A National Summit on Cultural Safety in Nursing and Midwifery: Summary report

November 5-6th 2014
Contents

1: INTRODUCTION ........................................................................................................................................... 1
  1.1 About CATSINaM ........................................................................................................................................ 1
  1.2 A National Summit on Cultural Safety in Nursing and Midwifery ...................................................... 2

2: CULTURAL SAFETY IN NURSING AND MIDWIFERY ........................................................................... 3
  2.1 Why cultural safety? ..................................................................................................................................... 3
  2.2 An overview of cultural safety .................................................................................................................. 6
  2.3 Practising cultural safety in different contexts ....................................................................................... 8
  2.4 How are we practicing cultural safety now? ......................................................................................... 15

3: TOWARDS ESTABLISHING A LINMEN .............................................................................................. 18
  3.1 Why a LINMEN? ....................................................................................................................................... 18
  3.2 Learning from others: The LIME experience ..................................................................................... 21
  3.3 Moving from concept to reality ............................................................................................................. 22
  3.4 The next steps in establishing a LINMEN ........................................................................................ 25

SUMMARY ......................................................................................................................................................... 26

APPENDICES ..................................................................................................................................................... 27
  Appendix A: Cultural Safety Summit Agenda .......................................................................................... 27
  Appendix B: Cultural Safety in Nursing and Midwifery background paper ....................................... 30
1: Introduction

1.1 About CATSINaM

The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) was founded in 1997. It is the national peak body that represents, advocates and supports Aboriginal and Torres Strait Islander nurses and midwives at a national level. We are a membership-based organisation and are governed by a nationally elected eight-member Aboriginal and Torres Strait Islander Board that has representatives from each State and Territory. The Board is supported by a small staff team of six positions based in Canberra.

The CATSINaM 2013-2018 Strategic Plan is framed by the following statement of purpose and focuses on four central areas:

CATSINaM honours an holistic and culturally safe approach to achieving optimal health and wellbeing for Aboriginal and Torres Strait Islander peoples and communities. We develop and promote strategies to ensure that this holistic and culturally safe approach is understood and applied by nurses and midwives working in Australia.

**Strategic Direction 1:** Elevate the profile of CATSINaM as the national peak body representing Aboriginal and Torres Strait Islander nurses and midwives.

**Strategic Direction 2:** Strengthen our effectiveness in advocating on behalf of Aboriginal and Torres Strait Islander nurses and midwives.

**Strategic Direction 3:** Strengthen our effectiveness in supporting the recruitment and retention of Aboriginal and Torres Strait Islander peoples in nursing and midwifery.

**Strategic Direction 4:** Increase our active involvement in research and workforce development projects that realise the vision of CATSINaM.

We believe that nurses and midwives are the backbone of the Australian health system. They represent over 50% of the health workforce and play a pivotal role in providing culturally safe health services to Aboriginal and Torres Strait Islander communities. As nurses and midwives often work in frontline positions, their capacity to do this effectively is critical. Therefore cultural safety is integral to pursuing our strategic directions.
1.2 A National Summit on Cultural Safety in Nursing and Midwifery

Purpose of the Summit

In September 2014, CATSINaM invited nursing and midwifery peak bodies, universities, state/territory health departments and the Australian Government Department of Health to attend the first National Summit on Cultural Safety in Nursing and Midwifery to be held in Australia (the Summit). The stated objectives of the Summit were:

1. To explore the strengths and weaknesses of current work on cultural safety in nursing and midwifery.
2. To identify what needs to occurs so we collectively achieve:
   - increased understanding and shared commitment to cultural safety in the nursing and midwifery professions
   - enhanced recruitment and retention of Aboriginal and Torres Strait Islander nursing and midwifery students and graduates in the health workforce
   - better health outcomes for Aboriginal and Torres Strait Islander Australians through all nurses and midwives providing culturally safe services

CATSINaM also proposed that Summit participants explore whether the nursing and midwifery professions should establish a ‘Leaders in Indigenous Nursing and Midwifery Education Network’ or LINMEN, as a mechanism for addressing the second objective. A LINMEN could operate in a similar manner to the Leaders in Indigenous Medicare Education (LIME) network that has been funded by the Australian Government Department of Health for several years.

Day 1 of the Summit focused on the first objective, and set the groundwork for addressing the second objective on Day 2. There were close to 50 people in attendance on Day 1, with 28 people returning for Day 2. The agenda is provided in Appendix A.

Prior to the Summit, all participants were sent a brief three page background paper to provide a context for the conversations (see Appendix B) along with three publically available CATSINaM documents:

2: Cultural safety in nursing and midwifery

2.1 Why cultural safety?

This question was addressed by Dr Tom Calma, Chancellor of the University of Canberra, who formally opened the Summit and then by Janine Mohamed, CATSINaM Chief Executive Officer.

Dr Tom Calma, Chancellor, University of Canberra

Cultural safety is core business, not a fringe matter to health and human services professions. In his August 2014 National Press Club address, which focused on racism as a social determinant of health, Dr Calma quoted Associate Professor Dennis McDermott, an Aboriginal psychologist and the Director of the Flinders University based Poche Centre: “in the nation at large, racism bypasses consciousness…if you are neither target nor witness you miss racist events”.

In order to achieve equity and participation for Aboriginal and Torres Strait Islander Australians, Dr Calma emphasised that we need recognition and equivalence of Aboriginal and Torres Strait Islander knowledges. Consequently, we need universities to reflect this knowledge in curriculum and teaching practices.

Dr Calma provided several recent examples of professions and universities that are demonstrating a commitment to name and address racism, and strengthen knowledge and skills in cultural safety. This includes social work, medicine, the Leaders in Indigenous Medicine Education (LIME) network, psychology, the University of Sydney National Centre for Cultural Competency and the Poche Centres for Indigenous Health (four exist and there is a fifth one in development). However, he noted that the challenges lie in successfully implementing the frameworks, plans and strategies that have been developed. Therefore, the nursing and midwifery professions are not alone in undertaking this process.

There are five questions that must be addressed when undertaking this work:

1. How do we create cultural safety in the classroom, field and academia for students, staff, clients and field practitioners?

2. How do we address anxiety that emerged when managing an already crowded curriculum - however, recognise that Aboriginal and Torres Strait Islander Australians are well over represented in all areas of social disadvantage in our country?

3. What are Aboriginal knowledges?

4. Who are Aboriginal and Torres Strait Islander peoples – how do we represent our diversity and heterogeneity, not just our commonality?

5. How do we bring staff and colleagues along on the learning journey?
Janine Mohamed, CATSINaM CEO

Cultural safety is of central importance to CATSINaM because Aboriginal and Torres Strait Islander nurses and midwives know how critical it is in closing the considerable gap that exists in:

- the health workforce representation of Aboriginal and Torres Strait Islander Australians - representation in the nursing and midwifery workforce ranges between 0.7 - 0.9% based on recent AIHW statistics
- both quality of life and life expectancy for Aboriginal and Torres Strait Islander Australians - the contemporary ABS calculations indicate it is ~10 years less than for non-Indigenous Australians.

In relation to cultural safety, Aboriginal and Torres Strait Islander Australians are more likely to seek access to health care, and achieve better health outcomes by accessing services that are respectful and culturally safe places. A lack of cultural safety and institutional racism are barriers to recruitment and retention of Aboriginal and Torres Strait Islander students, and graduate nurses and midwives. As a consequence, under-representation of Aboriginal and Torres Strait Islander people in the health workforce is a contributing factor to the lower rates of Aboriginal and Torres Strait Islander peoples accessing health services comparative to need. Janine directed people’s attention to the Summit pre-reading, which includes the evidence for these statements.

Given the significant inequity in health service experiences, health outcomes and life expectancy between Aboriginal and Torres Strait Islander Australians and non-Indigenous Australians, cultural safety within health services is paramount. It is severely compromised by racism, whether it is individual/interpersonal racism – racial prejudice and racial discrimination, or systemic racism – cultural racism and institutional racism.

CATSINaM is not alone in promoting greater understanding of cultural safety among non-Aboriginal people and organisations, as well as encouraging them to strengthen their work in planning, implementing and monitoring strategies to improve cultural safety. This is a shared concern for many Aboriginal organisations at national, jurisdictional and local levels that are being increasingly active in advocating on cultural safety, as well as developing related resources, guidelines or standards. As Dr Calma, pointed out, these concerns are now being shared by health and human services professions, and some universities, who are taking further steps in their journey of taking greater responsibility to address racism and strengthen cultural safety.

CATSINaM has formalised its stance on cultural safety in a policy position statement, provided in the Summit pack and available on our website <http://catsinam.org.au/?page_id=495>. The long term challenge is to find opportunities that embed cultural safety into systems to ensure it is not reliant on individuals and that it is enduring. The diagram in Figure 1 outlines some of CATSINaM’s thinking on this. We believe that nationally accredited cultural safety training needs to be developed for our professionals. Whatever we do needs to be Aboriginal and Torres Strait Islander led, reviewed, evaluated and centred. These opportunities exist within accreditation standards for our learning institutions, workforce competency standards and health service accreditation standards. Further, our leaders – both Aboriginal and Torres Strait Islander and non-Indigenous - need to champion cultural safety.
CATSINaM’s hope is that through our combined efforts, the strategies recommended for the different stakeholders outlined in our policy position statement will be implemented in full. Further, that when we as a profession review our collective efforts, there is evidence of meaningful and sustained positive change in the lives of Aboriginal and Torres Strait Islander Australians. This is a collective effort because it requires change from all of us - as Sarah Maddison emphasises:

*If we want to ‘close the gap’ between the values many of us profess to hold with regard to the status and life chances of Aboriginal and Torres Strait Islander Peoples and the reality our nation faces, what needs to change is us. For the status of Indigenous Peoples in Australia to change, we will all need to change.*

---

2.2 An overview of cultural safety

The Summit facilitator, Gregory Phillips provided an overview of cultural safety. This complemented and expanded on the documents provided to participants in their Summit pack, i.e. the CATSINaM Cultural Safety Position Statement and the CATSINaM paper, ‘Towards a shared understanding of terms and concepts: Strengthening nursing and midwifery care of Aboriginal and Torres Strait Islander peoples’.

In drawing together the learnings gained from previous work to articulate cultural safety and distinguish it from other terms (such as cultural awareness, cultural sensitivity and cultural competence), Greg outlined two important matters that emerged in his recently completed PhD.

First, the critical focus of cultural safety is to facilitate both individual and institutional change. Without change in both areas, Aboriginal and Torres Strait Islander Australians will not experience cultural safety. In terms of the nursing and midwifery professions, individual change occurs through developing greater awareness of self and others (reflexivity), and associated actions that demonstrate this shift in consciousness in personal and professional practice. Institutional change occurs through recognising how whiteness, white privilege and power are embedded in health and education systems, identifying strategies that disrupt our taken for granted ways of doing business and decolonise the profession, nursing and midwifery schools, and our full range of health services. It is imperative to recognise that “whiteness is not a skin colour…it is a mindset of power and privilege”, while “blackness is not a skin colour…it is living culture and spirit”.

Second, similarly to the approach to cultural safety taken in New Zealand, Aboriginal health and cultural safety are not the same thing. This is depicted in Greg Phillip’s model of applied cultural safety in Australia - see Figure 2. Aboriginal and Torres Strait Islander health is “paradigmatic…it is not simply another epidemiological cohort to be ‘fitted in’ or ‘included’ with no reference to power relations.”

---

**Figure 2: Greg Phillip’s model of applied cultural safety in Australia**

Aboriginal & Torres Strait Islander Health

‘the business’

Cultural Safety

‘levelling the playing field’

‘Aboriginal and Torres Strait Islander knowledge’ is about intellectual property, and depends on PLACE, history, social phenomena, languages, customs, cultures, spirituality, religions.

---
Greg highlighted that, by implication, there are different responsibilities and roles for Aboriginal and Torres Strait Islander and non-Indigenous peoples:

- **Responsibility and role of non-Aboriginal and Torres Strait Islander leaders and allies:** To set out strategic directions that make the system culturally safe - they must do the decolonisation work within our systems.

- **Responsibility and role of Aboriginal and Torres Strait Islander leaders and allies:** To set out priorities and strategic directions in Aboriginal and Torres Strait Islander health, and bring in the people to help do it, which can involve support from non-Indigenous people at the invitation of Aboriginal and Torres Strait Islander peoples.

On the basis of his work, Greg stated that a strategic and accountable approach regarding Aboriginal and Torres Strait Islander health in universities is yet to be adopted on a consistent basis. Approaches are more often individually focused, rather than directed at creating an organisational shift with targeted strategies, desired outcomes and regular reviews of progress.

**QUESTIONS AND DISCUSSION**

Questions and comments were invited from participants in response to Greg’s presentation. The main themes of this exchange were as follows:

- **Question:** Does the concept of ‘person-centred care’ have relevance for Aboriginal and Torres Strait Islander Australians? **Response:** It does but as that person is in a family and community context then our approaches must extend beyond the individual focus that is our usual approach in Australia.

- **Question:** Does this present an opportunity for a multi-disciplinary and team care approach in responding to Aboriginal and Torres Strait Islander peoples’ health needs? **Response:** This is possible but it must be based on providing high quality care, not just because it is a cheaper option.

- **Discussion on ‘what is culture’:** This discussion focused on the understandings that white Australians have about culture, particularly the tendency to think: we do not have a culture, that Aboriginal people are ‘other’ to us, Aboriginal culture is not part of our heritage, and how we have learned to fear the ‘other’.

- **Discussion on ‘moving past a fear of offending’:** How white Australians can have a “fear of offending”, “anxiety about doing or saying the wrong thing” or “can be paralysed with fear about being disrespectful”. This can result in people not talking about racism and cultural safety at all because white Australians are scared of talking about it and/or are confused about how to do this, so our task is to create the space and get people together to have this conversation. Cultural safety training is a forum where this can occur, but we can do this informally with each other as well. We need to teach cultural safety and Aboriginal and Torres Strait Islander health in a dedicated manner in our pre-registration health qualifications across the entire course so that non-Indigenous students can move from any initial struggles or rejection through to realising it has relevance and being appreciative of the learning gained.
Discussion on ‘increasing the Aboriginal and Torres Strait Islander health workforce’: The importance of also building capacity to address the Aboriginal and Torres Strait Islander health aspect by getting more Aboriginal and Torres Strait Islander Australians through the health education and professional system. We need to have a bigger Aboriginal and Torres Strait Islander health workforce. Further, once they are there we must ensure that they do not end up with the sole responsibility of responding to Aboriginal and Torres Strait Islander needs; this is a shared responsibility. It requires health organisations taking a strategic approach to cultural safety (as described above).

Discussion on ‘making a long-term commitment’: Addressing cultural safety requires long-term commitment to achieving generational change, and willingness to work through the discomfort, and personal and professional challenges that it raises. This has occurred in New Zealand since cultural safety was first talked about in 1992 and there are positive signs that generational change is occurring, as there is less challenge emerging from the new generation of NZ nurses and midwives entering the university system.

Discussion on ‘starting at the strategic level’: The importance of not rushing to operational matters, which commonly occurs, and ensuring that the foundation is set by starting with talking about values from an honest perspective: “who we are and what we believe in, in our heart of hearts, then talk about what we are doing, our motivations”. Only then can we talk about the terms of the partnership between Aboriginal and Torres Strait Islander and non-Indigenous peoples, governance and power relations, e.g. “How are Aboriginal people involved in making decisions on the Aboriginal health budget? If there isn’t one, how do we get things done without it?” We must work at the leadership and strategic level first, and then translate it into operational business.

2.3 Practising cultural safety in different contexts

This section of the day was in a panel and discussion format regarding the journey of four different organisations in addressing cultural safety: a nursing peak body, a health service and two universities. Each was at a different point in their journey, and shared their personal and organisational reflections on what they have learned about what works in addressing cultural safety and what they are planning to do within their organisations.

Karen Booth: President, Australian Primary Health Care Nurses Association

While thinking she had developed skills in working sensitively across cultures, Karen Booth explained how she was left speechless in response to attending the CATSINaM sponsored cultural safety workshop. This was due to recognising “what I didn’t know and didn’t do”, the “absences and oversights in primary health care nursing”, how she “has not understood the complexities” and “realising this has consequences”.

As a result, there are steps to take at a personal and organisational level.
“With having a better realisation that I don’t know, I am looking at steps I can take and influence I can have to improve my own care delivery and my organisation about being inclusive of the cultural needs of Aboriginal and Torres Strait Islander clients, and also our members at APNA.”

APNA is in a learning phase and is working to build stronger relationships with the CATSINaM staff team. Karen has joined CATSINaM as an Associate Member; two APNA Board Members attended the July 2014 CATSINaM Cultural Safety Workshop and three have expressed interest to participate in the February 2015 workshop. APNA wants to rethink some of its Member activities, how it can sharpen up its act in relation to cultural safety and put a Reconciliation Action Plan in place with input from CATSINaM. They are also conscious that the ‘Primary Health Care Collaboratives’ are developing an Indigenous Health collaborative, so APNA want to participate in this.

In Karen’s personal work context there are a considerable number of Aboriginal patients. Therefore, the GP and other nursing staff are undertaking the Aboriginal Cultural Safety learning modules available for the Medicare Locals to assist them with engaging with Aboriginal communities in their catchment. They are finding the idea of “unpacking” what they normally do so they can “repack and organise it properly”.

**Debbie Martin, Rural Regional Director, Barossa, Hills Fleurieu Country Health SA**

Debbie Martin relayed the cultural safety journey of her large rural health region, which started when it was the smaller Gawler Health Service (GHS). It was founded on a partnership that developed between herself and an Aboriginal woman, Mary Graham, eight years ago. Mary played a pivotal role in the transformation that occurred as she transitioned from being a community volunteer to the Aboriginal Liaison Officer and eventually the Aboriginal Health Team Manager. Sadly, Mary passed on 18 months ago.

Having set up a Stolen Generation group, Mary spoke to the GHS Community Health Director about what the service could do to support them. In that year’s strategic planning process, GHS management identified that they had no Aboriginal clients or staff, and had not thought about how Aboriginal people could have participated in their planning process. Mary was appointed as the Aboriginal Liaison Officer. The GHS management thought Mary would ‘fix things’, educate staff about what they needed to do and get Aboriginal clients into the service.

Within a year, Deb started as the Community Health Director. She had recently undertaken cultural respect and safety training in her previous organisation where she learned about what it meant to be white. While an Aboriginal program had commenced, as GHS was not a safe place due to individual and institutional racism, Mary ran it in community locations. Deb wanted to improve Aboriginal health outcomes and get Aboriginal people involved, so talked with Mary about what would make it better. Based on available funds only one more Aboriginal staff member could be employed, so Deb identified funds in another program and created a third Aboriginal health position. While this was filled, the person only stayed for three months.
This started a more focused journey on what the health service needed to do so it was a safe place for both Aboriginal staff and community members. They used the national 2004-2009 Cultural Respect Framework to develop an aligned policy and presented it to the Board and CEO, having first gained the support of the CEO and Director of Nursing. The intent was to embed cultural respect in governance, policy, program delivery and their workforce recruitment strategies. The Board, with all non-Aboriginal members, agreed for it to be adopted.

All new staff were oriented to the policy and Cultural Respect Framework by the Aboriginal Health Team, but this was challenging work and took away from service delivery. This blurred the lines on who was responsible for what. Deb advocated to put staff through cultural respect and safety training and engaged Sharon Gollan and her non-Aboriginal training partners. In early 2007, the GHS Management Team did the training. They decided it was fundamentally important to require all people in leadership positions or who supervised staff to do the training first, before going to other staff. This was also made compulsory, which had good and bad sides to it as there was some very poor behaviour.

Most of this poor behaviour came from nurses who would claim “I treat everyone the same”, “I treat everyone with respect. I am not racist.” It was clear that there was complete denial at an individual level that was supported by institutional racism across the organisation. In response, the CEO wrote a letter to all staff declaring that he would not tolerate racism in the organisation. The cultural respect policy would be followed, so if they engaged in racism this would be addressed and if it continued they could no longer work with the organisation.

What is the evidence that they have made valuable changes? Almost 10 years on, the region has 700 Aboriginal clients, a regular ‘Nunga’s lunch’ that enables community engagement and health promotion, an Aboriginal Birthing Program that is completely full so some Aboriginal families still have to use the mainstream program, and Aboriginal people choosing to pass away in their facilities which did not occur for a long time due to lack of cultural safety. There are now close to 20 Aboriginal staff, and while this is still insufficient this involves Aboriginal people in a range of positions, not just the Aboriginal Health Team. They have created a regional Aboriginal staff forum to create a safer space for conversation between Aboriginal staff, where they can talk about the hard things and gain support, and include non-Aboriginal staff at their request. In terms of accountability, Aboriginal staff are not responsible for ensuring strategies in the cultural respect and safety action plan are implemented (although they are certainly involved), all non-Aboriginal staff take this responsibility.

In summary, Deb emphasised that you “cannot do nothing and wait for the right time or thing to happen”. You must start with yourself and your own practice, and reflect on being part of the dominant culture and whiteness (for people who are white Australians). It is critical to get the leadership group on board and embed responsibility for cultural respect and safety in their job descriptions. There must be Aboriginal presence in governance, e.g. their Aboriginal Health Manager is included in the regional leadership group. Aboriginal people need to be on interview panels or, at a minimum, potential staff must answer questions about cultural respect and safety. It is not Aboriginal people’s responsibility to ensure our organisations are culturally safe, it is ours because it is our problem.
Wendy Edmonson, Acting Director, Poche Centre for Indigenous Health, Flinders University

Along with other Poche Centre staff, both Aboriginal and non-Aboriginal, Wendy Edmondson teaches on Indigenous health across the Health Faculty at Flinders University. She explained that the School of Nursing has decided that the semester long topic on Indigenous health (based on cultural safety) that Poche Centre staff teach will no longer be part of the Bachelor of Nursing. This is despite the topic gaining consistently good student evaluation feedback. From 2015, Poche Staff need to teach alongside lecturers in ethics and law for a few sessions during the first year, and are currently negotiating where they will be included in a third year topic.

Wendy shared the learning gained by Poche Centre staff in teaching this topic to date. This included the outcomes from a small research grant that enabled them to interview students after graduation (at various stages of practice) to determine if and how students integrated the cultural safety principles they learned and how they applied them to practice, i.e. what are the learning outcomes in the work context. They have recently completed the project and are currently finalising the report and a submission for publication. To their knowledge, follow-up of students into the workplace having completed cultural safety education at university has not occurred elsewhere in Australia.

In the initial stages of the semester, students expressed resistance about the ‘lens’ or attention being turned on themselves as occurs with a cultural safety approach, rather than the focus being on Aboriginal Australians. They found that first year students only had a superficial understanding of what their culture was. By the end of the 10 week semester, many students underwent a transformation. They understood that they had power as non-Aboriginal Australians and health professionals, and became aware of their invisible privilege. They recognised that they knew little that cultural safety is important, and expressed how valuable they found the topic.

In brief, the outcomes for students post-graduation fell into four main categories of a practice matrix (based on Wilson’s work regarding a continuum of practice – more information on this can be gained from Wendy Edmonson):

- **Don’t know** – Students in this group do not know what to do and cannot put principles into practice. They treat people the same regardless of whose values are being prioritised in the interaction. These students may want to know more, but lack confidence or interest to seek out further information or advice.

- **Too scared** – Students in this group also do not know what to do, fear of offending people, and are scared they will say something inherently racist. They are not sure how to approach Aboriginal and Torres Strait Islander Australians. They want a checklist of the ‘dos and don’ts’ - a formula – so their life is made easier, and do not recognise the diversity of Aboriginal peoples and communities. They often need a lot of confidence-building and benefit from cultural safety training. Wendy noted that it became clearly apparent that we cannot begin a journey in university that becomes sustained if it is not supported by the health care system, and graduates are provided with further opportunities to critically reflect on their practice. A process of continuous learning is needed.
Too hard – These students argue that they know cultural safety principles and understand power differentials, but it is too hard to change their personal values and practices, so they re-enter the dominant discourse and adopt racist positions. Therefore, they revert back to their starting position and may have peers who also revert back, so reinforce this position.

Barrier breakers – These students know what cultural safety is and are committed to practising it, but find that the system can get in the road. They experience time pressures and policy barriers, and are also challenged by their peers through direct resistance when they are endeavouring to elevate the importance of cultural safety.

Wendy reported that it was heartening for the Poche team to learn that there are students who take on the principles and practice them as graduates. The next stage for their research is to explore how student learning translates into practice or not from the Aboriginal client perspective. Aboriginal clients determine the quality of care and the presence of cultural safety, so we want to hear Aboriginal voices.

In summary, Wendy emphasised that we need to change the conversation with Schools of Nursing, as there is difficulty with understanding that cultural safety applies to colonised people specifically. Further, it is important the people teaching these topics find ways to look after themselves as it can be demanding to teach these topics, particularly for Aboriginal staff that have experienced the direct effects of racism.

Rose McEldowney, Head of School of Health, Charles Darwin University

Rose McEldowney began her nursing career and worked as a nursing academic in New Zealand prior to moving to Darwin. She reflected on the experience regarding the emergence of cultural safety within nursing and midwifery in which she was deeply involved, and the shift that occurred to ensure that Pakeha (non-Maori New Zealanders) examined themselves and their role in the nursing profession. The turning point in the NZ experience was the shift that occurred when Pakeha recognised and began acting on their responsibility: “We must ensure it is deeply embedded in our consciousness, part of what we do every day”.

In the early part of the NZ cultural safety journey, Rose was part of a group of Maori and Pakeha nurses who, having done racism awareness, explored how they could bring this learning into the nursing curriculum for students. They did this before the language of ‘cultural safety’ formally emerged in NZ. Initially they worked with the Maori students’ network at her university. Although this network began with both Pakeha and Maori students, the Maori students decided to continue with Maori only as they needed to have their own cultural space. This moved their work into being a ‘negotiated partnership’ where they worked in separate cultural groups (Maori and Pakeha), and then came together to talk as a whole. They referred to this process as ‘caucusing’.

In their separate cultural groups, each group would consider what needed to happen to have an equitable partnership – what was the role of Maori and Pakeha. One person would be selected to go between the two groups to monitor the conversations, and determine the appropriate point for bringing everyone together to share their learning and ideas, and identify what should
change, who should change and how this would happen. The shared conversations would occur at least once per year.

Rose also participated in projects that reviewed how cultural safety training was being implemented within Bachelor of Nursing programs in NZ. Most training programs had embedded cultural safety across all three years of the degree. The focus in the first year was on “who are we as we become a nurse”. During second year, the focus shifted to the principles and practices of cultural safety when out in the real world, particularly in Maori Health contexts. In third year, students looked closely at personal and institutional racism, issues of power, why “things are the way they are”, what partnership is and addressed ethical questions such as: ‘If I know it is not OK, then what am I going to do about it as a nurse?’ In Rose’s university they had a placement project where nursing students worked with a Maori health provider, negotiated what they could do that would be valuable to the health service (defined by the service and within the student’s capacity to undertake), developed the initiative and then gifted it back to the service.

Although Irihapeti Ramsden’s name comes up regularly in relation to the journey towards cultural safety in NZ nursing cultural safety in nursing, Rose acknowledged all who were involved in this shared endeavour. In terms of our current situation in Australia, she emphasised the need to share and reflect on the cultural safety work that is happening, and how it directs our future focus and actions. She believed the Council of Deans of Nursing and Midwifery is an important forum that must be involved in a shift towards more effective integration of cultural safety within pre-registration training, combined with the work that each university does: “We cannot do it alone, we must have a collective approach”.

**Questions and Discussion**

Participants were invited to ask questions or make comments in response to the panel presentations. Discussion focused on four areas – the main points covered are summarised here:

- **Discussion on ‘preparing for course accreditation’**: At present there are varied approaches to how universities approach the standards that focus on Aboriginal and Torres Strait Islander representation. Participants who are more experienced with this process emphasised the importance of identifying potential people and groups who can be involved in planning and curriculum governance groups (e.g. overall program oversight, curriculum development, course advisory groups etc.), having “deep discussion” and ensuring they have genuine influence (as determined by Aboriginal people). The need for the Council of Deans of Nursing and Midwifery, and ANMAC to have strong representation from Aboriginal and Torres Strait Islander nurses and midwives on governance and advisory groups was also raised.

- **Discussion on ‘being political’**: This discussion focused on whether or not being political is an inherent part of being a nurse or a midwife, as some people may use this as an excuse for not addressing or engaging with cultural safety. It was clarified that the use of the term ‘being political’ is not about ‘formal political parties’; how we choose to engage or not with an issue is political, so we are constantly in political space. The overall flavour of the discussion supported ‘being political’ as a normal part of nursing and midwifery, evident through the following examples of points that participants made.
Example 1 - Nurses are often focused on the care of individual patients, so they must directly address and/or report to Management anything that compromises the quality and safety of that care, such as racism.

Example 2 - Midwifery representatives reported that they tell students that they cannot come into their midwifery course unless they are political, as “it is the nature of being a midwife”.

Example 3 – Nursing students are often keen in being involved in advocating for change, which can include cultural safety.

Example 4 – Nursing/midwifery educators and professional associations must ensure that nurses and midwives see advocacy as part of their health professional role, including in Aboriginal health.

Example 5 – Nurses and midwives have been political in specific professional or health areas, but this is not as evident for cultural safety yet.

Example 6 – Nurses are involved in changing their role and focus in other areas of health, such as in primary health care and working with GPs, so we can do this for cultural safety because “we all come in with some ideas about what cultural safety is, but if we are not on the right track we must reset that”.

Example 7 – The current review of university funding models and the tight fiscal environment is creating pressure points that impact on the integration of cultural safety into the curriculum, with an increasing focus on inter-professional units. There is a risk of losing the uniqueness and importance of high priority areas, such as Indigenous health, and reducing the quality of teaching on Indigenous health. Nursing and midwifery educators do need to be political and call for the prioritisation of Indigenous health in the curriculum.

Example 8 - Nurses and midwives have power as a collective, so can exercise this by engaging with the political debate on Indigenous health.

Discussion on ‘Indigenous health and cultural safety as a discrete versus integrated unit’:
There were varied opinions amongst participants about whether Indigenous health should be taught as a discrete unit or as part of another unit – or even if it has to be a choice and both options occur. CATSINaM members were surveyed on this at the 2014 CATSINaM conference – 93% of the 86 Members voted for both a discrete unit and content being integrated into other topics, with the remaining 7% voting for a discrete unit. There are examples of universities doing this effectively in both professional-specific and inter-professional units, including through Aboriginal and non-Aboriginal teaching partnerships. The primary imperative for the approach taken must always be quality of the content and learning process, not saving money.

Discussion on ‘a collective effort to create change’: Participants spoke about the need for and interest in a collective effort within nursing and midwifery in Australia to elevate the importance of cultural safety so it is routinely addressed in both education and practice. The Summit itself and the strong participation from across jurisdictions and organisations was
evidence of this. The concept of ‘critical mass’ was raised through which it will be possible to translate personal into organisational commitment, and gain sufficient traction to achieve national momentum and consistency. It was suggested that a strategic approach under CATSINaM’s leadership should be pursued.

2.4 How are we practicing cultural safety now?

Trial of an organisational self-assessment tool

The Summit was used as an opportunity for CATSINaM to pilot the use of a draft ‘Cultural safety in practice: Organisational self-assessment tool’ that it is developing in partnership with another organisation. The draft tool does not cover all possible aspects of cultural safety as it is deliberately focused on organisational culture and systems (rather than personal practices). It is developed with educational institutions and health service organisations in mind, and written as a ‘rubric’, covering 12 key elements that indicate commitment to and level of development in embedding cultural safety across the organisation. In its current form, all elements apply to educational institutions, while nine apply to health organisations and services.

Organisations must rate their progress against each element as ‘absent, minimal, developing, developed or advanced’ based on the description of organisational practices associated with these different stages. Summit participants agreed to trial the draft tool in relation to their organisation, whether they were a university, health organisation (e.g. national nursing and/or midwifery body) or health service. However, as this was a trial they shared their outcomes in a confidential manner during the Summit and for internal CATSINaM use only after the Summit.

Summit participants reported that the tool helped to clarify what they needed to consider when embedding cultural safety in their organisations and to identify priorities for their attention. There was strong interest in having access to a final version of the self-assessment tool. Further development of this tool is under discussion at CATSINaM, and will consider the learning gained from the trial at the Summit; therefore copies will not be available until final decisions are made.

Exploration of three priority areas

At the Summit, participants decided to break into small groups and explore three high priority areas that were common for many of the organisations present. The conclusions that each group reached are summarised here:

- Professional development on cultural safety for staff: This group concluded that cultural safety professional development should be compulsory within their organisations. This requirement would benefit from being put into some form of standards or regulations in nursing and midwifery so it is seen as a requirement. For example, in NZ it is a standard requirement of pre-registration training. They also believed that once sufficient numbers have participated, a groundswell of people will be created who realise how it impacts on their practice and are motivated to stay involved.
The group also discussed who should deliver training/education on cultural safety and Aboriginal health. They determined that it must be people who are trained appropriately for the task, hence the necessity of cultural safety professional development. Further, they emphasised that both Aboriginal and non-Aboriginal people have responsibility, so this work should not be left to Aboriginal people. However, they were conscious that not everyone is ready and able to deliver cultural safety and Aboriginal health content. They proposed using an interview process to determine readiness and ability, then a learning and development program to support the people selected in the teaching process, including how to manage racism in the teaching space and facilitate dialogue around contested issues.

Curriculum content on Aboriginal health, culture, history and cultural safety: This group concluded that content needs to be delivered through both dedicated/discrete and integrated units. This was relevant in universities for registered nursing and midwifery, and registered training organisations (RTOs) for enrolled nursing. In their experience, the group participants indicated that content is lost when it is only delivered through integrated units. They considered that more work needs to occur in relation to registration standards set by the NMBA and, consequently, course accreditation standards set by ANMAC, i.e. the standards need to be more clearly articulated with more detailed guidelines for meeting them.

They concurred with the first group that cultural safety professional development must be provided to all education staff in order to develop strategies for including and delivering this curriculum content – this is consistent with the outcomes emerging under the soon to be finalised ‘Aboriginal Health Curriculum Framework’. This will require resources for training staff, which may include e-learning solutions as an ‘introduction’ that would need to be followed up with face to face options. It is imperative to start the process and get more people to recognise the need for a higher level of training.

The group emphasised the importance of Aboriginal and non-Aboriginal academic staff working together so curriculum content is informed by their expertise, reflects Aboriginal people’s priorities and there is Aboriginal ownership. This conversation also raised the need for supporting Aboriginal and Torres Strait Islander nurses and midwives to progress into academia – the group asked: Can we support innovative new ways to support culturally safe ways for this to occur? How can the Council of Deans of Nursing and Midwifery set targets for Aboriginal and Torres Strait Islander academics in Schools of nursing and develop strategic partnerships to achieve them?

Another lever for prioritising this curriculum content is working with Chief Nursing and Midwifery Officers in state/territory health to articulate what they want as graduate qualities, and raising Aboriginal health as a priority within these conversations.

Support for Aboriginal and Torres Strait Islander staff: It was clear for this group that support must be provided in an ongoing manner and be backed by a clear leadership commitment. Support should be evident to Aboriginal and Torres Strait Islander staff from the CEO down to frontline service and administrative staff. Consistent with the other two groups, professional development on cultural safety for all staff in the organisation is a critical starting point, as this establishes shared concepts and language.
This group described a cyclical process based on good communication and lines of accountability. Once the CEO and staff in leadership positions undertake the training, they should come back and debrief with people on the frontline staff after they have been trained. This promotes organisation wide involvement that fosters understanding, development and growth about cultural safety for all staff, including how to support their Aboriginal and Torres Strait Islander colleagues. However, these conversations need to be maintained so there is individual and organisational reflection on a revolving basis. This must occur within and across sections of an organisation – particularly important if it is a large organisation – and different levels of the organisation must talk together.

For example, this group suggested that after a round of staff training is completed, safe spaces should be set up at regular intervals for a diverse range of staff to have reflective discussions, i.e. talking circles where each group has a facilitator/co-facilitator (e.g. Aboriginal and non-Aboriginal staff member), establishes group agreements, sets standards of the discussion and agrees on topics to discuss. This will enable discussion on the learning gained through the training, and staff can share new ideas and experiences as ‘cultural safety in practice’ is progressed through the organisation. In addition, staff taking on the facilitation role must want to do this and have access to support and debriefing. This creates an opportunity for staff to ‘step up’ into greater responsibility and leadership, and be involved in inspiring and motivating others to create a more culturally safe environment for Aboriginal and Torres Strait Islander staff, students, clients and colleagues. As they pointed out, creating space and time for these conversations does not cost money.

Final reflections on cultural safety

In bringing this session and Day 1 of the Summit to a close, participants shared their reflections on their experience of the day. The main themes in these reflections focused on:

- gaining greater understanding about cultural safety
- leaving with more ideas about how to integrate cultural safety into their organisations and start overcoming resistance to doing this
- the desire to motivate their fellow colleagues to value and understand cultural safety
- the importance of making greater progress with embedding cultural safety concepts and practices across the nursing and midwifery profession in Australia and an expectation that this will occur
- the need for more resources to support the implementation of cultural safety concepts and principles
- appreciating CATSINaM’s leadership in raising the profile of cultural safety and holding the Summit.
3: Towards establishing a LINMEN

3.1 Why a LINMEN?

CATSINaM’s rationale for a LINMEN

Janine Mohamed outlined why CATSINaM is proposing that a LINMEN – Leaders in Indigenous Nursing and Midwifery Education Network – be established. The two objectives under Strategic Direction 3 of the CATSINaM Strategic Plan focus on supporting ‘recruitment and retention of Aboriginal and Torres Strait Islander peoples in nursing and midwifery’, and ‘raising the profile of and increasing access to cultural safety’ for Aboriginal and Torres Strait Islander nurses and health service users.

The two key indicators of need underpinning these two areas are that: 1) the recruitment and retention rates for Aboriginal and Torres Strait Islander students are poor, and 2) the statistics for our people’s health remain abysmal. Therefore, key questions to ask ourselves are:

- Are we doing enough in universities?
- Is what we are doing of high quality?
- How do we know?
- How well do our existing tools for determining quality really work – do they skate the surface or do they have depth?

In CATSINaM’s experience, universities have a variable response to addressing the ANMAC accreditation standards focused on ‘Aboriginal history, health and culture’. As noted in the background paper (see Appendix B), cultural safety is not consistently named in the standards. University responses fall into four main groups: those that are not delivering a quality product, those that are delivering a quality product but we do not get to hear about them, those that want to do this but are unsure how, and those that are not prioritising this area so are doing very little.

Nurses and midwives constitute almost 57% of the health workforce, and play a pivotal role in providing culturally safe health services to Aboriginal and Torres Strait Islander communities. Therefore, it is critical to have all nurses and midwives with the capacity to provide culturally safe services, so we must reach all nurses and midwives as part of their core training and provide high quality education on Aboriginal health and cultural safety. While there is an Aboriginal and Torres Strait Islander nursing and midwifery workforce, it is small and growing slowly. On current figures


Aboriginal and Torres Strait Islander Australians make up only 0.73% of all registered nurses and 0.8% of all registered midwives.\(^3\) In order to achieve population parity with non-Indigenous Australians, and factor in the higher burden of disease and higher birth rates, CATSINaM has calculated that the actual current need is for Aboriginal and Torres Strait Islander Australians to constitute 5.2% of all registered nurses and 3.6% of all registered midwives.

We need to retain Aboriginal and Torres Strait Islander students through to completion of their qualifications and support them in their transition to registered practice. We need to develop and deliver high quality curriculum content on Aboriginal health and cultural safety in pre-registration training. A LINMEN can play a role in these endeavours.

In summary, we are seeking good practice by all nurses and midwives, which results in good outcomes in Aboriginal health, but... you do not know what you cannot see and hear! In achieving good practice – we need to share our wisdom, our experience and our strategies, both what works and what does not work, and why. This could occur via a LINMEN.

**Stakeholder responses**

**Fiona Stoker: CEO, ANMAC**

Fiona started by noting that while nurses and midwives often lead the way in initiatives, they do not always profile their successes.

ANMAC is made up of people from the nursing and midwifery professions. It engages with these professions to develop standards through our expert advisory groups, and our consultation process is one of the best. ANMAC puts standards out, encourages nurses and midwives to input into them, and attends stakeholder forums to discuss them and gain feedback. The assessment of curriculum and delivery is done by nurses and midwives through peer review. ANMAC is here to work on improving the standards, particularly the standards we have not quite got right yet.

For example, the ANMAC Board is currently reviewing a draft explanatory note that was recently developed for Standard 4.6 of the Registered Nurse standard, which reads as follows:

*Standard 4.6: Inclusion of a discrete subject specifically addressing Aboriginal and Torres Strait Islander peoples’ history, health, wellness and culture. Health conditions prevalent among Aboriginal and Torres Strait Islander peoples are also appropriately embedded into other subjects within the curriculum.*

However, based on feedback received to date, as well as the discussions occurring at this Summit, the Board is planning to revise it. Fiona indicated that ANMAC needs to discuss whether and how to amend the standard and how best to address the explanatory note. While the standards are

---

more difficult to change at this point until the next formal review point, as they are ratified by the Nursing and Midwifery Board of Australia, improving and distributing the explanatory note could be a way of defusing some of the confusion that remains regarding Standard 4.6.

In terms of a LINMEN, Fiona stated it is a forum in which ANMAC could engage, as “it up to us to demonstrate leadership and want to be part of the solution; it is up to all of us and the education sector to collaborate”.

Fiona also addressed the following questions that participants asked about ANMAC, which were relevant to cultural safety:

- **Question:** How are assessors prepared prior to doing the accreditation assessors? Would the Board look at the process that is undertaken and what else needs to occur? **Response:** Many assessors have gone through cultural safety courses, but ANMAC can look at this. We need to get the explanatory note in place so there is a shared understanding across universities about what the expectations are of their practice.

- **Question:** Universities ask Aboriginal and Torres Strait Islander nurses and midwives to review curriculum, but they may have little or no experience with this, so training is imperative. Can we engage CATSINaM in that training? **Response:** Yes, ANMAC is fortunate to have the link with CATSINaM on their Board and through the organisation to explore this idea.

- **Question:** What representation of Aboriginal people exists in the ANMAC structure? **Response:** ANMAC seeks advice and counsel from CATSINaM and have a CATSINaM representative on the Board. However, on the organisational cultural safety self-assessment we undertook yesterday, we saw ANMAC as low in this area. There are good intentions and ANMAC is currently working towards changing our HR policies so we provide opportunities to Aboriginal and Torres Strait Islander people from a recruitment perspective. However, we need to establish ourselves as being more culturally safe.

**JOHN GROOTJANS: SENIOR LECTURER, UNIVERSITY OF SYDNEY SCHOOL OF NURSING**

John highlighted that as a profession and within our universities, we need to constantly collect data that reviews what we are doing and be willing to change direction to improve - data that leads to reflection. It is also important to get clear on the poor outcomes that can result from our good intentions. We must see the difference between benevolence and real empowerment.

His priority question is: What are the nurses I teach going to do when they get out in the workforce? Currently, the School of Nursing is part of a process of organisational change at the University of Sydney in how they recruit, retain and support Aboriginal and Torres Strait Islander students. While there are champions within the School who are advocating and supporting the change, there is a risk that if these people leave then the momentum is lost. We must do things that are sustainable beyond the individual champions.

John explained his School’s current process of change is about achieving targets in cultural safety. They have identified where they are failing and what they need to focus on. They have engaged every staff member of the Faculty to start to think about their role in this, including their
administrative staff. One of their initiatives is for all staff to undertake cultural safety training, as this will help them have a shared understanding of the issues and harness support for the initiatives they must implement to meet their targets.

In relation to LINMEN, John believed that this would be a very beneficial forum for their School of Nursing, and could see them actively participating. It would support them in their current work, and assist with improving what they are doing in the curriculum.

3.2 Learning from others: The LIME experience

The Leaders in Medical Education (LIME) Network was established in 2005 as part of the outcomes of the ‘Medical Deans Indigenous Health Project’, which was a partnership between the Medical Deans of Australia and New Zealand and the former Office of Aboriginal and Torres Strait Islander Health (OATSIH) in the Australian Government Department of Health and Ageing. Following completion of the ‘Medical Deans Indigenous Health Project’ in 2007, the LIME Network became a stand-alone project from 2008; it is currently funded by the Australian Government Department of Health until June 2015.

The aims of the LIME Network are designed to:

- enable the continuing development and implementation of quality Indigenous health curriculum to improve medical education for all medical students
- build on and strengthen appropriate recruitment and retention initiatives for Indigenous students
- build the capacity of those working in Indigenous health at medical schools
- develop pathways for vertical integration of Indigenous health curriculum and student recruitment strategies with specialist colleges
- strengthen Indigenous health initiatives across health disciplines
- facilitate key relationships between Indigenous community controlled health organisations and medical schools to improve collaboration, student placement opportunities and research initiatives.

They have developed objectives to operationalise these aims that focus on these areas: quality review processes regarding the Indigenous health curriculum in medical education program, professional development capacity building and support for teaching staff, research and evaluation of good practice in Indigenous health and medical education, professionalisation of Indigenous health as a discipline, multi-disciplinary and multi-sectoral networking, and advocacy and reform. In addition, they offer a biennial ‘LIME Connection’ Conference that assists in meeting these objectives.

As there are several similarities between the proposed LINMEN and what LIME has done in relation to ensuring the quality and effectiveness of teaching and learning of Indigenous health in medical education and curricula, LIME gave a presentation to the Summit about their experience.
This was undertaken by Odette Mazel, the LIME Network Program Manager. Odette showed a 10 minute DVD that provided an overview of the LIME Network, which is also available on their website: <http://www.limenetwork.net.au/content/lime-network>. Odette also responded to participant questions and discussions about their work.

In summary, the LIME Network has a number of notable features that are relevant for any future LINMEN, which include:

- high level leadership from the Medical Deans
- a shared approach between Australia and New Zealand, although this reflected the structure of the Council of Medical Deans as a joint initiative.
- governance arrangements - LIME is auspiced by the University of Melbourne with the oversight of the Medical Deans, and has a Reference Group of ~20 people, which is considered the “heart of LIME” and includes representation from medical students.
- shared ownership through the LIME Reference Group and other key stakeholders, i.e. Australian Indigenous Doctors Association (AIDA) and the Royal Colleges in the medical profession
- long-term resourcing, which has facilitated consistency of approach, participants and Secretariat staff who can action decisions from the LIME Reference Group
- development and distribution of a range of resources for universities, including preparatory tools for course accreditation
- fostering of good communication, trust, sharing and a collective approach, which is particularly evident through the biennial LIME Connection conference.

### 3.3 Moving from concept to reality

At this juncture of Day 2, Summit participants had expressed their strong support for pursuing the establishment of a LINMEN. Therefore, the focus of Day 2 turned to workshopping the key components of a future LINMEN. The discussion focused on developing draft goals and objectives, identifying who the stakeholders are, exploring how quality can be addressed, and considering operational and resourcing matters. This section summarises the final agreements reached through these discussions, which will become a basis for developing a more detailed proposal (see Section 3.4).

**Draft goal and domains of work**

After extended discussion regarding the core purpose of LINMEN and what is within its power to achieve, the following draft goal was accepted by the group:

**LINMEN draft goal:** To improve the quality of cultural safety education and training for students and educators in nursing and midwifery.
This draft goal is inclusive of both universities and RTOs as educational institutions. Further, achieving this goal will contribute to much needed positive change in: 1) more experiences of culturally safe care and better health outcomes for Aboriginal and Torres Strait Islander Australians, and 2) a greater proportion of Aboriginal and Torres Strait Islander Australians in the nursing and midwifery workforce.

Similarly to the LIME Network, a future LINMEN would work towards realising this goal through implementing strategies across several domains of work. For example, this could include:

- Aboriginal history, health, culture and cultural safety curriculum (including resources for both content and delivery)
- Workforce development for educators delivering curriculum
- Quality review
- Culturally safe teaching and work environments
- Research and evaluation of good practice.

A next step in planning a LINMEN will be to identify outcome indicators for this goal, finalise the domains or work and agree on the range of strategies to be implemented under each, and set targets against the domains of work. For example, indicators may include: improved recruitment, retention and completion rates of Aboriginal and Torres Strait Islander students; higher levels of cultural safety reported by Aboriginal and Torres Strait Islander students and staff; and demonstrated improvement in the amount and quality of Aboriginal history, health, culture and cultural safety curriculum in nursing and midwifery courses.

It would also be wise to develop program logic to demonstrate how the operation of LINMEN will lead to desired short, medium and long-term outcomes.

**LINMEN stakeholders**

Summit participants identified the stakeholders who would need to be involved in supporting a LINMEN and/or would benefit from its success. This list included:

- The Council of Deans of Nursing and Midwifery
- Nursing and midwifery educators (in universities and RTOs), both Aboriginal and Torres Strait Islander and non-Indigenous educators
- Nursing and midwifery students, both Aboriginal and Torres Strait Islander and non-Indigenous students
- Nursing and midwifery accreditation bodies and regulators
- Nursing and midwifery peak and/or professional organisations, including CATSINaM
- Aboriginal and Torres Strait Islander health peak bodies, i.e. NACCHO
health employers and workplaces in all sectors, including Aboriginal and Torres Strait Islander health services

- Australian, State and Territory Governments
- Aboriginal and Torres Strait Islander communities.

What contributes to quality for LINMEN?

A final area of discussion during the workshop was on issues of quality for LINMEN, i.e. what will contribute to the quality of LINMEN’s work, and enable LINMEN to support high quality outcomes in cultural safety education and training for nursing and midwifery? At this juncture, five areas were identified:

- Commitment and leadership from the Council of Deans of Nursing and Midwifery will give weight to the importance of LINMEN’s work and the expectations of high quality outcomes.
- LINMEN must draw upon existing evidence for good practice, as well as be involved in the evaluation and research of good practice.
- Good relationships with those who set quality standards in the profession and health service industry will be vital. This would include AHPRA, specifically the NMBA, as regulators of individual nursing/midwifery registration standards, ANMAC in terms of university course accreditation standards, the Community Services and Health Industry Skills Council (CSHISC) for RTO qualification training packages, and Australian Skills Quality Authority that sets the standards for registration as an RTO. It would also need to consider the accreditation standards in common use in the health sector (e.g. QIC, EQUIP etc.). All of these groups were identified by CATSINaM as critical to embedding cultural safety in the nursing and midwifery professions – see Figure 1.
- LINEMN will also need a good relationship with nursing and midwifery peak and professional bodies, due to the reach they have across the profession and their ability to influence their Members to engage with the priorities and work of LINMEN.
- The engagement of Chief Nurses and Midwives in Australian, State and Territory Governments will also be of value. It is important they understand the purpose and work of LINMEN, and discuss the graduate qualities they expect of nursing and midwifery graduates in relation to Aboriginal health and cultural safety.

Areas for further development

Section 3.4 outlines the next steps that the nursing and midwifery professions need to take in establishing a LINMEN. It is through this process that other areas will be explored in detail, such as governance arrangements, ownership, operations and resourcing matters. Summit participants also suggested that more consideration be given to the final name of a future LINMEN.
3.4 The next steps in establishing a LINMEN

The final discussion on Day 2 focused on how we could act on the ideas agreed on in Section 3.3 so that a LINMEN could be established. There was clear agreement that this required a collective effort, and both human and financial resources. The outcome of this discussion was to undertake a LINMEN Scoping Project as a two part process.

Part 1 involves two steps.

1. Establish a lead steering group with agreed Terms of Reference to oversee the Scoping Project and identify seed funding. Hold an initial meeting to discuss how to:
   - engage all stakeholders - seek commitment in further development (from represented bodies and those who were here)
   - identify sources for seed funding to undertake the Scoping Project (ANMAC made a commitment to contribute seed funding and assist in sourcing further funding)
   - develop the Scoping Project Plan

2. Develop a short discussion paper that include the proposed LINMEN goals, core values, domains of work and associated strategies, drawing on the Summit outcomes. It will also raise critical questions on other matters of significance, such as governance arrangements and what relationship a proposed LINMEN should have with the LIME Network.

More than 11 organisations and/or individuals expressed interest to be involved in the lead steering group or a wider Reference Group for the Scoping Project. CATSINaM has recorded their names and organisations. The proposed members of the lead steering group are:

- CATSINaM (3): CEO, Chairperson/Board Member, and Senior Policy and Research Officer
- Council of Deans of Nursing and Midwifery (2): Rose McEldowney and a second nominee
- ANMAC (2): CEO and a second nominee
- ACM (1) – CEO or nominee
- ACN (1): CEO or nominee

Part 2 of the LINMEN Scoping Project can proceed once funds are secured - this has four steps:

3. Undertake consultations regarding the discussion paper with stakeholder groups, and ensure input is sought from nursing and midwifery students and newer graduates.

4. Consider the options for how LINMEN could have a relationship with the LIME Network.

5. Analyse the consultation outcomes and determine what approach to adopt.

6. Write a full proposal that outlines the resources required to establish and implement a LINMEN, and evaluate its first three years of operation.
Summary

The CATSINaM ‘National Summit on Cultural Safety in Nursing and Midwifery’ was both a well-attended and well received event. It has forged a stronger sense of commitment and momentum for the nursing and midwifery professions to make progress in valuing the importance of cultural safety as a core concept, and embedding it in professional principles, policies, structures and practices.

Summit participants paid tribute to CATSINaM’s leadership in promoting cultural safety and making the Summit possible. Further, participants reinforced the importance of CATSINaM maintaining leadership on cultural safety, although the work to improve the professions’ integration and implementation of cultural safety is a shared responsibility.

The Summit has resulted in a formal agreement to undertake a LINMEN Scoping Project as the next step in working toward the establishment of a LINMEN for the nursing and midwifery professions. CATSINaM will liaise with ANMAC and the proposed representatives of the lead steering group for the LINMEN Scoping Project, and notify Summit participants, as well as the CATSINaM Membership, of progress with initiating the project. A copy of this report will also be distributed and made available on the CATSINaM website.
## Appendices

### Appendix A: Cultural Safety Summit Agenda

#### DAY 1: Cultural Safety in Nursing and Midwifery

<table>
<thead>
<tr>
<th>Time</th>
<th>Welcome and Summit Opening</th>
<th>Presenters</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00 – 9:25</td>
<td>Welcome and Acknowledgement of Country</td>
<td>Aunty Matilda House</td>
</tr>
<tr>
<td></td>
<td>Formal opening of the National Summit</td>
<td>Dr Tom Calma</td>
</tr>
<tr>
<td></td>
<td>CATSINaM – our focus and priorities</td>
<td>Janine Mohamed</td>
</tr>
<tr>
<td></td>
<td>Purpose of the Summit – why cultural safety?</td>
<td>Janine Mohamed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time</th>
<th>Who is here?</th>
<th>Presenters</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.25 – 9.45</td>
<td>Getting to know you activity - your hopes for today</td>
<td>Greg Phillips</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time</th>
<th>What is cultural safety?</th>
<th>Presenters</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.45 – 10.30</td>
<td>Unpacking cultural safety</td>
<td>Greg Phillips</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Morning Tea: 10.30 – 11.00**

<table>
<thead>
<tr>
<th>Time</th>
<th>Panel: Practising cultural safety in different contexts</th>
<th>Presenters</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.00 – 12.30</td>
<td>Cultural safety in universities and health workplaces</td>
<td>Karen Booth, Australian PHC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nurses Association</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Debbie Martin, Barossa Hills</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fleurieu Rural Region SA</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Professor Rose McEldowney,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Charles Darwin University</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wendy Edmondson, Poche</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Centre for Indigenous Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and Wellbeing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Professor Roianne West,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Griffith University (deferred</td>
</tr>
<tr>
<td></td>
<td></td>
<td>to Day 2)</td>
</tr>
<tr>
<td>Time</td>
<td>Yarning Circle</td>
<td>Presenters</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>1.30 - 3.00</td>
<td>How is cultural safety practiced? A self-assessment – our level of engagement with advocating and implementing culturally safe practices</td>
<td>Kathleen Stacey</td>
</tr>
</tbody>
</table>

**Lunch: 12.30 – 1.30**

<table>
<thead>
<tr>
<th>Time</th>
<th>Implementation: Moving from ‘talk’ to ‘walk’</th>
<th>Presenters</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.30 – 4.45</td>
<td>Strengthening cultural safety in everyday practice</td>
<td>Greg Phillips</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time</th>
<th>Reflections</th>
<th>Presenters</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.45 – 5.00</td>
<td>Closing comments and reflections</td>
<td>Greg Phillips</td>
</tr>
</tbody>
</table>

**Afternoon Tea: 3.00 – 3.30**

**Day 1 Close: 5.00**

---

**DAY 2: Towards the establishment of a ‘LINMEN’**

<table>
<thead>
<tr>
<th>Time</th>
<th>Reconnecting</th>
<th>Presenters</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:00 – 9:15</td>
<td>Implications of Day 1 for establishing a LINMEN</td>
<td>Greg Phillips</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time</th>
<th>Why a LINMEN?</th>
<th>Presenters</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.15 – 9.45</td>
<td>Strategic purpose and rationale for a LINMEN</td>
<td>Janine Mohamed</td>
</tr>
<tr>
<td></td>
<td>Stakeholder responses</td>
<td>Donna Mowbray, ANMAC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>John Grootjans, University of Sydney</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time</th>
<th>Learning from others</th>
<th>Presenters</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.45 – 10.30</td>
<td>Environmental scan: what else is happening and who else needs to be here?</td>
<td>Odette Mazel, LIME Network</td>
</tr>
</tbody>
</table>

**Morning Tea: 10.30 – 11.00**
<table>
<thead>
<tr>
<th>Time</th>
<th>Ownership and objectives</th>
<th>Presenters</th>
</tr>
</thead>
</table>
| **11.00 - 12.30** | LINMEN roles, partnerships and ownership  
LINMEN objectives | Greg Phillips   |

Lunch: 12.30 – 1.30

<table>
<thead>
<tr>
<th>Time</th>
<th>Operational and resourcing matters</th>
<th>Presenters</th>
</tr>
</thead>
</table>
| **1.30 - 3.00** | How could LINMEN operate?  
Options for resourcing LINMEN | Greg Phillips   |

Afternoon Tea: 3.00 – 3.30

<table>
<thead>
<tr>
<th>Time</th>
<th>Conclusions and next steps</th>
<th>Presenters</th>
</tr>
</thead>
</table>
| **3.30 – 4.00** | Summary of conclusions from across the day  
and proposed next steps | Greg Phillips   |

Day 2 Close: 4.00
Appendix B: Cultural Safety in Nursing and Midwifery background paper

Cultural safety is of central importance to CATSINaM. We know how critical it is in closing the considerable gap that exists in:

- the health workforce representation of Aboriginal and Torres Strait Islander Australians (representation in the nursing and midwifery workforce ranges between 0.8 - 0.9% based on recent AIHW statistics)
- both quality of life and life expectancy for Aboriginal and Torres Strait Islander Australians (the contemporary ABS calculations indicate it is ~10 years less than for non-Indigenous Australians).

We are not alone in promoting greater understanding of cultural safety among non-Aboriginal people and organisations, as well as encouraging them to strengthen their work in planning, implementing and monitoring strategies to improve cultural safety. This is a shared concern for many Aboriginal organisations at national, jurisdictional and local levels that are being increasingly active in advocating on cultural safety, as well as developing related resources, guidelines or standards.

CATSINaM has formalised our stance on cultural safety in a policy position statement, which we have attached (also available at our website <http://catsinam.org.au/?page_id=495>). Our hope is that through our combined efforts, the strategies recommended for the different stakeholders outlined in the policy position statement will be implemented in full. Further, that when we review our collective efforts, we have evidence that there has been meaningful and sustained positive change in the lives of Aboriginal and Torres Strait Islander Australians.

**Cultural safety and related concepts**

A direct response to ‘What is cultural safety?’ in both conceptual and practical terms will be explored in greater detail at the Summit. It is important to note that there has been discussion and training focused on the recognition and integration of Aboriginal cultures and Torres Strait Islander cultures within contemporary health practice for close to three decades. Different language has emerged over time as we have developed different concepts and approaches to understanding how this needs to occur.

A useful background document to read in preparation for the Summit presentations and discussions is the attached ‘CATSINaM Cultural Terms’ (2013) resource, which includes a comparison of the different concepts in terms of their key points, utility and outcome.

All terms included in this resource are important to understand and most have ongoing relevance. CATSINaM chooses to focus on cultural safety because the presence or absence of racism, and the presence or absence of cultural safety, are experiences that can only be defined by Aboriginal and Torres Strait Islander clients, regardless of whether health practitioners believe they are
demonstrating cultural respect within their practice. It is also a term that has developed in the context of First Nations peoples.

**Advocacy for Cultural Safety within the Health Sector**

It is not possible to provide a comprehensive overview of all documents in the health sector that highlight and advocate for cultural safety as a critical consideration in relation to the health workforce and health system. However the following are notable:


This seminal report was commissioned to address how participation of Aboriginal and Torres Strait Islander Australians can be maximised in the workforce through both recruitment and retention strategies. The definition of cultural safety that it adopted was “institutional reform processes that support making an organisation more respectful and safe for Aboriginal and Torres Strait Islander people” (p. x). Its recommendations emphasised the need for more concerted efforts to recruit and retain Aboriginal and Torres Strait Islander health staff, culturally safe learning environments, culturally safe working environments, and professional development in cultural safety for non-Indigenous staff in VET/universities and health services.


All states and territories are signatories to this national document. While it did not use the term ‘cultural safety’ specifically, it did include strategies that require dedicated efforts to enhance cultural safety at an institutional and individual level.

First, “1.1 Implement initiatives and actions to increase the numbers of Aboriginal and Torres Strait Islander peoples entering the health workforce across all levels” (p.11) and “1.2 Implement initiatives to create sustainable long-term employment and optimise the retention of Aboriginal and Torres Strait Islander peoples in the health workforce” (p. 12) as part of ‘Key Performance Area 1: Participation of Aboriginal and Torres Strait Islander peoples in the health workforce’. Second, through providing “education and training to the potential and current health workforce that reflects current, accepted approaches to health service delivery for Aboriginal and Torres Strait Islander peoples” (p. 12) as part of ‘Key Performance Area 3: Competent health workforce to meet the needs of Aboriginal and Torres Strait Islander peoples’.


This background paper provides a helpful overview of many issues relevant to cultural safety and cultural safety training, including: concepts and meanings, cultural safety and respect as a
human right, racism and cultural safety, good practice in cultural safety training, and organisation strategies that complement training to achieve improved cultural safety at an institutional and individual level.

AIDA, 2013, Position paper: Cultural Safety for Aboriginal and Torres Strait Islander doctors, medical students and patients, AIDA, Canberra.

AIDA’s position is similar to CATSINaM’s. They see that strengthening cultural safety is a shared responsibility between educational institutions, national peak bodies and health services, as well as government and individual non-Indigenous medical practitioners.

**Example of issues to address**

**ANMAC:** To date, it has not been possible to achieve a consistent approach by ANMAC to the inclusion of cultural safety as part of accreditation standards regarding content on ‘Aboriginal and Torres Strait Islander history, health, wellness and culture’ across all four sets of standards. For example, the criteria for ‘Standard 5: Curriculum Content’ of the 2009 Nurse Practitioner Accreditation Standards includes a statement that the “the curriculum addresses specifically Aboriginal and Torres Strait Islander People’s health and culture and incorporates the principles of cultural safety” (p. 14). The same approach is in the 2009 Enrolled Nurses Accreditation Standards under ‘Standard 5: Course Content’.

However, this emphasis has been lost in other standards that have been developed since this time. In the Draft Version 1 Midwifery Accreditation Standards (identified as ‘current’ on the ANMAC website), Standard 4.7 only talks about including content on “Aboriginal and Torres Strait Islander people’s history, health, wellness and culture” (p. 7). While there is a generic reference to cultural respect and safety in Standard 4.6 regarding content that gives “students an appreciation of the diversity of Australian culture” (p. 7), this leads to the misguided approach of subsuming cultural safety for Aboriginal and Torres Strait Islander Australians under multiculturalism or national cultural diversity. The same approach is taken in the 2012 Registered Nurse Accreditation Standards.

**Universities:** Through Professor Roianne West’s analysis of university nursing schools’ data over 2004-2008, there was consistently a 28% lower completion rate for Indigenous versus non-Indigenous students in pre-registration nursing courses. CATSINaM are currently undertaking work to look at whether there has been any change over the 2009-2013 period.

**In summary**

Our task is to ensure that cultural safety is well known and understood across the breadth and diversity of the nursing and midwifery professions, and, most critically, these concepts and practices are fully implemented. The Summit is designed to support us in this endeavour.