Kimberley Mums Mood Scale
KMMS

Training Manual
A perinatal mental health screening and assessment tool designed and validated for use among Kimberley Aboriginal women to identify depression and anxiety.
Acknowledgements

We would like to acknowledge those who have helped shape the Kimberley Mum’s Mood Scale (KMMS) including:

- Over 200 Aboriginal* women from across the Kimberley who were involved in the development and validation of the KMMS.

- The many midwives, child health nurses, Aboriginal health workers and health staff across the region who shared their knowledge and experience throughout the process.

- Ms Jayne Kotz who asked the question of East Kimberley Aboriginal mothers “how could we be better at screening and supporting Aboriginal women experiencing perinatal mental health concerns?”. This enquiry initiated a long, fruitful and collaborative journey with Aboriginal women and health providers across the region to develop the KMMS.

- Members (past and present) of the research team during the development and validation of the KMMS including: Ms Jayne Kotz, Ms Melissa Williams, Ms Sudha Coutinho, Ms Meleseini Tai-Roche, Dr Julia Marley, Ms Donna Stephen, Dr Catherine Engelke and Dr Stephanie Trust.

- The organisations throughout the Kimberley who supported the development of the KMMS, in particular: Kimberley Population Health Unit, Kimberley Aboriginal Medical Service, Derby Aboriginal Health Service, Yura Yungi Medical Service, Nindilingarri Cultural Health Service and Kununurra Hospital.

- The following organisations for their funding support for the KMMS project and training: Kimberley-Pilbara Medicare Local, Women’s Health Clinical Support Program (formerly WA Perinatal Mental Health Unit) - Women and Newborn Health Service, Rural Clinical School WA - University of WA and the National Perinatal Depression Initiative.

- The WA Perinatal Mental Health Unit Edinburgh Postnatal Depression Scale and Queensland Health Psychosocial Training manuals which informed the development of the KMMS Training Manual.

*Throughout this manual the term ‘Aboriginal’ has been used to describe Aboriginal and Torres Strait Islander people. No disrespect is intended.

KMMS (July, 2015)
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Photograph courtesy of Gaye Shepherd
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Social and emotional wellbeing in the perinatal period

The perinatal period is defined as the period from conception until 36 months after birth. This is a time of great change in a woman’s life, and it is common in this time for women to experience a wide range of emotions which can affect their social and emotional wellbeing.

Social and emotional wellbeing (SEWB) for Aboriginal people is defined as a multidimensional concept of health that includes not only mental health, but also encompasses domains such as physical health, connection to land or ‘country’, culture, spirituality, ancestry, family and community. SEWB is fundamental to the overall health, wellbeing and quality of life for Aboriginal people.

Having strong SEWB encompasses a balance and interconnectedness of all of these domains, not just for the SEWB of the individual but also of the whole community. When any of these domains are out of balance they can cause emotional distress for an individual, their family and the broader community.

Social and emotional wellbeing problems are distinct from mental illness, although the two interact and influence each other.

Given the degree of change encountered by many women during pregnancy and early parenthood, it is likely that most will benefit from increased support in the perinatal period, whether or not they experience psychosocial distress or depressive symptoms. Aboriginal women often receive this support from their family and community.

Psychosocial support can also be provided by health professionals caring for women in the perinatal period including midwives, child health nurses, parent support workers, Aboriginal health workers, general practitioners (GPs), obstetricians, mental health nurses and allied health professionals.
For some women, pregnancy and early parenthood can impact negatively on their SEWB and trigger symptoms of more serious mental health problems. The perinatal period offers a unique opportunity for identification of mental health concerns aiding prevention, treatment and recovery. Early intervention for women experiencing distress or depressive symptoms may help to prevent more serious mental health problems developing.

The likelihood of mental health problems developing is greater for women who have had mental health problems before, who do not have adequate support, or who have experienced cumulative difficult times (e.g. family problems, abuse or loss). For women who feel isolated either by distance, culture or both (e.g. women birthing away from family, community or country), the likelihood may be greater.

Pregnancy, childbirth and early parenting is a time of vulnerability for all women, but particularly for many Aboriginal women who experience inequity in health care as well as injustice and disadvantage more broadly. It is widely agreed that up to one in ten women will experience depression during pregnancy with the rates of anxiety thought to be even higher. Up to one in seven will experience depression or anxiety in the year after baby’s birth. The overall rates of depression and anxiety in Aboriginal women are higher than the rates experienced in the wider community. The 2012-2013 Aboriginal and Torres Strait Islander Health Survey found that the proportion of Indigenous people reporting high or very high levels of psychological distress in the four weeks prior to the interview was more than 2.7 times higher than of Non-Indigenous people in 2011-2012.

Key elements of supporting positive mental health care during pregnancy and early parenthood include considering each woman’s context, ensuring a trusting therapeutic relationship, supporting the woman’s emotional health, and tracking mother and infant wellbeing. In some situations, more intensive care such as psychological therapy or pharmacological treatment may be needed and may require referral to GP or specialist mental health services.

Promoting perinatal social and emotional wellness among Aboriginal mothers is important not only for women but also for their children, families and their community.

The KMMS assists professionals to understand a woman’s experience and can also assist in the early identification and appropriate support for women who may be experiencing psychosocial problems or depressive/anxiety symptoms.
Being culturally aware in your practice

Indigenous communities are as diverse as Indigenous languages. The Kimberley region covers about 423,000 km² with an estimated population of 35,000 people - half of whom are Indigenous. The region is known for its strong and significant Aboriginal culture and heritage that dates back more than 50,000 years (www.klc.org.au). The region is home to scores of language groups who span from the saltwater, to freshwater and into the desert.

Working towards cultural competence in our practice is a life time journey. Some professionals may be at the start of their journey, others further along the track and striving to enhance their practice.

Given the diversity of Aboriginal women living in the Kimberley, we encourage all professionals to work with open ears, eyes and minds. It is important to work in collaboration with Aboriginal health workers, SEWB workers and other cultural mentors within the communities to become culturally competent in your practice. Getting to know your local community, the mothers and the families with whom you are working, their values and beliefs and available resources is invaluable.

The journey of ‘knowing’ and ‘understanding’

Despite the diversity, there are common elements that promote and can affect resilience and support for families and communities. These include:

- The traumatic history that Indigenous Australians have endured which continues to have an impact today.
- The history of forced removal of children from families which has had an impact on Indigenous communities and has influenced the passing on of knowledge and skills in the area of birthing and parenting.
- Aboriginal women may feel fearful of being judged negatively by service providers, feel distrustful of mainstream services, or fear their baby may be taken away by child protection services.
- The strong connection to land, country and ancestors and spirits. Many Kimberley women are required to birth away from their traditional land/country and family which can cause much distress.
• The important role of Aboriginal Elders in decision making, teaching traditional skills and passing down knowledge, customs, stories and culture.
• The emphasis on the importance of family and community.
• The existence and importance of an extended family structure.
• The role of fathers who may become more involved as children grow up.
• The strong focus on family, kinship, culture, community, spirituality and humour which can provide strength.

Many Kimberley Aboriginal women do not speak openly about their pregnancy or baby until the baby begins to move (approx. 16 weeks).

Historically and culturally, Aboriginal men in the Kimberley have not had an active role during the perinatal period. Today, some Aboriginal men may not consider themselves a ‘Dad’ until the baby is born and therefore may not be active participants in the antenatal period. Grandmothers, mothers, aunties (who are also considered mothers) and sisters have the primary responsibility for supporting a woman’s social and emotional wellbeing during this time.

Ways of working in one community may not be appropriate in another. In some communities traditional rituals, healers and bush medicine may be used and different languages may be spoken within a family group. Kinship structure will also dictate who has the right to speak to whom and about what.

Aboriginal health workers can provide an important link between health professionals, and the mother, family and community. They can support health professionals by interpreting language and/or culture, and assist professionals shape their practice to enable them to work sensitively and successfully with women.

There are some general guides that can assist in ensuring you begin the journey to be culturally competent in your practice. Beyondblue have developed a guide for health care professionals to support individuals in understanding specific issues related to Aboriginal perinatal mental health. It can assist health professionals to work sensitively with Aboriginal mothers, fathers and families during this period. The KMMS supports this document as a useful tool to guide health professionals to work in a culturally competent manner. This document is attached in the training package and can also be viewed on the Beyondblue website. [http://resources.beyondblue.org.au/prism/file?token=BL/1081](http://resources.beyondblue.org.au/prism/file?token=BL/1081)

Further learning

Organisations in the Kimberley provide cultural awareness training and health professionals are encouraged to explore these options. Kimberley Aboriginal Medical Services Ltd (KAMS) has developed cultural safety programs in partnership with their member services throughout the Kimberley. Each program is specific to the language groups of a particular area in the Kimberley and provides local context.
Enriching your relationship with Aboriginal women

Rapport development made easier. “Where you from and who is your mob?”

When working with Aboriginal clients, building rapport is essential.

Culturally secure introductions involve two way sharing. Sharing some of your own personal information can assist to develop rapport. Remember the three important aspects to all Aboriginal people are family, spirituality and the land. Sharing where you are from, who is in your family, and how you find yourself on this country can be important for people to ‘place’ you in their world of understanding. Therefore, it is not good practice to get straight into business.

Building rapport often involves finding common ground, however it is not only about this. Frequently the starting-point to building rapport is demonstrating and acknowledging that you have a level of understanding and respect for the client and their uniqueness. The KMMS tool is an opportunity to hear and begin to understand a woman’s unique story.

Building solid rapport is a process that requires consistent effort. True rapport and trust may need to be established over time. Aboriginal women may not share their complete story with you in the first instance. They may wait and watch to see how you listen and respond before deciding to share further. Gathering the richness of a woman’s story using the KMMS may occur over several conversations. The initial meeting will alert women to your willingness to ‘hear’ their story with an open heart and mind.

The first few minutes of your initial interaction with an Aboriginal woman are crucial. If it does not go well, it may prove to be a lost opportunity. If you are unable to make her comfortable, it is likely that she will not communicate her concerns honestly and openly, and may not revisit the service.

Building rapport with an Aboriginal woman to the point where she is able to discuss her concerns with you, involves understanding and demonstrating respect for her cultural values and history. In addition, you need to respect that she may respond better to a different way or style of communicating from a non-Aboriginal woman. Both of these approaches will increase the possibility of a positive interaction. It is about being flexible and responsive, while at the same time creating an environment which is safe and open.

Many Kimberley Aboriginal people do not speak English as their first or second language and this should be considered when engaging with women and their families. Whilst the graphics in the KMMS can assist in communication you may need to engage an interpreter to ensure communication is clearly understood and that the woman can comfortably communicate her responses. The Kimberley Interpreting Service (KIS) can provide interpreters accredited by the National Accreditation Authority for Translators and Interpreters (NAATI) in more than 18 Kimberley and central desert Indigenous languages.

Kimberley Interpreting Service: 9192 3981   Mobile: 0439 943 612
Some hints for effective communication:

- Remain open and honest.
- Allow enough time for the appointment so that the woman does not need to be rushed. Be patient when waiting for replies.
- Be as flexible as possible with the time and venue of the conversation.
- Provide the opportunity for the woman to have a support person or family member present.
- Avoid technical language and medical jargon.
- Adopt a non-judgemental attitude and approach.
- Do not make assumptions. LISTEN to the story.
- Use open-ended exploring questions when attempting to get a picture of the woman’s experience.
- Acknowledge that you understand that certain issues may be embarrassing or difficult to talk about.
- Always check to ensure the woman has understood what has been said and that you understand what you have heard.
- Simplify written information as much as possible.
Mental health in the perinatal period

A person’s mental health and social and emotional wellbeing lies on a continuum which is not static. It is influenced by many factors; individual, social and environmental. Mental ill health is a section along the continuum which encompasses a variety of common mental health problems including the most severe mental disorders/illnesses.

Women will experience physical, emotional and social changes whilst pregnant and following birth. During this perinatal period, women are at the highest risk of developing mental health problems, with a varying range of severity and impact on functioning.

Following the birth of their baby, women may experience:

**Baby blues**
- Occurs in 8 out of 10 women (not considered abnormal).
- Occurs from third to tenth day post birth
- Usually passes within a few days but can take up to 1-2 weeks postpartum to resolve.
- Needs recognition, understanding, support, empathy and education.

**Symptoms of baby blues**
- Tearfulness
- Irritability
- Mood changes
- Anxiety
- Fatigue
- Feelings of sadness and loneliness

“The two most common things we see which alerts us to the fact that something may not be right is baby being left all the time with grandparents or other family members and an increase in drinking or drug use. We also see a withdrawal from everyone and the mother and baby will just stay in the room and not venture out. Aboriginal health workers knowledge of family members in the community can assist in identifying when there has been a change in behaviour and a home visit may be needed. Customary practice of law and culture may influence a woman’s ability to move around in the household or the community. Aboriginal health workers can be valuable in identifying whether behaviour is in response to customary practices”

_Senior Aboriginal SEWB Worker_
Depression

Antenatal depression is a depression occurring during pregnancy and is experienced by up to one in ten women.

Postnatal depression is a depression occurring within the first 2 years following childbirth and affects up to one in seven women.

There are varying levels of intensity of symptoms from mild to severe and so women may present with differing levels of distress. Aboriginal women may present with anger and/or irritability as the predominant feature of their depression rather than sadness.

Depression is a treatable illness.

**Symptoms of depression:**

Two or more weeks of depressed or anxious mood AND (at least 5 of the following symptoms):

- Decreased ability to concentrate
- Feelings of guilt
- Feelings of hopelessness or helplessness
- Loss of enjoyment (anhedonia)
- Less energy
- Weight gain or loss
- Disturbed appetite
- Disturbed sleep
- Loss of sex drive
- Suicidal ideas or acts
Anxiety disorders

Anxiety disorders are the most common mental health disorder in Australia. Common types include: adjustment disorder with anxiety, panic disorder, obsessive compulsive disorder, specific phobias, generalised anxiety disorder and post traumatic stress disorder.

Anxiety is a core protective response that is helpful in situations of realistic danger. It becomes problematic when the anxiety is more severe, out of proportion to the actual situation, long lasting and interferes with the woman’s ability to carry out her daily tasks and roles.

Symptoms of anxiety:
- Feeling restless or nervous
- Finding it difficult to relax
- Fatigue and/or sleeping problems
- Having a ‘racing mind’ - obsessional thinking and worrying
- Having a churning stomach or feeling nauseous
- Muscle tension
- Feeling a sense of dread
- Fears of going crazy or losing control

Acute episodes of anxiety:
- Feel anxious, frightened or a sense of impending doom
- Shortness of breath and/or chest tightness
- Dizziness or light-headedness
- Tingling in fingers
- Trembling or shaking
- Sweating
- Nausea

Further learning

KMMS recommends the Women’s Health Clinical Support Program Perinatal Anxiety Disorder (PAD) Training for further information and learning regarding anxiety disorders in the perinatal period.
Postnatal/postpartum psychosis

Postnatal/postpartum psychosis is a rare but serious perinatal mental illness which requires urgent specialist assessment and treatment. Experienced by one or two in a 1000 births. Psychiatric medication and hospitalisation are generally required to ensure the safety of the mother and infant. There is an increased risk for women with a history of bipolar disorder or who have experienced postnatal psychosis after previous births.

Symptoms of postnatal/postpartum psychosis:
- Suddenly and dramatic onset
- Disturbances in mood and thought processes
- Disjointed and bizarre thoughts (delusions)
- Disturbances in sleep
- Disturbances in behaviour – odd or bizarre

Further learning

KMMS recommends Aboriginal Mental Health First Aid (AMHFA) Training for health professionals who wish to increase their understanding and ability to identify and respond to those who may be experiencing mental illnesses. MHFA training is available throughout the Kimberley. Available courses and facilitators can be found on the MHFA website (www.mhfa.com.au).
Influences on social and emotional wellbeing and mental health

Social determinants of health:

- **Structural**: safe living environments, housing, employment, education and a supportive political structure.

- **Community**: a positive sense of belonging, social support and a sense of connection to family, community, land and culture.

- **Individual**: the ability to deal with thoughts and feelings, to manage life, emotional resilience and ability to cope with stressful or adverse circumstances.

Risk and protective factors

**Risk factors** increase the likelihood that mental health problems and mental disorders will develop and may also increase the duration and severity when a mental disorder exists.

**Protective factors** enhance and protect positive mental health and reduce the likelihood that a mental disorder will develop.

The KMMS provides an opportunity to identify risk and protective factors whilst listening carefully to a woman’s story.
## Mental health protective and risk factors in the perinatal period

<table>
<thead>
<tr>
<th>Protective factors</th>
<th>Risk factors</th>
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<tbody>
<tr>
<td>Supportive attachment to strong family</td>
<td>Being away from country or family</td>
</tr>
<tr>
<td>Attachment to country</td>
<td>Ongoing problems with family</td>
</tr>
<tr>
<td>Attachment to culture and traditions, including around the birthing process and perinatal period</td>
<td>Lack of current emotional or practical supports</td>
</tr>
<tr>
<td>Belief in traditional healing activities which assist the management of life stressors</td>
<td>Poor quality of relationship or absence of a partner</td>
</tr>
<tr>
<td>Personal sense of wellbeing, satisfaction with life, and optimism</td>
<td>Family violence (past or present)</td>
</tr>
<tr>
<td>Confidence to parent</td>
<td>Unwanted or unplanned pregnancy</td>
</tr>
<tr>
<td>Strong role models</td>
<td>Traumatic birth experience or unexpected birth outcome</td>
</tr>
<tr>
<td>Strong coping style, and problem-solving skills</td>
<td>Current major stressors or losses (e.g. bereavement, birthing away from community and family, or financial strain)</td>
</tr>
<tr>
<td>Strong social support systems</td>
<td>Past history of depression, anxiety disorder, or other psychiatric conditions</td>
</tr>
<tr>
<td>Access to appropriate support services</td>
<td>Depression in partner, either antenatally or during the early postnatal period</td>
</tr>
<tr>
<td>Secure base (including secure housing and finance)</td>
<td>Drug and/or alcohol misuse</td>
</tr>
<tr>
<td>Ability to ask for help when needed</td>
<td>Difficult relationship with own parents, particularly mothers</td>
</tr>
<tr>
<td>Confidence in negotiating the health system</td>
<td>Poor social skills</td>
</tr>
<tr>
<td></td>
<td>Unemployment</td>
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<td></td>
<td>Homelessness</td>
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Using the KMMS

The KMMS creates a base of understanding of a woman’s story. This understanding can increase engagement with a service and the early identification of issues or mental health problems. By accessing the right support the severity, duration and impact of these concerns on the woman, her infant, family and community can be reduced.

The KMMS takes between 30-60 minutes to complete with a woman. Some consultations may take less time if you already know some of her story.

Organisations need to plan on having enough time for staff to complete the KMMS. It is recommended that a separate extended consultation is booked to complete the initial KMMS early in a woman’s engagement with a service, so that an effective assessment and collaborative management plan can be implemented. This initial assessment may occur either antenatally or postnatally.

When to use the KMMS?

- As close to the initial booking appointment as possible. This is critical so that supportive measures can be put in place.
- Repeat at 28-36 weeks - checking on progress
- 6-8 weeks postnatally - checking on progress
- 3-4 months postnatally - checking on progress
- Anytime deemed necessary by a health professional to guide a conversation

Aboriginal women may not present regularly for their prescribed antenatal or postnatal checks therefore the KMMS may need to be used opportunistically.

Once a health professional completes a KMMS with a woman, subsequent KMMS conservations with the same worker, may take less time as the health professional will have heard some of her story. Regardless, at subsequent KMMS conversations, women should be given the opportunity to provide further information for each domain. She may wish to share more of her story, therefore increasing your understanding, or her circumstances may have changed. It is important that you consider the story already told and information already provided.

Practice guidelines:

- The KMMS is to be completed together, with the health professional sitting alongside the woman.
- Engagement, trust and rapport is important.
- The KMMS (both Part 1 and Part 2) needs to be completed in a conversational manner to get a holistic picture of the woman’s story. You may not hear the story all at once. It may become more complete, and your understanding much richer, over a period of time as the woman becomes more comfortable with you and realises you are genuinely enquiring and can respectfully ‘hear’ the story.
- The introduction of the KMMS is very important.
Exploring strengths and protective factors (see page 15) is crucial. These can help mitigate the issues and risks identified.

Management plans (see page 28) should be made with the woman’s involvement and agreement with a focus on reinforcing her protective factors and drawing on her strengths.

Introducing the KMMS to women

It is important that women who are screened with the KMMS:

- Understand the ‘universal’ use of the KMMS for Aboriginal women living in the Kimberley, ‘we ask all women these questions’
- Understand the purpose of the KMMS and the line of enquiry
- Give their consent to proceed
- Understand that when it is time to make decisions about whether follow-up is required, the type of follow-up needed (if any) will be based on the woman’s preference and your clinical judgement
- Understand the confidentiality of the conversation but also the limits of this confidentiality

Women have lots of different feelings when they are waiting for baby or when baby comes. We ask all women these questions so we get to know how they are feeling and their story.

Some women feel worried, sad or ‘no good’. Helping mum get the help she needs early can stop this ‘no good’ feeling inside get worse.

Having this yarn will help me understand what keeps you strong and what may be worrying you. It helps me understand your story.

Don’t be shame to ask for help. It is good to get support if you need it.

The Kimberley Mums Mood Scale has two parts and we will do them together.

First part is 10 simple questions about how you have been feeling over the last week.

The second part is when we will talk more about your story.

At the end we can see if we have understood each other and if there are any problems we can work them out together.

What we speak about is between us. If it needs to be shared with others we will talk about it first so you don’t need to keep repeating your story.

Is it OK with you if we do this together?
What do Kimberley Aboriginal women say about the KMMS?

“Good to talk to someone about how I feel in my pregnancy”

“Good to understand the questions and be able to open up and talk about anything”

“Thinking about my childhood brought up anger, but it’s OK - it’s good for health workers to know about our childhood to help us be in good health for baby physically and emotionally”

“The questions made me think, and thinking was good for me, because you understand me better now”
Determining your assessment

When listening to a woman’s story and considering the KMMS be aware of FLAGS.

GREEN: Strengths that support women – protective factors

ORANGE: Potential concerns – may alert you to something which you may wish to explore further as sessions progress

RED: Need to explore or address immediately. Primarily to do with safety issues: safety of mother, infant or others. A SAFER plan needs to be put in place (see page 23).

Part 1 gives you a flag score as a guide.
Part 2 assists putting the flag score into context.

Your overall judgement of whether a woman is at risk of experiencing a clinical depression and/or anxiety disorder should be based on the Part 1 flag score and Part 2 discussions.

Your clinical decision regarding the level of risk of depression and/or anxiety is moderated by protective factors and increased by factors such as the level of acute psychiatric distress or crisis, current abuse (including family violence), current drug and alcohol abuse and the presence of multiple environmental risk factors.

KMMS 4 Es for health professionals

- Enquire
- Explore
- Educate
- Encourage
KMMS Part 1

NB: KMMS Part 1 should always be used in conjunction with KMMS Part 2

Guidelines for administration

- KMMS Part 1 is to be completed together, with the health professional sitting alongside the woman.
- Provide the woman with a copy of the KMMS Part 1 document.
- Ask the woman to circle the response which comes closest to how she has been feeling in the last week.
- Remember, literacy may be an issue for some of the women you are screening. English may not be their first language and may be one of the many languages they speak. If this is the case, you may need to read the statement out loud and use the pictures to act as prompts. You may wish to point to the pictures as you read out the possible responses.

Scoring KMMS Part 1

- Use the KMMS Part 1 Scoring Sheet document to record the woman’s responses.
- Responses are scored 0, 1, 2, or 3 according to the severity of the symptom.
- The total flag score (30) is calculated by adding together the score of each of the ten items.

NB: Scores are a general guide only. Decisions should be based on clinical judgement when considering the woman’s entire story.

- High scores do not confirm a depressive illness but may flag a woman at risk and who will require further follow-up and assessment.
- The severity or clinical relevance of symptoms cannot be determined based only on a high score.
- The same score can reflect different presentations.

Remember

KMMS Part 1 provides a flag score. KMMS Part 2 assists by providing context for clinical judgement.
<table>
<thead>
<tr>
<th>KMMS flag score</th>
<th>Recommended action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Below 9</strong></td>
<td><strong>Educate</strong></td>
</tr>
<tr>
<td></td>
<td>Give basic information on perinatal mental health</td>
</tr>
<tr>
<td></td>
<td>Destigmatise perinatal mental health - eg common, can interfere with being the best mother they want to be and there are things that can help</td>
</tr>
<tr>
<td></td>
<td>Open the door for woman to come back and have another conversation if things change</td>
</tr>
<tr>
<td></td>
<td>Don’t forget clinical judgement - if you feel the women’s score is incongruous with her presentation persevere with your enquiries</td>
</tr>
<tr>
<td><strong>9 or over</strong></td>
<td><strong>Enquire</strong></td>
</tr>
<tr>
<td>Reasonable risk the woman may have depression and or anxiety disorder and other information is required and needs to be considered in context of KMMS Part 2.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How long have you been feeling this way?</td>
</tr>
<tr>
<td></td>
<td>Have you ever had times of feeling really no good (depression) or had times when worry has really got in the way (anxiety)?</td>
</tr>
<tr>
<td></td>
<td>What do you know about ‘depression’ and ‘anxiety’?</td>
</tr>
<tr>
<td></td>
<td><strong>Explore</strong></td>
</tr>
<tr>
<td></td>
<td>What supports are available - partner, family or friends</td>
</tr>
<tr>
<td></td>
<td>What has helped in the past when you have felt this way?</td>
</tr>
<tr>
<td></td>
<td>What do you think would help now?</td>
</tr>
<tr>
<td></td>
<td>Do you feel comfortable talking to the Doctor (or mental health mob) about how you are feeling?</td>
</tr>
<tr>
<td></td>
<td><strong>Educate</strong></td>
</tr>
<tr>
<td></td>
<td>About depression and anxiety including signs and symptoms and services for help</td>
</tr>
<tr>
<td></td>
<td>The importance of seeking help early</td>
</tr>
<tr>
<td></td>
<td>Services which are based or visit the community which may be helpful</td>
</tr>
<tr>
<td></td>
<td><strong>Encourage</strong></td>
</tr>
<tr>
<td></td>
<td>Activating supports within family/community</td>
</tr>
<tr>
<td></td>
<td>Further assessment if there are concerns about depression or other mental illness with GP/other health provider specialist mental health service</td>
</tr>
<tr>
<td></td>
<td>Linking with other services who may support the woman</td>
</tr>
<tr>
<td><strong>Question 10: Risk to self or others</strong></td>
<td><strong>ANY rating requires further enquiry and exploring.</strong></td>
</tr>
</tbody>
</table>
Responding to question 10

It is important for health professionals to know that enquiring about suicide or self harm does not increase the risk of someone having or acting on suicidal thoughts. In fact, asking the question can reduce the likelihood of suicidal behaviour as a woman is able to share her distress, which can be a protective factor as it allows appropriate support to be put into place.

Enquire
- Tell me more about these thoughts or feelings.
- When you say ‘thinking about doing something bad’ – are you talking about doing something to yourself, or others (baby, partner, family) or both?

Explore for presence and level of risk
- Sometimes when people are feeling ‘no good’ they feel like life is not worth living. Have you had any thoughts like this?
- Have you had thoughts about killing yourself?
- Have you felt so ‘no good’ in the past that you have hurt yourself? (History)
- Do you feel like lashing out or doing something bad to others?
- Do you feel like that towards baby?

Explore the following for each of the risks identified above:
- When was the last time you had any of these thoughts?
- How often do these thoughts come? Are they with you most of the time, or do they come and go? (Frequency)
- When are they worse? (Situation/Environmental stressors)
- How strong are these thoughts? (Intensity)
- Have you got to the point where you have been thinking of ways of hurting yourself (or others) or made a plan? (Plan)

Explore for protective factors
- What stops you from listening to these thoughts?
- What has helped in the past?
- Do you have people around you who are a support?
- Who can you turn to if the thoughts become too strong?

Refer for further assessment as required

A response by a woman of ‘yes always’ or ‘yes sometimes’ requires a health professional to have a clinical discussion with a GP or mental health professional regarding the woman’s presentation and to complete a referral for further risk assessment.

High risk – needing immediate action
- Suicidal plans and intent, unsafe to leave clinic- requires emergency specialist mental health assessment- this can be done by an experienced practitioner, GP, or mental health professional
Moderate risk

- Suicidal thoughts over the last week but denies intent or plan and has supports in place.
- Consultation with a GP, a mental health professional or someone more experienced in this area is recommended and a full assessment of risk should be completed.
- Recommend informing and involving family or others in the community (with consent) to provide increased support to assist maintaining safety due to woman’s vulnerability.
- Women should only leave the appointment once a SAFER plan (see below) is completed and the women and her family or supports are aware of actions to take if suicidal ideation increases in intensity.

In remote areas access to immediate further face to face risk assessment may not always be readily available by a GP or a mental health professional. Telephone support is available for health professionals to assist with risk management decisions.

Rurallink: 1800 552 002
TTY: 1800 720 101

Rurallink provides services to both clients and health professionals. During business hours you will be connected to your local mental health team in the Kimberley. After hours and on weekends your call will be transferred to experienced mental health staff who can assist you with management plan decisions.

The information you have gathered from your exploration of a scored response for question 10, including intensity and frequency of thoughts, current plan, past attempts, current stressors and protective factors will assist in your conversation with a GP or mental health professional to ensure an appropriate risk management plan can be developed.

A SAFER plan

A SAFER plan needs to be in place prior to a woman at moderate to high risk leaving the appointment and returning home (or place away from the home) safely.

A SAFER plan involves the following:

- Support and supervision, a safe place to stay, not alone and removed, protected from possible stressors
- Appointment time for follow-up
- Follow-up treatment arranged
- Engagement with the plan
- Resolution or partial resolution of the crisis (something has changed for the better)

Further learning

KMMS recommends ASSIST training for health professionals who wish to become better equipped with responding to suicidal ideation. ASSIST training is available through the Kimberley StandBy Suicide Response Team (www.anglicare.org.au).
KMMS Part 2

KMMS Part 2 compliments information gathered in KMMS Part 1 by providing a more comprehensive understanding of a woman's story. This part of the KMMS aims to identify protective and risk factors that may influence a woman's social and emotional wellbeing.

**Rationale for the key domains:**

Six key domains have been identified as being highly significant in contributing to poorer outcomes in maternal and infant mental health.

1. **Lack of support**
   - Absence of a partner, poor quality support from family or partner and social isolation are significant factors in predisposing women to depression, whereas for women with depression good support of any nature can reduce the impact of mental health problems.

2. **Major stressors**
   - Current stressors or stressors over the last year increase a woman's vulnerability to mental health problems.
   - Stressors may include an unplanned or unwanted pregnancy, a medically complicated pregnancy or birth, relationship difficulties, unstable accommodation, financial difficulties, or experiences of grief and loss.

3. **Low self esteem/high anxiety**
   - Strategies such as engaging in activities which connect women to strong family, culture and country, self nurturing, exercise, stress management and seeking help for problems can all help strengthen a woman's ability to manage difficulties and increase her coping abilities.

4. **Couples relationships/family violence**
   - Domestic violence increases risk of perinatal mental health problems.

5. **Adverse childhood experiences**
   - Past childhood abuse, exposure to physical, sexual or family violence may impact on a woman's mental health.

6. **Mental health issues INCLUDING substance use and misuse**
   - Women with a personal or family history of depression or other mental illness have an increased vulnerability to developing a mental illness during the perinatal period.
   - Substance misuse can also increase vulnerability.
   - It is important women have a basic understanding about perinatal mental health, perinatal illnesses and the avenues for help.
   - If currently on psychotropic medication it is important that the woman discusses her medication with her treating doctor to be educated about the risks and benefits of using medication in the perinatal period.
The KMMS Part 2 Psychosocial Screening Guidelines document provides prompts to support the enquiry and exploration of the key domains. We encourage clinicians to work with their Aboriginal colleagues to consider how to rephrase these questions to suit the women they are working alongside whilst ensuring the spirit of the questioning remains intact and the domains covered.

**Asking hard questions**

As a part of the screening process, you may feel anxious or worried about the questions that you will be asking:

- How will I ask the question?
- What if the client discloses?
- What will I do?

Practicing how to frame the screening and psychosocial questions improves your confidence, and with procedures in place, the process will soon become a skill. Talking to others about how they ask the questions will also help to improve your confidence.

- Develop a process with your team and/or supervisor on how to follow up if you remain concerned about a client following a screening with a disclosure.
- Offer and utilise peer supervision and support.
- Discuss the issue with your supervisor to review feelings, actions and outcomes and any need for follow-up.

**Managing your own anxiety – some strategies**

- Be clear about your role so you can let the woman know how you can assist or support her.
- Know what services and community resources are available to support women or where you can go to get this information.
- Know your local referral pathways (Refer to the Kimberley Perinatal Mental Health Referral Options document on the KMMS website).

**Remember**

Listening and empathy are the two key factors of good communication.
Checking your understanding of the story

Thank you for sharing your story
You have told me about a lot of things which keep you strong like...
You have also told me about some of the hard things like...
Would you like some help with any of those hard things?
Guide to determining risk of clinical depression and/or anxiety using the KMMS

NB: This is a guide ONLY.

Clinicians are asked to consider protective factors which may adjust the overall risk.

<table>
<thead>
<tr>
<th>KMMS Part 1</th>
<th>KMMS score less than 9</th>
<th>KMMS score 9 or greater</th>
<th>KMMS score 9 or greater</th>
</tr>
</thead>
<tbody>
<tr>
<td>KMMS Part 2</td>
<td>Consider cumulative effect of the following</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domains</td>
<td>Primary relationships and support</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Minimal social stressors</td>
<td>Some social stressors within the last year</td>
<td>Multiple social stressors within the last year</td>
</tr>
<tr>
<td></td>
<td>Strong family support</td>
<td>Reduced family support</td>
<td>Minimal family support</td>
</tr>
<tr>
<td></td>
<td>No history of family violence or abuse</td>
<td>History of family violence or abuse</td>
<td>Current family violence or abuse</td>
</tr>
<tr>
<td>Major stressors</td>
<td>Nil identified</td>
<td>Recent experience of grief and loss (including anniversary of loss)</td>
<td>Current experience of grief and loss (including anniversary of loss)</td>
</tr>
<tr>
<td>Personality factors and coping</td>
<td>Strong sense of self</td>
<td>Self doubt/self critical</td>
<td>Low self esteem/highly critical of self</td>
</tr>
<tr>
<td>Mental Health history and current issues (incl. substance misuse)</td>
<td>No past history of mental illness</td>
<td>Past history of mental illness: no current symptoms and/or well maintained on current treatment.</td>
<td>Current symptoms of mental illness/non-compliant with treatment</td>
</tr>
<tr>
<td></td>
<td>No current drug and alcohol misuse</td>
<td>Current drug or alcohol misuse</td>
<td>Current drug or alcohol abuse</td>
</tr>
<tr>
<td>Suicidal Ideation</td>
<td>Refer to ‘Responding to Question 10 Guidelines’ for suggested actions (see page 22). (NB: Suicide is a behaviour and not a mental illness. It may occur concurrently with a mental illness and should be assessed fully by a GP/mental health professional to determine if there is an underlying mental illness)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suggested ACTIONS</td>
<td>Maintain routine appointments and monitor for changes in mood/behaviour which may indicate deteriorating mental state</td>
<td>Arrange mental health assessment with GP/mental health professional to assess for depression/anxiety Non-urgent assessment Increase support through service NB: If risk of suicide identified follow suicide action guidelines</td>
<td>Arrange mental health assessment with GP/mental health professional to assess for depression/anxiety Increase support/monitoring through service till referral has been activated NB: If risk of suicide identified follow suicide action guidelines</td>
</tr>
</tbody>
</table>
Where to from here?

**Management plans**

Management plans are living documents that need to be developed with the women and reviewed regularly. In summarising the KMMS, you will have asked the woman what she thinks are the important things to address first. Your clinical judgement is also an important consideration.

Consider the influence and meaning of each identified risk and protective factor (see page 15), and the overall picture. This helps to determine a final decision about a) risk, b) priorities and c) strategies for a management plan. A considered use of the information provided can increase the likelihood of engaging supports and/or referrals into the most appropriate care pathway.

Women may feel overwhelmed with their situation and may require support to find appropriate solutions to the problems they face. One way to assist is to work together to set down the ‘problem’ or goal and then list all the possible solutions. It can be helpful to look at each solution in turn, thinking about the ‘good’ and ‘not so good’ points of each. This can help the woman identify which solution is best suited to her and can help put a plan of action into place. It is important to follow up on the action and see if the desired result was achieved.

Safety issues need to be addressed as a priority. A SAFER plan needs to be developed (see page 23).

**Further supports and referrals**

After consideration and discussion with the woman around the KMMS you may wish to encourage her to engage further supports. These may include family, friends, community or professional supports. Consider the most suitable referral pathway or support required to address the issues identified.

Women may feel nervous about engaging professional support due to ‘shame’ and fear about mental health problems. It is important to enquire around her hesitancy to access services as you may be able to provide her with information or problem solve potential barriers to alleviate some of her fears. You have an opportunity to be a good role model for help seeking behaviour. Consider your own beliefs and attitudes to mental health problems and help seeking behaviour and how you may directly or indirectly influence a woman’s decision.

Referral options in each town or community in the Kimberley vary and can also change as new services are introduced or others cease. It is important that you are aware of the services available for women in your community to address varying psychosocial needs. The Kimberley Mental Health Referral Options document provides local referral options and is available on the KMMS website. This is a living document and you are encouraged to provide updated information to your regional maternal and child coordinator as you become aware of outdated as well as new and useful support services.

Not all women will need to be referred to a specialist mental health service. Care pathways depend on the story you have heard and what your clinical judgement is telling you. Other factors such as housing issues, family violence, and financial stress can also cause a decline in social and emotional wellbeing – it may not be a psychiatric problem.
Regardless of who else a woman engages with for support, you as a health care provider will continue to have an ongoing role in supporting her. Your regular contact is therapeutic and may be all a woman needs from you to feel supported in her journey.

**Remember**

You will not be able to ‘solve’ all the concerns a woman has. However, having the knowledge of some of the challenges she is facing can assist you in being realistic and compassionate in your approach when working alongside her.
Support for health professionals

**Supervision**

Support and supervision is important for all health professionals - especially for those who are working in rural and remote areas with often complex case presentations.

The KMMS encourages all health professionals to access appropriate supervision - both clinically and culturally. Supervision can be through peers (at the same work place or elsewhere), line managers, more experienced health professionals or external providers.

**Appropriate and regular supervision can allow a space to:**

- Reflect upon the content and process of your work.
- Develop skills and knowledge.
- Provide an opportunity to be validated and supported for the work you are doing.
- Share difficulties and concerns. Sometimes this may involve exploring solutions and at other times it may simply be about having the opportunity to be heard.
- Talk through personal distress or concerns that may be raised though the work you are doing.

**Case discussions and secondary consults**

As a health professional you may feel unclear whether to refer a client to a specialist service or may want to talk through the presentation to feel confident around your clinical decisions. A case discussion or secondary consult can be a useful avenue.

This can occur during supervision sessions but you may wish to discuss the case outside of supervision time slots.

At times you may wish to discuss the case with someone whilst the woman is still in your room to assist in developing a solid management plan.

**Options include:**

- Talking with colleagues including Aboriginal health workers, senior staff, GPs or child and maternal health coordinators.
- Contacting triage or intake person of appropriate services (e.g. Boab Health Services or the Kimberley Mental Health and Drug Service)
- Contacting Rurallink: 1800 552 002
Caring for your own social and emotional wellbeing

Your self-care skills, or the ability to look after yourself, are important skills for health professionals to have when working in challenging rural or remote practice settings. Many self care issues can arise when living in small and sometimes isolated towns and communities, and when working with clients from a different cultural background than your own.

Knowing how to care for yourself is critical. Take a moment to consider how balanced the circles are for your own social and emotional wellbeing.

At times you may feel you need external support for your own social and emotional wellbeing. The Bush Support Line is a confidential, free 24-hour telephone service that is staffed by psychologists with experience working in rural and remote areas. The service offered is tailored to the individual's situation, with the capacity for repeat callers to speak to the same psychologist. Confidentiality for the caller is guaranteed and the caller can remain anonymous if they wish.

**Bush Support Line 1800 805 391**

Most employers have an 'Employee Assistance Program' (EAP provider) to support you access confidential and free counselling. Contact your manager or the Human Resources department of your organisation for more information.

You could also discuss a mental health care plan with your GP and a referral to counselling or a mental health service for support (e.g. Boab Health Services or the Kimberley Mental Health and Drug Service)

*Remember*  
Getting help early is as important for you as it is for the women you work alongside.
Think about the past 7 days, not just how you feel today.

KIMBERLEY MUMS MOOD SCALE (KMMS)

Part 1

4. I worry too much and don't know why

3. I blame myself when things go wrong

1. I can sit down and have a good laugh

5. I feel frightened and shaky a lot

6. I can't handle all the stress or I stress out

8. I can't sleep because I am sad or think too much

9. I am so sad I have been crying

10. I think about doing something bad to myself or others

Yes, always
Yes, sometimes
No, never
No, not much

2. I look forward for good things to happen

7. I feel really no good, like no-one loves me

Documents
Think about the past 7 days, not just how you feel today.

1. I can sit down and have a good laugh
   - Yes, always
   - Yes, sometimes
   - No, not much
   - No, never

2. I look forward for good things to happen
   - Yes, always
   - Yes, sometimes
   - No, not much
   - No, never

3. I blame myself when things go wrong
   - Yes, always
   - Yes, sometimes
   - No, not much
   - No, never

4. I worry too much and don't know why
   - Yes, always
   - Yes, sometimes
   - No, not much
   - No, never

5. I feel frightened and shaky a lot
   - Yes, always
   - Yes, sometimes
   - No, not much
   - No, never

6. I can't handle all the stress or I stress out
   - Yes, always
   - Yes, sometimes
   - No, not much
   - No, never

7. I feel really no good, like no-one loves me
   - Yes, always
   - Yes, sometimes
   - No, not much
   - No, never

8. I can't sleep because I am sad or think too much
   - Yes, always
   - Yes, sometimes
   - No, not much
   - No, never

9. I am so sad I have been crying
   - Yes, always
   - Yes, sometimes
   - No, not much
   - No, never

10. I think about doing something bad to myself or others
    - Yes, always
    - Yes, sometimes
    - No, not much
    - No, never
### KMMS Scoring Template

#### Part 1

**Instructions:**

Add up total to determine a ‘Flag’ score to be considered in context of part 2. NB any score in Q10 requires further exploration.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I can sit down and have a good laugh</td>
<td>Yes, always</td>
</tr>
<tr>
<td>2. I look forward for good things to happen</td>
<td>Yes, always</td>
</tr>
<tr>
<td>3. I blame myself when things go wrong</td>
<td>Yes, always</td>
</tr>
<tr>
<td>4. I worry too much and don’t know why</td>
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</tr>
<tr>
<td>5. I feel frightened and shaky a lot</td>
<td>Yes, always</td>
</tr>
<tr>
<td>6. I can’t handle all the stress or I stress out</td>
<td>Yes, always</td>
</tr>
<tr>
<td>7. I feel really no good, no-one loves me</td>
<td>Yes, always</td>
</tr>
<tr>
<td>8. I can’t sleep because I am sad or think too much</td>
<td>Yes, always</td>
</tr>
<tr>
<td>9. I am so sad I have been crying</td>
<td>Yes, always</td>
</tr>
<tr>
<td>10. I think about doing something bad to myself or others</td>
<td>Yes, always</td>
</tr>
</tbody>
</table>

**TOTAL Score:**

**CURRENT Risk of harm to self or others**

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>No</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Risk</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Low Risk</td>
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<tr>
<td></td>
<td>Moderate Risk</td>
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<td></td>
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<tr>
<td></td>
<td>High Risk</td>
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<td></td>
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</table>

**Comments:**

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## KIMBERLEY MUMS MOOD SCALE (KMMS)
### Screening Tool Part 2

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<th>DOMAIN</th>
<th>COMMENTS (Include risk and protective factors)</th>
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<tr>
<td>1. Support</td>
<td></td>
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<tr>
<td>2. Major stressors</td>
<td></td>
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<td>3. Self-esteem, anxiety levels</td>
<td></td>
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<tr>
<td>4. Relationships</td>
<td></td>
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<tr>
<td>5. Childhood Experiences</td>
<td></td>
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<tr>
<td>6. Social and Emotional Wellbeing INCLUDING Substance use/misuse</td>
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**Current risk for perinatal depression/ anxiety** (Determined using clinical judgement based on Part 1 and Part 2 of KMMS)

- [ ] No Risk
- [ ] Low Risk
- [ ] Moderate Risk
- [ ] High Risk

**Management Plan**

Review Date/Next Appointment: ____________________________

Clinician Name: ____________________________ Date of conversation: ____________

Signature: ____________________________
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<tr>
<th>Risk</th>
<th>Enquire</th>
<th>Explore</th>
<th>Encourage</th>
<th>Educate</th>
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</table>
| 1. Lack of support | • Are there people who will help you with your baby?  
• Do you have someone to talk to about your worries?  
• How does your partner/family feel about baby coming/being here? | How do they/will they help?  
What other help do you have? | Use of available supports or to identify and engage new ones to help manage. | About what other supports & services are available in the community |
| 2. Major stressors | • Have you had big worries over the last 12 months?  
• Have you had family member pass away recently?  
• Is someone’s anniversary coming up? | How do/did you cope?  
What do/did you do to help keep you strong? | Identifying strengths and supports | Explore & Identify strengths, other supports & services.  
May use Grow Strong Stay Strong Plan |
| 3. Low Self-esteem, high anxiety | • Are you a confident person?  
• How are you at managing with everyday things like family, work or home life? | Is that just today or nearly all of the time?  
Does it worry you if things get messy or out of place?  
Are things getting on top of you? | Strength based approach to problem solving.  
Regular practice of stress management techniques | Regarding stress management techniques including problem solving relaxation, goal setting available services /supports.  
May use Grow Strong Stay Strong Plan |
| 4. Couples relationship / Family Violence | • Having a baby can be a stressful time for everyone, are you having problems with your partner/family?  
• How do you get along with your partner/family? Do they treat you good?  
• Is there lots of fighting at home?  
• Does your partner get jealous? Do they accuse you of being with other men?  
• Do they jealous you for baby?  
• Do you get frightened of your partner/ex partner? | Does your partner try to control you by saying they will hurt you or your family?  
Have you been hit or hurt by your partner?  
Has your child/children seen family violence or been hit?  
Are you safe to go home where you live now?  
Does your partner get wild with the kids?  
What happens?  
Who is your child/children with now?  
Are they safe? | Counselling and couples support option.  
If she/children are at immediate risk develop a concrete safety plan before she leaves to ensure safety. | Available services/supports.  
Information about violence and abuse including risks to women, baby in utero & after birth.  
Provide referral info, names & numbers. |
### 5. Adverse Childhood Experiences

- Now that you are having a child of your own, you might think about or remember your childhood.
- Did you feel safe growing up as a child?
- Were you hurt/hit or abused in any way as a child? (physically, emotionally, sexually)

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</table>
| Adverse Childhood Experiences             | • Now that you are having a child of your own, you might think about or remember your childhood.  
• Did you feel safe growing up as a child?  
• Were you hurt/hit or abused in any way as a child? (physically, emotionally, sexually) | How do you feel about becoming a parent?  
Do you have any big worries about being a parent? | Women to seek support of they are struggling.  
Provide emotional support and reassurance. | Parenthood can remind us of feelings about our own childhood, both good and bad memories. Not all children who have been abused become abusive or fail to protect their children.  
Available support services and networks. |

### 6. Mental Health Issues INCLUDING Substance use/ misuse

- Have you felt really worried, no good or depressed over the past few weeks?
- Have you ever felt like that before for more than a few weeks?
- Does / did it stop you getting on with things or cause problems (upset your relationships) with family?
- Do you drink grog? smoke cigarettes? smoke gunga? Other drugs?
- When? How much? How Often?

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<th>Enquire</th>
<th>Explore</th>
<th>Encourage</th>
<th>Educate</th>
</tr>
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</table>
| Mental Health Issues including Substance use/misuse | • Have you felt really worried, no good or depressed over the past few weeks?  
• Have you ever felt like that before for more than a few weeks?  
• Does / did it stop you getting on with things or cause problems (upset your relationships) with family?  
• Do you drink grog? smoke cigarettes? smoke gunga? Other drugs?  
• When? How much? How Often? | What helps / has helped in the past?  
Are you getting help/ treatment for these kind of worries? Or have you in the past?  
Regarding substance use:  
What are some of the good things about your use?  
What are some of the not so good things about your use?  
How do you feel about your drinking/smoking/drug use? Does it worry you?  
What impact do you think your drug use has on you, your baby/family?  
Where are your kids/baby when you drink/smoke/use drugs? | Women who seek help now or on the near future. If they are feeling worried, no good or depressed.  
Identification of ambivalence regarding substance use / abuse - motivational interviewing | Mental Health and Well-being needs.  
PND is common and supports are available.  
Use resources such as 'Boodjarri Business', 'Just Speak Up - Kimberley Way' adverts.  
Impacts on self, family and baby of substance misuse.  
Utilise the Strong Spirit Strong Mind resource's |
Bibliography


Mental-Health-First-Aid-Australia and beyondblue (2008). *Cultural Considerations and Communication Techniques: Guidelines for Providing Mental Health First Aid to an Aboriginal or Torres Strait Islander Person*. Aboriginal Mental Health First Aid Training and Research Program, Melbourne, Mental Health First Aid Australia: 4.


