

We the undersigned are all Maternal and Child Health Nurses (MCHNs) working in central Victoria. All of us have as a minimum set of qualifications a hospital certificate in general nursing, a further hospital certificate in midwifery and a certificate in maternal and child health. Most of us have a bachelor's degree in nursing, a post graduate diploma in midwifery, and a post graduate qualification in maternal and child health. Our youngest staff member is not yet 30 and has been working in MCH for just under two years, while our oldest is 62. With 16 nurses we have a combined total of about 300 years of experience in the field. We have seen many changes in our position description, our conditions of work and remuneration, and in the demographics and needs of the communities we serve. Many of us are local, born and bred, but at least half of us have come from 'outside' and have worked in other cities, towns, states and countries. We have all worked as midwives at some stage of our careers, and many of us still do, or work as general nurses as well. Two of us work full-time, the rest work between 1 and 4 days per week. Most who work part time also have another position as either MCH in a neighboring community or as a nurse or midwife. Some would like more hours as MCH, most are quite happy with the fit between work places and home responsibilities.

We are a universal service with a brief to provide access to families with children from birth to school age; promote optimal health and development outcomes through a focus on the child, mother and family; build partnerships with communities and collaborate with other services and organizations; provide a responsive and accountable service for the mother, child and family; and deliver a safe and quality service. (DEECD 2009 Maternal and Child Health Service Program Standards) Our primary tasks include education, support and counseling through the initiation and maintenance of breastfeeding which is incontrovertibly proved to be an important primary health objective. We provide information, counseling and education promoting immunization. We assist families to provide a safe sleep environment to prevent sleep injuries and Sudden Infant Death Syndrome. As part of our role in promoting safety and preventing accidents we advise on car restraints, give advice on first aid and accident prevention, home safety, road safety and water safety as well as safety with pets. Our role in promoting optimal development in the early years has a strong focus on language and communication development. We assist parents with strategies to develop play, imagination, literacy and numeracy prior to kindergarten. (DEECD 2011 Maternal and Child Health Practice Guidelines)

A new mother is often isolated and alone and thinking she is the only one who feels this way. We help develop communities by running first parent groups as well as promoting playgroups and putting new parents in touch with others as well as with community peer support groups. This is especially important for parents of children with special needs.

We assist parents to normalize troubling but common issues of childhood such as teething, what to give for first foods, how to toilet train their child, how to stop him or her biting, and throwing tantrums, etc. We are the first stop for parents needing any advice, strategies, or referrals for their parenting issues. As such we have to be responsive to their cultural norms and beliefs about childrearing so as to provide them with the options they need. We are aware we cannot be a one solution-fits-all service. Therefore we have to be culturally safe, reflective and experienced in dealing with diversity.

Where things do not go well, we are often the first person the parent has contact with. We are skilled at detecting physical and developmental problems and delay, and understand and use our referral pathways as we have them. These are not always available or easily responsive, especially in the country areas, and we find ourselves supporting parents emotionally and with strategies to help their children for long periods until referral services accept them.

We have a role in screening for maternal physical and mental health problems, and in primary counseling and referral for these problems. In addition, we are also screening every woman for intimate partner and family violence, providing safety strategies and referrals where needed.

Our role includes a large component of counseling and education around healthy eating and exercise for the whole family, as well as advice on appropriate amounts of screen time. This leads to assessment of healthy weight in children and the rest of the family. We are also heavily promoting the Quit message for healthy families into the future, as well as dental hygiene, doing dental assessments on all children. Unfortunately there is a critical lack of public dental services to which families can be referred and we have an appalling dental health differential between the poorer and richer families in Victoria.

We provide advice on sun exposure, Vitamin D deficiency, prevention of infectious seasonal diseases, vaccinations and other safe travel, access to kindergarten and school, where to access a GP or specialist doctor, recipes for good eating, safe toys, appropriate footwear and clothing, and any number of other incidental concerns parents have. Our networks have to be local, up to date and comprehensive and we have to develop our referral processes according to local availability.

Our academic preparation in Midwifery and in Maternal and Child Health has been critical in developing our skills in counseling, health promotion and education, infant and child assessment both physical and developmental, family assessment, mental health assessment, maternal health assessment and supporting lactation and the development of parenting skills and attributes in the family. Without these qualifications we would be unprepared to deal with autonomous and often isolated practice, or with issues of child neglect and abuse.

Your report contends there is no evidence that our service is any more or less effective than other services around the country, but our new Key Age and Stage Framework which includes all the aspects outlined above, and more, was not in full implementation at the time of the research on which this report is based.

We have read the Report and would like to respond specifically to Draft Recommendations put forward in Chapter 12.

Draft Recommendation 12.1

To ensure the cost-effectiveness of child health services and to better inform consideration of future child health workforce needs, state and territory governments should seek to improve the evidence base for child health services, in particular to determine the optimal number and timing of child health checks

We agree there needs to be more consideration about the timing of child health checks. For example, between the ages of 2 years and 3.5 years, a time when language is developing, we believe there should be at least one Key Age and Stage check to ensure that services are provided to those children with a language delay. Our local Speech Pathology service admits that most referrals for speech assessments come from MCHNs and that most of the concerns the nurses have are well-founded. If speech problems are caught sooner they are easier to treat. It is better to have these treated before starting school, rather than waiting until the child is likely to fall further behind and be marginalized by peers, etc. We therefore submit that we are effective in detecting and referring problems such as delayed speech, that this is a vital role in protecting the wellbeing

and development of the child, and that we would be more effective with a screening visit at around 2years 9 months or 3 years.

Draft Recommendation 12.2

Scholarships for postgraduate study in child health nursing may encourage a small number of additional nurses to obtain qualifications in child health or to practice in areas of high demand. The cost effectiveness of scholarships as a method of achieving this goal should be assessed by governments before any expansion of scholarship programs

While it may be true that many potential child health nurses would indeed do the study without scholarships, why should they? Nursing is not a highly paid profession, particularly where there are no penalty rates. There are scholarship programs across many other areas of endeavor, in teaching, in medicine, in allied health, in engineering and general management, even in policy development in government departments. The average scholarship offered is a mere fraction of the cost of this training to the individual, and pales into insignificance in terms of opportunity cost of the nurse forgoing wages to study, forgoing what could be purchased with that money to do the study. If there is a small benefit in attracting a MCHN through a scholarship, perhaps that's because the scholarship is small! We strongly suggest that scholarship programs are expanded amongst all specialist nursing groups. It is of concern that scholarships to qualify nurses to work with women and small children, amongst the most voiceless and vulnerable members of our community, might be considered not to be of value.

Draft Recommendation 12.3

In order to reduce obstacles to attracting new child health nurses, state and territory governments should not require child health nurses to have qualifications in midwifery in addition to their qualifications in nursing and child health

It is important to emphasize that the knowledge base obtained particularly in midwifery is vital to the work we do. Without a thorough understanding of midwifery and obstetric practice MCHNs would not have the grounding needed to deal with a lot of the complex issues that arise for both mother and baby. Those of us who work as midwives as well as MCH nurses find the ability to work in both capacities enriches our job satisfaction, but it also provides a very comprehensive skill set to our clients. Those who have worked as midwives contend it allows very good local knowledge about how birth and parenting is conducted in our area. We are able to really understand women's stories and where they have come from through their pregnancy and birth. This allows efficiencies in taking histories, getting facts, counseling around birth disappointments, referrals back to the birthing facility and/or practitioner, and generally creating a rapport for the relationship that will last the next four years. In some cases, we have even delivered that baby in question. We believe there are many MCH nurses working as we do, working full time across two disciplines, and that the Report has not captured this or explored the significance of it.

Women come to see us when they are pregnant with subsequent children. They often have questions that only someone with midwifery knowledge can answer. Similarly, only someone with a well-grounded understanding of how pregnancy and birth can affect early parenting and beyond can provide the comprehensive service set out in our Program Standards and Practice Guidelines. The knowledge and skills we gained as a midwife have assisted a more mature and habitual, though very reflective, ability to work *with* a client rather than *for* a client. It has promoted an ability to meet women and families where *they* are, rather than where *we* are as professionals. This is crucial for building rapport and trust. Our midwifery education and skills

enable us to ask the right questions about how pregnancy and birth is still affecting the woman and her family. It also helps us to create bridges with the local hospitals, helping to make sure families don't 'fall through the cracks'.

Midwifery and general nursing as well as studies in sexual and reproductive health counseling, and lactation studies, has deepened our general counseling skills repertoire. We would in no way have had the depth of knowledge or confidence, or professional stature to be able to provide the service we do now as a raw graduate or very young nurse. We think it's a good thing that on the whole maternal and child health nurses are older and more experienced, and have more education. We work in isolated practice, sometimes with very vulnerable clients, sometimes with aggressive and defensive ones, and on occasion with violent ones. Some of us have been to court on more than one occasion to testify against parents' ability to safely care for their children. Without years of study, variety of practice, and depth of experience and knowledge we would not have been able to present as a credible witness for the welfare of those children. This is with us each time we make a notification to Child Protection about parenting capacity. Working with families involved in Child Protection is a daily feature of our work. With young, inexperienced and barely trained Child Protection Workers, who have an average tenure in the Department in Victoria of just six months, it is even more crucial that our experience and qualifications are used in effective ways. In fact the Department is trying to find ways to use us more because of our experience and our acceptability to the clientele.

If indeed we are arguing for fewer obstacles to becoming a MCHN we submit the Commission should consider a pathway for direct entry midwives into MCHN. Their courses are all about women, families and babies. They have excellent preparation for primary counseling in the areas of core business in child health services such as breastfeeding, babycraft and early parenting, relationship and role changes, women's health, etc. They have been prepared for work in the community and in midwifery models of care which are great grounding for autonomous practice. They would be much better suited with their in-depth midwifery to MCHN than a general nurse graduate. Instead of removing midwifery from the skill set of MCHNs we should include direct entry midwives!

Draft Recommendation 12.4

In areas where children are unlikely to have access to a child health nurse, other health professionals such as remote area nurses and Aboriginal health workers should receive training in child health

We tend to agree with the Commission that any professional working in contact with young families should have as a minimum some training in child health. We would also strongly recommend that to just offer *something* is not good enough. Why should children in remote areas be any less deserving of a fully qualified practitioner than the middle class children of Brighton or Double Bay? The State and Territory Governments should develop a long term strategy to support the training and education of appropriately qualified MCHNs to work with remote area nurses and Aboriginal Health Workers, or for RANs and AHWs to become fully qualified MCHNs.

Furthermore, we resist ANY attempt by any State or Territory Governments to downgrade qualifications for MCHNs to the lowest common denominator. This has not been shown to provide quality, and there is no evidence to suggest that a well-trained and experienced worker is any less effective than one less so. Just enough is not good enough for women and children. We would rather that child health workers everywhere in Australia are as well qualified as Victorian

MCHNs. Early years' research from around the globe emphasizes the importance of the first three years for setting up health, wellbeing and a productive adult. We contend that increasing the quality of early years workers will assist in creating savings for future generations. We believe this report foreshadows at best, and facilitates at worst, an attempt to remove or curtail our conditions of work and remuneration and we will resist this wholeheartedly.

It behooves our national registering body to protect the public. To do so they must collect adequate data on the workforce. If they had taken all the data fields that Victorian nurses and midwives had to complete prior to the commission of AHPRA, they would have that information lacking throughout Chapter 12 of this report. They would know where MCHNs work, how many hours in child health work, what their qualifications are.

Finally, we are also considerably concerned that a full and fruitful consultation process with Maternal and Child Health Nurses in Victoria did NOT take place. Before ANY changes take place in Victoria I trust the Commissioner will rectify this oversight by meeting with us and as many of our colleagues as would like to put their view.

Signed

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