

Shining brightly: lessons from rural health time in the sun

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So I'm really interested to hear what our speakers this afternoon have got to say about the people of a bright future for rural health in this country of ours. Now the first of those this afternoon is Michael Bishop. Michael is a stalwart of the Rural and Remote Health Sector, having been involved with the first National Rural Health Conference in what is his hometown, Toowoomba. It is Michael's drive and creativity that's resulted in the establishment of Services for Australian Rural and Remote Allied Health, one of the Alliance member bodies, and he was also behind the establishment of the Friends of the Alliance, as well. Michael's worked in rural and remote communities as a practising therapist, including in Aboriginal and Torres Strait Islander communities. After a stint in Tasmania, Michael has now returned to Toowoomba—and what a fabulous part of the world it is. So, to hear a little bit about shining brightly this afternoon, lessons from rural health, time in the sun, please welcome, Michael Bishop.

Thanks very much Lee. I'd like to acknowledge the traditional owners of the land that we're meeting on, and their elders past, present, and future. I'd also like to acknowledge the National Health Alliance and thank them for the opportunity to speak to you today. What I would like to do is present you three stories about the people. And I'm going to use three quotes to illustrate the stories and I hope that they inspire you, these stories, as much as they inspire me.

This quotation here from Margaret Mead really talks about how important it is for small groups of people to come together. SARRAH and the National Health Alliance are examples of these particular experiences. So SARRAH, as an organisation, arose out of a small group of allied health professionals who were unhappy with our national associations' response to our professional development needs. We did not have a way of accessing, or being able to become involved with, the policy agenda that was sweeping the country in terms of rural health. We did not have a way of interacting with the Rural Doctors Association or the Council of Remote Area Nurses of Australia, or for the Australian Association of Rural Nurses, or even with the National Health Alliance through our national associations. We tried, and we failed.

So as a group of people, we decided to set up our own grass-roots organisation. SARRAH, over the last decade or so, has become a very influential allied health organisation. And I wanted to talk to you about some of the achievements that we've been involved with. We've heard at this conference that we now have a Chief Allied Health Officer. We've been speaking about that for a long time and it's a fantastic thing to celebrate. Michael Wooldridge, at one of their national health conferences, told me, and the other allied health people, that allied health will never have access to Medicare. Australia will never be able to afford to have the allied health professionals involved with Medicare. And what a big achievement we've heard when allied health had been able to access Medicare in Australia.

We're very close in Australia now to forming a national peak allied health organisation, but I'm hopeful it will be called the National Allied Health Alliance, and so therefore, for the first time in our history, we'll be able to link in our national associations, the Indigenous Allied Health Organisation, organisations such as SARRAH, the National Allied Health Casemix Committee, the Australian and New Zealand Allied Health Leaders Organisation to be able to have a voice. What's happened out of SARRAH though, is that we've been able to link in to a number of other key international organisations. And, for example, we are now part of the International Chief Health Professions Officer Organisation. So at the SARRAH conference, the most recent SARRAH conference, there was also an international meeting of the Chief Health Professions Officers. So those people are not the Chief Medical Officer or the Chief Nursing Officer, but the people for the professions, not those, and represented across the OECD countries and also Asia. So, imagine the excitement of me, a boy from the bush, an occupational therapist, who knows a lot about clinical practice, being able to talk to people

who are really important across the world about primary health care, and about the social determinants of health and illness, and how important it was to link the disability, aged care, education, child protection, and health sectors. To be able to have a voice for people who operate in different ways across all of those sittings.

So, that is an example of how important it is for small groups of people to get together and start talking. That's why this conference is so important and why it's so exciting. Because people come together and their voices are heard and they're listened to, and it's very, very important if you're working in a rural or remote area—whether you're a consumer, or you're a health provider—to have your voice listened to. So that's the first story I wanted to tell you about.

The second story I wanted to tell you about is in my current position. And I'm quoting Tanya, who presented yesterday. 'Necessity is the mother of invention and irritation is its father.' So, one of the things that I find challenging in my life is that it's very easy for people to whinge. You know? It's very easy for people to tell you a bad story and a problem, and I've been a regional director in Child Protection Services in Queensland and it's very easy to hear all the terrible stories. It's a bit harder, and we heard yesterday from James in his presentation, about how we need to stop focusing on the problems and start focusing on the solutions associated with these problems. We know the problems. It doesn't take rocket science. We don't need double-blind clinical control trials to understand what the problems are.

So in my current job, it goes from the border, the New South Wales and Queensland border, and there is a town called Goondiwindi. And in New South Wales there is a community called Toomelah Boggabilla, or Boggabilla Toomelah community, that is an area of extreme disadvantage. So, earlier ... I've been in my job 10 months. And about 2 months into my job, I was asked to take over managing oral health services for the Darling Downs, and in the handover, there was kind of a throw-away line or besides, oh and by the way we've got a project with Toomelah Boggabilla and we think it's going to start in about 4 weeks' time. And so, not having experienced the torture of cross-border issues before, I waded right into this particular project.

So this is about an organisation called Filling the Gap, which is a Sydney-based organisation of people who are very altruistic and who are passionate about making a difference to Aboriginal health and had just done a very successful project in north Queensland in Wuchopperen, and they decided that they would then try and work with the Toomelah Boggabilla community. NSW weren't able to provide the professional or other financial support to the particular oral health project and so, Queensland, the Darling Downs Hospital and Health Service was chosen as the next person who could support it.

Now the model is, that this non-government organisation would recruit dentists, from Australia and overseas, and would provide a continuous supply of dentists to work in a clinic that I would support, or we would support, in our hospitals and health service, and that they would organise transport for Aboriginal people from those communities to come to Goondiwindi to have essential primary oral health services provided.

So that sounds easy. It is not easy. The credentialling process that's associated with dentists is very difficult and different between Queensland and New South Wales. And so every time you had a change of dentist, there had to be a full credentialling process, and that includes a licence or ability to practise there. On top of that, we needed to have culturally appropriate dental assistants. And so that's a kind of unusual thing that you wouldn't normally expect. And then there is the order of who counts the service? So, do we count the service in Queensland and count it as a Queensland service? Do we count it in New South Wales as a New South Wales service? And under the National Partnership Agreement with oral health services, counting of the services is very important, because there's money tied to it.

On top of that, we then had the problem that in Goondiwindi there's a six-and-a-half year waiting list for primary oral health services in our public system, and I didn't have a dentist in Goondiwindi. And so, the other problem is, Goondiwindi is in the Queensland Minister for Health state electorate, and so

here I was in the Minister for Health state electorate providing oral health services to New South Wales people in Goondiwindi, and all of the complexities that go with that particular service. It has been absolutely amazing. It is incredibly complex, incredibly bureaucratic, incredibly time-consuming, but incredibly successful. And people who would not normally have got an oral health service, were able to achieve that service thanks to a whole lot of goodwill and the people overcoming the bureaucratic barriers associated with service delivery. So that's my second story.

My third story, in the abstract I talk about those two, and I've tried to rush those two so I can tell you about a third story. This is about mental health. This is about arts in health, and some of you who know me very well have heard me talk about this before. One of the highlights of my life was receiving high commendation from the Australian Human Rights Commission in 1992 for my work in destigmatising mental illness. And that has arisen out of a project that involved people with mental illness in Launceston. It started in 1988.

So in Christmas in 1988 I went into the ward at Launceston, it was called the Lindsay Miller Clinic, and it looked pretty dreadful. It was an old building that was about to be demolished and condemned. On the ward, there were four people. One of those people was a grandmother. And she cried when I gave her a little gift for Christmas and said, 'If I had been in a normal hospital my family would have come to visit me. It's because it's this horrible mental health ward no one's come to visit me. You're the only person who's given me a gift. Thank you so much.' One of the other fellows who was on the ward said, 'Well the only reason I'm here is I got kicked out of my accommodation because my landlord found out that I had schizophrenia and he didn't want a nutcase renting out his flat.' And the third person who was of significance, was a young woman who lost her job because her boss, she worked in a bank, and her boss had discovered that she had slash marks up her arms, and she was thought to scare off the customers, and she'd made a suicide attempt on Christmas Eve.

I was indignant. I was outraged that these people really were in hospital and were having their experience made much, much worse because of this stigma associated with their illness. My job at that stage was half of Tasmania and I was the sole occupational therapist working in mental health. And I had a long history with the arts, having been involved with the establishment of the Australian Art Therapy Association and Disability/Disadvantage in the Arts Australia, and so I decided that what we needed to do was to come up with a community arts project that would change people's attitudes towards mental illness in Launceston.

So what I said that we'd do, I had a group of young adults with schizophrenia who were my primary clients, I said to them, 'What we need to do is something like *Love Story*. We need to create a story. We need to create a story that tells people about mental illness, but doesn't scare them, and talks about courage and human determination and bravery.' And so, we wrote a rock musical, as you do, [laughing] as you do. And so we wrote a rock musical and when I went to the team meeting of the Launceston Mental Health Service and said to my team, 'I think we're going to do a musical in about nine months time.' They thought that I was probably certifiable in terms of my grandiosity. But we did create a musical. We had a local band, Boo Boo Gazoo, and they got one of the songs of our musical to the National Song Competition finals in 1989, and what happened was, the musical was a story about a young woman who had a nervous breakdown, who went to hospital, what happened in hospital, and then what happened when she got out of hospital, and then finally she had a relapse and went back into hospital. But all through this, there was one consistent person in her life who never gave up on her and that was her boyfriend, called Sam. And so, our cast was made up of people with mental illness, my clients, staff from the ward, doctors, nurses, other people, family members, kids from the community, and we put it on. And so we booked the Princess Theatre in Launceston, which seats 1,400 people, and it was packed.

Two things happened I want to tell you about, and Steve, was the name of the man who played Sam, Lillian's boyfriend. Steve was a man with an unusual form of schizophrenia where he had auditory, visual, and olfactory hallucinations when he was unwell; it's very rare. And he was very handsome, but

he was a bricklayer, and so he was built like a brick shithouse. You know? He was solid and muscly and he wasn't much of a dancer, but he was really handsome and charismatic and he was really passionate about being in this particular role. And we'd been working for nine months. Fundraising, cake stalls, chook drives, pie drives. Tasdance got involved and helped us with the choreography. The Terrapin Puppet Theatre helped us with the puppets that were representing the auditory hallucinations.

And what happened was, two weeks before the show, Steve's mum died, and so an amazing thing happened. After her funeral, no one had arranged it, but the entire cast, the entire cast and crew showed up at his mom's funeral. And of course Steve became very unwell. He loved his mum. And he had a relapse and started becoming quite psychotic. And he was then heavily medicated. And our antipsychotic medication is much better now than it was in the late 80s, but it still provided some side-effects. So he had a dry mouth, he had blurred vision, muscular rigidity, but he indicated that he wanted to go onstage. So his psychiatrist, Dr Joel [phonetic] Swinda, Joel decreased the medication enough so that he could still perform. We were all very worried. He was very, very unwell. And I started learning the lines, and I was very worried about that, I can tell you, I'm no actor.

So on the night the Princess Theatre was full. Hadn't been full for four years, except for a previous Christian Revival Meeting there four years previously. My heart was in my mouth. I was very nervous. I had arranged for people to be singing in the orchestra pit so that it would sound okay. There were five dancers behind Steve. This was the hit song, 'Don't Shut Me Out, I Won't Be Ignored.' It was the main song for the whole musical. It was about stigma. And so, I couldn't watch it. So I was at the back of theatre, being camp as a row of tents with my hands over my eyes [background laughter], being very, very stressed about the whole thing. It sounded okay, but there was no applause at the end of it. I was really worried! So I open my eyes, and then the whole auditorium, 1,000-odd people, stood up and gave him a standing ovation. Because they had heard about how courageous he was. That he was onstage, hallucinating, with the side effects, and he had determined to go onstage. So that kind of courage inspires someone, you know? It inspires me still today.

When I went to Toowoomba after leaving Tasmania, I had to repeat the project. We did it in Toowoomba and to the Queensland Performing Arts Complex, with 100 people this time. And, we got letters of support from all around the world. From the music industry, from politicians, from all sorts of people. And since 1992, when that production, when we got our human rights commendation, Lillian has been done somewhere in the world just about every year. So it's been done in every state. And as a community arts project, it's continued to empower and encourage and inspire people to work together.

I did some research about the project, looking at whether the medication levels, the hospitalisation rights, and also people's understanding of mental illness in our communities, and presented that research at a World Federation of Occupational Therapy Congress and got an award for that. So that's about people. That's about inspiring. That's about encouraging. That's about the passion that you need.

When we started the rural health movement, Bruce Trida and other people who were here, would go on and talk about fire in the belly. It is absolutely essential to have a passion. It is absolutely essential to not just have the passion, but to do something about it. It is important that you set yourself on fire. Set yourself on fire and liberate yourself to get involved with the rural health movement.

And, with that, I thank you.