

AUSTRALIAN ASSOCIATION OF MATERNAL, CHILD AND FAMILY
HEALTH NURSES Inc.



Ms Angela MacRae
Presiding Commissioner
ECD Workforce
Productivity Commission
MELBOURNE VIC 8003

Dear Madam,

Thank you for the opportunity to provide feedback on the Draft Report of the Productivity Commission on the *Early Childhood Development Workforce*,

The Australian Association of Maternal Child and Family Health Nurses (AAMCFHN) is the peak professional body for nurses practicing in primary health care services for families with children 0-5 years of age and our members reside in each State and Territory of Australia. The AAMCFHN advocates for the views of members to policy making bodies, and supports members through continuing professional education. Based on your figures of the child health workforce (p.217), approximately 1 in every 6 child and family health nurse is a member of the AAMCFHN.

All States and Territory governments have responded to the international research on infant mental health and child and family wellbeing and have put in place multifaceted health care services for young children and their families. As the Productivity Report notes (p. 216), nurses employed in child and family health services have diverse titles, although their work may be similar. They may be known as maternal and child health nurses, child health nurses or child and family health nurses (including Tasmania – there is an error on p 216). For ease of reference, this paper will use the term ‘child and family health nurse’ in referring to nurses educationally prepared to work in the community with children 0-5 years of age and their families.

The range of services provided by child and family health nurses is reported within the Productivity Commission’s Report. We believe, however, that the child and family health nurse’s role is primarily support for parents during the important early years of a child’s life and includes health promotion, child protection and early intervention. Therefore, the scope of practice of child and family health nurses extends well beyond the child health checks that are noted in the Report.

Consequently, we believe the Report lacks sufficient detail and does not adequately represent the contributions of the child health sector to family functioning and child wellbeing. The heavy emphasis on the early childhood care and education sector masks the very real contributions made by child and family health services. It is worth noting that child and family health nurses, because of their position in frontline services that provide health care to families with new babies, have frequent contact with young children in the early and

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formative years of life, well before they reach the age to need early childhood education services.

We believe the majority of child and family health nurses provide high quality services to families with children and families. Child and family health nurses are highly valued by families and lack the stigma of many other government services to families, such as child protection and welfare services.

Below we address topics of concern in the Report.

Demand for child health services

It is pleasing to note the Report recognises the increased demand for child and family health services. We agree that there are differences between jurisdictions in the number of funded child and family health visits, and support a national approach. Indeed, the AAMCFH is a partner in the ARC study cited in the Report on page 221. However, we would caution against a reduction in the number of scheduled services, as the current lack of evidence alone is not sufficient reason to reduce services to child health.

Qualifications and educational preparation

The Report addresses the issue of recognised qualifications in child and family health nursing. The section on page p217 that reports on nurses working in child health does not properly clarify definitions. As Child and Family Health Nursing is considered a specialist area of nursing, nurses working in community-based, universal well-child services for the 0-5 year olds are overwhelmingly Registered Nurses with additional post graduate education in the area of child and family health. Nurses working in this field typically hold a post-graduate qualification (this is all but an essential requirement)¹ that prepares them to work in primary health care. Nurses working with children in hospital settings tend to hold a paediatric post-graduate qualification and consequently are known as paediatric nurses. They may coincidentally hold a child and family health qualification. Nurses working in schools do not require the same level of preparation, as they are working with older children, so that being a registered nurse can be the minimum requirement. Enrolled nurses (EN's) have a limited role in community Child and Family Health services as they do not have the skills to undertake health and development assessments and require supervision. The role of EN's and/or mothercraft nurses tends to be in second level services such as parenting centres providing residential care, where they are supervised by registered nurses. We note that mothercraft is not an undergraduate qualification (p218): it is a VET sector qualification.

We agree that there are differences between jurisdictions in the level of educational preparation required to practice as a child and family health nurse. A recent mapping of education programs of child and family health nurses across Australia commissioned by the AAMCFHN (Kruske and Grant, under review) found substantial variation in course length and

¹ The national nursing board only recognises the qualifications of RN, EN and NP. Employment regulators (e.g. Tasmanian State Service Commission) determine 'essential' qualifications, for employment purposes, as determined by the registration board. Employers require the qualification, although only 'desirable', recognising the vulnerability of the population group (the early years are the period of fastest growth and development, and variations can have a lifetime impact), the need to work effectively with parents to achieve positive outcomes and the isolated nature of this nursing practice (a second opinion is not easily accessible).

content across Australia, suggesting significant limitations in a number of programs currently providing pre-service programs.:

Our position is that the level of qualification should be uniform across States and Territories to facilitate movement between jurisdictions. In a mobile society, such as Australia, it becomes an issue if nurses' qualifications are not transferable, so that they may be refused employment in one jurisdiction but accepted in another to do the same work. This issue will become more pertinent if a national framework is put into place.

Furthermore, we believe there should be national minimum educational standards for child and family health nursing practice so that families receive the same quality of care from the same level of qualified staff across the country. One way in which this can be achieved is the increased use of practice support programs, particularly for nurses new to the specialty. An excellent example of such a program, which includes the use of mentors/preceptors, is the NSW Department of Health Child and Family Health Nurses Professional Practice Framework. Dissemination of support programs of this extent and quality would promote quality of care and support the retention of child and family health nurses.

In regard to your statements regarding the limited success of scholarships to attract nurses to areas of unmet demand, we suggest that this has not been tested. Data from Victoria should not be extrapolated to other jurisdictions such as rural and remote areas of Queensland, Western Australia and the Northern Territory. Rather than recommending restriction of incentives for health staff to achieve education, we believe scholarships should be increased to improve access for all families to a suitably qualified child and family health nurse.

We recognise the political sensitivity in the issue of whether or not to require midwifery registration as an essential qualification in child and family health. Indeed, any discussion of midwifery qualifications should begin by recognising that nursing and midwifery are now separate professions with separate registration requirements. We note that the criteria for employment are presently determined by each State and Territory because child and family health services are under the control of State and Territory government departments. A move to place child and family health services within federally controlled primary health care will necessitate a review. We would assert, however, that the statement on page 215 that there is little evidence to suggest requiring midwifery as an essential qualification leads to better outcomes for children, is actually untested. Whilst we agree it creates an additional hurdle to workforce recruitment we believe we need to find the evidence to either support it or not, rather than immediately remove the requirement.

Recognition of complexity of child and family health nursing practice

We would assert that the complexity of child and family health nursing practice should be recognised in the Report.

Parents and carers access child and family health services for both parenting support and advice and developmental assessments. These occasions of service provide many opportunities for health promotion, role modelling, networking and other family support activities. Child and family health nurses receive complex and sensitive information from clients and require skills in persuasion, negotiation and conveying empathy or reassurance. These nurses try to influence the long-term health of infants and young children but must rely on working with parents in order to do so in a way that is respectful and values the

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parents' knowledge of their child. The role of the child and family health nurse is therefore much more sophisticated than routinely assessing a child's development. For instance, parenting may be negatively influenced by mental illness and the child and family health nurse has to ensure the child's safety and wellbeing, trying to support the parent to ensure the child is safe, gauging the point at which notification to child protection services may be required or negotiating with the parent to put strategies in place to support the family. The child and family health nurse may also need to advocate for the family's needs with mental health services.

Nursing shortages in child and family health nursing

We dispute your comment on page 213 that Australia's nursing shortages do not apply to this sector as '*child health nursing is a relatively attractive nursing speciality*'. Currently the age of child and family health nurses is older than the Australian average and education programs are failing to produce graduates in numbers required to supply workforce demand (Kruske and Grant, in press).

Furthermore, the statement that the numbers of '*child health nurses currently working as practice nurses in general practices provide a reserve pool of trained workers*' is also not believed to be accurate. Anecdotally there are very few practice nurses with child and family health nursing qualifications. In addition there is no qualifying information to indicate whether practice nurses with child and family health nursing qualifications have maintained their knowledge and skills to work safely in the child health area.

Recruitment and retention

On page 228 you state that '*If there were substantial concerns about the quality of graduates of child health nursing courses, in the absence of major workforce shortages it could be expected that graduates may have difficulty obtaining employment in the field. This does not appear to be the case, as study participants did not express concern about graduate quality*'. We have reason to believe there ARE substantial shortages or qualified staff indicated by the high numbers of generalist nurses without specialist qualifications working in some jurisdictions. Current workforce data do not keep records on all nurses who hold speciality qualifications in child and family health nursing.

We agree it is difficult to maintain the supply of demand for child health nurses in remote areas in particular. Aboriginal children living in remote areas are some of our most disadvantaged children in Australia and require our most skilled workforce possible. The Healthy Under Five Kid's package provides some attempt to remediate educational deficiencies in the general workforce. However, we believe this should not be an acceptable endpoint to the provision of child health services in remote areas. Rather, additional efforts should be put to place to educate some members of the remote work in high quality post graduate programs in child and family health (such as in the example you note on p. 234 with the Graduate Diploma in Child and Family Health available through Charles Darwin University, which provides one subject credit for the successful completion of the Healthy Under Five Kids education package).

We acknowledge the important role that Aboriginal Health Workers have in encouraging access to child health services. We note, however, that there is no reliable data to tell us to what degree they are involved in the delivery of child health services and believe this needs to be addressed.

Other concerns

We are concerned that the Report omits reference to other professionals working with children. For instance,

- We note there is no mention of second level child and family health services, such as Parenting Centres, in the Report. We believe this is an important oversight and these services should be included in a review of the child and family health workforce.
- There is also no mention of the child protection services, which provide a very important role.

Carolyn Briggs
President AAMCFHN
30th August 2011