



## Infant and Family Mental Health: Integrating Lived Experience Expertise into Your Practice

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Vicki Mansfield (00:00:01):

Welcome everyone to our webinar this evening, The Infant and Family Mental Health: Integrating Lived Experience Expertise Into Your Practise. It's great to have you with us all tonight and I'll go to our next slide and I'd like to acknowledge that I'm meeting from Awabakal Country and to acknowledge the traditional owners of the countries throughout Australia and recognise the continuing connection to land, waters and communities. I'd like to pay my respect to elders past, present and emerging and acknowledge the importance of memories, traditions, culture, and hopes of Aboriginal and Torres Strait Islander people and recognise the strengths and resilience that have nurtured children for thousands of years.

(00:00:50):

So as I said, welcome everyone. I'm Vicki Mansfield, a practise development officer with Emerging Minds and I'll be moderating tonight's session. This is our second webinar in this series and I'm a social worker by background and have a background also of working in perinatal infant mental health. So it's a joy to be meeting with you all tonight and to once again be joined by our panel of lived experience expertise and we'll meet them. So to kick us off tonight, I've got a question for each of you about what is your favourite time of day? So I'll introduce Ash, Ashley Allan, who's a perinatal lived experienced peer worker. Ash, welcome.

Ash Allan (00:01:43):

Thanks, Vicki.

Vicki Mansfield (00:01:47):

What's your favourite time of day, Ash?

Ash Allan (00:01:50):

I say this with all the love in the world, but it is the first thing in the morning when I'm up before my girls and just get to have my coffee and do my pottering around in peace, watch the sunrise, listen to the radio.

Vicki Mansfield (00:02:07):



Lovely. Thank you. I'm with you, Ash, on the first thing in the morning. And a very special welcome to Jess Jackson, who's a carer and peer support worker. Welcome, Jess.

Jess Jackson (00:02:20):

Thank you, Vicki.

Vicki Mansfield (00:02:22):

Lovely to have you with us again. Thank

Jess Jackson (00:02:24):

You. It's lovely to be back and I've got my voice this time, so that's good. I'm actually a bookend to Ashley because I love sunset. And for me, it's the end of the day. It's often when I take my dog for a walk and it's just when everything's a bit quieter and I'm on the rural outskirts of Melbourne. So it's just really beautiful, very peaceful.

Vicki Mansfield (00:02:45):

Oh, lovely.

Jess Jackson (00:02:45):

You like our peace ash, I'm noticing that.

Vicki Mansfield (00:02:50):

And welcome to Viv Kissane, who's the CEO and founder of Peachtree Perinatal Services. Welcome, Viv. Are you either end or in the middle of the day? What's your favourite time?

Viv Kissane, OAM (00:03:04):

Well, I'm definitely, definitely at one end of it. So my vote is for the productive time early in the morning. So that time between probably five o'clock and eight o'clock is when I get most of my stuff done that I have to get done. And I've got a nice little routine that kind of sets my day up for success.

Vicki Mansfield (00:03:28):

Oh, lovely. So the brain's firing nice and early. Thank you. Well, it's great to have you with all of you with us again. And so your learning aims for the webinar tonight is within the resources that you've received. And we'll just recap from our first webinar. And this was our second webinar. The first one was on lived experience expertise supporting the transition to parenting through the story of Ruby, Alex, and Mia. And so as we can see, Ruby was delivered Mia at 34 weeks and Mia is admitted to NICU due to respiratory issues. And the family's time, Ruby, Alex and Mia's time in NICU is marked with a lot of



exhaustion and worry, which is fairly common often for Nick's early births. Ruby and Alex are both exhausted feeling lost and eager to find routine and Mia's weight gain is slow and Ruby feels very committed to wanting to continue breastfeeding.

(00:04:41):

And the panel last time shared their lived experience expertise and spoke about how NICU can be complex and overwhelming for families and lived experience workers offer support when navigating this complexity and really offering a values-based relational lens on that support and that lived experience expertise brings forward insights when supporting parental wellbeing, the parent-infant relationship and infant mental health and also spoke about the importance of peer support to reduce stigma and shame and foster healing and self-compassion during that perinatal period and in that transition through pregnancy into parenting, which is such a life-changing experience for everybody. And so tonight we'll continue on with that. We'll go to next slide. We'll continue on with hearing about Ruby, Mia, and Alex, and we'll look at how lived experience workers promote family mental health in that early development. So being that transition out of hospital into community and how they enable and collaborate within teams to support parents in practise and continue to explore the journey of Ruby, Alex, and Mia in that first 12 months or so.

(00:06:14):

And so for us to start our discussion today, we wanted to frame the discussion by inviting Viv to explore with us. Viv, what's the concept of social prescribing? It's a concept within lived experience and is this a change of mindset for services?

Viv Kissane, OAM (00:06:42):

Yeah, thanks, Vicki. It absolutely does require a mind shift as social prescribing really challenges that traditional medical model as well as the dominant discourse that we have around parenthood. And it really encourages us to think about how sometimes we may overmedicalize and over pathologize the parenting experience. So in a nutshell, social prescribing is really just the practise of connecting people to community, to social relationships and to meaningful activities that will support and foster their positive health and wellbeing. So it also recognises that not every problem requires a medical intervention, but also social prescribing doesn't replace clinical care when it's needed. Rather, it compliments by being able to address that broader issue of social determinants of health. So as we've been discussing over the last webinar and through this webinar, we know that social isolation and loneliness are significant factors in the perinatal period and addressing the factors that contribute to that isolation is really critical in protecting not only the parent, but also the infant's wellbeing.

(00:08:11):

There are many contributing factors and barriers for parents to be able to find and access support, but we know that prolonged isolation in this period ultimately results in higher chances of things like postnatal depression or anxiety or any types of psychological distress and therefore having that knock-



on effect of being able to impact the whole family. So the social prescribing model really just advocates for social prescriptions as an important way that health professionals and GPs can really look beyond that traditional healthcare model and prescribe social prescribing. So that might look like things physical activity and being in nature. It might be creative and cultural activities, community connections, peer support groups, play groups, mother's groups. It may also be learning new skills and development, but also addressing that practical assistance around financial counselling or housing support, legal aid or food relief or transport assistance. There's really quite a long list of things that might cover.

(00:09:43):

Social prescribing absolutely falls within the scope of the lived experience workforce. So I think it's a really interesting model to explore and has the potential to really make low cost and effective, but a really impactful support for parents.

Vicki Mansfield (00:10:03):

An impactful support, Vivint. It sounds like it's a really, as you said, a framework that helps broaden and for lived experienced peer workers, it can be really central in some of the roles that they take as well and I imagine is quite central to Peachtree's services as well.

Viv Kissane, OAM (00:10:23):

Yes. And essentially what Peachtree does is social prescribing, but we've just not traditionally had that language around it. So it's emerged a lot over the last few years and I think is really valuable in helping parents being able to navigate and find services.

Vicki Mansfield (00:10:43):

And it sounds like that also really recognises that this is a normal transition for everyone and that everyone is a social being and needs social support at this really pivotal time in their life.

Viv Kissane, OAM (00:10:56):

Absolutely. And by encouraging early help seeking and prevention, I think it could be a really effective in reducing the potential of escalation into more serious mental health concerns.

Vicki Mansfield (00:11:13):

Yeah. Thanks, Viv. And one of the questions that come up in the last webinar we thought we'd bring into this webinar because we didn't have the opportunity to explore it. And so in our case study, we have partner Alex and one of the questions was how does lived experienced workers support dads or non-birthing partners in that transition to parenting and also the changes in the couple relationship which occur in this stage as well and why is this important was the question. And so yeah, Jess, do you want to share your perspective on this?



Jess Jackson (00:11:58):

Yeah, thanks, Vicki. I think that unfortunately dads and non-birthing partners across the board are often unintentionally sidelined in perinatal care. So coming from a place of lived experience, we can really help them feel seen and thinking about our experience over anyone who needs a refresher or wasn't on our first webinar, we've got a beautiful boy who was born premature and there was a lot of birth trauma that led to three and a half months in hospital, mostly in ICU. So it had a huge impact. He's our first and only child. So for my husband, even from the early appointments before he was born, sometimes he'd say to me, "Do you realise that that clinician didn't actually look me in the eyes at all?" He would ask a question in that answer to me and it was very unintentional. I think the mother's so central to that and for him, especially just the trauma, we talk about possible vicarious trauma for non-birthing partners, but he experienced the most full-on trauma along with me.

(00:13:10):

And I think the difference is that sometimes as women we might connect more or we might share more with other people in our environment, but there was this pressure for my husband and he said he's happy to share his story to help others as well, but just that he felt like he needed to be my rock and he also was working, whereas I stopped work for a long period of time. So for him, just all those feelings that were coming up for him and he just said, "I just had to push it down or push it aside and just keep working." And yeah, he had the financial pressure. He just wanted to make sure that he was there for my son and I. So it was a lot for him. And when I'd say, "Why don't you go and talk to someone thinking maybe therapy if you had time." And he just said, "I don't see the point of talking to someone that just doesn't understand, that hasn't been through it."

(00:14:06):

" For him, it just wasn't a place that he was willing to go to open up and be vulnerable and have someone just not understand the exact feelings. And we love clinicians, certainly we've had so much help from clinicians all the way. So it's certainly not anything against their work. It's just I think we can add an extra dimension of helping those non-birthing partners and all families feel seen.

(00:14:40):

Ashley, do you want to talk a little bit more about that or about our work with mom-birthing partners?

Ash Allan (00:14:46):

Yeah. Thank you, Jess, and thanks to your husband too for so generously sharing your experiences and your stories really resonate personally for me too. And yeah, just really to mirror what you've said around and just acknowledge that we know how important the mental health and emotional wellbeing of dads and non-birth parents is. We know the perinatal period is a really vulnerable time for their mental health too. And we know from our own experiences and our work in this space that there does remain a really significant gap in the provision of care that wraps around the whole family through meeting their needs for support as people and as partners and as new parents. And yeah, it's just so



important to also take the opportunity to really acknowledge the diversity of parents and families in our communities and just how vital it is that our perinatal care and our services are culturally sensitive and safe and inclusive and trauma informed.

(00:15:48):

When we think about the first 2000 days, that's about enabling the best start to life for every child. And so we really need to be guided by our families and our communities in advocating for and providing safe and inclusive care and support to every parent and family. And I really feel that for the lived experience peer workforce, we have such an important role in this space as we continue to emerge and grow and bring the diversity of our lived experiences to teams and services, as well as in establishing our own services to meet the needs of our diverse communities. So yeah, hand over to Viv to speak more deeply about father inclusive services and resources.

Viv Kissane, OAM (00:16:36):

Yeah. So as a perinatal and infant mental health service, I think we hold that dual lens. So what we're trying to do is intervene early to support safe and nurturing environments for infants, but we absolutely also at the same time have to recognise and respond to really complex trauma histories of parents. So we know that up to 70% of Australians will have at least one experience of trauma. So therefore how we operate at Peachtree is that it actually doesn't matter who walks through our door or where they've come from, that we're using our trauma-informed principles and our values-based work to really underpin how we work with people. So trauma-informed principles of safety, trust, choice, collaboration, and empowerment. So I thought it just might be helpful to give some examples of what that actually looks like in practice though. Yeah. So when you're thinking about safety, this is about how we greet people as they walk through our door or they make first contact with us.

(00:18:00):

And so that might be a, "Oh, welcome. We're so glad to see you. We're so glad that you're here." And there's also a physical location to that as well in terms of the environment in which people walk in and see nice, friendly, welcoming kind of atmosphere to our service. If we're thinking about trust, we offer everyone who makes contact with us a service navigation session on entry. So we're really able to provide a clear explanation in terms of what support might look like for them and what we offer and how they might access particular groups or services. In terms of choice and control, we don't have any expectation that parents disclose anything to us that they might not want to disclose until they feel comfortable and ready to do that. So we really meet parents with where they're at and go at a pace that feels right and comfortable for them and they can choose to opt in and out of services and programmes as they like.

(00:19:24):

In terms of collaboration, I think this is a really, we work with people so we're not trying to fix any problems as such, but rather we're here to walk alongside with you and we know things might be



challenging at the moment, but we're here essentially. And then empowerment is really recognising that it takes a bit of courage to reach out and ask for help and to have a little bit of self-compassion for yourself and recognise that you need to prioritise yourself up the list of all of the needs of the family. So we really try to create an environment where parents can really feel like they have all of the right information to make informed choices and to feel really empowered to do that self-help and that help seeking. And lastly, it's hope if I was to add another one in there in that they don't have to navigate this alone and that our community and our workforce is here to support them.

Vicki Mansfield (00:20:43):

Viv, I think I've heard you talk previously about that also the supporting a couple through the changes that a relationship occurs through becoming parents and that there were some resources that might've been particularly relevant. Is it *Becoming Us*? Do I remember you mentioning that?

Viv Kissane, OAM (00:21:08):

Yeah. *Becoming Us* was created by a lovely perinatal psychologist called Ellie Taylor. So she has written a book as well as created a programme which really works early in that antenatal stage about helping couples navigate what those relationship changes might be and how to be a little bit more prepared around that. I would say it's a very, very common experience. 92% of couples will experience conflict within the 12 months after having a baby. We know that domestic and family violence either presents for the first time or escalates within the first 12 months after having a baby. So there are a lot of issues around identity changes, but also how the couple's relationship changes as well.

Vicki Mansfield (00:22:02):

Yeah. So thanks, Viv. I think again, coming back to thinking about that these are common experiences that many people will have and thanks for sharing the insights around the values that are really guiding lived experience. I think that really helps paint us a picture of that work as well. And so let's go back to visit the family story and hear how things have been since they have been discharged home. So we'll just go to ... So the family are at home, Ruby and Alex are feeling stressed, anxious, and sleep deprived. The family's trying to find routine, which is often pretty tricky in those early months of family life. And Alex's shift work is compounding the family's challenge of finding a routine, Alex being a paramedic and having changing shifts as well. And so we can hear that that presents some challenges for the family. And then we'll also, I think Viv, as you mentioned, this can lead to some sense of isolation.

(00:23:25):

So we'll go to the next slide and hear what's happening for Mia as well. So in terms of the isolation, Mia is unsettled in the car and Ruby and Alex are also worried about Mia's health. And so they're cautious about going on too many outings in the community and trying to reduce Mia's distress. But what this means is that they are feeling maybe less connected and have less fuel in the tank to be engaging in social as well, social activities. And so I'm wondering if we think about that transition for Mia, Ruby, and



Alex and that finding of routines, sleep deprivation, trying to establish and maintain breastfeeding. I'm wondering, Jess, if you wanted to share with us knowing that baby Mia come from NICU and that there are some concerns about her health, what's the emotional experience of transitioning from a neonatal intensive care unit to community and home?

Jess Jackson (00:24:45):

Thanks, Vicki. Just even seeing those slides makes me think about all the emotions that we had and it really is all the emotions. So just the joy of it, I can't believe it's happening, the fear, trepidation, not knowing what to expect and that's just getting in the front door. We spoke last time about how hard things can be emotionally in NICU, but at the same time the strength of that is that you're in a cocoon and you've got someone looking after your baby, keeping them alive if they be 24 hours a day. And the idea that you think at the time is when I get home, my baby's going to be healthy or get into this life that we imagined it would be like. And for us, it was just moving the ICU home. So we didn't expect it, but we came home still on feeding tube attached to a milk up 19 hours a day at the start there was suction plus oximeter, CPAP for severe obstructive sleep apnea.

(00:25:54):

So there were all these things that we didn't expect. So thinking about our relationship from the last question, we'd moved from being partners and all of a sudden we're parents first, nurses second, and then the whole partnership sort of goes down the ladder. So yeah, the sleep deprivation was insane for us and all the monitors and the alarms and everything just came home with us as well at nighttime between all the monitor alarming, the milk pump needing, changing, the CPAP machine, all the rest of it we ended up just splitting and just taking four hour shifts so that someone could get some sleep, which was on the floor of the next room. And then the other person would swap ships and wake that person up. I was like, "Are you serious? I feel like I've been asleep for 20 minutes." And I think with all of that, it did become really hard to leave the house.

(00:26:56):

We definitely made an effort, but it was a huge effort. It was sort of a mental hurdle to get over. And so for that reason, I mean, I didn't end up joining any maternal, so any mother's groups at all because I just thought the community groups they just wouldn't understand and I don't think I had the capacity to listen to what was happening for them and just feeling a fish out of water. And my experience was very different. I do wish that someone had prompted me to get in contact with one of the other peer groups that look after prem babies or that had sick babies like Miracle Babies or Life's Little Treasures I mentioned was sort of we were introduced to them in hospital. So there's that sort of isolation, especially when my husband was back working long hours for his own business so he was doing everything and then the health anxiety was another huge one and that is real.

(00:27:58):

But the problem is sometimes you question yourself and if you're worried about your child breathing or just whatever else might be going on, you think, what's my parental instinct that this problem is happening or that this is a dangerous situation potentially versus what's just effectively a trauma reaction and I'm having a response. So just learning when to trust yourself and when not to trust yourself. So that was another thing that

(00:28:27):

We went through. There was so much joy in it. I just want to say it was the best thing ever, but it was scary and exhausting and just to look upside down.

Vicki Mansfield (00:28:40):

Yeah. And listening to, you described that, Jess, I think what stands out to me is that when we're sleep deprived, it's very hard to be thinking clearly that there's a real brain fog about that, but also you're describing there that there could potentially the energy that it would've taken to link in socially was really very, very low, but also that there is really a role maybe for GPs and child and family nurses to be checking in or prompting in terms of even discharge when you're discharging as well, NICU, to proactively support that some of those things might be tricky factors to navigate.

Jess Jackson (00:29:33):

Yeah. I think it's really important to know some of the resources that are available just so you're not ... I mean, the maternal and child health nurse is wonderful, but just knowing that there's a little bit more out there, just

Vicki Mansfield (00:29:46):

Thinking a little

Jess Jackson (00:29:46):

More armed.

Vicki Mansfield (00:29:47):

Yeah. And Ash, for you as a perinatal infant mental health multidisciplinary team, how can a peer worker in a multidisciplinary team support continuity of care in that transition for Ruby and Mia and Alex because in the first webinar we spoke about that there could be a role for a peer worker to connect potentially whilst in NICU, but yeah, what might the role be in terms of a continuity of care and that bridging and navigating systems?

Ash Allan (00:30:24):



Yeah, so that continuity of care to support the transition home is so important. It's such a vulnerable time and such an opportunity for gently supporting someone to connect with care early and hopefully to be preventative. And that continuity of care is a really vital part of the PIM peer worker role. So having had the opportunity to connect with Ruby while she was in hospital and to have begun to foster that relational connection with her that's grounded in that empathic understanding of having walked a similar path as a new mom as a perinatal peer worker, I'd be able to offer that support by walking alongside her as she navigates her experience of transitioning home.

(00:31:14):

I'm deeply aware of the vulnerability and complexities of transitioning home and adjusting to new parenthood in the context of Ruby's experiences and of how the experiences and the impacts of trauma and perinatal mental health challenges can appear outwardly when you're still in shock or if you don't have the words or you're too scared or ashamed to articulate what you're thinking and feeling inside. So my focus as a perinatal peer worker through those early days and weeks would be to continue to offer and to build that relational connection and safety with Ruby, offering to check in with her regularly, holding space for her as she makes meaning of her experiences through offering empathy and validation, a safe space to be seen, just letting her know she's not alone and having those opportunities to have conversations and share lived experience in a really sensitive and nuanced way that would hopefully empower her with knowledge about the ways that their experiences might impact and emerge for her and Mia and so supporting her and engaging with care sooner.

(00:32:27):

And I'd also really focus on highlighting her strengths and supporting her to see all that she is doing well as a new mom and in her connection with Mia and really encouraging that self-compassion and going gently with herself, supporting her to engage with PIMs as well as fostering those support networks and navigating, building those connections in community with where she's at and what feels comfortable and safe for her.

Vicki Mansfield (00:32:55):

And I imagine Ash, that's such a pivotal kind of support in terms of checking in, thinking about Viv saying, staying with where mom's at and Ruby is at in this instance. So yeah, that checking in might be the consistency and containment that she's needing if there isn't time and space to do a lot of social connection.

Ash Allan (00:33:20):

Exactly.

Vicki Mansfield (00:33:22):



Yeah. And that then becomes a way of also communicating within your broader team as well as to where the family's at. Is that kind of how correct in my assumption there?

Ash Allan (00:33:33):

Yeah, absolutely. Because being embedded within the PIM multidisciplinary team, but as the peer worker, if I am that person who has been able to foster that relational connection, it's being that touchpoint and that bridge to navigate that engagement with PIMs for the care and support that our team can then provide.

Vicki Mansfield (00:33:59):

Awesome. Thanks, Ash. And Viv, if someone was coming, we're in the car and we're landing at a peer service similar or to yourself. Is there anything else you want to add about how someone might ... Yeah, what might be the first responses and maybe you've painted that picture a little for us already. I'm not sure if there's anything else you want to add.

Viv Kissane, OAM (00:34:22):

I think it's just important to highlight how hard it is and walking through the front door for the first time is usually the hardest part once people are in and they realise that what the environment is and where lived experience and there's no judgement or whatnot, you can visibly see the relief on parents' faces sometimes, but we just make it clear that if parents are having a hard time getting through that door, then we're happy to do anything we can. So sometimes we will arrange to go and meet mom out in the car park when she's arrived. So we walk through the door with her. They're very welcome to bring a support person for the first time or for the couple of times until they feel comfortable they can come on their own or sometimes people might bring their caseworker as well and that's fine too.

(00:35:26):

So I think we just really need to acknowledge how difficult it can be and be really conscious and mindful of how we can really gently encourage and enable that first contact.

Vicki Mansfield (00:35:40):

Yeah, thanks Vivian and that really speaks to that, helping them navigate the service. Yeah. Thanks. That's great. And I've just noticed here, Jess, someone in our audience has asked, can you repeat the name of the two groups that you heard about Little Miracles and the second one before we move?

Jess Jackson (00:36:03):

So Life's Little Treasures Foundation. Yes. And Miracle Babies.

Vicki Mansfield (00:36:10):



Miracle Babies. Thank you. Yeah, that's awesome. Thank you. And so let's turn back to the family's story now and hear about Mia progressing more a little further and Mia's six months old and Alex and Ruby are starting to consider introducing solids, which can be quite stressful and they can be feeling quite stressful. Mia is also starting to explore her world, gaining some more mobility. And at the same time, Ruby finds out that she's anaemic and low in vitamin B. And so it's also quite challenging for Ruby to keep up with Mia and her energy levels are quite low thinking that we also had sleep deprivation and the busyness of having a bub. And so yeah, thinking about that from your peer advocacy work, Jess, because you have an advocacy role as well, what's important for teams to consider around Mia as she continues to develop and becomes more active during these first few years, what would you like to share from your peer advocacy perspective?

(00:37:39):

Yeah,

Jess Jackson (00:37:39):

Thanks, Vicki. I think the main thing is that I'd be encouraging the team

(00:37:45):

And I think there's a lot more awareness now, which is wonderful, but just to look out for signs of developmental and mental health challenges for Mia she grows older, I think for our experience when we left NICU, we didn't really know to look out for any signs of mental health distress, but that certainly happened for us. And I do want to say that I did get permission from my son to say a little bit of his experience. I always do, it's his journey, but we did agree that I had to say that he is the best child in the world, so I'm just putting that out there.

Ash Allan (00:38:26):

We are all

Jess Jackson (00:38:27):

Here for that.

Ash Allan (00:38:28):

Exactly.

Jess Jackson (00:38:29):

I love you in deep trouble one day. So for my son, for example, when he started kinder, so he didn't do childcare. So when he started kinder, that's when he started showing a lot of signs of separation and social anxiety, which is a big one, but it just seemed a lot bigger than what the other kids were going through and then sort of it grew into obsessions about goodies and baddies and who would protect him



and then a lot of rumination about death as well, which is really distressing and just getting up in the middle of the night in tears and just wondering what's going to happen. So what I would love is for clinicians to arm parents with information about what might develop and definitely in a gender way, which I think I might have mentioned in the first webinar. So I'm not talking about trauma or anything like that, that's too much to take home.

(00:39:28):

It's like if you've just made out the doors of NICU, you're feeling pretty fragile and yeah, that's not helpful, but just to know that if there are signs that show what to look out for and then what to do about that. So speaking to a maternal and child health nurse, speaking to their paediatrician or going to the GP to get a mental health care plan to see a mental health professional, which is one thing that we ended up doing as well, which was absolutely brilliant. And I do want to mention, so the research in this space of the impact of NICU on the mental health and babies, it's still emerging from the research that we do have and also just for me speaking to other lived experience family members and PREMs in particular, because I love to ask them 20 questions, is that there definitely is an increased risk of mental health challenges as these babies grow and that can be anxiety and depression.

(00:40:31):

It can also be things like symptoms presenting as ADHD, but they may actually be a trauma presentation and that's something that we had to navigate as well. So in terms of the education, I think of clinicians coming through within hospitals, there's definitely a knowledge gap in the training that they have. And I think a lot of the times there's just not that background to teach them what might happen once the families are out the door and a success in the medical model is a baby leaving healthier, a lot healthier than when they came to hospital, but not thinking about the neurodevelopmental, mental health impacts that might happen later on. But it's a really good thing. I think that we can raise awareness just to empower parents and clinicians to embed trauma-informed practises in NICU and also at home. And this is all part of that early intervention that we're talking about as well, just to embed it early.

(00:41:38):

So to have early healing and then prevent hopefully that mental health spiral that might happen later on. So things for myself that I wish I had have known and I still carry that guilt, we're talking about guilt and shame last time as well is that so we thought about helping our son to self-soothe and let him sort of cry it out before going to sleep, not for extended periods, but for a reasonable amount of time. And then after I have sort of done my own research and a whole lot of reading and to find out later that that's the worst thing that we could have done, that babies that have been hospitalised for extended periods of time, they need much more co-regulation and basically if they're crying out, the best thing that someone can do is to attend them quickly to reassure them that they're safe in this world because so much of the time in NICA, they didn't feel safe and parents weren't always there, which also leads us to the disruption in attachment that can affect their relationships and the baby's view of how they feel in the world, the way their nervous system has developed and these difficulties can come from parents being absent for long periods because we can't stay overnight.



(00:43:00):

Parental mental health, obviously as we've discussed,

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It can be so overwhelming and that can also cause a disruption in attachment and also the babies are undergoing painful procedures often without the parents there as well. So that's just some of it that sort of builds up into what may be a future mental health picture. But yeah, the good news is the more we can get the word out there and the more that clinicians can know to ask about the birth history of a baby and we're doing that so much more now and I'm so proud of where I work at the Austin because it's like one of the number one things we do is get a full birth history from conception. So yeah, it's wonderful. I think there's much more awareness, but I just don't want to hear any more lucky they won't remember this about the babies in hospital because as much as we hope that that's the case, it doesn't set us up for good understanding once we leave the hospital.

Vicki Mansfield (00:44:05):

And such an important point, Jess, that babies are sensory and so they're remembering in a sensory aspect. And so I think it's really great that you highlight that importance of getting a birth story and a birth history and really fantastic that you're highlighting the importance of clinicians and being at allied health clinicians post discharge really thinking about those aspects and supporting people if they come to see them around exploring and curiosity around that. Thanks, Jess. Yeah. And what you're highlighting, Jess, is that importance of relationship and connection. And Ash, I wonder if you can share with us how in your lived experience peer work you hold both parent, in this case Ruby and child Mia, and their developing relationship in that first 12 months, which is a period of getting to know each other. And as Jess has just highlighted where in this instance, and often that getting to know each other can be quite tricky when there's been tough things to navigate.

(00:45:31):

Yeah. Can you share your lived experience peer worker role there?

Ash Allan (00:45:35):

Yeah. And yeah, thank you so much, Jess, for so generously sharing yours and your son's experiences.

(00:45:45):

I just again want to mirror your reflections and speak a bit from Ruby's perspective to really highlight from the lived experience perspective, how both Ruby and me as well being are interconnected, how that might emerge for both of them and how we as perinatal peer workers can hold a parent and infant through supporting their relationship. So this aligns really closely with my own experiences. I didn't have the language or the knowledge about the impacts of our traumatic birth and early postnatal experiences on myself, on my daughter, on our relationship and on my sense of myself as a mom.



(00:46:25):

And that contributed really significantly to the distress and the perinatal mental health challenges that I experienced and to how I was understanding and responding to my daughter's experiences and needs as she grew and developed. And that was for me through that lens of fear, shame, overwhelm, and feelings of failure, but it was through gaining that knowledge through my own recovery journey and the care that I had with PIMs that was so vital to my healing through making sense of our experiences, through bonding eventually after, because I think that was a really big thing for me, knowing that it is a real kind of spectrum of experience in terms of that bond and that connection and that feeling, that love. And for me, it did take time because there were all these additional layers and I just didn't know that that was actually part of the experience.

(00:47:20):

So yeah, through bonding with my daughter and healing through our relationship, I was able to move through guilt and shame and build confidence in myself as a mom and it really would've made such a difference to both of us if I'd been able to connect with that knowledge and support sooner.

(00:47:36):

Similarly to Ruby, breastfeeding was a really difficult experience for me. I was incredibly anxious about starting solids with my daughter as that felt so overwhelming. I was really isolating myself and really struggling to get out to attend appointments or do anything really that I'd expected to be part of my experience of new motherhood. And although there was care and support there, it felt really overwhelming and shaming for me and it brought more layers to the sense of failure that I was already feeling with that focus on the early parenting challenges that I did feel able to present with and not what was going on underneath those challenges that I needed support with, but I didn't know how or feel able to express and wasn't being picked up on. And I think for me, that really speaks to why and how perinatal peer support's so impactful and what it is that we as lived experienced peer workers bring to the support we offer and within the multidisciplinary teams alongside clinician knowledge and care, that we're able to hold space and offer that relational connection through mutuality and that safety to support both the parent and their infant from the perspective of having been there and being able to share knowledge and stories and hope from our own healing and parenting journeys, being able to say, "I've been there too, and I remember when I felt that way and you're not alone in this, to speak to the knowledge of attachment, attunement, co-regulation, infant development from the lived experience lens while you're also holding your own experiences and healing journey as a parent and walking alongside parents and being that relational anchor that supports them to engage with and navigate the care and the services that are there for them.

Vicki Mansfield (00:49:29):

Thanks, Ash. And I think what really stood out for me there is, and I think you said that in the last section as well, is that having a peer lived worker lens and then providing that within a team gives you a language and a way of describing it that lands differently than just talking about attachment, because



that's not a word we kind of use as a everyday language. So what does that really look and feel like, or what are those things underneath and you're bringing a lens that helps make meaning of it, which I think is so powerful and that can maybe, as you said, provide that recovery and compassion with a little bit more ease maybe. Yeah. Thank you for sharing. And you mentioned that process of recovery and one of the questions that come through earlier was around the lived experience values. Someone highlighted that it sounds like very similar to a recovery oriented framework and they wondered if there was a connection to there.

(00:50:49):

Is recovery kind of framework a familiar reference point within lived experience? Viv, I know you mentioned the values or ASH. Yeah. Does anyone want to comment on that question before we move along?

Jess Jackson (00:51:05):

The only thing that made me think of is that even though peer work is fairly fresh in a lot of services at the moment, it's actually been around for such a long time. And I remember doing our training for intentional peer support and they pointed out that peer support's been around even since the start of Alcoholics Anonymous. That was one of the first models of peer support and that I had to check back because I didn't know, but 1935, I think that started. So whilst I'm not very familiar with the recovery model, it obviously has been embedded very early on and that was about people who had addiction supporting others to support each other and it's that walking alongside each other as well, which I think

Vicki Mansfield (00:51:59):

Is really

Jess Jackson (00:52:00):

Important and not rescuing. That's another big thing as well. We're not here to fix anything. We can sit in the really dark in the really murky waters with everyone. And yeah, I guess we're a place to reflect and we can certainly discuss the problems, but it's really about walking with people and helping them to help themselves. It's certainly not about a quick fix because we had to go on that journey ourselves. We had to find our way. And if we think about our experience, if someone came along and said, "Oh no, just do this, this and this and you'll be fine. Your recovery will be fast tracked." Yeah, it doesn't work like that and that doesn't

Vicki Mansfield (00:52:41):

Sit

Jess Jackson (00:52:42):



Well.

Vicki Mansfield (00:52:43):

Yeah, that might feel quite dismissive by the sounds of it, Jess, if that's ... Yeah. So being alongside. Yeah. Thanks, Jess. That's really great to get that this is a long history that sits behind lived experience work.

Viv Kissane, OAM (00:53:01):

Can I also jump in there and add? So there are kind of core principles of lived experience and recovery orientated practise is one of them also things like strengths-based approaches, self-determination, dignity of choice, those types of things. But I think in terms of using the word recovery, I always like to really pull apart the difference between clinical recovery and personal recovery. And I think certainly when we're talking about in lived experience practise, we are talking about personal recovery because that's everyone's individual and what purposeful and fulfilling life is for them and that may be with or without medication, it may be with or without diagnosis. So it's really individualised.

Vicki Mansfield (00:54:04):

Yeah, great point. I think that's a really important clarification. Thanks, Viv. That's really helpful. And that leads us into probably the next question. So in our pre-registration process, we had a range of questions come in which were about the process of implementing lived experience peer work within services, organisations and systems. And so in that theme, I invite the panel to share from your experience what needs to be in place at a system and organisational level to successfully implement and support perinatal peer workers. We're talking specifically about tonight. Viv, you mentioned some frameworks or supervision, what helps implement a successful and well-supported perinatal peer lived experience workforce?

Viv Kissane, OAM (00:55:10):

So I think the first thing I would do is point people towards the lived experience governance framework. So that was published in 2023 by the National Mental Health Consumer and Carer Forum and Maline, which was the National PHN Lived Experience Body. And that's a really informative framework, which really speaks very specifically and identifies what's needed for sustainable growth of the lived experience workforce. So it speaks to things like fidelity around lived experience practise. It talks about organisational readiness and actually has a little bit of a toolkit and a checklist that services can use to see if they're ready for embedding lived experience into their model. It talks about the importance of role clarity. It talks about having the importance of having career pathways and those important opportunities for growth in their career and also speaks to what the embedded supports that are really needed for that continuous development such as reflective practise or supervision.

(00:56:30):

So that's a really good document as a starting point I would point people



Vicki Mansfield (00:56:36):

Towards. Having that document, you mentioned reflection supervision. I know there was interest in that in our first webinar as well. What does that look like for peer lived experience workforce? Is it the same or different to clinical reflective supervision?

Viv Kissane, OAM (00:57:00):

So I would say it's probably not too dissimilar in terms of that it's really creating an intentional space to really be reflective around how we have been using our lived experience in a way that supports safety and quality and sustainability. So I can speak a little bit to how we do that at Peachtree and Jess and Ash have probably their own experiences within their employment as well, but we've actually created a peer practise pathway at Peachtree and it really is just a map in terms of all the different ways that we can have reflective practise in our day-to-day jobs, I suppose. So that reflective practise is self-inquiry or curious questioning of yourself, but it's also debriefing after every group or programme that we deliver. It might also be a direct line manager in terms of talking about operational issues as well. Operational is very distinct and different from practise conversations.

(00:58:23):

And then it also talks about group reflection in terms of community of practise and then also the external supports that we can lean into such as an EAP or independent supervision.

Vicki Mansfield (00:58:43):

So some of that organisational readiness is about the systems ensuring that they put time and energy and structures in place for all those things to occur by the sounds of it.

Viv Kissane, OAM (00:58:55):

Absolutely.

Vicki Mansfield (00:58:56):

Yeah. And Ash and Jess, do you want to add anything there around reflections around the importance of reflective practise and supervision or in terms of the broader question around what's needed in a team or system of care for implementing peer work?

Jess Jackson (00:59:17):

Do you want to go first, Ed? I don't want to follow Viv. She's too good.

Ash Allan (00:59:21):

Oh, okay. Yeah, I can go. Thank you so much for your wisdom, Viv. Yeah, it's so vital that we're guided by lived experience, peer workforce guidelines and frameworks and by leaders in the perinatal lived



experience peer space, including PEACHTREE and PANDA as well for the intentional and informed establishment of perinatal lived experience peer roles. It's really important to acknowledge that in established health systems and services, the perinatal space is an emerging space for lived experience peer roles and that the perinatal peer role is a specialised role within the broader lived experience peer workforce. That's reflective of the unique complexity and vulnerability of the perinatal period and the additional layer of knowledge and skills and scaffolding that's required for meaningful, safe, and sustainable lived experience practise in this space. I've had the privilege of being part of establishing and embedding perinatal peer worker roles within perinatal and infant mental health service as well as the Nurturing Connections Programme, which is a newly established innovative programme within New South Wales, an early intervention programme that prioritises relational connection and collaborative care that wraps around families and it's responsive and flexible to be guided by them.

(01:00:48):

It's focused on supporting the development of vulnerable infants and kids through supporting the caregiver-child relationship, parental mental health, and the social needs of vulnerable families in partnership with local NGOs. So yeah, I've had the opportunity to be part of developing the programme alongside PIM clinician colleagues and the unique lens that I brought as a perinatal lived experience peer worker was deeply and equally valued. I'm now working alongside other incredible perinatal peer workers across the Nurturing Connections teams to continue to shape our practise as a programme and as a lived experience workforce as part of deeply connected and values aligned multidisciplinary teams. We're involved in the ongoing evaluation, the continuous process of learning, growth, and development of the programme guided by the lived experience expertise of our families. I've been really incredibly fortunate to work with people in leadership roles within services who deeply value the perinatal peer worker role, what we bring to the multidisciplinary team and the families we support.

(01:01:55):

They're willing to navigate our emerging workforce alongside us, advocate for and invest in us as we continue to develop our scope of practise and our models of care in ways that honour and hold the integrity of our lived experience roles. And as we establish what's needed in terms of structure and scaffolding for the co-reflection and perinatal lived experience peer supervision, that's vital to our practise and for our continuing professional development.

Vicki Mansfield (01:02:27):

And Ash, really highlighting, that's so fantastic. You highlighting the layers of things that ... Last webinar we spoke about the individual support for individual peer workers that might be required in the training, but you're also highlighting that there's a role in regards to co-design and clear valuing of that contribution across an organisation and also the importance of leadership having a curiosity, but more than a curiosity, a real intention to that to be a really pivotal part of the system of care, which I think sounds really important in terms of both providing, I think Viv said, that clear role and clarity around it. Yeah. Anything you want to add, Jess?



Jess Jackson (01:03:31):

Yeah, I get really excited listening to Vivint Ash just talking about all the wonderful work that they've done and just showing how far peer work has come and just the values that it embodies and just how it's really becoming embedded in that perinatal space and the mental health service and just what a difference it's making. So thank you both first of all for that And just echoing what they've said as well, just I think our service is quite similar and obviously puts a lot of weight on the importance for supervision, co-reflection, debriefing, as well as our training. And I think it's just highlighting again, it's really important to do those things, especially with supervision correflection and debriefing with the multidisciplinary clinical team as well as with the lived experience team. And just in terms of what it's like on the ground working within a multidisciplinary team, I think the great thing is that we learn a lot from each other and there are times, especially if I've been with a family and if it's about family violence, for example, where I feel a little bit out of my depth and want to know how to support the family, I've found that they've been extraordinarily supportive with me sort of talking things through on the debrief and letting me know I guess different perspectives, especially when I think the first time I did it, I felt a real emotional pull and we continue to be empathetic, but we need to be good at our jobs and not be taking it home and supervision in the same way, like having a team leader supervision, so clinical supervision is so helpful but completely different to a lived experienced supervision.

(01:05:36):

And then there's also external supervision where someone can be a devil's advocate and not be sitting in your service and not knowing everyone that you're talking about. So all of those things have been really invaluable to me as well.

Vicki Mansfield (01:05:49):

And the importance, I think, again, of the layers there, which really stand out for me, that there's the training, there's the leadership support, there's the reflective and intentional practise. And as Ash, I think you highlighted that really importance in terms of perinatal peer support work is some sort of really pivotal understandings of knowledge around that space, your lived experience, knowledge, but also some other aspects of social prescribing, like we've started our conversation with today as well. There are a few questions. Actually, there's lots of questions and comments, some really amazing comments around everybody's sharing of their insight, but there was a question from Ali, and I'm not sure whether this is one we'll be able to answer, and that's okay if we can't, but thank you for this insightful session. As a psychology student from Pakistan, I'm next, which that's probably a bigger question than we can answer here, but I was, are there

Jess Jackson (01:07:16):

Any global- So sorry, you froze for me. Did you-

Vicki Mansfield (01:07:19):



Yeah, me too. I didn't hear the question. I dropped off for a second. Yep. I'm getting several messages there that I dropped off for a minute, but we had a student psychology student wonder whether there was any global models of peer support, lived experience work being implemented outside of Australia. And that may not be within the knowledge base, but do you guys know of any examples outside of Australia?

Jess Jackson (01:07:52):

Intentional peer support. So IPS is one of the most respected trainings in peer support. It is a little bit more consumer peer support focused, but it is also for family and care, lived experience workers. That is an international model. So it has been delivered in Australia, unfortunately it looks like that's either finishing up or maybe they're just sort of recalibrating, but yeah, it definitely-

Ash Allan (01:08:25):

Recalibrating. ...

Jess Jackson (01:08:27):

Offered worldwide. Yes. It's a little bit of a watch this space at the moment, but it still can absolutely be accessed worldwide.

Vicki Mansfield (01:08:34):

Yeah, thank you. That's really helpful. I knew that there might be some wisdom sitting amongst you all. The other question that stood out, we spoke about supporting non-birthing parents and dads, but there was a question, what are the effective ways of supporting parents with a toddler adjusting to a new baby in the family? And this stands out for me in that we spoke about Baby Mia at six months starting solids. Those first five years are so many changes for an individual bub, but that also sometimes can mean that siblings, they already have siblings, they might be second bub, et cetera. But yeah, how is peer support work helpful in that context? I'll leave it open to anyone to offer that.

Viv Kissane, OAM (01:09:33):

Well, I think first and foremost, the beautiful thing about peer support is you're not alone. This is something that we've also experienced. This is something you're connecting and building relationships of support with other people who are kind of at the same stage of life with you and having similar experiences in terms of those challenges. And that can be just extremely validating and so helpful just on that particular point

Vicki Mansfield (01:10:11):

That you're not alone and that to again, draw on the collective experience of people and having that awareness of how they make meaning of managing too. I know managing 23 months apart felt like a



whole new world again. So yeah, thanks. Yeah. Any other comments anyone wants to add in there? Yeah. And there was also the peer support framework that we mentioned. We'll add that into the resources. Someone asked if we can add that into the resources which we can. And this was a question, I think we had this last time, but I will ask again, is Peachtree a service in Queensland only or is it a national service? Viv, I think you have affirmed that you are growing in Queensland, but just Queensland at this point?

Viv Kissane, OAM (01:11:12):

At this point, yes. So we now have seven parent wellbeing centres spread between Cairns and the Gold Coast and approximately 50 lived experienced staff members that deliver those services. And I think if I had a dollar every time someone said to me, "We want Peachtree to come to our part of the country, I probably wouldn't need government

Vicki Mansfield (01:11:40):

Funding." And in terms of workforce development, thinking about that last question in terms of building up the capability of peer support work, are there any other recommendations from any of the panel members about services? I know Peachtree has a capability framework that's being developed. Any other recommendations for resources that people can access in terms of if there's a ... Yeah, I know you mentioned a few early, but yeah, any other final ones before we move to our last point of reflection?

Viv Kissane, OAM (01:12:19):

No, I just give a plug for our perinatal mental health lived experience capability framework that has basically been built after about 10 years of us using this workforce and looking at some core competencies. So at the moment we've kind of mapped what that capability is at a very broad level, which is very peer work type of foundational skills and we're really excited that we will be commencing to further broaden that out and to add that perinatal specialisation into it.

Vicki Mansfield (01:13:01):

Yeah. Awesome, Viv, which is fantastic document for people to resource to make meaning of the potential aspirations of how, but also of the logistics of what training and the values and those principles and guiding kind of frameworks. So yeah, thanks so much.

Viv Kissane, OAM (01:13:23):

I think it can be really hard sometimes to articulate exactly what it is we do because sometimes it might just look like we're sitting on the couch and having a coffee in a chat, but the purpose of the framework was to really try and pull that apart and really be clear around what are the skills that we are using in those moments.



Vicki Mansfield (01:13:47):

Yeah. So there is a rich lot of skills which I can certainly hear reflected in our discussions tonight. We started this evening thinking about the experience within NICU and we heard those pivotal roles and the advocacy, Jess, that you spoke about and highlighting that advocacy, we spoke about the transitions and how important and pivotal perinatal lived expertise is in supporting continuity of care, helping families navigate systems and helping families navigate and making meaning of some of their experiences in a way that's alongside rather than the medical model and linking and thinking about those social prescribing. So some really rich discussion I think that really represents the values and the strengths that you bring to the workforce. So thank you very much for sharing. And for us to finish up tonight, we have a final question if you don't mind each answering your gold nugget take home that you'd like our audience to consider around the lived experience role in perinatal.

(01:15:14):

Yeah, what would you like our audience to take home? I'll go from the bottom up this time, Viv.

Viv Kissane, OAM (01:15:20):

Okay. I guess what I'm hoping is that everyone recognised that lived experience really strengthens and offers complimentary and really valuable and different support. So it should equally be respected as a professional discipline alongside other health disciplines. And I guess I hope that everybody feels a little bit more informed and hopefully inspired to go away and have a think about how lived experience might add value into the way that they're practising .

Vicki Mansfield (01:16:03):

Yeah. And I can see lots of inspiration in the chat as well. Thanks, Ash. Do you want to share what you'd like people to take away tonight?

Ash Allan (01:16:12):

Yeah. So just thank you everyone for being here tonight or watching the recording. And it is so inspiring that there's so much interest and passion for lived experience expertise in the PIM space. I hope that people will take away that lived experience peer practise offers a framework for intentional, safe, and sustainable relational practise where connections grounded in our shared humanity, where we build trust and foster safety. And through that relational safety, parents, infants, and families are nurtured and supported to thrive. And it's this relational practise and care provision that's vital for all of us in the perinatal space for families, for clinicians, for services and systems. I hope everyone leaves inspired to advocate for the transformation of perinatal care through embedding the perinatal lived experience peer workforce and I'll need to give a dollar because I hope everyone advocates for Pinch Tree across Australia

Vicki Mansfield (01:17:08):



Inspirational. Thank you so much Ashley and Jess. Oh,

Jess Jackson (01:17:13):

Thank you. I'll give you another dollar please.

(01:17:18):

Yeah, I love that so many people have joined this webinar and the last one. I think it's amazing to show how far peer workers come and how valued it is. And I know sometimes it can be a great unknown if it hasn't been embedded in the service. So I hope we have help to share what our work is about, what our values are and how we can really connect with families and help bring about change and how we're an enhancement for the clinical services that are already there and that we really can work together so well with the same common goal, just coming at it from different directions. So hopefully we've given everyone the confidence to either work with lived experience or to think very seriously about embedding us in their service.

Vicki Mansfield (01:18:08):

Awesome. It's been my privilege to share the two webinars with our panellists and thank you so much for sharing your knowledge and expertise and we wish you all goodnight and thanks so much for sharing the last two webinars with us. Thanks so much. Thank you,

Jess Jackson (01:18:27):

Vicki. Thanks everyone.

Ash Allan (01:18:29):

Thanks everyone.