Q&A Summary

Q1. Shannon, did you go straight to working with remote clientele or did you first gain experience from working in clinical practice e.g. hospitals?

I had a very gradual transition to remote communities. I started out going straight into a community primary health service in South West WA that was predominantly rural. I then went into a rural community which was also slightly more remote than where I started. After this, I made my way to a larger remote community, so I gained that experience and confidence across a range of settings, rather than just diving into a largely remote communitiy from the beginning.

When we throw practitioners into those environments without the necessary experience or training, it isn't beneficial to either the practitioner or the client. I recommend getting that experience in more urban or rural type of environment first.

Q2. How have you dealt with real life situations when things go wrong, perhaps when cultural boundaries are subconsciously crossed or sensitivity not understood?

A lot of humility and an apology goes a long way. If the person has completely lost contact, the relationship can be difficult to repair. That's where your networks can be really helpful.

I think you tend to know you crossed a line. Ultimately, it's important to be transparent and direct about the situation.

For example you could say *"I know I did [XYZ] and I'm really sorry if that wasn't okay or upset you in anyway, I didn't intend to and I would love to learn what I can do better next time, Would you be okay to share that with me or is there someone I can talk to for guidance."*

Q3. How do you navigate the hours with NDIS plans when extra time is required to build that relationship

We are open and transparent about how many hours we expect to take. Most of our clients, especially in remote communities, have a coordinator of supports in the team. So, it's a lot of advocacies around why services should be structured with a key worker instead of four different practitioners. Ultimately, we include the hours that it's going to take and what is expected of the time. If there is limited time available, I think it's actually better value to use those hours to build that trusting relationship.

This means we can get a clear understanding of what the family and child's needs and goals are, which we can then advocate back with a change in circumstance form or request for a plan review. Utilising the time this way gives us a good source of information and source of truth that we can advocate back for.

Q4. What can we do as health professionals to advocate for Indigenous rights?

As health professionals we do have a lot of sway. There has definitely been some dilution of that within NDIS and it depends which system you are working in. We should advocate as fiercely as we would with every client.

Especially when we're in the NDIA, talking about why goals aren't appropriate, why goals cant be met and why services needed to be delivered in this way. When we are advocating for it as being a client-centred service and promoting choice & control, that's when we can use our powerful voice to advocate for our client. We can use positive influence across all sorts of organisations.

Q5. Would there be issues with been a male worker in the area working with children if seen as women's business?

Great question. There can be. It's important to be aware of potential areas that may cause discrepency and offer the choice to the client to have a female present.
As an OT for example, If your starting to talk about toilet training, that could be a sensitive topic. If there's an option to have a female worker with you, whether that's a Indigenous allied health worker, allied health assistant or teacher, who can help to bridge that gap, that can make it okay. In most cases, you will know if the family are uncomfortable, as typically they will disengage at that point. Try and have a female in the room if it's unclear, or it's a grey area. It can also help to ask the family about their preferences.

Q6. Do you (or providers in the NT) host students on placements or work shadowing?

There are organisations that take placements, it just depends where you are looking at going. Darwin, Katherine, Alice Springs are the bigger centres in the NT. You wouldn't typically be able to go to a highly remote community on a placement, but this would vary between communities. You can get really good rural experience in other places. For example, Flinders in Katherine have a placement program where they take students based out of school and then they have a supervisor supervising those Speech Pathology students, working in the school and wider Katherine community.

Q7. Do you take new graduates at Early Start Australia?

Yes, we absolutely take new graduates. Working in remote communities isn't usually something that happens from the get-go. However, we have had graduates that have gone out after about 6 months, as they have grown up in, or are from, a country area and they are showing us they have the confidence and capability to manage that role and be okay.

If you've recently graduated, we have positions available across all of our clinics around Australia with our graduate program. The program will give you the opportunity to grow and specialise in your field while making a difference in the lives of children and their families. Graduate positions are all permanent full or part time roles that will support you to grow your skills. As part of a national organisation there will be opportunities to work around the country as well as grow your career across multiple global brands and businesses within the APM Group. Other benefits include paid annual leave, flexible working hours, competitive salary package and an annual professional development allowance. Find out more here.