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Senate Select Committee on Regional and Remote Indigenous Communities

The School of Medicine (SOM), Flinders University, welcomes the opportunity to make a submission to the Senate Select Committee on Regional and Remote Indigenous Communities. The SOM is well-placed to contribute to the Select Committee's deliberations. The SOM and its sister School of Nursing and Midwifery together comprise the Faculty of Health Sciences at Flinders University.

The SOM is an internationally-recognised innovator in the provision of rural and remote health training and research. Flinders University Rural Clinical School (FURCS) aims to serve both Flinders University and the rural and remote communities of South Australia through high quality medical education, research, and clinical service for, and in, rural communities. Rural Clinical School staff-members are based in several locations throughout South Australia. The main FURCS administrative centre is in Renmark, 250 km north-east of Adelaide in the Riverland.

Additionally, the SOM, Flinders University, has a long-standing involvement with the health and well-being of Aboriginal communities in the Northern Territory. Aboriginal Health is a designated Flinders University Area of Strategic Research Investment (ASRI). Through the operation of the Flinders Aboriginal Health Research Unit (FAHRU) it has built an exceptionally strong research profile in Aboriginal health. FAHRU's health scientists, educators and psychologists, based in Adelaide and Alice Springs, are core partners in the Cooperative Research Centre for Aboriginal Health (CRCAH, based in Darwin) and the national Centre for Clinical Research Excellence in Aboriginal and Torres Strait Islander Health. Further partnerships have been developed with a range of Indigenous and non-Indigenous health care institutions and industry. A particular SOM research strength is an emphasis on research transfer: Flinders Aboriginal health research outcomes are characterised by their level of direct benefit to community, practice or industry operation.

The SOM places a strong emphasis on rural and remote health in its teaching programmes and is widely acknowledged as a leader in this field. Its links with the Northern Territory are significant in a number of spheres of activity and it has established Clinical Schools or Departments of Rural Health in locations as diverse as Darwin and Alice Springs, with a further presence in centres such as Katherine and Nhulunbuy.

The SOM acknowledges that the original report, Ampe Akelyernemane Meke Mekarle: Little Children Are Sacred, was a pivotal document, a serious attempt to comprehensively address a serious issue. It is in that spirit, of contribution to addressing issues of major importance for Aboriginal Territorians, that we make this submission.

SOM, FLINDERS, RESPONSE TO EACH SELECT COMMITTEE TERM OF REFERENCE:

(a) the effectiveness of Australian Government policies following the Northern Territory Emergency Response, specifically on the state of health, welfare, education and law and order in regional and remote Indigenous communities

Overview

1. The School of Medicine's major point of submission to this Committee's review is its considered, unqualified support for the 2007 submission to the Northern Territory Emergency Response Review Board provided by the Australian Indigenous Doctors' Association (AIDA). The School is of the view that this submission is of particular pertinence and is well founded in research and experience on the ground. It draws on the findings of a health impact assessment (HIA) that involved recognised Indigenous health researchers and that specifically explored Indigenous community perceptions and concerns relevant to the Emergency Response.

2. In particular, AIDA's comments on the child health examinations need the strongest endorsement. It is our view that such examinations have, in practice, proved to be an exercise in duplication of existing human resources: a costly one. We are cognisant of staff reports of specialist referral for a particularly-broad range of abnormality detected. In operation, the examinations have bypassed the expertise of remote medical practitioners and thrown a heavy burden on specialist services and resources to review conditions that were, either, already known, or for which specialist review was deemed unnecessary.

3. Arising from these comments is a second major tenet of our submission. The funding burden related to such interventions as the child health examinations has resulted in a lost opportunity for those financial resources to alleviate known problems. We concur, whole-heartedly, with AIDA's contention that: "It is absolutely vital that Indigenous health, as well as child abuse issues, be addressed in measured, far-reaching and sustainable ways." One senior academic and clinician, with 40 years experience working in the Northern Territory described his dismay at:

… the prospect of disorientated, well-meaning practitioners popping into a community for a few weeks to do child health checks, finding exactly what those of us on the ground already know they will find and then disappearing back to the cities, leaving those behind to deal with the consequences of their checks with no ongoing, extra resources.

4. If health inequities are to be addressed, then many more long-term health practitioners are undoubtedly required in the NT. Not only are these practitioners difficult to recruit, but even if they do wish to come, in many areas there is severely limited accommodation available to come to.

5. There have been a number of lost opportunities for specialist consultation for new cases, due to system overload.

We will now turn our attention to specific aspects of the Emergency Response.

What is working?

6. One positive outcome from the NTER was reported to be the transferring of CDEP staff onto 'real' wages, where those people are working in govt services. A noted example was aged care. It was considered Important that a mooted Commonwealth Government evaluation of this particular project proceed.

7. Community response to income management appears mixed. Flinders' NT staff-members report reactions ranging from:

> *I think that income quarantining has had some benefit*

through to location-specific outcomes. Some sources maintain that quarantining seems to work well in some locations, in terms of money being spent on food and clothing, while other areas report the mixed nature of effects, including substance substitution (see next section: What isn't working).

What isn't working?

8. *Substance substitution* has been cited as a concern. In one area, a situation was described where:

> *Kava use has almost disappeared and alcohol consumption has fallen, but marijuana and solvent abuse seems to have increased.*

9. One clinician's report suggest that – in the absence of serious engagement with appropriate and effective management of substance abuse - income management may simply *postpone* violence and other, unwanted negative effects, involving untreated or poorly-managed substance abuse, until money becomes available:

> *Since then we have had the Christmas bonuses paid to those on a pension. The impression is that this has again increased alcohol consumption with attending increase in violence. (Dr. A) is the local eye surgeon and has been operating on mashed-up eyes following drunken violence on the last three weekends. Three cases in a month is not statistically provable but feels like an increase to me and the poor 18 year old girl who now only has one eye as a consequence.*
>
> *Dr. A also reported some people in (Town A) were buying TVs with the pension bonus, then selling the TVs for a quarter of their value and then buying alcohol.*

10. Some communities have reported that income management has forced people to use a limited number of corporate suppliers. This has other consequences, also, in terms of location of suppliers causing transport and extra financial burdens.

11. Against some comments on the benefits of income management, a number of other observers have noted the disempowering effects of income management and unintended outcomes:

> *It is undoubtedly discriminatory and I have heard many anecdotes of families having no concept of how to use their card. Surely such measures should either be applied to all welfare recipients no matter what their colour or replaced with adequate social workers and teachers to teach financial literacy and budgeting.*

12. We would again support the HIA evidence presented by the earlier AIDA submission, in regard to the profound consequences of loss of control and loss of power engendered by such blunt and discriminatory intervention tools. Degree of control over one's circumstances and degree of (dis)empowerment are acknowledged, crucial determinants of one's health and well-being (CSDH, 2008). The psychological literature similarly attests to the significance of the degree to which one is able to exercise 'mastery' over one's immediate environment (Seligman et al, 1995). At least one author has linked a diminution of control and mastery to the NTER, with concomitant negative impacts on health and well-being (O'Dea, 2008).

How is each NTER measure performing and how should each be taken forward?

13. Senior SOM staff-members on the ground in the NT have provided useful individual perspectives on the success of the NTER in particular relation to Phase 2 and questions of dental health, housing, the ENT 'blitz' and violence.

13.1 Firstly, an academic-clinician notes:

> *The follow up process (Phase 2) has been over-zealous, although the methodology was useful, and could be adapted to other review/recall areas. Generally Phase 2 was poorly organised, resource wasteful, and the waste is ongoing. (Demountables provided for Phase 2 activity are not yet commissioned although Phase 2 is over. The demountables have design faults which make them virtually unusable.) ENT problems need particular note, in addition to those already noted in AIDA's submission. The medical examination was deficient in that there was no history of ear disease obtained, and the otoscopic observations requested were too subjective to be of value. The outcome was an under-reporting of ear disease compared with known figures from studies by research institutions such as Menzies. The fear has been expressed that this will translate into under-funding of programs related to ear disease. ENT and audiological review and a change of policy regarding fitting of hearing aids has led to marked increase in the provision of hearing aids, but not to any programmes to improve educational facilities or services for these children.*

13.2 Secondly, another practitioner describes her disappointment with a lack of change, as various phases of the response are rolled out.

> *My stance has changed little with Phase 2 and we are still waiting to see any benefit from phase 3. There is still no new housing or other incentives for local indigenous health workers and although we have had two sets of fly in fly out surgeons mending ear drums there has been little evidence of any addressing the underlying social determinants causing the problems and no promise of any long term commitment to ear surgery or dental services. If anything the numbers of FACS workers on the ground is diminishing.*
>
> *It is good to see that AIDA is involved in this enquiry I know that along with Menzies they have been monitoring the effects very closely and already have a number of research projects underway. I'll look forward to hearing the Senate's conclusions*.

13.3 A third response was:

> *It is quite heartening to see that many other doctors and medical organisations have the same response as myself … I think it is vital that we work to insist on the supply of more housing and infrastructure as a meaningful and practical step for resolving the problems in the bush. If you are any parent white or black living in a household of 20 other people with limited sanitation facilities and income then your ability to protect your child from the ravages of recurrent strep infections, rheumatic fever, kidney disease, ear infections, trachoma, intestinal parasites, dental caries, anaemia, malnutrition or sexual predators is severely compromised whether you are drug and alcohol affected or not. If you have no where else to go and no one to offer reliable long-term assistance or protection what choice do you have but to continue to put up with it? As important as we doctors like to think we are, most of the major health advantages in our dominant culture have actually been achieved by plumbers, carpenters, civil engineers and teachers.*

13.4 Yet another academic-clinician noted that:

> *1km outside Nhulunbuy is a group of almost 70 indigenous people including children and teenagers who have been displaced from the nearby community where they had lived and worked because of concern over violence, alcohol and child safety. They have been living in and around 3 rundown houses with inadequate septic systems. Even if they wished to return to their previous situation they cannot because their houses are already full with other people. They have been told the waiting list for Territory housing in the area is 2-3 years. It has been suggested they be housed at another community 16km away that also has an average of 18 people per household or to return to their homelands in the Wessels islands where there are no adequate houses schools or medical facilities. If this group, so close to a town with one of the highest per capita incomes in Australia, can get so little meaningful help, what hope do other outlying communities have of caring for their vulnerable members?*

What progress has there been in improving the safety and well–being of Indigenous children?

14. Some reduction in the levels of violence in town camps has been reported.

15. However, the health checks conducted by the intervention have been described as having had minimal benefit to Indigenous children. It was particularly noted that if the same resources had been given to local communities and local providers, far more could have been done.

Will the suite of measures deliver the intended results?

16. The sequestration of income, and associated measures imposed on families and communities have consequences beyond the financial and the behavioural. As the earlier AIDA submission makes clear, and reports from numbers of those affected reinforce, they are perceived by many Indigenous Territorians as shamefully and disturbingly disempowering. As such they fly in the face of global best practice in overcoming disadvantage through appropriately addressing the social determinants of health. A comprehensive body of research, assembled over a number of decades tells us that removing people's autonomy does not lead to change. Such a sense of agency – described in the literature as 'the control factor" or 'control over one's destiny' – has been shown to be an important determinant of health outcomes (Syme, 2004). The significance of its role has been recognised by the World Health Organisation (WHO) in its landmark assembly of effective ways to engage with the social determinants of health (CSDH, 2008). In some jurisdictions, any action that:

> *… diminishes, demeans or disempowers the cultural identity or well-being of an individual …*

is defined as 'unsafe' cultural practice that circumscribes a health professional's duty of care, and may have ramifications for professional registration (Nursing Council of New Zealand, 2005; NZ Psychologists' Registration Board, 2006).

Have there been any unintended consequences?

17. There have been a number of specific reports of people moving to avoid income management, compulsory health checks, or even non-specific fears. As one Darwin academic noted:

> *I know Larrakia have researched the expanding numbers of people living in the long-grass since the NTER. We have established a new program with them this year with students going out with some of their programs to the long grass areas.*

18. Other staff-members report that bringing in medical practitioners from outside the NT has had major unintended consequences. They report:

18.1 A failure to use the current information already known about people in the communities.

18.2 That it sent a message to current staff that the job being done by them in difficult circumstances was not enough. There are personal reports of several key permanent staff having left their positions as a consequence of a sense of being pushed aside and not valued. A reported perception was that “the visitors were heroes and the locals were losers”.

18.3 That patients and families were unnecessarily frightened

18.4 That the measures had the potential to destroy hard won trust between Indigenous people and the health service.

18.6 That paying doctors from outside, with no experience of Indigenous health, was culturally inappropriate.

18.7 That the above led to an unnecessary duplication of work. For example, there were reports that doctors who came for the first round, refused to come a second time because they would only be paid the same as NT doctors. This again reinforced perceptions of a devaluing of the local medical workforce, and heightened perceptions of inadequate remuneration.

Will NTER lay the basis for a sustainable and better future for residents of remote communities and town camps in the NT?

19. The logic of an “emergency response” dictates that the utilisation of measures such as income management must be considered as a short-tem tool to alleviate a pressing problem while a more-durable solution is found. The continuation of income management over subsequent phases of an “emergency response” does little to reassure those affected that a permanent, more-equitable, solution is on its way.

20. As the earlier AIDA submission reported, income management has provoked profound reactions, including anger and increased mistrust, even despair, from Indigenous people. The comments of non-Indigenous staff-members with experience of the affected communities echo this strong response. The utilisation of income management as a preferred tool – over other, less-divisive measures with fewer negative outcomes - was seen as both evidence-ignoring and paternalistic. As one senior academic in the NT bluntly noted:

> *Income management for Indigenous people, but not for non-Indigenous is blatant racism; either all on welfare should have income management or no-one.*

21. Overall, SOM holds that momentum generated by NTER – and the dissenting responses thus generated – may, taken together, galvanise fresh policy and sustainable funding that, in turn, may prove able to lay some “basis for a sustainable and better future”. Our perspective is that this would only be possible if there is a reversion to a

model that is underpinned by widespread consultation with Indigenous people and meaningful collaboration with current service providers, and that works to empower, not disempower, Indigenous Territorians.

What alternative measures should be considered?

22. A common view, here succinctly put by an academic on the ground, is:

> *We need to develop Indigenous capacity not destroy it.*

23. A parallel contention is the centrality of political will to engage with rural and remote Australia. Such ngagement needs then to flow into sustained development of human and material resources to effectively transform the underlying determinants of poor health and well-being. SOM staff-member comments were brutally frank, reflecting widespread disillusionment with past policy and funding practices:

> *[What is needed is] real investment in infrastructure, schools and community development projects, not short term splash cash and dash.*

24. Rather than (well-meaning, but inappropriate) 'blitzes', which are likely to confound – rather than augment - existing arrangements, the SOM recommends the value of building environments for change. This needs to be undertaken collaboratively with Indigenous Territorians. Two measures of significant potential would be a substantial, and sustained, investment in housing improvement, twinned with support of Indigenous choice to live on country, however remote country might be. The two are, in fact, dual aspects of a major social determinant of health: place. There are tangible and far-reaching benefits of improved and less-crowded housing (on outcomes as varied as hearing loss/educational failure and interpersonal violence/child abuse) and there are evidenced benefits (for physical, mental and spiritual well-being) of on-going connection to country. As the Final Report of the (WHO) Commission on the Social Determinants of Health succinctly puts it:

> *Healthy places make healthy people* (CSDH, 2008)

Are there other ways of working that would better address the circumstances facing remote communities and town camps?

25. Allied with Point 21 (above) this submission contends that commitment to long-standing principles of intensive consultation with those Indigenous people, organisations or communities affected by policy initiatives is the only way to attain real change (NHMRC, 2003). Rather than running a ready-made programme past (possibly) key people, this approach involves tailoring an intervention to met the specifics on the ground. It mandates full community participation from the initiation of planning.

26. The lessons drawn by Syme from some, self-described, 'failed' work (often sophisticated, well-thought-out, multi-million dollar interventions) are also helpful here. Drawing on an array of solidly-conceived and implemented studies that proved manifestly

ineffective, he concluded that clinical, individual approaches, or interventions that directly attack specific variables or risk factors - such as obesity, interpersonal violence, smoking, or depression - offer much less hope of success than dealing with people in their lived context and with the fundamental issues affecting their everyday existence (Syme, 2003). Syme's conclusions are particularly pertinent to interventions developed within the dominant Australian culture, noted in the research of Hofstede as *the most individualistic* of a range of internationally-compared cultures (Hofstede, 2001). Hofstede's seminal work reinforces Syme's call to replace the individual as the major locus of change efforts. It points to the ineffectiveness – and, indeed, waste of resources – where solutions based on a (misplaced) belief in the efficacy of individual agency to bring about needed change are imposed on cultures, as those of Indigenous Australia, that are largely *collectivistic*. Such a call, in fact, echoes the precepts of the holistic Indigenous approach to health. As Syme notes: "[W]e rarely identify and intervene on those forces in the community that cause the problem in the first place" (Syme, 2004).

(b): the impact of state and territory government policies on the well-being of regional and remote Indigenous communities

Positive or promising

27. In relation to the recognised need for a substantial augmentation of the Indigenous health and well-being workforce, Flinders and collaborator researchers have foregrounded a role for comprehensive state and territory engagement with Indigenous health workforce issues. Dwyer, Silburn and Wilson (2004) note three critical areas:

i. "The low capacity of mainstream agencies to provide culturally appropriate and evidence based care to Indigenous people who often have co-morbidities and complex care needs."
ii. "The limited number of appropriately skilled personnel in rural and remote areas."
iii. "The limited number of Indigenous health care professionals."

Flinders SOM recognises these three issues as positing rational initiatives of potentially powerful leverage. In well-planned take up, they offer government achievable outcomes in Indigenous health workforce development. Taking each of these in turn:

i. There is under-recognised benefit, in terms of effectiveness of health interventions, to be gained by transforming the non-Indigenous health workforce into a culturally competent / culturally safe workforce. The impact on patient or client comprehension of practitioner instruction/education, treatment/medication compliance, retention in treatment, uptake of prevention/lifestyle modification initiatives, and overall engagement in their own care is major. The SOM holds that investment in research examining effective models of cross-cultural work and training [better curricula and workforce development], plus the industry-wide recognition of the benefits of tying achievement of graded progress towards cultural competence/cultural safety *as a mandatory requirement for professional*

registration, would pay substantial dividends [in relation to improved health outcomes].

ii. The attraction of skilled personnel to rural/remote locations is a complex issue involving interplay between proactive local champions and national endeavours. Serious inroads into the shortfall will only occur in the presence of innovative, sustained and well-resourced initiatives specifically targeting these barriers to the recruitment of the personnel required.

iii. Although many tertiary training institutions are working to increase places available to Aboriginal and Torres Strait Islander medical, nursing, and allied health students, insufficient attention has been directed to the factors likely to ensure retention of these students to successful graduation. There are exemplar initiatives available to government (AIDA, 2005; Drysdale et al, 2006), but their penetration and take up is patchy. Additional research – particularly targeted at pre-school engagement, primary school literacy, numeracy and retention, and high school support, mentoring and career/subject choice counselling - is essential. The roll-out of results will only have an impact where research results are disseminated and acted upon through inter-sectoral programme collaboration (particularly between health and education). The final imperative, arising from the literature, to markedly increase the Indigenous component of the Indigenous health workforce is for the development of culturally safe university courses and campuses, allied with innovation in tertiary student funding (Arkles et al, 2007).

Negative or problematic

28. Dillon and Westbury, amongst other commentators, have pointed to a comprehensive "structural government disengagement in Aboriginal affairs in remote…Australia" (Dillon and Westbury, 2007). Such commentators note that, under the aegis of supporting Aboriginal self-determination, essential services – such as the delivery of health in remote locations – has been outsourced to the community controlled sector, yet massively under funded. The consequence is an inability of Indigenous Australia to enjoy the same level of government services as its non-Indigenous counterpart.

29. Tendencies in policy for a 'solution for remote communities' in the relocation – indeed assimilation – of people from such communities into town camps, major rural towns, and outer metropolitan areas, according to this analysis, are simply doomed to exacerbate existing problems in those areas. Indeed, such policy underpinnings have been termed 'retro-assimilation', and dubbed paternalistic (Haebich, 2008).

Ways forward

30. The solution arising from our analysis, to that which a number of commentators have described as "the failure of the architecture of government", is a policy of appropriate engagement with Indigenous Australia. This needs to particularly manifest

through the provision of infrastructure to increase employment opportunities (Dillon and Westbury, 2007).

(c): the health, welfare, education and security of children in regional and remote Indigenous communities

What actions, policies and realities are under-recognised in their negative contribution?

31. A number of SOM researchers working in regional and remote communities report that the efficacy of otherwise well-planned initiatives is frequently compromised by issues relating to time. They report that too-short time frames for funding, for reporting, and for confidence- and capacity-building, actively impede progress to a stage where the initiative is capable of yielding substantive outcomes. They note:

- The necessity of securing longer-term funding to provide projects with the ability to establish a foundation and credibility in the community
- Whilst collaboration is mandated at a policy level, it is not always realised at the practical level. There is scope for specific training and professional development on how non-Indigenous/Indigenous partnerships may flourish
- Even with a shared desire for better outcomes, substantial mistrust, on the one hand – a consequence of past practices and experiences – and misreading and misjudgement on the other, may still occur between Indigenous communities and non-Indigenous service providers. The sustainability of promising initiatives is dependent on the level of concerted programmes to build capacity, cultural safety in service provision and open-heartedness and transparency in the relations between mainstream and community-controlled organisations.

32. The SOM, Flinders University, as earlier pointed out, notes that although child well-being is intricately tied to the availability of resources to support that well-being, the on-going maintenance of such resources has been inadequately addressed, as a consequence of the above-noted, decades-long process summarised by Dillon and Westbury as:

> *… the systematic disengagement by government from remote Aboriginal Australia since the 1970s … (Dillon and Westbury, 2007)*

33. Such disengagement is at odds with both Indigenous perspectives and, increasingly, a body of evidence noting the health and well-being benefits of continuing connection to traditional country (Burgess and Morrison, 2007; McDermott. R. et al, 1998). As Scrimgeour notes:

> *The evidence shows that the poor health status of Indigenous people is found in all areas where they live and that, on some indicators, living in remote areas has health benefits … Government policies aimed at relocating Indigenous people from*

their traditional lands are not supported by evidence, and may further entrench Indigenous disadvantage. (Scrimgeour, 2007)

Ways forward

34. As noted above, in our response to (b) dot point 2, no. (i), the SOM considers the development of appropriate (and sustainably-funded) mechanisms to ensure culturally-safe delivery of relevant services to be one of the most potent modes of intervention. In another jurisdiction (New South Wales), where the enhancement of child protection was, again, the focus of a high level report, the Special Commissioner – referring specifically to an exemplar programme to address child sexual abuse issues in a regional/remote Aboriginal community - observed:

> *19.170 An area which does seem to require more attention … [is] the need for … those delivering services in the area, to acquire a better understanding of the history that led to these communities becoming dysfunctional, and of the differences in culture that might lead to a better understanding and partnership. (Wood, 2008)*

35. One media report following the release of the recommendations of the NSW inquiry, in fact positively contrasted the "softy, softly" approach of the longer-time frame, consultative, and whole-of-community intervention referred to by Justice Wood with the approach adopted in the NTER. (Gibson, 2008)

36. In the context of building the capacity of the Indigenous health workforce to better support the health, welfare, education and security of children in regional and remote Indigenous communities, we note that the SOM, Flinders University, has advanced plans to increase the numbers of Aboriginal medical graduates with links to the Northern Territory through development of the opportunity for students to gain a complete medical education at its Darwin campus. Such moves would bolster, not only, recruitment (by providing locally-based education to potential students with NT commitments to family, community or country), but also assist rates of student retention to graduation. The proposal also has the capability to enhance the Non-Indigenous workforce's cultural and clinical skill set, whilst providing a solid foundation (now observed with students who spend significant time, during training, in rural locations) for the retention of those students in the NT after graduation.

37. A separate, but allied, proposal has also been advanced – and is currently under funding consideration – that would develop clear, strongly-supported and mentored pathways to substantially improve school retention for NT Aboriginal children and to guide and ready them for health-related careers. The SOM believes that these two measures, taken together, are moves of significant promise for improving health, welfare, education and security outcomes for Aboriginal children in the Northern territory.

(d): the employment and enterprise opportunities in regional Indigenous communities

36. Some respondents reported that appropriate support for self-generated Indigenous enterprise provided the most promise. Again, respondent bitterness arose in the context of unintended consequences of the NTER:

> *The model of a tourist development at Tjikala is a great example of what can be done - and sadly how the intervention killed it!*

Ways forward

37. The SOM concurs with Dillon and Westbury's call for political support for regional and remote Indigenous Australia – with concomitant support for infrastructure, including services and civil society – as providing the necessary foundation for increased economic opportunity. There is also logic in their analysis, which holds that there is a confluence of national security interests, national environmental interests and Indigenous economic advancement, which suggests mutual benefit from increased support for conservation activities on both traditional and national parks land, and opportunities in customs and border protection activities (Dillon and Westbury, 2007).

38. Flinders researchers are also active in development of proposals around 'smart settlements' in desert/remote locations. Their work suggest Indigenous economic on-flow from more research into innovative and holistic settlements, where planning actively accounts for the specificity of that desert/remote 'place'.

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