Infant and Child Mental Health
Professional Development Webinar Series

WEBINAR TRANSCRIPT

What are infants telling us: From neonatal nursery care to supporting optimal infant development

Disclaimer: The following transcript has been autogenerated and may contain occasional errors or inaccuracies resulting from the automated transcription process.

Vicki Mansfield (00:00:02):

Welcome everybody to what are Infants telling us from neonatal nursery care to supporting Optimal Infant Development. Welcome this evening, and I'd like to acknowledge the traditional custodians. I'll just get the next slide. Thanks. I'd like to acknowledge the traditional custodians of the land, seas, and waterways across Australia, upon which our webinar presenters and participants are located this evening. And we wish to pay our respects to elders past, present, and acknowledge the memories, traditions, cultures, and hopes of Aboriginal and Torres Strait Islander people. I'd like to recognise the important of connection to country and culture for infants, children and families across Australia, and I'd like to acknowledge that I'm meeting with you this evening on Awabakal country. So welcome everyone who's joined us tonight for the webinar and also for the viewers who are watching us on the recording. We have a fantastic event this evening. I'm Vicki Mansfield from Emerging Minds. I'll be facilitating tonight's session. This is our sixth webinar in the seventh series on Infant and Child Mental Health, presented by Emerging Minds in the Mental Health Professionals Network.

(00:01:24):

And so I'll just go through some housekeeping and introductions, some housekeeping before we do our introductions. So if you'd like to access our supporting resources, there's some prior reading in there. Our bios for our panellists view the supporting resources, click on the button under the video panel to access those resources. There is a live chat and you can participate in the live chat by opening the chat box, which is the icon located in the top right hand side corner of your screen. If you have any technical support, technical issues throughout the webinar, click on the bottom in the top right hand corner of your screen for tech support and you can toggle on and off. And the stream chat top right speech bubble is there as well. So hopefully that's all smooth. But that's there if we need. And as we go through the webinar, we're really always happy to have engagement and conversation in the chat and certainly to receive your questions, but we'd ask everybody to be respectful of other participants and the panellists and keep comments on topic in the chat box as well.

(00:02:46):

So I'll just go next slide. So our learning outcomes for this evening, I won't go through them completely, but we've got a great, really diverse range of that are all focusing on an incredibly important area of work, which is the pre term or medically unwell infants. And we'll be looking at the resilience associated with preterm birth. We'll also be looking at the outcomes and emotional impacts for families, examining why it's important to observe and understand infant's cues and behaviours and identifying the strengths and the strategies that support parent-child relationship and the infant's neurodevelopmental and mental health needs. And we'll outline some practical strategies to nurture preterm infants communication, emotional, social, and relational skills during the first year. So we have a great panellists who I'll introduce to you now. The bios for our panellists

are in the additional resources, so you can pop in and have a look at those. But I'll introduce first Dr. Nat Duffy, who's a neonatologist. Welcome Nat. I'll get you to unmute. Nat.

Dr Natalie Duffy (00:04:07):

Hi team, everyone. Thank you for having me.

Vicki Mansfield (00:04:10):

Thanks for being with us, Nat. And just to get us started, what's one thing or a fun fact our audience might not know about your role as a Neonatologist?

Dr Natalie Duffy (00:04:22):

Yeah, sure thing. So as I said, thanks very much for having me. It is a pleasure. Not many people will know this, but my mom who lives in Scotland, she is an amazing knitter and one of the things that she does is knit tiny baby hats. And whenever I'm going to the birth of a baby who I know is going to need a little bit of extra help, I always take one of those little hats with me. It's like bringing a little bit of Scottish bravery, something that's warm and full of love to give the baby strength for the journey and the road ahead of them. And she gives me bravery. So there you go. No, everyone knows that.

Vicki Mansfield (00:05:00):

Thank you, Natalie. That's so special. And so yeah, it's a very caring of your mum and of you, and I'm sure the families and the little ones appreciated immensely. We look forward to hearing from you shortly. Now welcome Erin Church who's a neonatal intensive care nurse in Victoria. Welcome, Erin.

Erin Church (00:05:22):

Thank you so much for having me.

Vicki Mansfield (00:05:24):

And Erin, to get us started and learn a little bit more about you, what's your favourite part of working with infants and families?

Erin Church (00:05:35):

There's so much that I enjoy, but I think for me the best parts are a lot of getting the firsts for them. So when they've been in hospital for such a long time, a lot of the babies don't have a bath for many, many, many months until they're much bigger. So a first bath is always a wonderful thing to facilitate first cuddles, first time siblings meet their little brother or sister. They're the moments that make a sometimes very difficult job. Really lovely.

Vicki Mansfield (00:06:07):

Oh, lovely. And that's very, very special and I can't imagine how many firsts you've been a part of. And finally, welcome to Susan Nicholson, Associate Professor and GP. Welcome Susan.

Assoc Prof Susan Nicholson (00:06:26):

Hi, nice to be here.

Vicki Mansfield (00:06:28):

Thank you so much Susan for being with us. And I'm wondering, what's one thing infants have taught you in your work with infants?

Assoc Prof Susan Nicholson (00:06:38):

Yeah, I mean the first thought that came to mind there is that they're amazing. And then I thought you need to do better than that. And I thought it's really, really that if I can manage to just quieten down and be with them really openly and fully, they will guide me to the connection they need. I just need to follow. That's really what they've shown me. Yeah, yeah.

Vicki Mansfield (00:07:09):

Thank you Susan. And I feel like we've really jumped into having such a warm conversation about infants already, and so I'm excited to hear also now our presentations from each of you. First of all, I invite, we'll go to next slide and I'll invite Nat back to share with us her presentation.

Dr Natalie Duffy (00:07:40):

Thank you very much, Vicki. So each year in Australia, over four to 8,000 babies are born either prematurely or critically ill requiring admission to the NICU after they're born. So to put that into context, during the time that we are together for this webinar tonight, approximately nine newborns will begin life separated from their parents requiring specialised medical care. And the long-term implications of this early separation are profound with lasting effects not only on the infant, but on the wellbeing of their entire family. Next slide please. So neonatal care is essential, it's lifesaving. However, alongside the medical support that we provide, it's important to acknowledge the growing body of evidence that highlights how early life experiences in the NICU can influence long-term development. So hospitalised infants are exposed to a range of environmental stressors, and you can see some of those things on the screen. So this includes separation from their parents, repeated exposure to painful and stressful procedures or interventions, and then inconsistent and unpredictable caregiving from a rotating healthcare team.

(00:09:03):

And all of this occurs within a really highly stimulating environment, which is marked by noise, bright lights, complex technology, and constant activity. And you can see there on the screen that it's a far cry really from a nursery that you would find in the typical home. And all of these factors contribute not only to the physical health risks, but also to potential challenges in social, emotional, behavioural, and cognitive development for the infants that we care for. So therefore, as healthcare professionals understanding and addressing these stressors is key to improving both the immediate moment to moment experience for the babies, but also long-term health outcomes for infants in our care. Next slide please.

(00:09:56):

So infants are powerful communicators long before they can speak. They share their experiences with us through their behaviours, their cues, and their changing states of alertness. And some of these signals just as you can see on the pictures, are easy to spot, a loud cry or a sudden startle. But others can be more subtle, a slight furrow in the brow, a softening in their cheeks, or perhaps a change in their skin tone in any clinical setting. When working with infants, it's important to remember that they, they're an individual each with their own strengths, vulnerabilities, and ways of engaging with the world. Infants are not passive. They're born ready to communicate and ready to connect. They're actually biologically wired to seek out interaction, to explore and to make meaning of their surroundings. And when we take the time to observe closely and respond thoughtfully, we're not just supporting their comfort in that moment, we're actively shaping their developmental future. Next slide, please.

(00:11:06):

And this understanding forms the foundation of my PhD research, the experience study which explores the infant's lived experience of hospitalisation in nicu. At the heart of this research is phenomenology qualitative approach that seeks to understand the experience as its lived. When we speak of lived experience, we're referring to how individuals perceive, make sense of and respond to the world around them. So in this case, how infants experience and are affected by the NICU environment, phenomenology aims to describe the essence of their experience, both what is experienced and how so that we can begin to see the world through the infant's lens. We've described our methodology and the literature and you have the link to the paper and the resources. But in brief, holding the infant's experience at the centre of our investigation, we've utilised multiple lenses to understand their experience. We begin with the infant and what they can communicate through direct observation at the bedside.

(00:12:12):

Each infant also had a bedside diary to catalogue their everyday encounters and interactions. And finally interacting with the infant. Using the MBO, the newborn behavioural observation system, which is a relationship building tool, infants were able to showcase their individuality to deepen our understanding of the infant's lived experience. We then triangulated that data by conducting semi-structured interviews with both parents and members of the healthcare team. We invited them to reflect gently, but directly from what they believed the experience had been like for their child or patient. These conversations offered valuable insights into how those closest to the infant perceived and interpreted their hospital journey. Next slide please. The study was conducted on a coter NICU in Melbourne. We recruited seven infants and 37 of their adult caregivers conducting 73 bedside observation sessions, collecting 17 diaries and carrying out 11 MBOs. We then held 40 semi-structured interviews, and then all of this data was analysed using the principles of Broun and Clark's thematic analysis. Next slide please.

(00:13:37):

In our first paper, we have identified four themes that capture the infant's lived experience and theme one encompasses the inherent tension of their NICU experience. NICU is both the ultimate safe space because a child's life is saved by neonatal care, but from the infant's perspective, it's also scary and unknown and foreign and hostile. And some of those words are direct quotes from the adults In the study, theme two captures all the physical things that happen to an infant on their NICU journey, their reaction to these events, as well as the reaction and responses of their adult

caregivers. In theme three, we described the range of emotions experienced by the infants, how they express these emotions through their body, language and behaviours, and the interpretation of this emotional rollercoaster made by their adult caregivers. Theme four represents moments of meeting between infants and their caregivers. These moments of connection reflect the intimate human side of NICU where infants experienced nurturing love despite the complicated technological surroundings. Next slide, please. And now I would just like to share some of the data from the research. So this is from a member of the medical team. She's in a unit with a breathing tube in her mouth, down her throat. Her room is filled with alarms. If she's lucky, she gets a little bit of sunshine. She's surrounded by people always talking around her about things that probably don't make sense to her rather than having what a baby should be having time with her family, uninterrupted and growing. Next slide please.

(00:15:28):

And this is my own personal reflection, which also form part of the data collection. Watching this infant and these events unfold, I'm overcome with emotion. I need to leave. I feel worried that he's experiencing sadness, worry, uncertainty, even fear. Next slide please. And from a bedside observation session, T'S body is mostly still her breathing settled as she gazes up at her mother. She's grasping her mother's finger sucking vigorously on her dummy. She spits the dummy out and blows bubbles. Her mother affectionately wipes them away for a short time. It's like a game between them mother jokingly and playfully saying, are you blowing bubbles at me? Cheeky. Cheeky. Next slide please.

(00:16:23):

So again, in your resources, you have a link to the full article, but in essence, I hope in this short presentation I've shown you that hospitalised infants can effectively communicate their experience and that the experience study has provided us with a fine-grained comprehensive exploration of the complexity of life in NICU from the infant's perspective. And we believe that this provides us with an impetus for change, encouraging us to think actively and urgently about how neonatal care is delivered. Thank you for listening. And I would also just like to acknowledge the bravery of the babies and the families and the staff members who so graciously gave me their time during my study. Thanks very much, Vicky.

Vicki Mansfield (00:17:13):

Thanks Nat. And Nat, thanks so much for shining a window into the lives of infants and families in NICU and certainly in the resources, there's the articles in, there's also a podcast that we recently recorded with Natalie, part one and part two will be out next week and it really shares some more conversation about what Natalie just spoke and is really a great insights into the nuance and the experience of infants in nicu. Thanks so much. And now my pleasure to bring Erin back to share from her perspective and to talk with us about the newborn traffic light tool. Thanks, Erin.

Erin Church (00:17:59):

Thanks, Vicki. Good evening everyone, and thank you again for having me. Tonight I'll be presenting on the newborn traffic light tool, which takes a practical approach supporting infant mental health and neuroprotection in the neonatal unit. Next slide please. So let's start with why we should care about pain and stress in the neonatal unit. As Nat has touched on, pain and stress in the unit can

lead to detrimental effects on the developing brain, including poor neurodevelopmental outcomes, especially in the areas of language learning and motor development and poor infant mental health outcomes relating to emotional regulation and trauma responses. And why, because of what's termed experienced dependent neuroplasticity, or you may have heard the phrase, what fires together, wires together. So in essence, the more frequently that neurons fire together, the stronger their connection becomes and the more likely that they're going to fire together in the future.

(00:18:59):

And this principle is crucial for understanding how the brain learns and adapts to the world around us. Intense, prolonged, or repeated experiences are the neurological engines of development for better or worse. And for preterm infants, they impact on the pivotal period of myelination that unfolds from 28 weeks onwards. So caring about pain and stress in the neonatal unit is also important as we know what works and what we should be doing. But this evidence-based practise is not prioritised or consistent. Pain is always stressful, but stress is not necessarily painful. And the evidence tells us that certain cues and behaviours have been shown to be linked with one or the other. Something as seemingly innocuous as a nappy change can be and is stressful for babies in the neonatal unit and where babies undergo 14 to 17 painful procedures per day. On average pain scoring is not used properly, appropriately, or at all, and analgesia is not used 42 to a hundred percent of the time.

(00:20:07):

Next slide please. So how does this translate for the babies in the neonatal unit? Babies respond to pain and stress in the same way they show physiological responses such as heart rate and breathing changes or skin colour changes from birth. And babies will also exhibit behavioural responses such as crying and limb extension like the pictures you saw in that's presentation. However, these responses may be muted in a preterm population until around 32 to 34 weeks gestational age. So when babies are exposed to pain or stress, their ability to regulate themselves is hierarchical and systematic. Their autonomic system or their physiological responses needs support before they can regulate their motor system, their control of their body. Their motor system must then be well supported before they can regulate their organisation, which pertains to their smooth movement through states of alertness. And this must be supported before they can then successfully regulate their responsivity where they're able to meaningfully engage with the world around them.

(00:21:16):

Regulation across this system called the Amore system requires individualised support from caregivers. Next slide, please to guide this individualised support. Myself and my wonderful team developed the Newborn Traffic Light Tool launching it in 2023 at the World Association for Infant Mental Health Congress in Dublin Island. Important to note is that the tool is not another pain scoring tool. We have plenty of those. The tool was originally intended for parents at the bedside, but it was noted in its development phase that clinicians required education first to be able to support parents with this knowledge. The newborn Traffic light tool is an advocacy tool to highlight individual baby behaviours during moments of pain and stress to encourage clinicians to keep the individual baby in mind at all times and hopefully empower them to speak up when they see stress cues so that care can be slowed or haltered momentarily to support the baby back to a calm regulated state. Next slide please.

(00:22:23):

The newborn Traffic Light tool is an overarching package which includes a double-sided clinical advocacy poster to be displayed in the neonatal unit in areas where pain and stress occur. So treatment bays on resuscitate at the cot side, wherever we think it's required. Importantly, it also includes a short interactive online learning module, which includes photos and videos taken within the neonatal unit, which show baby and more behaviours, how to support them using the tool as a guide and where to get more training in baby communication. The cues and supports within the tool are based on established validated frameworks including Brussel's Newborn Behavioural Assessment Scale or their N Bs AL'S Sign, active Theory of Development and eugen and colleagues, newborn Behavioural Observation System or NBO, which Susan will speak to in her presentation. Next slide please.

(00:23:21):

The front of the tool provides practical advice on ways to achieve or support approach behaviours from the baby, including what to do when stress or approach cues are exhibited and ways to support the baby before, during, and after moments of pain and stress. Next slide please. The back of the poster lists baby behaviours under the Moore headings, as you can see on the slide there, and groups them under the universally identifiable traffic light colours where green means regulated and ready for interaction. Yellow are early stress signs and red means stop unstressed or dysregulated. And yes, we identify that green is at the top, but this is to signify the importance and our constant aim of regulation for the babies in our care. Next slide please. So next I'd like for you to watch a short video from the module on how the tool can be used within the neonatal unit to keep the baby in mind and decrease stress.

(00:24:32):

The infant is provided positive touch with gentle pressure on release. We see right-sided body squirm on handling. There is another body squirm. The nurse slows and waits and he relaxes to a normal flexed tone. On application of the BP cuff, he becomes tense and cries. The nurses use containment via hand hugs and supported flexion. A trial of non-nutritive suck is unsuccessful. On release of containment we see finger splay, he becomes difficult to soothe despite containment. He exhibits colour change and finger splay cries intensify end to end and midline containment are used along with calm, soothing voice and he's provided with further opportunities for non-nutritive psych. He shows extended posture when supporters withdrawn, the nurses respond to the infant's needs and wait while using soothing voice and containment, his body relaxes and his cries stop. The monitor illustrates return to autonomic regulation. Containment in supported flexion is maintained while the thermometer is placed. He shows stress cues again, prying with finger sway, but responds well to supports of ongoing containment and soothing voice and achieves regulation faster, showing soft cheeks and a normal flexed tone.

(00:26:42):

So a note, a note in that video there regarding individualised responsiveness to the baby's needs. A lot of you who might work with premature babies might know that we don't pat them a lot because they don't like that stimulus, but we knew that this baby actually responded to patting. So the nurse was able to do that to add that into her toolkit for helping with this baby's stress cue. So just to show you that despite there being a tool with listed behaviours and supports, you can individualise it for the baby. So I hope I've been able to give you a small insight into the newborn traffic light tool and its practical application within the neonatal space, the tools being used internationally with over 300

clinicians worldwide having registered to complete the online learning module. It's the topic of two current research studies and we have longer term plans to complete a parent education module with the possibility of further research studies. So if you'd like to register to complete the newborn traffic light tool, the registration link and the QR has been shared with you and your resources and I thank you very much for your time.

Vicki Mansfield (00:27:59):

Thank you so much Erin, and thank you for sharing such an in-depth but also such a felt sense of how it is for infants and how care can be responsive to them and what their cues are telling us. Yeah. Thank you so much. Thank you. And it'd be great now to hear from Susan, a general practitioner perspective. Welcome back, Susan.

Assoc Prof Susan Nicholson (00:28:32):

Thanks Vicki. Yeah, my aim in the next few minutes is really to take what both Nat and Erin have mentioned, this idea of the infant expressing their experience and seeking connection and efforts to tune into what they're telling us in the NICU and then beyond. And one tool that can be useful for this for a broad array of professionals who may not be predominantly an infant mental health clinician by any means is the newborn behavioural observations. So I'm going to talk a little bit about how that might be useful in that later part of time in the NICU in particular and then out into the community. Next slide. Thanks.

(00:29:35):

So our argument will be of course that infant mental health support should begin as early as it can and that can be before birth. And that the first days and weeks are utterly foundational for the infant's mental health and development. They're relying on protective caregiving in relationship to buffer the stressful experiences that they have. And so what we mean really is that the baby is seeking safety, which touched on in the experience study, understanding of their experience as communicated by the behaviour and then interactive support that helps to regulate their physiological and feeling states. So to do that, the parent, the clinician, whoever is there, needs to regulate their own feelings to in a way, see what the baby is saying, begin to understand that, be open to it and to be responsive. Much easier said than done. And particularly for parents of babies in the NICU where it's very brave work for them to open themselves up to what their baby is actually experiencing and to then see themselves as someone who makes a difference to their baby can be extraordinarily powerful and motivating, done with some sort of insight and expertise by the professionals around.

(00:31:14):

So that's the aim. Next slide, please.

(00:31:19):

Yeah, it's a nice simple thing to say. Being able to see, read and understand their baby's behaviour is a really core family functioning capacity that we can offer to parents and family. And quite simply, it comes through us taking the time and attention to learning in some depth about the nuances of baby behaviour, what to understand it better and to be able to let baby guide you to what connection they are seeking. Okay, next slide. Thanks. So the appeal of the newborn behavioural

observations, and I must immediately own some potentially viewed as conflict in the part of my paid role at the women's hospital, is to lead the Newborn Behavioural Observations programme. They're training professionals how to use this clinical tool in their work with families, but the appeal of it to me and to those who use it in their workplace is that it's got some structure to it.

(00:32:35):

It's very flexible in terms of the setting and your professional discipline may be that it's absolutely baby led. So 18 neurobehavioral observations that are a mix of passive and interactive and that completely depend on what baby is communicating in the moment. So what's included, the order that it happens in an MBO session is led by the baby's expressed experience and their communication. So it's administered by trained professionals, but training is brief and very feasible. It's increasingly used in neonatal units and I suppose its power is in something that Nat touched on, this idea of helping parents connect with what baby's saying and creating these little moments of meeting, which could be something along the lines of what you can see in the photograph there, the anxious parent with the bitten nails, the baby with very, very great vulnerability at the same time gaining comfort just from having a hand curled around her finger. Next slide. Thanks.

(00:33:54):

So the guiding principles of the newborn behavioural observations are that it's absolutely infant focused. It's about meeting baby directly and at the same time the clinician's stance is to be looking for clues about how this parent is emotionally managing the situation, what support they may or may not need, what the background situation is for this family. It's absolutely strengths-based, not in a jargonistic sense, but in the sense of every family has strengths from which they can build towards parent and infant becoming closer and having these moments of true connection that can take them forward. And then it's also the clinician has a sort of humbleness, if you like, in terms of attempting to be responsive to this family's cultural and community context. We can't know what it is, but we can be curious and open and interested to do good work. We need to have all of those four elements in our minds. Next slide. Thanks.

(00:35:13):

This again for the clinician is a lovely simple thing to hold in mind. One may have met many babies, but I haven't met you. I'm going to spend a little bit of time with you and see what you want to tell me. And you're alongside the parents. The parents aren't left alone. They have you there holding their emotional reaction to the situation in your mind, you're curious about baby, but also about them and just seeing if there are moments where they can become closer. Okay, next slide. Thanks. This slide literally shows that over the first three months going from left to right, the infant is increasingly managing afa, autonomic stability and thereby more increasing times of motor regulation organisation of their state and their little moments of responsiveness, being open and interested in their surroundings and looking for responsiveness from the humans who are there, their caregiver, their parents, their clinicians, and interest in even items of almost playfulness that may be presented. So this is the developmental trajectory, but also in any particular moment in time, one will see moments of regulation followed by dysregulation or cost, which needs a different kind of support. So one's flexibility in being able to offer the right kind of support depending on what babies communicates is key. Next slide please.

(00:37:11):

This still shot is of a mother who had been extremely dedicated in the neonatal intensive care unit in Wellington after her son was born at 23 weeks and six days the baby, he had retinopathy of prematurity quite significant and had had surgery for hernias. The nurses were concerned about mom's attentiveness staying in the dark in the room. This clinician, who is an occupational therapist, is spending time with her really to see if there's ways to bring down the level of anxiety to see what baby Noah can show his mom that she may or may not have already noticed. And in this moment, Noah does turn to his mother's voice and follows a little red ball, and this is with retinopathy being present. And so this is the thing that the newborn behavioural observations can do is be absolutely accepting of who this baby is, what their strengths and vulnerabilities are, but also allow the parent perhaps increasingly to begin to see their baby as a person and not just a bundle of vulnerabilities and of parenting tasks that they don't feel they've had the chance to really develop in this very constrained environment can really shift the way baby is understood and build connection.

(00:38:57):

That leads to the next slide, which shows that the NBO is something yes, that can be used in the NICU environment. It's really valid up to three months corrected age approximately, and often used as serial sessions. When a clinician is able to offer continuity, there's real power in the sort of idea that multidisciplinary professionals in a setting like NICU might all be able to speak the same kind of baby's experience language. That's a very appealing idea and help create just a whole unit of therapeutic and support people working in one place. So it's got this potential as one infant mental health intervention that's useful, right? In the very early days with even very vulnerable infants of giving the baby a voice, the baby's already actively seeking relationship and this little clinical tool can just help us to notice and respond. Thank you.

Vicki Mansfield (00:40:19):

Thank you Susan. And I loved hearing that description and I've met many babies, but I've never met you. To me, that just brings that beautiful curiosity to about who's this little person. And through all of your presentations, it really stands out that your work is about getting to know this little person, but also as you said, Susan, holding the many emotional reactions for the family as well. And so thank you all for your presentations and we'll go to our q and a for the evening and we have some pre-registration questions and we are also getting some questions through as we have progressed. So thanks everybody for sending through your questions. And I'll go to one that come through just after Nat spoke. And so this is directed for Nat and it was about niku design. So what changes would you suggest or make to help support optimal development for NICU babies? Very interested to hear your thoughts on this, not just as a neonatologist, but also in light of your PhD research. Nat, would you like to share your insights for Amanda?

Dr Natalie Duffy (00:41:41):

Yeah, absolutely. Thank you. Thank you for the question. I think that over the years there's been lots of tension and focus on the design of NICUs and we've moved from really busy open phase to single private rooms thinking that that would bring benefits. And the research shows that it does and it doesn't. I actually would go beyond the infrastructure and I think what I noticed the most when I spent time with the babies is that all of that stuff around them, we can't take it away because they need it, but actually their place of safety and their safe haven is their parents. So the design of the

unit doesn't matter. It's the culture and the welcoming nature of the staff within that allow parents to be there to allow them to feel safe and to be with their baby.

Vicki Mansfield (00:42:47):

Thank you. Thank you Nat. And I can hear in Susan's last comment, but also in Erin's discussion about changing the culture of care that we can provide. I think by even bringing to life this little person is a person. And yeah, there's some really great questions. One of our pre-registration questions which I will anyone can offer, and maybe Susan you might start us off. One of our pre-registration was as a psychologist and I'll broaden that to also allied health practitioner. How can I practically support these dyads or parents and children probably post discharge? So in the community, what might they hold in mind? Yeah,

Assoc Prof Susan Nicholson (00:43:42):

I think a combination of what would be something that a family would really expect from visiting a psychologist would be the opportunity to speak about the experience of parenting a premature or unwell baby. And that there is no doubt that that will be very beneficial, but including the baby in the consult, letting the baby speak, interrupt, letting the consultations be much more messy in that baby will speak, will show live in moment to moment what they're feeling and experiencing that we are at the same time getting a very rich picture of the nature of the existing connection. What is already working well? Where do the relational vulnerabilities and challenges lie in the connection that is and isn't there between this parent and this baby, how it looks. And then working in a strength-based way to build on those little moments that are visible. Check in with the parent about the feeling.

(00:45:04):

Did they notice that when they just adjusted their posture a little bit, baby was wriggling a bit, but then they went settled. Did you notice that these things can happen subconsciously and when they're brought to consciousness they can be really motivating for a parent in terms of realising what they're already doing? Well, I think that's a really great way to work, to work in the moment, but also bearing in mind a lot of symbolism that will be playing out in the parent's mind, that the psychologist would be the perfect person to be also able to address that. And it all hinges on being a really skilled observer of infant behaviour. Now with any look, you can do a full one year of infant observation, but there are shorter ways in and the newborn behavioural observations will be one of them.

Vicki Mansfield (00:45:56):

Yeah, thanks Susan. And that I like you validating and normalising that when we invite the infant in, it might look a bit more messy, but it's incredibly powerful and there's such power in that observation and bringing forth the moment to moment relationships. And there's a question here that I will ask because it's specifically about the newborn traffic light. So Stephanie has asked, is the traffic light tool to provide regulation processes that healthcare professionals can utilise as well as parents? So is it supporting the parents' regulation as well as for healthcare guidance? And as a clinical nurse educator within a mother baby unit, I think it could be really beneficial to teach parents, but want to know more about how clinicians can have the appropriate resources to teach

this to parents. So I'll let you, Erin have, it's a big question. I grant that it's more, it's the million dollar question, isn't

Erin Church (00:47:02):

It? So firstly, I would encourage you to register to do the newborn traffic light module for yourself. I'd also encourage you to do NBO training because it looks at not just the more behaviours for baby, but looks at clinician are more and parent are more and understanding everyone's intentions within that space. So it gives you a much more rounded picture of how to those relationships and find those strengths Regarding the tool and parent education, well, as I briefly spoke to, it really was initially going to be intended for parents. It was going to be a poster on the wall that parents could look at when maybe clinicians are a bit too focused on the task at hand to say, Hey, my baby's doing X, Y, Z, can we stop slow down? In that process when we were going through and getting feedback from experts in baby behaviour and infant mental health, the question was raised as to whether or not that was quite a big burden for parents to take on themselves in a space where they're already filled with a lot of stress, maybe a lot of self blame about their baby being within a neonatal unit and then how they got to this point.

(00:48:26):

And so to decrease that, that was where the thought process came from for clinicians to learn it first so that we could really facilitate maybe drip feeding this a little bit to parents at the start and getting just to recognise their baby's cues and behaviours. And we are still in a sort of formalised rollout phase where these studies are coming from at the moment for clinicians. And then after that, once we've had official rollouts and some data back on how it's used within the neonatal unit, we really do hope to make a parent app or module that they can complete and can do in their own time and maybe come back to it, which is why an app would be great so they can come back and read those about these behaviours and hopefully learn more about their baby's communication. I hope I answered that mostly. It was a big question.

Vicki Mansfield (00:49:27):

It was a big question. Thank you. Thank you, Erin. And I don't know if Susan and Nat, feel free to add anything if either of you, if any of you, when I ask a question, add anything if you have anything to add. But there's a great question here from Jim and it's around a lived experience peer workers employed by hospitals dedicated to a nicu, and he's wondering if there's a role for a lived experience. And he had a lived experience as a parent in two NICU and a lot of the parental support was sometimes an additional job for the nurses, or if there was a need, it would also include general social worker. But he was wondering, having a lived experience peer worker could help regulate parents' emotions to ensure the infant's emotions are regulated. We found when we as parents, were calm, our daughters were calm, which in turn would allow for rational support of our children. Would anyone like to comment about the role and if there's a role and that Jim's generously shared his lived experience with us? Thank you, Jim.

Dr Natalie Duffy (00:50:40):

I might go if that's all right, Susan and Erin. So thank you Jim. Thank you for sharing that. And I think you've touched on a point that is evolving but is definitely missing in the NICU and that is lived

experience. So Erin and I have the privilege to share the journey, but we have never experienced this journey. We've never walked this walk and the literature's coming through now about the value and the huge amount of support that peer support brings. And within Australia we have two, and there's probably many, many more, but in the hospital that I work in, we have two incredible charities, medical babies and life's little treasures foundations who are created by people who have lived this and have walked it, and they offer peer support in many, many ways. And we couldn't do the job that we do without the valued contribution of those volunteers because they bring something that the medical nursing and allied health team predominantly may not have. Now, every individual may, there could be people within the team that have lived experience, but it's not something that all of us have. And I think that there is huge benefits to peer support. And I thank you, Jim. And it's something that we are developing more and more on the floor and with the internet and all of social media, there's lots of ways to connect with veteran parents to help with the stress and the anxiety and the trauma associated with an admission to nicu.

Erin Church (00:52:22):

I might just add to that if that's okay, Vicki. So in speaking to people with lived experience, being able to help regulate parent emotions in this space, it firstly relies on the logistics and the politics of a unit, being able to have these people within there, which is always going to be different at different workplaces regarding learning baby behaviour and infant cues, whether it be through the Newborn Traffic lab tool or something else. I would hope that this is a tool when we do have the parent resources that we might be able to send to charities like Life's Little Treasures and Miracle Babies and have their peer support people do the training themselves so that when they are in the units and then maybe go and do NBO training or whatever training they want to do in baby behaviour, if that's what speaks to them and interests them to be able to support parents in that journey, I think that would be really helpful. You touched on extra tasks for nurses and things, we can get very task oriented, and this is why this idea came about because we wanted to remember the person in the front of us. And so I am hoping that it encourages clinicians to look past their tasks and see the person, but we know that no one's perfect and sometimes we do forget who's in front of us. So I think yeah, peer support would be a great addition to how this gets out there.

Vicki Mansfield (00:54:03):

Thanks Erin. And one of the other questions I will ask Susan, how are premature infants screened or supported during their early years of life? But I'll ask Susan maybe what role might GPS play and what in that post discharge and in supporting and screening preterm infants or medically unwell infants once they're discharged?

Assoc Prof Susan Nicholson (00:54:37):

So in their GP setting, we often are very much guided by the follow-up that premature or unwell babies will be having, that we will receive that information and we will be working in a system that really means that we have still brief consults. We will be doing screens at set times, we'll be liaising with the maternal and child health information. We are always looking at the data that we receive in the system for that. And that all kind of works. It kind of works. What's left out is the GPS in confidence about what relational support is and what their role might be in it. And emerging minds, I

have to say, has been a game changer for us gps in that, I mean, I might be a bit of an outlier in that I've kind of done a deep dive into environmental health over nearly 20 years now.

(00:55:54):

But for those in general practise, it has really opened up the world of infant mental health on what can be done in very brief consults. So the screening to me is less worrisome. I'd be very interested in that's view of whether or not there's a sense that we gps fail infants in that respect, but I think it's more relationally where the opportunity is huge for us to be reducing the mental health cost for both parents, infant and thereby families where they have had this very kind of challenging and vulnerable beginning but survived and are now in the community. And the opportunity is that the GP with this ongoing relationship can really help them thrive and get appropriate support when they need it, whether it be medical or relational.

Vicki Mansfield (00:56:53):

And I like that awareness of thriving and having even I think the wonderful presentation that you guys have presented gives us a window into a nicu, which unless you have had an experience of as an allied health professional, that's not an experience that we have a sense of. So I think, yeah, it's really great to have a sense of what it is like in the NICU from even this brief window, but also the role we have in relationally supporting people going forward. And thanks Susan for highlighting that importance of the physical and the relational. Yeah, they're both paramount. And there was another great question here. There's so many great questions, we won't be able to get through all of them unfortunately, but they're really rich questions. But from Savannah, and what do you think is the most warmhearted moment you've come across in completing your research concerns and risks can often dominate research funding, but what do you think you've taken away into your practise? So yeah, Nat, do you want to start off and Erin and Susan, that could also be a reflection you might like to provide.

Dr Natalie Duffy (00:58:20):

Thank you Savannah for the question. I think from myself, from an individual and how I approach my therapeutic relationship with the babies and the families, the biggest thing I've learned is to slow down. I haven't been afforded the opportunity as a clinician until really the point of my PhD of just being allowed to sit and watch and wonder. And yes, we work in an incredibly busy and it's intensive care, but it's not always intensive care. So you can afford yourself the opportunity to just slow down and meet the babies and the things we've talked about and the MBO has shaped, has shaped my professional career immensely, but getting to meet the baby in front of me, bringing the family in, and we all just learn together. And it doesn't to be, I sat for the babies for hours, didn't I in my PhD, but if it's just two or three minutes at the beginning of a ward round, but at the beginning of a consultation just to ask, what have you got to tell me today? And actually give yourself the chance to listen to the answer and then you can do what you have to do. And I just think it frames things a little bit differently.

Vicki Mansfield (00:59:49):

Thanks. Matt. And Erin or Susan, both of you are also involved in developing resources, researching. Would either of you like to offer how it's impacted your practise, a moment of reflection? Yeah,

Erin Church (01:00:06):

Definitely. So I'm still in the beginning phases of my research doing my doctorate on the newborn traffic light tool, and it's going to be more with clinicians. So I look forward to having moments with clinicians where they realise that these babies are telling us much more than maybe they realise and having those moments to slow down. And I will just say having worked with Nat for a long time, she talks about being able to slow down now, she's the only consultant I've ever met who after a ward round would come back and feed a baby. So she's got it down pat. She's great. I think for me. So I've done NBO training and I'm working towards becoming a trainer and using the NBO in sort of my everyday interactions with the babies that I care for gives me satisfaction in my work because we are looking after such vulnerable infants and babies who have maybe not open to their eyes to look at someone before because it's all been too loud and too bright and too stressful. But using the tools that I've learned to support them just by holding their hands in the midline, speaking calmly to them, keeping everything really calm and then they open their little eyes for a moment and look at you, that's everything. And it really helps you see the person in the bed. And it means next time you come back, you are more likely to continue to see the person in the bed.

Vicki Mansfield (01:01:50):

Thank you, Erin. That's a lovely, lovely description. Susan, anything to add or will I take us to one last question off mute? Just take yourself off mute.

Assoc Prof Susan Nicholson (01:02:07):

Well, very quickly I think there is potential to, of working in this way to actually reduce burnout amongst professionals. But I could talk a lot about that, but I won't. But it's certainly highly motivating in one's work. But I'm really keen for you to manage to fit in another question, so I'll just shush it up.

Vicki Mansfield (01:02:30):

Well, actually I will use, I was looking for a question. I was scrolling and actually hits just the mark that you started, so I'll give you permission to talk more about that. So this question was from Kathleen and she said, just a question on your self care from working in such a high pressure environment, do you become attached to these little angels and will done folks for the wonderful work you all do? So yeah, how do you take self care and do you become attached to the little angels?

Assoc Prof Susan Nicholson (01:03:06):

Yes, and yes, you do become attached, you do become affected, you do become emotional, and it reregulating oneself is important, but not shutting oneself down. So we often become very task focused because the work is pressured, but also because it feels emotionally safer and one cannot be respectful of the baby in that way. So that's the work. But I'd really much rather hand over to Nat, given her really, really spending a lot of time and thought on this. And yeah,

Vicki Mansfield (01:03:51):

Thanks Susan.

Dr Natalie Duffy (01:03:54):

Yeah, thank you. You do become attached. But I think that that is the human side of NICU and that we have to, with the infrastructure around us and the culture and the teamwork, allow ourselves to become attached because we are human and we have to think about relationships and our interactions and our listening are just as much are essential components of the care. As to everything else, I have struggled. I can admit that to all of you that I saw things in my PhD that I know myself that I have done as a doctor, but we never do anything. We always have the baby's interest in medical needs, I suppose, at the forefront of our mind.

(01:04:56):

But I think it's just about looking through a different lens now. And I know that myself, and that's where I talked about time. It's just allowing yourself the time and having a support network around it. And I think that comes down to culture and about, we're incredibly grateful to emerging minds for this and this opportunity because perhaps the mental health of babies, the mental health of parents and the mental health of the staff is not thought about as much as it should be within the high acuity of the nicu, and we can collaboratively work together to help everyone.

Vicki Mansfield (01:05:36):

Yeah, lovely

Erin Church (01:05:38):

Answered that question.

Vicki Mansfield (01:05:39):

Absolutely. Well said. Natalie and Erin, would you like to add any final thoughts there?

Erin Church (01:05:45):

No. Susan and Natalie speak so beautifully in that space. I don't want to change that at all.

Vicki Mansfield (01:05:53):

Okay. Well, that's all of the time we have for questions. And thank you everybody for your great questions. And we certainly will keep track of the wonderful questions. There might be more opportunities in the future to talk about this topic. And thank you, Susan, Erin, and Matt for your wonderful presentations this evening. It's been such rich learning. But I'd ask each of you just for one, take home message for the audience and I will be consistent and predictable and start with Nat, what's your one take home message for the audience this evening?

Dr Natalie Duffy (01:06:38):

That babies are born, ready to communicate and looking for interaction and slow down and afford them the opportunity.

Vicki Mansfield (01:06:49):

Lovely. Thank you, Nat. Erin?

Erin Church (01:06:55):

Yes, that would've been probably one of mine. So I'll go with something more nursing focused where I come from and say that something like the newborn traffic light tool or anything that we implement into a unit to improve outcomes for these babies can often be seen as an extra thing to do and it makes it hard to implement them with overwhelming support because it's something else to think about. But I would implore those of you online who are listening to consider that this should be standard of care. We know that it's the best way to care for these babies and we know it. We just need to do it. And hopefully something like the Newborn Traffic Light tool can keep the baby in mind in a way that doesn't add any extra tasks, but opens up the relationships with the babies.

Vicki Mansfield (01:08:02):

Wonderful, Erin. And that's such a perfect advocacy message for your advocacy tool and for practise. So thank you so much. And Susan, what's your take home message for that audience?

Assoc Prof Susan Nicholson (01:08:14):

Even as I'm about to open my mouth, I'm not sure what's going to come out, but something to do with this idea of moments of meeting that Nat has had come out of her PhD work, and that is written about beautifully by an expert, Nadia Bush Stern, those moments of meeting that one has the opportunity to enable can also be profoundly moving for oneself as a clinician, whatever your discipline. And there is rich reward to be had by going down this pathway professionally. That's it.

Vicki Mansfield (01:08:59):

Thank you. And yeah, thank you all so much for your insights tonight and for the take home messages and for such as a person who has a great interest in infant mental health, it's been lovely to hear, and I'm sure our audience has really enjoyed the window into the lived experience for infants in nicu. And so just to finalise this for the evening, so thank you to everyone for participating and for the fantastic questions this evening. And you will receive a statement of attendance and a link to the recording and the associated resources within the next week. And the webinar will be available on MHPN and Emerging Minds Sites for you to watch back again or to share with colleagues. And we would invite you to share your feedback about the webinar because that always helps us to build our future webinars as well. And so you can click on the feedback survey in the button below, on the green button and provide feedback that would be greatly appreciated.

(01:10:20):

And I'll also just prompt everyone not being a medical person that even watching the presentation and seeing the photos, this can be emotionally provoking for each of us. And so I would encourage everyone to be mindful of their own self-care or to reach out and have a chat with a colleague or a GP or within your own respective supervision if it has been an emotional presentation. But I also think it's very powerful to have had the experience of the emotions roller coaster that is NICU for both parents and infants. And thank you everybody for your attendance this evening, and we look forward to seeing you at future webinars, which will be coming up and can be seen on our site and on the MHPN site as well. And I think that's the end of the slides and I'll let everybody go and enjoy

the rest of their evening again. Thanks Natalie, Erin and Susan, thank you so much for your time this evening.