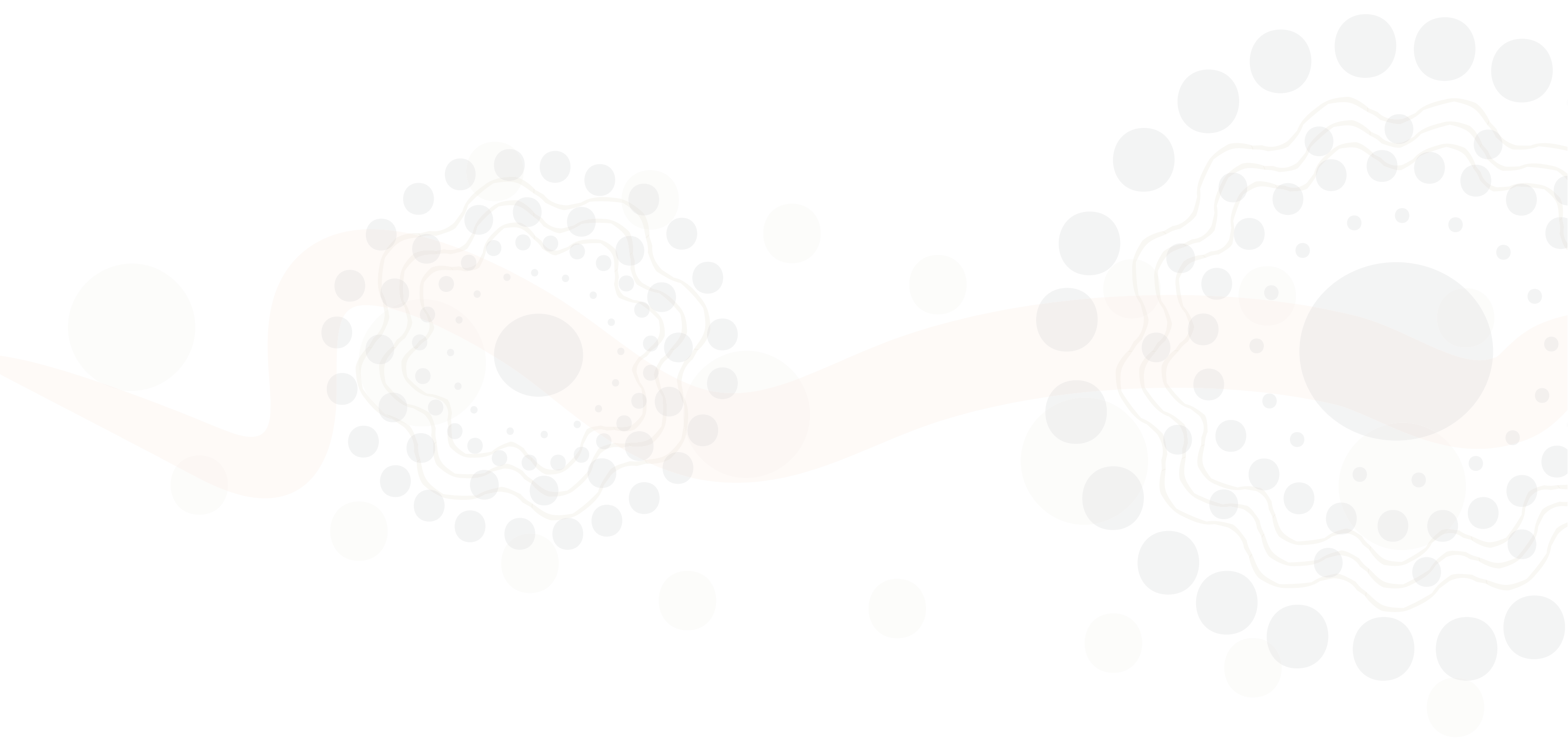
Kimberley Mum's Mood Scale (KMMS)

Training Manual



Contents

Background and rationale 4
- Development of the Kimberley Mum's Mood Scale 5
- Validation and implementation of the Kimberley Mum's Mood Scale 6
- Perinatal mental health and Aboriginal and Torres Strait Islander women 7
- The role of protective factors and risk factors 8

The KMMS approach 9
- Yarning 10
- Opportunity for engagement 11
- Enhancing clinical engagement 12

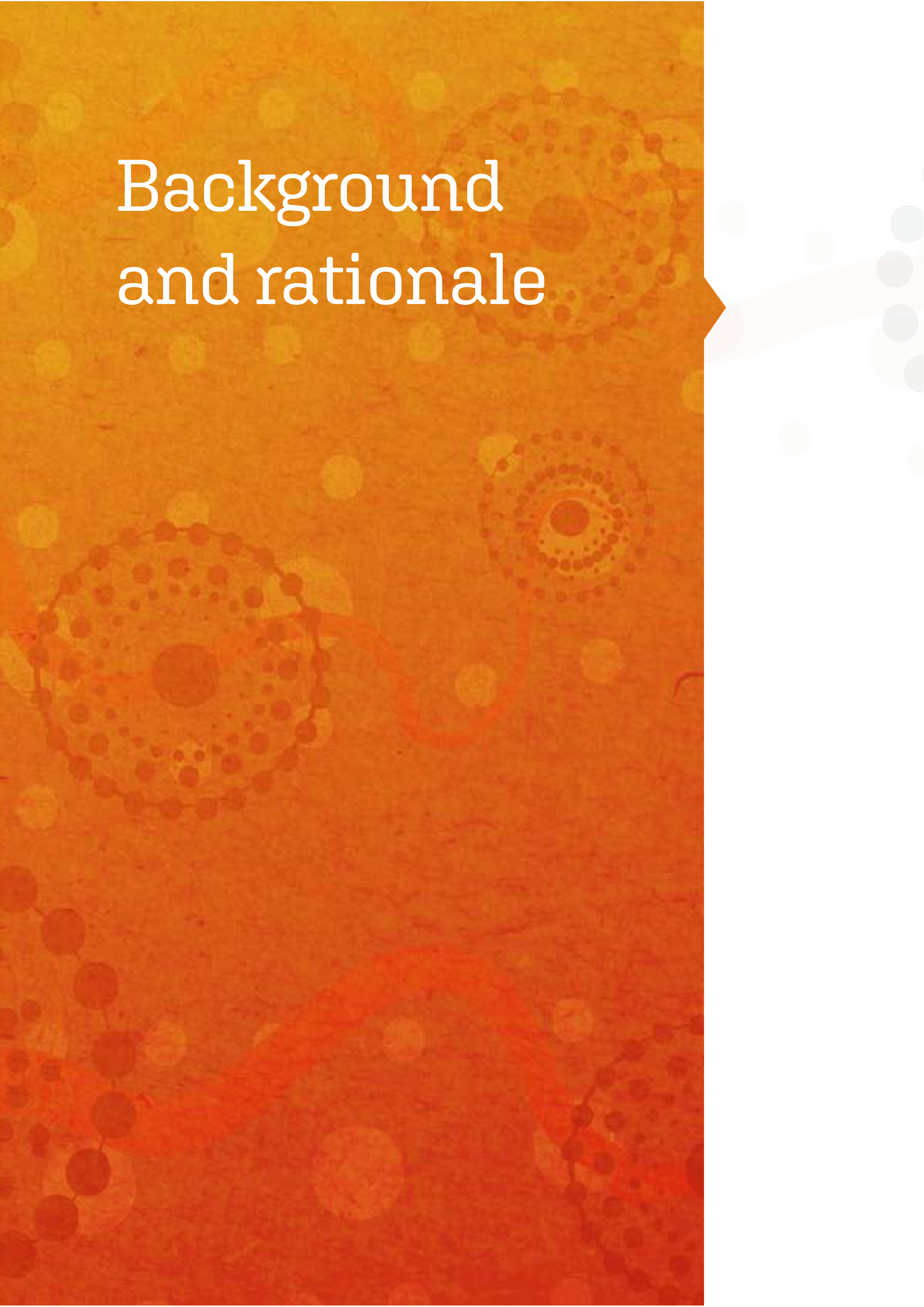
Using the KMMS 13
- Overview of using the KMMS 14
- When to use the KMMS 14
- Introducing the KMMS to women 15
- KMMS Part 1 instructions 16
  - Guidelines for administration 16
  - Responding to Question 10: Self harm / harm to others 16
- KMMS Part 2 instructions 17
  - Guidelines for administration 17
  - Determining risk 17
  - Risk likelihood summary 19
  - Follow-up actions 20

KMMS Tool 21
- Part 1 tool 22
- Part 1 scoring 23
- Part 2 tool 24

Appendices 25
- Appendix A: Mood and mental health disorders during the perinatal period 26
- Appendix B: Self-care for professionals 28
- Appendix C: Questions for each psychosocial domain 29
- Appendix D: Self-care for women 30

References 32

Acknowledgements 33



Background and rationale

Development of the Kimberley Mum's Mood Scale

Pregnancy, childbirth and early parenting is a time of vulnerability for many women. In the general population, 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.

Although there has been little research about depression and anxiety for Aboriginal and Torres Strait Islander women, their risk of antenatal and postnatal depression has been found to be higher than among non-Indigenous women.[1]

Promoting perinatal mental health and wellbeing among Aboriginal and Torres Strait Islander mothers is important not only for women but also for their children, families and community. If perinatal mental health disorders are left untreated they may have a severe impact on the mother, child and extended family. Some impacts of perinatal depression and anxiety may include: poorer birth outcomes, poorer bonding and attachment between mother and baby, ongoing emotional and cognitive difficulties for children, and enduring (and possibly escalating) mental health disorders for the woman.[2, 3]

Routine clinical screening is seen as an effective way to identify and respond to mental health concerns.[2] The development of the Kimberley Mum's Mood Scale (KMMS) was motivated by concerns about the appropriateness of recommended perinatal mental health screening practices for Aboriginal women in the Kimberley. Was the Edinburgh Postnatal Depression Scale the best way for Kimberley health professionals to engage with women? How could Kimberley health organisations improve the identification and management of mental health disorders for Aboriginal women?

These questions were answered through an extensive community consultation process which included over 100 Aboriginal women from eight language groups and more than 70 workers from Aboriginal Community Controlled Health Services (ACCHS) and Western Australian Country Health Services (WACHS) throughout the Kimberley. Discussions and yarns about perinatal mental health and screening found that Kimberley Aboriginal women place high value on a trusting relationship with the administering health professional, time to yarn, completing tools jointly (sitting side by side), and a strengths-based approach to follow-up.[4] The consultation resulted in the development of the two-part KMMS as a more culturally secure approach to screening for depression and anxiety during the perinatal period.

Part 1 of the KMMS adapts the Edinburgh Postnatal Depression Scale (EPDS), developed in Scotland in the 1980s,[5] using language and graphics as determined through the Kimberley consultation.

Part 2 involves talking or yarning to explore important psychosocial protective and risk factors. The yarning topics (or domains as they are hereafter referred to) were identified as important through the consultation process and are consistent with recent recommendations for good care in the perinatal period.[2]

Most importantly, the KMMS enables a different approach for communicating with women. This approach prioritises time, trust, rapport and understanding as a foundation for improved perinatal care. It values improved physical health outcomes for mother and baby, early identification and management of mental health concerns, and supporting women around other broader social and emotional wellbeing concerns. The aim of the KMMS is to identify concerns as they arise during the perinatal period so women can receive appropriate support quickly. This in turn minimises the potential impact, severity and duration of the effects of perinatal depression and anxiety on the mother, child, and family.

Validation and implementation of the Kimberley Mum's Mood Scale

KMMS Kimberley Validation study (2013-2014)

The KMMS (Part 1 and 2) was validated with 91 Kimberley Aboriginal women from 15 communities and towns. Women completed the KMMS with midwives or child health nurses, and were then separately assessed by a GP (who was blinded to the midwife/child health nurse assessment). A KMMS risk assessment of moderate or high detected everyone who was diagnosed with moderate or high severity anxiety and/or depression by the GP. This confirmed the KMMS can detect women most at risk. Further, the KMMS was well-accepted by women and health care providers.[6]

It is important to note that the validity of the KMMS comes from using both of its parts. Part 1 is a traditional screening tool assessing a woman against known criteria of depression and anxiety. It also provides an introduction to talking about 'mood' and how a woman has been feeling. Part 2 explores the woman's current psychosocial situation including her protective and risk factors. Using both parts, the health professional is able to assess the risk of a woman experiencing perinatal depression and anxiety and provide relevant and responsive follow-up support.

The validation of the KMMS found that as women opened up and talked about their lives, health professionals were able to gain a fuller understanding of the woman's situation. Completing Part 2 and exploring the presence and number of protective and risk factors is essential to provide context for the Part 1 score and adequately determine the woman's risk of perinatal depression and/or anxiety.

Evidence from the Kimberley validation study shows that midwives and child health nurses have the skills and the experience to accurately assess risk using the KMMS. While the overall approach of the KMMS may be new, it leverages the existing skills, experiences and clinical judgement of the health professional to provide a culturally secure framework for classifying risk and ensuring appropriate care for the woman.

The KMMS has been endorsed by the Kimberley Aboriginal Health Planning Forum (KAHPF) and is recommended for use in the Kimberley with Aboriginal women as per the Kimberley Perinatal Depression and Anxiety Protocol. This protocol can be found at www.kahpf.org.au/clinical-protocols.

KMMS Moving Forward: 2017-2021

The Rural Clinical School of Western Australia (RCSWA) and its partner Aboriginal Community Controlled and Government run health services were successful in receiving funding from the Western Australian Department of Health and from a National Health and Medical Research Council partnership grant. The aims of this funding are to:

- evaluate and re-validate the KMMS in real-world settings across the Kimberley (in partnership with KAMS, KAMS member services and WACHS)
- trial and validate the KMMS in the Pilbara region (in partnership with Mawarnkarra Health Service and WACHS)
- trial and validate the KMMS in Far North Queensland (in partnership with Apunipima Cape York Health Council).

The study will describe the effectiveness and acceptability of the KMMS when taken outside of a 'study context' and implemented as a routine feature of clinical care in the Kimberley. It will also assess if the KMMS can be validated for other regions and used more broadly as a culturally secure and effective perinatal depression screening tool for Aboriginal and Torres Strait Islander women.

Perinatal mental health and Aboriginal and Torres Strait Islander women

The perinatal period is a time of many changes in a woman's life. It is common for women to experience a wide range of emotions. For some women, pregnancy and early parenthood can have a negative impact on their social and emotional wellbeing and mental health.

This can include the baby blues, perinatal depression and anxiety, and less commonly psychosis. For more information on specific mental health concerns refer to Appendix A.

Social and emotional wellbeing problems are distinct from mental health problems, although the two interact and influence each other. Factors that impact on a woman's social and emotional wellbeing such as intergenerational trauma, insecure housing, financial worries or family and domestic violence are often contributors to depression and/or anxiety. Aboriginal and Torres Strait Islander women have reported feeling distrust in mainstream health services, reluctance to ask for help, and fear of possible consequences such as removal of children if they are seen to have a mental health disorder.[4] These are significant barriers to women receiving appropriate perinatal mental health care.

It is likely that most women will benefit from increased psychosocial support in the perinatal period, whether or not they experience mental health problems. Psychosocial support delivered as part of routine clinical screening helps women feel safe and cared about, increasing the likelihood of clinical engagement and thus improving maternal and child health outcomes.

For more information about this figure see p. 57–61 in *Dudgeon P, Milroy H, Walker R (Eds.) Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice (2nd Ed).*[7]

The role of protective factors and risk factors

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

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

The more risk factors there are in a mother's life, the higher the likelihood that the mother (and possibly entire family) will require additional mental health support during the perinatal period. An effective way to promote mental health is to explore the protective factors relevant to that particular mother, rather than trying to modify risk factors. These factors can help protect a person from developing a mental health disorder arising from difficult times or stress.[7]

Protective Factors	*Risk Factors*
• Strong family relationships and connections	• Lack of current emotional or practical supports
• Personal sense of wellbeing, satisfaction with life and optimism	• Poor quality of relationship with, or absence of, a partner
• Access to appropriate support services	• Family and domestic violence (past or present)
• Cultural traditions, especially around the birthing process and perinatal period	• Traumatic birth experience or unexpected birth outcome
• Presence of social support systems	• Current major stressors or losses such as bereavement, lack of stable housing or financial strain
• High degree of confidence in own parenting ability	• Past history of depression and anxiety disorder or other psychiatric condition
• Interconnectedness of cultural practices, spirituality, identity, family and community, connection to land/Country	• Depression in partner
• Belief in traditional healing activities which assist the management of life stressors	• Difficult relationship with own parents
• Economic security	• Poor social functioning
• Strong coping style and problem-solving skills	• Unemployment
• Adequate nutrition	• Drug and/or alcohol misuse
• High levels of health literacy	• History of childhood abuse or neglect (physical, emotional, sexual)

From *Dudgeon P, Milroy H, Walker R (Eds.) Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice (2nd Ed).*[7]

The KMMS
approach

Yarning

The KMMS is informed by an approach of clinical yarning. Yarning is a type of conversation that is common in Indigenous cultures. It is also viewed as a culturally-appropriate way to engage with Aboriginal and Torres Strait Islander people[8] and gather information in a clinical setting.[9]

The key features of yarning are:

- Informal and relaxed, removing hierarchies of clinician/patient.
- Person-to-person; a two-way exchange rather than question and answer.
- Involves the telling of a story and the health professional listening to and reflecting back on that story.
- Holistic, looking at the entire person not just a 'presenting problem'.

'Clinical yarning' may improve health care for Aboriginal and Torres Strait Islander people as it involves breaking down clinical power structures by developing a trusting relationship, storytelling, active listening, and collaborating to develop an agreed plan.[9]

The story-telling process can itself aid healing. There is a power in telling your story, being heard and having somebody facilitate a discussion around protective and risk factors. Further, yarning and listening closely helps health professionals learn about the people they are working with. Building trust, rapport and an understanding of the story will help with early identification of problems and may lead to the person being more responsive to support and treatment.[10] This in turn may limit the duration, severity and impacts of the issues being experienced.

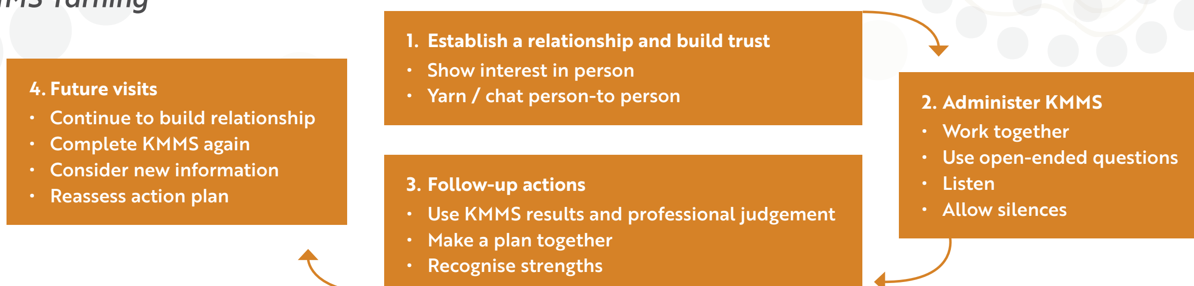
Yarning with an Aboriginal or Torres Strait Islander woman, to the point where she is able to discuss her concerns with you, involves understanding and demonstrating respect for her cultural values and history. A woman may not share her complete story with you in the first instance. She may wait and watch to see how you listen and respond before deciding to share further. Gathering the richness of a woman's story using the KMMS through yarning may occur over several conversations.

Hearing a woman's story can be confronting for a health professional; a woman may disclose details that you find troubling or upsetting. This is a normal response. Seeking professional support and supervision is recommended. For some simple self-care techniques refer to Appendix B.

What women have said about the yarning during the KMMS:

- "Good to talk to someone about how I feel in my pregnancy."
- "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."
- "Good to understand the questions and be able to open up and talk about anything."
- "The questions made me think, and thinking was good for me, because you understand me better now."

KMMS Yarning



Opportunity for engagement

The perinatal period poses a tremendous opportunity for initiating effective, culturally relevant primary prevention strategies that may impact positively for the rest of the child's life. The KMMS screening tool can provide a culturally safe start for this process.[4]

Prevention and early identification of mental health concerns are the key drivers of universal screening for perinatal women. Having a health workforce that is skilled, and committed to using the KMMS, lays a positive foundation for managing perinatal mental health into the future.

Health professionals need to be aware of the barriers and enablers that enhance or limit the likelihood of an Aboriginal or Torres Strait Islander woman engaging with them.

Enablers

- Trust/rapport
- Openness and honesty
- Continuity of care
- Respect
- Setting mutual goals
- Providing social support
- Listening and hearing
- Being empathetic
- Having a female health professional administer the KMMS
- Celebrating and amplifying the strengths/ protective factors
- Accepting silence and pauses as a positive part of communication

Barriers

- Being rushed
- Not showing interest
- Not seeing mental health or social and emotional wellbeing as part of your job
- Not knowing local supports
- Lacking confidence to ask and engage in difficult subjects
- Assuming knowledge/making judgements
- Not really 'hearing' what is being said
- Feeling unsupported/unsupervised in the workplace

Many Aboriginal women in regional and remote locations will speak languages other than English. If you are experiencing language barriers please consult with your organisation about the use of appropriate interpreters.

Enhancing clinical engagement

// ACTIVE LISTENING

Health professionals can show engagement and that they are listening through:

- eye contact, if appropriate (or respectfully looking down and away from the woman but remaining focused on her)
- soft, open facial expressions
- open body language, facing or sitting alongside the woman
- making encouraging responses (e.g. "uh-huh", nodding)
- paraphrasing (recapping the woman's key points every now and then)
- checking their understanding of what the woman has said
- reflecting and helping the woman to identify her feelings (e.g. "It sounds like you're feeling pretty worried about things.")
- not doing other paperwork/computer work at the same time.

// USING OPEN-ENDED QUESTIONS

Open-ended and probing questions encourage self-reflection and problem-solving. For example:

- "What do you think about . . .?"
- "Can you tell me more about . . .?"
- "What is worrying you at the moment?"
- "What is it that your partner is doing that is making you stressed?"
- "What are some of the things you have tried?"

Closed-ended questions (those that require a yes or no response) have been shown to limit conversation. Some Aboriginal and Torres Strait Islander people (and people from other cultural groups who have experienced colonisation and/or language barriers) may appear to agree to every closed question, even when they do not agree or understand what has been put to them.

// BEING ABLE TO ASK THE HARD QUESTIONS

As a health professional you may feel worried or anxious about asking some of the KMMS questions:

- How will I ask the questions?
- What might my patient tell me?
- What will I do?

Responding to 'the hard stuff':

- Be confident in asking open-ended follow-up questions.
- Be clear about your role so you can let the woman know how you can assist or support her, i.e. you are not able to solve her problems but together you can look for some support/solutions.
- Know what services and community resources are available to support women or where you can go to get this information.
- Understand mandatory reporting requirements and your responsibilities in accordance with this legislation.
- Know how to close the conversation.

// CLOSING THE CONVERSATION (FOR NOW)

It can sometimes be difficult to know when to end a yarning conversation. It may be helpful to let the women know you can talk for a particular amount of time.[8]

As the time is drawing to a close:

- Summarise and check your understanding of the woman's story.
- Reflect on what the woman has told you, noting strengths and resiliency.
- Move to the co-development of follow-up actions around areas of risk/worry.
- Reassure the woman you are always available to listen.
- Arrange a follow-up appointment time.

Using the KMMS

Overview of using the KMMS

The KMMS facilitates an exchange between a woman and her health professional. It provides a framework for a woman to tell her story, and the time and space for the health professional to hear her story. Through this facilitated yarn, the KMMS can assist in the early identification of mental health risks. It can also assist in a shared understanding between the woman and her health professional of what is happening in the woman's life and what support she may need from her health professional or others. The KMMS is more than a screening tool; it is an *approach* to perinatal care that values the social, emotional and mental wellbeing of the woman alongside her (and her baby's) physical health and wellbeing.

The initial KMMS may take 30-60 minutes to complete with a woman. Ideally this would be completed in full, early in a woman's antenatal care. However, developing trust and rapport and 'hearing' a woman's story may take place over several antenatal visits. The KMMS is a living document to be reflected on at each antenatal and postnatal visit. The nature of reflection is at the discretion of the health professional or may be led by the patient; it may involve asking follow-up questions around a recent major stressor, gently enquiring if the woman had followed up on a referral, or reminding the woman how well she is doing and reflecting on her coping skills/resiliency.

When to use the KMMS

As close as possible to your first contact with a pregnant woman, or a woman with an infant if the KMMS has not been completed previously.

- Women are to be offered the opportunity to complete Part 1 and Part 2 of the KMMS early in pregnancy and at least once more later in pregnancy. Then three times during the first postnatal year: at the 8 week, 4 month and 12 month child health check.
- Part 2 will ideally be reflected on regularly at most perinatal appointments, noting any changes in the woman's circumstances or any more of her story that she chooses to tell you. This will often be quite brief unless problems have arisen.
- Any changes in Part 1 should be noted and explored with the woman, e.g. "Last time we completed this you were feeling (X) and now I see you are feeling (Y), would you like to tell me about why this has changed?"
- The KMMS can be used anytime that a health professional feels it may be required if there are concerns about mum's mood.

Introducing the KMMS to women

It is important that women who are screened using the KMMS understand:

- the purpose of the KMMS, Part 1 and 2, including a conversation about mood, feelings, depression and anxiety
- that decisions about follow-up will be determined by both the woman's preference and your clinical judgement
- the confidentiality of the conversation but also the limits of confidentiality.
- In the Kimberley it is important to advise women that the KMMS is the regional perinatal depression and anxiety screening tool. e.g "we ask all Aboriginal women these same questions, it's part of looking after you during pregnancy/when you have a young child."

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

Having this yarn will help me to understand what keeps you strong and anything that might be worrying you. It helps me understand your story.

Some women feel worried, sad, alone or no good. Helping women to get the help they need early can stop this no good feeling from getting worse.

Sometimes you can feel no good in yourself and it's what gets called "depression" or "anxiety". Anxiety is feeling really worried and it doesn't go away. Depression is feeling really down for a long time. If depression happens during pregnancy or after the baby is born, we call it perinatal depression. There are things that can help with depression and anxiety.

We say to all women, don't feel shame to ask for help. It is good to get support if you feel sad, alone or no good.

The Kimberley Mum's Mood Scale has two parts and we will do them together.

The first part is 10 questions about how you have been feeling over the past week.

In the second part I will be asking you to tell me your story.

At the end we can make sure 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 now?

KMMS Part 1 instructions

Part 1 is a modified version of the EPDS. This version uses Kimberley English and graphics to assess a woman's mental state against known symptoms of depression and anxiety.

Part 1 is also an important way to introduce concepts and language around perinatal depression and anxiety.

The KMMS validation study showed that this short screening is not sufficient in understanding the likelihood of perinatal depression and anxiety for Aboriginal women in the Kimberley. Part 2 (the psychosocial yarn) is required to clinically explore, provide context and understand the results from Part 1. Together they provide a tool for understanding a woman's risk of perinatal depression and/or anxiety.

// 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 past week.
- If literacy is an issue, you may need to read the statement out loud and use the pictures to act as prompts. You may wish to point out the pictures as you read the possible responses.
- On each occasion the KMMS is completed, the Part 1 score will be compared to previous Part 1 scores. Variations in scores (particularly increases from previous scores) need to be explored further.

// RESPONDING TO QUESTION 10: SELF HARM / HARM TO OTHERS

It is important for health professionals to understand that enquiring about suicide or self-harm does not increase the risk of someone having or acting on suicidal thoughts. Asking the question can reduce the likelihood of suicidal behaviour, because the woman is able to share her distress and because often some appropriate supports can be put in place.

Any score greater than 0 on KMMS Part 1 Question 10 requires further enquiry and exploration.

QUESTIONS TO GUIDE FURTHER ENQUIRY

- Who do you think about doing something bad to?
- Can you tell me more about these feelings and thoughts you are having?
- When did you have these thoughts?
- Do you have a plan?
- What keeps you safe?

If, after speaking further with the woman about her response to Question 10, you have **immediate concerns** about risk of harm to herself or others, do not continue with the KMMS. Take immediate action in accordance with your organisation's policy or regional protocols.

OR

If after speaking further to the woman you are confident that there is no immediate risk of harm to herself or others, continue with the KMMS.

KMMS Part 2 instructions

Part 2 is a psychosocial yarn that expands on and complements information gathered in 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 and her risk of perinatal depression or anxiety. Yarning is a culturally appropriate way to engage with and care for Aboriginal and Torres Strait Islander women during the perinatal period.

// GUIDELINES FOR ADMINISTRATION

Part 2 is to be completed sitting alongside the woman. Be sure to explain to the woman that these question are about hearing her story, there are no right or wrong answers, and if she needs to take a break she can do so at any time. The establishment of rapport prior to starting Part 2 is essential.

Refer to the completed Part 1 and note any questions that the women scored higher on. These areas may be a good place to open the discussion by asking the woman to tell you more about the feelings and thoughts she is having in relation to the particular question.

Continue working through the identified domains by asking open-ended questions that allow the woman to think and respond in her own time. Examples of questions for each psychosocial domain can be found in Appendix C.

In Part 2, note any protective and risk factors raised by the woman. These will assist you in determining the woman's overall risk of perinatal depression or anxiety.

Remember to get clarification if you do not entirely understand something the woman has told you.

// DETERMINING RISK

The KMMS relies on clinical judgement and experience to combine and interpret Part 1 and Part 2 to determine a woman's risk of perinatal depression or anxiety.

If there is any answer to Question 10 except 'No, never', refer to the information on page 16 of this manual before proceeding to Part 2.

In determining risk, it is important to remember:

1. A Part 1 score of 9 and above indicates an elevated risk.
2. The Part 1 score is not a sufficient standalone measure of assessing a woman's risk.
3. Protective and risk factors that are explored in Part 2 are crucial in assessing the woman's risk (and follow-up support needs).

The table below can be used as a guide to assist with overall risk assessment; however, clinical judgement needs to be relied on at all times.

Risk assessment guide*

Part 2	*Part 1*	*Assessment of risk*	*Follow-up*
Many protective factors Few/minor risk factors	Any score **	Low	Self-care recommended
Combination of protective and risk factors	< 9	Low	Self-care recommended
	≥ 9	Moderate	Clinical assessment within 1 week
Few/minor protective factors Significant risk factors	Any score	High	Clinical assessment within 48-72 hours

* *Clinical judgement to be used at all times.*
** *If Part 1 score and the information collected in Part 2 is conflicting then review information and consider referral for medical or mental health review.*

Assessing risk: Notes from the field

The KMMS validation study demonstrated that protective and risk factors are not always neatly defined or separate from each other. Often risk factors were tied together with the protective factors, showing how a woman manages the risks or stressors in her life. Here are some examples of notes taken by midwives or child health nurses from the validation study:

Inappropriate touching by family member when she was younger, ran away from home in her early teens. Took the family member to Court when she was a young adult and she feels strong for this.

Sometimes problems with jealousy—sometimes domestic violence but stays with sister if there is violence. Has been receiving counselling for support.

Lost several family members this year—'talking to family helps me to cope'.

The interplay between protective and risk factors is complex and sometimes challenging. The validation study showed that maternal and child health staff are very competent in analysing protective and risk factors to determine a woman's overall risk of perinatal depression and/or anxiety.

There is no exact formula for determining risk, but analysis of the 91 women assessed in the validation study showed common characteristics for low, moderate and high-risk study participants. This has informed the risk assessment table (on the previous page). More details about the common characteristics in the validation study are provided below:

Low-risk participants	*Moderate-risk participants*	*High-risk participants*
• More protective factors than risk factors. • Few risk factors. • The risks have strategies around them; women use protective factors to 'manage' risk factors. • Q.10 score was either 0 (No, never) or 1 (No, not much).	• Combination of protective and risk factors. • Often an acute and current stressor (e.g. recent death). • Half had 0 score in Q.10. Half scored 1 (No, not much) or 2 (Yes, sometimes). No one scored 3 (Yes, always).	• Fewer (or no) protective factors. • High levels of current and historical trauma. • High levels of family and domestic violence or other unspecified 'issues' with partner. • All had Q.10 score >0, with the majority responding 2 (Yes, sometimes) or 3 (Yes, always).

// RISK LIKELIHOOD SUMMARY

Low Risk

Assessment:	In your clinical judgement, this woman is not currently at risk of experiencing perinatal depression or anxiety.
Actions:	Determine any follow-up actions by discussing with the woman any concerns raised during the KMMS. Provide her with any information regarding relevant local supports/support services or self-care that can assist her in maintaining her positive mental health in the perinatal period.

Moderate Risk

Assessment:	In your clinical judgement, the woman is at some risk of depression or anxiety but is not severely unwell or presenting as a short-term risk to herself or others.
Actions:	Discuss with the woman your concerns that she may be at risk of depression or anxiety; reassure her this is not uncommon and does not reflect on her ability to be a good mother. Summarise her protective factors and speak with her about the importance of keeping herself strong. Assist her to access relevant local community supports/support services (including family supports if appropriate). Seek her consent to refer her for further clinical assessment to be conducted within 7 days.

High Risk

Assessment:	In your clinical judgement, this woman is at high risk of having depression or anxiety and requires prompt clinical assessment.
Actions:	Assess the need for crisis intervention. Ensure the safety of both woman and baby. If you have significant concerns, follow up with a GP or mental health professional immediately by phone and follow this up in writing. If you think the woman is safe to leave the clinic, discuss with her your concerns that she may be suffering from perinatal depression or anxiety. Seek her consent to refer her for clinical assessment. Speak with the woman about an action plan including her supports, engagement with relevant community resources or other services. Provide information on after hours support and contacts. Refer the woman for a mental health assessment that can be conducted within 48–72 hours. If you deem it necessary, ensure the woman is followed up by the clinic sooner.

// FOLLOW-UP ACTIONS

Now that you and the woman have worked through the KMMS, you both have an understanding of her protective and risk factors regarding her perinatal mental health and wellbeing. Thank the woman for sharing her story with you. Acknowledge the difficult things she spoke about, and then repeat to her what she has told you that is keeping her strong and what she is doing well.

Together with the woman, determine some next steps. This may include:

Psychosocial support

Having support from a caring person can be very important in helping women cope in the perinatal period. Providing relatively simple information and guidance can help the woman cope with stressors and worries she is experiencing. Psychosocial support can help prevent worry or stress developing into something more severe. It does not need to be provided by a trained mental health professional. You do not have to provide all the answers or find all the solutions; just listening and being there can make a big difference.

Many women cannot readily access specialist treatment services. In this situation, staff can play an important role in supporting women with perinatal depression or those showing risk factors. Staff can:

Listen and reassure

- Encourage the woman to discuss any symptoms she may be experiencing.
- Assure the woman that perinatal depression can be treated and managed.
- Be empathetic to her situation.

(See 'The KMMS approach' section for more information.)

Provide information

- Provide the woman with information about perinatal depression.
- Provide details of local service agencies or helplines if she is feeling distressed and needs support.
- Offer information to the woman's partner and/or family (with consent).

Direct to care and support

- Encourage the woman to identify and draw on possible supports (including family/friends) and services that may be available to her for practical and/or emotional support.
- Encourage the woman to consult with her GP or other qualified health professional.
- Remind the woman that she can go to the local hospital or clinic if she feels she is at risk of harming herself or others.
- Encourage the woman to call a support service or mental health crisis line if other help is not available.

Clinical or agency referrals

Follow your organisational process on clinical referrals. Non-clinical services vary depending on location. Refer to your regional KMMS website for local community resources and referral options.

Discuss self-care strategies with the woman

Talking to women about self-care can be important. Yarning about the small things that help a woman feel good, and the importance of being with people that help the woman feel supported, can help with feelings of stress or low mood. The following self-care strategies are aimed at producing positive feelings, which can improve confidence and self-esteem:

- Develop/maintain a support system of family, friends and professionals (e.g. health worker, nurse, doctor). Ask for and accept help when needed.
- Discuss your feelings with family and friends.
- Try to eat healthy meals including fruit and vegetables, and drink lots of water.
- Do some enjoyable physical activity every day.
- Listen to some music. Dance.
- Try to have a good sleeping pattern.
- Have some time to yourself.
- Practice ways of relaxing, such as muscle relaxation and deep breathing.
- If away from family/friends, plan a visit to see them.

More information about self-care for women is included in Appendix D.

KMMS Tool

Kimberley Mum's Mood Scale (KMMS) Part 1

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

NAME:
DOB:
DATE:

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

Kimberley Mum's Mood Scale Scoring Template

NAME:
DOB:
DATE:

Part 1 Instructions: Add up to determine total Part 1 score.
Any score > 0 in Question 10 requires further exploration.

Question	Yes, always	Yes, sometimes	No, not much	No, never	SCORE
1. I can sit down and have a good laugh	0	1	2	3	
2. I look forward for good things to happen	0	1	2	3	
3. I blame myself when things go wrong	3	2	1	0	
4. I worry too much and don't know why	3	2	1	0	
5. I feel frightened and shaky a lot	3	2	1	0	
6. I can't handle all the stress or I stress out	3	2	1	0	
7. I feel really no good, like no-one loves me	3	2	1	0	
8. I can't sleep because I am sad or think too much	3	2	1	0	
9. I am so sad I have been crying	3	2	1	0	
10. I think about doing something bad to myself or others	3	2	1	0	

For any response other than "No, never", ask exploring questions. E.g. Who do you think about doing something bad to? Can you tell me more about these feelings and thoughts you are having? When did you have these thoughts? Do you have a plan? What keeps you safe? Comments:

☐ Immediate concerns: Follow organisational policy or regional Suicide/Self Harm Protocols.
☐ If no immediate concerns, continue with KMMS Part 2.

TOTAL PART 1 SCORE

Kimberley Mum's Mood Scale Part 2

Refer to the KMMS Manual for information on how to facilitate the yarn, guidelines for administration, examples of enquiring/exploring questions for each psychosocial domain, how to determine overall risk, and options for follow-up actions.

EXPLORE THE WOMAN'S STORY, NOTING THE SITUATION AND HER PROTECTIVE AND RISK FACTORS
SUPPORT:
MAJOR STRESSORS:
SELF-ESTEEM / ANXIETY:
RELATIONSHIPS:
CHILDHOOD EXPERIENCES:
SUBSTANCE MISUSE:
SOCIAL, EMOTIONAL AND CULTURAL WELLBEING:

OVERALL RISK OF DEPRESSION AND/OR ANXIETY (PLEASE TICK) Consider Part 1 score and the risk and protective factors identified during Part 2 in determining	
LOW	Self-care recommended
MODERATE	Clinical assessment within 1 week
HIGH	Clinical assessment required within 48–72 hours
IMMEDIATE CONCERNS	Clinical handover required immediately

FOLLOW-UP ACTIONS: Explore relevant referrals, or next steps with the woman.

Appendices

Appendix A Mood and mental health disorders during 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, biological, social and environmental. Mental ill health is associated with significant, long-lasting distress and incapacity to manage everyday tasks and feelings. The common types of mental disorders that affect people are anxiety, mood and personality disorders. Women experience physical, emotional and social changes while 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.

If perinatal mental health disorders are left untreated they may have a severe impact on the mother, child and extended family. Some impacts of perinatal depression and anxiety may include poorer birth outcomes, poorer bonding and attachment between mother and baby, ongoing emotional and cognitive difficulties for children and enduring (and possibly escalating) mental health disorders for the woman.

Perinatal depression also affects men. If you suspect a father may be suffering from depression, providing psychosocial support or linking him to someone he can talk to is crucial.

Baby blues

The 'baby blues' can involve overwhelming feelings but is completely normal and natural; it is due to the sudden change in hormonal levels following the birth.

The baby blues:

- occurs in 8 out of 10 women
- 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
- requires recognition, understanding, support, empathy and education from the health care professional.

Symptoms of baby blues:

- Tearfulness
- Irritability
- Mood changes
- Anxiety or anxiousness
- Fatigue
- Feelings of sadness and loneliness

Depression

Australian research indicates that up to 1 in 10 women experience depression in pregnancy and around 1 in 7 experience depression in the year following the birth. The causes of perinatal depression can be complex and are often the result of a combination of factors.

Depression can have significant effects on the health and wellbeing not only of the mother, but also her partner and the development of the fetus/baby and other children. In many instances perinatal depression is not recognised, as symptoms are often overlooked in the context of pregnancy or adjusting to the baby. In addition, high levels of stigma may prevent women seeking help.

There are varying levels of intensity of symptoms from mild to severe; women may present with differing levels of distress.

Symptoms of depression include:

Two or more weeks of depressed mood or decreased interest or pleasure plus at least four of the following:

- 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 condition in Australia. These disorders 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 real danger. It becomes problematic when the anxiety is severe, out of proportion to the actual situation, long lasting and interferes with the woman's ability to feel good in herself and manage her life.

Symptoms of anxiety include:

- 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

Symptoms of acute episodes of anxiety include:

- 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

Postnatal/postpartum psychosis

Postnatal/postpartum psychosis is a rare but serious mental illness which requires urgent specialist assessment and treatment. It is experienced by one or two women in 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 are often characterized by a sudden and dramatic onset of:

- Disturbances in mood and thought processes
- Disjointed and bizarre thoughts (delusions)
- Disturbances in sleep
- Disturbances in behaviour

Reflections from the field

"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

FURTHER LEARNING

KMMS recommends Aboriginal and Torres Strait Islander 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.

The Centre of Perinatal Excellence (COPE) has free online training for health professionals: Basic Skills in Perinatal Mental Health. **www.cope.org.au**

The information for this Appendix has been sourced from beyondblue, The Centre of Perinatal Excellence, and the DSM IV.

Appendix B Self-care for professionals

Self-care skills (or the ability to look after yourself) are important skills for health professionals. Many self-care issues can arise when living and working in small and sometimes isolated towns and communities.

Developing meaningful connections with colleagues and maintaining connections with your family and friends can help promote mental wellbeing. Relaxation, meditation, yoga/stretching, exercise, good diet and prioritising sleep all help.

If you have responded to something that has impacted upon you, debriefing by a manager or other support may help.

Asking if your workplace has a provision for clinical supervision is another great way to reflect on your work and have the space to talk through events.

Most employers have an employee assistance program to support you to access free counselling. Contact your manager or the Human Resources department of your organisation for more information.

There are a number of issues that can impact on a worker's ability to function well, particularly when they have heard a traumatic story or experienced a traumatic event. Here are some things to consider:

Type of problem affecting you	*Description*	*Example of behaviours that identify the problem*
Vicarious trauma	The impact of traumatic experience of someone you work with or from working with traumatised individuals (countertransference).	• Unable to manage anger, shock or grief • Negative view of the world • Lack of energy for self • Sense of disconnection from family/friends
Compassion fatigue	No longer empathetic or shows indifference to others in need. The problem is due to constantly being required to listen and offer support to those who are suffering.	• Excessive blaming • Physical and emotional exhaustion • Irritability • Substance abuse to mask feelings • Frustration, cynicism and other negative emotions
Secondary trauma stress	The emotional duress experienced when hearing a distressing story from another person, e.g. hearing about domestic violence directly from a family member.	• Similar to Post Traumatic Stress Disorder • Feelings of distress • Nightmares • Pounding heart, nausea, sweating, reliving the experience as one's own
Burnout	Physical, mental and emotional exhaustion—the demands being placed on you exceed the resources you have available to deal with the stressors.	• Physical and mental exhaustion • Lack of motivation • Slipping work performance • Not taking care of yourself • General decreased satisfaction with work

Appendix C Questions for each psychosocial domain

Domain	*Psychosocial questions*	
Support	How are you feeling about becoming/being a parent? Do you feel like you have good support around you?	Who are your supports? How are they helping? Do you have someone to talk to about your feelings and your worries?
Major stressors	Are there any things happening in your life right now that are stressing you? Do you have any big worries or losses from the past year that are still worrying/affecting you?	How did/are you coping with these worries/stresses? How are you feeling about giving birth/history of birth experiences/pregnancy?
Self-esteem/anxiety	How are you feeling in yourself? Why do you think you are feeling like that? Do you feel like this just today, or much of the time? Are you worrying a lot or stressing out (feeling anxious)? Can you tell me what gives you those feelings?	How are you managing with everyday things like family, work, home life? Have you been previously diagnosed with depression or anxiety? Have you had medication before to help you manage your depression/anxiety?
Relationships	Having a baby can be a time of big change for everyone, especially the people that you are living with. Who is living in your house? How are they feeling about the pregnancy/baby? Do your family live nearby/with you? Are they supporting you? Has your relationship with the baby's father changed since pregnancy/having the baby?	Do you feel like you have a safe home for you and bub? Have you ever experienced any harmful behaviours from another person? Are these impacting you now? Are you experiencing any jealousy or violence in any of your relationships? Would you like to talk more about any of these things?
Childhood experiences	At this time (pregnancy/young baby) women often think back on their own childhood experiences. There might be good things or hard things that come up. Is there anything you are worrying about? If you would like to talk about anything I am here to listen.	What are some of your happy memories growing up? What were some worries or problems when you were younger? Tell me more about these memories/experiences. Would you like any support to talk about your childhood?
Substance use	Part of keeping you and baby strong is knowing if you are you currently using cigarettes, alcohol or other drugs. Are you currently using any of these?	How has your use changed since being pregnant/having baby? Does your use worry you? How/why? Would you like to get some support and help for these things?
Social and emotional wellbeing	How is your sleeping, eating and physical activity?	You have shared a lot today, thank you. Can you tell me some of the things that keep you strong?

Appendix D Self-care for women

Caring for yourself and having a healthy lifestyle will help to keep your mind and body happy, healthy and strong. These are some tips to keep strong.

Talk to your family and friends about your feelings. Ask for help when you need it.

It is good to talk to someone that you trust about your thoughts and feelings. You might choose to talk with family or friends, someone from the clinic or elders. Talking to others can help you feel understood and to see things from a different point of view. If you are not comfortable talking about your feelings, then just sitting with family or friends and doing something enjoyable with them like fishing or cooking can help.

www.headspace.org.au
www.blackdoginstitute.org.au
www.healthyfamilies.beyondblue.org.au

Eat good foods.

Healthy food is fuel for your body. A good quality diet is made up of a variety of nutrient rich foods such as fruits, vegetables, and high fibre cereals, fish, good quality meats and vegetable oils such as olive oil. Drink lots of water!

www.foodandmoodcentre.com.au/diet-in-pregnancy/

Get some physical activity every day.

Exercise makes you feel good because it releases chemicals like endorphins and serotonin in your body that improve your mood. If you exercise regularly, it can reduce your stress and symptoms of mental health conditions like depression and anxiety, and help with recovery from mental health issues. Exercise also helps improve your sleep.

All you need to do is get your heart pumping a bit faster. Try a brisk walk or a dance around the house.

www.healthdirect.gov.au

Get a good night's sleep

Sleep is important for your health and wellbeing. Adults need 7–9 hours sleep each night. Regular, good quality sleep is important for brain functioning, emotional wellbeing and physical health. These are some ideas for having a good sleep:

- Try ways to relax like breathing and muscle relaxation.
- Avoid alcohol (it can make people feel sleepy, but it makes them have a worse sleep).
- Set your 'body clock' by getting up at the same time every day, and getting some sunshine in the morning.
- Relax your mind in the last hour before sleep (e.g. do not use your phone).
- Listen to your body, if you are tired—go to bed.
- Try to make the room a good temperature and dark.
- The nicotine in cigarettes is a stimulant (makes your body and mind work faster) so smoking can make it harder to sleep.

www.betterhealth.vic.gov.au
www.mindthebump.org.au

Make time for yourself

You might need time to connect to yourself, the land and your thoughts. If you do, talk to family or friends about looking after your children and try to make some space for yourself. You may use your time alone to check in with yourself or reflect on a personal experience. This might help you feel less stressed. Some women like to spend their 'alone time' gardening, reading, listening to music, watching movies, or cooking.

www.take5tosavelives.org
www.sparkhealth.com.au

Practicing deep breathing

When we are stressed, we usually take small breaths with our upper chest. We can feel less stressed if we slow down our breathing and do abdominal breathing instead of upper chest breathing.

If you put one hand on your chest and one on your abdomen (guts), you can feel that they move while you breathe. Try to breathe so that your chest stays still and your abdomen is moving.

www.betterhealth.vic.gov.au

Practicing muscle relaxing

One of the body's reactions to fear and anxiety is muscle tension. This can lead to muscle aches and pains and leaves some people feeling exhausted. Muscle relaxing is tensing muscles on purpose, then relaxing them.

Tense up a body part for 5 seconds, make sure you can feel the tension, then relax it for 10 seconds. Then do another body part (e.g. fist, upper arm, raise eyebrows, shut eyes tight, open mouth wide, curl toes, bring shoulders to ears). Work your way through your entire body; you will feel the difference!

www.healthywa.wa.gov.au

Plan to visit family or friends

Being away from a loved one can be difficult and sometimes talking to them on the phone is not enough. Plan to visit them or for them to visit you. Even if it is a few months away, simply knowing that you will be seeing them soon will give you something to look forward to and could improve your mood.

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Notes