‘Oh, I need to go and get a health check, I can just go and see them.’ Well, they can’t. The appointment was at 10 o’clock this morning. We don’t seem to be flexible enough to meet the lifestyle and the day-to-day living that these people survive in.” (Service Provider D)

Service providers described the health and social service system as highly complex with lots of different agencies providing a wide range of specialised services. Some interview participants thought that the system was far too complex for Indigenous visitors to understand and navigate on their own. For example, many service agencies were limited in their capacity to respond to holistic Indigenous service needs because they were only funded to provide specific services (e.g. accommodation only, drug and alcohol services only, or

mental health services only). Hence, if their clients needed additional services they had to refer them on to other agencies—sometimes with the result that Indigenous visitors not used to the system became disoriented and lost in larger urban centres. A lack of experience in navigating their own way around urban centres, paired with language barriers and a severe gap in information and support services (for example, interpreters or social workers) was one of the main reasons why Indigenous visitors often became lost and ultimately ended up being homeless.

“Many of the people who come down tend to have complex needs and, you know, without either information ahead of time before they come, or information on arrival and support to be able to navigate the range of systems and services that are here in an urban or regional centre, people can become vulnerable really quickly. (...) It could be simple things like ‘You catch the bus to the hospital on that side of the road not this side of the road.’ Unless that’s explained to people... And there’s also issues with language, you know, English being a second or third language. So even access to interpreters—how do people access interpreters down here? That sort of stuff, or support to fill out a form.” (Service Provider E)

3.2 Strategies to Manage Challenges and Factors Limiting Their Effectiveness

Service providers were asked how they were trying to deal with the challenges arising from temporary Indigenous mobility and how they evaluated the effectiveness of these strategies. Interview participants listed a range of strategies that were used to deal with temporary Indigenous visitors but also identified several reasons why they thought that these strategies were not working as well as they should.

Some interview participants thought that an increase in outreach services in the health care sector was one of the most important strategies to reduce the number of temporary visitors seeking medical treatment in regional centres. However, they admitted that current models of outreach services were largely ineffective because of the infrequent delivery of service (service visits to communities are limited to a couple of times per month), a lack of qualified staff, and a lack of sufficient funding to extend outreach services beyond basic primary health care.

“[Service provider F] gets money to look after people here in [Regional Centre A]. But there needs to be extra money because what doesn’t happen but should happen—there should be outreach services. (...) There should be dedicated health workers that go out to people’s homes. (...) Not much service is given, believe me, we can vouch for this. They might go up to those areas once a month, they might go up once every three months, and there is no conversation in between. A lot of it is because of funding.” (Service Provider G)

In addition, some participants criticised that outreach services would only meet the needs of a very small proportion of temporary visitors—those who need medical services but do not want to leave their communities. According to one participant, a major flaw in the design of outreach services is the general assumption that the delivery of better health services to remote communities would automatically stop people's desire to leave their home communities and visit regional centres. This approach does not take into account that leisure, family and culture related reasons are often the main drivers of Indigenous mobility decisions (Carson et al., 2008; Long et al., 2007; Prout et al., 2010), and that an increase in outreach services is unlikely to affect mobility patterns of non-health related temporary migrants.

Although service providers were aware of the diversity of travel motivations, it seemed that many of them failed to recognise that people with different travel motivations are likely to have different service needs. For example, several interview participants admitted that the service sector was not set up well to deal with the large proportion of temporary Indigenous 'leisure visitors' in regional centres. They argued that, while the influx of large numbers of leisure visitors was a long standing issue, there were still not enough support services such as accommodation, transport and information services in place to respond to the needs of these visitors. However, funding limitations and an over-specialisation in the service sector (i.e. agencies can only provide the service they are specifically funded for) meant that most service agencies simply did not feel responsible for this target group.

It was also argued that the few available service providers that cater specifically to temporary Indigenous visitors (such as hostels and transitional accommodation centres) clearly did not meet the needs of Indigenous leisure visitors. Temporary accommodation facilities tend to have numerous restrictions, for example on length of stay, group size, mixed dormitories, curfews, and alcohol consumption. Temporary leisure visitors often want to avoid such restrictions and rather camp in public places instead. Participants in both regional centres criticised that there were almost no services in place to look after Indigenous leisure visitors who preferred 'sleeping rough' to staying in one of the Indigenous town camps.

“But [the public campsite] is an area where people go because they can't drink in the Town Camp and they can't drink in the community itself. The community is a dry area so they go to [the public campsite] to party, to drink, and they tend to camp at night and come back to town in the mornings. (...) But they [local council] are reluctant to put any services out there or any infrastructure. They are reluctant to put toilets, water supply, permanent services out there because the view is that it will encourage more people to camp there.” (Service Provider H)

The most common management strategies identified by interview participants were aimed at providing services in a culturally appropriate way to overcome issues of intercultural differences. These strategies were consistent with many of the strategies that have previously been advocated in the literature (Gruen et al., 2002; Hayman et al., 2009; McLennan et al., 2004; Watson et al., 2001). They included the employment of Indigenous health and social workers who were familiar with Indigenous cultural backgrounds; the design of information material (e.g. brochures and videos) in Indigenous languages; the use of

language interpreters; the integration of traditional Indigenous healers (Ngangkari) in mainstream services; the provision of same-sex service staff for Indigenous clients; and the requirement for non-Indigenous staff to regularly participate in some form of cultural awareness training.

Despite the long list of culturally appropriate services, it appeared that many service providers applied the same strategies to all of their Indigenous clients and did not differentiate between service needs of temporary visitors and permanent residents. In particular, service agencies in the mainstream health sector (e.g. hospitals) were not set up to respond to more complex service needs of temporary visitors. According to one participant, mainstream health providers tend to focus on delivering specific health services only. There is limited recognition of the need to check whether temporary clients (and their families who usually follow them) have adequate access to accommodation, transport, information, counselling and family support while they are in town.

Several service providers acknowledged that this apparent lack of attention to temporary visitor needs existed simply because ‘transient’ Indigenous people were not seen as a service priority compared to the larger permanent resident population. They were seen as only ‘passing through’ and were then expected to become someone else’s problem.

“The other thing that we find as well is that people aren't connected to services when they come here, they are treated as transient. So for example, a child may enrol at school or a young adult may go into [welfare agency] and be a job seeker. But how they are treated by those services is 'Oh they are only transient, just give them their welfare'. (...) Or education. They might get enrolled at school but then, if they don't show up for a week, people just kind of go 'Oh they must have gone back'. And nobody does the follow-up to ensure where they are. And it could be that the family is under enormous stress. It could be about homelessness that these young people may not be attending school or whatever. We should not make the assumptions that they've just gone back, which is what we do. We treat them like they are transient, treat them like they are just passing through.” (Service Provider I)

Many service providers argued that the service sector needed to differentiate more systematically between different types of Indigenous clients. A common argument was that service providers would have to apply better ‘case management’ approaches that would allow them to respond to complex Indigenous service needs on a case by case basis and provide better targeted health and support services, as well as post-care monitoring. Some agencies have started to employ specific Indigenous service coordinators (such as Aboriginal liaison officers or Aboriginal patient pathway officers) to coordinate different services and make sure that Indigenous clients get all the services they need during their stay. Again, however, these support services were only targeted towards visitors who came specifically to access health services. They were not designed to help visitors coming for non-health related purposes.

Some participants acknowledged that, while individual case management and a bigger picture approach to Indigenous service needs were critical, attempts to

apply such case management approaches were often stalled by a somewhat embedded lack of collaboration between individual agencies. Due to rigid government funding models and the temporary nature of many funding programmes, service providers essentially saw themselves as competing for clients to continue to receive government funding. One service provider, for example, mentioned that one of the major concerns for his agency was to maintain government funding and keep their staff employed. Service agencies constantly have to convince funding agencies (in funding applications and performance reviews) that they have a large enough client base that warrants ongoing government support. As a result, many service agencies seek to cater to the largest possible target group (usually the permanent resident population). This ultimately causes services to become very similar to each other, increases competition and limits inter-agency collaboration.

“I don't think that services work together enough, you know like communicate between each other enough. There's a lot of services that do the same thing, so there is sometimes a lot of protection about clients and services and things like that.” (Service Provider J)

The rigid funding structure was also one of the main reasons why most service providers cannot afford designing more differentiated services that meet the needs of various temporary Indigenous visitor groups. Having to service the largest possible group of clients means that there is limited room for service agencies to develop differentiated strategies for ‘niche markets’, even if they know these niche markets exist. A few service providers openly admitted that they did not have the resources and capacities to provide specific services to temporary visitors as they had to focus their attention on the permanent resident population.

“We have people coming here looking for assistance to get from A to B, and usually we refer them to [Service provider K]. (...) We just refer them on to the agencies, who we think can give them immediate help. We don't run a specific service to assist transient people get from A to B. It's more programs in [Regional Centre B] for the Indigenous people in [Regional Centre B].” (Service Provider L)

As illustrated in the previous quote, attempts to improve collaboration and coordination between service agencies were essentially limited to referring clients on to other agencies if they could not provide the required services themselves. There appeared to be limited inter-agency collaboration in terms of exchanging information and data to improve the actual process of planning and designing services. Again, some service providers blamed funding constraints for the lack of sharing information resources. They also mentioned that different funding agencies used different data systems and did not allow the exchange of information due to issues of confidentiality and client protection.

The lack of collaboration and information exchange was particularly problematic in cross-border cases where clients from the remote APY Lands obtained services from agencies in both South Australia and the Northern Territory. Different funding structures and funding responsibilities in both jurisdictions made it almost impossible to set up a more systematic exchange of client information across the border.

“Like [service provider M], their main office is based in Alice Springs. They’ve got a whole database which is all connected but the hospital here can’t get into that because they are not our clients. So they are different health clinics, (...) they’ve got lots of health clinics around the APY-Lands, so they are all connected but when those APY-Lands people come here, we can’t connect in. We can ring and ask questions but we can’t connect in.” (Service Provider N)

4.0 Conclusion

This research sought to get an in-depth perspective from urban-based health and social service providers on how they attempt to deal with temporary Indigenous mobility and the challenges it presents for service provision. Service providers in two regional centres of South Australia were interviewed to identify 1) what the main challenges are for efficient service delivery to temporary Indigenous visitors; 2) what strategies they have used to manage these challenges; and 3) how well they thought these strategies were working.

The study has found that temporary Indigenous mobility presents a range of challenges for service providers, including: 1) the difficulty to measure and forecast short-term mobility and plan for fluctuating demands, 2) issues for follow-up treatment and post-care monitoring, 3) intercultural differences, 4) the incompatibility of Indigenous mobile lifestyles with the highly inflexible and stationary service system, 5) and a lack of specific support services for temporary visitors (including transport and information). These findings are not necessarily new and confirm previous observations in the literature that temporary Indigenous mobility is commonly regarded as problematic for service providers in urban centres (Carson et al., 2009; Holmes et al., 2008; Prout, 2008; Taylor et al., 2011).

The study has shown that service providers in the two case study locations have started to implement a range of management strategies to deal with these challenges, including improved outreach services (seeking to reduce temporary migration), culturally appropriate service design, case management approaches and specific Indigenous service coordinator positions and service delivery programmes. Again, these findings are not surprising given that similar solutions have repeatedly been discussed in the literature (see, for example, Fuller et al., 2005; Gruen et al., 2002; Hayman et al., 2009; Maher, 1999; McLennan et al., 2004; Watson et al., 2001;).

What this research has contributed, however, is an additional perspective on how service providers evaluate the effectiveness of existing strategies. Service providers have identified a range of issues that continue to place constraints on the implementation of successful management strategies and perpetuate gaps in the range and quality of services for temporary Indigenous visitors.

Rigid and inflexible government funding models were described as one of the main reasons for the lack of appropriate services for temporary Indigenous visitors. Funding constraints were responsible for the extensive fragmentation and over-specialisation of services, a lack of collaboration and coordination between individual service agencies, and a lack of flexibility in service design. Service providers were often aware that temporary Indigenous visitors had service needs that were fundamentally different from those of permanent Indigenous residents (for example, in terms of accommodation, transport,

information, or family support). However, the inflexible funding structure did not allow service providers to focus on temporary and transient clients since their agencies were set up to cater to the larger permanent Indigenous (and non-Indigenous) resident population.

The study has also shown that service providers and funding agencies have so far failed to differentiate between different types of Indigenous visitor populations. The literature suggests that there is great diversity among the temporary Indigenous visitor population, as people move to urban centres for a variety of reasons (Carson et al., 2008; Long et al., 2007; Prout et al., 2010). This means that services for temporary visitors can not follow a one-size-fits-all approach. While ‘chasing health services’ (Prout, 2008) is a common reason for remote dwelling Indigenous people to move to regional centres, these people are by far not the only ones who end up requiring health, social and other support services during their stay in town. In particular, non-coerced forms of temporary Indigenous mobility, such as leisure visitors and people visiting family and friends, are currently not factored into service design in regional centres.

It appears that leisure visitors are more often than not considered as those who cause problems such as excessive drinking, gambling, illegal camping, and overcrowding in houses of family and friends. To reduce such problems, service providers and funding agencies will have to start considering these visitor groups as what they are: tourists who seek entertainment and recreation and want to visit family and friends. Refusing to accept these people as leisure tourists means that service providers and funding agencies will most likely continue to produce inappropriate services that fail to meet the needs of leisure visitors. The example of the local town camps in this study has shown that the current service model (temporary accommodation facilities with curfews, drinking restrictions, barb wire fencing, and isolated location outside town) is not necessarily the preferred option for leisure visitors who seek recreation and want to enjoy their time with friends and relatives in town.

There seems to be a clear need for both service providers and higher-level government agencies to systematically assess the service needs of different Indigenous visitor populations and address these differences in their planning and funding strategies. Given the lack of formal data sources on temporary Indigenous mobility, more research is needed to quantify the frequency and unique characteristics of short-term mobility patterns and identify the specific service needs of various groups of temporary Indigenous visitors. Future government funding strategies will also have to consider ways to reduce inter-agency competition and increase collaboration in terms of collecting and sharing information on temporary visitor populations.

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6.0 References

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