



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

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About the Cover: Winners of the 2026 CRANaplus Australian Remote Health Awards. Left to right: Milly Grigg, Katherine Goulliart, Jane Christmas, Sarah Worth, Fiona Cameron, Haidee Noonan and Katrina Molloy.

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From the CEO and Board Chair



Dear colleagues,

Welcome to the September edition of CRANaplus Magazine.

This edition celebrates the people, partnerships and initiatives strengthening rural, remote and isolated healthcare across Australia.

Earlier this year, many of us came together in Boorloo (Perth) for the 2026 CRANaplus Remote Nursing & Midwifery Conference. We look back on some of the highlights, including Sarah Worth's Aurora Award for Remote and Isolated Health Professional of the Year (page 10) and the presentation of inaugural Honorary Fellowships to Adjunct Professor Shelley Nowlan and Adjunct Associate Professor Alison Weatherstone (page 16).



The conference also marked an important step in our commitment to Cultural Safety through the introduction of an Elder in Residence (page 7). We thank Aunt Lesley Radloff for sharing her wisdom and generosity, helping create a space where everyone felt welcome and respected.

That commitment continues through the commencement of our First Peoples Advisory Committee (page 4), which will help guide CRANaplus on First Peoples health, Cultural Safety and meaningful engagement, ensuring First Peoples' voices remain central to our work.

This edition also features a thoughtful conversation with Deputy National Rural Health Commissioner for Nursing and Midwifery Linda Deravin, whose reflections on growing our First Nations nursing and midwifery workforce offer valuable insights for us all (page 32) and an update from our Chief Remote Area Nurse, sharing insights into current priorities and developments across the remote health

sector (page 36). We're also pleased to share new resources from our Mental Health & Wellbeing team, including a practical guide on moral injury (page 54), alongside an upcoming calendar of webinars designed to support your wellbeing and professional practice (page 70).

We hope you enjoy this edition of CRANaplus Magazine and look forward to continuing to work alongside you throughout the remainder of 2026.

Warm regards,

Emma Barritt, CEO, CRANaplus

Dr Ann Aitken PhD, 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.

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First Peoples

CRANaplus' First Peoples Advisory Committee has begun its work

This July marked an important milestone for CRANaplus, with the inaugural meeting of its First Peoples Advisory Committee. Bringing together Aboriginal and Torres Strait Islander nurses, midwives, practitioners and health leaders from across Australia, the committee will help shape our work in Cultural Safety, workforce support and advocacy across rural and remote health.

Chaired by CRANaplus First Peoples Advisor Dallas McKeown, the committee includes respected professionals and leaders Carrie Rofe, Leeona West, Cherry-Lee Bilston, Kellie Kerin, Jason Coombes and Naomi Zaro.

From the very first meeting, conversations were grounded in connection, shared experience and a commitment to strengthening the rural and remote health workforce.

Members spoke candidly about the challenges facing Aboriginal and Torres Strait Islander health professionals, including workforce shortages, burnout, cultural load and the isolation that can come with working in remote communities.



Photo: LisaGageler - stock.adobe.com

Strong discussion also focused on the future workforce, particularly the need for clearer and more consistent support for Aboriginal Health Practitioner trainees.

Clinical placements, supervision, role clarity and workplace support were all identified as priorities.

Importantly, members highlighted opportunities for CRANaplus to further strengthen its leadership in culturally safe workforce support, advocacy and organisational accountability across the rural and remote health sector.

As the committee's work continues, it will provide a space for practical problem-solving, peer support and knowledge sharing, while helping guide CRANaplus advocacy and action.

We are honoured to work alongside this exceptional group of leaders and look forward to sharing more as their work progresses.



Meet First Peoples Advisory Committee member Leeona West

"We were born into health," says Leeona West, a proud Kalkadunga/Djaku-nde woman, CRANaplus Fellow and member of CRANaplus' inaugural First Peoples Advisory Committee.

Along with her twin sister and brother, they all trained to become registered nurses 20 years ago.

"Three RNs in our family came about because of a community-based program in Mount Isa," says Leeona.

"I am sure we wouldn't have done our nursing degrees otherwise.

"We come from an absolutely amazing mother who was a health worker for many years," says Leeona. ►►

► “Historically, health workers have been managed by nurses. And as we know, Aboriginal nurses are rare – only 1 in 10,000. It is very hard when you are Aboriginal to advocate for your people, reporting to someone who doesn’t share your upbringing and values.

“Our mother wanted us to get a nursing degree. Our progress to senior levels in health comes from the passion she embedded into us to fight for better health for our people. We hold our cultural responsibilities very close to our hearts.

“We come from a demographic where, sadly, there’s a lot of exposure to unwell people – family and distant family. Our homes are full of people who are sick.”

“Nursing runs in our family,” says Leeona, currently Nurse Educator of the First Nations Workforce in Mount Isa, working with the North West Hospital and Health Service.

“The first Aboriginal nurse at Mount Isa, where I live on Country, is my aunty – Aunty June.”

As a CRANaplus First Peoples Advisory Committee member, Leeona is passionate about ensuring services are delivered in culturally safe ways, and

that healthcare approaches reflect the realities of Aboriginal and Torres Strait Islander communities.

Drawing on her experience as Director of Nursing at Gununa (Mornington Island) Hospital, Leeona has seen firsthand the complexity of delivering care in rural and remote settings. She believes there is an opportunity to continue building the workforce’s understanding of primary healthcare, alongside the acute and emergency care skills that are so critical in remote practice.

“The definition of primary healthcare, especially in the Aboriginal context, is holistic,” says Leeona.

“I want to be part of CRANaplus’ efforts to define primary healthcare. We need to understand what primary health and Aboriginal health mean for our communities.”

As the committee’s work continues, Leeona hopes it will help strengthen understanding, support and advocacy for Aboriginal and Torres Strait Islander health professionals, while ensuring community voices remain at the centre of rural and remote healthcare.

“We need to understand what primary health and Aboriginal health mean for our communities.” ●



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Why an Elder in Residence matters

At the 2026 CRANaplus Conference, we proudly introduced Aunt Lesley Radloff (pictured below), a respected Elder of the Kairi Nation and Yuuwaalaray/Euahlayi Nation, as the Elder in Residence. Aunt Lesley was invited to join us in this role to provide cultural guidance, support and connection for delegates, speakers and attendees. Here, CRANaplus First Peoples Advisor, Dallas McKeown (pictured right), shares why having an Elder in Residence was such a valued part of this year’s conference.

I have seen firsthand the difference that culturally safe spaces can make. That’s why appointing an Elder in Residence was such an important step for this year’s conference.

For many organisations, Cultural Safety is discussed as a concept. We wanted to make it visible, practical and meaningful.

The role of an Elder in Residence is varied and is organisation-specific.

An Elder in Residence encourages and promotes understanding and respect for First Peoples’ perspectives, cultures, and values.

They provide support and encouragement to delegates and provide a cultural connection to them on their learning journey. ►►



» Aunt Lesley explains why the role is so important.

“I think having an Elder in Residence is really important in most conferences, but particularly if you have a large population of First Peoples professionals coming through, so they’ll feel a little more comfortable having someone that they know that they can go to and just have a bit of one-on-one with them, and it’s treated confidential.”

Elders hold a unique place within communities. They are mentors, guides, teachers and knowledge holders. They carry stories, culture, language, history and lived experience. The stories they carry are not just memories – they are identity, survival, culture, strength, love and legacy.



An Elder in Residence can provide spiritual support, encouragement and guidance while helping create an environment where learning, reflection and connection can occur in culturally safe ways.

Bringing an Elder into a conference space is not simply about creating a role. It is also about ensuring the environment itself is culturally safe. Cultural Safety is about shared respect and shared power. It is about truth-telling and not denying history, identity or experience.

Before the conference, I spoke with Aunt Lesley to understand what she needed to feel comfortable and supported in the role. She requested a quiet space that was easily accessible to delegates and where private conversations could take place if needed.

The CRANaplus Mental Health and Wellbeing team helped make this possible through the Conference Wellbeing Lounge (pictured below). The space allowed delegates to pause, recharge and reconnect through mindfulness activities, meaningful conversations or simply by finding a quiet place to reset. It became Aunt Lesley’s base throughout the three-day event.

Importantly, Aunt Lesley told us that the Wellbeing Lounge felt welcoming and culturally safe for both herself and delegates.



She also shared insights about the importance of language.

“There are two common phrases that a lot of people say, and they don’t realise that it’s offensive to Aboriginal people because no one has ever told them, and of course you don’t know what you don’t know, so it’s not your fault. One of them is ‘you people’ and the other phrase is ‘our Aboriginal people’.”

Importantly, Aunt Lesley noted that she had not experienced these issues during the conference and that nobody had approached her regarding any cultural concerns.

The value of having an Elder in Residence extended well beyond formal conference sessions. It brought a sense of respect, care and understanding to the event and reinforced the importance of relationships, connection and community.

For CRANaplus, the experience demonstrated the positive impact an Elder in Residence can have for both First Peoples and non-Indigenous delegates. The role created opportunities for learning, cultural connection and support in ways that are difficult to achieve through a conference program alone.

I would encourage other organisations to consider the role of an Elder in Residence when planning future events. It is a meaningful way to strengthen Cultural Safety, support First Peoples participants and create environments where people feel welcome, respected and connected.

We are deeply grateful to Aunt Lesley for sharing her wisdom, knowledge and guidance throughout the conference.

The attendance of an Elder in Residence at the 2026 CRANaplus Conference was made possible thanks to support from Limelight People. ●

In Focus

Falling in love with remote health

Having worked in Far North Queensland for over 23 years, Sarah Worth has spent the last few building a Transition to Remote Practice Program to bolster the region's workforce. Her efforts have earned her recognition as the Remote and Isolated Health Professional of the Year.

When Sarah Worth (Director of Nursing – Clinical Education, Torres and Cape Hospital and Health Service (TCHHS)) received the phone call from CRANaplus telling her she had won the Aurora Award, she initially thought it was a prank call.

"I was so humbled and grateful for the recognition," she says. "A little overwhelmed, really, because I love doing what I do."

As a matter of fact, it was love at first sight. 25 years ago, as a graduate nurse walking the wards on the Gold Coast, she could feel that there was something more out there; something that offered greater autonomy and connection.



"Something was missing. So I went searching for what that might be."

Her first role was on Palm Island, and she was swept off her feet. After Palm Island came Woomera, continuing Sarah's wandering upbringing, which saw her live in Sydney, Cairns, Tasmania and the Gold Coast.

But she soon found a permanent home. Following her postgraduate studies in education, she taught the enrolled Diploma of Nursing with TAFE, and travelled to Bamaga for an 18-month posting.

Sarah then joined Torres and Cape Hospital and Health Service in 2010 in a nursing role at the Weipa Integrated Health Service, before moving into a Nurse Educator position.

In 2018, she took on her current role as Director of Nursing – Clinical Education.



Sarah and her colleagues soon found that some new-to-remote health professionals, attracted to the career, were quickly falling out of love with it. That is, their traditional training, focused on acute skills, was setting them up for heartbreak.

"Going in as a very young nurse, it was a very steep learning curve," she recalls.

"I always reflect on that – what is it that people actually need to become a remote nurse, and how do we encourage people from the metro areas to come and have the opportunities that remote nursing can give them?"

With these questions in mind, Sarah and her peers developed the Transition to Remote Practice (TRP) Program, a 12-month scaffolded pathway that includes contextualised simulation, on-country education and structured mentorship and is co-designed with First Nations Leaders and Remote Directors of Nursing.

Early evaluation of the program has shown promising results – with managers consistently rating graduates as >4/5 for clinical proficiency, and >4.5/5 for team integration and Cultural Safety. ►►

▶ Participants also reported feeling significantly more confident. At Lockhart River, three participants have since accepted permanent positions. One later joined Sarah at a statewide rural and remote nursing forum, sharing how the program gave her the confidence to leave city practice and build a career in the community she now calls home.

"The goal with contextualised simulation is to get you familiar on site," Sarah explains.

"We take the equipment out and involve the whole clinic in a simulation.

"How do you get [a heavy client] from the toilet to the emergency bay? What is it you do then, who do you need to escalate to? It's moving that theoretical knowledge they may have into practice.

"We can't teach everything that you're going to face; you know, you're going to care for people across the lifespan from birth to death to acute illnesses to chronic illness.

"What we want to teach you is to have critical thinking skills and problem solving skills to know what you need to do, take a step back and think about how you're going to achieve it, and then implement safe care using the guidelines available to you."

This isn't the only program Sarah has been involved with. The graduate program she has been a part of is also helping to grow the service's First Nations Workforce capability in a meaningful way. In all of her work, she is quick to acknowledge her colleagues.

"You'll notice I say 'we' because you can't do anything alone."

"I am so fortunate to have the privilege to work in TCHHS, with an amazing team and support from strategic leads to implement innovative education and workforce capacity building."



Sarah has been attending CRANaplus conferences since around 2012, and says the organisation has only grown more important to her across her career.

"I think it's really important to recognise the specialty that remote and isolated practice is."

"Having [an organisation] like CRANaplus, celebrating remote and rural nurses, midwives and others – I can't put a price on that. It gives us our identity."

Her goals from here are an extension of the work already underway: to help health professionals discover and fall in love with remote health practice, and thrive beyond the honeymoon period.



"[All with the goal that] we can provide the best possible, culturally safe care to those we serve, and live alongside," she says. ●

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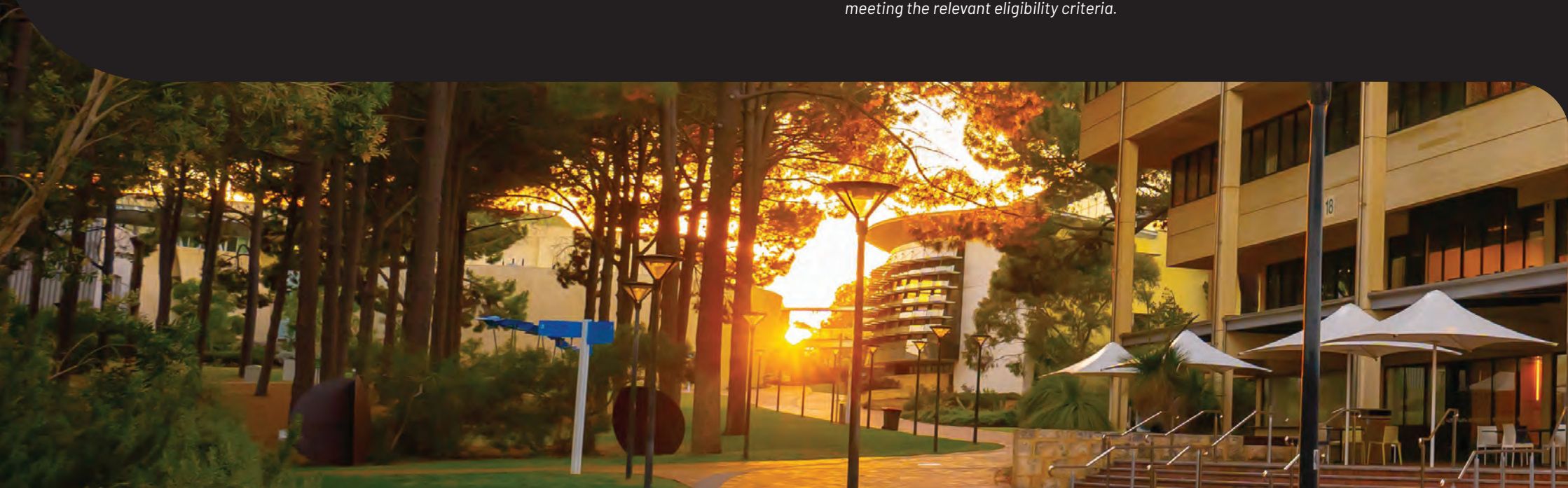
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Introducing CRANApus' inaugural Honorary Fellows

CRANApus has launched a new Fellowship category, the Honorary Fellow, recognising exceptional individuals whose leadership, advocacy and service have made a lasting impact on rural and remote healthcare.

At the 2026 CRANApus Remote Nursing & Midwifery Conference, we were very pleased to congratulate the two inaugural Honorary Fellow recipients, Adjunct Professor Shelley Nowlan and Adjunct Associate Professor Alison Weatherstone.

A CRANApus Honorary Fellow is an exceptional individual who has made a significant contribution to rural and remote health and/or CRANApus.

Receiving this Fellowship is a recognition of many years of commitment, leadership, and service. Awarded by invitation or Board nomination, this Fellowship honours individuals whose influence, advocacy, or leadership has had a major positive impact on CRANApus' mission.

Shelley and Alison were chosen due to their outstanding contribution to rural and remote nursing and midwifery.

They both have played a pivotal role in strengthening the rural and remote health workforce, influencing policy and championing leadership.

Their commitment extends beyond individual achievement, and they have both made a lasting contribution to their professions.

Adjunct Professor Shelley Nowlan



With more than 39 years' experience, Shelley has dedicated her career to ensuring nurses and midwives are supported to serve regional, rural and remote communities.

Her leadership has included previous roles such as Deputy National Rural Health Commissioner, Queensland's Chief Nursing and Midwifery Officer and then Chief Nurse Officer. She has been instrumental in supporting the Australian Government's initiatives to expand rural health services and tackle workforce shortages, and led the development of the National Rural and Remote Nursing Generalist Framework 2023-2027 as the Steering Committee Chair.

Shelley says, "I have been humbled and privileged to be honoured as an Honorary Fellow of CRANApus."

"It has been really special to be honoured and recognised by my peers for the contributions that we've made as registered nurses working in rural areas and remote areas, but most of all the contributions we make for policy and regulation that can make big differences to the working life of a rural or remote nurse in Australia."

Adjunct Associate Professor Alison Weatherstone



Alison is currently the Executive Director of Nursing & Midwifery at WA Country Health Service, and before this role was the inaugural Chief Midwife for the Australian College of Midwives, and served as Co-Chair of the Global Chief Midwife Community of Practice with the International Confederation of Midwives.

She is an advocate for culturally safe care and community-informed service delivery, and is dedicated to developing a health workforce capable of meeting the diverse needs of rural and remote populations.

Alison says, "I was so humbled to become an Honorary Fellow for CRANApus."

"I grew up in the Pilbara region of Western Australia, and one of my key drivers during my career has been to improve access to care for rural and remote families. My interest in nursing, and global maternal care in particular, has always been about equity of access. So, I think to align my visions and my values with an organisation like CRANApus has just been fantastic."

"It's organisations like CRANApus that continue to provide education and awareness of priority, innovative and every day matters that are happening in our profession and rural healthcare. I genuinely believe in organisations that are committed to the cause." ●



Shelley and Alison alongside Dr Ann Aitken PhD, Board Chair, CRANApus (left) and Emma Barritt, CEO, CRANApus (right).

What good collaboration looks like



CRANaplus Board member Naomi Zaro has been named a CRANaplus Fellow, recognising her commitment to the organisation and a career focused on encouraging collaboration between nurses, Aboriginal and/or Torres Strait Islander Health Practitioners and other staff in remote clinics.

"Good collaboration involves working together – not just working alongside," says Naomi, herself a Torres Strait Islander Health Practitioner with years' of experience as a clinical educator in Aboriginal and/or Torres Strait Islander Health Practitioner training.

"When collaboration, based on mutual trust, works well it means better outcomes for patients, communities and the nursing staff.

"Clinics can feel safe or intimidating," says Naomi. "If community see everyone's getting along in the clinic, they'll be more likely to come."

Naomi has watched the development of Aboriginal and/or Torres Strait Islander Health Practitioner training over the years, from a role as translators and cultural bridges to

continued expansion of their clinical skills, with many choosing to go on to become enrolled or registered nurses.

The role of an Aboriginal and/or Torres Strait Islander Health Practitioner has diversified again, broadening their scope of practice, says Naomi. It has moved from being cultural to clinical and now it looks more holistic, bringing in the social and emotional wellbeing of clients, health promotion and the mental health and wellbeing side of things.

Naomi says a highlight of her work as an Aboriginal and/or Torres Strait Islander Health Practitioner trainer is when her students get the 'aha' moment.

"You see that they get it and you just go, 'Yeah. Job done.'"

For Naomi, however, the quality of care in remote clinics depends less on individual expertise than on what happens between people moving in and out of roles with confidence, respect, and clarity.

"Health literacy within a community is very important, but, too often, people delay visiting clinics because they do not feel comfortable," she says.

"Sometimes they only come when things have already become an emergency. By then, something treatable may have become serious. A dental infection becomes sepsis. A manageable condition becomes an evacuation."

In practice, Naomi says 'dream situations' she has witnessed are when staff recognise when to lead and when to step back.

"Aboriginal and/or Torres Strait Islander Health Practitioners often become the first point of contact," she explains. "They can put clients at ease when they come into the clinic. Then they'll bring in the nurse when something is outside their scope."

Naomi also outlined situations when a registered nurse, with extensive credentials but little experience in a remote community, recognises the cultural knowledge the Aboriginal and/or Torres Strait Islander Health Practitioner brings to the team.

Naomi says that community activities, such as health promotion and vaccination days, barbecues and school visits help strengthen trust and are a positive way for community members to get to know the nurses. And for nurses to get to know the community.

"Some nurses arrive with a Florence Nightingale mindset, ready to fix all the problems, and quickly," says Naomi. "But communities don't work that way. Change is gradual, repetition matters and trust develops slowly as relationships are made.

"Take your time," is Naomi's advice to newly arrived nurses.

"Don't try to become everyone's friend in week one. Allow the community to get to know you."

Workforce realities shape what is possible in remote communities, Naomi acknowledges. There are not enough Aboriginal and/or Torres Strait Islander Health Practitioners to meet demand in many regions, and retention is an ongoing challenge.

Some leave because of family commitments. Others move on after training.

There are also tensions within practice itself. Aboriginal and/or Torres Strait Islander Health Practitioners often carry responsibilities that sit between professional boundaries and cultural obligations – including mandatory reporting in situations where family and community ties are deeply present.

And with registered nurses who go remote, the environment can be daunting, says Naomi. There's no coffee shop within five minutes. There's no McDonald's just down the road. There's no public transport.

"Nurses arrive in communities from urban hospitals and may have never worked alongside an Aboriginal and/or Torres Strait Islander Health Practitioner," she says.

"I urge a new nurse in a community to sit down with them and ask questions. It's an ongoing task to educate about the evolution of the role, and to get others in the workplace to see Aboriginal and/or Torres Strait Islander Health Practitioners as equals.

"I think one of the biggest things is acknowledging that we're all out there for the same reasons." ●



Call for more support for RANs



For Fiona Hildebrand, the most important lesson she learned as a graduate nurse was the value of structured systems to support nurses in their goal to provide high-quality care. She is now a nurse education and research consultant, and never forgot that lesson. Here is Fiona's story.

During her nursing career, Fiona Hildebrand saw the rewards of successful support systems but, more usually, she saw nurses in remote locations who didn't feel adequately supported. She decided to do something about that.

Now, with more than 20 years' experience in remote communities and this year named a CRANaplus Fellow for her commitment to nurses working in some of Australia's most isolated communities, she is ready to test a system she has developed called BRANCHES, which she believes can strengthen clinical confidence, improve nurse retention and improve care for people living in remote communities.

"Remote nurses are taking on increasingly complex roles, and the systems that support them need to evolve as well."

Australia is currently exploring who delivers healthcare and how; assessing the scope of practice for everyone involved in primary health care; and who can take on expanded responsibilities. The reason for this review is because of the burden now facing doctors, such as increasing numbers of patients with chronic diseases.

"This is the perfect time to recognise the urgent need to reform educational support systems for remote area nurses," says Fiona, "and provide funding for those systems, similar to those already in place for other health professionals.

"Remote nurses are at the forefront of primary care in outback communities, already demonstrating advanced and generalist skills and asked to do increasingly complex work.

"They are already working beyond their scope of practice. That's what RANs have become, because there is a need in communities for someone, anyone, to be able to provide our service and the nurses and Aboriginal Health Practitioners are the ones on the ground."

"But it's not necessarily recognised by the wider public or by governing bodies that that's the work they're doing. These communities deserve the highest quality care and remote area nurses deserve a supportive education system to provide it with confidence and competence.

"Successful clinical supervision programs already exist in medicine. Remote nursing deserves similar investment."

"We already fund structured supervision and support programs for doctors working in rural and remote Australia. Why wouldn't we test whether similar support benefits remote nurses?" ►►



▶▶ A pilot of her BRANCHES model, tested in remote communities, could provide the evidence to show what that support might look like.

"I've spent years researching RANs perspectives on this and here's what could work," she said, presenting details of her system at the 2026 CRANaplus conference earlier this year.

Remote area nurses assess, identify, treat, educate, counsel and respond to emergency and non-emergency situations, says Fiona, in communities where health services are stretched and specialist support may be hundreds of kilometres away.

They may have experience in some clinical areas, but they need to work beyond what they feel comfortable doing, often in isolation, and the system assumes they will somehow educate and support themselves.

Fiona, who has always seen education as a key, says she was shocked the culture of learning she enjoyed in her graduate training years at Fremantle Hospital was not apparent everywhere.

"A positive learning culture is essential for nurses. But that doesn't just happen automatically. Much of the time there needs to be a lot of calculated initiatives to ensure a positive learning culture grows."

"There are two main ingredients to provide a supportive space: giving people protected time off the floor to learn, plus a psychologically safe environment where it's fine to be vulnerable and say, 'I don't know this,' and, 'I really want to learn this.'"

Which components of BRANCHES adopted in each situation would be dependent, says Fiona, on what the nurse brings and what the

supervisor and the nurse negotiate on what would be the appropriate course to take.

The first option in the model is based on a general practitioner's clinical supervision model, and provides up to ten-days in-person clinical supervision at the nurse's place of work.

"That first option is difficult to achieve but not unachievable," Fiona asserts.

"This is based on something I've witnessed in action for nurses, and the results were amazing. You saw people go from apprehensive to absolutely calm and confident."

Other components are virtual due to the logistical issues facing remote area nurses. Using a strengths-based approach, the other components include group, individual, immediate or delayed supervision sessions, with an avenue to discuss topical or current cases. There is also a strong emphasis on developing supervision skills and collegial support.

Securing funding to pilot her clinical supervision model is the next goal for Fiona who developed BRANCHES as part of her PhD studies and now wants to road test it in those real situations in real time.

"A funder who steps forward could be a health service, a government organisation, a charity: if there's someone interested in funding the pilot, I'd love to hear from them."

"It would build the evidence to prove the case to show government and research bodies that the model works, and justify funding.

"And that is my ultimate goal – for remote area nurses to have opportunities to improve and expand the care they provide to the people who need it the most". ●



Fiona with husband Irawan and daughter Sage, in Darwin.

Compassion in correctional care



After almost 30 years in health, Yidinj woman Kirsty Leo who acknowledges the Darumbal Land and peoples as a caretaker on their land, has built a career spanning Aboriginal health, remote clinics, and now correctional health. Across every role, one thread has remained constant – advocating for equitable healthcare.

As Nursing Director of the Capricornia Offender Health Service with Central Queensland Hospital and Health Service (CQHHS), Kirsty says correctional nursing has brought together the skills she developed over decades working in rural and remote Australia.

Beginning her career as an Aboriginal Health Worker in the 90s, Kirsty was exposed early to remote practice, and has since spent almost 20 years as a registered nurse.

Today, she leads this multidisciplinary primary healthcare service caring for around 1,300 men. The service manages everything from chronic disease and opioid treatment programs to dental care, allied health and emergency responses, with close to 40 nurses providing 24-hour care.

Clients come from all over Queensland, from the Torres Strait right down to Brisbane and out to the west. The population reflects many of the

inequities and challenges seen across Australia's correctional services. There is significant overrepresentation of First Nations people, high rates of chronic disease, and more than 300 people receiving opioid dependence treatment.

Although correctional nursing presents unique challenges such as correctional operations impacting patient movements, lockdowns interrupting schedules and complex discharge planning, Kirsty believes many rural and remote nurses already have the skills to thrive in the environment, and she finds the work familiar.

"My work probably hasn't changed that much, just the environment in which I have to manoeuvre has changed."

Much of the work focuses on primary health care, and managing chronic disease.

"Many of these guys have unfortunately been involved in high-risk behaviour in terms of their health and wellbeing, and that sometimes is extended usage around alcohol and other drugs. Then, it's not congruent with good eating patterns, good sleep hygiene, all of those sort of things that go with that," Kirsty explains, which has led to an overrepresentation of chronic health issues.

Every consultation is an opportunity to build health literacy, recognising patients may be transferred or released into the community with little notice.



Photo: Erik Glez – stock.adobe.com

"It's really important with our chronic health patients that at every opportunity we're actually having these clinical yarns, these clinical interventions and education [sessions], because we really don't know how long we will have them with us."

Also like remote nursing, correctional health requires strong advocacy to ensure people in custody receive the same standard of healthcare as anyone else.

"We need to keep the fact that all of our clients, regardless of whether they're in prison or not, should be expected to receive the same level of care as anyone out in the community."

Providing person-centred care within a correctional environment can challenge assumptions, but Kirsty says the culture within her team remains firmly focused on equitable healthcare. Building that culture requires close collaboration with the corrective services while remaining focused on the rights and healthcare needs of individuals.

"I'm not saying we're perfect, but I think, in terms of our clientele, we do really well. We nurse with kindness and compassion, which at the end of the day is what you want all of our nursing teams to be able to work with."

For Kirsty, advocacy also means shaping the systems in which care is delivered. As a First Nations nurse leader, she believes culturally safe leadership and representation are critical, particularly given the overrepresentation of First Nations people in correctional settings.

"I think in all honesty, just having First Nations nursing leadership probably goes a really long way in regards to actually eliminating racism, and that's certainly our equity agenda within Queensland Health. We're not naive to how difficult it will be to do that, but it's definitely a goal of ours."

Kirsty is the first First Nations Nursing Director appointed within CQHHS, a milestone she hopes will encourage greater representation across all levels of nursing leadership.

She believes visible leadership in mainstream executive roles creates opportunities to challenge assumptions and influence organisational culture.

"When I go into a room, I'm not just there as the Nursing Director, I have a First Nations background."

"I think it's really important to understand the impact that nurses have in this space and that First Nations people need to take up roles at all levels."

Kirsty's commitment to leadership and rural and remote nursing continues through her involvement with the CRANaplus Nursing & Midwifery Roundtable.

Having relied on CRANaplus education for her teams in the past, she sees the Roundtable as an opportunity to contribute to the future of the profession.

"It's a professional opportunity to actually sit somewhere where it's not directly related [to your role], but you're contributing to the whole of the nursing and midwifery remote/rural space."

"We need to be sitting on there and sharing our knowledge."

The CRANaplus Member Nursing & Midwifery Roundtable brings together CRANaplus Members from every state and territory who are passionate about advocating for the rural and remote workforce. To learn more or express your interest, email workforcesupport@crana.org.au

At the heart of it

A CRANaplus Undergraduate Remote Placement Scholarship supported nursing and midwifery student, Nikitha Pallagundla, to complete a five-week placement at Alice Springs Hospital. Her reflection highlights the people, relationships and cultural connections that lie at the heart of nursing in rural and remote Australia.

I am a fourth-year nursing and midwifery student at Monash University. As part of my course, I had the privilege of attending a placement at Alice Springs Hospital in November 2025. I had never travelled to a remote community up until this point, so I was both nervous and excited for this new opportunity.

At the heart of it, learning about the people and the cultures is one of the main reasons I came to Alice Springs. After the completion of my placement, I now realise that I have barely scratched the surface of knowing the cultures and the people.

It is so vast and rich, full of connection and deeper meanings. It warmed my heart to see how the people I cared for were welcoming and kind despite the trauma they have experienced within the healthcare system.

Being in connection with the First Peoples community reinforced my ideology that all peoples should be approached with an open mind and a caring attitude, putting aside our personal bias to the best of our ability to provide the best health care possible.

The nurses that I met made this experience quite pleasant. They were very skilled and knowledgeable, and it was a privilege to be trusted by them while working and caring for the patients. As expected, the remote hospital environment differed from a metropolitan area. The five-week placement I was part of was truly eye-opening and informative.

I worked on the paediatric ward among children and their families. It was interesting to see how some children had to wait for several months just to meet with a specialist for a scan or a consultation – something so simple and more available in the cities. Although everyone knew how to manage a condition, the lack of facilities and services prevented adequate, timely diagnosis and intervention. I saw how children here suffered from chronic conditions such as renal disease and heart issues. One particular child had to wait several weeks before being flown all the way to Melbourne for a kidney transplant. Many children and their families came from out of town – needing to stay elsewhere in Alice Springs every time they were discharged from hospital.

One particular lady whose baby was under our care openly shared that “living out bush is safer” than in Alice Springs despite not having many healthcare services there. It was clear that better health here wasn’t just about access to a hospital, but much rather about changing the conditions people live, work and thrive in if better outcomes are to be seen.

I saw the true impact the social determinants of health have on people’s views, habits and overall health. For the first time, I was able to connect theory to practice. Despite the effort, there remains a huge gap in providing adequate remote healthcare in a developed country like Australia. As such, I would love to come back to remote areas to help in whatever ways I can. ●



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RURAL & REMOTE

A new direction for CRANApplus

At the 2026 CRANApplus Remote Nursing & Midwifery Conference in May, Board Chair Dr Ann Aitken PhD launched the new CRANApplus Strategic Plan 2026-2031 (pictured overleaf). While strategic plans can sometimes feel distant from day-to-day practice, this one has been shaped around a very practical question: How do we better represent, support and educate the remote and isolated health workforce over the next five years?

The plan sets out a clear direction for CRANApplus as we continue working to promote the delivery of safe, high-quality healthcare in rural, remote and isolated communities.

Built around six strategic pillars, the plan focuses on strengthening membership value and engagement, advancing advocacy and workforce support, embedding Cultural Capability and Cultural Safety, leading quality and innovation in service delivery, fostering financial sustainability, and driving operational excellence.

Each pillar speaks to a different part of CRANApplus' work, but together they form a connected roadmap. For Members, this means a continued focus on value, connection, professional development and practical support. For the broader sector, it means strengthening the voice of the rural, remote and isolated health workforce, and advocating for the conditions, pathways and services needed to sustain it.

A significant feature of the plan is the way CRANApplus' former First Peoples Strategy has been embedded across the organisation's work and elevated as its own dedicated pillar. This reflects a renewed commitment to Cultural Capability, Cultural Safety and Cultural Responsiveness, and to centering First Peoples' voices, partnership and accountability in meaningful and ongoing ways.

The plan also looks inward. Strong advocacy and better services rely on a sustainable organisation, sound governance, capable people and systems that make it easier to do good work well. By focusing on smart ways of working, data, partnerships and innovation, CRANApplus is positioning itself to respond to the changing needs of Members and the communities they serve.

Most importantly, the Strategic Plan is not an end point. It is a guide for action and accountability over the next five years.

It gives CRANApplus a shared language for what matters, where we are heading and how we will measure whether our work is making a difference.

For Members, stakeholders and partners, the message is simple: CRANApplus remains focused on the workforce at the heart of remote health. The new strategy provides a practical framework to keep listening, improving and leading alongside the people and communities we exist to serve. ●

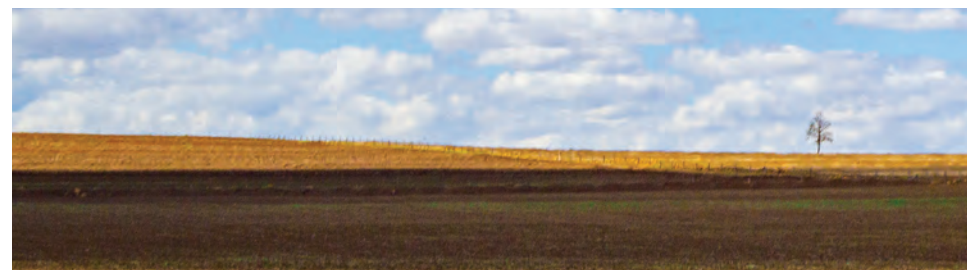


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CRANApplus Strategic Plan 2026–2031

CRANApplus' strategic plan sets a clear direction to strengthen remote and isolated health through Operational Excellence, Cultural Capability, Workforce Sustainability and Innovative Service Delivery.



Our Vision

To be the leading experts supporting the remote and isolated health workforce.

Our Mission

To represent, support and educate the remote and isolated health workforce to promote the development and delivery of safe, high-quality healthcare.

Pillars

Strengthen



Strengthen Membership Value, Retention, Growth and Engagement

- Grow a thriving and connected community through increased value proposition and member retention
- Engage membership through continuous refinement and improved systems

Advance



Advance Sector Engagement, Advocacy and Workforce Support

- Elevate the voice and impact of the rural, remote and isolated health workforce
- Support a sustainable workforce through wellbeing, access to services and strengthened workforce pipelines

Embed



Embed Cultural Capability, Cultural Safety and Cultural Responsiveness

- Build Cultural Capability, Cultural Safety and Cultural Responsiveness across people, policies and practices
- Centre First Peoples' voices, support self-determination and deliver inclusive, effective services

Lead



Lead Quality and Innovation in Service Delivery

- Deliver high-quality, accessible education and workforce support through innovation and technology
- Use data, governance and partnerships to support professional development, wellbeing and practice

Foster



Foster Growth and Financial Sustainability

- Strengthen financial foundations through robust systems, governance and accountability
- Diversify revenue streams and partnerships to ensure long-term organisational sustainability

Drive



Drive Operational Excellence

- Align people, systems, governance and culture to strengthen efficiency, agility and resilience
- Embed smart ways of working and strong People & Culture capability to deliver consistent, high-quality outcomes

Our Values

Integrity • Social Justice • Excellence • Respect • Inclusiveness • Accountability • Safety

Q&A with Professor Linda Deravin

Professor Linda Deravin, Deputy National Rural Health Commissioner for Nursing and Midwifery, is a respected leader in Australia's rural health landscape. Her career has been defined by a deep commitment to strengthening nursing and midwifery workforces in regional and remote communities, with a particular emphasis on creating sustainable, culturally safe pathways for First Nations clinicians.

Professor Deravin's work spans policy, education, and workforce development, focusing on how career pathways, accessible training models, and targeted recruitment and retention strategies can expand opportunities for nurses and midwives across rural Australia. Her expertise and long-standing advocacy for equitable health access positions her as a powerful voice in shaping the future of rural nursing and midwifery. We invited her to share her reflections on the following questions.



How can we better leverage existing First Nations health worker and health practitioner roles as pathways into nursing and midwifery careers in rural and remote settings?

Leveraging existing First Nations health worker and practitioner roles as pathways into nursing and midwifery is a critical strategy for strengthening the rural and remote health workforce. First Nations health workers and practitioners already form the cultural and relational backbone of care in these settings, bringing deep community connections, cultural authority, and substantial clinical experience that position them as ideal candidates for transition into nursing and midwifery.

Yet this progression remains insufficiently supported and formalised. Recognising prior learning through structured bridging programs that grant credit for Certificate III/IV and practitioner qualifications can reduce duplication and shorten training time. Flexible, paid, community-based study models including paid study leave, backfill funding, and "earn while you learn" arrangements, are essential to enable participation without financial hardship. In my role as Deputy National Rural Health Commissioner, I am continuing to advocate for education for our future health workforce as close to home as possible.

We are also encouraging educators to consider alternative entry and exit pathways for nursing and midwifery to support a wide range of potential students in both the postgraduate and undergraduate space. Local and flexible education pathways will support our existing First Nations health workers and health practitioners to extend their qualifications.

What barriers currently prevent First Nations students in rural areas from accessing nursing and midwifery education, and what policy levers are available to address these?

First Nations students in rural and remote areas face a combination of financial, cultural, geographic, and digital barriers that limit access to nursing and midwifery education. High costs of travel, accommodation, relocation, and unpaid placements further deter students who often support extended family networks. Cultural and family responsibilities need to be recognised by mainstream institutions. The scarcity of First Nations academic staff contributes to this isolation however this is something where we can make a change through a commitment to improving Cultural Safety and eliminating racism in all forms both within the health sector and across education institutions.

What workplace Cultural Safety measures have demonstrated measurable impact on retention of First Nations nurses and midwives in rural health services, and how can these be scaled?

Workplace Cultural Safety measures that most strongly support the retention of First Nations nurses and midwives in rural health services are those that embed cultural respect and accountability into everyday practice. Approaches that should be considered include mandatory Cultural Safety training, clear anti racism protocols, culturally grounded mentoring by senior First Nations clinicians, and flexible leave arrangements that recognise cultural obligations such as Sorry Business.

Retention also improves when First Nations leadership is embedded in governance and decision-making. Scaling these measures requires long-term funding, that supports national Cultural Safety standards linked to accreditation.

The Office of the National Rural Health Commissioner contributed to the Second Edition of The National Consensus Framework for Rural Maternity Services. The framework provides a clear outline of best practice Cultural Safety measures in maternity care.

What innovative models of service delivery could redistribute workload and reduce burnout among nurses and midwives in under-resourced rural and remote areas?

Innovative service delivery models that reduce burnout among rural and remote nurses and midwives are those that distribute care across broader, more flexible teams and reduce the pressure on a small number of clinicians. Team based approaches that integrate First Nations health workers, nurse practitioners, midwives, paramedics, and allied health staff help share workload more evenly, while hub and spoke and outreach models allow specialist support without requiring constant on site presence. Continuity of care models, such as midwifery group practice, improve job satisfaction.



Visit to Beverley District Health Service, WA Country Health Service (WACHS): (Left to right) Susan Chambers, Acting District Director, Wheatbelt, WACHS; Zoe Lear, Health Service Manager/Director of Nursing for Beverley Health Service, WACHS; Dr Trish Cook MP, Member for Bullwinkel; Professor Linda Deravin (National Rural Health Deputy Commissioner); Peta Sands, Wheatbelt Regional Aboriginal Health Consultant, WACHS; Lesley Watson, Acting Aged, Care Manager, WACHS; and Amber Reynolds, Personal Assistant to District Director, WACHS.



An expanded use of telehealth, remote monitoring, and virtual supervision decreases unnecessary travel and provides timely support for isolated clinicians.

Encouraging education for our health workforce as close to home as possible has the added benefit of creating a local professional network for staff in the area. Accessible professional development and support close to home have additional benefits for retention and can reduce burnout.

What systemic racism and structural barriers within rural health organisations most significantly impact the recruitment and retention of First Nations nurses and midwives, and what accountability mechanisms could drive change?

Systemic racism and structural barriers within health organisations most affect First Nations nurse and midwife recruitment and retention when discriminatory hiring practices, unchecked interpersonal racism, and the absence of First Nations leadership create workplaces that feel unsafe and culturally unsupported. Driving meaningful change requires strong accountability mechanisms, including transparent reporting and responses to racism, Cultural Safety standards tied to accreditation, independent First Nations oversight, and governance structures that embed First Nations leadership and decision-making authority.

How can funding models be restructured to support long-term investment in First Nations workforce development rather than short-term project-based initiatives?

Long term investment in First Nations workforce development requires shifting funding models away from short-term, project-based cycles and moving them towards sustained, community led approaches that allow workforce initiatives to grow over time.

This means embedding First Nations workforce development as a core, recurrent budget line rather than through competitive grant activity.

Multi-year funding agreements, tied to measurable workforce outcomes rather than short term deliverables, would provide stability for programs such as mentoring, bridging pathways, and “earn while you learn” models.

Strengthening accountability through transparent reporting, co governance with First Nations leaders, and national workforce targets can further ensure that investment remains focused on long term growth rather than temporary short-term initiatives. ●

An update from our Chief RAN



CRANaplus Chief Remote Area Nurse Heather Keighley shares insights into initiatives helping to grow, support and recognise the remote nursing and midwifery workforce, from leadership development and advocacy to stronger education pathways.

This year's CRANaplus Conference, launched fittingly on International Nurses Day, brought together leading thinkers in contemporary health leadership. Keynote speakers Professors Odette Best and Jill Klein

challenged us to confront two leadership issues that remote clinicians navigate every day: the harmful realities of racism in health settings and the self-doubt that can surface when mistakes occur.

Their insights reinforced why leadership remains a central priority for CRANaplus.

For remote and rural nurses and midwives, leadership development is not a luxury; it is a necessity. We recognise a clear gap in support and professional growth opportunities for clinicians working in these specialised settings, and we are working to address it through leadership education and training programs, as well as targeted scholarship opportunities such as the CARPA Remote Health Leadership, Management and WHS Scholarship.



At CRANaplus, we believe strengthening leadership capacity across the remote workforce is central to ensuring safe, sustainable and culturally responsive care.

Showcasing rural and remote excellence in Parliament

The Parliamentary Friends of Nursing event in Canberra at the end of June offered a powerful display of how nurses and midwives are reshaping care delivery across Australia. Federal ministers and parliamentarians saw firsthand the impact of nurses and midwives working to their full scope of practice across wound care, immunisation, ear health services, nurse practitioner-led care, endorsed midwifery models, primary care and remote health services.

It was particularly inspiring to see another nurse elected to Parliament in Western Australia: Trish Cook, the Federal Member for Bullwinkel, a rural and remote nurse and one of our three Parliamentary Friends.

Our host, Dr Helen Haines, Independent Federal Member for Indi, proudly highlighted her own nursing and midwifery background and emphasised the importance of continuity-of-care midwifery models.

Dr Haines also convened the Parliamentary Friends of Maternal Health the following day, where migrant women shared their experiences of maternity care in Australia.



Trish Cook MP at the CRANaplus booth during the Australian College of Nursing National Nursing Forum, August 2026.

These stories underscored the universal need for culturally safe maternity care, an issue felt acutely in remote communities where access, continuity, and cultural responsiveness are often stretched.

Our third Parliamentary Friend, Dr Anne Webster, Federal Member for Mallee, continues to be a strong advocate for rural and remote health, and for nursing and midwifery. Her support remains invaluable as we work collectively to elevate the voices of clinicians serving Australia's most isolated regions.

Expanding education pathways for remote nurses and midwives

CRANaplus is strengthening university partnerships to create clearer, supported pathways into advanced education for rural and remote clinicians. These pathways reduce barriers for clinicians seeking postgraduate qualifications while recognising the advanced skills already gained through remote practice.

We have formal agreements with La Trobe University Rural Health School and the University of Southern Queensland, and early discussions are underway with Charles Darwin University, whose footprint spans multiple states and territories.

These collaborations will allow CRANaplus courses to be recognised toward Graduate Certificate qualifications, with up to one unit of study credited for eligible CRANaplus course completion within the past five years.

Our long-term goal is ambitious but essential: for every nurse and midwife practising in rural and remote settings to hold a relevant Graduate Certificate. This level of preparation is critical to improving health outcomes in communities that consistently lag metropolitan areas across key health indicators.

Enhanced qualifications also support workforce retention by recognising the complexity and expertise inherent in remote practice.

Strengthening national alignment and advocacy

CRANaplus remains committed to working closely with national peak bodies in nursing and midwifery to strengthen advocacy and ensure rural and remote practice is visible, valued and supported. All partnered programs align with the National Rural and Remote Nursing Generalist Framework, our hallmark guide for safe, high-quality practice in remote settings. This alignment is helping build a unified voice for remote nursing and midwifery, one that is increasingly influencing policy and investment.

As we look ahead, I feel genuine optimism. Through collaboration, strong leadership, and expanded education pathways, rural and remote nurses and midwives are gaining the recognition and support they deserve.

Together, we are shaping a future where remote nurses and midwives are recognised not only for their resilience, but for their leadership, expertise, and essential role in the health of rural and remote Australia. CRANaplus will continue championing this workforce and the communities they serve. ●



Photo: John White Photos – stock.adobe.com



Trish Cook MP and CRANaplus representatives at the Parliamentary Friends of Nursing event in Canberra, June 2026.

Corporate Members and Partners



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 healthcare manuals suite.
Website: www.carpa.com.au



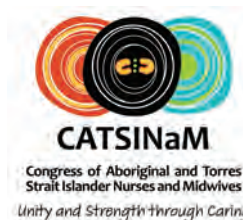
Central Australian Aboriginal Congress (Congress) is a large Aboriginal Community Controlled Health Service (ACCHS) based in Alice Springs. We are one of the most experienced organisations in the country in Aboriginal health, a national leader in primary health care, and a strong advocate for the health of our people. Since the 1970s, we have developed a comprehensive model of primary health care that includes multidisciplinary clinical care; health promotion and disease prevention programs; and action on the social, cultural, economic and political determinants of health and wellbeing. Congress delivers services to more than 14,000 Aboriginal people living in Alice Springs and remote communities across Central Australia including Ltyentye Apurte (Santa Teresa), Ntaria (Hermannsburg), Wallace Rockhole, Utju (Areyonga), Mutitjulu, Amoonguna, Kaltukatjara (Dockers River), Yulara and Imanpa.
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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.



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The **Indian Ocean Territories Health Service** manages the provision of health services on both the Cocos (Keeling) Islands and Christmas Island. Website: 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 Website: www.cqcrh.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.



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Miwatj Health Aboriginal Corporation is an ACCHO designed to facilitate Aboriginal and Torres Strait Islander (Yolngu) 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 Yolngu. However, we also depend on health professionals from elsewhere who work together with Yolngu staff. Website: www.miwatj.com.au



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 multi-disciplinary student health network, bringing together people studying medicine, nursing and allied health, encouraging them to pursue rural health careers. Email: executivecommittee@nrhsn.org.au Website: 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.



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 healthcare 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: liz.unkles@health.nlk.gov.nf Website: www.norfolkislandhealth.gov.nf



Oak Valley Health Service (OVHS) delivers culturally safe, high-quality primary and preventive health care to the Anangu community of Oak Valley, located on Maralinga Tjarutja Lands in remote South Australia. Established in 1985 for Anangu displaced by British atomic testing at Maralinga, Oak Valley Community's essential infrastructure includes a clinic, aged care facilities, school, store, arts centre, ranger program and airstrip. OVHS focuses on supporting healthy beginnings, promoting strong bodies through chronic disease prevention and management, empowering Anangu across all life stages with tools and education and building a healthy future through community-led, culturally grounded programs. OVHS has been a member of NACCHO for over 40 years, providing comprehensive health services aligned with national standards and operates under the governance of Oak Valley (Maralinga) Aboriginal Corporation ensuring services reflect community needs and priorities. Email: reception@maralinga.com.au Website: oakvalley.com.au



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 Website: www.puntukurnu.com



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 healthcare services, with a long-term vision of establishing a regional Aboriginal Community Controlled Health Service.



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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 healthcare 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 Website: www.ruralhealthwest.com.au



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Support

Between two worlds

Returning to work in the season of matrescence

Sarah-Jane Stratton, Clinical Psychologist with the CRANaplus Bush Support Line, speaks about remote mental health work, motherhood, and the often-unspoken complexities of returning to work after having children.

I spent four years living and working as a Child and Adolescent Mental Health Service (CAMHS) Clinician in the Kimberley, remote WA, before relocating to rural WA to be closer to family when we had our first child. I've always felt drawn to rural and remote mental health work. There's something deeply meaningful about the connection that happens in smaller communities. After moving to rural WA, I started as a Clinical Psychologist contractor with the CRANaplus Bush Support Line, supporting rural and remote health workers and their families.

I loved this work immediately because I felt in some way still connected to the more remote parts of Australia through the stories I was hearing. I also believe that our nervous systems talk to each other, so when health workers feel grounded, calm, and supported, they are better able to help others feel safe and regulated, too. And in communities where trauma, loss, disasters, and adversity are not uncommon, this is so important.

I was working with the CRANaplus Bush Support Line, and in a rural WA CAMHS clinic, when I made the decision to step away from the latter. Shortly after, we found out we were pregnant with twins. I took a second stretch of maternity leave and these days I divide my time between my work as a Clinical Psychologist with the CRANaplus Bush Support Line and the unpaid, often unseen work of raising our three young children; a role that has challenged, stretched, and shaped me as much as any professional role ever has.

While every family's circumstances, choices and opportunities look different, I'm fortunate that this arrangement works for our family at the moment.

For much of my career, I have sat alongside people navigating significant life transitions, helping them make sense of change, loss, identity shifts, and the challenge of adapting when life no longer looks the way it once did. What I didn't realise was how profoundly I would come to understand these experiences myself through becoming a mother.

I remember sitting in a clinical review at CAMHS, not long after returning to work after having my first child. This space had once felt familiar and energising – but suddenly there was this really strange disconnect. My colleagues were moving through case presentations quickly, formulating clearly, offering treatment recommendations, and I was just drawing blanks and hearing 'The Wheels on the Bus' over and over again!

At the time, I remember thinking, "What has happened to my brain?"

But underneath the brain fog, there was this unexpected, quieter kind of confidence. I was able to make decisions more quickly (definitely not because I had more clarity), but because I just no longer had the capacity to endlessly analyse every possibility.

That experience captured something important about early parenthood for me: the strange push-pull of feeling both diminished and expanded at the same time.



Photo: HansWismeijer - stock.adobe.com

Part of me grieved the sharpness and professional identity I once relied on so heavily. But another part of me was growing in ways I didn't yet fully understand. My attention was constantly split between multiple emotional worlds, wanting to be fully present at work while also carrying the invisible mental load of motherhood.

It was only later that I came across the term *matrescence* – a concept initially introduced by medical anthropologist Dana Raphael back in the 70s and more recently expanded on by Psychiatrists like Dr Alexandra Sacks – to describe the transition into motherhood (Raphael, 1973). ►►

► And honestly, discovering that word felt relieving.

Why? Because matrescence explains something we don't talk about nearly enough: that becoming a mother is not simply an event, but a profound developmental transition. Much like adolescence, it involves biological change, emotional upheaval, identity reconstruction, and loads of disorientation! (Sacks & Birndorf, 2017) Yet unlike adolescence, there is an expectation that women move through it more quietly and without disrupting the rest of their lives.

Matrescence didn't just reshape my life outside of work, it also began to influence how I experienced my work. Parental anxiety and overwhelm were no longer concepts I understood only professionally; they had become lived experiences. I found myself holding greater compassion for the realities families face and the sheer difficulty of trying to make meaningful changes while already running on empty. Some aspects of the work felt emotionally closer to the surface than they once had.

Parenthood also changed my relationship with energy and time. There was less of both. I became more aware of how unrealistic many

expectations – both personal and professional – can be, particularly for parents trying to balance caregiving, work, relationships, and their own wellbeing all at once.

And then there were the quieter challenges. The guilt. Feeling like I wasn't giving enough at work, while simultaneously feeling like I wasn't giving enough at home. The exhaustion – not just physical tiredness, but cognitive and emotional depletion. The emotional complexity of daycare drop-offs: holding my child's separation distress before stepping into a role that involved emotionally holding space for others.

And honestly, one of the most complicated parts has been the joy of motherhood itself. There have been moments when I felt I couldn't quite admit how much I genuinely enjoy being present for ordinary moments with my kids. At times, it has felt strangely uncomfortable to acknowledge that fulfilment openly – as though loving motherhood too much somehow conflicts with professional ambition or identity.

Over time, I've found a few things that have helped.

Understanding matrescence and having a language for why I could feel deeply competent and deeply uncertain at the same time was hugely helpful.

I realised I wasn't failing to "get back to" being the clinician I had been before kids – I was returning as someone fundamentally different. Expecting myself to move through a major developmental transition unchanged wasn't realistic.

I've also learned the importance of boundaries and sustainability. I don't access work emails from home. I try to work strategically around my energy levels. I aim for small, achievable goals rather than impossible standards.

And perhaps most importantly, I've had to practice offering myself the same compassion I so readily offer other people.

Returning to work after becoming a parent meant letting go of an old measure of success. I could no longer give my work the same singular focus I once had, and initially, I saw this as a deficit.

Over time, though, I realised that my capacity hadn't shrunk, it had been reorganised, and in some ways, expanded. My energy was now shared across multiple roles and relationships, competing demands, and overlapping emotional worlds. But rather than making me less effective, this has allowed me to approach my work with more intention, perspective, and compassion.

Motherhood has taught me that adapting isn't about doing everything perfectly. It's about learning to hold what matters most in a particular season of life. Like the metaphor of juggling glass and rubber balls, the goal isn't to juggle every ball perfectly, but to recognise which ones are most important in the present moment and give those your attention.

References

Raphael, D. (1973). *The tender gift: Breastfeeding*. Prentice-Hall.

Sacks, A., & Birndorf, C. A. (2017). *Matrescence: Lifetime impact of mothering*. *Psychiatric Annals*, 47(9), 483–486. ●



When caring hurts: Understanding moral injury



Working in healthcare in rural and remote Australia often asks unexpected things of ordinary people. Whether you are a nurse, doctor, Aboriginal and/or Torres Strait Islander Health Worker, allied health professional, administrator, cleaner, manager or volunteer,

you are generally part of a team that regularly goes above and beyond for your community.

We generally expect to be busy, to have a lot asked of us, and to feel emotionally exhausted. But sometimes what we bring home after our day is not just stress. Sometimes it is the dilemma of not being able to do what we know is right. This is known as moral injury, writes MC Mandile, Senior Psychologist, Bush Support Line.

Moral injury is different from burnout. Burnout develops when there is prolonged workplace stress, whereas moral injury occurs when we are prevented from acting in ways that align with our values, or when we witness situations that challenge our sense of what is right. In rural and remote healthcare, this might mean limited resources, delays in care, workforce shortages, racism, or watching patients wait far too long for the care they need.

The hardest part of moral injury is that it often hides in plain sight.

A lot of people show up every day doing great work, while their self-talk says things like, "I should have done more," or "I should have said something." When we talk to ourselves like this for long periods, it can start eating away at our confidence, connection, and the meaning we find in what we do.

Moral injury can also be a sign that your values remain intact. You feel distress precisely because you still care. This doesn't make the experience any more comfortable, but it can be reframed as a sign of integrity, rather than failure.

One of the most helpful ways to protect ourselves is through connection. Talking about what is going on with trusted colleagues, supervisors or mentors, or the Bush Support Line can help us make sense of difficult experiences without having to carry them alone. Naming moral injury and calling it out for what it is can also reduce shame and remind others that things are not ok; the system may be challenged, not us.

At CRANaplus, we know that rural and remote health professionals deserve practical, evidence-informed support, and that is why we have developed a new tipsheet on moral injury. This resource contains more information on moral injury, some signs to look out for, and what can help. To access the tipsheet and related Mindful Monday article, search for moral injury on the CRANaplus website or scan the QR codes. Take a moment to read these resources and start the conversations we all need to have, because caring for the carers is just as important as caring for our communities.

Sometimes the first step towards healing is working out what is going on and then knowing that you do not have to carry it alone. If this is where you are, please reach out and take that first step today. ●



Mindful Monday



Tipsheet

Wellbeing for the Bush **MORAL INJURY**

Healthcare workers in rural and remote Australia are committed and passionate about helping others. They often work in small teams with limited resources, far from support systems, while also carrying potential exposure to community trauma. As healthcare workers, most days your commitment and passion carry you through; but sometimes what you feel is right, and what your organisation requires do not align, and your moral code is challenged. This is known as moral injury.

What is moral injury?

Psychiatrist Jonathan Shay first explored moral injury and defined it as "a betrayal of what is right by someone who holds legitimate authority in a high-stakes situation" (Shay 2014), and usually develops through repeated exposure to ethically distressing situations. There are psychological, behavioural, social, and spiritual impacts because you were either perpetrating, failing to prevent, or witnessing acts that rock deeply held personal moral beliefs and expectations (Litz et al. 2009).

Signs you may be experiencing moral injury

Common signs and symptoms include:

Behavioural

Withdrawing, avoiding, increased irritability, overworking to try to compensate, considering leaving your role or profession.

Emotional

Guilt, shame, numbness, powerlessness, or anger after shifts, due to a clinical decision, resource constraints, or leadership decision.

Cognitive

Rumination about "what I should have done", losing trust in the workplace and processes, harsh self-criticism, confusion about professional identity.

Psychological and somatic

Trouble sleeping, somatic tension when thinking about events, difficulty staying calm when having to make decisions in stressful situations.

Professional and identity disruption

Questioning if you still want to work in your area of training, disengagement from your organisation, questioning your morals, ethics and values, losing pride in your work.



Educate

Launching our Remote Primary Assessment Suite

CRANaplus is expanding beyond emergency care into primary health care education for rural and remote clinicians – delivering the first modular, CPD-ready primary health assessment suite designed specifically for rural and remote practice. Building on the foundations of CRANaplus' former Clinical Assessment Suite, the resource has been reimagined and updated as the new Remote Primary Assessment Suite. Remote Clinical Educator, Anna Heaton, shares what to expect.

Primary health care is at the core of healthcare delivery in remote communities. Expanding on its established emergency care programs, CRANaplus has launched the new Remote Primary Assessment Suite, providing education that reflects the breadth and diversity of contemporary remote nursing practice.

This suite shifts our offering from primarily emergency response education to a whole-of-practice model, while still maintaining a strong emergency lens where it matters. It responds to a need identified by many, as there is currently no standalone CPD course providing comprehensive primary health assessment for rural and remote clinicians outside university programs. This is an important step in supporting workforce capability.

What makes it different

We've designed this suite for both ends of the workforce. For new-to-remote nurses, it's a structured, comprehensive onboarding pathway, and for experienced RANs, it's an opportunity to complete an efficient, case-based refresh and targeted CPD.

The suite reflects the realities of remote practice, where clinicians manage everything from routine primary health care presentations

to acute deterioration. Each module follows a consistent learning pathway, beginning with a self-assessment of prior knowledge before exploring comprehensive primary health assessment through the RAN Model of Consultation. Recognising that emergencies can occur in any setting, modules also incorporate Primary and Secondary Survey approaches to support escalation and retrieval when required. Common presentations and population-specific considerations are then explored, helping clinicians develop systematic assessment skills, clinical reasoning and confidence across the breadth of rural and remote practice.

Modules are interactive and engaging with self-directed, case-based learning, knowledge checks, and practical application. With this modular, flexible CPD (two to five hours per module), learners can engage as deeply as needed – whether completing full modules or targeting specific learning gaps.

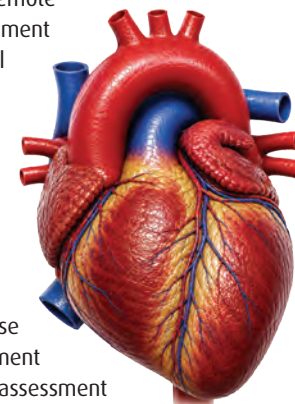
Each module works independently or as part of a progressive learning pathway toward advanced practice, so modules can be approached as a stackable pathway, or a standalone product.

What's coming

The first modules will be available in September, with more on the way. They provide a practical foundation for primary health assessment in remote settings, designed for immediate use in practice.

This first suite will include:

- Introduction: Remote Primary Assessment
- Gastrointestinal Assessment
- Cardiovascular Assessment
- Respiratory Assessment



Additional modules covering areas from ear, nose and throat assessment to dermatological assessment are already in development. Stay tuned as we launch these next stages over the coming months.

By expanding education beyond emergency response and into everyday primary health care, the Remote Primary Assessment Suite aims to better reflect the realities of rural and remote practice and support clinicians to provide safe, confident care across the full scope of their role.

To stay up to date, visit
crana.org.au/education ●



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Taking the family remote, and getting ready for the reality

Remote area nursing gave Nikki Naish and her family an unforgettable adventure, but it also taught her an important lesson. While her three young children flourished in remote Australia, embraced by community and immersed in a completely different way of life, Nikki discovered just how vital preparation is for remote area nurses. It's a lesson she now shares as a volunteer CRANaplus course facilitator.

Nikki Naish has three children aged four, six, and eight, and says that taking her family remote was one of the best experiences they've shared. She worked as a remote area nurse in East Arnhem Land, while her husband was employed by the same company as a jack of all trades – maintenance, driver, security.

"My kids were all born and raised on the Gold Coast, so were used to the beach and lifestyle, and then we went full bush – nothing within 400km, full red dirt – and it was just the most amazing experience," she says.

"They fully embraced the bush life. They got super involved. The community that we were in was amazing. It was really supportive and welcoming and they had really amazing bush programs where the Elders were involved, and they welcomed my kids and my family straight into it.

"I feel really privileged because I know that a lot of people don't get to experience what we did. It's something that even to this day, my four-year-old, who was 18 months at the time, looks at photos and he's like, 'I remember that,' or he'll talk about the boys he played with in play group, and it's really special.



"And my kids got to see what I do firsthand. There were some times that my husband and I were both on call and the kids had to come with us to do an airport run or to go chase a buffalo off the airstrip or something. Just getting them involved was really cool for them."

It was an experience Nikki would recommend to anyone considering rural or remote nursing. But looking back, she can also see how unprepared she was when she first arrived – a lesson that has since shaped her commitment to supporting other nurses entering rural and remote practice.

Prior to this role, Nikki had stepped away from hospital-based nursing and landed

in a telehealth triage position for remote communities. It opened her eyes to the world of remote area nursing that she had never known existed. She asked her employer what she would need to do to work remote herself, and just two weeks later was relocating her family to East Arnhem Land for this role.

"I spent 12 months full-time as a remote area nurse in this nurse-led clinic with two other nurses and that's when I did all my upskilling – all of my CRANA courses," Nikki says.

She says CRANaplus courses, focused on rural and remote realities, really resonated with her at this time. ►►



"As a new remote area nurse, I didn't realise how unsafe it was for me to be in the community until I had done the courses. I was like, 'Oh my God, I really should have done this before I came out.'"

"So then I was really advocating for the agency nurses, because we always had agency nurses, to make sure that they had all of these certificates as well."

This passion for education leads wonderfully into Nikki's role now as a volunteer facilitator on CRANaplus courses.

Being new to remote is still fresh in her mind, and she knows how easy it can be to be naive about the realities of rural and remote work, which helps her connect with participants.

"I think anyone can just think that they can go remote and be a bum on a seat and learn as you go, but once you're out there ... when it's only you and potentially one or two other nurses, you need to [have the knowledge and skills to be a RAN]."

"I think that's something that, especially as a new grad, you don't know."

"Usually I'm doing courses with Leanne or Kathy [Remote Clinical Educators] who've got more years of experience between them than I've been alive. I'm quite new to remote, so I like being the new one because I feel like I relate to a lot of the participants who are either new to remote or looking to go remote."

"I feel like I can share my experience and stories and be a good resource for those people."

It's the role Nikki once needed herself, and one she's now proud to play for the next generation of rural and remote nurses.

CRANaplus courses are contextualised to remote and isolated practice, and we are always looking for skilled, experienced and positive volunteer facilitators to help run them. To express interest in becoming a CRANaplus facilitator, email education.admin@crana.org.au ●

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Bringing private training directly to your health service



High-quality professional development shouldn't always have to mean taking your team away from the communities they serve. Acting General Manager Clinical Education, Michelle Mason, shares how CRANApplus private education courses

bring training directly to workplaces, making it easier for organisations to build skills, confidence and capability in their health settings.

Accessing high-quality professional development can be challenging in rural and remote Australia. Travelling long distances for training takes clinicians away from their communities, can add costs and place extra pressure on already stretched teams.

That's why CRANApplus offers private, on-site education courses, bringing nationally recognised training directly to your workplace. Designed for remote health services, mining companies and agencies, these courses give clinicians the opportunity to build their skills together, in a familiar environment, without the need to travel.

Our private courses are tailored to your organisation's needs while delivering the same high-quality education CRANApplus is known for across Australia.

Hosting a course is simple. Your organisation provides a suitable venue and catering, while CRANApplus takes care of the educators, equipment and all pre-course learning, making it an easy and seamless experience for employers and participants alike.

There is a range of private courses tailored to the realities of rural and remote practice available, including:

Remote Emergency Care (REC)

For many employers, the REC course is a mandatory prerequisite for working in remote locations, and for good reason. REC is designed to deliver a personalised learning experience for clinicians who may be required to manage critically ill or injured patients with limited support.

The course is suitable for nurses, midwives, Aboriginal and/or Torres Strait Islander Health Workers/Practitioners, paramedics, and medical officers. It focuses on building



confidence, clinical reasoning, and practical skills that are essential for emergency care in isolated environments.

Practical Skills (PS)

For teams seeking targeted, hands on training, the PS course offers an invaluable opportunity to strengthen everyday clinical capability. Participants learn essential skills in suturing, plastering, and ENT assessment, all delivered through culturally safe, best practice instruction.

This course is particularly beneficial for clinicians working in low resource settings, where timely intervention can significantly improve patient outcomes. By building practical confidence, PS helps strengthen workforce resilience and supports safer care across rural and remote communities.

Maternity Emergency Care (MEC)

The MEC course is designed for non midwife practitioners who may be required to manage maternal or neonatal emergencies. Grounded in a

Below: Participants from Panaceum Group at a private CRANApplus Practical Skills course in Geraldton, WA, August 2026.



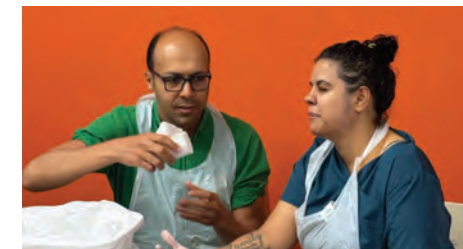
wellness oriented, woman centred model of care, MEC equips clinicians with the knowledge and practical skills needed to recognise, respond to, and reflect on both routine and non routine outcomes.

Every CRANApplus course is aligned with the National Rural and Remote Nursing Generalist Framework capabilities, helping clinicians strengthen the practical skills, confidence and clinical decision-making needed to provide safe, high-quality care in rural and remote communities.

For employers, hosting a private course is an investment in both your workforce and the communities you serve.

Your team receives practical, relevant education without leaving the workplace, building capability, confidence and stronger patient outcomes close to home.

To explore private course options or request a quote, contact education.admin@crana.org.au



Engage

Distance. Dedication. Difference. Reflections from Perth 2026

The 2026 Remote Nursing and Midwifery Conference brought remote health professionals from across Australia together for three inspiring days of learning, connection and collaboration.

The program featured a diverse mix of keynotes, oral presentations, hotspot sessions and practical clinical workshops, giving delegates opportunities to learn from grassroots workers through to sector leaders, while building skills directly relevant to rural and remote practice.

A few highlights included presentations from Professor Odette Best, Professor Jill Klein, Adjunct Professor Alison McMillan and CRANaplus' newly appointed Honorary Fellow, Adjunct Associate Professor Alison Weatherstone. Their presentations sparked important conversations about Cultural Safety, leadership, workforce sustainability, and the future of healthcare delivery in remote communities.



Delegates consistently identified the hands-on clinical workshops as a standout feature of the program. These sessions provided opportunities to refresh existing skills, build confidence and learn alongside colleagues who understand the realities of working in isolated settings. ►►



Photo: Caseyjadew - stock.adobe.com

» Equally popular was the vibrant conference Expo, which brought together organisations from across the health, education and workforce sectors. The Expo created valuable opportunities for networking, collaboration and discovering products, services and programs that support remote practice.

The highly valued Escape Room challenge also gave delegates the opportunity to put their clinical knowledge, teamwork and problem-solving skills to the test through realistic remote health scenarios.

Beyond the formal program, the conference provided countless opportunities for delegates to connect with peers, share experiences and build lasting professional relationships.

From networking events and informal conversations to shared learning experiences, the strong sense of community that defines remote health was evident throughout the event.

Once again the ever-popular Wellbeing Lounge (and therapy dogs!) remained a favourite destination throughout the conference, providing a welcoming space for delegates to relax, recharge, connect with colleagues and learn about CRANaplus Mental Health and Wellbeing services.

CRANaplus extends its sincere thanks to all sponsors and exhibitors whose generous support helped make the conference possible. We especially acknowledge our Platinum Partner, Edith Cowan University; Gold Partners,

Scholarship recipient spotlight

"I'm appreciative and grateful to have received a CRANaplus Conference Scholarship. I wasn't entirely sure what to expect going in, being new to rural and remote healthcare, but I came away with a lot of food for thought. The following are just a few I've considered.

The conference started on International Nurses Day, notably fitting. How Cultural Safety was permeated through the talks, as a lens rather than a checkbox, was significant.

I am only at the beginning of transitioning from metro to rural practice, of what I heard will shape how I move forward, whether I realise it or not. I'm glad I was given the opportunity to attend to help further guide my direction. I appreciated learning about the challenges faced by rural and remote healthcare, as well as the many advantages. The data on rising rates of syphilis and diphtheria in rural communities stuck with me. Equitable healthcare delivery matters, wherever we work.

Jill Klein's session on innovation and dissonance gave me a lot to think about in terms of my own experiences. Rosalie Schultz's talk on volunteering in the Solomon Islands also stayed with me. A slight comment made that you don't have to feel entirely ready before you act was well timed for me.

The hands-on workshops were appreciated, such as the ear health and PID skill session. It was a good reminder of how broad rural and remote practice can be to meet the needs of communities.

The Purple House data was striking. It was inspiring to see how they went from having the worst dialysis survival rates in the country to the best in two decades. Disparity in Indigenous Health gets a lot of coverage and rightly so, but it was good to hear about something that is working.

Lastly, rural and remote nursing is advanced practice at the edge of complexity. Well said."

Selena, Conference Attendance Scholarship Recipient



Miwatj Health and the Australian Nursing and Midwifery Accreditation Council; and Silver Partner, the University of Southern Queensland.

Your support enables us to deliver a high-quality event that strengthens the remote health workforce while fostering innovation, collaboration and professional growth across the sector.

Another highlight of the 2026 conference was the introduction of the Remote Nursing and Midwifery Conference Attendance Scholarship.

The program supported undergraduate health students, clinicians new to remote practice, and First Peoples clinicians working in rural and remote communities to attend the event.



By helping remove financial barriers to attendance, the scholarship enabled a broader range of voices, experiences and perspectives to be represented throughout the conference. For many recipients, it provided access to professional development, networking opportunities and mentorship that may otherwise have been out of reach.

The success of this initiative means the scholarship program will return in 2027, continuing to support and inspire the next generation of remote health leaders. If you are an undergraduate health student, a clinician new to remote practice, or a First Peoples clinician working in rural or remote Australia, keep an eye out for applications opening soon. »





While we celebrate the success of Perth 2026, excitement is already building for next year.

We are delighted to announce that the 2027 Rural and Remote Nursing and Midwifery Conference will be held in Garramilla (Darwin) from 30 May to 1 June 2027.

Until then, keep an eye out for scholarship applications, sponsorship and exhibition opportunities, speaker announcements and Remote Health Award nominations.

We look forward to once again bringing the sector together to learn, connect and celebrate the people making a difference in rural and remote Australia.

cranaconference.com.au ●



More ways to learn and thrive

Following the launch of the CRANaplus Workforce Support Webinar Series earlier this year, we're pleased to share a range of upcoming live and on-demand webinar opportunities designed to support rural and remote health professionals wherever they are in their career journey.

The series continues to deliver practical, relevant learning that reflects the realities of rural and remote practice. Covering clinical, operational, leadership, cultural and professional development topics, the program is also expanding to include a stronger focus on mental health and wellbeing, recognising the unique challenges and opportunities that come with working in rural, remote and isolated settings.

These sessions provide opportunities to learn from experts and strengthen your knowledge in areas that support you and matter most to your work.

If you missed some of our recent sessions, a number of webinars are now available on-demand, including *CPD that works for you*, *My journey to Nurse Practitioner* and *Understanding reproductive coercion and abuse*.

These recordings offer flexible learning you can access at a time that suits you.

Below are the upcoming live webinar opportunities for 2026 available for free to CRANaplus Members and the wider rural and remote health workforce. We encourage you to register early.

2026 (Tuesdays)			
22 September	12:00 & 16:00	Wellbeing	Supporting Yourself and Others After Traumatic Events
6 October	12:00 & 16:00	Wellbeing	Managing Cumulative Loss and Grief in Remote Practice
20 October	12:00 & 16:00	Wellbeing	Work-Life Integration in Remote and FIFO Roles
3 November	12:00 & 16:00	Mindfulness	Mindfulness and the Stressed Body – Working with Your Nervous System
17 November	12:00 & 16:00	Wellbeing	Sustaining a Career in Remote Health – Identity, Meaning and Longevity
1 December	12:00 & 16:00	Wellbeing	Stress and the Silly Season – Managing the Holiday Period in Remote Roles
15 December	12:00 & 16:00	Wellbeing	Writing Your Way Through – Gratitude, Narrative and the Stories We Tell Ourselves

Please note: Webinar times are Australian Eastern Standard Time (AEST) and dates, times, and topics are correct at the time of publication but may be subject to change. Please visit the CRANaplus website for the latest information.

Upcoming 2027 live webinars – Dates to be announced soon

New Year Reset – Intentions, Values and the Year Ahead
Preparing for Remote Work – Practical and Psychological Readiness
Moral Injury – What It Is and Why It Matters/Recognition and Response
Vicarious Trauma – Understanding the Accumulation
Sleep, Fatigue, On-Call and Shift Work in Remote Practice
Psychological Safety – Retention, Engagement and Patient Outcomes
Vicarious Post-Traumatic Growth – From Surviving to Thriving
Navigating Workplace Conflict in Remote Communities
Mindful Communication – Presence, Listening and Difficult Conversations
Reconnecting After Remote Work – Transition, Identity and Relationships
Cultural Safety in Practice – Working Respectfully in First Nations Communities
When People Leave – Managing Transition, Loss and Continuity in Remote Health
Burnout and Compassion Fatigue – Telling Them Apart/What Actually Helps
Security and Personal Safety in Remote Communities

Coming soon to on-demand

No registration required; keep an eye out for new on-demand webinars coming soon.

- Syphilis: current updates and best practice
- National Rural Health Student Network: supporting the future rural and remote workforce
- Allergy care and eczema management
- Inspirational models of care in rural and remote communities

We are committed to delivering education that responds to emerging priorities and supports clinicians working across Australia's rural, remote and isolated settings.

Have a topic suggestion?
We'd love to hear from you. Contact workforcesupport@crana.org.au with your ideas for future webinars. ●

Preparing the next generation



In 1980, Fiona Cameron arrived in Cape York with a shortwave radio, guitar and little remote experience. More than 40 years later, her work as a lecturer on Flinders University's Remote Health Practice Program has earned her two major honours at the 2026 CRANaplus Conference: the Excellence in Education and/or Research Award (sponsored by the University of Western Australia) and CRANaplus Fellowship.

In 1980, Fiona walked into the Department of Aboriginal and Islander Affairs in Brisbane and asked: "Do you have any jobs?" Within a few weeks, she was working in Cape York.

"It was an amazing transition from Brisbane," she says.

"There was no telephone and no TV. You had to write a letter to the supermarket to Cairns to say what you'd like sent on the plane."

She wasn't yet a midwife, a gap she quickly felt. Pregnant women had to leave their communities to give birth in larger towns or cities, she explains – but it didn't always work out that way.

"A lot of the women wouldn't go, or they'd go and they'd come back, and they'd present in the middle of the night with a baby about to be born," she recalls.

"That was frightening for me, but I did learn a lot. That was one of the reasons I said I'm never going remote again until I'm a midwife."

Fiona returned to study, worked in larger hospitals and gained her midwifery qualifications before returning to remote health for good in 2000.

Above, left to right: Dr Ann Aitken PhD, Board Chair, CRANaplus; Fiona; Emma Barritt, CEO, CRANaplus. Right: Fiona and Olivia Gallagher, Professor and Head of Nursing, The University of Western Australia

Since then, Fiona has worked in remote NT, the Torres Strait, the Kimberley, Cape York and Central Western Queensland, in clinical, education and senior leadership roles.

Four years ago, she took up her current post as Lecturer in the Remote Health Practice Program at Flinders University in Alice Springs. It was a full-circle moment. She'd first heard of the program decades earlier, working in the Torres Strait as a young nurse.

Echoing the sentiments which gave rise to the course in the 1990s, Fiona says, "The history of remote nursing has been like – people just get thrown in and you sink or swim.

"So that's why, delivering education, going out with them, supporting them, is so important."

Due to the connections she has formed through years of work in remote places, Fiona has been able to introduce a series of guest lecturers who are specialists in the field.

"It probably gets a bit boring listening to me!" she laughs.



"I've been lucky because I've been in Alice Springs now since 2009 and working in primary health care. So I built all those networks over the years."

She uses the same networks to help students find their footing. "I try to help remote nurses think about how they're going to develop their career, what directions to go," she says.

"They do a two-week placement in a remote health centre, and if they need to, I organise that for them with someone in Central Australia.

"We now have a program where if they've got suitable qualifications that the Department of Health will take them on for a longer contract and pay them to do the placement."

She emphasises that the program teaches so much more than just clinical skills, covering areas like self-care and safety.

Despite the positive impact she has had, Fiona was still shocked to be recognised with the Excellence in Education and/or Research Award – and to be bestowed CRANaplus Fellowship at the same conference.

"Dallas [from CRANaplus] had my CV on stage and was reading everything I have done," she recalls. "And I'm going – oh my goodness, I haven't really done all that, have I?"

When asked what the proudest moment in her career is, Fiona shares a clinical anecdote – one which testifies to the importance of being prepared.

It happened when she was working in the NT as an educator. One day, she went out to the clinic only to find her student was off sick.

"There were two remote area nurses with me, and we had this fellow come in and have a huge myocardial infarction. He arrested, and we saved him," she recalls.

"I couldn't believe it. By the time the RFDS came, the man was sitting up in bed like nothing had ever happened to him."

It's for moments like these that Fiona is preparing the next generation. ●

A team that goes the distance

The Central Australian Remote Midwifery Team travels vast distances to ensure women can access continuity of midwifery care in community. It's work that demands flexibility, collaboration and deep community connection, which has been recognised with the Collaborative Team Award at the 2026 Australian Remote Health Awards.

This team of six midwives provide care to 18 remote communities across Central Australia, covering 600,000 km² and 40 per cent of the Northern Territory.

Together, Katrina Molloy, Jane Christmas, Marilla (Milly) Grigg, Katherine Gouliart and Sally Halton, led by manager Glenda Gleeson, deliver maternity, reproductive and sexual health care to women within their remote communities, bringing women-led midwifery continuity.

Milly says, "The Remote Midwifery Team has been running for over 20 years, ensuring remote women during their health lifespan have access to culturally safe, considered and consulted care, working with Aboriginal care providers and stakeholders providing excellence in clinical care, community-led women's health and autonomy."

Some midwives are based within remote communities, while others travel out to provide care. Reaching women and babies can mean hours behind the wheel or, for the most distant communities, travelling by charter flight.

Glenda says, "Accommodation for health staff in remote communities is limited and at times weather events prevent road and air travel. Midwives are continually planning and adjusting their visits to communities depending on all the factors that are necessary to come together."

Despite the logistical challenges, providing care in community makes a significant difference for women and their families.



Above from top: Left to right: Katrina Molloy, Jane Christmas, Katherine Gouliart, Leesa Thomas, General Manager Education and Engagement, Rural Health West and Milly Grigg; O & G specialist team; Dakota and Milly. Right: Young women's education.

Jane explains, "It reduces their travel time to town. We can do a lot of their antenatal and postnatal care out in community, so it helps build safe relationships and get to know the families and the communities, and also the clinic staff that we work with."

Katherine says those relationships are central to the team's success.

"We need to spend lots of time onsite to create those relationships, and once it works, it's absolutely fantastic."

When face-to-face care isn't possible, technology helps bridge the distance.

Glenda says, "The other main bonus in the care of women with the midwives is the use of the mobile phone.

"The women get the midwives telephone number, and the midwives have the woman's telephone number, and they quite often are calling each other, or they are on text message, just updating on management care plan. What is the plan? When do the women need to have blood tests? When do the women need to be visiting Alice Springs to see a consultant or have a scan or something like that? Really, the mobile phone has transformed life in Central Australia."

Glenda says that the complexity of women's care, as well as being able to engage with women in their home environments, gives the remote midwives a meaningful and rewarding role.

"It is a joy seeing a woman achieve a pregnancy to the best of her health status, resulting in the birth of a healthy newborn."

Milly agrees, "I just love my work. I love my team, and the community really embrace us."

The team were awarded the CRANaplus Collaborative Team Award, sponsored by Rural Health West, at the 2026 Australian Remote Health Awards. They each say they were honoured to receive this recognition.

Katherine says, "I am feeling very happy to be noted, because this is a job that is asking a lot. As much as it is absolutely fantastic, there's no job like this job, but we are so busy driving left, right and centre that we probably feel at times that we are not noted."

Katrina adds, "I'm really proud to be a part of this team. I'm really proud of the work we do. It feels really good to be recognised by CRANaplus. We all work really hard, we care about the work that we do and the people we provide care for, and it's nice to be recognised for that."

For the team, the award is ultimately a recognition of the relationships they've built with women, families and communities across Central Australia.

Milly says, "We are proud to accept this award and dedicate it to all the families who we work with, past, present and future ... it is an honour and a privilege to work in these communities."

Do you know a nurse, midwife or health professional who deserves recognition for their positive impact on rural or remote health? Nominations for the 2027 Australian Remote Health Awards will open soon. To stay up to date, visit crana.org.au/awards ●



Leading with your heart



With stories about how she managed lockdown on Home Island and advocated for a second air-conditioner in a sweltering laundry, Nicola Coleman illustrates the complexities of remote health management. In this tough but rewarding field, there's clearly a need for leadership and WHS training, and the scholarships like CARPA's that make it more accessible.

Nicola grew up in the Pacific Islands and trained as a nurse in London's hospitals before relocating to Australia to work in some of nursing's most remote postings – from Groote Eylandt to the Cocos (Keeling) Islands.

When I connect with her over the phone, she's preparing for her next move, packing boxes in her Kalbarri home during an unusually rainy day.

Someone so widely travelled and with 40 years of nursing experience might be expected to know it all. But Nicola recognises that learning is a lifelong process.

That's why she applied for the CARPA Remote Health Leadership, Management & WHS Scholarship, which offers up to \$2,000 to help successful applicants complete a course.

As a successful applicant, Nicola undertook a Diploma in Leadership and Management through the Australian Institute of Management, which involved online learning and face-to-face intensives in Perth.

"It's given me more confidence to do what I do in management; it's given me the theory background," she says.

"Nursing is theoretical, which you learn in your head. But how you deliver it is through your personality, through your heart."

The complexities of remote leadership go beyond clinical skills, she says. Managers must contend with levels of complexity that their metropolitan counterparts rarely face.

Facing this complexity, at times alone, can make a manager feel isolated.

"It can be very lonely as a manager, because you're sort of the meat in the sandwich," she says.

"You're trying to follow direction and support budgets from above while your team at the coalface just want to get on and do their job [and access what they need to do the job well]."

A story from a previous posting illustrates how leadership in remote health often means solving problems from the middle.

"The outside laundry was in a very old building that was early 19th century," she says, "with single brick walls, glass louvres, one massive industrial size tumble-dryer, and just one wall-mounted air-conditioner blowing on it.

"When the temperature got to 44 degrees outside, even with that air conditioner on, the temperature in there was still 42 degrees minimum.

"When I came in, I asked: what are the yucky bits about working here? The bottom line is it's not safe for you to work in here and you're working in isolation on your own. If you were to faint or pass out or were to be bitten by a snake, nobody's checking on you regularly. I need to put it in language like this to make a change.

"I went about it from a work health and safety perspective, but it also then helped my team know that I was listening to them and that I was going to do something about it."

By raising it in risk meetings, making a maintenance request, and a preparing a safety risk report with reference to a risk matrix, Nicola was able to get a second air-conditioner over the line.

"[By adding that there are] middle aged menopausal women working in there, [the additional air-con unit] got approved straight away!" she laughs.

"That demonstrated to my team that I'm here as your manager. I need everybody to feel safe so that they come to work, do the best work they can, and go home looking forward to coming back."

Nicola shares another story that illustrates the complexities of remote health management.



Nicola and her children in Carnarvon.

Acting as nurse manager on the Cocos (Keeling) Islands with the Indian Ocean Health Service when COVID-19 hit in early 2020, she played a key role in helping lead Home Island's 450 Malay Muslim residents into what Nicola recalls as the first community lockdown in Australia.

The logistics were staggering. To prepare, she had to imagine the worst-case scenarios and ask herself: how to convert the cyclone shelter into a makeshift hospital? How to respect the cultural practice of quick burial with limited human resourcing and soft sand and crabs to contend with? How to make do with a small morgue?

However, the biggest challenge wasn't logistical, but social. How do you implement a lockdown in a close-knit Muslim community where the mosque sits at the centre of daily life and people gather for prayer five times a day?

Community trust has to be earned. Fortunately, Nicola had gained that already. When a woman had presented with a severe allergic reaction during Ramadan and refused antihistamines on religious grounds, Nicola suggested they say a prayer together asking for forgiveness before she took the tablet. Her cultural respect and handling of the situation earned her respect in turn and prevented an evacuation.

By the time Nicola stood up to announce the lockdown, the community was ready to trust her.

It is exactly the kind of situation, Nicola reflects, where formal management training proves its worth. It gives you the frameworks to think clearly under pressure, communicate up the chain, and bring people with you.

The CARPA Remote Health Leadership, Management & WHS Scholarship is open to remote health practitioners working in MMM 6-7 locations and is accepting applications until 30 September 2026.

It offers up to \$2000 to assist with the cost of approved health leadership, management or WHS training/course fees.

You can find out more and apply at:
crana.org.au/scholarships ●

Connect

“As long as I’m learning”

There are many routes to remote nursing. Here, registered nurse Rachael Ferris, originally from Newcastle in NSW, outlines her own “zig-zaggy” pathway.

“I’m always very flexible about where I go and what I do. So long as I think I’m having an opportunity to learn, that’s the main thing for me,” says Rachael.

“Even going into nursing was not set in concrete on leaving school,” she says.

“I started one degree at university and transitioned into nursing through discussions with a mentor. What I did know was that I wanted to do some sort of humanitarian-focused work, so that was the end goal.”

Rachael’s career began on home ground at the John Hunter Children’s Hospital in Newcastle, (population more than 500,000); a job opportunity came up in refugee health and so she moved to Armidale, (rural with a

population around 25,000). She then spent nearly a year in a remote community in the Northern Territory (a population of 300 people), before returning to New South Wales where she is currently Clinical Nurse Specialist in Refugee Health at Armidale Rural Referral Hospital, and a clinical nurse educator in Guyra Multipurpose Centre.

“When I moved from urban to rural, I thought, ‘Oh my goodness, the grocery stores close at 8 pm.’ I thought that was diabolical. Then I went remote, there’s one store, it’s open 9 till 5, Monday to Friday, and if you miss it, then you miss it.

“Moving back to Armidale, my entire perspective had shifted; I was now thinking, ‘This is a big city with so many conveniences.’ It really made me appreciate what I took for granted before.”

Rachael’s view is that nurses moving between urban, rural and remote settings enjoy many benefits outside of career progression.



“I had a really theoretical understanding of various contexts, but actually seeing and experiencing how that is in practice, how all of these pieces fit together, has been life changing.

“I was aware of transport and employment limitations, but seeing how those things affect daily life gave me a much more holistic view of inequity. In remote settings, you really see those compounding social determinants of health: lack of access to things like fresh food, electricity, warm water and housing.

“That was valuable for me, to really understand what goes on in our own country and what Aboriginal communities experience in these remote settings. I came to understand how the effects of colonisation are always present, and how the effects of the Stolen Generations are still evident in a lot of community dynamics.”

“Everyone will have a very unique experience in the workspace,” says Rachael. “For me, a gradual transition to remote worked well. It will be different for others. Work and life experiences, and expectations, can influence people’s reactions when they move between different degrees of remoteness.

“I’m really glad my pathway took the road it did, with my background in acute paediatrics, and experience working with refugee communities in the rural setting, I felt more prepared to approach remote work. For somebody who has maybe worked in ED or ICU, they may feel well equipped to work remotely sooner. Inversely though, they may find the transition to primary health care as core business more challenging.”

“That’s something I have come to appreciate,” says Rachael. “If we can provide quality primary healthcare at the right time to people, it can prevent a lot of complications down the line. For example, for somebody living with diabetes, if we can manage their blood glucose levels in the early stages then they’re much less likely to have those complications that affect their quality of life later, like chronic ulcers and amputations.”

Those experiences are now shaping Rachael’s future ambitions. Alongside her clinical work, Rachael is studying a Master of Public Health (One Health), and is a Policy Fellow with the Australian College of Nursing.

“Improving health equity begins at the system level,” she says. “Good policy is where you optimise care. That’s the field I’d like to eventually work in.” ●

Photo: katarix - stock.adobe.com

Celebrating community-led care

Three framed awards line Kelly Hosking's office windowsill – a quiet reminder of an extraordinary evening at the 2026 NT Nursing and Midwifery Excellence Awards. While they reflect her success, Kelly spoke about them with humility, focusing instead on the impact behind them.

"It was an honour and I really appreciated the acknowledgement, especially for the public health and research side of things," Kelly says.

"But I think as a nurse, and as health professionals, we're not doing our work for personal recognition, we do it to improve health outcomes ... it was incredibly humbling."

The three awards – the Excellence in Research/Quality Improvement Award, proudly sponsored by CRANaplus, the Excellence in Primary Care, Public Health and Community Nursing/Midwifery Award, and the NCCTRC Nurse of the Year Award – recognise an extraordinary career. But they also reflect a lifelong commitment to partnership, culturally safe practice and improving health outcomes for communities.

Kelly is the Director of Sexual Health and Blood-Borne Viruses Strategy and Policy Unit at NT Health and Co-Deputy Director of Viral Hepatitis Programs at Menzies School of Health Research, working at the intersection of policy, research, education and clinical practice.

"I have a lot of different aspects to my role. I kind of get FOMOW – fear of missing out on work. I just collect all of the things that I love, and do them all!"

While the responsibilities are diverse, they are united by a common purpose to improve health outcomes through genuine partnership with communities.

"I really enjoy bridging the gap between policy, strategy, operations, research and practice.



"The goal is to ensure decisions are evidence-informed, equity-focused and genuinely driven by community priorities," she says.

Her influence also extends beyond the NT. Kelly chairs the National Blood Borne Virus and Sexually Transmissible Infections Standing Committee, which provides expert advice to the Australian Health Protection Committee.

"I just love being part of the national public health discussions, absorbing and learning from the expertise from all the massive brains around the country, and also having a voice there, ensuring that the NT priorities and perspectives are represented," she says

For Kelly, having a seat at one of Australia's highest public health tables is also an opportunity to demonstrate the breadth of nursing.

"Nursing is such a diverse profession. I am very proud to be a nurse. I think we should recognise the breadth of opportunity available to us, and we shouldn't just pigeonhole ourselves. Nurses bring unique perspectives to leadership, policy and public health and absolutely belong at decision-making tables."

After graduating in 1996, Kelly worked in oncology before discovering a passion for prevention, public health and remote practice. Experiences in Laos, post-tsunami Indonesia, Fiji and the Torres Strait shaped her philosophy of working alongside communities rather than leading them.

"Whether we're working as nurses internationally or in a remote community, we are not the experts. We are there as guests. We need to listen, build relationships, trust and support the communities to achieve their priorities. They have the answers, knowledge and strength that drive sustainable change."

That lesson continues to guide her work today, particularly in Aboriginal and Torres Strait Islander health. Kelly believes meaningful improvements can only happen through genuine partnerships and co-design with communities.

Those principles underpin the Hep B PAST program, where Kelly has played a leading role in improving Hep B care across the NT. Through her PhD and ongoing work, Kelly helped identify people living with Hep B, connect them to care and build the capability of the Aboriginal and Torres Strait Islander health workforce.

Today, the Northern Territory is the only place in Australia meeting and exceeding national Hep B elimination targets.

For Kelly, however, the statistics tell only part of the story.



One of the moments that stands out most came after an Aboriginal Health Practitioner completed one of the program's education courses. Returning to their community, they were able to identify someone who had been difficult to reach for years, organise testing, explain the diagnosis in the person's preferred language and connect them to care. They also traced family members who required follow-up, demonstrating the powerful impact that culturally safe education and local leadership can have on health outcomes.

Building the confidence and capability of the Aboriginal and Torres Strait Islander health workforce has become one of Kelly's greatest passions. Her education model emphasises shared learning, respect and culturally safe environments, recognising people learn best when they feel safe, connected and supported.

The Hep B PAST model has since been recognised internationally, with Kelly presenting alongside Aboriginal Health Practitioners in Portugal and Bangkok, and the program informing similar work overseas.

Despite these achievements, Kelly remains quick to credit the people around her.

"We never do anything by ourselves in health, do we? All of our successes are a group effort."

That collaborative mindset has helped transform research into real-world change, something Kelly says has always been essential to her work.

"I could not have done research that's not implemented and where you can't actually see change," she says.

"We can achieve things. Meaningful change takes time, but we have to start, and we have to do that alongside Aboriginal and Torres Strait Islander colleagues and communities.

"Not everything works, and we have to reflect, learn and adapt along the way, but there are ways forward and solutions, and we just need to find approaches that improve outcomes, and when we find them, we should celebrate and build on those successes." ●

Keeping syphilis on your clinical radar



Remote health professionals have long been at the forefront of Australia's response to syphilis. In this article, Laura Berry, Workforce Support Coordinator and sexual and reproductive health Nurse Practitioner, shares practical

insights to support clinicians in recognising the signs, initiating timely treatment and confidently navigating partner notification and follow-up.

In 2025, syphilis was declared a Communicable Disease Incident of National Significance in Australia following rising rates nationally and increasing concern around congenital syphilis. While this brought national attention to the issue, remote communities have been carrying the burden of this outbreak for many years, noting that Aboriginal and Torres Strait Islander peoples have been disproportionately affected since the outbreak began in Queensland in 2011 before spreading across the Northern Territory, Western Australia and South Australia.

For those of us working in rural and remote health, syphilis is now something we see, hear about and manage regularly. Despite this, it is still very easy to miss.

Many people are asymptomatic and when symptoms do occur, they can look like almost anything, which is why syphilis is known as the "great pretender". A painless genital ulcer may be dismissed as trauma or irritation. Syphilis may also present as painful genital lesions and be mistaken for herpes. A rash may look viral or fungal. Sometimes people just present generally unwell with swollen lymph nodes, fatigue or vague symptoms that do not immediately trigger the thought, "That's syphilis".

One of the most important things we can do as remote clinicians is maintain a low threshold for testing and treatment. In remote communities, people may only engage with healthcare services intermittently, making every presentation a valuable opportunity to identify and treat syphilis as early as possible. Testing is easy and requires serology for syphilis antibodies. If there is an ulcer or lesion present, a dry swab (NAAT or PCR) will allow for testing.

Making syphilis testing a routine part of consultations, including adult health checks, antenatal care, contraception visits, STI screening and routine blood collection, can improve case detection. Antenatal screening remains essential to prevent congenital syphilis.

What to look out for

Primary syphilis – highly infectious

- Single painless ulcer (chancre)
- Genital, anal or oral lesions (this can include the cervix)
- Local lymph node swelling

If you notice any of these symptoms, swab the lesion for confirmatory testing.

Secondary syphilis

- Rash, often involving palms and soles
- Fevers, malaise and lymphadenopathy
- Mucosal lesions (mouth and/or genitals)
- Patchy hair loss

Early latent syphilis

- Usually asymptomatic
- Diagnosed on serology only

Treatment for syphilis is usually straightforward. Benzathine benzylpenicillin 2.4 million units IMI as a STAT dose remains first-line treatment*, with dosing dependent on the stage of infection.

One practical tip is to warn clients about the Jarisch-Herxheimer reaction before treatment. This commonly occurs in primary and secondary syphilis around 6–12 hours after treatment and can cause fever, headache, malaise, rigors and joint pain.

Symptoms generally settle within several hours and can usually be managed with rest and analgesia. Preparing people beforehand can prevent a lot of anxiety.

Contract tracing

I appreciate that partner notification can feel challenging, particularly in small communities where confidentiality and overlapping relationships are important considerations. These conversations require sensitivity, kindness and a non-judgemental approach. One thing I often do is leave a pen and paper with the client while I step out to organise treatment. I ask them to write down anyone they have had sexual contact with during the contact tracing period and reassure them that everything is confidential. It sounds simple, but it often breaks down a barrier and makes the conversation easier.

Syphilis is a notifiable condition and contact tracing is an important part of reducing transmission and preventing reinfection.

Once you have the names of contacts, presumptively treat all sexual contacts from the last three months of patients with primary or secondary syphilis regardless of serology.

Current recommendations are:

- Primary syphilis: trace back three months plus duration of symptoms.
- Secondary syphilis: trace back six months plus duration of symptoms.
- Early latent syphilis: trace back 12 months or since last negative test.

Syphilis can be overwhelming. If you are unsure about staging, management or contact tracing, contact your local syphilis register. They are an excellent resource.

Syphilis Registers

- **Queensland:** 1800 032 238
- **South Queensland:** Qld-syphilis-surveillance-service@health.qld.gov.au
- **North Queensland:** North-qld-syphilis-surveillance-centre@health.qld.gov.au
- **South Australia Syphilis Register:** 1300 232 272
- **NT Syphilis Register:** Darwin (08) 8922 7818; Alice Springs (08) 8951 7552



We all play a huge role in the response to syphilis. Recognising the signs early, having open conversations about sexual health and making testing part of routine care can have a meaningful impact. Sometimes the most important thing is simply talking and testing.

To support clinicians in building confidence around syphilis prevention, testing and management, CRANaplus is hosting an on-demand webinar featuring Dr Ian Anderson, Sexual Health Physician from Kirketon Road Clinic in Sydney. Visit crana.org.au/webinars page to stay up to date with sessions. You can also access practical tools and training to support syphilis prevention, testing and management at ashm.org.au/stopsyphilis/ ●

* It is acknowledged that there is currently a shortage of Benzathine Penicillin with the shortage expected to last until 30 November 2026. Please discuss with a specialist regarding alternative treatment.

Spotlight on hidden load of healthcare providers

If nurses can better describe and measure the threat of cognitive burden causing patient harm and 'burn-out', managers may finally have a way to understand and address it through better systems.

That's the view of nurse researcher, Anu Surendran who has spent nearly a decade studying Cognitive Mental Workload (CMW).

Picture an emergency nurse triaging patients while keeping an eye on the waiting room, responding to alarms, answering questions and mentally prioritising who needs help first.

Across the country, a remote area nurse has a patient entering the clinic with chest pain and is suddenly managing a cardiac arrest, making split-second decisions that could mean life or death, co-opting an admin officer to do CPR while she phones the Royal Flying Doctor Service.

This is the world of high CMW in the nursing sphere: the mental effort involved in processing information, making decisions, prioritising, remembering, filtering distractions and carrying out tasks.

"My aim is to make this invisible problem visible and spread awareness," says Anu, who is in the final stages of a PhD aimed at developing a nursing-specific tool to measure the hidden labour that is been inadvertently forgotten during healthcare system planning.

"It will give nurses a subjective tool that gives them language to describe what they experience during crucial patient care and to help managers and policymakers understand the invisible pressures they face.

"My goal is for policymakers to integrate the insights stemming from my research to strengthen healthcare infrastructure."

Anu, who works as a telehealth nurse practitioner for hubMed, and a casual nurse in a rural emergency department in Queensland, says her focus is driven partly by seeing fellow nurses leave the profession, and by her own burnout during COVID-19.

"A certain amount of CMW is essential," she says. "But problems arise when demands exceed the brain's available mental resources. That is when performance decline, burnout and patient harm begin to suffer."

She believes understanding nurses' CMW, measuring, spreading awareness and optimising it could shift focus away from individual blame, towards designing safer systems to reduce errors.

To her and a team of expert researchers from University of Southern Queensland, addressing CMW overload to improve care and support nurses' wellbeing isn't about individual coping or simply working harder. Rather it requires broader, systemic solutions.

"We need to start asking different questions: from asking, 'Who made that mistake?' to 'What in the system created conditions where mistakes became more likely?' and 'What can be done?'"

"To err, after all, is human."

Healthcare often talks about workload in terms of patient numbers or staffing ratios. But Anu says those measures can miss the invisible load inside a clinician's head.



"One critically ill patient in a tiny remote facility may create a much greater CMW to a remote nurse than several routine patients in a larger urban hospital with multiple staff and resources."

Many industries have long recognised the importance of reducing CMW for best performance and have developed systems to optimise it. Although the consequence of CMW of nurses and patients are severe, the health care sector is still to catch up.

For example, one system, NASA TLX, is popularly used among pilots, space explorers and nuclear operators to measure their CMW and they have multiple methods to reduce their cognitive load.

Nearing the end of her own research and design phase, Anu is seeking help from 100 nurses to complete a 10-15 minute survey, adding to the 130-plus responses she has gathered so far.

She is very much aware of the irony, saying, "It's a lot to ask someone busy to add something to their list of things to do."



To make life a bit easier, here is a QR code to take you straight to the survey.

In the meantime, Anu lists some simple tools and strategies that make systems simple, streamlined and supportive, removing unnecessary mental effort, allowing clinicians to focus on their patients.

- Clear guidelines and checklists are invaluable during emergencies because they reduce the need to remember everything under pressure.
- Quick-reference charts and bedside cognitive aids help offload mental effort.
- Reliable digital decision-support tools, especially those that work offline, can be particularly useful in remote settings where internet access may be patchy.
- Good documentation and effective hand-overs matter too. Write it down if possible.

Anu also points out that sharing the load through telehealth support, contacting retrieval services such as RFDS early and even calling a colleague for a chat can help.

And her final piece of advice: pause briefly during a busy shift, clarify priorities, plan ahead and share responsibilities whenever possible.

A reminder to the rural and remote health workforce and their families: the CRANaplus Bush Support Line offers free, confidential counselling 24 hours a day, 365 days a year. Call 1800 805 391 at any time to speak with a psychologist experienced in the unique challenges of rural and remote life and work. ●

What 70 hospitals taught me about rural and remote Australia

Jane Krautz has worked across 70 hospitals and health services throughout Australia, spanning rural, remote and aeromedical settings. In this reflection, she explores what has stayed with her most – not the complexity of the work, but the humanity of rural and remote Australia and the deep sense of connection found within its communities.

Over the past decade, nursing has taken me through 70 different hospitals and health services across Australia, through each state and territory.

I have worked as a remote area nurse, midwife, and international aeromedical retrieval nurse in places many people will never see – small rural towns, remote communities, and overstretched hospitals where healthcare workers quietly carry enormous responsibility.

And after all those places, one thing has stayed with me: rural and remote Australia is the soul of this country.

In rural and remote healthcare, you are never just treating patients. You are caring for neighbours, families, farmers, children, and entire communities.



You celebrate births, respond to trauma, sit beside grief, and hold someone's hand as they leave this world.

You become part of people's lives.

Some of the most extraordinary clinicians I have ever met work in small rural hospitals with limited resources and little recognition.

Rural and remote nurses adapt, improvise, and keep going – not because it is easy, but because their communities need them.

But what impacted me most was not the hardship. It was the humanity.

It was watching communities rally around one another during floods, droughts, loss, and crisis. It was seeing kindness from people who had very little left to give themselves.

It was realising that strength in rural and remote Australia is often quiet.

After working in 70 different hospitals, across many different contexts, I have learned that rural and remote Australia gives you far more than experience.

It gives you perspective. It reminds you that healthcare is not only about medicine – it is about people. Connection. Community. Showing up for one another when things are hard.

And once rural and remote Australia becomes part of you, it never really leaves. ●



Rural and Remote Connect: Strengthening care where Queensland needs it most

Queensland's rural and remote communities depend on a nursing and midwifery workforce that can adapt quickly, travel widely and keep equity at the centre of care. In 2024, Queensland Health took a significant step towards strengthening that workforce, approving its first agency-style nursing and midwifery model designed specifically for remote and very remote communities. Now known as Rural and Remote Connect, the program is helping connect experienced clinicians with the places where they are needed most. Here, Christine McIntosh, Nursing Director at Queensland Health, highlights the difference Rural and Remote Connect is making in its early stages.

Rural and Remote Connect was created as an internal nursing and midwifery agency, bringing experienced clinicians into remote services in a way that is new in scale and complexity for Queensland Health.

To help attract highly skilled nurses and midwives from across Australia, an above-Award hourly rate was negotiated for remote sites, supporting the program to compete nationally for the workforce it needs.

Recruitment began in March 2025, with roles including registered nurses, clinical nurses and clinical nurse consultants. By June 2025, midwives had also joined the program, further expanding the skills and support available to rural and remote services.

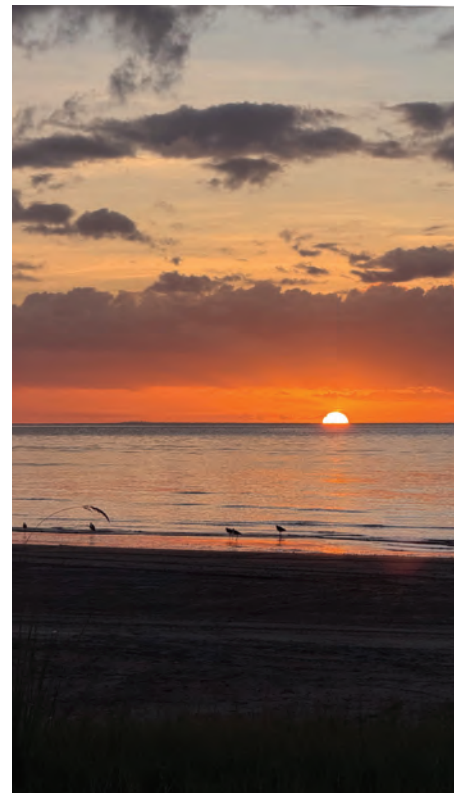
More than 209 nurses and midwives from every state and territory have now joined Rural and Remote Connect. Together, they bring experience across rural generalist nursing, ICU, renal, perioperative, mental health and other specialty areas.

Building on this early success, Rural and Remote Connect is now recruiting directors of nursing to support multi-purpose health services and primary care clinics, many of which operate as one- or two-nurse posts. This growing mix of skills is helping meet the complex needs of remote communities.

A new way to support remote services

By August 2025, the first Rural and Remote Connect clinicians were being deployed across nine remote-classified hospital and health services. Since then, the numbers tell a powerful story: the program has filled 251 contracts and covered more than 4,500 shifts, supporting countless patients in communities where continuity of care can be life-changing.

The impact is already evident. Remote facilities report improved stability, enhanced clinical capability, and a renewed sense of confidence among local teams.



Eleisha's story

Among the many clinicians answering the call is Eleisha, whose journey reflects the spirit of Rural and Remote Connect. She has completed four contracts from MPHS to PHCC. Eleisha's adaptability and skills have made her an invaluable contributor to each site she has supported.

Her story is one of many demonstrating how this initiative is not only filling workforce gaps but also enriching the professional lives of the clinicians involved.

Rural and Remote Connect continues to grow, driven by a shared purpose: ensuring Queensland's most isolated communities receive the safe, high-quality care they deserve. The early success of the program highlights what is possible when innovation, investment, and clinical excellence come together. The momentum is unmistakable – and so is the impact.



To learn more about Rural and Remote Connect, scan the QR code or visit: www.careers.health.qld.gov.au/nursing-and-midwifery-careers/rural-and-remote-relief-nursing-and-midwifery ●



Full scope and full responsibility: Remote nursing in Eucla

CRANApplus Member, Simone Parker, was delighted to work in Eucla, Western Australia. Her passion for remote nursing and enthusiasm for this community shine through in this reflection, as she shares the rewards, responsibilities and professional growth that came with practising to full scope of practice in one of Australia's most isolated communities.

When the opportunity finally aligned to work in Eucla, it was less about ticking off a destination and more about stepping into a setting that demands genuine readiness.

Highly isolated placements are never just about geography. They require clinical currency, confidence in independent practice and an understanding that distance changes the way decisions are made. In Eucla, assessment carries weight, communication must be deliberate and backup exists, but never immediately.

The drive in sets the tone. Whether approaching from the east or west along the Eyre Highway, towns stretch further apart until they disappear altogether and reception drops out. Out here, the road becomes its own quiet social network.

There is the single-finger wave from passing drivers, the more enthusiastic two-finger salute and occasionally, depending on recent overtaking decisions, the expressive middle finger option. You will probably never see these people again, but for a moment you share the same understanding of distance and concentration.

Roadhouses punctuate the Nullarbor. You stop for fuel and leave with weather updates, community news and sometimes subtle insight into what may present clinically in the coming days. In remote practice, where people gather, health care inevitably follows.

The road also does not always remain open. Fire, flooding and severe weather can isolate Eucla with little notice, delaying supplies, staff movement and patient transport.

Monitoring state emergency apps and road condition alerts becomes routine. Retrieval options may depend on information gathered long before a patient presents.

Preparation for travel mirrors preparation for practice. A practical rule of thumb is simple: never let the fuel tank fall below half, always carry water and treat check-ins as routine rather than optional.

Long stretches without reception offer time to settle mentally into the work ahead, and a reminder to download enough music beforehand.

Eucla itself is isolated, but not inactive. Supplies arrive from Esperance at intervals, electricity relies on local generation and water is produced locally. The clinic is modern and central to community life.

Continuity of care occurs naturally in a small population and trust develops quickly. Professional boundaries remain clear, yet familiarity strengthens care rather than complicates it.

What makes Eucla different is the intensity of full-scope practice. Without immediate diagnostics or nearby escalation, nursing assessments must be structured and deliberate. History taking becomes detailed, examination systematic and observations interpreted rather than simply recorded.

Formulating a differential diagnosis is not theoretical. It determines whether a patient remains local, requires retrieval or can be safely observed. Documenting a working diagnosis matters because escalation decisions may occur hours after the initial consultation.

Emergency care highlights the collaborative nature of remote work. Preparing for retrieval often involves working alongside police and country fire services, particularly at night.

Airstrips require lighting and assessment, hazards need checking and patient stabilisation continues while coordination unfolds. Remote nursing may feel autonomous, but it is deeply interdependent. Local knowledge quickly proves invaluable. I learned this after confidently driving onto soft beach sand and promptly getting bogged, an outcome widely predicted by the community. Assistance arrived quickly, along with good-natured commentary, reinforcing that humility integrates faster than orientation.

What made Eucla special was not the remoteness itself, but the clarity it brought. Full-scope practice here is both privilege and responsibility. Comprehensive assessment, structured reasoning and collaborative retrieval processes sharpen practice in ways metropolitan environments rarely demand.

For nurses considering working in a place like Eucla, the encouragement is simple. Prepare thoroughly. Respect the systems that support you. Remain curious. The professional growth is significant, not because the work is dramatic, but because it is accountable. Remote nursing in Eucla is not about doing more. It is about doing what matters well, in a place where distance amplifies responsibility and community connection gives the work meaning.

If you're a CRANApplus Member who would like to share your story, reach out to us with your ideas at communications@crana.org.au

Intertwined: Harm reduction and BBV prevention

Hepatitis SA's latest outreach to regional communities, with a two-pronged approach that recognises that blood borne virus (BBV) prevention and harm reduction are intertwined, has been a huge success.

Hepatitis SA – South Australia's hepatitis peak body – has developed a training package for its regional workforce, together with an intervention strategy for clients delivered by staff from Adelaide with lived/living experience of both hepatitis C and drug use.

The training package is in response to requests from regional service providers for workforce development in harm reduction to support regional staff to engage with the drug-using community. Topics include how to overcome barriers to engagement, harm reduction in practice to prevent BBV transmission, and improving health outcomes for people who use/inject drugs.

To ensure the community intervention component was appropriate, peer workers from Hepatitis SA liaised with local service providers to gain an understanding of issues specific to people who use/inject drugs in those regions.

And to increase community engagement, unique 'goody bags' of resources and treats were handed out.

These goody bags included BBV prevention resources, harm reduction information and drug use paraphernalia such as tourniquets to support single-person ownership and reduce the transmission risk arising from sharing.

Below, top left: SA Harm Reduction Peer Services worker, Fiona, with Aboriginal Drug and Alcohol Council Worker, Di Wilson. Below, top right: Regional health workers welcome the chance to develop new skills in harm reduction. Below, bottom: Participants from the Harm Reduction workshop in a happy group snap. Opposite page: Fiona showing what's in the goody bag.



Workshops and community interventions were initially delivered at Murray Bridge, Port Lincoln, Port Pirie, Berri, Mount Gambier and Port Augusta. At Port Augusta, point-of-care hepatitis C testing done by a peer worker was also offered at the Aboriginal Drug and Alcohol Council's Stepping Stone service.

These SA workshops, put together by SAhrps, Hepatitis SA's peer-run harm reduction program, were funded by the federal government, delivered to state and territories via Hepatitis Australia's HepLink program.

SAhrps Project Officer, Fiona Poeder, says, "We did this outreach to regional communities because services are limited or non-existent in some areas and, just as we hoped, it was very popular.

"We had local service providers telling us they found the shared personal experiences valuable and informative.

"They also said they would send more staff to register for these workshops if we were to run them again ... and so Hepatitis SA's outreach team returned to Mount Gambier in April.

"We ran clinics over two days as part of the Burnet Institute's national 'It's Your Right' campaign to increase hepatitis C testing and treatment among people who inject drugs. We not only spoke with needle-and-syringe program clients about harm reduction, but also provided on-the-spot hepatitis C testing for those who were at-risk.

"Both days were fully booked out – testament to the need for these outreach services."

Speaking on ABC South East SA radio, Hepatitis SA's hepatitis C testing coordinator, Lisa Carter, said, "The thing about rural areas like Mount Gambier is that it's good when workers like us come in to address an issue like this, because confidentiality is often a problem in rural areas ... people want to get tested but don't want to run into their auntie at the local doctors ... so it good that people can come here and have anonymity."

Lisa also highlighted the advantages of rapid testing where people can get an almost painless finger prick test, go have a coffee and return for their results.

Asked about the importance of offering an inviting, safe space for people who come for this kind of support, Fiona said, "All of us are peer workers, which means we're non-judgmental. We have the lived experience. We make it as comfortable as possible and support people in other ways, not just around hep C but any other harm we can reduce, so it's safer and healthier for them.

"We want to keep people alive and healthy."

For more information: fiona@hepsa.asn.au



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