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CRANA plus
improving remote health

magazine

the voice of remote health

40th ANNIVERSARY EDITION

Aboriginal and Torres Strait Islander readers are advised that this publication may contain images of people who have died.

Contents

About the Cover: Katie Pennington (left) receives the Aurora Award for Remote & Isolated Health Professional of the Year from Board Chair Fiona Wake (right) at the 40th CRANAplus Conference in Cairns in October 2023. *Photo: Andrew Watson.*

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CRANA plus improving remote health

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From the CEO and Board Chair

Dear colleagues,

Welcome to the long anticipated 40th anniversary edition of CRANAplus Magazine. This edition includes an extended feature article on our organisational history, starting on page 20, for those who are interested to learn more about how their peak professional body has grown into what it is today.

The article provides food for thought about how much has changed and yet how much has stayed the same. CRANAplus has retained its connection to the grassroots and continues to be propelled forward by its volunteers. While there have been some improvements to remote health and workforce challenges since 1983, the situation has not by any means improved across the board; in some regards, Australia is staying still, or moving backwards.

There are plenty of examples within CRANAplus' history of the organisation delivering innovative solutions to challenges that had beforehand seemed like 'facts of life'. Rather than an exercise in nostalgia, this history is intended to be a source of inspiration in the modern day and will hopefully be a rallying call to all readers to consider the impact they can have through their involvement with CRANAplus – whether that is by supporting the organisation as a Member, or becoming actively involved, for example, as a volunteer facilitator.

On another note, thank you to everyone who joined us in Cairns this October for the 40th CRANAplus Conference (see page 68). This year's program told the story of a workforce that is piloting many innovative and resourceful approaches to improving remote health. It showed the way to supporting successful ageing, empowering nurse practitioners, containing tuberculosis in remote Australia, and utilising the Rural and Remote Nursing Generalist Framework, to allude to just a few of the presentations.

A few months on, we hope that everyone has returned to work feeling connected as a professional group. This year's conference was a timely reminder that we are not alone in our experiences, nor our goals. Beneath local differences, we often share the same opportunities and challenges, and recognising this is both validating and empowering.

Wishing you a safe and happy festive season,

Linda Kensington, CEO, CRANAplus
Fiona Wake, Board Chair, CRANAplus Board of Directors

CRANAplus acknowledges the Traditional Owners and Custodians of the land, waters and sky, and respects their enduring spiritual connection to Country. We acknowledge the sorrow of the past and our hope and belief that we can move to a place of equity, partnership and justice together. We acknowledge Elders past, present and emerging, and pay our respects to the cultural authority of First Peoples.

First Peoples

Photo: 169169 – stock.adobe.com

2023 Gayle Woodford Scholarship recipient

Tiffany feels fortunate to have been awarded the 2023 Gayle Woodford Memorial Scholarship and says it will give her the upper hand in expanding her career in remote health.

"I'm just that excited," beams RN RM Tiffany Cattermole, thrilled by the opportunity she has received to expand her skills to support remote communities and improve Aboriginal health.

"I have 50 million ideas running through my head as to where I need to be, but I'm like, 'You need to calm down, you haven't even started the course yet'."

After some time spent in Katherine in the Northern Territory, proud Barkindji woman Tiffany has returned to work in her place of birth, Wilcannia, a small outback town nestled on the banks of the Darling River in the far west of New South Wales.

Nearby in Broken Hill, she started her career in health in 2009 as an administrative assistant for Aboriginal community-controlled organisation Maari Ma Health, where 15 years on, she now works as an outreach midwife servicing communities of Broken Hill and Wilcannia.

"Positions came up for an Aboriginal Health Practitioner traineeship, I applied for that and spent 18 months in the course learning clinical skills," she says.

Initially, her sights had been set on direct entry midwifery but her pathway took a turn as she developed an unexpected interest in wound care and found that she "loved the nursing side of things much more than I expected."

After completing her nursing and then midwifery qualifications, she went on to work as a Midwifery Group Practice (MGP) midwife in a mainstream health setting but has since been drawn back to a holistic, comprehensive community-controlled role with an emphasis on cultural safety.

"What drives me is being in Aboriginal health," explains Tiffany. "The fact that we get to really know the women and the families we care for, and essentially spend nearly 12 months with these families – that's what I absolutely love – the continuity of care."

Tiffany loves everything about her current work, which is further sweetened by many "baby cuddles" and explains that she is in no rush to leave, though she does admit to having some big dreams brewing.

"I would like to be able to build on what I learn in the next 12 months, and then when my kids are just a little bit older and moved out of home, I'd like to go remote and work out in those very, very hard to access areas – that's where I want to be. Though, I don't know how my partner feels about it yet," she laughs.

Tiffany is inspired by the experiences of her community and family as they face challenges navigating chronic illnesses and accessing appropriate healthcare.

"You sort of grow up with that whole mentality of 'Why do we have to go have these checks? There's nothing wrong with us'.

"I think that's the biggest thing that drove me, that is: 'Actually no, you can get the education you need to stop you from going into hospital, or from having these conditions, or prevent them from happening so early in life'.

"There's a big stigma when you go to the doctor – [the idea that] you're going to get nothing but bad news. I want to be that person who helps to provide that education, and say that going to a doctor isn't such a scary thing."

Tiffany is confident that this scholarship will enable her to provide more education to families and particularly mothers about the prevention of chronic illness in remote areas.

"[This scholarship] means that I can go forward and achieve what I want to. This is going to definitely give me the upper hand, I'm quite excited!"

Tiffany would like to thank Flinders University, CRANAplus and all those involved in making this scholarship possible.

For more information on the grants and scholarships available through CRANAplus, visit crana.org.au/scholarships ●

In Focus

Finding the home paddock

CRANAplus Member Dr Kirsten Due MO writes in about inspiring nursing couple, Jason and Melanie. The pair met in Alice Springs and lived in remote Alaska, before returning to Australia to continue nursing/midwifery while pursuing their dream of running a sustainable farm.

I work in the remotest parts of central and northern Australia and have met many remarkable people in the last 15 years. While working on Milingimbi in the 'Crocodile Isles' recently, I met Jason, a remote area nurse who comes close to being top of my list.

He has been an inspiration to me – highlighting that medicine and nursing can go hand-in-hand with other passions. Every conversation he and I had in the remote community hospital began with Jason's thoughts about how best to care for the Indigenous patients he knew and cared about.

And every conversation ended with his other passions – black garlic, his wife's flowers and their growing herd of angus cattle in Welshpool, Victoria.

After decades of remote area nursing in Australia and overseas, Melanie and Jason decided to give farming a go. Now they manage to do both. But it's not just any farm. They hope to be one of the only producers of black garlic in Australia and have aspirations of selling overseas. After some heartbreaking delays with the COVID pandemic, they're finally on the road to a dream come true.

The two nurses first met in Alice Springs and worked in central Australia for 16 years. Chasing more adventure, but also wanting to learn from a different culture, and help bridge gaps in health care, they moved to the most northern part of Alaska called Tuktoyaktuk where their two children were born.

The kids went to the local Inuit school and soon spoke fluent Inuvialuktun (a rare Inuit language) as well as French and English.

In 2015 Jason and Melanie moved back to Australia with the dream of establishing a farm while the kids were in boarding school. Melanie did a 12 month course in horticulture and she decided they'd focus on flowers and garlic. Their non-negotiable vision was to be chemical free, self-sustainable and organic.

When staff at the remote clinic in the NT talk about their families back home, Jason talks about how many bulbs of garlic Melanie can plant. Between nine and 12 thousand a day – "and all in a squatting position between the raised beds we built".

When he's not driving the 4x4 dented converted troop-carrier/ambulance around communities, he's driving around their farm on the opposite end of Australia. Just around the coast from Wilsons Prom in Victoria, their property gets a good rainfall.

To begin with Jason built (by hand) 86 raised beds and together they filled them with organic material and soil.

Melanie manages four big worm farms and uses a worm juice/water mix to spray on the produce instead of chemicals. The first year they started with just 800 garlic plants. The crop grew from 800 to about 28,000 in the second year and despite the huge numbers they are planting and harvesting, they do it all themselves.

The plants are grown in special raised beds that Jason built by hand. Each row is 110m long and it takes 40-tipper loads of organic soil to fill one row. When it's time to make a new row, Jason shovels the tons of soil into the Polaris and Melanie races up the hill to tip it out as best she can each time the tipper bucket is re-filled.

Now Melanie's hundreds of flowers have taken over the original garlic beds which have been transplanted to another paddock. She's turned what was a bland space around a fallen down farmhouse into an oasis. The local florists can't get enough of her daisies, freesias and tulips.

And since she still loves delivering babies at the local hospital, a fair number of her plants go to staff and patients.

Some time ago Melanie began experimenting with garlic salt and handing it around to the neighbours. Eventually they were fighting over it, Jason says, so they began making batches of that too. By default, Melanie and Jason have fallen into stock and have a growing herd of robust Angus cattle. Soon they'll be incorporating 400 chickens which will be in chicken tractors and follow the cattle from paddock to paddock.

Jason has shared photos with me of the two of them at work and explained how Melanie carefully plaits ten garlic bulbs and plants after harvesting and hangs them in the shed "as big as a small hospital" that Jason designed.

Up until now they have been selling their garlic to a couple of small local shops and neighbours and the products Melanie makes have been snapped up as word spreads.

Just recently they enlisted some help to put a website together and finally, after a long wait due to COVID, they will be transitioning to black garlic – a process. He's put in an industrial kitchen, bought all the equipment to ferment the bulbs at the right temperature and humidity – and purchased hundreds of jars from an Australian supplier – more expensive than buying from overseas, but "so much more satisfying to know you're supporting a local business".

This year will be the first black garlic season and they're waiting to see if all the training they've done and the equipment they've built will see it through. Next year, all being well, they'll apply for a grant to get their small business off the ground and maybe exporting overseas.

But they still plan to keep nursing, Melanie will keep delivering babies and Jason will keep sharing his stories and how many bulbs of garlic she can plant in a day.

You can find out more about Jason and Melanie's business at indigofarmwelshpool.com.au or @indigo_farm_welshpool on Instagram. ●

Our responsibility to graduates

CRANAplus Member and Riverina-based District Nurse Educator Dalya Holowinski explains the process of identifying the learning needs of the emerging workforce, the roving CNE model, and the responsibilities that established nurses have towards those just starting out.

Thanks for joining us, Dalya. Can you tell us about your journey to becoming a nurse educator?

When helping to start a new hospital, I quickly realised that I loved educating. It took a while before I successfully applied for a CNE role – you're not always going to be successful the first time you step out your comfort zone.

When I did become a CNE, I sought to develop myself to be a better educator. I looked at how to be a Nurse Educator (NSW Health has CNE, NE 1, NE 2, and NE 3 levels).

I studied a post-graduate degree through University of New England in training and development. The development side helped me with managing performance, which ends up in an educator's bucket. During this study I was successful in a Nurse Educator role, and quickly developed courses that were missing, and podcasts.

I finished my study and received really good results – I think this gave me the confidence to extend myself again into a NE 2 role, which put me back into critical care.

Photo: Taras Vyshnya – stock.adobe.com

Working at a major tertiary hospital again made me look at education differently.

During my time there I pushed for change and the development of nurses through collaborative approaches with medical and speciality staff. I was there during COVID which triggered me and my family to say, "Let's get out of Sydney".

The role of District Nurse Educator, which is a grade 3 NE, was available – again, it took a few goes, but when the role for Murrumbidgee Local Health District (MHLD) came up, I was ultimately successful. Then it was time to move my whole family, the dog and five chickens.

Congratulations on your growth as an educator. What's it like to nurse in the Riverina?

At MLHD, we take a caring and supportive direction when it comes to developing our nurses and midwives. You can nurse in two very busy hospitals and see everything you will see at a big metro site. At the multi-purpose service and district hospital sites you become a specialist nurse in everything. We had a great advertising campaign that you may have seen which includes pictures of cows, llamas, and emus and how these animals have caused injuries which you will see and treat patients for.

We have a roving clinical nurse educator (CNE) model for early career nurse support and development, which means that at whichever site you work, you will always have education.

MLHD has also developed a Virtual Nurse Assist Model where you can call a CNE for anything at any time for support and guidance through patient care, assessment, and treatment.

We have a young district with many young families. There is a lot of farming, canola – it looks beautiful travelling around and seeing emus run through the fields.

We have a huge focus on preserving nature including our koala population at Narrandera.

It sounds like a lovely place to work. Since heading rural, why have you decided to participate in the CRANAplus Nursing and Midwifery Roundtable? Do all nurses have a role to play in advocacy?

I have realised that we need to speak up more for equitable access to health and healthcare education. As part of the Roundtable, we can influence some great collaboration and the development of nurses, midwives, and allied health in rural and remote.

All nurses need to remind themselves of their 'why' and their commitment to making our lives better through better patient experiences in healthcare.

As a Nurse Educator, how do you identify the workforce's learning needs?

Incidents, serious adverse event reviews (SAERs), learning needs analysis, speaking with staff, visiting sites, patient and family feedback, and sometime government recommendations.

Even global meetings like International Council of Nurses, or conferences too.

At the 2022 CRANAplus Conference, you presented on this roving CNE model. How successful has this been?

There has been a significant increase in training participation. Our new graduate numbers have increased, and we have been able to do that through providing an educator to come out and work with them.

We've got 33 sites, and the roving model contributes to connection and collaboration between them.

Speaking on a national level now, what solutions do you think could bring about a larger, better prepared workforce?

The promotion of nursing as a positive job. We need to remove the negative media and remind ourselves about the good things we can do. It's a really good job to have, really stable. ▸▸

Dalya with her goats Steph and Sam

Photo: Taras Vyshnya – stock.adobe.com

We've got multiple pathways, we can become Nurse Practitioners. We can achieve so much in nursing.

A rethink of the funding model from the Australian Government would be great. Doctors are not the solution to a lot of workforce supply and nurses and midwives need to be able to work at the top of their scope.

Our universities could do more to produce work-ready graduates and to instil an understanding of the role and its responsibilities. We need a four-year degree, nurse and midwife internships where we are supernumerary, and to be given Training Education Study Leave (TESL) as in the medical field, so we can afford to continue our education.

As an educator, what are your thoughts on learning on the job, versus bringing your skills with you to the role?

Well, that's a curly one, as right now our junior workforce does not always enter the workforce with fully-fledged skills in nursing but will look at things differently and want 'express' pathways. Of course, you have to learn on the job. It's hard to teach experience, and you can't be an expert after six months.

But we've got to counterbalance that – we need people to be performing at the top of their scope earlier. This has been weighing on my thoughts as an educator lately, and I don't have the answer. Except to say that we can educate you to be the best in whatever you decide to do, just as long as you stay in nursing and midwifery.

What else can nurses do to support undergraduates and recent graduates?

Nurses need to nurture all our workforce, including our colleagues in allied health and medical. We need to work and train together. There are great initiatives like at John Hopkins Hospital where all the nurses, physios and doctors attend the same orientation – how amazing would that be?

All nurses have a responsibility to encourage others to be nurses, and no matter what our day entails, we need to remember our 'why' and how this will bring about a better patient experience. ●

Adding skills to the RAN toolbox

Remote area midwife and CRANAplus facilitator Di Evans is passionate about empowering and supporting RANs. Here Di shares what drives her volunteer contribution to CRANAplus' "something for everybody" Maternity Emergency Care (MEC) course.

Di's first taste of rural and remote midwifery was over the Christmas period of 2015, when she took long service leave from her Midwifery Unit Manager role on the Gold Coast to help a friend in the Katherine Maternity Unit.

"I absolutely totally loved it. I saw that there was a niche that met my core values in maternity care-providing, and gave me the opportunity to think outside the box to deliver maternity care," she says.

Over the past seven years, Di's remote area midwifery work has also seen her living and working alongside RANs in Aboriginal communities, including two-and-a-half years that she "absolutely loved" in Wadeye, NT delivering continuity of care and making a difference.

Nowadays, you will find Di travelling in her Landcruiser 200 series across rural and remote Australia undertaking 12-week contracts in communities in need of midwifery care.

"From Wadeye I went to the Torres Strait, to Thursday Island, and to Port Hedland and communities in WA and Queensland," says Di.

"Recently I've been doing some rural placements, Gladstone, Esperance and Carnarvon, with that rural and Indigenous health focus – they're not as remote, but just to recharge and keep current."

Di used to run impromptu emergency birthing courses when she met RANs at outreach centres. She has since transferred this passion to her volunteer role as a CRANAplus facilitator on the Maternity Emergency Care (MEC) and Midwifery Upskilling (MIDUS) courses. 16 months in and she has five course facilitations under her belt.

"I have huge respect for remote area nurses, having worked with them really closely in remote communities," Di says.

However, Di believes a fear of maternity can at times pose a risk to the provision of evidence-based care to mothers and babies in remote areas, where birthing services are not often available locally.

Di says that the MEC course is about expanding the "massive toolbox of skills" RANs have even further, in order to alleviate understandable anxiety about maternity care including emergencies and equip RANs with the right questions to ask and the awareness of whether a woman can be managed in Community.

The end result is that they will be able to collaborate as effectively as possible with the midwife or district medical officer, and provide as much care as possible on Country.

"For example, is it preterm labour or is it just a simple urinary tract infection that is giving her contractions?" Di asks.

"If we treat the infection early, she may not have to go into a tertiary unit for weeks prior, to await the arrival of her baby."

Di says that RANs can also play a vital role in shaping healthy pregnancies and limiting the occurrence of preterm birth; for example, by screening for STIs and anaemia during the preconception period.

"A healthy mum grows a healthy baby," says Di.

A trusted, fluid, culturally safe and appropriate healthcare service that strengthens healthy literacy is key to preventing preterm birth and achieving optimal maternal outcomes.

"It's about being in that yarning space, being trusted," says Di.

"Trust is the most important thing... and these RANs are trusted, and they're there all of the time, as unfortunately, not all services have access to a midwife on the ground.

"We just need to empower that trust... that goes some way to preventing adverse outcomes."

Di encourages any nurse who has an interest in rural or remote health to attend a MEC course and expand their toolbox further.

"Once nurses have done a MEC, they have the skills to take back to their individual working environments and provide great immediate antenatal assessment and care," she says.

"We're not expecting RANs to know how to be a midwife; we're just expecting them to be able to know what's normal... and know that it's okay to not know and to consult and refer." ●

Cementing my passion for remote

Aspiring remote area nurse Gillian Edmiston from Charles Darwin University shares insight into her four-week placement in Maningrida, an Aboriginal community in West Arnhem Land, NT, where she worked with "some of the most experienced and capable" RANs.

In June this year, I was lucky to attend a four-week remote nursing placement in Maningrida Community. Maningrida is an Aboriginal Community in West Arnhem Land in the Northern Territory. I have worked in remote communities in the Top End on and off for the past five years as a support worker but have never visited Maningrida before. I have always found working in Communities to be humbling, exciting and sometimes tough, but these times are held as some of my most memorable life experiences.

Due to these previous experiences, I have aspired to one day work as a remote area nurse in the Top End. Being offered this placement sparked excitement in me as I realised I would finally get a taste of what the work of a RAN would actually look like.

So, I packed my bag and hopped on a small plane to Maningrida. The flight over Arnhem Land and the beautiful snaking rivers of the Top End is a view that everyone should experience in their life and is absolutely breathtaking. Mala'la clinic where I was placed is an Aboriginal Community Controlled Health Organisation (ACCHO) that supports Maningrida town and its nearby outstations. Mala'la offers acute health care and operates many programs including child health, women's health, chronic disease management and maternal health. I was impressed with how well-staffed the clinic was and how welcoming and willing to share knowledge everybody was.

The staff at the Mala'la clinic were very welcoming and I was lucky enough to get experience in many different areas.

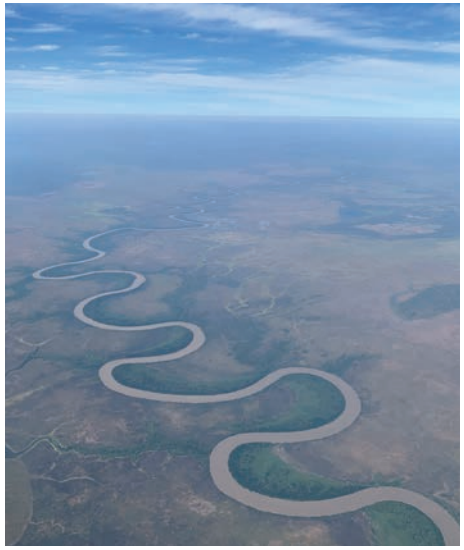
The remote area nurses and Aboriginal Health Professionals welcomed me with open arms and taught me the ways of the clinic and how to support clients in the Community setting.

My first two weeks were spent working in the Healthy Under 5's child health program.

Opposite page: Gillian with AHP, Valda. Above: Gillian, Carolyn Pearse and Cathy Peirce.

I worked alongside two very experienced child health nurses. I learnt about the challenges to health access and how small issues can turn into much larger health conditions and chronic diseases, such as rheumatic heart disease.

My second two weeks were working in acute care and emergency. This further compounded that building relationships in Communities is paramount in providing health care to Aboriginal and Torres Strait Islander peoples. ▸▸



The RANs working in these settings are some of the most experienced and capable nurses I have come across. Seeing the extra responsibilities the RANs working in these settings take on was awe-inspiring. The confidence and trust in their abilities to problem solve and make clinical decisions was very impressive.

This placement was a whole new experience and really cemented that this is where my passion lies. There were many unique experiences that you probably wouldn't get in an urban setting like a stingray barb all the way through someone's finger and creepy crawlies in places they shouldn't be.

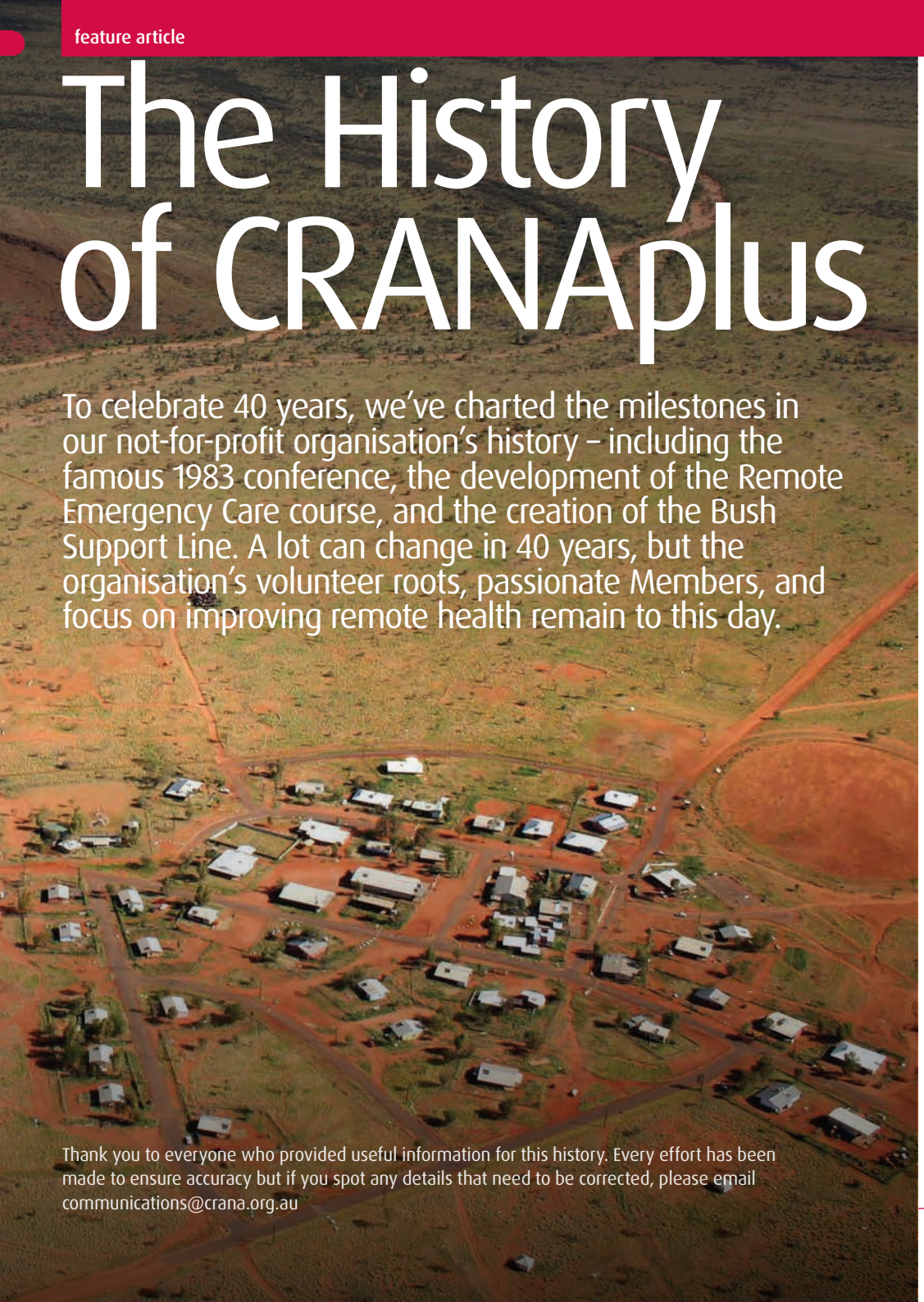
All of my experiences highlighted the real difference that access to primary health care can make to people's lives and the health disparities that occur within these settings. Thanks to CRANAplus and CDU for making this life-changing experience possible.

CRANAplus Student Members can apply for Undergraduate Remote Placement Scholarships at crana.org.au/scholarships

This CRANAplus Undergraduate Remote Placement Scholarship was sponsored by HESTA.

The History of CRANAplus

To celebrate 40 years, we've charted the milestones in our not-for-profit organisation's history – including the famous 1983 conference, the development of the Remote Emergency Care course, and the creation of the Bush Support Line. A lot can change in 40 years, but the organisation's volunteer roots, passionate Members, and focus on improving remote health remain to this day.



Thank you to everyone who provided useful information for this history. Every effort has been made to ensure accuracy but if you spot any details that need to be corrected, please email communications@crana.org.au

1982–1985: CRANA's origin story

The formation of the Council of Remote Area Nurses of Australia in the early 1980s represents a collective triumph against the odds. Remote area nurses at the time were frequently under-resourced and under-prepared, but being scattered by distance, they could not know that the issues they faced were widespread.

Moreover, remote area nurses were a predominantly female professional group within a patriarchal society, and prevailing values of religious duty, bush stoicism and service to country often suggested one should quietly 'get on with the job'.

But beneath the surface, the workforce was stirring, recalls remote area nurse Sally Johnson, who was working as a nurse in the Gulf Country at the time.

"I was sitting on a beach in the Gulf of Carpentaria not far from Normanton," she says, "contemplating the reality and the fairness of this situation."

The year was 1982 and she was with fellow remote area nurse, Jenny Klotz. Jenny had recently been asked to relieve an RN at a nearby clinic. The nurses' flat was occupied and her request to stay in a motel was at first refused because there was a "perfectly good" hospital trolley in the clinic for her to sleep on. She successfully protested for better accommodation with the help of the Queensland Nurses Union (QNU), but this was just the tip of the iceberg. RANs in the area were finding themselves under-prepared and equipped to respond to car crashes, premature births, and other complex presentations.

"What we were thinking at the time was: we are out here expected to have skills that we have never been taught," Sally says.

Jenny Cramer and Jenny Klotz in Rockhampton, 1991.

"And we are learning on patients and that is not fair to them or to us. So, what to do? Well, this type of nursing had taught us to find a way to fix things."

The pair compiled a list of clinical and general nursing skills required by remote area nurses, and Jenny, who was active within the QNU, developed a special interest group called the Queensland Isolated Nurses Association.

The group soon attracted a membership of 31. This was a lightbulb moment for Jenny and Sally; clearly, fellow Queenslanders shared their plight. But did nurses in other states and territories feel the same?

"I recall two ladies – one was a registered nurse (RN) – who were travelling the outback with the Isolated Children's Parents' Association," Jenny says. "They were delivering books and social support to outlying and remote stations and small communities.

"[These ladies] were a godsend. They had connections... In Queensland we had a step ahead, but now word was spreading across Australia through their informal network."

The RN in question was Terri Ormiston who lived in Mt Isa and worked for the Uniting Church Frontier Services. In 1982, she flew into Sydney for the Royal Prince Alfred Hospital Centenary celebrations. ▸▸

The day marked 100 years for this urban healthcare institution, but Terri discussed the plight of remote area nurses. Her presentation attracted a standing ovation.[1] June Cochrane, Executive Director of College of Nursing Australia, took note.

June offered the College's annual conference as a forum to gauge the interest in establishing a network of RANs from all states and territories.

The interim committee that formed following this event included Mary Barr from Alice Springs, Jenny Cramer from NSW, Billie Scott from WA, and Stephanie Muir from the Top End. They successfully applied for Government funding of $4,000 and started to promote the event through their newfound networks, while nurses in Alice Springs including Mary, Doris Kubisch and Sandy Werchon worked tirelessly on planning.

"We collected all the Australian telephone books from the post office at Normanton and looked for the addressees of any remote clinics, sending each of them an invitation to come and discuss our situation in Alice Springs," Sally says.

"We didn't ask them to reply because it was all snail mail and we were busy with our jobs out there. We just thought, we'll throw it out there and if nobody comes that's alright, but if 30 or 50 come, we can talk about it."

Rallying together in 1983 and 1985

Over 100 nurses arrived in Alice Springs on 27 October for the two-day event. The precise attendee count is lost to time, with 110, 130 and 150 commonly quoted, but the import of the number remains. To accommodate the group, the committee had to change the venue three times (finally settling on a room at the Memorial Club) and borrow cutlery, glasses, cups and saucers from Alice Springs Hospital.

[1] Terri also famously called for a year of the remote area nurse in the Australian Nurses Journal in early 1983.

The theme was 'Remote area nursing – myth or reality?' At this time, there was minimal understanding of the role, even among other nurses. RANs were at times even viewed as drop-outs from the mainstream system. Now, suddenly, the Minister for Health Neal Blewett was on the stage, acknowledging their reality.

"[Pyramid structures with doctors at the top, paramedics in the middle, and nurses at the bottom] are probably inappropriate in any health setting," he said. "For the RAN they are simply irrelevant. He, or she, has to be a doctor, paramedic and nurse rolled into one." It must have come as a pleasant surprise.

The first few conferences were like releasing the valve on a pressure cooker, Sally says.

"There was so much pent-up energy, frustration and passion among remote area nurses. They needed a safe place to air their grievances, a place they knew they would be heard and understood, a place where they could gain support from their peers."

Jenny agrees. "The opportunity of finally being able to discuss and share our common interests and concerns was like a seed that was planted in our hearts and minds. [The conferences] gave us a sense of belonging, solidarity and power in our own shared knowledge and experience."

Left: CRANA did not know this many RANs would turn up to its first Conference. Top: RANs at the first CRANA Conference. Above: Alice Springs in 1983.

In 1985, the group had its breakthrough conference in Townsville. Its success hinged on generous external support; the Government provided enough grant money to cover conference costs, including reparation of travel expenses for attendees who did not receive financial support from their employer. In Jenny's words, they were recognising that "we as a group of feisty women and men were justified in our righteous quest to improve the education and support of RANs".

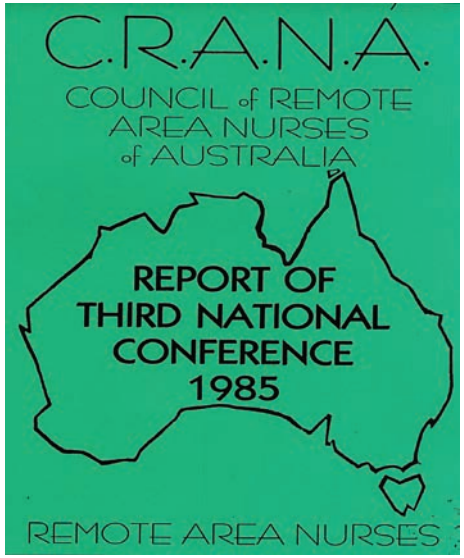
The organisation settled on its name, with 'CRANA' succeeding over alternatives such as 'Remote Area Nurses Corporation' or 'Organisation of Remote Area Nurses Australia'. It inaugurated Jenny Klotz as President, Sabina Knight as Vice President, Margaret Dawson as Secretary, Bernice Blain as Assistant Secretary, Jenny Cramer as Treasurer, and Ann Kreger as Assistant Treasurer.

"We did lots of work at that [1985] conference in small groups, highlighting our most prominent issues," Jenny remembers.

"At the end of the day, when other participants left to find some recreation and relaxation, we, the core group, collated all the information that had been written on multiple, multiple pieces of butchers paper, and came up with the final key concepts that as an organisation we wished to address."

These issues were crystallised into the famous 1985 conference report and included education, legal issues, occupational health and safety, and the "special problems of living and working in remote areas" (such as isolation, community tensions and higher levels of poverty) which meant that "straightforward duplication" of urban services would be inappropriate. Jenny Klotz, in glasses and pearl necklace, stares out from the pages of this small, glossy booklet, her gaze serenely but calmly demanding a fair go for RANs. CRANA distributed the report widely, to state and federal Government, opposition, union and non-government organisations.

Though the booklet focuses on the issues faced by RANs, this was a means to an end; CRANA's goal was always to improve health outcomes in remote Australia. Other details have been lost to time, but this unifying purpose can be traced back across four decades.

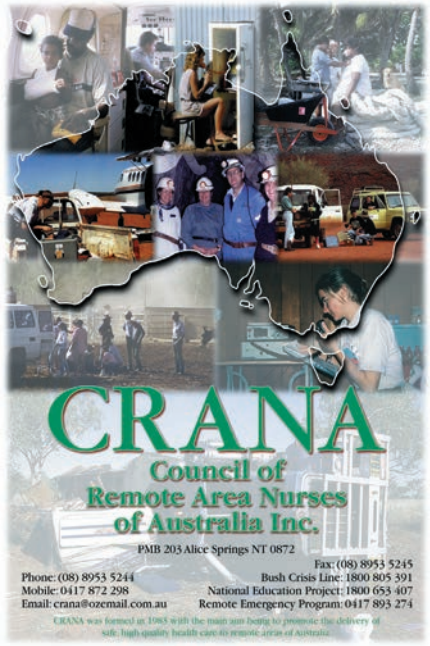


Top left: The inaugural CRANA Board in 1985 (referred to as the Executive at the time). Left: The cover of the influential Report of the Third National Conference 1985. Above: The fourth CRANA Conference in 1986.

Preparing the workforce: the push for education

At the 1985 conference in Townsville, education (or lack thereof) was identified as the single most important issue facing RANs. The state of affairs was summarised succinctly in the Conference Report:

"As the sole medical representative in an isolated community, the remote area nurse requires extra skills and training. Yet nurses arrive to begin with... little or no preparation for the situation they will be encountering, both socially and professionally. At present there is no adequate pre-training and only very limited in-training."



Above: An early CRANA promotional poster once the organisation had been funded to deliver a range of services. Right: CRANAplus President Sandyl Kyriazis, Dr John Wakerman and Sue Lenthall in 1999.

So began the task of convincing the rest of Australia. In 1987 CRANA formed an education committee led by CRANA Member Margaret Davidson, and by 1990 it had succeeded in obtaining $16,000 for research into educational needs and related issues for RANs. Ann Kreger (CRANA's first Assistant Treasurer) took the post as project lead.

"Most published literature to date reflects a romantic rather than a realistic perspective of remote area nursing," she said at the 1990 CRANA conference on the eve of the report's publication. "There is a paucity of research examining remote area nursing practice and associated educational needs. Both are essential for the development of a specialist course for remote area nurses."

The resulting paper, *Remote Area Nursing Practice: A Question of Education*, was released in 1991. The romantic notions Ann had spoken of were in pieces on the floor. 21 recommendations rang out loud and clear, among them that:

- Development of remote area courses be done in a rational and nationally coordinated manner so that both the limited material and human resources can be utilised appropriately and ensure good access...
- Short-term and long-term planning of RAN education courses be undertaken so that the needs of both hospital-based and tertiary educated RNs are addressed.
- All courses for RANs either multi-disciplinary or nursing, be developed in conjunction with tertiary qualified RANs.

The plight faced by RANs had been starkly documented for one of the first times. It was a sobering moment, but also a moment of hope.

Money was circulating. That year, 1991, CRANA received funding for its first National Secretariat, allowing it to appoint a paid Executive Officer for the first time. The year before, the government had initiated the Rural Health Support Education and Training (RHSET) Program.[2] Big things were in the offing for CRANA, but it would still be a while before the budding organisation's ambitions were realised.

University-based education

In the 1990s, university-based under-graduate education for nurses was still a developing industry. Only in the previous decade had the Australian nursing sector commenced its transition from hospital-based to university-based education, and it was not until the early 90s that the transition had been completed on a national scale.

Throughout, and even before, this transition, CRANA called for the development of a postgraduate course for remote health practice. It would ultimately collaborate with Flinders University in the late 1990s to develop the postgraduate Remote Health Practice Program, but this breakthrough followed a long and at times frustrating campaign for a postgraduate course.

In the early to mid 1990s, CRANA had consulted with universities on remote area health subjects, but never an entire program. Resistance from academia and the largely state-based funding model for nursing education acted as barriers; as did the fact that CRANA took a no-nonsense approach to what nurses in remote areas were expected to do. At times, this meant aiming to teach necessary skills that were "technically illegal".

In 1997, national momentum swung in CRANA's favour with the establishment of University Departments of Rural Health and the commencement of the Remote Area Nursing Competencies Project. This was a Government-funded project with CRANA representation through Sally Johnson and Board Member and remote area nurse, Toni Dowd. It set in stone what such a postgraduate course for RANs should aspire to teach.

Within this window of opportunity, CRANA received financial support via the Office of Aboriginal and Torres Strait Islander Health towards the development of the aforementioned postgraduate Remote Health Practice Program. Flinders University agreed to partner with CRANA and deliver the course. CRANA held a three-day stake-holder workshop in Alice Springs in the spring of 1997 to develop the curriculum.

[2] This program aimed to fund the development and trial of new ways to provide health services, focusing on educational opportunities and support for remote and rural health workers. It would allocate close to $37 million over the next decade, according to Harvey, D., Webb-Pullman, J. and Strasser, R. (1999), *Rural Health Support, Education and Training Program (RHSET): Where to now?* Australian Journal of Rural Health, 7: 240-248.

In a case of déjà vu, this Alice Springs based event blew all expectations out of the water. Where 30 attendees were expected, over 100 arrived – 25 of them from CRANA. Course development was a triumph of interprofessionalism, with organisations such as the Australian College of Rural and Remote Medicine and Services for Australian Rural and Remote Allied Health involved.

Informed by this workshop, the post-graduate course that CRANA had envisioned for so long suddenly materialised through Flinders University's Remote Health Practice program. Sue Lenthall, a remote area nurse who had recently served as Executive Officer with CRANA, became the first course coordinator. The program was headquartered in the newly minted Centre for Remote Health (CRH) in Alice Springs, and in April 1999, Sue delivered the first lecture there. As of 2023, the program has gone on to graduate hundreds of people.[3]

Clinical preparedness

CRANA also had a longstanding vision of a course teaching advanced emergency skills and trauma management. This idea would blossom into the Remote Emergency Care (REC) course.

Up to this point, available education in remote emergency care was not fit-for-purpose. Few courses came out to rural and remote areas and those in urban Australia were time-consuming and costly to access. They taught how to deliver care within a well-equipped team, with an ambulance and doctor close at hand, within and not across cultures. What remote health professionals needed was a course that acknowledged their reality, and taught them how to find solutions within it without compromising on quality of care.

Top: Facilitators in 2005. Above: Sue Kildea delivers an early MEC course. Opposite page: Sue Kildea, Libby Bowell and Sue Kruske – key players in the development and delivery of CRANA's short clinical courses.

CRANA gained the boost it needed through RHSET funding in 1997. After a period of consultation with consumers and health practitioners to develop the curriculum for this fledgling REC course (led by RN and later Board Member, Kathryn Zeitz), CRANA hit the road in 1998 to deliver pilot courses in Alice Springs, Broome, Port Augusta and Thursday Island.

Educators lugged the mannequins with them on small aircraft and "begged and borrowed" what they could to get the show on the road, but the courses were immediately well-received, particularly the hands-on skills stations. Moreover, participants felt validated. Here was proof that their role was uniquely challenging and *in need* of a specialised course. More than 15 years had passed since Sally Johnson and Jenny Klotz had written the original skills list in 1982, but CRANA's persistence had finally paid of.

Within no time, CRANA sensed the need for a Maternity Emergency Care (MEC) course. In the early 2000s, Members fed back that they felt underprepared for the maternity emergencies they regularly had to attend. It often fell to RANs and Aboriginal Health Workers (AHWs) to deliver these services in the absence of resident midwives or doctors. This knowledge didn't fall from the sky.

CRANA applied for a grant in 2001 to develop its MEC course. Following development by midwives including Sue Kildea and Sue Kruske, the first Maternity Emergency Care course was delivered in April 2003 and immediately, participants reported feeling more confident around childbearing women and better able to understand maternity conditions.

Despite its success, the course was not without well-meaning opposition. Some felt it aimed to teach non-midwives routine antenatal care. It was necessary for CRANA to clearly define the course's purposes and limitations.

To quote from a 2006 paper on the development of the MEC[4] the course is "Not intended to promote the delivery of comprehensive antenatal care by RANs and AHWs. Rather it is to encourage them to be alert, so pregnancies are diagnosed earlier and screening, care and services are offered as soon as possible, with the woman then referred to appropriately skilled providers."

In the 2003/2004 financial year, CRANA delivered 13 courses to 278 participants. By 2013, CRANAplus was delivering 90 courses in the calendar year.

[3] CRANA also had an Education and Research Officer role based at CRH in the 2000s. This expanded CRANA's academic influence and saw the organisation actively involved in research into the remote health workforce.
[4] Kildea, S., Kruske, S. and Bowell, L. (2006), *Maternity emergency care: Short course in maternity emergencies for remote area health staff with no midwifery qualifications*, Australian Journal of Rural Health, 14: 111-115.

The growth can be accounted for in a few ways. Throughout the years, increases in funding and the growth of an incredibly generous and skilled pool of volunteer facilitators have increased CRANAplus' ability to deliver an ambitious national schedule.[5] CRANAplus has continued to develop new courses in response to emerging workforce needs. The launch of its online learning portal in 2010 helped to further bridge the tyranny of distance.

Health services throughout Australia have increasingly embedded CRANAplus' courses within their onboarding and ongoing professional development processes.

The organisation's national relevance and the transferability of training from state to state increased with the establishment of the National Registration and Accreditation Scheme (NRAS) in 2010 and when CRANA became a registered training organisation in 2013.

[5] At times it has even become an 'international schedule'. For example, CRANA delivered courses in PNG in 2006.

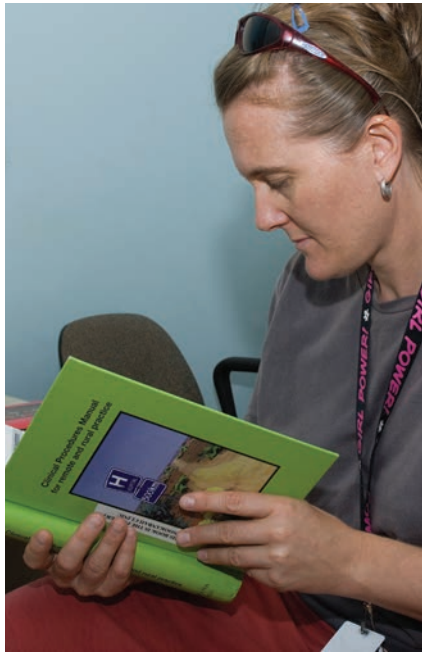
Clinical Procedures Manual

There was still one final jewel to insert into the crown of CRANA's educational achievements.

By the late 1990s, the Queensland Primary Clinical Care Manual (PCCM) and Central Australian Rural Practitioners Association (CARPA) Standard Treatment Protocol Manual had successfully established best practice in the treatment of common clinical situations.

It was a useful 'what to do' guide but there was not an equivalent 'how to do it' resource for the clinical procedures that were part of these standard treatments, and so there arose a call for a companion manual.

Top left: CRANA delivered education in PNG in 2006 (current board member Nick Williams is in the yellow shirt to the left). Left: CRANAplus ramps up its educational logistics in 2013. Above: CRANA gals in 2007 (Sabina Knight, Tess Ivanhoe, Christine Davey, Sharon Weymouth and Sue Lenthall). Right: Vanessa Page, former CRANAplus Board Member, peruses the Clinical Procedures Manual.



CRANA successfully applied for a RHSET grant to develop the manual in 1999. A committee chaired by Sabina Knight was appointed and it set about developing a concise, jargon-free, culturally sensitive manual with a practical design and layout.

The first national clinical procedure manual ever written for rural and remote health practitioners contained 300 procedures and 500 illustrations, and an overwhelming 500 copies were distributed in the first few weeks.

From the outset, the Clinical Procedures Manual was intertwined with the CARPA Manual. Therefore, over time, it was decided that the manuals would be edited in tandem. CRANAplus has maintained its involvement by actively participating in the manual's governance and editorial committees. To this day, the manuals assist practitioners to competency and confidently carry out clinical procedures.

The fight for identity: validating RAN practice

How can you make your voice heard when you are out of sight from the majority of Australians? As Jenny Klotz put it in 1985, "The Tyranny of Distance is a daunting factor in trying to achieve any goals for an organisation such as CRANA."

"However, [distance] is also our most saleable asset," she continued. "Aside from the fact that the press at large is more interested in the gore, horror and extremes faced by Remote Area Nurses, I feel that we as an organisation are just beginning to tap into a huge public and political empathy for the work we perform."

To establish this empathy for the profession, CRANA realised that it would need to develop a set of standards outlining the unique skill set required by remote area nurses. Despite its efforts, it would sometimes take a widely publicised traumatic event to catalyse change.

The need for standards

While the campaign for education was going on, a concurrent campaign to develop remote area nursing standards was also underway.

Excellent work was being done by RANs but how could one know it was excellent work, without standards? And if a RAN or a health service had room to grow, how could they assess themselves and know what to aim for?

The issue was pronounced for RANs, who outside of the CRANA conference had limited opportunity to interact with peers, meaning that even 'informal', socialised standards were sometimes missing.

In 1986, CRANA convened its first subcommittee to develop standards. Committee convener, Angela Low, summarised the challenges they faced:

"How could nurses from such a diversity of backgrounds from Aboriginal Communities of Arnhem Land and the centre, to company and prospector mining towns, to the deserts of the centre and the west and the snow fields of the south, and even the islands of the Indian Ocean, explain to the profession at large the elements of their role they all instinctively felt they had in common.

Opposite page: The emerging RAN standards needed to build in the principles of primary health care; Sabina Knight and Sandyl Kyriazis busy on the advocacy trail in 1999. Top: Not your everyday nursing. Above: Sophie Heathcote.

"Further, how could they convince their colleagues that despite this diversity they were a unique entity that has special needs and responsibilities which often, of necessity, went beyond the accepted bounds of nursing practice?"

The subcommittee felt a heightened sense of urgency in the late 1980s. A young English nurse, Sophie Heathcote, had been sent to work in remote New South Wales. There was an incident with a tragic outcome. A young man died. What followed included a series of investigations and inquiries, and Sophie was temporarily deregistered.

CRANA believed that Sophie had been unfairly made into a scapegoat and at the 1989 CRANA conference, remote area nurses signed a petition for Sophie's cause.

In 1990, CRANA published its first remote area nursing standards which included its famous statement on the philosophy of remote area nursing. In 1991, Sophie's appeal was upheld. She was later invited to speak of her experience at the CRANA conference.[6] These two events marked a turning point in the national conversation. Suddenly, there was greater acknowledgement that RANs in the field were not being properly prepared or supported.

Continuing to push for standards

Throughout the next decade, CRANA continued to grow its representation on committees, including the budding National Rural Health Alliance and the Australian Pharmaceuticals Advisory Committee. As stated in a CRANA communique in 1996, "involvement in all of these groups marks a significant change in the public recognition by legislators of the ability of RANs to become involved in defining the rights and scope of their practice, if not self determining in this regard."

Thanks in part to CRANA's ongoing advocacy, the Federal Government invited tenders to develop competency standards for remote area nursing in 1997, as already mentioned. A team of researchers with strong CRANA representation applied. Utilising CRANA's network, this group consulted widely with RANs, consumers and others in the development of a nationally recognised set of competency standards for RANs. They envisioned that these new competencies, now funded, nationally recognised, and consistent, would give CRANA great strength to argue for the development of accreditation criteria and curricula designed to enhance remote practice.

These two themes – accreditation and curriculum development – define the legacy of the standards. The results were fast and instantaneous for curriculum development, in the form of CRANA's postgraduate and Remote Emergency Care courses. The journey towards accreditation was to involve many more twists and turns, and is in many ways ongoing.

Advances and setbacks in recognition

In 2003, CRANA initiated its awards program, adding another string to its bow in the quest for professional recognition. CRANA's Fellowship program was developed with similar goals in mind. Fellows were inducted to embody the standards of remote health practice and set an example in a largely self-regulating industry.

CRANA implemented initiatives like these with the ultimate goal of ensuring that nurses sent to remote areas were adequately prepared so that they could deliver high-quality, culturally safe care.

[6] Sophie says that "the fact that CRANA reached out and found me is something that has always stayed in my heart" and that it inspired her Presidency of the Board in the 2000s. This gave her a platform to promote the need for education and preparation. She is now a CRANAplus Fellow.

Left: Vicki Gordon. Top: John Wright and Fiona Wake in 2014 (both are current Board Members). Above: 2015 Aurora Award recipient, Sandra McElligott, with then CEO Christopher Cliffe (left) and President Janie Smith.

However, when the Northern Territory Intervention was announced in 2007, many feared that the progress made in this direction would come undone.

The Intervention followed the *Little Children are Sacred Report* and one of the measures it was to involve was compulsory child health checks. A fly-in, fly-out workforce, separate to existing primary health care arrangements, was to be created and include interstate staff.

CRANA was approached to be involved in preparing this workforce and it faced a challenging decision.

After discussing the matter with Aboriginal Medical Services Alliance Northern Territory (AMSANT), CRANA made the carefully controlled decision to proceed. As President Christopher Cliffe wrote at the time, "If we are not involved then we would have no capacity to ensure that resources are appropriate and staff well prepared".

Vicki Gordon, a CRANA Board Member in the 1990s and Remote Support Officer at this point in time, represented CRANA in the coordination and delivery of orientation to staff in Alice Springs and Darwin, working alongside paediatrician Dr Jim Thurley.

They were on the shortest of timeframes. Vicki began delivering 'rapid briefings' within nine working days of the announcements. On day 10, the first Child Health Check Team was deployed. Vicki in turn conducted the debriefs with returning staff.

"The Intervention had a huge negative impact on remote Aboriginal people, but CRANA thought 'it's happening and we need to make individual teams and people in community as safe as possible'," Vicki reflects in hindsight.

"It wasn't something that CRANA would have ordinarily have done, but these were extraordinary times."

Refreshing remote nursing standards

The National Registration and Accreditation Scheme was introduced in 2010. It aimed to ensure that all registered health professionals meet the same national standards, and to increase workforce mobility between states and territories. The Intervention was still front of mind for CRANA (by now known as CRANAplus), and sensing good will and opportunity for change, the organisation reignited its campaign for RAN standards.

Its own Remote National Standards and Credentialing Project commenced in 2012 and culminated in the endorsement of a new set of Professional Standards of Remote Practice: Nursing and Midwifery. CRANAplus aspired to make these standards user-friendly, contemporary, and reflective of the diverse practice areas under the remote and isolated banner.

Although then as now, nurses could be endorsed as Nurse Practitioners in a specialty relevant to remote practice, endorsement for RAN practice was not nationally consistent, available or recognised (for example, Rural and Isolated Practice [Scheduled Medicine] endorsement was only available to RNs in Victoria and Queensland). Therefore, CRANA set out to establish a nationally consistent credentialing process for the remote nursing and midwifery workforce – the RAN Certification Program. This involved a self and peer assessment to confirm that a remote area nurse met the minimum essential requirements to be a safe provider of remote health care.

However, as Angela Low from the Standards Subcommittee had intuited in 1990, the value of standards is "limited unless employers and employing bodies acknowledge that they too have a role in maintaining a professional standard of remote area nursing practice." CRANAplus promoted its up-to-date standards and engaged in conversations nationally to encourage employers and jurisdictions to embed them.

This campaign brought about significant local successes, but overall, its success was mixed.

CRANAplus does not currently offer the RAN Certification Program, but has been actively involved in the next chapter of remote area nursing standards. The organisation recently participated on the steering committee for *The National Rural and Remote Nursing Generalist Framework 2023–2027*, convened by the Office of the National Rural Health Commissioner.

This document describes the unique context of practice and core capabilities for rural and remote RN practice. As with the landmark documents that have gone before it, its potential to bring about change is palpable. In fact, the remote health sector is poised at a critical moment. The extent of implementation is set to be the decisive factor.

"The Framework provides nurses with a tool for self-assessment, enabling them to work meaningfully with educators and mentors to build their capabilities," outgoing CEO Katherine Isbister said in March.

"Importantly, the Framework is also a tool that employers, educators, governments, and peak bodies can use to assess their current programs, consider scope of practice and tailor their professional development opportunities. The Framework is a meaningful step towards a structured and widely available remote area nursing pathway, on par with the rural generalist pathways for medicine and allied health."

Above: Members of the Steering Committee at the launch of the Framework at Parliament House, 2023.

From cottage industry to corporate entity

It is safe to say of the early days that CRANA's aspirations exceeded its budget. Before 1991, CRANA was run by volunteers working in their lounge rooms and using fax and phone to communicate.[7] It had received sporadic funding for conferences and projects but rather than restrict itself to its funding streams, it built itself into a committed community organisation around them.

Above: The Board in 1996, with the organisation on the cusp of sudden expansion. Right: Board Members in 1998, during the boom years of major expansion. Opposite page: Sally Johnson, President in the 1990s; Sally Johnson speaks out in the Cairns Post in 1993.

In 1987, CRANA published its first newsletter, the 8-page Outback Flyer.[8] In 1988, the organisation became incorporated under the Associations Act, Victoria. The modest Membership revenues of the day built up a small working fund that allowed CRANA to pursue these goals. In 1991, Membership cost $50, or $25 for students, and the organisation had 287 Members.

The organisation's horizons expanded in 1991, when CRANA received $50,000 in funding towards its National Secretariat from the Federal Department of Health, Housing and Community Service.

Suddenly, it could appoint an Executive Officer and open its first office. The first EO was Bernie Ibell who was based in Tasmania but the organisation soon shifted to Cairns, where it set up shop in a modest two-room office.

CRANA's first major funded project

CRANA was right on cue. Still hanging the wallpaper in the new office so to speak, it found itself responding to an evolving situation on Cape York.

Sally Johnson was CRANA president in the early 1990s. She explains that at one stage there was an average of one assault of nurses per month on the Cape and that in some remote communities the turnover rate exceeded 200 per cent.

[7] CRANAplus' maintains its volunteer roots to this day. A passionate group of over 130 volunteer facilitators continue in the spirit of CRANA's early volunteers and make it possible for the organisation to deliver contextualised education on a national scale.

[8] Additional copies were available for $1. The Flyer would eventually become CRANAplus Magazine.

"I was particularly concerned that it was difficult for nurses to stay in remote areas, because I knew that our best work was done after the first few years in a community, when trust had been earned on both sides," Sally says.

"At that time Indigenous groups and communities were dealing heavily with results of dispossession of their land, forced relocation, separation from family, external control, rapid social change and many other traumatic events associated with colonisation."

Sally spoke extensively with the media at this time and in the background, CRANA set about being a part of the solution. By March 1993, it could announce its two-year 'Locum Support and Relief Pilot Project', which it would deliver in partnership with the Peninsula and Torres Strait Regional Health Authority.

Drawing on Government funding and coordinated by CRANA's Margaret Dawson (who had been CRANA's first secretary), the project involved four experienced RANs working as locums, relieving RANs in the field and seeking to embed a primary health care philosophy.

The RANs who had been relieved would head to Cairns, where they could then attend professional development and cross-cultural awareness workshops, or simply take some time out, utilising furnished rooms in town.

The project had many facets, among them the provision of a 24-hour, telephone-based counselling service for RANs. This detail, blending in though it did, would ultimately prove to be the project's lasting legacy.

Building up to the Bush Crisis Line

In 1994, the remote area nursing workforce suffered a series of awful reversals. The Locum Support and Relief Pilot Project was not re-funded or expanded. CRANA's secretariat funding itself appeared to be at risk of non-renewal. 21-year-old nurse Sandra Hoare was also tragically murdered in outback New South Wales.

Top: Janie Smith at the 1994 Cairns Conference. Above: Toni Dowd, Sally Johnson and Sabina Knight at the 1995 Darwin Conference. Below: Sally Johnson and Vicki Gordon dance with Tiwi Island family at the 1995 Darwin Conference. Right: An old Bush Crisis Line poster.

CRANA kept in the fight. By 1995, the not-for-profit had managed to extend its secretariat funding arrangement, and Sally Johnson was inducted as a Member of the Order of Australia for her contribution to remote area nursing and Aboriginal health in a move that seemed to point to wider recognition of RAN practice.[9]

This year also saw the publication of the *Context of Silence* report which included Janie Smith, then EO, and Jenny Klotz among the research team. The report set down on paper the reality of occupational violence.

It found that RANs were living with frequent threats to their personal safety while on and off call and duty, and that a majority did not feel adequately prepared for their current work.

A quarter of respondents were the only health professionals in their community; a third no longer felt confident in reporting violent incidents to their employers based on previous reporting experiences; over a third were in fear of their personal safety; and more than half had no access to a security escort when on call.[10]

[9] Order of Australia honours are usually bestowed early in the year, but CRANA negotiated for Sally's investiture to occur at the Darwin conference. It has been said that this is the first time the Tiwi Islands flag (adopted in July 1995) was flown on the mainland.

[10] Fisher, J., Bradshaw, J., Currie, B.A., Klotz, J., Robins, P., Reid Searl, K. and Smith, J. (1995), *"Context of Silence": violence and the remote area nurse*, Central Queensland University.

The reality faced by RANs could no longer be denied, and there was a sudden urgency to the report's recommendations, which included the following:

- Federal, State and Territory Government and employing bodies... develop formal and informal mechanisms to provide appropriate and adequate 24-hour debriefing and post-trauma services for RANs and other health staff.

The support line associated with the Locum Support and Relief Pilot Project had continued even after the project terminated, but on skeleton funding. During this phase it was up to the Executive Officer, not a trained psychologist, to answer these calls and provide support.

This all changed when the Bush Crisis Line was funded to commence in 1997 by the Office of Aboriginal and Torres Strait Islander Health Services. It was officially launched at the Launceston conference of that year. CRANA began promoting the service and rapidly distributed 1,000 fridge magnets, 8,000 telephone stickers, and 3,500 flyers.

The need for the service quickly made itself apparent. During the first six years, the service provided over 1,500 hours of counselling, across more than 2,000 calls and delivered wellbeing workshops in the likes of Broken Hill, Cooktown and Alice Springs.

The line would subsequently be rebranded to the Bush Support Line in the early 2000s, in recognition of the fact people can and should access help before they reach crisis point. It continues to this day.

Safety and security

The fulfilment of the 24-hour support recommendation was not the *Context of Silence* report's only legacy. It also played a hand in propelling funding for CRANA's educational offerings, reducing single-nurse posts, improving accommodation and facility safety, and shaping employer attitudes.

However, in 2016, any sense of progress came to a halt with the tragic murder of well-respected and dedicated remote area nurse Gayle Woodford in Fregon, South Australia. Janie Smith was president of CRANAplus at the time.

"The whole remote workforce was grieving and there were people who were so angry and who feared their safety and started leaving remote areas," she recalls. "It was an unsettling time for the whole remote workforce."

In the wake of the tragedy, the sector began to critically reflect on its long-held practices and challenge its acceptance of risks that were routinely considered 'just part of the job'.

CRANA representatives travelled to Canberra for a roundtable with Fiona Nash, then Minister for Rural Health. In-line with its long-term policy, CRANA mounted calls that RANs should not go out on call by themselves, but always be accompanied by another person.

CRANAplus soon received funding from the Commonwealth Department of Health to undertake the Remote Area Workforce Safety and Security Project. It consulted extensively with the workforce and convened an expert advisory group containing senior nursing representatives from around the country, and published Safety and Security Guidelines for Remote and Isolated Health, the Working Safe in Remote and Isolated Health Handbook, a risk assessment tool and various training materials.

Flinders University and CRANAplus also initiated the Gayle Woodford Memorial Scholarship in memory of Gayle.

In 2019, the SA Government introduced new legislation known as Gayle's Law, that states health practitioners in remote areas of South Australia must be accompanied by a second responder when attending an out of hours or unscheduled callout. However, there is still much work to be done, including the full national implementation of an 'Always Accompanied' approach to practice.

Opposite page, from top: CRANA celebrates its 25th Anniversary in Broken Hill in 2007; Advisory group members included Director Professional Services Geri Malone and Rod Menere (Project Officer) who had both been involved with CRANA since the 1990s, as well as CEO Christopher Cliffe. Top: Jo Appoo in 2009. Above: The front gate of the Alice Springs CRANAplus office in 2009.

Diversification

CRANA's biggest growth spurt may have occurred in the late 1990s, but a second spurt followed in 2008.

CRANA was in name an organisation for remote area nurses, but actions speak louder than words, and they suggested that CRANA represented the entire remote health workforce. For example, health professionals from many disciplines taught, and were taught, on its courses.

CRANA found itself in a position where its name did not reflect its activities, nor its constitution its ambitions.

As Janie Smith put it at the time, "While being 'a nurse' and being 'registered' may have been the 'ideal' 25 years ago when CRANA was established [these constitutional requirements] no longer [reflect] the realities of the current workforce environment, the multidisciplinary nature of remote work and the national push towards a more interprofessional practice".

This, and the need to be 'remote' (which left out isolated professionals), was resulting in the exclusion of health professionals who otherwise subscribed to the cause.[11]

"This was when CRANA was sitting in Alice Springs in this gorgeous little rock building," Janie Smith says of the Bath Street head office CRANA had at the time.

"CRANA was like a little cottage industry, doing its thing, struggling for funding. It was at the stage of needing to move itself into more of a corporate entity. It was teetering on being something bigger. There was huge potential to expand and government good will to make that happen."

CRANA decided it was time to make the bold move. It incorporated itself in the NT in 2008 to become 'CRANAplus', and transitioned from a remote-area-nurse-only organisation to one that welcomed a wider Membership and represented all people working in and for the health industry in remote Australia.

Within two years, around 14% of CRANA's Members were paramedics, doctors, Aboriginal health workers, and other non-nursing health professionals.

[11] These themes and quoted phrases emerged in an organisational evaluation carried out by Janie Smith, through RhED Consulting, and published in 2008.

Ongoing growth

CRANAplus has continued to mature and diversify following this important constitutional change. It opened an office in Adelaide in 2008 and in Cairns in 2012; the latter became the head office shortly thereafter. In 2013, it took on its first Patron, human rights expert and Former Justice of the High Court of Australia, Michael Kirby.

Membership structures have changed over the years. In the beginning, CRANA had state representatives who reported back to CRANA on key issues and sought to grow Membership in their state. This connection with the grassroots persists in the modern day through the CRANAplus' Nursing and Midwifery Roundtable, as well as the annual Member Survey.

Thanks to the history documented here, CRANAplus has established itself as a well-respected authority on remote health. Governments, health services, Primary Health Networks, rural workforce agencies, universities, committees and steering groups value its collaboration.

Despite its 40 years, CRANAplus still has the fast reflexes that enabled its rapid response to the Intervention. Perhaps two of the most significant national events of recent years have been COVID-19 and bushfires, and CRANAplus has been involved in both the COVID-19 Clinical Evidence Taskforce and the delivery of workshops and resources for health professionals in drought and bushfire-affected areas.

Multiple landmarks in CRANAplus' journey walking alongside Aboriginal and Torres Strait Islander Peoples demonstrate its progress. In the early 1990s, CRANA's Toni Dowd and Sally Johnson were involved in the development of Binang Goonj, a seminal cross-cultural educational model that is still influential today.

Top: Former Board Chair Paul Stephenson with the Hon Michael Kirby AC CMG, CRANAplus' Patron through the 2010s. Above: The Hon Tanya Plibersek MP cutting the ribbon at the opening of the CRANAplus Cairns Office, with Christopher Cliffe and Carole Taylor. Opposite page, from top: CRANAplus staff at the 39th Conference in 2022; Amelia Druhan (former Deputy CEO) and Katherine Isbister (former CEO) at the Birthing on Country Conference in 2022.

CRANA was a fierce advocate for Congress of Aboriginal and Torres Strait Islander Nurses (now CATSINaM) in its early years, and the two organisations continue to collaborate.

In 2008, Bunjalung woman Jo Appoo was the first Aboriginal appointee to CRANAplus' Board of Directors. In 2015, CRANAplus launched its first Reconciliation Action Plan.

This was followed in 2020 by its First Peoples' Strategy, which has provided new ways to privilege and amplify First Peoples' voices as we move towards genuine reconciliation and justice.

40 years on, CRANAplus' story continues to unfold. It remains a story of people, united in recognition of their shared interests and concerns, and the knowledge that their voices are stronger as one.

As Sabina Knight said during her presentation at the 40th CRANAplus Conference, "Some [people] have stayed a long time, others have had an intense and short experience, but each of those contributions has been vital to the development of our organisation, the profession and the remote health landscape".

Which really brings home one of CRANAplus' best traits. The organisation is not an abstract, anonymous entity. It's the sum its people – its Board, its staff, its volunteers and its Members.

And what bonds these people together into a community is the desire to improve remote health, to give back to the profession, and the question: "what can I do to make a difference?" ●

Corporate Members and Partners

2XM Healthcare is an Australian-owned and operated Rural and Remote Nursing specialist. Based in WA our consultants have over 20 years' combined experience in the industry and have experience in supporting remote area clients and candidates in their searches. We are committed to developing high-quality relationships and our mission is to support the R&R community as best we can. For all our up-to-date jobs, please visit www.2xmhealthcare.com.au or call (08) 6388 0700.

Affinity is a nurse-owned and managed agency with in-house Clinical Educators providing your professional development. As a non-commission-based agency, we focus on finding the right match for you. Join today to experience the Affinity difference. www.affinitynursing.com.au

Alliance Rural & Remote Health, known as CQ Nurse, brings quality nursing care to rural and remote areas of Australia. Alongside Alliance Nursing, we're part of the Alliance family. Together, we bring a combined 140 years' experience. We're 100% Australian-owned, and for-purpose, meaning that all our profit is reinvested back into Australian communities.
Ph: (07) 4998 5550 Email: info@allianceruralremote.com.au
www.allianceruralremote.com.au

AMI Australia is a physician-owned and physician-led organisation delivering tailored medical solutions in Australia. With expertise in aeromedical evacuation, search and rescue, regional healthcare, nursing placements, immunisations, marine medical services, and resource sector support, AMI Australia ensures timely and comprehensive healthcare services across diverse sectors. Ph: 0477 985 910
Email: aucontacts@amiexp.health Website: amiexp.health

AMRRIC (Animal Management in Rural and Remote Indigenous Communities) is a national not-for-profit charity that uses a One Health approach to coordinate veterinary and education programs in Indigenous communities.
Ph: (08) 8948 1768 www.amrric.org

The **Australasian Foundation for Plastic Surgery (The Foundation)** is a not-for-profit organisation that supports quality health outcomes for those involved with Plastic Surgery, with a particular focus on rural and remote communities. Email: info@afps.org.au
www.plasticsurgeryfoundation.org.au

The Australasian College of Health Service Management ('The College') is the peak professional body for health managers in Australasia and brings together health leaders to learn, network and share ideas.
Ph: (02) 8753 5100 www.achsm.org.au

The **Australasian College of Paramedic Practitioners (ACPP)** is the peak professional body that represents Paramedic Practitioners, and other Paramedics with primary health care skill sets. ACPP will develop, lead and advocate for these specialist Paramedics and provide strategic direction for this specialist Paramedic role.
Email: info@acpp.net.au www.acpp.net.au

The **Australian Council of Social Service** is a national advocate for action to reduce poverty and inequality and the peak body for the community services sector in Australia. Our vision is for a fair, inclusive and sustainable Australia where all individuals and communities can participate in and benefit from social and economic life.

The **Australian Indigenous Health*InfoNet*** is an innovative Internet resource that aims to inform practice and policy in Aboriginal and Torres Strait Islander health by making research and other knowledge readily accessible. In this way, we contribute to 'closing the gap' in health between Aboriginal and Torres Strait Islander people and other Australians.
www.healthinfonet.ecu.edu.au

The **Australian Primary Health Care Nurses Association (APNA)** is the peak professional body for nurses working in primary health care. APNA champions the role of primary health care nurses to advance professional recognition, ensure workforce sustainability, nurture leadership in health, and optimise the role of nurses in patient-centred care. APNA is bold, vibrant and future-focused.

The **Australian Stroke Alliance** is a $40 million program bringing together 40 organisations committed to transforming prehospital stroke care. We plan to take brain imaging to the patient via road and air medical retrieval, speeding up diagnosis and treatment. This is a once-in-a-generation opportunity to address an unmet clinical need and to deliver urgent stroke care for all Australians. Ph: (03) 9342 4405 austrokealliance.org.au

Benalla Health offers community health, aged care, education, and acute services to the Benalla Community including medical, surgical and midwifery.
Ph: (03) 5761 4222 Email: info@benallahealth.org.au
www.benallahealth.org.au

Central Australian Aboriginal Congress was established in 1973 and has grown over 45+ years to be one of the largest and oldest Aboriginal community controlled health services in the Northern Territory.

The **Central Australian Rural Practitioners Association (CARPA)** supports primary health care in remote Indigenous Australia. We develop resources and support education and professional development. We also contribute to the governance of the remote primary health care manuals suite.
www.carpa.com.au

CQ Health provides public health services across Central Queensland, in hospitals and in the community. CQ Health is a statutory body governed by our Board. We serve a growing population of approximately 250,000 people and employ more than 3,700 staff, treating more than 700,000 patients each year.
Email: recruitment.rockhampton@health.qld.gov.au
www.health.qld.gov.au/cq

The **College of Emergency Nursing Australasia (CENA)** is the peak professional association representing emergency nurses across Australia and internationally. There are large numbers of nurses working in emergency and many more in circumstances which see them providing emergency care to patients outside of emergency departments. This includes nurses working in small regional and rural hospitals, health care centres and flight nurses. Ph: (03) 9586 6090
Email: national@cena.org.au www.cena.org.au

The **Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)** is the peak representative body for Aboriginal and Torres Strait Islander nurses and midwives in Australia. CATSINaM's primary function is to implement strategies to embed Cultural Safety in health care and education as well as the recruitment and retention of Aboriginal and Torres Strait Islander People into nursing and midwifery.

Cornerstone are the medical matchmakers™. We are remote and rural nursing and midwifery recruitment specialists, with agency, contract and permanent roles in public and private sectors across Australia.

The **Derby Aboriginal Health Service** is committed to core principles including Aboriginal self-determination, access, equity, empowerment, and reconciliation. Allied health programs include women's and child health, sexual health, social and emotional wellbeing, health education, diabetes, antenatal, renal and youth advocacy and support.

Downs Nursing Agency (DNA) was established in 2000 and is 100% Australian-owned and operated. Our agency understands both the lifestyle needs of nurses and the health care provider requirements. We are a preferred supplier for governmental and private health care facilities in Queensland. Contact us on (07) 4617 8888 or register at www.downsnursing.com.au

E4 Recruitment has launched a new division that is dedicated to securing Registered Nurses and Midwives contract opportunities in regional and remote Australia. Helping to ensure that every Australian has access to health care and services that they deserve. e4recruitment.com.au

Passionate about providing top nurses and health care workers to rural and remote areas of Australia, the **Evolve Healthcare** team have devoted their careers to the recruitment of highly skilled professionals within rural government hospitals, Indigenous health care, chronic disease, non-for-profit organisations, aged care, and mental health practices. Evolve Healthcare has dedicated offices and consultants within every major Australian state and offers local health care recruitment services throughout Australia. Ph: (02) 9189 3089 evolvetalent.com.au/healthcare/upload-cv/

Flight Nurses Australia is the professional body representing the speciality for nursing in the aviation and transport environment, with the aim to promote flight nursing, and provide a professional identity and national recognition for flight nurses. Email: admin@flightnursesaustralia.com.au flightnursesaustralia.com.au

Flinders NT is comprised of The Northern Territory Medical Program (NTMP), The Centre for Remote Health, The Poche Centre for Indigenous Health, Remote and Rural Interprofessional Placement Learning NT, and Flinders NT Regional Training Hub. Sites and programs span across the NT from the Top End to Central Australia. Ph: 1300 354 633 flinders.edu.au

Healthy Male is a national organisation that helps men and boys lead healthier lives by providing evidence-based, easy-to-understand information on men's health topics. They aim to make information available to everybody, regardless of gender, age, education, sexual orientation, religion, or ethnicity. Ph: 1300 303 878 www.healthymale.org.au

Health Workforce Queensland is a not-for-profit Rural Workforce Agency focused on making sure remote, rural and Aboriginal and Torres Strait Islander communities have access to highly skilled health professionals when and where they need them, now and into the future.

Heart Support Australia is the national not-for-profit heart patient support organisation. Through peer support, information and encouragement we help Australians affected by heart conditions achieve excellent health outcomes.

Henderson Healthcare is more than just an Agency and team of expert Healthcare Recruiters. We are a supportive, energetic, and hardworking group of passionate professionals who seek to empower and encourage our staff to make the perfect match and find the best role that fits your needs.
Email: enquiries@hendersonhealthcare.com.au
www.hendersonhealthcare.com.au

HESTA is the industry super fund dedicated to health and community services. Since 1987, HESTA has grown to become the largest super fund dedicated to this industry. Learn more at hesta.com.au

IMPACT Community Health Service provides health services for residents in Queensland's beautiful Discovery Coast region. IMPACT delivers primary and allied health care services, including clinical services, lifestyle and wellbeing support and access to key health programs.

Inception Strategies is a leading Indigenous Health communication, social marketing and media provider with more than 10 years of experience working in remote communities around Australia. They provide services in Aboriginal resource development, film and television, health promotion, social media content, strategic advisory, graphic design, printed books, illustration and Aboriginal Participation policy.

The **Indian Ocean Territories Health Service** manages the provision of health services on both the Cocos (Keeling) Islands and Christmas Island.
shire.cc/en/your-community/medical-information.html

James Cook University – Central Queensland Centre for Rural and Remote Health (Emerald). Here at JCU CQCRRH our aim is to attract, build, and retain a high-quality health workforce across Central Queensland. This in turn will lead to the delivery of better health, aged care, and disability services in regional, rural, and remote communities across Central Queensland. Ph: (07) 4986 7450 www.cqcrrh.jcu.edu.au

James Cook University – Murtupuni Centre for Rural & Remote Health is part of a national network of 11 University Departments of Rural Health funded by the DoHA. Situated in outback Queensland, MICRRH spans a drivable round trip of about 3,400km (nine days). Its vision of 'A Healthy, Vibrant Outback Queensland' shapes its values, partnerships and commitment to building a workforce in and for the region.

KAMS (Kimberley Aboriginal Health Service) is a regional Aboriginal Community Controlled Health Service (ACCHS), providing a collective voice for a network of member ACCHS from towns and remote communities across the Kimberley region of Western Australia.

Katherine West Health Board provides a holistic clinical, preventative and public health service to clients in the Katherine West region of the Northern Territory.

The Lowitja Institute is Australia's national institute for Aboriginal and Torres Strait Islander health research. We are an Aboriginal and Torres Strait Islander organisation working for the health and wellbeing of Australia's First Peoples through high-impact quality research, knowledge translation, and by supporting a new generation of Aboriginal and Torres Strait Islander health researchers.

Majarlin Kimberley Centre for Remote Health contributes to the development of a culturally-responsive, remote health workforce through inspiration, education, innovation and research. Email: marjalin@nd.edu.au

Mala'la Health Service Aboriginal Corporation services Maningrida, a remote Indigenous community in Arnhem Land, Northern Territory, and surrounding homelands. It provides different services aimed at eliminating poverty, sickness, destitution, helplessness, distress, suffering and misfortune among residents of the Maningrida community and surrounding outstations. Ph: 08 8979 5772 Email: admin@malala.com.au malala.com.au

Marthakal Homelands Health Service (MHHS), based on Elcho Island in Galiwinku, was established in 2001 after traditional owners lobbied the government. MHHS is a mobile service that covers 15,000km^2 in remote East Arnhem Land. Ph: (08) 8970 5571 www.marthakal.org.au/homelands-health-service

Medacs Healthcare is a leading global health care staffing and services company providing locum, temporary and permanent health care recruitment, workforce management solutions, managed health care and home care to the public and private sectors. Ph: 1800 059 790 Email: info@medacs.com.au apac.medacs.com

Miwatj Health Aboriginal Corporation is an ACCHO designed to facilitate Aboriginal and Torres Strait Islander (Yolŋu) people in communities across East Arnhem Land taking control over their health. In addition to our Miwatj clinical services, acute care, chronic disease management and longer-term preventive care, our ACCHO focuses on education and primary prevention programs. Today, a significant proportion of our Miwatj workforce are Yolŋu. However, we also depend on health professionals from elsewhere who work together with Yolŋu staff. www.miwatj.com.au

The **National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners Ltd (NAATSIHWP)** is the peak body for Aboriginal and/or Torres Strait Islander Health Workers and Aboriginal and/or Torres Strait Islander Health Practitioners in Australia. It was established in 2009, following the Australian Government's announcement of funding to strengthen the Aboriginal and Torres Strait Islander health workforce as part of its 'Closing the Gap' initiative. www.naatsihwp.org.au

Farmer Health is the website for the **National Centre for Farmer Health** (NCFH). The Centre provides national leadership to improve the health, wellbeing and safety of farm men and women, farm workers, their families and communities across Australia. www.farmerhealth.org.au/page/about-us

The **National Rural Health Student Network (NRHSN)** represents the future of rural health in Australia. It has more than 9,000 members who belong to 28 university rural health clubs from all states and territories. It is Australia's only multidisciplinary student health network. www.nrhsn.org.au

Ngaanyatjarra Health Service (NHS), formed in 1985, is a community-controlled health service that provides professional and culturally appropriate health care to the Ngaanyatjarra people in Western Australia.

Nganampa Health Council (NHC) is an Aboriginal community-controlled health organisation operating on the Anangu Pitjantjatjara Yankunytjatjara (APY) lands in the far north-west of South Australia. Ph: (08) 8952 5300 www.nganampahealth.com.au

NT Dept Health – Top End Health Service Primary Health Care Remote Health Branch offers a career pathway in a variety of positions as part of a multidisciplinary primary health care team.

The Norfolk Island Health and Residential Aged Care Service (NIHRACS) is the first-line health service provider for the residents and visitors of Norfolk Island. Norfolk Island has a community of approximately 1,400 people on Island at any one time and is located about 1,600km north-east of Sydney.
Ph: +67 232 2091 Email: kathleen.boman@hospital.gov.nf
www.norfolkislandhealth.gov.nf

NT PHN incorporating **Rural Workforce Agency NT** is a not-for-profit organisation funded by the Department of Health. We deliver workforce programs and support to non-government health professionals and services. Working in the NT is a rewarding and unique experience! www.ntphn.org.au

Nurses' Memorial Foundation of South Australia Limited. Originally the Royal British Nurses Association (SA Branch from 1901) promotes nurse practice, education and wellbeing of nurses in adversity. It provides awards in recognition of scholastic achievements, grants for nursing research, scholarships for advancing nursing practice and education, and financial assistance in times of illness and adversity.
nursesmemorialfoundationofsouthaustralia.com

Omega Medical helps employers source medical and healthcare talent when they need to fill temporary, locum or permanent positions. They specialise in Aged Care, Hospitals & Allied Health. Omega Medical has a vast clientele in need of Aged Care workers such as: hospices, retirement homes, in-home care, respite care centres, nursing homes.
Email: avi@omegamedical.com.au www.omegamedical.com.au

Omeo District Health is a publicly funded, small rural health service in East Gippsland's high country. It has provided a range of health services to the Omeo community and surrounds for over 100 years. Currently it delivers primary, hospital, residential and home based support services, GP outreach services, dental and some paediatric outpatient services.
Email: reception@omeohs.com.au www.odh.net.au

Palliative Care Nurses Australia is a member organisation giving Australian nurses a voice in the national palliative care conversation. We are committed to championing the delivery of high-quality, evidence-based palliative care by building capacity within the nursing workforce and, we believe strongly that all nurses have a critical role in improving palliative care outcomes and end-of-life experiences for all Australians.

Faced with the prospect of their family members being forced to move away from country to seek treatment for End Stage Renal Failure, Pintupi people formed the Western Desert Dialysis Appeal. In 2003 we were incorporated as **Purple House (WDNWPT)**. Our title means 'making all our families well'.

Puntukurnu Aboriginal Medical Service presently provides services to Jigalong, Punmu, Kunawarritji and Parnngurr with a client base of 830 and growing. PAMS' Clinics are located at Jigalong (Hub), Punmu, Parnngurr and Kunawarritji. PAMS has over 830 registered clients with the majority living in Jigalong.
Ph: (08) 9177 8307 Email: pams.pm@puntukurnu.com
www.puntukurnu.com

The **Remote Area Health Corps (RAHC)** is a new and innovative approach to supporting workforce needs in remote health services, and provides the opportunity for health professionals to make a contribution to closing the gap.

The **Red Lily Health Board Aboriginal Corporation (RLHB)** was formed in 2011 to empower Aboriginal people of the West Arnhem region to address the health issues they face through providing leadership and governance in the development of quality, effective primary health care services, with a long-term vision of establishing a regional Aboriginal Community Controlled Health Service.

The **Royal Flying Doctor Service** is one of the largest and most comprehensive aeromedical organisations in the world, providing extensive primary health care and 24-hour emergency service to people over an area of 7.69 million square kilometres. www.flyingdoctor.org.au

Do you work in a rural or remote health care facility? Is it difficult to go on leave due to a team member shortage? You may be eligible for Australian Government-funded support to help alleviate the pressure of finding a temporary replacement. Our program officers will recruit, screen and place highly experienced locums. Are you interested in becoming a locum? For every rural and remote placement, you receive complimentary travel and accommodation, and incentive and meals allowances. Ph: (02) 6203 9580 Email: enquiries@rurallap.com.au www.rurallap.com.au

Rural Health West is a not-for-profit organisation that focuses on ensuring the rural communities of Western Australia have access to high-quality primary health care services working collaboratively with many agencies across Western Australia and nationally to support rural health professionals. Ph: (08) 6389 4500 Email: info@ruralhealthwest.com.au www.ruralhealthwest.com.au

SHINE SA is a leading not-for-profit provider of primary care services and education for sexual and relationship wellbeing. Our purpose is to provide a comprehensive approach to sexual, reproductive and relationship health and wellbeing by providing quality education, clinical, counselling and information services to the community.

Silver Chain is a provider of primary health and emergency services to many remote communities across Western Australia. With well over 100 years' experience delivering care in the community, Silver Chain's purpose is to *build community capacity to optimise health and wellbeing.*

Skilled Medical's Nursing and Midwifery Division, led by a team of dedicated nurses, specialises in recruitment and placement services tailored for rural and remote areas. Our nurse-led approach guarantees that our placements align with the unique requirements of both healthcare providers and the communities they serve. Ph: 1300 444 100 Email: enquiries@nursingjobsaustralia.com.au www.skillednursing.com.au

The **Spinifex Health Service** is an expanding Aboriginal Community-Controlled Health Service located in the Tjuntjuntjara Community on the Spinifex Lands, 680km north-east of Kalgoorlie in the Great Victoria Desert region of Western Australia.

SustainHealth Recruitment is an award-winning, Australian-owned and operated, specialist recruitment consultancy that connects the best health and wellbeing talent, with communities across Australia. It supports rural, regional and remote locations alongside metropolitan and CBD sites. Ph: (02) 8274 4677 Email: info@sustainhr.com.au www.sustainhr.com.au

Talent Quarter works with a shared and singular purpose – connecting the best health care talent with the best opportunities to have a positive impact on people's lives! By empowering people to deliver that difference, we aim to be your agency of choice in health care recruitment. NSW, VIC, TAS & QLD Ph: (02) 9549 5700 WA, SA & NT Ph: (08) 9381 4343 Email: hello@talentquarter.com talentquarter.com

Tasmanian Health Service (DHHS) manages and delivers integrated services that maintain and improve the health and wellbeing of Tasmanians and the Tasmanian community as a whole.

The Torres and Cape Hospital and Health Service provides health care to a population of approximately 24,000 people and 66% of our clients identify as Aboriginal and/or Torres Strait Islander. We have 31 primary health care centres, two hospitals and two multi-purpose facilities including outreach services. We always strive for excellence in health care delivery.

WA Country Health Service – Kimberley Population Health Unit – working together for a healthier country WA.

Your Fertility is a national public education program funded by the Australian Government Department of Health and the Victorian Government Department of Health and Human Services. We provide evidence-based information on fertility and preconception health for the general public and health professionals.
Ph: (03) 8601 5250 www.yourfertility.org.au

Your Nursing Agency (YNA) is a leading Australian owned and managed nursing agency providing high-quality health and aged care workers and support since 2009. YNA provides highly skilled registered nurses, enrolled nurses, specialist nurses, midwives, care workers and support to private clients, community and in-home programs, government agencies and hospitals. Email: recruitment.regional@yna.com.au
Head to www.yna.com.au for more information.

Photo: Hypervision – stock.adobe.com

Support

CRANAplus Wellbeing Lounge

At this year's 40th CRANAplus Conference, the CRANAplus Mental Health & Wellbeing Team hosted another successful Wellbeing Lounge.

With over 90 visitors to the Wellbeing Lounge each day, delegates visited for a range of reasons, including to:

- connect with new and old colleagues
- experience a 5-minute head and neck massage
- recharge themselves, phones and devices
- sample mindfulness activities
- learn more about CRANAplus' Wellbeing workshops, resources and the Bush Support Line
- share wellbeing strategies, and
- meet members from CRANAplus' Mental Health & Wellbeing team.

Feedback from visitors indicated that the Lounge was highly valued and provided a safe space to relax and rejuvenate. Overall, visitors to the Lounge rated the usefulness of the space 4.6 out of 5 (with 1 = not at all useful and 5 = extremely useful).

Feedback along the lines of the comments below was common:

"It's a great space to relax, recharge and reset after sitting and listening all day."

"Keep everything, I love it!"

The Three Minutes Angels masseuses were very popular, as was the Mindfulness Wall.

The wall activities provided a great opportunity to reflect on participants' own wellbeing, connect with what keeps them grounded and share with others the tools they use to keep themselves well.

Many delegates appreciated the opportunity to meet the team and explore strategies for wellbeing. If you would like our team to deliver a wellbeing session in your workplace, don't hesitate to contact us at wellbeing@crana.org.au.

We look forward to seeing you in the Wellbeing Lounge at the next CRANAplus Conference!

Mindfulness to go

In the busyness, and with the competing demands in our lives, it is essential to prioritise our physical health and wellbeing. We are constantly bombarded with suggestions for what is required. "Drink 2 litres of water, exercise 30 minutes a day, sleep 8 hours, meditate 20 minutes, eat 5 veggies and 2 fruits, stretch often to prevent muscle tension, be patient with your partner and children... Oh, and be mindful."

These messages come to us from a variety of sources such as media, well-meaning friends and family and social media posts. They can leave us feeling deficient because we are simply not doing enough!

OK. Take three deep breaths and imagine your shoulders relaxing with each outward breath.

Now, just as there are breakfasts to go and takeaway meals that are aimed at the busy and time-poor, there are mindfulness practices that we can incorporate into the normal course of our day. In fact, the emphasis of mindfulness is on being, not doing. The beauty of mindfulness to go is that it won't take up extra time or become something that you must place on your to-do list or become an expert at.

Remember these tips are meant to be easily incorporated into your day and they will make a significant difference to how you feel physically and mentally with the minimum of effort.

Sound good?

Great! Let's step through some examples of how simply shifting your focus makes your experiences richer and meaningful. Our nervous systems love this stuff.

As you awaken and before getting out of bed, bring to your mind a couple of things that you are grateful for. Savour them and luxuriate in the wonderful feelings they evoke.

While the kettle is boiling for that important cup of tea or coffee, watch yourself place the tea bag into the cup or the coffee into the plunger or machine. Take in the glorious smells – stay in that moment for just a few extra seconds. Watch yourself pour in the hot water – what can you see/hear/smell? Notice if your mind wanders off and bring yourself back to the present moment.

Note: Your mind will typically want to hijack you at this point! It's there saying "great, about time you woke up – now let's think about everything we need to achieve today". Take no notice of it. We may not be able to switch it off completely but what we can do is not buy into the thoughts.

Heading out the door for a walk or run? Notice the sky – the colour, the clouds or the early morning light. If you are lucky enough to be at the beach, notice the sand and how it feels beneath your toes, the tiny patterns that have formed overnight and other footsteps perhaps. Feel the coolness or the lack of breeze, feel the quality of the air on your skin. Hear the sounds – take a moment to listen for any faraway sounds. Perhaps there is some traffic noise or birds off in the distance or the sounds of quiet rustlings in the undergrowth. Look into the water and imagine the myriad of sea life that you cannot see but you know is there. Notice the patterns of the waves or the tide gently lapping the shore.

Be completely in this experience for just a couple of minutes – enough so that you could later recount the experience to a colleague or friend.

Simply taking your coffee into the garden or finding a sunny spot inside is great if you are not able to get out for a walk. Putting yourself in the environment where you can experience some of the elements is like a power boost for your day. If that is in your own backyard, that is okay.

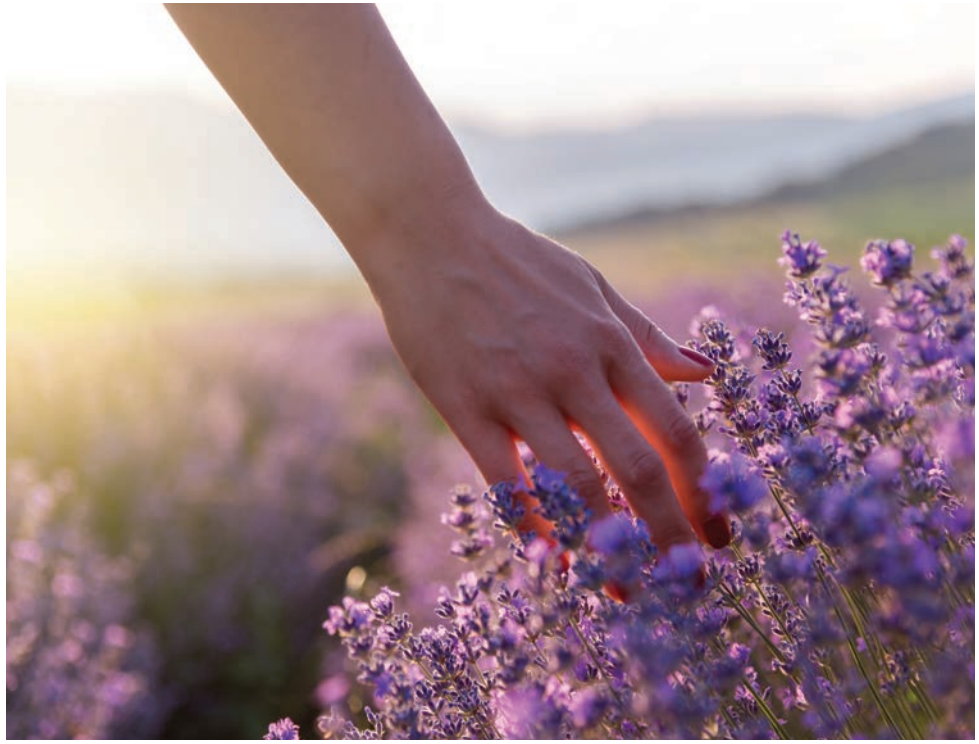


Photo: Grigor – stock.adobe.com

Maybe you need to get some children to school. Take the time to be fully present with them, have a little joke or be silly for a minute – revel in that hug or kiss goodbye.

Taking some time to do YOUR life before you go into work is extra beneficial. Our jobs and professions are very important but we simply cannot do our best work if we do not feel at our best.

See the workplace as another opportunity to practise some 'mindfulness to go' by being fully present when engaging in tasks, meetings and conversations.

Some of the ways to do this are:

- Avoid multi-tasking – focus on one thing at a time if possible.
- Practise active listening by paying full attention to your colleague or patient. Really connect with them.
- Pay attention to your surroundings and any tension in your body.
- Consciously choose to take perspective and look at the bigger picture rather than sweat the smaller stuff if you find yourself being frustrated.
- Create opportunities to lighten the mood if appropriate.

These suggestions will have the added benefit of improving your focus and productivity as well as enhancing your wellbeing and emotional intelligence.

We can all afford some 'mindfulness to go'. It actually doesn't cost us anything – just a shift in our focus that further enhances our everyday experiences.

Yours in the present moment,

Therese Forbes, Senior Psychologist
Bush Support Line, CRANAplus

Photo: Adam – stock.adobe.com

Educate

2024 Education Schedule

Below we have published our course schedule for January–June 2024 following its release this October.

Please visit the CRANAplus website for up-to-date information on available courses. Courses for the second half of 2024 will be released early next year and as usual, CRANAplus Members will have early access to bookings.

Clustered courses

Many of our Remote Area Emergency courses are delivered in conjunction with Advanced Life Support or Triage Emergency Care courses in the same location, allowing participants who want to undertake several courses to save on travel and take just one block of leave.

Remote Emergency Care

Northern Territory

Darwin	24–25 February	BOOKED OUT
Alice Springs	13–14 March	BOOKED OUT
Darwin	13–14 April	BOOKED OUT
Katherine	25–26 May	

Queensland

Cairns	4–5 May
Longreach	1–2 June

Western Australia

Perth	6–7 February	BOOKED OUT
Katanning	9–10 March	
Geraldton	4–5 May	

South Australia

Adelaide	3–4 February	BOOKED OUT

Victoria

Shepparton	23–24 March	BOOKED OUT

Tasmania

Hobart	2–3 March	BOOKED OUT

Advanced Remote Emergency Care & Advanced Life Support

Northern Territory

Alice Springs	6–8 April

Queensland

Cairns	1–3 May

Western Australia

Perth	3–5 February

South Australia

Adelaide	1–3 June

Advanced Life Support

Northern Territory

Alice Springs	15 March

Queensland

Cairns	6 May
Longreach	3 June

Western Australia

Perth	8 February

South Australia

Adelaide	5 February

Victoria

Shepparton	25 March

Triage Emergency Care

Northern Territory

Darwin	12 April

Western Australia

Katanning	11 March

Tasmania

Hobart	4 March

Traige Emergency Care Intensive Online

Online

13 February	BOOKED OUT
16 April	
18 June	

Mental Health Emergencies Online

Online

7 February–20 March

Maternity Emergency Care

Northern Territory

Darwin	23–24 March	BOOKED OUT
Alice Springs	30 April–1 May	

Queensland

Longreach	3–4 February
Cairns	28–29 May
Roma	22–23 June

Western Australia

Katanning	17–18 February
Perth	9–10 March
Geraldton	18–19 May

South Australia

Adelaide	9–10 April
Adelaide	15–16 June

Paediatric Emergency Care & Paediatric Advanced Life Support

Queensland

Cairns	22–23 June

Western Australia

Perth	15–16 May

South Australia

Adelaide	27–28 February

Midwifery Upskilling

South Australia

Adelaide	1–3 March

Tasmania

Hobart	24–26 May

Scan the QR code (left) or visit crana.org.au/courses to browse or book into courses.

Engage

At the ruby-themed gala dinner.

40th Conference Recap

This October, more than 200 delegates and stakeholders gathered in Gimuy/Cairns at the CRANAplus 40th Anniversary Conference, for three days of networking, reminiscing, and envisioning a better future for the remote health workforce and the communities it serves.

With the theme, 'Building on strength for a sustainable, skilled, and safe workforce', our 40th Anniversary Conference provided an opportunity for remote health professionals from across the country to come together in celebration of their achievements and to explore opportunities to improve remote health.

While the mezzanine buzzed with thought-provoking conversations at over 30 exhibitor stalls, the CRANAplus Wellbeing Lounge, back again for another year, provided a supportive retreat to relax and recharge (see page 62).

CRANAplus also held its inaugural Message Stick Gathering, where delegates came together to discuss the National Rural and Remote Nursing Generalist Framework 2023–2027, in particular, domain one – 'Culturally Safe Practice'. A collective message of Cultural Safety, crafted by the group, was then taken forward and passed on to the wider conference.

Left: Message Stick Gathering participants. Above, from top: Sabina Knight recollects the history of CRANAplus; Welcome to Country by Gimuy Walubara Yidinji Elder Henrietta Marrie.

As delegates viewed the history photo wall, memories flooded back and the pictures on display turned into tales of past events. New and old friends alike shared experiences, knowledge and expertise. Delegates smiled over the wins, both big and small, and pondered the solutions in a series of robust discussions.

Delegates were introduced to newly appointed CRANAplus CEO Linda Kensington, who launched the two-day program. Commonwealth Chief Nursing and Midwifery Officer Alison McMillan PSM followed on with a hopeful opening address, stating that "With crisis often comes opportunity. We know the challenges of providing equitable, sustainable healthcare, but what we are seeing now is a willingness to challenge the boundaries traditionally affecting nursing and midwifery."

Above, from top: Dr J'Belle Foster PhD; MC Dallas McKeown takes to the stage with Linda Kensington, CRANAplus CEO; Alison Weatherstone; Dr Eddy Strivens; Adjunct Professor Shelley Nowlan; Adjunct Professor (Practice) Alison McMillan PSM; Lesley Salem; Michelle Taylor; Michelle Appo reflecting on the future in the final presentation at the event.

Above, from top: The RFDS exhibit; The AMSANT exhibit; Ann Aitken, Belinda Gibb, Fiona Wake, Naomi Zaro and Nick Williams; Bruce McKay, Paul Stephenson, Fiona Wake, Janie Smith, Sabina Knight and Isabelle Skinner; Delegates at the gala dinner.

We heard from Professor Eddy Stivens and Diane Cadet-James on research findings and success stories from the Healthy Ageing Research Team and their collaborative approaches with communities in Far North Queensland. Other moments included the impassioned presentation from Wonnarua woman and NP Lesley Salem on the continued challenges and underutilised capabilities of nurse practitioners in rural and remote locations; Dr J'Belle Foster PhD on translational research and her work to improve tuberculosis outcomes in the Torres Strait; Alison Weatherstone, Chief Midwife at the Australian of Colleague of Midwives on the organisation's optimistic vision for the future; and Michelle Taylor, psychologist and leadership coach on new ways to approaching self-care. Workforce sustainability and retention emerged as key themes at this year's event, as did scope of practice, cultural safety and co-design.

The conference was closed out in style with a touch of ruby sparkle at the gala dinner to commemorate and celebrate the significant 40-year milestone.

We would like to take this opportunity to thank our major sponsors Flinders University and JCU Central Queensland Centre for Rural and Remote Health for their valued contribution to this event.

To our many exhibitors and delegates, we are grateful for your continued support and commitment to improving remote health.

We look forward to seeing you at future events!

To view the full gallery of images, scan the QR code (left) or visit crana.org.au/2023conferencegallery

The call to advocacy

This year's recipient of the Aurora Award for the Remote and Isolated Health Professional of the Year, Katie Pennington, reflects on the power of nurses' voices, the community health model of care, and her work from East Timor to East Tasmania.

"I have to speak up when I see a situation I'm not willing to accept," says remote area nurse Katie Pennington. "Changing systems can be slow, but it doesn't mean we shouldn't give it a try, shouldn't make a start."

"'I believe we have a duty to negotiate and advocate on behalf of our clients. We might be the only people they have who are health workers and who have a broader knowledge of the health system.

"We have the knowledge to explain the inequities to the decision-makers."

In receiving the Aurora Award, Katie was acknowledged for her 'quiet dedication to and advocacy for the health of remote communities', and for her philosophy and nursing practice revolving around evidence-based care.

"Through my practice in remote communities over the years, I have found significant barriers, systemic barriers in the main, that prevent us giving that care," says Katie.

"For example, the ability to facilitate pregnant women attending appointments with a family member. A simple but important task. Identified and well-acknowledged. If that service is not supported in real life by healthcare systems, then we know we are not providing the best care."

Katie says that research is one part of her nursing career where she has been able to look at influencing a change in systems that aren't working well.

"The research I undertook as part of my Masters involved a small project examining legislation, [and it] has seen some changes in legislation in WA," she says.

"The project findings are now being considered in terms of current broader national projects such as RN-designated prescribing, scope of practice review and national nursing strategy. I am hopeful that the research will contribute to positive change for nurses and communities in remote Australia.

"This shows that one small question, one everyday nurse doing one small thing, can indeed have a ripple effect."

Katie, originally from Adelaide, lives with her family on a rural bush property on the east coast of Tasmania, in the Chain of Lagoons area – which, she says, is as picturesque as it sounds.

Until moving there in 2018, the family spent several years in remote communities in the Pilbara and central desert regions of Western Australia.

"The children were coming of school age and they had spent most of their lives away from family," says Katie.

"We wanted them to develop their identity with a sense of place, so we came back to Tasmania, where my husband comes from, and we are now embedded in this local community."

Opposite page: Katie being presented the award by Board Chair Fiona Wake. Above: Katie travelling with her family in the Great Victoria Desert when her children were younger (her husband is currently Acting General Manager for a remote Native Title Body Corporate and Indigenous Ranger program).

Katie works at the Bicheno Medical Centre, where she's currently involved in helping transition the practice to a community health model of care, similar to the model used by Aboriginal Community Controlled Health Organisations (ACCHO).

"Community health models of care are cost-effective models for vulnerable populations," says Katie, "with the flow-on effect of reducing the cost on the acute care system down the track.

"In Tasmania, we have several vulnerable communities. Apart from being in a remote area with extremely limited health services, we have, here where I work, a hyper-ageing population, lots of people over the age of 75. In addition, across the demographic, we have quite a lot of clients with complex comorbidities – overlapping on occasion with mental health or alcohol and other drug concerns."

Katie says it is exciting to be a part of the project, funded through the Primary Care Rural Innovative Multidisciplinary Models (PRIMM) program.

"The funding is exactly what's needed to help us better understand the needs of this region and, working with the community, to co-design health services that are more fit for purpose than what is currently available."

The inequitable level of health care available in remote Australia was first brought home to Katie while she was serving as a medic with the Australian Army from 1998–2002.

"I did a bit of work in a remote community in Australia on a development project and, shortly after that, I was deployed to East Timor," she explains.

"What was a real eye-opener were the similarities I saw between the health care available in remote areas of Australia and those in East Timor, in the early days after conflict."

When Katie left the army, she started a law degree but soon realised she missed working in healthcare and swapped her studies to start training as a nurse in Tasmania. An opportunity to attend a CRANAplus Conference in Darwin set the course of her career, she says.

"I knew I wanted to work in remote Australia. I also knew I didn't want to go remote without the right knowledge and skills and was determined to get into the Graduate Diploma in Remote Health Practice at Flinders University, considered one of the best courses of its kind.

"I think my time in the Army and in East Timor helped me get a place even though I was new to nursing."

Katie later undertook a Graduate Certificate in Child and Family Health Nursing to fill in her knowledge gap at the time in child health nursing, a critical component of health practice in remote communities.

A CRANAplus Member since 2006, Katie has represented her home state of Tasmania as a member of the CRANAplus Member Nursing and Midwifery Roundtable; advocated for rural health care at the Tasmanian Parliament Legislative Council Inquiry into Rural Health Services in Tasmania in 2020 as a CRANAplus representative; and sits on the Australian Commission on Safety and Quality in Health Care, Primary Care Committee, as a nominee of CRANAplus.

The Aurora Award will mean Katie has quite a full mantelpiece, having earlier taken out the CRANAplus Primary Health Care Champion Award winner in 2011 and the CRANAplus Excellence in Research in Remote Health Award in 2019.

"'I would like to urge all remote nurses to take the time to realise the power of their voice, and what that voice can mean for creating positive change for individuals and communities that they work with," Katie says in closing.

This page, from top left: Driving from WA into SA on Anne Beadell Highway; Working on APY Lands as part of SA Health COVID-19 Rapid Response Team; Opposite page: Two types of protein to go, maku vs egg, on a women's bush camp.

"Politicians, legislators and bureaucrats may think they are meeting the needs of people in remote communities, but they are so far removed from [that] reality, that they don't know the extent of the needs of people in these remote locations, the complexity of the situations or the frontline impact of our fragmented systems of care. As remote area health workers we can use our unique expertise and voice to break it down for them, to help make sure that the systems we work in are fit-for-purpose."

At home in the Wheatbelt

Laura Black, Nurse Practitioner from the tiny town of Moorine Rock in the West Australian Wheatbelt, is the 2023 recipient of the CRANAplus Excellence in Remote and Isolated Health Practice award.

Laura has been working as a Nurse Practitioner for more than a decade. She was the first primary health Nurse Practitioner in WA at a time when NPs were more often employed in hospitals, particularly in Emergency Departments.

She currently has three jobs. One day a week, she works in Westonia 45 minutes from home, where she runs a clinic that is visited by a GP every six weeks. In this role she also undertakes home visits and provides telephone support to the community on the days she is not in town. She also works as a Registered Nurse at the Southern Cross Hospital, a 20-minute drive in the other direction. The third project she is involved in is research into the use of Artificial Intelligence to enable non-skilled people to undertake echocardiograms.

When she isn't nursing, Laura and her partner run a wildlife sanctuary called Parnanapikurtu which loosely translates as 'kangaroo place' where they rescue and care for birds, reptiles, and kangaroos.

Laura has long advocated to local, state and federal government for increased funding to support healthcare delivery, particularly for Nurse Practitioner services in rural and remote areas she serves in WA.

She is a strong believer in the value of collaboration with GPs and has in the past worked more extensively with GPs in funded positions. She has not pursued self-employment because she values these collaborations and understands the community's need for affordable healthcare.

"With the long waiting lists to see a GP, it is crucial that partnerships between GPs and NPs are encouraged in rural and remote settings. It would certainly improve access to speedy healthcare delivery," she says.

"NPs have done a Masters Degree, we have the education, the skills and the training, but so many of us are working as Registered Nurses."

More Nurse Practitioners are working in communities in the primary health area than before, Laura says. She hopes this trend will continue and that NP services will be prioritised in areas with limited healthcare access and public transport, and long GP waitlists – including within the Wheatbelt.

Laura is grateful to receive the Excellence in Remote and Isolated Health Practice Award, which is her second this year after receiving the People's Choice Award at the 2023 Rural Health West and WA Country Health Service Excellence Awards. However, with her skills and qualifications, she knows she could do more to help the community.

"If winning this award helps to promote the value of the Nurse Practitioner role, I'll be very happy," she says.

The 2023 Excellence in Remote and Isolated Health Practice Award was sponsored by James Cook University/ Murtupuni Centre for Rural & Remote Health.

New starter Micah makes a difference in West Arnhem

The recipient of the 2023 Early to Remote Practice Award, Micah Haslam RN, describes receiving the award as a surprise and honour. Here, she talks about her newfound love of Gunbalanya.

A 'going remote' flyer caught Micah's eye back in 2022 when she was working at the Darwin Hospital, after she and a friend had road-tripped up from Melbourne for a change of scenery.

"The plan was to stay [in the NT] a year, and now I've been here for three years," she says.

"I must admit I didn't really know what was involved with [going remote]. I saw part of the program was a four-wheel drive course, and I thought 'That sounds awesome'.

"So I applied and now here we are," Micah laughs.

Upon delving further, Micah decided to undertake a supported transition to remote and on-call via a Northern Territory PHN program which included the following courses: CRANAplus' Remote Emergency Care (REC) and Maternity Emergency Care (MEC), Flinders University/ Centre for Remote Health's Transition to Remote Area Nursing, and pharmacotherapeutics.

"Before I started doing remote, in the early days, I was really nervous to do on-call, where you're just talking to the doctor on the phone, and you don't have all of the support team around you," says Micah.

"But the REC course gave me a lot of confidence. "Later down the track I did the MEC, which I found to be one of the best courses ever, I loved it. I think a lot of people coming out of it [feel inspired] to do their midwifery."

If you pass over the East Alligator River at Cahills Crossing, and head down the dirt road for about 20 minutes, you'll find yourself in Gunbalanya, a large remote town in West Arnhem.

With the right preparation under her belt, Micah undertook her first remote health placement here in September 2022 and hasn't looked back.

"It's stunning," Micah says. "They call it Stone Country here because it's escarpments all around you. It's surrounded by flood plains, and there's a big billabong in town where you can see all the crocodiles. It's just beautiful."

She was nominated for this award by her manager who oversaw her placement when she first arrived in Gunbalanya.

"She was with me when I first started doing remote and was a great support. She saw me evolve from the start of my remote nursing career to where I am now," says Micah.

The award recognised Micah's significant contributions to the health and wellbeing of the community where she has strengthened partnerships with community services, particularly teachers, and built relationships with community Mums and her health professional colleagues.

The role has seen her providing education to families and immunising the 0–5 cohort, organising the school screening program and coordinating doctors, teachers, nurses, and administrative staff.

Micah initially felt nervous to work with children but found encouragement in the potential to improve child health through strong relationships and regular engagement, and has recently decided to take on the chronic child health portfolio to ensure that vulnerable children are supported, and connected with the necessary allied health and NDIS services.

She also plans to undertake a Well Women's course to further expand her scope and knowledge of women's screening, contraception and reproductive health. She has finished her placement but remains in Gunbalanya in a permanent position.

"I was a bit suss because everyone was trying to get me to go to Cairns, and I knew there was a CRANA conference on," says Micah, who was interstate at the time of the awards ceremony.

"I got the award down at the Billabong. It was really nice, one of the local ladies presented it to me, so it was really lovely."

"Every day is something different. I'm working with a great team, in a beautiful community and I feel very welcome here," she says. "I love it here and I'm not ready to leave!"

For Micah, some of the best parts of her new career include variability; an expanded scope of practice; the beauty of the landscape; and the honour of living and working alongside and providing care to First Nations people.

"Anyone who is thinking about remote, I highly recommend it," she says.

"It's just an amazing job doing things that you really never thought you would do, and you see some amazing stuff.

"Thank you to CRANAplus and Flinders University for the award, it's an honour and I really appreciate it." ●

The 2023 Early to Remote Practice Award was sponsored by Flinders University – Rural and Remote Health.

Flinders University

Above: Micah (right) with Aboriginal Community Worker Roxanne Naborlhborlh (left) at Injalak Hill in Gunbalanya.

Photo: Michael – stock.adobe.com

Connect

Turning Tides on TI

Maxine Lenehan CM works within the Midwifery Group Practice on Thursday Island. She explains how MGP works in the Torres Strait, the logistics of island-based healthcare, and the "beautiful influence" of local cultures on birth.

Standing on the balcony of Thursday Island Hospital, Maxine Lenehan can see across a few kilometres of ocean to Horn Island, Prince of Wales Island and Friday Island.

If she was to squint while gazing out at the green mountainous headlands, she might almost be in Sydney, where she used to live in the western suburbs.

But when she steps inside again, it will be into a different world: her new life as a midwife working in the Midwifery Group Practice (MGP) on Thursday Island.

The MGP based on the island services the populated outer islands and five indigenous communities on Cape York.

If deemed safe to give birth on TI, women travel to stay in local accommodation when they are 36 weeks pregnant and then birth in the hospital's maternity suite.

"All women receive MGP care," Maxine says, "meaning they are engaged in their own healthcare. We have a continuity of care philosophy, where the women get to know the team of midwives looking after them.

"Three midwives look after the Torres Strait islands, and three look after the communities on the Cape. On TI there is also a midwife 24/7 on shift in the hospital.

"I care for women on the eastern cluster of islands, including Murray Island, Darnley Island, Stephens Island, Yorke Island and Yam Island.

"We make day trips, often by helicopter or fixed wing, to the islands we cater for, and have appointments with women at the health clinics.

Above: Mum Louisa and baby Angelina with Maxine (left) and midwife Tomika.

"Having the presence of a midwife who services communities, who comes to women rather than the women having to come to hospital – that presence and continuity is great for building trust and relationships."

Before this role, Maxine worked in Westmead Hospital in Sydney for five years, beginning with a year of shift work before four years within the Midwifery Group Practice.

"But it's always been a goal of mine to move out of the city," she says.

"I've been here 11 months now; I've stayed here and loved it. It was definitely a culture shock – getting my head around the change in lifestyle. But it was the most welcoming place and I've been really well supported.

"I'm glad I got to start out as one of the shift work midwives, to understand the hospital, the processes, before moving into MGP.

"I have had a lot of educational opportunities here. For example, I did a Strength with Immersion (SwIM) program in Townsville Hospital in the neonatal intensive care unit.

"It was incredible to see the other side of the story, to understand what happens when the baby gets to Townsville [in the case of a medivac]."

The biggest change for Maxine since she started working on TI has been the need to consider logistics, not just clinical care. ▸▸

Above and right: TI maternity team: Ana Vranes, Louise Riches, Rosina Sailor, Natasha Baxter, Florence Ketchell, Jade Yeung, Emily Vink, Karyn Wilson, Lin Hu, Paula Dawson, Quynira McKeon and Maxine Lenehan.

"On the mainland, in urban and some rural locations, when you need supplies or assistance, it is often just a matter of a drive away," Maxine says.

"Here, a woman may go into premature labour or her waters may break prematurely, and if she is on the outer islands, it usually requires a helicopter flight or tasking the RFDS. And because of where we are, in the tropics, sometimes the weather means the helicopter can't fly or land for a while.

"When I was doing shift work as a midwife [on TI], sometimes the staff on the outer islands would have women present who may be in premature labour so we, along with a doctor, would support the RANs in the clinic, who have maternity training but are not necessarily midwives.

"We would talk to them over telehealth, and there was one instance where a woman from one of the outer islands was in labour. She was tasked to come to TI, but in the meantime, over telehealth, myself and the GP obstetrician provided advice on how to care for her.

"Providing midwifery care over the camera was daunting, but it was a good outcome for all."

Maxine regularly provides care in a cross-cultural context and she acknowledges the vital role played by Torres Strait Islander assistants in midwifery and nursing, including Margaret and Flo, who have almost 60 years of experience between them.

"Having that cultural connection is highly important for health promotion and for bridging the gap between [non-Indigenous] midwives and the local women, who have respect for [Torres Strait Islander] health workers and midwives," Maxine says.

"They have cared for generations of babies; they are part of the community, and understand the culture, and the cultural differences. Sometimes they also support women in labour, when these women do not have their escort or support person with them for birth, because they are working back home and cannot take a month off to be on Thursday Island."

Being able to observe and learn from women while delivering cross-cultural care has been one of the most rewarding aspects of the job for Maxine.

"Tides are something that impacts your work, your life, whether you can get out on the water, and there is a cultural belief, strongly held by the community, that tides also impact whether or not a woman is going to labour and when she will give birth," Maxine says.

"Women will look at the change of tides, which are a lot less predictable than on the east coast. One of the beliefs is that if the tide is coming in, their labour will be fast and strong, and they'll give birth soon. If the tide is out, their labour will be slow and prolonged, and things won't progress until the tide turns.

"I have noticed that if the women say, 'the tide is coming in around this time, this is when I'll give birth', then they are right every single time. That's been pretty incredible." ●

Volunteering in Vietnam

Last year's CRANAplus Early to Remote Practice Award Winner, Lorraine Woods, put her prize money towards a volunteering trip to Vietnam, where she and her friend Judith delivered resources and education to local women and girls.

Earlier this year, Lorraine spent three weeks trekking in Lào Cai province in north-west Vietnam alongside her friend Judith.

At every break in the forest, they would be rewarded with views of terraced rice fields and towering peaks, but this was not a sightseeing holiday. They trekked rain or shine, in gumboots through the mud, carrying Days for Girls reusable hygiene packs as well as birth packs.

These packs contained items such as washable, reusable sanitary pads, scalpel blades, nappies, gloves, soap, wash cloths, and other items that are invaluable in one of Vietnam's poorest areas.

The pair carried them to empower local ethnic hill tribe women and girls (in this instance, mostly H'Mông women and girls) including those who birth at home in unhygienic conditions and have limited access to menstrual hygiene products.

"We'd meet up with a local H'Mông interpreter and learning educator, Nhu, who knew the area and she'd let people know we were coming and trek with us to the villages," Lorraine says.

"We would make our way, usually to a meeting place like the church, and all the mums and girls would come.

"Then we would give out the hygiene packs and birth packs, and deliver an education session – teaching the local women and girls about contraception, menstrual periods, hygiene, and to be safe from men.

"Nhu would translate. One of Judith's goals was to upskill her to teach the local women and girls, so that when we are not there, she can still go out to the villages to teach as well."

The trio also delivered opportunistic education on the go.

"As we went along, we would meet families with babies and kids, stop and give them beanies and other items of clothing, and talk with them," Lorraine says.

"The hill tribe women, they often walk miles and miles to sell their trinkets in the streets, to make money for food. We would meet with these women too, taking the opportunity to talk about safe birthing and hygiene."

Asked what she gained from the experience, Lorraine says perspective.

"The local communities often live with no running water, no flushing toilets.

"Young girls can't go to school when they have their periods, because they have no money to buy pads. Thanks to these packs, they can go to school; more kids can be educated.

"There is a hospital in Sa Pa, but how do these women get there? They don't have the means and that is often why they don't head to hospital when in labour; they labour at home. In one house, we asked 'how did you cut the cord?' and the mother brought the scissors out of the kitchen.

"These resources are not to encourage women and girls to birth at home; but if they are going to, this way, it's hygienic and safe." ●

Health response to Kimberley floods gets statewide recognition

The combined efforts of Kimberley health service providers in responding to the worst floods WA has ever seen have been recognised as part of the 2023 Institute of Public Administration Australia (IPAA) awards.

The Kimberley Flood Recovery – Working Together Response has been shortlisted for the category for Best Practice in Collaboration Between Government and any other Organisation.

WA Country Health Service's Rex O'Rourke said the devastating floods presented serious health challenges for the region.

"We had communities and hospitals completely cut-off from the rest of the state," Mr O'Rourke said.

"Not only were we trying to treat patients with floodwater-related injuries and diseases, we were also working to maintain regular deliveries of hospital supplies and medications."

Mr O'Rourke said responding to the floods would have been impossible without working hand-in-hand with health service providers located right across the region.

Above, left to right: James Sherriff (WACHS), Douglas Hoggs, Leithan Wise, Claude Carter (Gooniyandi Aboriginal Corporation) and Sue-Ann Wiseman (WACHS).

"From the outset we worked with Aboriginal Medical Services and the not-for-profit sector to form a cohesive, united, partnership approach to responding to the critical health needs of impacted communities," he said.

"Our response team included leaders from WA Country Health Service, Kimberley Aboriginal Medical Services (KAMS), Broome Regional Aboriginal Medical Services (BRAMS), Derby Aboriginal Health Service (DAHS), State Health Incident Coordination Centre (SHICC), Royal Flying Doctor Service (RFDS), St John Ambulance (SJA) and WA Primary Health Alliance (WAPHA)."

Mr O'Rourke said the group worked together to identify, and respond to, immediate health risks and critical service issues.

"We also worked closely with the Department of Communities, Department of Fire and Emergency Services (DFES) and the Shire of Derby/West Kimberley," he said.

"Together, we were able to coordinate critical patient transfers and supply drops, ensured that our sickest and most vulnerable patients were supported throughout and importantly, we were able to keep our doors open.

"The involvement of our AMS partners was integral – they took the lead in the social and emotional wellbeing space and represented the voices of the impacted communities."

Mr O'Rourke said the flood response was a great example of how the community comes together to support one another in the Kimberley.

"We've formed very strong partnerships with a focus on delivering culturally safe, quality health care that promotes better outcomes for Kimberley communities," Mr O'Rourke said.

The 2023 IPAA WA Achievement Award winners will have been announced in early December by time of publication. ●

Ready for the next pandemic

Is Australia ready for future pandemics? Whether we can curb the spread will depend on the nation's ability to run effective quarantine facilities, writes Senior Research Officer, Angela Sheedy. Along with a project team at Charles Darwin University Menzies School of Medicine, she has recently made her contribution to the cause, distilling the lessons from the successful Howard Springs Quarantine Facility into a set of open-access online guidelines.

Did you know, the first case of the Spanish flu pandemic of 1918 arrived in Australia in Darwin? Due to quarantine policies, the case was isolated at Channel Island and the flu never spread to the community. It was not until 1919 when a ship from interstate brought the virus to NT soils that Spanish flu spread across the Territory (interstate vessels not required to quarantine).[1]

Sound familiar?

In modern history, we no longer saw a need for quarantine. This was thanks to public health actions such as vaccinations, and established and enforced customs and border policies and processes. COVID-19 re-introduced quarantine practices to Australia and the world, but it was problematic to see where this service belonged.

In some parts of Australia, it was managed by police; in others, by the health department. Quarantine appeared in hotels, special care hostels and stand-alone facilities, each offering varying levels of health support for residents. It was confusing for staff, caused anxiety and fear for residents and in some cases led to large outbreaks of COVID-19 into the wider community.[2]

As we are aware it is not a matter of if, but a matter of when the next pandemic occurs and we owe it to health staff and communities to be better prepared next time. This means preplanning for a coherent quarantine service response.

This page, from left: The landing at the Channel island quarantine station, which housed Australia's first infected case of Spanish flu. *(Supplied: Library and Archives NT)*; CNR repatriation resident arrival, August 2021; CNR domestic resident arrival, August 2021. Opposite page, from top: CNR working site map with resident zones marked; Aerial photo of CNR site.

Howard Springs Quarantine Facility

Located approximately 30km out of Darwin, The Centre for National Resilience (CNR), Howard Springs Quarantine Facility was originally Ichthys LNG Project's Manigurr-ma Village (workers camp) able to hold around 3,500 workers.[3]

On completion of the Ichthys LNG project the site was handed over to the NT Government in early 2019 and was vacant at the time the COVID-19 pandemic arrived.

Reflecting the diverse and innovative pandemic responses of health staff, the site consisted of a large health and nursing leadership team and provided residents access to basic primary health services.

Senior nursing staff received CRANAplus ALS, REC and MEC training to assist with onsite resident emergencies and a primary health-based transition to practice nursing course was established with the Australian Primary Health Care Nurses Association.

New health team models were introduced, with hybrid approaches of non-health/administration staff trained to work alongside nursing staff and the site saw the introduction of the Assistant in Nursing role, bringing student nurses officially into the NT Health workforce for the first time.

The site quarantined over 33,000 residents from humanitarian flights such as Afghan refugees, repatriated Australians from across the world, international travellers inclusive of CDU students and fruit pickers, and domestic residents.

At its peak, the site hosted 2,600 residents onsite with over 500 staff.

Despite having staff working in a hot tropical region with risk of heat stroke, resident snakes, and many other challenges in this unique health workforce environment, the site upon its closure in June 2022 had no record of COVID-19 transmission from residents to staff.

Applying the lessons learned

At Charles Darwin University, Menzies School of Medicine, a project team set out to determine what was required for a coherent and supportive quarantine service with a focus on the Centre For National Resilience (CNR), Howard Springs Quarantine Facility.

This page, from top: CNR Green Zone signage; CNR Orage Zone signage; CNR resident zones and rooms.
Opposite page, from left: CNR staff in Orange Zone; CNR nursing staff skills refresher and training.

This project sought to learn from CNR's quarantine service delivery and resident care that contributed to its success and present these as an open-access resource for use in future pandemics; a quarantine 101 guide. Ultimately, it's the resource we never want to use but know we need to have. The outcomes of the project have now been collated to inform a set of six guidelines presented for use as an open-access web resource across:

1. Processes, infrastructure and communication
2. Infection prevention and control
3. Health Workforce
4. Resident care
5. Health, wellbeing and clinical care
6. NT COVID-19 response

The guidelines are testament to the diligence of the site's workforce to establish coherent policy and processes.

They present a resource that can be used locally and globally, not just for future pandemics but for any health disaster or emergency where isolation or quarantine is required.

References

1. Libraries and archives NT. Spanish Flu in the Territory, 1918-1919. (n.d.) Territory Stories. https://lant.nt.gov.au/explore-nt-history/spanish-flu-territory
2. Australian Government, D. o. H. a. A. C. (2020). National Review of Hotel Quarantine. Australia: Department of Health and Aged Care. https://www.health.gov.au/resources/publications/national-review-of-hotel-quarantine?language=en
3. INPEX Media Releases. (2013, Sept 18). Ichthys LNG Project's Manigurr-ma Village open for business. https://www.inpex.com.au/news-and-updates/media-centre/media-releases/ichthys-lng-project-s-manigurr-ma-village-open-for-business/

To access the webpage, scan the QR code (left) or visit quarantine-guide.cdu.edu.au

To enquire about the project, email QuarantineGuideContact@cdu.edu.au

Sexual Health in Regional & Remote Populations

Nikki Brandon from SHINE SA provides an update on the challenges of STI screening in remote areas, some tips on encouraging screening, and asymptomatic STIs.

Access to inclusive and safe sexual health care is essential but can be challenging in regional and remote areas. There are several reasons for this including reduced access to medical care, health professionals knowing their patients in a social context, or with locums having little opportunity to build relationships with patients. Sexual Health has been defined by the Australian Government as:

- respect for the right to healthy relationships, equality and safety
- safety to express individual sexuality, sexual orientation and gender identity
- freedom from coercion, discrimination, violence and stigma
- access to information and health care
- protection from, and treatment of sexually transmitted infections (STIs).

However, the rates of STIs such as chlamydia, gonorrhoea and syphilis are increasing. In 2021 there were 86,916 chlamydia notifications, 26,577 gonorrhoea notifications and 5570 infectious syphilis notifications made across the country. The Australian STI guidelines were updated in 2022 to assist in the goal of eliminating HIV transmission and to address the rise in syphilis notifications across Australia. It is now recommended that HIV and syphilis testing are included in an asymptomatic STI screen.

Testing advice is to screen young people (aged 15–35) living in regional and remote areas annually for chlamydia, gonorrhoea, HIV and syphilis.

Trichomoniasis rates are more common in regional and remote Australia and can easily be included in screening (refer to local guidelines). STI screening should be offered to all who request it, those who have a new sexual partner/s, have a known exposure to any STI or who have a history of an STI within the last 12 months.

Taking a sexual history may present as a potential barrier to STI screening; however, it should not prevent STI screening from being offered. The discussion can be quite simple and can begin by normalising the process with a phrase such as "we offer STI testing to all people under the age of 35 as STIs are common, often do not have symptoms and are important to treat early. Would you like to test today?"

The use of a hook can encourage screening, with phrases such as "chlamydia is very common and often has no symptoms yet can cause complications if left untreated" or "there has been a rise in syphilis recently which can be serious for your health but it is easy to test and treat".

It can also be incorporated into an existing consultation, for example "as you are here today for cervical screening/contraception/menstrual irregularities, would you like an STI screen also?" or "as we are taking blood/urine test, today would you like us to include an STI screen?"

If a test returns positive, then a more detailed sexual history should be taken to include details around the number of sexual partners and type of sex. Further testing from other sites may be required to ensure treatment guidelines are adhered to. Treatment should be given, and the patient advised of the need to abstain from sex for at least seven days following treatment. Due to the increase in macrolide resistance, doxycycline is now the first line treatment for chlamydia, unless compliance is a concern. Sexual partner(s) from the previous two to six months will need to be tested and treated.

Test	Patients with a penis	Patients with a vagina	Treatment and Follow-up
Chlamydia & Gonorrhoea **Nucleic Acid Amplification Test (NAAT)**	First pass urine at any time of the day	Self-collected vaginal swab (preferred) or First pass urine at any time of the day	Chlamydia: Doxycycline 100mg BD for 7 days or Azithromycin 1g stat (see guidelines for anorectal infection) Contact trace back 6 months Gonorrhoea: Take a culture swab (M,C&S) from all positive sites prior to treatment but do not delay treatment Treatment options may vary, check local guidelines Contact trace back 2 months
Trichomonas **Nucleic Acid Amplification Test (NAAT)**	Can include in above sample. May test negative as more likely to spontaneously resolve but should still be treated as a contact if sexual partner tests positive	Self-collected vaginal swab (can be included in the above sample)	Metronidazole 400mg PO with food BD for 7 days
HIV & syphilis	Blood test (same tube)	Blood test (same tube)	HIV: repeat bloods required to confirm and antiretrovirals are recommended immediately on diagnosis Syphilis: Infection needs to be staged and treated accordingly with Benzathine penicillin 2.4 mu IMI

Presumptive treatment should only be considered if there has been sexual contact in the last two weeks or if the contact partner is unlikely to return for treatment if the result is positive. A test of cure is only needed for chlamydia if the patient is pregnant or had a rectal infection. A test of cure is needed with all cases of gonorrhoea due to reduction in susceptibility of first line treatment.

References

About sexual health | Australian Government Department of Health and Aged Care: https://www.health.gov.au/topics/sexual-health/about

HIV, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance report 2022 (unsw.edu.au): https://www.kirby.unsw.edu.au/sites/default/files/documents/Annual-Surveillance-Report-2022_STI.pdf

Regional and remote populations – STI Guidelines Australia: https://sti.guidelines.org.au/populations-and-situations/regional-and-remote-populations/

SHINE SA

Popular Courses

CRANA plus
improving remote health

Remote Emergency Care (REC) course

On responding with confidence to emergency situations and delivering safe and quality care in the remote setting.

Maternity Emergency Care (MEC) course

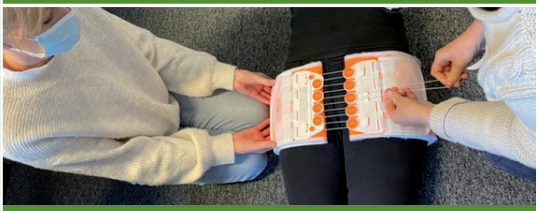
On providing unplanned maternity and emergency care for women and their babies in a remote or isolated setting.

Advanced Life Support (ALS) course

On managing the patient prior, during and after a cardiorespiratory arrest in the remote and isolated setting.

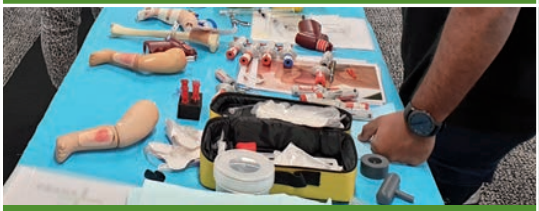
Midwifery Upskilling (MIDUS) course

On best practice in antenatal, intrapartum and postnatal care including complications in pregnancy/birth and emergency management.



Advanced Remote Emergency Care + Advanced Life Support (AREC+ALS) course

On extending competencies of the experienced Remote Health Practitioner to an advanced level.



Paediatric Emergency Care + Paediatric Advanced Life Support (PEC+PALS) course

On the emergency management of children in low-resource settings.

To find a course near you visit crana.org.au/education