Submission to

Early Childhood Development Workforce Study

Productivity Commission Draft Report

August 2011

Introduction

Thank you for the opportunity to offer a response to Early Childhood Development Workforce Study (ECDW) draft report. My name is Leanne Sheeran and I have been a registered nurse for 30 years. I have practised as a maternal and child health (MCH) nurse in rural Victoria for 20 years, the last 17years with the Mitchell Shire MCH service. Seven weeks ago I commenced a new position as Coordinator for the postgraduate Child & Family Health Nursing Program at RMIT University Bundoora. This involves coordinating and teaching maternal and child health nursing to postgraduate nurses and midwives.

My maternal and child health nursing experience includes: home visiting parents with new babies, centre consultations, Key Age & Stage assessments (as per the Victorian revised MCH framework) and facilitating group programs (such as for first time parents, general parenting programs and mother-infant groups for women with postnatal depression). My experience has also included lactation counselling and day stay programs, working with vulnerable families through the Enhanced Maternal and Child Health Service and liaison and collaboration with a range of community service providers.

My professional and academic qualifications comprise:

- Registered as a Nurse and Midwife with AHPRA.
- Qualified as a Maternal and Child Health Nurse
- International Board Certified Lactation Consultant (IBCLCE)
- Infant Massage Instructor

- Diploma of Nursing *Phillip Institute of Technology*
- Bachelor of Applied Science (Advanced Nursing- Midwifery) *Lincoln Institute*
- Graduate Diploma of Child and Family Health Nursing *Latrobe University*
- Master of Nursing Studies *Latrobe University*
- Master of Arts (Women's Studies) *Deakin University*
- Doctor of Philosophy *RMIT University* in progress (2004- current)

- My PhD research explores *Women's Experiences of Early Motherhood* and is due for submission 1 Nov 2011.

Focus

My submission focuses on chapter 12 'The Child Health Workforce'. While a number of these issues are intertwined I will try and separate them out for discussion. I am particularly concerned with the following issues raised in the ECDW draft report:

1. Removal of midwifery as a prerequisite for MCH nurses in Victoria (Rec 12.3)
2. Determining optimal timing of child health checks (Rec 12.1)

3. Omission of consideration of the role of the mother and family in child health and development and child and family health services.
4. Questioning the benefit of scholarships for MCH students (Rec 12.2)

Having well qualified teams of MCH nurses has enabled Victoria to provide a universal MCH service to families which eminent academics and researchers have described as a "world class service" (Edgecombe 2009) , and "the envy of other parts of the country and well beyond the shores of this country" (Scott 2011).

1. Midwifery

Midwifery, along with general nursing is the solid foundation on which Victorian MCH nurses build their maternal and child health nursing education and practice. Midwifery knowledge and skills add critical depth and credibility to our interaction with and support of families with infants and children. Some examples of how MCH nurses draw on their midwifery skills include:

- Experience with normal and high risk pregnancies and births provide a rich understanding of the range of issues affecting women and their healthy, sick or preterm infants.
- Helping women debrief and process their birthing experience over the puerperium and at times later in their infant's first year and beyond.
- Assessing and managing breastfeeding difficulties such as problems with latching, sore, bleeding or cracked nipples, over or under supply, mastitis or thrush infections, tongue tie.
- Enhanced interpersonal skills, refined via working collaboratively with families during the intensely personal experiences of pregnancy, birth and the puerperium and perinatal loss.
- Prompt recognition of and referral for medical assessment of a range of maternal antenatal and postnatal complications, such as maternal pre-eclampsia, reduced foetal movements, haemorrhage, deep vein thrombosis, mood disorders and infections.
- Identification and management of neonatal conditions such as infections, jaundice, feeding problems.

Further details and examples are noted in the attached Appendix 1 "Why Midwifery is Important in MCH Nursing."

The Health and Wellbeing of Victoria's Children

The ECDW Report comments that "there is little evidence to suggest that [the midwifery] requirement leads to better outcomes for children" and so should be removed (Productivity Commission 2011:215). A later part of the report states that the Commission 'could not find any evidence that Victorian children had better health outcomes than children in other states (Productivity Commission 2011:231) and contends that there is little justification for requiring child health nurses to hold qualifications in midwifery. This applies a simplistic argument when health and welfare are complex multifaceted and interconnected phenomena. I argue that the main reason for their being little data on child health outcomes is because there has been difficulty developing child health indicators and little research undertaken. This is similar to the lack of evidence to demonstrate that doctors with paediatric qualifications improve children's health, as little research has been done in either field of practice.

It is, however, timely that findings recently released by the Australian Institute of Health and Welfare (AIHW 2011) highlight that Victorian children are doing better than their interstate counterparts in five of eleven indicators and are similar to the remainder of the country in the other 6 indicators. For example:

1. **Child death rates due to injury**
   Child death rates due to injury were lower in Victoria than nationally (4.4 deaths per 100,000 children compared to 5.8 nationally. The national range was 3.2 – 20 per 100,000 children) (AIHW 2011:13-14)

2. **Developmental vulnerability**
   Proportionately fewer Victorian children were developmentally vulnerable on one or more domains of the AEDI at school entry (20 per cent) compared to Australia overall (24 per cent). (The national range was 20 – 39 per cent). (AIHW 2011:13-14)

3. **Literacy**
   Year 5 students in Victoria were somewhat more likely to achieve the national minimum standards in reading, (94 per cent compared to the national rates of 92 per cent). The national range for literacy was 65-94 per cent (AIHW 2011:13-14).

4. **Numeracy**
   Year 5 students in Victoria were somewhat more likely to achieve the national minimum standards in numeracy, (96 per cent compared to the national rates of 94 per cent). The national range for numeracy was 74-96 per cent (AIHW 2011:13-14).

5. **Teenage Birth Rate**
   The Victorian teenage birth rate was considerably lower than the national rate, (10 births per 1,000 females compared with 17 nationally). The national range for teen births was 7.8 – 51.4 per 1,000 females (AIHW 2011:13-14).

6. **Child Protection, Infant Mortality, Low Birth Weight, Immunisation, Dental and Overweight**
   Victorian statistics regarding substantiated child protection cases, rates of infant mortality and low birth weight, immunisation, over weight and obesity and dental health were all similar to Australia overall. (AIHW 2011:13-14)

This data provides evidence of better outcomes for Victorian children in five (5) of eleven areas, and similar outcomes to the rest of Australia in the remaining priority areas reviewed by the Australian Institute of Health and Welfare (2011). These outcomes are probably due to multiple factors, including a skilled workforce. Comprehensively prepared MCH nurses (ie qualified in general nursing, midwifery and MCH nursing) are more experienced and better equipped for the rigor of practice as community based MCH nurses. The Victorian Key Ages & Stages program integrates evidence based health and developmental screening with targeted health promotion interventions. These include specific accident prevention discussions at four (4) key developmental ages, developmental screening assessments at 10 key developmental stages, and early literacy promotion discussions and provision of supporting materials at two key ages and stages. These specific features of the MCH program were implemented to achieve the key performance indicators detailed above where Victorian children have performed better than their interstate counterparts.

Having a highly trained workforce and evidence based practice framework is most desirable for promoting child and family health and achieving good outcomes for children. Victoria needs to retain both.

These findings are also consistent with the research concerning the importance of early brain development and the long term benefits of nurturing relationships and intervening with supportive care. This concept of positive early intervention supporting children's cognitive and social development and having long term outcomes has been documented in the research regarding the Perry Street Preschool Project and the Chicago Child-Parent Centre findings cited in Appendix C of the report itself (Productivity Commission 2011:342-343).

2. Determining optimal timing of health checks (Rec 12.1)

Any determination of the optimal number and timing of child health checks need to be assessed by people skilled and knowledgeable in this area and based on sound research evidence. It is concerning that the draft report fails to consider and identify the numerous strengths of the Victorian MCH Framework, which should be the benchmark for other states. The Victorian program is located in an evidence base framework for both timing of visits and program content. It is structured program and well supported by the Department of Education and Early Childhood. The comprehensive educational preparation required for practice in Victoria in MCH nursing enables Victorian MCH nurses to provide a complete package of care to mothers, children and families. This avoids the fragmented approach that exists in other states where many different health professionals provide care. The Victorian framework provides and promotes continuity of care for families 0-6 years of age facilitating the development of a trusting relationship between families and the MCH nurse. Participation rates in the Victorian program are very high (99 per cent initially) and families report high levels of satisfaction with the service (DEECD 2011). The revised framework of Key and Stage visits situate Victoria at the forefront of evidence based MCH practice in Australia.

Final overall data on the outcomes of the Victorian Department of Education and Early Childhood Development evaluation of the Victorian MCH program will be available in 2012. The project has reported on the first year findings and is currently analysing the year 2 findings of this three year evaluation, and will provide evidence of the impact of the Victorian Key Ages and Stages program. I believe it is not acceptable to advocate major change in the absence of research evidence to support the change. It is important that further research should be undertaken to thoroughly investigate this issue.

3. Omission of the Role of the Mother and Family in Child Health & Development

The report seems to have minimal focus on the role of the mother and family and their contribution to the overall health and wellbeing of the child in an integrated family system. The report concentrates on the child as if the child existed on his or her own. This contrasts with the MCH service which is child centred and family focussed. Children do not exist on their own or in a vacuum. Their wellbeing is determined by the degree to which they are

enveloped and supported in a warm nurturing family. The extent to which a family can generally be nurturing is determined largely by the extent to which the adults in the family have their needs met and are supported so they can, in turn, support and nurture their children. Donald Winnicott commented "there is no such thing as a baby… [there is always] a baby and someone. A baby cannot exist alone." (Winnicott 1964/1978:88).

Recently discoveries about the importance of early brain development have demonstrated that promoting infant mental health is a critically important health promotion strategy that impacts on the trajectory of infant's lives for decades (Mares, Newman & Warren 2011). Supporting parents as they learn how to care and nurture their baby and young child is an investment in the future that recoups funding dollars many fold.

4. Scholarships for MCH Study Programs

Last week, in my new role coordinating and lecturing in the Child and Family Health program at RMIT University I discussed the topic of scholarships with current postgraduate students. In one class 16 out of 18 MCH students reported holding scholarships from Victorian local government councils to assist with their studies. The students all said that the partial subsidy made the difference regarding their ability to undertake their studies. Most students were simultaneously studying and working part time and a number were working full time due to family or financial commitments. Local government scholarships generally range from $2,000 to $4,000 dollars per student (MAV 2011). In addition, the Department of Education and Early Childhood Development also offers scholarships for MCH studies and in 2011 granted 15 students scholarships valued at $3,500 according to priority workforce requirements (MAV 2011). This assistance is vital for most students as tuition fees are approximately $12,000, and students still have to pay for text books, travel, accommodation and living costs over their one year full time or two year part time program. These scholarships are cost effective as potential employer and government scholarships cover about 25 per cent of tuition costs, with the student funding the remaining cost of the tuition plus text books, accommodation and travel.

Summary

Victoria's MCH service is a highly developed, robust, standardised and evidence based service. It is supported by well qualified, energetic and passionate MCH nurses. Children don't exist in isolation and a strong outcome focussed service needs to provide health care and developmental supports to children in the context of their family relationships and settings. Just as antenatal care promotes healthy mothers and babies, supporting parents and children in a well-resourced one-stop-shop service promotes and optimises the health of parents and children in an ongoing cycle.

End Note:

Two (2) Appendices are attached to this document as they are relevant to the issues under discussion.

Appendix 1:
Why Midwifery is Important in Maternal and Child Health Nursing (L. Sheeran 2011).

Appendix 2:
Commentary on Draft National Framework for Universal Child and Family Health Service (A. Wallis & L. Sheeran 2010).

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Appendix 1:

Why Midwifery is Important in Maternal and Child Health Nursing

The following statement is based on discussions with eight (8) MCH nurses working in Mitchell Shire, a rural municipality in north central Victoria. It was prepared by Leanne Sheeran and revised 30th August 2011.

As Maternal and Child Health Nurses we use midwifery knowledge every day in maternal and child health nursing practice. Midwifery, along with general nursing are the solid concrete foundation which underpin our maternal and child health education and practice. Midwifery knowledge and experience add increased depth and credibility to our interactions and collaborative work with families with young children. As practitioners in rural Victoria we strongly believe that a strong background in midwifery and paediatrics is needed to provide safe and comprehensive maternal and child health nursing services to families.

Midwifery is Important for MCH nursing

The 'maternal' component of maternal and child health nursing is a critical part of our work with families. Midwifery knowledge and experience from conception to puerperium enable us to have a rich understanding of a range of issues that impact on women and their families as they become parents. We draw on midwifery skills as we listen to women's birth stories when we collect health histories at the initial home visit. Our midwifery knowledge and experience are used as we help women process and debrief their birthing experiences during the puerperium. We use our midwifery knowledge when we address breastfeeding problems such as cracked nipples, bleeding nipples, positioning problems, attachment issues, low supply, oversupply, mastitis or thrush. Midwifery knowledge is also used in new parent group sessions when we discuss the transition to parenthood and further debrief women as they share and try to make sense of their birth experiences.

Maternal Well Being

Knowledge and understanding of concerns associated with both normal pregnancy and in high risk pregnancy inform our practice everyday. Some examples of these issues include morning sickness, anaemia, miscarriage, termination of pregnancy, hypertension, fertility issues, pre eclampsia, multiple pregnancy, intrauterine growth retardation and medication use. Women regularly seek advice or support for these issues when they attend for well child visits with older children. Midwifery experience is also essential to understand women's experiences of labour and delivery. Some examples include preterm labour, induction of labour, prolonged labour, ante partum haemorrhage, foetal distress, instrumental deliveries, caesarean section, postpartum haemorrhage, and perineal trauma. Midwifery knowledge and experience is also vital in informing postnatal care. Some examples of this include care of perineal sutures, management of urinary or faecal incontinence, lochia and uterine infections. Detection, referral and management of postnatal depression and puerperal psychosis are informed and enhanced by a foundation of midwifery knowledge and skills. These skills form a basis to understand some of the complex issues that can underpin these conditions. We have had women over the last few years that have suffered extensive postpartum haemorrhages and have had lifesaving hysterectomies following childbirth. These women have needed ongoing emotional support and debriefing over many months. Our midwifery knowledge and experience has provided the foundation, understanding and credibility for us to support these women in a caring and ongoing way as we provide well child health assessments. This is perhaps a hidden and publicly unrecognised part of our work, but it is one of the interventions that ensures that the Victorian

Maternal and Child Health Service stays at the forefront of the provision of excellence in supporting families with young children..

Child Health
Midwifery knowledge and experience are also pivotal and providing care for neonates and young children. Understanding the pregnancy and birth experience of the child greatly informs our nursing practice. Comprehension of Apgar scores, understanding neonatal jaundice, experience in working in special care nurseries, knowledge and experience with premature or sick infants, as well as the range of neonatal issues are enhanced by the foundations of general nursing and midwifery practice.

Life Skills
Midwifery knowledge and experience also underpin a range of women's health issues. The skills and experience gained in studying midwifery provide life skills and a depth to nursing experience that can only be gained from being with and supporting women through 12 or 24 hour labours, sharing the moment of birth and caring for them as they learn how to mother their newborn baby. Caring and supporting families as they cope with a premature baby or a baby with a malformation or grieve the loss of a stillborn baby, are also a part of midwifery education and give a sound foundation to work in maternal and child health nursing. This depth of life experience, and respect for women as mothers is critical to work in women's health where sensitive issues of infertility, sexual difficulties, incontinence, or domestic violence may not be readily spoken about, and require delicate handling.

Admired Interstate
In our municipality we have a number of families transfer in from interstate child health services while stationed at the army base at Puckapunyal. The Victorian Maternal and Child Health Service is strongly admired by families who have experienced child health services in other states of Australia. Reasons given include the nature of the service provided and the comprehensiveness of the program. Families particularly value the breadth of knowledge and skills that nurses have through their preparation as general nurses and midwives underpinning their maternal and child health qualifications.

Staffing Issues
We understand that staffing issues have been problematic for some maternal and child health services. It is also argued that staffing in maternal and child health is more a distribution problem. Our experience as a rural municipality is that staffing is more complex than this, but which we have been able to address. Eight (8) years ago our municipality had multiple vacancies for MCH nurses, which through some creative measures we filled. Last year was the first time we advertised for MCH nurses for seven (7) years. Our staffing issues were addressed by a multi-faceted approach. Two key strategies involved Council offering partial scholarships for midwives to study maternal and child health and by a definite shift to valuing and nurturing the MCH team. Willingness to address some of the personal needs of team members, in particular, has meant that MCH nurses stay working, even though several of our MCH nurses travel extensive distances (150 km plus per day) to work here. We understand that Bendigo is also a regional area that has addressed staffing issues through supporting midwives to undertake MCH studies.

Child Health and Wellbeing Inextricably Linked with Maternal Wellbeing
The importance of midwifery and the 'maternal' component of maternal and child health nursing has been strongly emphasised. These are important as child health and wellbeing are inextricably linked with maternal health and wellbeing. The most vulnerable and at risk children

are those where maternal health or wellbeing are challenged or compromised by factors such as poverty, chronic health problems, mental health issues, substance abuse, isolation or language barriers. Promoting and maintaining maternal health and wellbeing is crucial to ensuring infant and child health and wellbeing. Midwifery knowledge and skill provide a strong basis to promote maternal and child health.

Recent findings concerning early brain development highlight the critical importance of the early years on learning, behaviour and health at later stages of the life cycle (McCain and Mustard 1999). The new research shows that warm, nurturing interactions and quality sensory stimulation are essential for optimal development (McCain and Mustard 1999:21). Negative experiences can cause long-lasting effects such as antisocial behaviour and violence, which can be hard to overcome later (McCain and Mustard 1999: 29-33). As women are usually the main carers for young children, supporting and promoting maternal health and wellbeing will ensure the best possible health and wellbeing of children. Maternal and Child Health Nurses in Victoria are highly qualified; but it is this solid grounding in general nursing, midwifery and maternal and child health nursing that equip us to provide a world class service to Victorian families.

Appendix 2

Commentary: Draft National Framework for Universal Child and Family Health Service.

by Angela Wallis and Leanne Sheeran (2010)

The proposed National Framework for Universal Child and Family Health Services has developed from concerns to address the inconsistent child and family health service available to Australian children. The draft national framework document was disseminated to Victorian MCH Nurses via DEECD and local municipalities. Victorian Maternal and Child Health (MCH) Nurses had the opportunity to participate in three consultations held in Melbourne early February 2010. The endeavour to provide consistent high quality child and family health services to all children in Australia is to be commended. However, there are some concerns about the draft framework. This article will explore four of these concerns: inadequate emphasis on maternal health issues, inadequate emphasis on some child health issues, concern about lack of continuity of care in the proposed framework, and concern about fragmentation of service delivery.

Inadequate emphasis on Maternal Health and Wellbeing

The draft framework appears to have an inadequate emphasis on maternal health issues. In the early childhood period families are the major source of support and interaction for young children. Better outcomes for children are linked to parent capacity. Child health services are focussed on the child but simultaneously involve the whole family as clients, as it is in this context in which child health and development is nurtured. Supporting the family and in particular the primary carer, who is generally the mother, promotes health for the child. It is far more effective to support the mother in caring for the child in a primary prevention capacity than to refer and treat behavioural, mental health or developmental concerns after a difficulty has developed.

Infant brain research reveals the importance of positive early interaction and care with a primary caregiver. Optimal infant health and development is intricately linked with maternal wellbeing. Supporting the new mother requires skilled assessment and intervention. Promoting and supporting maternal health and wellbeing protects and promotes infant health and development.

Inadequate emphasis on some child health issues.

The second area of the draft framework that appears to have inadequate emphasis is that of child health issues. Breastfeeding is identified as providing optimal nutrition, immunity and some protection for children from health problems including obesity, gastroenteritis, respiratory tract infections, diabetes and allergies. Women wishing to breastfeed or to overcome breastfeeding problems often need support; particularly as there are shorter hospital stays after childbirth, isolation in the suburbs and more older women and grandmothers in the work place.

There also needs to be a greater focus on supporting parents in the transition to parenthood to optimally facilitate parent-infant attachment for all infants. Ongoing education and support to facilitate attachment between parents and toddlers and preschoolers is also an area that needs development. It is significantly easier to actively promote attachment with anticipatory guidance than to try and redress problems after they occur.

Health promotion and health education concerning infant and child nutrition promotes optimal wellbeing for the developing child. This is continued into a healthy lifestyle where healthy

family nutrition is promoted, and in turn, promotes long term health which reduces the risk of dietary diseases and many other illnesses. This area needs more emphasis.

Consistently in our practice as MCH nurses we have observed the number of parents seeking support to respond to infant and child behaviour issues, such as: persistent crying, tantrums, sleeping difficulties, eating problems and aggressive or non-compliant behaviour. Support, education, normalisation of behaviour and clarification of age appropriate expectations enable families to respond positively and repair and promote relationships, rather than diverting to an adversarial interaction that can impair understanding and contribute to fractious relationships.

Concern about lack of continuity of care in the proposed framework.

It is important to advocate for continuity of care for families wherever possible, as a child and family health service is a relationship based service. Continuity promotes knowledge of child and family history and previous issues. It can also promote family confidence, enhance reassurance, reduce conflicting advice and promote comfort.

While a schedule of visits has not yet been proposed, a reduction in the schedule of visits would have a negative impact on the development of a relationship between the family and the nurse. Currently other Australian states provide a schedule of 6-9 visits to children and families over five years (Allen Consulting Group:14). Continuity of carer is a key component in establishing nurse-client rapport. Provision of ongoing care by a known midwife or obstetrician or other medical specialists is seen as positive and the gold standard in continuity of care. Similarly, as consumers most of us choose to attend the same dentist, GP or hairdresser. However, the draft framework document notes concern "to avoid the co-dependant relationship between the nurse and the parent" (Allen Consulting Group: 40). This has no more relevance in the case of maternal, child & family health nurses than in any other professional relationship.

Child and family health services as proposed in the framework appear to becoming increasingly fragmented. While a few components of the child and family health program could potentially be delivered by staff with lesser qualifications than registered nurses and midwives with postgraduate qualifications in child and family health, this does not necessarily make it best practice, particularly in terms of continuity of care. Midwifery qualifications are not required to record blood pressure readings or test the urine of women attending antenatal clinics or labour ward, but these tasks are usually undertaken by the midwife as part of holistic midwifery or continuity of care. Similarly, the provision of routine universal child health assessments does not require six years of medical studies plus specialisation as a GP; however in many areas this would reduce the availability of community medical services for infants and children who are unwell. Having said this, we support the elements of effective continuity of care or integration.

Concern about the fragmentation of service delivery

Currently maternal, child & family health nurses deliver the vast majority of universal maternal, child & family health services and collaborate with multidisciplinary services. The proposed framework seems to propose a situation of multidisciplinary staff delivering child & family health services, discounting the benefit of specialist nursing skills.

The report indicates that a range of workers currently deliver child & family health services in Australia, however details about the extent of this appear to be missing in the report. It would be useful to clarify and confirm how many EFT workers with different backgrounds provide

maternal, child & family health services in Australia. The pool of professionals providing child and family health services in the report is identified as: maternal, child & family health nurses, general practitioners, Aboriginal health workers, mothercraft nurses / child care workers, social workers and health educators. This data is required to provide the context for this issue. Having a mixed team of professionals providing different aspects of the child & family health program will impact on the continuity of care offered to families and would mean families would be seeing different staff members at a number of visits.

As MCH nurses practising in a rural area we doubt the feasibility of having a mixed team of primary health & early childhood workers delivering the universal service. Most rural centres only operate part time with a MC&FH nurse delivering all assessments. There would be inadequate staff in many rural areas to staff a service this way.

This article has detailed concerns about the draft national framework for universal child and family health services in Australia. This is a complex issue and requires careful and comprehensive consideration prior to the implementation of any changes that may dismantle what is excellent and working in maternal, child and family health services. We remember the changes wrought in Victoria with the introduction of the *Healthy Futures* program.

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