Kathryn Geyle

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Commissioners
Early Childhood Development Workforce Study
Productivity Commission
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Dear Sir / Madam,

My name is Kathryn Geyle and I am a Maternal & Child Health Nurse. I have been practicing in this area in a variety of settings since completing a Graduate Diploma in Community Health and Maternal & Child Health in 1984 in Victoria. My interest in working to support women and children has been complemented and further encouraged over the years initially through being awarded the Myrtle Ivy Quick Scholarship for studies in Nursing in 1984 (this was before council oversaw MCH service provision and offered scholarships). I have recently been awarded the Vera Scantlebury Brown Memorial Trust 2010 Scholarship (founder of Infant Welfare in Victoria in 1939) to go toward my undertaking a graduate Diploma in Infant & Parent Mental Health.

It was my work as a midwife that initially influenced me to undertake Maternal & Child Health studies, and this field has continued to capture my professional interest and supported a continuing and rewarding career of over 25 years. I have utilized my Maternal & Child Health Nursing background broadly whilst residing overseas for nearly a decade in a developing country, working as a health consultant in providing seminars and workshops, and also supporting an expatriot community of women who had no access to the services such as those provided in Victoria. I have worked in MCH Nursing in both Victoria and interstate, in Hospital Maternal Child Health Division discharge planning with a high turnover of Aboriginal children, coordinated Education and Training programs to support Maternal & Child Health Nurses working in Urban Community, Rural and Remote areas in the NT, participated in review of Maternal & Child Health services and competencies, and implemented a number of pilot programs for recipients of MCH service programs. I am currently enjoying employment back in my home state of Victoria with the ongoing education available to support my work. This has included providing Universal, Enhanced and 24hour Maternal & Child Health telephone advisory service to families from many different backgrounds, including refugees. I have also chosen to return to work casually in an acute midwifery service to remain abreast of the continuity of care issues that Maternal & Child Health Services encounter on a day to day basis.

Prior to the implementation of the Australian Health Practitioner Regulation Agency (AHPRA) in 2010, myself and my Victorian colleagues held registration with the Nurses Board as a Nurse, Midwife and Maternal & Child Health Nurse. I am now dismayed to learn that my qualifications and 26 years of experience and those of my colleagues no longer warrant recognition by AHPRA. I therefore hold current registration as a Nurse and Midwife with the Australian Health Practitioner Regulation Agency.

As a Victorian Maternal and Child Health Nurse I am extremely concerned by the recommendations 12.3 of the draft report to be considering that midwifery no longer be a pre requisite for Maternal & Child practice and entry into study in Victoria or elsewhere. It was my experience when in the Northern Territory that Midwives were encouraged to engage in supported work placements to help complement the skills shortage of experienced Maternal and Child Health Nurses.

My submission is limited to Chapter 12 of the Early Childhood Development Draft Report, and the "Child Health Workforce", with particular concern with the recommendations 12.1. 12.2 & 12.3,

The Maternal and Child Health practitioner who has Nursing and Midwifery experience has a level of intrinsic, holistic, culturally sensitive knowledge and skills in observation, assessment, and the opportunity to provide opportunistic & harm minimization education. The in-depth understanding of family dynamics and being placed in a position to offer counseling or referral for same is so important at this time of great change for couples and their developing infants. There are too many essential competencies to mention here, but the Maternal & Child Health nurse has an interdisciplinary role and the ability to determine what is problematic in the context of the environment. This permits identifying functional rather than individual diagnosis, and early detection of the potential for emotional as well as physical disorders in the infant / child . To achieve the necessary outcomes the Maternal & Child Health service cannot function in a meaningful or effective manner by simply following a set checklist of health and development milestones and making referrals to external service providers.

1930s Paediatrician Donald Winnicott first described the role of the environment in early relationship problems through his observations of infants brought up in institutions. His vast contributions to the understanding of the ' *profound signifigance of infancy in the total life of human beings'* memorably stated 'there IS no such thing as a baby'. (Phillips 1998). Also noteworthy is the special aspect of diagnosis and treatment in relation to the fine balance of offering infants the best chance in life.' Because of the interconnectedness of development, diagnosis is inseparable from treatment. How things are defined or labeled is a powerful tool for change. Although one always begins with the problem the family brings to the consulting room, what part of the system one addresses at any given time will determine what happens'. (Emde 1985: 325)

Maternal & Child Health Nurses engage with the Mother and her infant, and this infant's development is dependent upon the good enough provision of his/ her environment. He/ she becomes a young baby, toddler and preschooler, and his mother, father, older siblings, teenagers, grandparents, and extended family and community all play a part in influencing his health and development.

The nomenclature Maternal & Child Health or Child Health have been well debated and determined as not going far enough to embrace and proclaim the existence of the influential ' family environment' by its practitioners. It is well evidenced that a healthy fetus, newborn, infant baby, toddler, and preschooler is exposed to many influences on his developmental journey. The healthy physical, well-adjusted emotional and psychic growth commences and continues to be dependent on the provision of nurture and stimulation from constant and signifigant caregiving. Today this increasingly encompasses both parents, same sex couples, step parents, single parents, foster or adoptive parents, siblings, extended families and friendships.

I also wish to highlight the ways in which midwifery comes into play from the Maternal & Child Health Nurses service from the time the mother and infant are discharged from hospital through the progressive years whilst spacing and experiencing subsequent pregnancies.

Early discharge home with a new born infant often results in having to manage unseen complications in the community setting. The increased rates of premature births, invitro fertilisation resulting in multiple births are well documented today, as are the physical and psychological complications for women who have undergone active management regimes such as induction and unexpected medicalization of birth. Beyond Blue statistics reveal that 1:7 women are at risk of peri-natal depression. (Beyond Blue 2010).

A midwife's knowledge and understanding of the consequences of psycho-social or physical exposure to mechanical birth trauma is required in detecting and managing mothers' approach to feeding. In the concentrated 2-4hrly regime for a newborn this can amount to a degree of torture for a mother's confidence and health if difficulties go unattended.

An Infants mis-diagnosis can be deleterious but preventable when a MCH Nurse is cognisant of common obstetric practice and midwifery processes. Birth trauma associated with consequential physical pain or discomfort delays postnatal recovery, contributes to experiences of sleep deprivation, and often psychological sequelae for the mother. Pain incurred from surgical intervention can also impact on the mother's confidence and ability to nurture and breast feed her newborn. (Thompson et al 2010)

In my role and capacity as a qualified Maternal & Child Health Nurse I have drawn on my midwifery skills to identify a wide variety of abnormal conditions that infants and their mothers have presented with in the clinical and home setting. I have been in a position to seek urgent follow- up for suspected medical emergencies that may otherwise have been left unattended by the mother.

Infant complications identified in my practice as a MCH Nurse have included sleep apnoea and neonatal jaundice in infants seen by their parents as 'a really good baby who is a dream sleeper' requiring hospitalization for poor weight gain and failure to thrive. Cases of undescended and strangulating testes, strangulated umbilical and inguinal hernias, and pyloric stenosis have required surgical intervention. Parents have overlooked the dangers of mismanaging metabolic abnormalities, acute urinary tract infections, overlooked malfunctioning kidneys manifested as a gradual change in infants behavior and persistent low grade fever, bronchialectasis, suspected Reyes disease following administration of aspirin, motor delay diagnosed as cerebral palsy, foot talepes and hip dysplasia.

More disturbingly have been those cases that may have been missed were it not for the gradual development of a trusting relationship through ongoing health and developmental assessments. The most memorable and concerning of these is the identification of child sexual abuse, feeding a young infant cow's milk 'cos it's more affordable than formula' (risking subsequent mental retardation) and over medicating a crying baby with analgesics risking long term liver damage.

My background in Nursing has further enabled the timely management of conditions such as severe ecsema, toddler's bothersome or irritating cough subsequently identified as asthma, contact dermatitis, food related skin allergies, streptococcal throat and staphylococcal skin infections, undiagnosed scabies, thrush, presentation of bothersome skin rashes identified as communicable diseases such as Fifths Disease, Foot and Mouth Disease, Chicken Pox and frequently conjunctivitis.

Maternal complications averted are those dismissed by women silently suffering considerable discomfort, who when questioned, revealed symptoms such as serious perineal haematomas, secondary haemmorhage due to break down of internal sutures, anal fistula following forceps delivery, thrombosis and pelvic instability. Others, complaining of just general tiredness and not lactating well, had severe iron deficiency and thyroid insufficiency. I have encountered newly arrived refugee women who fail to appreciate the importance of taking medication for their Vitamin D deficiency (particularly prior to their next pregnancy) pregnancy induced cardiac sequalae not detected in their own country and missed on opportunistic clinical review, excessive thirst relating to imbalance of blood sugar levels due to unresolved gestational Diabetes. The more concerning issues have related to time poor mothers failure to seek contraceptive advice, denial of possibility of unplanned pregnancy, missed abortion and cases of post-traumatic stress triggered by the birth of their infant related to a history of sexual abuse.

In a recently published paper by Thompson et al on the account of signifigant events influencing Australian breasfeeding practice, it has been found that breast feeding difficulties can cause silent agonies for mothers which midwives are expert in identifying. These may include flat, inverted or cracked nipples, thrush, and blocked milk ducts. If these are poorly managed or left undetected, initially benign conditions can result in mastitis requiring urgent treatment. Sometimes mothers give up breast feeding as it is all too fraught with pain and an ongoing sense of failure.

'Experienced in managing a women in labour and delivery a midwife has an appreciation of the affect that mechanical extraction by forceps or vacuum extraction can have on the new born infant. 'It can impede smooth muscle function of the bilateral temporo-mandibular joint restricting lower jaw and self-regulated cervical vertebrae movements, leading to unsynchronized suck swallow reflex, headaches resulting in ineffective sucking. A Midwives skills also enable them to consider the impact on the connections between the central nervous system, temporo-mandibular joint malfunction, cranio-spinal and intra oral misalignment, neurological and physiological functions which can all present with unsettled behaviour and poor attachment and breast feeding. Midwives are also well placed to know when to attribute a newborns poor feeding to drugs or other substances he came into contact with antenatally, during labour or through breast feeding. (Thompson et al, 2010: 99)

Maternal Emotional Health: Mothers experiencing unidentified emotional disturbances require understanding and an opportunity to debrief and sometimes grieve after experiences such as a difficult or premature birth, or coming to terms with an infant presenting with suspected disabilities. A midwife has the ability to provide sensitive and timely support, and to ensure that appropriate psychological resources are available if needed.

Research on the role of infant factors in maternal depression have been identified as particularly caused by an infants unrelenting irritability and poor motor behavior. (Murray 1998) This is frequently experienced with infants who are small- for- gestational- age or premature. This can be passed over by other professionals who see a mother fleetingly for other reasons, by unsuspecting partners, extended family or friends who are focused more on the new baby. The hard to soothe infant can progressively erode a mother's confidence and feelings of efficacy. Society's expectation that all babies cry plus the 'mask of motherhood' that new mothers present needs to be addressed to prevent more serious post natal depression. An infant's functioning in the 10 days immediately following birth is influenced by the nature of the labour and delivery and particularly the medication delivered to the mother. (Murray 1998)

Statistics reveal today's increasingly high medical and surgical induction of labour and caesarian section in Australia. [' LUSCS 21%= 1998, Induction of labour rate = 25% of women who gave birth and 63% experienced some degree of perineal trauma, ranging from 1^{st},2^{nd},3^{rd} &4^{th} degree tear to Episiotomy with extended tear'] These commonly lead to women's unidentified pain, delay in physical recovery, discomfort when trying to breast feed, impact on lactation and bonding with infant and subsequent impact on a couples sexual relationship. (Thompson et al 2010: 99)

An Infant Mental Health Initiative has developed a program which aims to help "parents develop specific relationship capacities, rather than learning techniques to manage behaviours. Parents who come with a history of their own disrupted childhood attachments are best supported through assistance to develop reflective functioning and to engage with their infants and children in the regulation of their emotions". (Parent Infant Research Institute) It is this level of parent functioning that is the challenge for Maternal and Child Health Nurses to address in their daily and ongoing practice.

Draft Recommendation *12.1: While child health nurses are, on average, older than other nurses, this reflects their higher level of qualifications and experience and does not appear to be a cause for concern.*

The above statement alludes to a generalisation and assumption that the higher level of qualifications of the older nurses relates to their practicing time line.

In 1984 the criteria for entry into Community Health / elective in Maternal & Child Health Nursing was extensive experience in Nursing & Midwifery practice, life experience and demonstrated maturity. If asked I am confident that the aging workforce referred to here would attest to be being a strong body of highly competent, committed and professional Maternal and Child Health Nurses who have followed their passion to work with women and children in preventive health. The history

of this service in Victoria well demonstrates how valuable this specialist field has been in providing families with the support and guidance they so readily embrace.

Draft Recommendation *12.2: Scholarships for postgraduate study in child health nursing may encourage a small number of additional nurses to obtain qualifications recommendation 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.*

I believe that access to the scholarships does instill a vote of confidence for Nurses to extend their existing professional qualifications to enable them to participate in a very rewarding, dynamic and essential area of health. As the cost of education for Nurses with family responsibilities today can make it difficult to commit to taking time without pay to embark on further studies, I see great value in offering more substantial scholarships in the future.

Draft Recommendation *12.1 : "To ensure the optimal effectiveness of child health services and 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.*

Today's families often present with complex emotional and psychosocial needs, and available services for the highly vulnerable need to be respectful and cognizant of their sensitivity to perceived criticism. The erosion of the entire concept of the Victorian Maternal & Child Health Nursing Service would fragment support available to families who access this service voluntarily. It is my experience working across numerous MCH services that families who are sometimes difficult to engage also come with a history of inter generational poverty. Coupled with prior engagement with Departmental protective services, these families rely on developing a single trusting relationship. They can be highly suspicious of what they might consider to be premature attempts to link then with other services. (Payne 2001)

Thankyou for the opportunity for Maternal and Child Health Nurses to submit our experiences and view for consideration.

Yours sincerely

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