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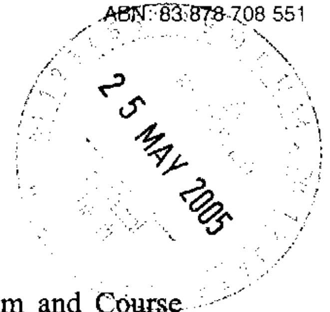

25 MAY 2005

18th May 2005,

Dear Mr Holland,

My name is Jane Havelka I am the Director of the Djirruwang Program and Course Coordinator of the Bachelor of Health Science (Mental Health) Course at Charles Sturt University, Wagga Wagga campus. This submission is supported by the School of Clinical Sciences within the Health Faculty of Charles Sturt University where the Djirruwang Program is located.

I am submitting on behalf of all the Aboriginal and Torres Strait Islander Mental Health Workers/students who are bearers of University Mental Health degree's from a range of Universities throughout Australia. These professionals work tirelessly within their communities without "Professional Recognition" and professional career pathways.

I am aware the Royal Australian and New Zealand College of Psychiatry have produced a Position Statement No. 50 which also supports the issues raised in this submission. This is available to the public and is located on their website. I am also aware there is currently a process to improve the status of Aboriginal Health Workers Generally, however it is not intended this process will consider the needs of those people seeking degree qualifications from outside the VET Sector in respect to their professional standing and career pathways offered by courses such as the Djirruwang Program.

After reading though the Terms of Reference (TOR) it is noted that provisions for Professional Recognition is omitted. This we hasten to presume is not intentional, rather an exclusion that is often absent in documents and literature regarding mental health.

For this reason we feel that the Senate Select Committee on Mental Health is a great forum to raise the very important issue for graduates of this program to the wider Mental Health Community. It is not our intention to address the entire TOR, however we feel the following are addressed in this submission.

f. the special needs of groups such as children, adolescents, the aged, Indigenous Australians, the socially and geographically isolated and of people with complex and co-morbid conditions and drug and alcohol dependence;

g. the role and adequacy of training and support for primary carers in the treatment, recovery and support of people with a mental illness;

The Commonwealth Register of Institutions and Courses for Overseas Students (CRICOS) Provider Number is 00005F for Charles Sturt University and the Charles Sturt University Language Centre.

h. the role of primary health care in promotion, prevention, early detection and chronic care management;

The Djirruwang Program delivers the Bachelor of Health Science (Mental Health) Degree and has restricted entry to Aboriginal and Torres Strait Islander people. The course is conducted over a three-year period. This involves a mixture of **compulsory** block release residential teaching, supplemented by teaching/topic materials and **compulsory** workplace experience.

The course provides the opportunity for students to explore a broad range of issues that impact on the mental health of people. This approach and the subject content are consistent with those identified in the *'Ways Forward'* National Consultancy Report into Aboriginal and Torres Strait Islander Mental Health, 1995 under the National Mental Health Strategy.

The Office for Aboriginal and Torres Strait Islander Health and the Health Priorities and Suicide Prevention Branch jointly fund the Program. It is the result of twelve years of development and was initially funded through the Rural Health Support Education and Training (RHSET) in 93/94. The Program has also received financial assistance in the past from the NSW Centre for Mental Health. The Program currently receives direct student support funds as scholarships from the NSW Centre for Mental Health. As a result of the confidence expressed by the above organisations in their continued support, the Djirruwang Program is now setting the pace in the mental health industry with regard to workforce accountability in clinical practice development.

"The *National Practice Standards for the Mental Health Workforce, 2002"* have been incorporated into the Djirruwang Program's Clinical Handbook and Course Competencies document. This achievement has been acknowledged in a letter from the National Mental Health Working Group *for "consideration of a nationally consistent framework for professional regulation"* (Attachment A)

The Djirruwang Program's Clinical Handbook and Course Competencies document has been developed. The document authors are Mr Len Kanowski (Assistant Director Mental Health First Aid) who has had continued involvement with the program since it began and Mr Tom Brideson (Former Director, Djirruwang Program.). This was completed with the assistance of a development team of Aboriginal and Non-Aboriginal mental health professionals. Mr Len Kanowski and Mr Tom Brideson are co-author of "The struggle for systematic 'adulthood' for Aboriginal Mental Health in the mainstream: *The Djirruwang Aboriginal and Torres Strait Islander Mental Health Program, 2004"* (Attachment B). Mr Tom Brideson is the author of *"Moving beyond a 'Seasonal Work Syndrome' in mental health: Service responsibilities for Aboriginal and Torres Strait Islander populations, 2004"* (Attachment C).

The Djirruwang Program gratefully acknowledges the work undertaken by the National Mental Health Education and Training Advisory Group and the National Mental Health Working Group who developed the *Australian National Practice Standards for the*

Mental Health Workforce. Charles Sturt University is particularly grateful to the Commonwealth Department of Health and Ageing who have encouraged and provided permission to use the *Australian National Practice Standards for the Mental Health Workforce* as the basis for the development of the Clinical Handbook and Course Competencies document.

The Clinical Handbook and Course Competencies document works in a very simple process by linking theoretical learning to clinical experience and clinical practice. For example the Djirruwang Program provides the foundation theoretical knowledge in the course and the mental health industry provides the avenue for our students to gain meaningful clinical experience, knowledge and skills at the service level. All clinical activity is agreed between students and the mental health industry (in accordance with the document) under a formal learning agreement. All levels of competence are signed off by the mental health industry. Therefore the mental health industry will take a lead role in contributing to the building of an efficient and effective Aboriginal and Torres Strait Islander mental health workforce by signing off on a student's level of clinical competence in accordance with its own blueprint for practice.

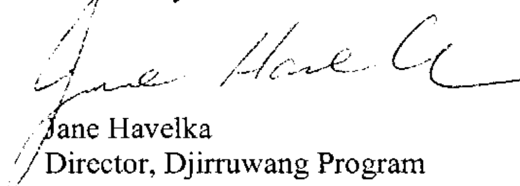
Importantly, in the development of the Clinical Handbook and Course Competencies document the Aboriginal and Torres Strait Islander students enrolled in the Bachelor of Health Science (Mental Health) in 2002/03 supported the need to be consistent with developments in the mental health industry. It is intended the document will also improve collaboration between industry stakeholders and our students who are seeking formal university qualifications. The Djirruwang Program believes this development will be a significant contribution to the mental health industry.

As the course is consistent with the mental health industry's own blueprint for practice, the intention is to set the platform of a recognised professional clinical qualification nationally for Aboriginal and Torres Strait Islander graduates of this course, as with other disciplines include psychiatry, psychology, social work, mental health nursing and occupational therapy. Professional recognition is currently inconsistent within services and across each State and Territory. We believe this situation is unacceptable and requires serious consideration particularly given our inclusion of the industry blueprint for practice.

We are now under no illusion that the Djirruwang Program offers the most comprehensive set of practical and theoretical skills of any undergraduate mental health course in Australia. The major professions simply offer components applicable to the mental health field, whereas, all course subjects included in the Djirruwang Program relate specifically to mental health and wellbeing (Attachment D). This situation alone is compelling justification for the national recognition of graduates of the Djirruwang Program. These are important issues that require the consideration and the support of the Senate Select Committee on Mental Health.

This year, there are 50 students from across Australia currently studying in the Bachelor of Health Sciencc (Mental Health). Since commencement as a pilot program in 1994 the course has contributed significantly to the mental health workforce with 38 students who have graduated with a three year degree and 40 who have graduated with a two year diploma.

Yours truly



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NATIONAL MENTAL HEALTH WORKING GROUP

Mr Tom Brideson
Director
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Locked Bag 588
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NSW 2678

Dear Mr Brideson,

Re: Djirruwang Aboriginal and Torres Strait Islander Health Program Clinical Handbook and Core Competencies

Thankyou for your recent letter advising of the use of the National Practice Standards for the Mental Health Workforce in the development and assessment of competencies in the Djirruwang Program Bachelor of Health Science (Mental Health).

This is an exciting development and you and the development team are to be congratulated for the considerable effort that has been made to incorporate the Standards into the curriculum, as reflected in the Clinical Handbook and Course Competencies.

It is hoped that the use of the National Practice Standards for the Mental Health Workforce will assist in creating a dynamic, responsive high quality mental health workforce that will work towards improving outcomes for the consumers of mental health services. Furthermore the use of the Standards can assist in the consideration of a nationally consistent framework for professional regulation.

The Nursing Workforce Supply, Recruitment and Retention Project, which is currently being undertaken by the National Mental Health Working Group in collaboration with Australian Health Workforce Officials Committee, and the National Practice Standards Implementation Group, are considering these matters.

Yours sincerely,

Dr. Tony Sherbon
Chair
National Mental Health Working Group
17 March 2004

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The struggle for systematic 'adulthood' for Aboriginal Mental Health in the mainstream: The Djirruwang Aboriginal and Torres Strait Islander Mental Health Program

Tom Brideson[1] and Len Kanowski[2]

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2. Senior Mental Health Clinician, Southern Area Health Service, New South Wales, Australia

Paper adapted from Background Issues Paper for consideration by the Indigenous Strategies Working Group, 17-18 March 2004 for the Health Priorities and Suicide Prevention Branch, Commonwealth Department of Health and Ageing. Also presented at 9th NSW Rural Mental Health Conference, Armidale, New South Wales, March 2004

Abstract

The title of this paper refers to issues of growth, development and maturity in Aboriginal Mental Health as it emerges as a specialised profession in the mainstream mental health system. The aper raises many challenges to the existing mental health structures. It asks a number of key questions the professional status of Aboriginal Mental Health Professionals operating in the mainstream mental health industry. The paper describes the approach the Djirruwang Aboriginal and Torres Islander Mental Health Program is taking to ensure that its students graduate with all the skills, attitudes, knowledge and values to be effective professionals in their own right. It highlights the collaboration required by the mental health industry to ensure that the entire mental health and the services in which they operate create a supportive environment for the development of the and Strait Islander mental health workforce. Finally it seeks the support of the mental health industry and professional organisations to move towards systematic adulthood with respect to 1) the professional recognition of students and graduates of the program, and 2) the need for professional organisations, and service management and staff to take responsibility in their responses to Aboriginal mental health issues. The need to effectively deal with the above workforce issues is based on the evidence that Aboriginal and Torres Strait Islander people suffer from higher levels of emotional distress and possible mental illness than that of the wider community. Suicide and self-harm rates are also considerably higher in comparison to that of the broader population (AIHW, 2001). Surely, if there is a higher level of identified need there must also be a higher level of orchestrated effort required.

Keywords
Aboriginal and Torres Strait Islander mental health, education, workforce development

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Brief History of the Djirruwang Program

The Djirruwang Program delivers a three-year Bachelor of Health Science (Mental Health) Degree (see Table 1) with exit points at Degree, Diploma and Certificate levels. Course entry is restricted to Aboriginal and Torres Strait Islander people. The Program commenced in November 1993. In 2004, there are 46 students from across Australia studying in the course. Since commencement the program has contributed significantly to the mental health workforce. Seventy students have graduated from the course (34 with degrees, 35 with diplomas and one with a University Certificate). The Course was initially developed in a collaborative process between the mental health services and Aboriginal people. In 2002 a process was undertaken to revise the curriculum and course structure. This was completed under the direction of a National Reference Group consisting of a range of representative stakeholders from the mental health industry, Aboriginal community controlled sector, and the education sector including Charles Sturt University. The curriculum was reviewed and rewritten where appropriate. The process was undertaken by Aboriginal and non-Aboriginal people from the mental health industry. The course is delivered by Aboriginal and non-Aboriginal mental health professionals as well as university lecturers.

The Djirruwang Program response to the policy context

In regard to curriculum development and the longer term directions, the Djirruwang Program has consistently aligned itself with broader developments in the Aboriginal and Torres Strait Islander health and mental health arenas. These developments stress the need for an effective professional workforce, quality training and building the capacity of services that are ultimately responsible for the delivery of health care needs. In particular the program has taken extreme care to remain consistent with the following mental health policy directions, and broader health industry policies and initiatives:

- *National Practice Standards for the Mental Health Workforce* (Commonwealth Department of Health and Ageing, 2002)
- *National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for Action by Governments* (National Aboriginal and Torres Strait Islander Health Council, 2003)
- *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework* (Standing Committee on Aboriginal and Torres Strait Islander Health, 2002)
- *The National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing 2004 – 2009* (Australian Health Ministers' Advisory Council, 2004)
- *National Mental Health Plan 2003–2008* (Australian Health Ministers, 2003) • *National Standards for Mental Health Services* (Australian Health Ministers' Advisory Council, 1997)
- *RANZCP Position Statement #50, Aboriginal and Torres Strait Islander Mental Health Workers* (Royal Australian and New Zealand College of Psychiatrists, 2002)
- *Ways Forward: National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health* (Swan & Raphael, 1995)
- *NSW Aboriginal Mental Health Policy* (NSW Health Department, 1997)

The Djirruwang Program is the first in Australia to respond to the *National Practice Standards for the Mental Health Workforce* in terms of curriculum and competency development. The program suspects it also precedes the mental health industry's application of the agreed generic mental health clinical practice standards, at the professional and service level.

Context to the Djirruwang Program approach

The Program has incorporated the National Practice Standards into the curriculum to ensure it is graduates with consistent skills, knowledge, values and attitudes of like-minded mental health professionals, whilst maintaining a deep sense of cultural integrity. The program has always had a strong history of clinical competence linked to education delivery, dating back to 1994 (Kanowski & Westerway, 1996). At the time these competencies were innovative and formalised through the university and individual health services. The release of the National Practice Standards gave the opportunity to link these previous competencies with the agreed industry standards for the mental health workforce.

Table 1. The Djirruwang Program: Course structure by semester, year and mental health clinical activity
(mental health professionals deliver the course content in most subjects)

	Year One	Year Two	Year Three
Semester One Autumn	Generic Skills in Mental Health	Aboriginal Mental Health and Wellbeing 2	Research in Mental Health (year long)
	Health Promotion	Gender and Mental Health	Healing our People (Counselling 2)
	Aboriginal Mental Health and Wellbeing 1	Diagnosis and Management in Psychiatry 1	Sexual Assault
	Introduction to Mental Health	Crisis Management 1	Mental Health and Substance Use (Dual Diagnosis)
Semester Two Spring	Healing our People (Counselling 1)	Ageing and Mental Health	Research in Mental Health (cont.)
	Healing our Spirit: Grief and Loss	Forensic Mental Health	Child and Adolescent Mental Health
	Working with Families	Crisis Management 2	Family Violence
	Substance Use: Assessment and Management	Diagnosis and Management in Psychiatry 2	Professional Issues in Aboriginal Mental Health
Total Yearly Clinical Placement	Clinical Placement 4 weeks	Clinical Placement 8 weeks	Clinical Placement 8 weeks

Box 1. Bachelor of Health Science (Mental Health) Course Objectives

The objectives of the Bachelor of Health Science (Mental Health) course are to provide high quality mental health information and experiences for students to:

- ensure Aboriginal and Torres Strait Islander people have the opportunity to participate in high quality tertiary education in the field of mental health;
- contribute to the creation of a highly skilled and effective Aboriginal and Torres Strait Islander mental health workforce;
- be consistent with and demonstrate competence in the recognised National Practice Standards for the

Mental Health Workforce;
- provide safe, effective mental health care, as a beginning mental health practitioner, for individuals and groups across the age continuum in a variety of health care settings;
- respond appropriately to the context in which mental health care occurs;
- apply scientific and social science knowledge to the provision of mental health care;
- have an appreciation of the cultural, psychological, physical, social, environmental, spiritual and political factors impacting on people experiencing mental health issues;
- appreciate the importance of research in building mental health evidence;
- have an awareness of the extent to which personal values and beliefs may impact on mental health care;
- undertake responsibility for personal professional development and self evaluation; and
- demonstrate the generic skills of graduates of Charles Sturt University and the Faculty of Health Sciences.

(Kanowski & Brideson, 2003)

Box 2. Djirruwang Aboriginal and Torres Strait Islander Mental Health Program – *Clinical Handbook and Course Competencies* summary The Djirruwang Program's *Clinical Handbook and Course Competencies 2003,* document was developed at Charles Sturt University by the Bachelor of Health Science (Mental Health) course. The document was developed by Kanowski and Brideson (2003) with the valuable assistance of a development team comprising Aboriginal and Non- Aboriginal mental health professionals (see acknowledgements). The *National Practice Standards for the Mental Health Workforce, 2002,* are successfully incorporated into the document.

Importantly, in the developmental stages of the *Clinical Handbook and Course Competencies* document, the Aboriginal and Torres Strait Islander students studying for the Bachelor of Health Science (Mental Health) in 2002/03 unanimously supported the need to be consistent with developments in the mental health industry. It is intended the document will improve collaboration between industry stakeholders and students who are seeking formal university qualifications. The Djirruwang Program believes this development will be a significant contribution to the mental health industry.

Application

The *Clinical Handbook and Course Competencies* document works in a very simple process by linking theoretical learning to clinical experience and clinical practice. This makes the application of skills immediately relevant and applicable. All clinical activity is agreed upon between students and the mental health industry under a formal learning agreement. As with all previous course competencies, the levels of competence are signed off by clinical supervisors from the mental health industry. The inclusion of the *National Practice Standards* into the course means the mental health industry will take a more formalised lead role in contributing to the building of an efficient, effective and clinically trained Aboriginal and Torres Strait Islander mental health workforce. This information was communicated in a background paper and presentation and then agreed to by all NSW Area Health Service, Directors of Mental Health at their regular forum conducted by the NSW Centre for Mental Health in May 2003 (Brideson, 2003).

Requirements

Students of the program are required to undertake a minimum of 20 weeks of clinical placement throughout the duration of their studies. The duration of 20 weeks was to be consistent with similar professions working in mental health. Each year students complete the bulk of their clinical activity within mainstream mental health services. Students also undertake placements within Aboriginal Medical Services and drug and alcohol services. This is designed to provide a broad perspective on issues that impact of people's mental health - not simply the diagnostic criteria without the cultural and social context.

Uses

The *Clinical Handbook and Course Competencies* aims to prepare students to develop the appropriate knowledge, skills, attitudes and values to work at the beginning practitioner level in a mental health setting. The competencies reflect the specialist nature of Aboriginal and Torres Strait Islander mental health work as well as reflecting the core skills required of all members of the mental health and alcohol and other drug workforce.

Clinical placement objectives

The objectives of the clinical placements are to provide students with the opportunity to interact with people experiencing mental and substance use disorders and their families/carers and to develop and extend the skills learned in the theoretical program. The placements are also important learning environments to assist students to develop and refine the necessary interpersonal and clinical skills required during their

professional careers. Important areas covered include working directly with people in a clinical environment and to develop an understanding of legal and ethical issues associated with clinical practice. These objectives are designed to assist students in their transition from their role as a student to their role of competent and safe beginning practitioner.

Some quarters of the mental health industry suggest that students and graduates of the program are not equipped with the ability to perform within a clinical role. One of the reasons (as with any professional group) is that it may well be the individual qualities of the worker rather than the quality of education as the problem. It may be the lack of support, training or clinical supervision provided by the mental health industry that could have contributed to the worker not performing to the service's desired standard in a clinical role. Interestingly, not all professionals are necessarily good clinical workers upon graduation. Comments like these make one wonder why there is a reference that the university training is the issue. Would this mean when a member of another profession performs poorly during their careers that their university course is responsible? Absolutely not!

Another anecdotal comment floating through the industry is that the graduates are not qualified counsellors. Could this comparison now suggest that other workers in the mental health field are not counsellors? No. These are simply absurd ways of some industry people attempting to devalue the status of Aboriginal students and graduates. For all these reasons the program has ensured that the course structures and processes meet with the mental health industry's own blueprint for effective clinical practice.

Clinical supervision responsibilities

It is important for the reader to know where the responsibilities lie in the development of the clinical skills in a mental health setting. Most of the students or graduates referred to in the issues above are or were employed by the workplace as Aboriginal Mental Health Trainees and then supported by the workplace to enrol in the Bachelor of Health Science (Mental Health). The purpose of undertaking formal studies is to understand the theoretical components that complement clinical practice. The workplace still provides the venue and is responsible for clinical experience, clinical supervision and clinical skill development at the service level. This has been the approach the Djirruwang Program has taken since it first commenced in 1994. Further to this, other mental health professionals are not expected to graduate from a course and then hit the ground running in the area of mental health. There is support provided to them to ensure they are equipped to function effectively within a mental health setting. So the mental health industry needs to think about similar principles in regard to graduating students from Aboriginal mental health courses such as the Djirruwang Program. There exists the attitude that Aboriginal people are expected to be automatic experts either during training or at the end whereas some other professions for example have a period of supervised clinical practice.

Professionals and management who are territorial with their discipline specific fortresses are laying down a minefield for students and graduates to navigate. As professionals there is a need to recognise that this attitude is contributing to people deserting the industry for more lucrative and less stressful environments. In order to compete with this territorial theory of colonialism maybe Aboriginal Mental Health Professionals need to apply similar rules by creating a new professional discipline to work under – to consider the privileges of collective bargaining across awards and professional status. The responsibilities of services and professions need to reflect the general attitudes they have towards Aboriginal Mental Health as a growing profession rather than simply a patronizing response. Such a response can be demonstrated by examining the factors inherent in the *Seasonal Work Syndrome* (Brideson, 2003, 2004).

The Royal Australian and New Zealand Congress of Psychiatrists produced a position statement in 2002 clearly outlining the issues for Aboriginal and Torres Strait Islander Mental Health Workers (RANZCP, 2002). A paper presented to the Congress by Brideson in 2003 outlined the need to move beyond the *Seasonal Work Syndrome* in the mental health system in regard to Aboriginal mental health.

This definition (Brideson, 2003, 2004) may explain the concept:
'People who work in positions that are responsible for limited tasks and specific time limited roles in the workplace that are:
a) generally viewed upon by others as being much less important, and/or,
b) made to feel that their role is much less important than other 'real professions'.

Seasonal Work Syndrome is a very simple concept that implies Aboriginal and Torres Strait Islander people are employed in some instances as cheap labourers to perform the menial tasks that services and professions are reluctant to or possibly unable to perform. Similarly, the notion of 'seasonal work' relates to the farmer who employs unskilled labourers to pick fruit or to chip cotton for a cheap price. (This fictitious syndrome is explored in more detail in a guest editorial in this issue - see Brideson, 2004.)

Professional recognition

As the course is consistent with the mental health industry's own blueprint for practice, the intention is to set the platform of a recognized professional clinical qualification nationally for Aboriginal and Torres Strait Islander graduates of the course. Professional recognition is currently inconsistent within services and across each State and Territory. This situation is unacceptable and requires serious consideration particularly given the inclusion of the industry blueprint for clinical practice.

There is no doubt that the Djirruwang Program offers the most comprehensive set of practical and theoretical skills of any undergraduate mental health course in Australia. Whilst the five major professions offer components applicable to the mental health field at an undergraduate level, all course materials and clinical activity included in the Djirruwang Program relates specifically to mental health and wellbeing (refer to Table 1). This situation alone is compelling justification for the national recognition of the graduates of the Djirruwang Program. These are important issues that require the urgent consideration and the support of the mental health industry as Aboriginal people search for a welcoming party that may begin to consider them as equals with the same level of professional standing other mental health disciplines currently enjoy. This reflects a move towards the issue of 'adulthood' that is urgently required by the mental health industry.

This development however does not mean the Aboriginal or Torres Strait Islander mental health professional is required to leave their cultural identity at the door of a mental health service. The underlying philosophy of the Djirruwang Program promotes mental health learning in the context of cultural identity. This means that students are respected as cultural brokers in order to make sense of the mental health industry and to apply their learning to the cultural context. This may mean that services need to reconsider their current approach and work within the context of the issues outlined in the Position Paper by the Royal Australian and New Zealand Congress of Psychiatrists in 2002. As with the spirit of the *National Standards for Mental Health Services* (Australian Health Ministers Advisory Council, 1997) diversity should be considered an asset or at least, core business, in the management and delivery of an effective mental health service. It should not be considered a simple policy response or something additional or 'special' by the mental health industry.

Why restricted entry?

The issue as to why the course has restricted entry to Aboriginal and Torres Strait Islander people requires explanation. The answer to this is very simple. The Djirruwang Program is in the business of creating an effective and efficient Aboriginal and Torres Strait Islander mental health professional workforce. Program staff are committed to ensuring that student's have opportunities to learn in a safe environment and have input to their learning in a culturally appropriate manner. There is overwhelming information about education systems and their treatment of Aboriginal and Torres Strait Islander people. If services and professional groups are to assist and be committed to the creation of the Aboriginal mental health workforce as a valued and essential component of the mental health system the issue of restricted entry should be promoted, not questioned.

The fact remains that the broader mental health workforce and services are ill equipped to respond to specific population groups with complex needs. This was clearly communicated in the *International Mid-Term Review of the Second National Mental Health Plan* (Thornicroft & Betts 2002). Some of the population groups identified were people of Aboriginal and Torres Strait Islander backgrounds, people experiencing issues of dual diagnosis and people with forensic mental health issues. This is a major concern to the training that professionals are receiving from their professional organisations or the broader education system. All professional groups should be questioning their professional organisations as to why their educational institutions have failed to provide them with the necessary knowledge, skills and attitudes to effectively address the specific needs of these population groups. Perhaps professionals should be seeking the urgent attention of their relevant organisations to assist in identifying strategies to overcome this predicament. However there is a more serious issue to consider. That is the concern that the mental health services may not be effectively operating in accordance with the *National Standards for Mental Health Services*.

The final reason for restricted entry is that given the territorial fortresses, there is the risk of potentially end up creating a whole new group of people as 'experts' in Aboriginal issues who know what is best for Aboriginal people. Unfortunately this has been seen before with disastrous outcomes. Take for example the protectionist and assimilationist policies. This is one of the main reasons Aboriginal people are in the mental health arena in the first place and are still dealing with the impact of a shared history and past policies and practices. There is a further risk of having Aboriginal identified positions in mental health services replaced by people with 'expert' theoretical knowledge who completely lack the application to the cultural context. The education and training of the professions or the workplace is therefore not the responsibility of the Djirruwang Program. It is strongly suggested that professional education issues be taken up directly with health service management and professional organisations. Aboriginal people have enough on their plates in dealing with the higher levels of emotional distress in their communities. For all the reasons identified above it has the potential to fail to acknowledge students and graduates of the Djirruwang Program as valued and welcome in the workplace.

Linking with professional pathways

The five mental health professional groups have generally been slow to establish pathways into their professional fortresses for Aboriginal and Torres Strait Islander people. There are probably many reasons for this. These reasons certainly require further investigation and discussion. Regardless, the Djirruwang Program is very keen to establish dialogue on how students and graduates can dovetail into these mental health professions and how appropriate credit transfer arrangements can be established with the view to increasing the numbers of Aboriginal and Torres Strait Islander people in these professional groups. The Djirruwang Program sees this as very necessary across the area of mental health given the limited numbers of Aboriginal and

Torres Strait Islander people with qualifications in these five disciplines (Wenitong, 2002, Ch. 6). The Program is offering an opportunity that may work if the transfer arrangements across disciplines are suitably recognised. Certainly the inclusion of the industry practice standards opens the door for these opportunities to be explored. Certainly a number of students have indicated interest in these professional pathways.

Conclusion

If the Aboriginal mental health workforce is allowed to grow into a valued, respected and component of the workplace those people occupying the professional positions will provide the cultural context to the workplace. The inclusion of the National Practice Standards into the program has provided a vehicle to establish equivalence as professionals in their own right and to move into 'adulthood' in respect to mental health service delivery. The incorporation of the National Practice Standards (endorsed by all mental health professions and all levels of government) is only the beginning and in the Djirruwang Program's view an attempt of finding a suitable solution. Establishing stronger links with the mental health industry and working together through these issues will assist the process. There is an urgent need to address the issues identified in this paper and this work can only be performed by the willingness of the mental health industry and professional organisations. Failure to do so has the potential to perpetuate the current poor mental health status of Aboriginal and Torres Strait Islander people and therefore the potential to make significant structural, service and Aboriginal community based improvements will be lost.

Professionals, their organisations and management groups in the mental health field need to learn to work with Aboriginal people and not to continue to work on them. They are definitely not seeking permission on these issues – they are seeking support to enable them to move into 'adulthood' as qualified professionals within the systematic arrangements of the mental health industry. The question that management, services, professions and their educational systems need to ask themselves is, are they doing all they can to alleviate the emotional distress facing your Aboriginal colleagues and communities?

Acknowledgements

The Djirruwang Program gratefully acknowledges the work undertaken by the National Mental Health Education and Training Advisory Group and the National Mental Health Working Group who developed the Australian National Practice Standards for the Mental Health Workforce. Charles Sturt University is particularly grateful to the Commonwealth Department of Health and Ageing who have encouraged and provided permission to use the Australian National Practice Standards for the Mental Health Workforce as the basis for the development of the Clinical Handbook and Course Competencies document.

The Office for Aboriginal and Torres Strait Islander Health and the Health Priorities and Suicide Prevention Branch jointly fund the Program. It is the result of ten years of continued development and was initially funded through the Rural Health Support Education and Training (RHSET) in 1993/1994. The Program has also received financial assistance in the past from the NSW Centre for Mental Health. The Program currently receives direct student support funds as scholarships from the NSW Centre for Mental Health.

The Clinical Handbook and Course Competencies Development Team (positions were at the time of development):

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Guest Editorial

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

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

This paper is designed to complement the recentRoyal Australian and New Zealand College of Psychiatrists' Position Statement #50, Aboriginal and Torres Strait Islander MentalHealth Workers (RANZCP, 2002). The position statement highlights many issues that have emerged in regard to this developing workforceand 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, 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 maximize 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 byWorkers
- 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 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 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 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

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Course Subjects

Semester One Autumn	Year One	Year Two	Year Three
	HHS 100 Generic Skills in Mental Health	HHS 200 Aboriginal Mental Health and Wellbeing 2	HHS 301 (yr long) Research in Mental Health (year long)*
	HHS 110 Health Promotion	HHS 202 Gender and Mental Health	HHS 303 Healing our People (Counselling 2)
	HHS 103 Aboriginal Mental Health and Wellbeing 1	HHS 206 Diagnosis and Management in Psychiatry 1	HHS 309 Sexual Assault
	HHS 101 Introduction to Mental Health **Clinical Placement Subject**	HHS 205 Crisis Management 1 **Clinical Placement Subject**	HHS 304 Mental Health and Substance Abuse (Dual Diagnosis) **Clinical Placement Subject**

Semester Two Spring	Year One	Year Two	Year Three
	HHS 112 Healing our People (Counselling 1)	HHS 211 Ageing and Mental Health	HHS 301 (cont) Research in Mental Health (cont.)*
	HHS 111 Healing our Spirit: Grief and Loss	HHS 212 Forensic Mental Health	HHS 307 Child and Adolescent Mental Health
	HHS 106 Working with Families	HHS 213 Crisis Management 2	HHS 308 Family Violence
	HHS 113 Substance Abuse: Assessment and Management **Clinical Placement Subject**	HHS 221 Diagnosis and Management in Psychiatry 2 **Clinical Placement Subject**	HHS 310 Professional Issues in Aboriginal Mental Health **Clinical Placement Subject**

	Year One	Year Two	Year Three
Total Yearly Clinical Placement	Clinical Placement 4 weeks	Clinical Placement 8 weeks	Clinical Placement 8 weeks

* Year long subject