



Guest Editorial

Moving beyond a 'Seasonal Work Syndrome' in mental health: Service responsibilities for Aboriginal and Torres Strait Islander populations

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Aboriginal and Torres Strait Islander mental health, workforce development, service responsibilities

This paper is designed to complement the recent Royal Australian and New Zealand College of Psychiatrists' *Position Statement #50, Aboriginal and Torres Strait Islander Mental Health Workers* (RANZCP, 2002). The position statement highlights many issues that have emerged in regard to this developing workforce and builds on some of the major developments over the past 10 years in the area of Aboriginal Mental Health. It makes a strong case for the need to recognise and support the valuable contributions Aboriginal Mental Health Workers make in mainstream mental health services and the Aboriginal Community Controlled Health sector.

The paper focuses on issues related to mental health service responsibilities, in particular ensuring that Aboriginal and Torres Strait Islander Mental Health Workers are seen as an essential component of the mental health system and not, as the title suggests, 'seasonal workers' with limited value placed on the very important role they perform in any given service.

The format of the *Diagnostic and Statistical Manual of Mental Disorders 4th Edition* (DSM-

IV: American Psychiatric Association: APA, 2000) has been used as the basis for a fictitious category called *Seasonal Work Syndrome*. I suggest there are many service difficulties and structural issues in relation to the ongoing development of this essential workforce – not exclusively 'worker difficulties'. By using the DSM-IV format to an audience of psychiatrists it was anticipated the service issues, the broad social issues, and worker issues, could be put forward in a context relevant to their profession.

This paper was originally presented at the 2003 RANZCP Congress in two parts. The second part, which focused on mental health training opportunities for Aboriginal and Torres Strait Islander people offered at Charles Sturt University, is explored in depth in an accompanying paper in this issue (Brideson & Kanowski, 2004). It describes the Djirruwang Program which offers a Bachelor of Health Science (Mental Health) to Aboriginal and Torres Strait Islander people to gain the necessary skills and qualifications to work in the mental health field. The course has increased its quality by the inclusion of the *National Practice Standards for the Mental Health Workforce*

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(National Mental Health Education and Training Advisory Group, 2002) into the clinical experiences for students undertaking compulsory mental health placements. The program is attempting to create a critical mass of highly skilled Aboriginal and Torres Strait Islander practitioners to assist in dealing with the emerging mental health issues in their communities.

Despite people being trained in mental health there is at times an attitude in the workplace that views a qualification obtained outside the five main mental health disciplines as less worthy. Whether this is real or perceived it has the potential to place limited recognition on the worker's qualities. This is one of the main reasons the course has attempted to make significant links to the mental health industry. The Djirruwang Program as part of Charles Sturt University is the first in Australia to incorporate the *National Practice Standards for the Mental Health Workforce* into the curriculum content and competency assessments.

The issues highlighted in this editorial and the accompanying paper ([Brideson & Kanowski, 2004](#)) are related to the development of responsibilities of services and professional organisations related to mental health. There exists a multitude of documents that highlight the issues, as well as policy documents at all levels of service provision that are essentially the guiding documents for implementation into practice. The First and Second National Mental Health Plans (Australian Health Ministers, 1992, 1998) highlighted Aboriginal and Torres Strait Islander mental health issues as areas of high need and generally these needs remain unmet and these issues are service responsibilities. The development of the National Mental Health Plan 2003 – 2008 (Australian Health Ministers, 2003) may make some inroads to addressing this deficiency, ensuring service responsibility to vulnerable populations.

Seasonal Work Syndrome

DSM-IV defines a syndrome as 'a grouping of signs and symptoms, based on their frequent co-occurrence, that may suggest a common underlying pathogenesis, course, familial pattern, or treatment selection' (APA, 2000).

My definition of *Seasonal Work Syndrome* is:

People who work in positions that are responsible for limited tasks and specific roles (often repetitive) in the workplace that are:

- a) *generally viewed by others as being much less important, and/or,*
- b) *made to feel that their role is much less important than other 'real professions'*

For example if we look at the similarities to seasonal work we can better extract the meaning. Cherry pickers, cotton chippers and labourers are employed at a specific time to perform a specific task. Often this task (while necessary) is less than prestigious in the overall scheme of importance to the function it fulfils. The salary is also commensurate with the limited importance placed on the role. The tasks are repetitive and labour intensive and require limited skills. The role is to aid and assist the farmer maximise his/her crop.

Similarly in mental health, Aboriginal Mental Health Workers are a recent development in some services and not standardised across services, often employed to perform a specific task at the discretion of their immediate manager. The role is often about getting Aboriginal people into the service where the prestigious professions can provide treatment and care. Salaries are in some ways comparable to seasonal work as limited importance is placed on the role. The tasks are, at times, repetitive and labour intensive. The role is often to aid and assist the service to perform a role that makes services look good or look like they are providing a comprehensive service.

Diagnostic features

The essential feature of *Seasonal Work Syndrome* for the Aboriginal Mental Health Workforce is a prominent undervaluing of a meaningful contribution that is judged to be due to the direct effect of systemic adaptability. This combined with a limited commitment in mental health services to improve Aboriginal Mental Health causes the syndrome. There must be evidence from history of a major disturbance to life for individuals, families and cultural norms. The disturbance can also be best described as exclusion from systematic arrangements to improve mental health services. Often the syndrome is masked with a promise of inclusion,

limited inclusion or default inclusion ('experts' with a social conscience). In the very extreme, there is no inclusion.

Subtypes

One of the following subtypes may be used to indicate the predominant symptom presentation:

- Limited recognition given to the role of an Aboriginal Mental Health Worker
- An undervaluing of the role of the Worker
- Increased stress levels on Workers
- Frustration in the workplace experienced by Workers
- Limited opportunities for training
- Lack of systematic Career Development and Professional Opportunities for the Worker

Recording procedures

In recording *Seasonal Work Syndrome* the clinician should first note the presence of the Aboriginal Mental Health Worker, then the identified role and function of the worker, and finally the appropriate inclusion of the community into the working arrangements of the service.

Associated general working conditions

A variety of general working conditions may cause *Seasonal Work Syndrome*. The syndrome is not simply limited to the area of mental health. In fact many other areas express a correlation to this syndrome. These could include (at least) Aboriginal Health Workers, Aboriginal Housing Officers, Aboriginal Welfare Workers and Aboriginal Education Officers. From this information we can conclude that as the Aboriginal workforce grows so too does the syndrome.

Prevalence

A prevalence rate for *Seasonal Work Syndrome* is extremely difficult to estimate given the wide variety of forms in which this condition might present itself. Environmental factors and working arrangements are often service based and reporting of this syndrome is not a requirement in most jurisdictions. Reporting issues in many instances are focussed only on the surface issues and fail to fully engage broader Aboriginal concepts into the service's

working arrangements. Preliminary research does suggest that the syndrome at present is grossly under-diagnosed in the general mental health setting. Anecdotal evidence suggests the rate could be as high as 100% across all areas in Australia. This indicates an emergence of a major syndrome of potentially catastrophic proportions.

Course

Seasonal Work Syndrome is generally a series of recurrent events that impact on the worker's ability to feel they are a meaningful part of the mental health system. An exacerbation of these events leaves the worker feeling less than worthy. These events are sometimes described as those that undermine the worker's role, placing limited value on what the worker has to offer, seeing the worker as not a real worker, and those that view the worker as not equal/equivalent to other professional groups.

Differential diagnosis

If there is evidence of recent or prolonged activity resulting in stressors on the Aboriginal Mental Health Worker, *Seasonal Work Syndrome* should be considered. Onset can occur both at early stages and late stages of employment.

Diagnostic criteria for Seasonal Work Syndrome

- A. The Aboriginal Mental Health Worker feels undervalued and unsupported.
- B. There is evidence from history of exclusion of Aboriginal people from services.
- C. There is evidence of poor structural relationships with the Aboriginal community, exclusion from service planning, development and delivery.
- D. There is limited or no evidence of a responsibility to make genuine improvements to these relationships.
- E. There exist National and State documents that direct service responsibilities but there is evidence that services do not fully comply with these directions.

We should not be quick to assume that after a diagnosis of *Seasonal Work Syndrome* the problems can be easily rectified. Many components of *Seasonal Work Syndrome* have the potential to have a negative influence on the

outcome therefore creating a whole set of new problems. However what we do know is that to do nothing fails to acknowledge the existence of the syndrome, further complicating the outcome with negative effects.

Treatment for Seasonal Work Syndrome

The best approach to the treatment of this syndrome is not to prescribe medication. An acknowledgement that the syndrome exists and raising the issues are important. Counselling is at times useful provided the issues raised are taken seriously, and effort to pursue action is genuine. Mental Health Service Systems need to fully consider their approach to Aboriginal Mental Health issues. Systemic issues require a service commitment to State and National documents in both knowledge and, most importantly, application. Support needs to be considered for the professionalisation of Aboriginal Mental Health as a recognised and valued profession in the mainstream mental health arena.

Potential impact

If the syndrome is allowed to continue for too long the impact could well be worse than the intended purpose of the role. This problem if left unattended could lead workers to feel less than worthy, have limited confidence in their ability and become disillusioned with the structures designed to assist people. As a result workers can appear angry, confused, aggressive, tired, withdrawn, frustrated and at times extremely stressed.

Conclusion

The Djirruwang Program through the Bachelor of Health Science (Mental Health) course ([see Brideson & Kanowski, 2004](#)) is attempting to address some of the deficiencies identified in international, national, state/territory, regional and local mental health documentation. We do so in an attempt to reduce the alienation, to improve access, to ensure equity and ultimately to reduce burden. What remains is a long path to travel to ensure these issues are realised. The opportunities for Aboriginal and Torres Strait Islander mental health workers are at this point in time limited. To truly feel like welcomed contributors in the mental health fields is a major issue for the industry as a whole to address. Or do we maintain the *Seasonal Work Syndrome*?

Tom Brideson is a Kamilaroi person from Gunnedah, NSW. He has been actively involved with the Djirruwang Program since its inception in 1993. He worked for several years as an Aboriginal Mental Health Professional in a clinical setting. At the time of this paper he was Project Director for the Djirruwang Program at Charles Sturt University. He has completed a Diploma in Health Science (Mental Health) and a Bachelor of Arts (Welfare Studies). He studied in the Master of Applied Epidemiology (Indigenous Health) Program at the National Centre for Epidemiology and Population Health at the Australian National University.

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