Aboriginal Mental Health

Sandra Kelty & Gemma Carter

2017

Acknowledgement

- We would like to acknowledge the Traditional Custodians of this land. The land we are gathered on today belongs to the people of the Dharug Nation. We pay our respects to our Elders both past and present and would like to say a special thank you to all Aboriginal people here today.
- We would also like to acknowledge our host Wentwest and thank you for inviting us here to speak about Aboriginal Mental Health.

Know your Community

One of the first things we were taught at university is the importance of knowing your community. So my advice to you is know your community, get to know community Elders, introduce yourselves to the local Aboriginal Organisations, other Aboriginal workers, our local families find out who is who and who is related to who. Attend as many local outreaches as possible and as many cultural events, be seen in the community and get yourself known.

A bit about us as Aboriginal Workers

- Aboriginal health and in deed Aboriginal Mental Health is extremely multifaceted meaning there are many layers to our wellbeing. Each of us Aboriginal workers have our own core business mine is mental health. We all have an understanding of each others core business. This understanding might just be in relation to the other workers role, we show respect for that role and for our differences. As workers we look to see how we can enhance our own practice and the practice of each other.

Aboriginal Mental Health Traineeship Program

- Gemma Carter is our 5th and current trainee and works full time in the LHD.
- Gemma is a 1st year trainee and in her 2nd year at university.
- Gemma is currently enrolled in the Bachelor of Health Science Degree (Mental Health). This degree is also known as 'The Djirruwang Program' at Charles Sturt University in Wagga Wagga.
- Every Wednesday Gemma co-facilitates a group at Marrin Weejali

Case Study

- Mr XYZ and his wife presented to The Shed wanting to speak with MH. They were homeless and referred by the Aboriginal worker at the local court for an assessment. Mr XYZ is on a Bond and sees his P+P officer at Mt Druitt. Mrs XYZ has been charged with Break and Enter x 3, and has been referred for Circle Sentencing.
- Mr XYZ was previously linked with MH services in Queensland and has a diagnosis of schizophrenia, he is prescribed oral medication by his GP. Mr XYZ has not seen a psychiatrist for 3 years and is not willing to take his medication. Mr XYZ is complaining of people talking about him.
- Mr XYZ and his wife are regular ICE and THC users and both state they use drugs to block out negative thoughts.

Mr XYZ: Services Involved

- Crisis Team
- Court (Circle Sentencing)
- P+P
- The Shed
- Marrin Weejali
- DOH / Mission Australia
- GP SWAHS
- Pharmacist
- NGO

Mr LMN

- Mr LMN has a diagnosis of schizophrenia and is currently case managed by Blacktown MH. Mr LMN has a monthly depot injection and is on a CTO. Mr LMN lives alone and spends his mornings at The Shed. Mr LMN does not engage with his case manager but relates well to the cultural workers at The Shed, mental health at The Shed and the other men who use the services at The Shed. Mr LMN is willing to have his injections at SWAHS if taken to SWAHS. His uncle and big supporter is currently incarcerated.

Services Involved

- The Shed
- Ray
- SWAHS
- WSLHD
- Pharmacy
- MRRC

Case Study: Mr ABC

- Mr ABC has a history of schizophrenia and is currently managed by his GP at SWAHS. Mr ABC smokes THC and was becoming unwell. Mr ABC's brother contacted his cousin who works at Mt Druitt Police Station. Police agreed to escort Mr ABC to Blacktown A+E for assessment. Police contact Clinical Lead to notify of Mr ABC's pending presentation, background history and his need to be seen ASAP. Clinical Lead contacts MH staff in PECC re his presentation he was seen immediately and admitted to Bungarrabi House for treatment.
- 2 days later Mr ABC was given 2 hours ground leave and failed to return. Mr ABC told his family he was discharged from hospital. Mr ABC's family contact his GP at SWAHS as they are concerned Mr ABC was discharged too early. GP contacted Clinical Lead who visited Mr ABC at home. Mr ABC initially declined to return to hospital as he was worried he would 'get into trouble'. Clinical Lead contacted his psychiatrist in Bungarrabi and Mr ABC and his brother both spoke with the psychiatrist and a review by the psychiatrist was organised. Mr ABC and his brother were driven to Bungarrabi, Mr ABC was reviewed by his psychiatrist and formally discharged. Mr ABC and his brother were driven home with his belongings. Mr ABC's GP at SWAHS was given feedback and referred to Marrin Weejali. Mr ABC is currently followed up by Blacktown Case Management Team, his GP @ SWAHS and Marrin Weejali.

Services Involved

- Police
- Bungarrabi House
- SWAHS
- Crisis Team
- Community Mental Health Team
- Marrin Weejali

Case Study: Mr EFG

- Mr EFG is released from custody on a Friday afternoon with a 2 year parole order. He has a diagnosis of Schizophrenia and is aggressive when unwell. Mr EFG was not referred to MH on release, he is prescribed oral medication for his schizophrenia and was given 3 days supply of medication on release. Mr EFG is staying with his aunt as he is homeless and over the weekend Mr EFG started smoking THC and ICE. When being assessed the following week at P+P, his officer notices that Mr EFG was agitated and slightly irritable. Mr EFG is linked in with SWAHS but refuses to see a GP. Mr EGF agrees to see 'someone' from MH if 'they' come now and will not attend the hospital for an assessment.

Mr EFG: Services Involved

- P+P
- Prison medical records
- SWAHS
- LHD (Mental Health)
- Aunt (family)
- Marrin Weejali
- DOH (Mission Australia)
- The Shed

Any Questions?

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