

JOHILA



Journal of Health Information and Libraries Australasia
Volume 5, Issue 2, 2025

Table of Contents

EDITORIAL

Is that all you do?	Daniel McDonald	2-4
---------------------	-----------------	-----

REGULAR FEATURES

Convenor's Focus 2025	Gemma Siemensma	5-6
-----------------------	-----------------	-----

ARTICLES

From the Drawer to Stories: how the health library brought 150 years of Horsham Hospital history to life	Michelle Pitman	7-12
The power of diversional therapy: employing co-creation as a process to design a culturally responsive mural using the kawa model.	Margaret Power; Amanda Rendle-James; Rebekah Lewis	13-27
Doing a PhD	Dr John Gillett	28-34

MEMBER SPOTLIGHT

The Prince Charles Hospital Library	Jana Waldmann	35-36
-------------------------------------	---------------	-------

Editorial – Is that all you do?

Daniel McDonald

Librarian, Darling Downs Health | Editor, JoHILA

Daniel.Mcdonald@health.qld.gov.au | <https://orcid.org/0000-0001-8385-3671>

Recently my 4 year old son was eating breakfast (a minor miracle in itself, probably helped by the fact it was his very specific order of four pieces of bread (NOT TOAST) cut into dinosaur shapes, one with strawberry jam, one with Nutella, one with peanut butter, one with vegemite, plus a babycino... with marshmallows (I know, just like Bandit I'm a dodgy dad). As I was gathering my things preparing to leave for the day ahead he casually asked, "Dad, what do you do at work?". I did not want to be further delayed (see – ridiculous breakfast order above), knowing these conversations can extend and diverge across wildly different topics, usually ending in a soliloquy on type A road trains and concrete mixers (thank you civil engineer grandfather), so I simply replied "my work involves finding information for doctors and nurses at the hospital so they can know what to do to help sick patients get better".

As I finished tying my shoelaces and grabbing my non-dinosaur-shaped lunch and headed for the door came the devastating reply: "Oh, is that all you do?".

Sigh.

Yes son, that is all health librarians do.

Sigh.

All they do is find information for doctors and nurses by navigating databases of 30million+ descriptions of articles, employing (to the initial bewilderment and eventual astonishment of said doctors and nurses) a controlled syntax of 35000+ terms, then adding in keywords, then combining all these artfully together with Boolean operators, then deftly filtering result lists into manageable sums, then appraising abstracts and parsing publication types, then walking the tightrope between sensitivity and specificity, then interrogating found relevant results for clues to more relevant results, then exporting those results to some software that manages references. Then doing it all over again in a database that has some of the same material but enough unique nursing and allied health literature to justify replicating the search. Then doing it all over again in a database that has some of the same material but enough unique mental health literature to justify replicating the search. Then getting interrupted part way through and timing out and losing forty lines of search and stepping out onto the verandah for some fresh air and a deep breath rather than throwing the keyboard through the window and then doing it all over again in a database that has some of the same material but enough unique mental

health literature to justify replicating the search. And then doing it all over again in a database that has some of the same material but enough unique literature indexed by those fastidious Europeans who insist on including every conference abstract published in biomedicine to justify replicating the search. Then presenting to said doctor or nurse a curated list of relevant results that may or may not be a heartbreaking work of staggering genius given its elegant concision and profound sense-making of an unwieldy topic, but which definitely saved time, and probably money, and sometimes tears, and maybe saved a life, or helped a career progress, or a new service to be introduced, or a catastrophic failure to never happen again. And also definitely means more full-text retrieval is on the way.

And then all health librarians do is take this complex corpus of knowledge, built up over 10000 hours of no two searches exactly alike, and then attempt to teach said doctors and nurses how to do all of this in the hour they have to spare and then ten minutes of actual cognitive load they are able to set aside.

And then all health librarians do is build collections of resources and make them accessible, navigating budgets and price increases and vendors and price increases and purchasing systems and price increases and software platforms and price increases and consortia arrangements and price increases and methods of authentication and price increases and cataloguing records and classification rules and promotion efforts and loan returns and whatever is sticking the pages together of Miller's Anesthesia.

And then all health librarians do is make sure a physical space is fiercely guarded from those green-eyed project managers wanting office space for project managers to manage their projects, and then filled with comfy chairs to study in or sleep in, and computers that turn on and log on, and wifi that beats a hotspot, and a printer full of paper and toner, and air-conditioning that exactly meets the temperature requirements of all users at all times, and pens, and lollies, and SPSS, and NVIVO.

And then all health librarians do is contribute to clinical education, and procedure development, and mandatory training, and postgraduate education, and professional college education, and research project support, and systematic review support, and scoping review support, and explaining the difference between the two, and human research ethics committee membership, and computer trouble-shooting, and publishing support, and publishing metric support, and manuscript editing, and reference correcting, and local history efforts, and university liaison, and design input for new hospitals, and enterprise bargaining negotiations, and hospital foundation fundraisers, and Grand Rounds presentations, and staff orientation, and the profit margins of the local coffee shop.

And then all health librarians do is reckon with the great questions of the age, be they technological or philosophical or biomedical. They are usually ahead of the curve, fusing great leaps forward while striving to leave nobody behind. They are pragmatic, solution-focused, rarely ideological or given to great cynicism. They care about their community, and passionately believe in the power of clean and clear information to transform healthcare. They are deeply frustrated by misinformation in all its forms, and will hit you with a stick if you “just google it” or if you request articles fabricated by slop keening towards intelligence but marooned in artificiality. Speaking of which, they will also recognise insightful commentary when it is made, and share it with those of like or open mind, such as this portion from a piece by Charlie Warzel:

It’s difficult to deny that generative-AI tools are transformative, inasmuch as their adoption has radically altered the economy and the digital world. Social networks and the internet at large have been flooded with AI slop and synthetic text. Spotify and YouTube are filling up with AI-generated songs and videos, some of which get millions of streams.

Bots are everywhere, and they have produced profoundly strange and meaningful effects on digital life. Sometimes they’re racist. Many are sycophants. Other times, they summon demons. Google’s AI summaries are cratering traffic and rewiring the web. In schools, ChatGPT hasn’t just killed the student essay; it seems to be threatening some of the basic building blocks of human cognition. Some research has argued that chatbots are homogenizing the way people speak. In any case, they appear to have inverted the promise of the internet as an endless archive of information one can navigate for themselves. *Do your own research* has, in short order, become *Get one canonical answer*.

Sometimes this is helpful: A bot artfully summarizes a complex PDF. They are, by most accounts, truly helpful coding tools. Kids use them to build helpful study guides. They’re good at saving you time by churning out anemic emails. Also, a health-care chatbot made up fake body parts. The FDA has introduced a generative-AI tool to help fast-track drug and medical-device approvals—but the tool keeps making up fake studies. To scan the AI headlines is a daily exercise in trying to determine the cost that society is paying for these perceived productivity benefits. For example, with a new Google Gemini-enabled smartwatch, you can ask the bot to “tell my spouse I’m 15 minutes late and send it in a jokey tone” instead of communicating yourself. This is followed by news of a study suggesting that ChatGPT power users might be accumulating a “cognitive debt” from using the tool.

Good enough has been keeping me up at night. Because good enough would likely mean that not enough people recognize what’s really being built—and what’s being sacrificed—until it’s too late. What if the real doomer scenario is that we pollute the internet and the planet, reorient our economy and leverage ourselves, outsource big chunks of our minds, realign our geopolitics and culture, and fight endlessly over a technology that never comes close to delivering on its grandest promises? What if we spend so much time waiting and arguing that we fail to marshal our energy toward addressing the problems that exist here and now? That would be a tragedy—the product of a mass delusion. What scares me the most about this scenario is that it’s the only one that doesn’t sound all that insane. [Warzel, C. *AI is a mass-delusion event*. The Atlantic; 18 Aug 2025.

<https://www.theatlantic.com/technology/archive/2025/08/ai-mass-delusion-event/683909/>]

Sigh. So yes, son, that is all that I do. No, I did not know a B-double truck has an articulated axle and a semi-trailer does not. I’m off to work now. I love you. You can go to your room, you are grounded until you are 18.

Convenor's Focus | 2025

Gemma Siemensma

Library Manager, Grampians Health | HLA Convenor

Gemma.Siemensma@gh.org.au | <https://orcid.org/0000-0002-2817-1528>

Health Libraries Australia (HLA) continues to champion the essential role of health libraries in supporting evidence-based healthcare, clinical decision-making, research, and education across Australia.

Recent Highlights include:

NSQHS Standards Submission: HLA has prepared a submission to the Australian Commission on Safety and Quality in Health Care (ACSQHC) to ensure that the value of health libraries is recognised in the National Safety and Quality Health Service (NSQHS) Standards. This is a critical step in embedding library services into the national healthcare quality framework.

HLA Conference in Sydney: We recently held a vibrant and successful conference in Sydney, bringing together health library professionals from across the country. The event was a hub of knowledge sharing, professional networking, and innovation. Attendees engaged with expert speakers, explored emerging trends, and experienced live demonstrations from leading vendors showcasing the latest in library technologies and services.

Updated Competencies: Our professional competencies are nearing completion, thanks to the dedication of a large and diverse reference group. These updated competencies will reflect the evolving skills and knowledge required of health library professionals in today's dynamic healthcare environment.

Ongoing Professional Development: HLA's online professional development sessions continue to thrive, with over 100 participants attending each session. These events provide accessible, high-quality learning opportunities and foster a strong sense of community among health library professionals.

Looking Ahead: 2026 and Beyond

As we look to the future, HLA is focused on strategic planning for 2026. We want to ensure health libraries are:

Embedded in Clinical, Educational and Research Workflows - Advocating for libraries to be recognised as integral to healthcare teams, educational programs and research initiatives.

Digitally Advanced and Data-Driven - Supporting the transition to digital-first services, data literacy, and AI-enhanced knowledge management.

Sustainable and Visible - Promoting the value and impact of health libraries to stakeholders, funders, and policy-makers.

Together, we are shaping a future where health libraries are not only relevant but indispensable.

We welcome your input!

Please do send through anything that you think may be of relevance to hla@alia.org.au

Gemma

From the Drawer to Stories: how the health library brought 150 years of Horsham Hospital history to life

Michelle Pitman

Medical Librarian at Grampians Health, Victoria.

Michelle.Pitman@gh.org.au | <https://orcid.org/0000-0002-1193-5157>

No conflicts of interest are reported.

No funding from any source other than normal library budgets was received for the following report.

ABSTRACT

Horsham Hospital in Victoria has a long history. It is also the site for Australia's first known spinal block anaesthetic in 1902. In 2024, the hospital celebrated its 150th year of operation. This event required a great deal of work sifting through a jumbled "archive" of ephemera by the onsite health librarian. This work was, however, successful in bringing together community and health care staff through the stories of the past. Health librarians are often expected to do this work unfunded and ad hoc and while this can be extremely difficult to do at times, the benefits can be worthwhile. Strategic investment in health service archival practice, is however, needed.

In 2024, the Horsham hospital in Victoria – now part of Grampians Health – acknowledged its 150th year of operations. This report reflects on our experience as hospital librarians gathering the stories of the past, which helped our staff and community celebrate this major milestone.

As one of four Grampians Health librarians, Michelle has an interest in how our member hospitals were founded. She enjoys hunting through the historical record, which is just as well, because the reality is that our hospital archives are messy, eclectic bundles of reports, documents, uncategorised photos in boxes and albums, very old patient record books, scrapbooks, clippings, and random old medical equipment. For example, Horsham library has three Pinard horns – a type of stethoscope used to listen to the fetal heartbeat during pregnancy – in different sizes and materials. Interesting, but why?

It's a jumbled conglomeration of ephemeral noise that could have potential meaning if only there were time and finances to make that meaning a coherent reality. Despite this overwhelming pile, Michelle began poking into it during the COVID years, aiming

to track down some interesting facts about Horsham's healthcare past that could be faithfully shared and preserved for the historic record.

As health librarians, we have all experienced the time when someone randomly drops by and asks a specific history question that sees us digging through the "archives" for an answer. Grampians Health Library has been diligent these past two years, digitising and uploading our member hospital annual reports into our [Grampians Health Archives and Research Repository](#) (GHARR). This project alone has proved essential to many of these random questions and our own research. [We get quite excited by annual reports now – especially when they're dated 1858!](#) These documents are often treated as disposable, but they're so important to the hospital's historic record.

Digging into a hospital's history and then recounting it in an accessible way is, in essence, storytelling. Hospital librarians take on this extra "hat" and are often required to piece together fragments of truth and fact to answer those ad hoc history questions which inevitably arise. We need to critically appraise and cross-check these facts and we need to identify photos of people – usually, former staff – placing them into the fabric of "the times," and telling their stories within the context of the specific hospital.

For the 150th anniversary of the Horsham hospital, Michelle spent time between her usual tasks, cross-referencing images to reports, trawling news articles in [Trove](#), piecing and matching data points into thematic wholes. Despite having casually dipped in and out of our fonds these past few years, Michelle still spent in excess of 100 hours across the first eight months of 2024 building our knowledge about the people and timeline of the Horsham hospital. The notes she created ended up being used in promotional and marketing materials, radio and newspaper pieces, leadership speeches, commemorative posters, and local public library displays. To do all this, Michelle relied heavily on our historical archive, GHARR, Trove newspapers, and other monographs kept in the jumble of ephemera stuffed into various cupboards and drawers.

We would have liked to have gone to our local historical society to dig for more, but as there was no budget for paying the research fees required, we had to work with what was at hand or free to access. Regretfully, we also didn't tap into the vast resource that is the local Past Trainee Nurses group – who have many stories, along with truckloads of old ephemera and memories for identifying former staff in old photos! That was a lost opportunity for us, mainly due to pure ignorance at the time. But now we know and will take advantage of this resource in the future. We recommend reaching out through your volunteer program or local Historical Society to find these people if they're still around! It may save you time.

Grampians Health was fortunate in that our Communications team embraced the Horsham 150th celebration early and enthusiastically. We had a committee established by the beginning of May 2024 and began working on the celebration – scheduled for Monday, August 26th, 2024 (Horsham hospital’s “official” birthdate is August 27th, 1874). Michelle spent considerable time identifying the young nurses in a 1917 photo, and this became a leading image for the celebration.



L to R: Miss Curran, Miss Booth, Miss Anderson (behind railing), Matron Annie G. Duffy (seated); Miss McCarlie (seated on ground), Miss Veitch (at back), Miss McClounan, Miss Hawkin, Miss Haycock. Horsham District Hospital about 1917.

We decided that hospital staff should be the focus of the celebration, because in reflecting on stories about past and present staff, we could help build a sense of camaraderie which comes from belonging to a longstanding continuum of care; something that would engender pride after the maelstrom years of COVID. We also have staff whose relatives had also worked long careers at this hospital before them, so that sense of family ancestry can be very powerful.

Other ideas flagged were a circulating ‘Memory Book’ in which current and former staff - and the public - could write a memory about their career or about their experiences at this hospital: a case of saving the stories of today for the historic archives of the future?

We developed a colouring-in competition for local primary school children focused on a character we nicknamed Dr Harrie Healthcare, a gender-neutral medical professional.

Michelle’s job was to find factual stories that would inspire action for these activities. What would make staff want to recount their memories? This question had us tell stories about former staff: about our doctors, nurses, and matrons. What would

inspire children to enter our colouring-in competition and maybe – just maybe – think about working at this hospital someday? Here, we told a story about how people with broken legs and typhoid fevers had to bounce about on open-air bullock trays or on horseback across rough bushland to get to Stawell hospital, 65km away.

These simple stories, researched in depth to ensure they were factual as well as entertaining, garnered much success with the Memory Book and colouring competition.

There was more besides! The communications team developed a series of posters that told the stories Michelle was working on. She was also the designated public radio voice for our celebrations and did at least two radio spots plus a couple of local paper interviews. The key to success here lay in being able to recount fast points of historic “trivia” – with dates, places, names: little stories that can capture interest and the imagination of the community.

Did you know that Horsham Hospital is the site of Australia’s first known spinal anaesthetic block? It was performed by Dr Robert Ritchie on January 7th, 1902, and was done so he could perform a leg amputation on a 78-year-old male. It’s an extraordinary story, which we found both fascinating and inspiring. You can read Dr Ritchie’s 1902 account of this pivotal event in the reference link below this article. Horsham Hospital’s legacy to Australian medicine, particularly anaesthesia, has been a wonderful journey of discovery and has impressed on us the value of adding knowledge of archival practice to our professional capabilities and duties as health librarians.

For the day of the anniversary celebration, 26th August 2024, we set up a display of posters, original photos – some dating back to the late 1800s – medical equipment, and ephemera in our Horsham hospital boardroom, and this became part of a hospital-wide tour we offered at our main event. Over 100 people, former staff and community members enjoyed the celebration. The Communications team had placed a number of large core flute posters about the campus, detailing facts about Horsham hospital’s history. A few former nurses on the tour, reminisced long and happily in the library, as they pored over photos of former staff. The day proved to be great fun... if a lot of work!

Reflecting on this journey, we’ve learned that there is a fantastic return on investment in preparing historical stories about a hospital, especially in terms of how the stories told can engender ownership, brand recognition, and public satisfaction. But we do need a better way to manage our eclectic and incredibly important archives across all our member hospitals at Grampians Health.

There needs to be investment into the planned, strategic bridge-building work required to make each hospital's historical archive functional, effective, and accessible. Hospital librarians can ill-afford to waste time poking around in an unfunded, messy archive, even if it's really interesting. Simultaneously, our history collections are as important to our usual work of delivering best evidence, but only insofar as that history can and should tell a great story.

Historical archives – digital and analogue - need context and conservation to be useful. We expect our clinicians to be on the front foot of the latest medical evidence, discarding outdated and disproven practices, while our local communities demand we prioritise pride in *their* hospital's history, often judging us harshly on what we discard. It means, that for the hapless hospital librarian, we are managing our history collections to massage all available benefits from our public relations obligations, while also ensuring our staff are reaping benefits from current best evidence. Which of these is our "real job"? We believe both of these aspects are of mutual importance to our roles as health librarians.

Historic stories can be immensely valuable to hospital leadership, even if they only seem to realise that when there's an imminent anniversary! This ensures our historical collections are every bit as important, deserving the same kind of recognition and investment as our usual daily work in evidentiary discovery. The two polarities in our collections, past and present, are interchangeable even if they carry a wide spectrum of challenges around truth-telling, facts, change and evidence.

Grampians Health Library plans to develop a formal collections policy for receiving and keeping historical items so that there is a clear procedure for what and why we keep what we do. We also need to explicitly detail how we'll arrange our archival collections so they're effective and, above all, efficient to access. Much of what we have in our drawers and cupboards needs digitising, so this access becomes easy for people. It is a vital step in that bridge-building needed to manage the sometimes wildly different expectations of our communities and staff when it comes to our role within the hospital.

Our digital historical archive, GHARR, receives many hits per week because when we digitise our reports and images, they are accessible by anyone with an internet connection. It has been hugely successful, but there is so much more archival work that must be done. The enormous number of random images, document ephemera, old medical equipment, historic books, and memoirs, needs to be properly contextualised into their time, place, and purpose. All this effort will require time and attention as well as investment in the library's capacity and its librarians' capabilities. We are not archivists, but we need to know some of what archivists know. Sooner rather than later.

The journey of uncovering and celebrating 150 years of Horsham hospital's history has highlighted the invaluable role of hospital librarians in preserving and narrating the past. Through diligent research and – sometimes epic - storytelling, we have brought to life the rich heritage of Horsham hospital, fostering a sense of pride and continuity among staff and the community. This endeavour has underscored the importance of investing in organised and accessible archives, ensuring that the hospital's historical records from each of its founding member health services, are preserved and utilised effectively.

As hospital librarians, we balance the demands of providing current clinical evidence with the need to maintain and share our hospitals' historical narratives. This dual role enriches our professional practice and strengthens the connection between past and present, enhancing public relations and community engagement. Moving forward, strategic investment in archival practice will be crucial to preserving our member hospitals' legacies while also supporting the ongoing work of health librarians in telling the stories that bridge history with modern healthcare.

References:

Ritchie, R.H. (1902). Amputation through the middle of the thigh, under the anaesthesia resulting from the injection of cocaine into the lumbar sub-arachnoid space. *The Intercolonial Medical Journal*, 1902, January 20.

<https://bhsdigitalrepository.bhs.org.au/bhsjspui/handle/11054/2899>

The power of diversional therapy: employing co-creation as a process to design a culturally responsive mural using the kawa model.

Margaret Power

Advanced Recreation Officer, Rehabilitation and Recovery Service, Darling Downs Health Service, Toowoomba, Queensland, Australia

Margaret.Power2@health.qld.gov.au | <https://orcid.org/0000-0002-4392-9202>

Amanda Rendle-James

Amanda Rendle-James is a Senior Occupational Therapist working in adult mental health services, graduating from Brunel University in 2004. She has worked in a variety of mental health settings in Australia and the UK and is currently employed in the Rehabilitation and Recovery Service, Darling Downs Health Service, Alcohol and Other Drugs, Queensland, Australia.

<https://orcid.org/0009-0000-2448-8846>

Rebekah Lewis

Assistant Director of Occupational Therapy, Rehabilitation and Recovery Service, Darling Downs Health Service, Toowoomba, Queensland, Australia

<https://orcid.org/0009-0004-9026-6183>

Abstract

Background:

To describe a diversional therapy project completed within an adult forensic mental health unit in regional Australia.

Method:

The mural diversional therapy project planning, co-design process and implementation are described. Reflection on identified outcomes are discussed.

Results:

A small cohort of adult forensic mental health consumers participated in a group diversional therapy program involving the co-creation of a wall mural. The co-design process involved collaborative input from unit mental health consumers, the unit's Occupational Therapist and the Advanced Recreational Officer. The resulting mural design integrated elements of the Kawa Model into a culturally responsive mural design. Mental health consumers' participating in the project identified themes such as experiencing a sense of pride, achievement, connection, relaxation and ownership. It is anticipated that the mural's embedded visual symbolism and cultural responsiveness may provide consumers with ongoing therapeutic outcomes.

Conclusions:

Mural diversional therapy had positive effects on adult forensic mental health consumers. Embedding Kawa Model metaphoric symbolism into the mural design using a co-design approach adds a therapeutic legacy for future forensic mental health consumers, which has relevance for adult psychiatric inpatient care.

Key Words:

Co-creation, mural, forensic mental health, Kawa Model

Background

From the 1930s onward, psychotherapists and arts practitioners have posited that non-language-based forms of visual self-expression possess benefits for people with mental health problems (George & Kasinathan, 2015, p. 49). An emergent evidence base supporting this view from claims made by art therapy, community arts and health organisations, mental health consumers, artists and mental health care practitioners that mental health consumers who participate in arts-based programs can better express their lived experience of illness, enjoy greater social inclusion and experience improved mental health recovery (Parr, 2006; Howells & Zelnick, 2009, p. 221). Current literature within the *arts and health* field with a focus on arts-based therapeutic interventions in mental health can be divided into two broad categories. One category includes studies that identify arts-based approaches used in non-clinical settings eg. participatory or community arts (Jensen A & Bonde L, 2018; Power, 2018), and the second includes studies of art therapy within clinical settings (Van Lith, 2016; Goodman-Casanova et al. 2023). Findings from both literature sets suggest 'positive and reliable psychological effects' for consumers of mental health services with a 'range of diagnosed illnesses' (Jensen & Bonde, 2018, p. 2).

A recent systematic review of interventions initiated by creative art therapists and other arts and health professionals across a wide range of modalities suggests five common mechanisms of change that promoted positive changes in mental health symptomatology. These mechanisms include physical (e.g., neurochemical effects), intra-personal (e.g., enhanced self-concept and agency; processing and communication of emotions), cultural (e.g., creative expression, aesthetic pleasure), cognitive (e.g., stimulation of memory), and social (e.g., increased social skills and connection) (Dunphy et al, 2019, p, 1). Likewise, a comparative summary of claims by community arts-based interventions in mental health suggests that generative mechanisms such as positive affect of feelings of wellbeing, improvements in self-expression and mental health, enhanced physical health, cognitive stimulation and improvements in attention and memory, increased social connectedness and sense of belonging, and access and connection to culture (Power, 2018, p. 23-27). Interestingly, both literature sets claim similar or interrelated mechanisms of change.

While searching across these two broad literature sets, few studies describe arts-based diversional therapy approaches used in long term mental health consumer recreational programs. Little evidence currently exists that identifies and describes the processes used in arts-based psychosocial interventions involving long-term forensic mental health consumers. This paper will describe the co-creation process used to create a wall mural in forensic mental health unit in regional Australia.

Psychosocial interventions

Findings from Jensen and Bonde's (2018) literature review of the use of arts interventions for mental health and wellbeing in clinical settings suggests that arts-based programs that provide meaningful creative activity can promote and nurture psychosocial resources. These psychosocial resources include the redirection of focus toward optimistic life experiences which improve self-esteem, promote active coping skills, boost identity building and ability to enlist social supports (Jensen & Bonde, 2018; Reynolds & Lim, 2007). While improvements to the wellbeing of participants with mental health problems was evident, it must be noted that larger, longitudinal studies are required to establish greater research rigor and understanding of longer-term effects (Jensen & Bonde, 2018, p. 4; Dunphy et al, 2019). From the growing research evidence identified in *arts and health* literature, arts-based activities provide mental health consumers with a 'holistic, low cost, and non-medical interventions' with the potential to improve wellbeing (Jensen & Bonde, 2018, p. 5; Power, 2018). The mural project described in this paper highlights the observed improvements to wellbeing noted among in-patient participants who took part in the co-creation process.

Co-creation process

Terms such as 'co-design', 'co-production' and 'co-creation' have been used to describe the development of initiatives or projects that involve the participation of multiple stakeholders in a shared project outcome (Vargas et al. 2022, p. 1). These terms have more recently evolved from the broader concept of Participatory Action Research and its specific methods (Vargas et al., 2022). While these terms are often used interchangeably, co-creation is viewed as an 'overarching guiding principle encompassing co-design and co-production' (Vargas et al., 2022, p. 1). The co-creation process 'promotes the creation of value' by bringing together stakeholders to understand complex problems, and design and assess solutions that work within that context (Vargas et al., 2022, p. 2). Currently, consensus on whether co-creation is an approach, or a method remains an unanswered question (Szebeko, 2010).

However, De Koning et al. (2016, p. 273) *Steps of Co-creation*, seen in Figure 1, provides a framework in which to describe the multiple steps in the co-creation process and make sense of its iterative nature. The six steps of De Koning et al.'s 2016 model involve the interrelated concepts of identifying, analysing, defining,

designing, realizing, and evaluating or reflecting on phenomena, in this instance, the creation of a mural.

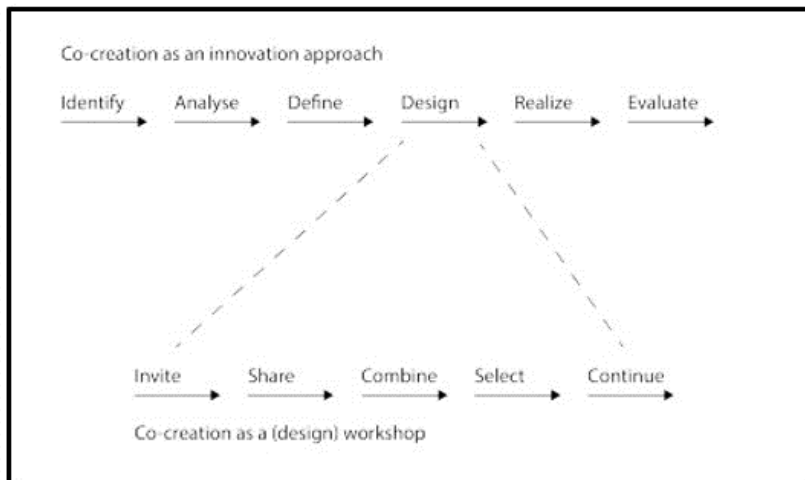


Figure 1 The Steps in the Co-Creation Process (De Koning et al., 2016, p.273)

The paper will use the term co-creation to describe the active collaborative approach used between stakeholders, in this case forensic mental health consumers, occupational therapists and advanced recreational officer, in the design and creation of a wall mural in a forensic mental health unit. By describing the co-creation process used, the paper aims to explore the approach used, the possible change mechanisms at play within the mural project’s co-creation process (Vargas et al., 2022, p. 2) and describe the utilization of the Kawa Model to develop mural imagery for therapeutic purposes.

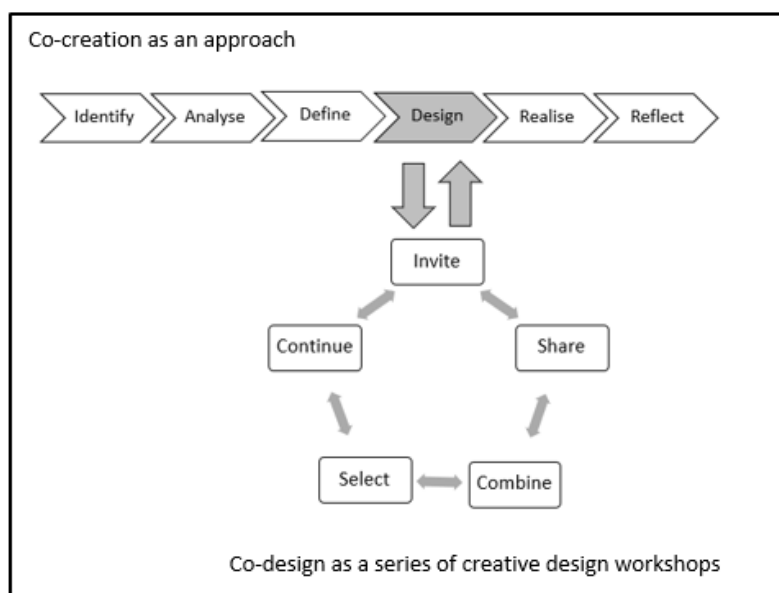


Figure 2 Steps to Mural Co-creation Process

The steps used in the mural co-creation process follow the majority of De Koning et al. (2016, p. 273) stepped process, however the final step of De Koning et al. has been modified to better represent the co-creation process used with consumers. The term "analyse", used in De Koning's Figure 1 model, has been substituted for the term "reflect". This change in terminology reveals the way stakeholders, including consumers, Advanced Recreational Officer (ARO) and Occupational Therapist (OT), discussed and considered design changes during and after the creation and realization of the mural. In addition to this change, the co-design process used to create the initial mural design used a series of design workshops that were non-linear in that they started at one spot and finished at another like the process described in De Koning et al. 2016 model. The mural workshops instead used an iterative process that involved a cyclical process which refined the latest version of the design ideas to make a subsequent rendering of the design. The co-design process, while iterative in nature is also shown to move in a forward and reverse direction depending on the views and subsequent decisions of the stakeholders (see Figure 2). The integration of the Kawa model into the development of the mural occurred within this design step is a good example of this iterative process.

Kawa Model

The Kawa model was developed by Michael Iwama in early 2000s in response to the cultural context in which he was practicing (Turpin & Iwama, 2011, p. 159). The Kawa model uses the visualization of a 'river' and its elemental parts as a metaphor to represent 'life flow or energy' (Turpin & Iwama, 2011, p. 160). The river and its elements are used to describe the history of an individual, family or organisation, with each element, the river floor and walls, rocks, and driftwood, representative of personal circumstances (Iwama, 2006). The river water flows through the elements which can increase or decrease the river flow. Change can occur in the size, shape and location of the elements which subsequently alters the river flow (Turpin & Iwama, 2011, p. 160). The possibility of change underscores the reasoning behind occupational therapy recovery interventions. The Kawa model as an intervention which nurtures components of recovery in a way that is person-centered and culturally responsive (Gregg et al., 2015, p. 368).

The integration of the Kawa model through the co-creative process was determined on the basis that this model can be applied in a psychosocial context that embraces dimensions of culture like shared values, attitudes, beliefs, language and symbols in a holistic way from an individual and collective perspective (Gregg et al., 2015, p. 369). The innovative use of the Kawa model within the context of mural project described in this paper provides a clear example of the Kawa model's potential for cultural inclusivity and adaptability.

Method

Setting

The mural project was set in a 30 bed, adult mental health unit providing psychiatric rehabilitation care to forensic patients, within a psychiatric hospital situated in regional Australia.

Participants

The mural project participants who worked directly with others in the co-design and painting included 15 consumers, all male, with ages ranging from 20 to 58 years. Over half identify as First Nations people and have a varied diagnosis of mental illness. Over the ten months the project operated, 2 new patients were admitted to the unit during the project's life cycle. During the project 2 of the participants were discharged out of the unit and 4 more were in various stages of transitioning to community settings. Of the original 15 consumer participants 9 remain as patients within the unit post project completion.

Procedure

The ARO from the Rehabilitation and Recovery team attached to the hospital was both the project's lead and facilitator. All unit mental health consumers were encouraged to take part in the mural project at morning meetings within the unit. The ARO provided two, 3-hour sessions, per fortnight over a 11-month period from January to November 2023. Each of the weekly sessions operated using a psychosocial framework. During the painting of the mural participants had to have the correct leave conditions to work on the mural which is situated outside of the unit. Consumers who didn't have leave were able to watch the painting of the mural from inside the unit.

The co-creation process used in the mural project utilizes the six steps found in model De Koning et al. (2016) model shown in Figure 1 that were subsequently adapted to the unit setting. The six interrelated steps used in the mural co-design process, illustrated in Figure 2, include identifying, analysing, defining, designing, realizing and reflecting used in the development of the mural are detailed in the paper along with the outcomes from a collaboration with occupational therapy used to embed the Kawa model within the imagery of the mural.

Results

Co-creation process

Identify

In this stage of the co-creation process, the ARO set about identifying the 'value created' through the process of bringing together stakeholders, consumers, allied

health and nursing staff, to understand the creative project at hand, and design and paint the mural within that context of the unit. The aims of the mural project were three-fold:

- to engage adult forensic mental health consumers, allied health practitioners and nursing staff together in a collaborative psychosocial activity that utilised a co-creation process to complete the mural.
- to involve the consumers in a longer-term art-based project that are culturally responsive, improved the unit's aesthetic environment while enhancing consumer wellbeing; and
- to add value to the mural by embedding metaphoric imagery derived from the Kawa model that can used with current and future consumers as a therapeutic assessment tool by occupational therapists.

Analyse and Define

Once the mural project's aims were identified, the next step was to tease up components of the project planning, examine the mural site and define how to best communicate and engage with stakeholders. Planning for the mural project required a Risk Management Plan and the support from the Nurse Unit Manager and Director of Nursing at the hospital. The site of the mural was outside of the secured fenced area around the unit on a retaining wall that encircles half of the unit buildings. The cement block retaining wall, which was approximately 2.20 m high and 14 m long, required cleaning before painting of the mural could begin. The retaining wall site was strategically chosen by the ARO to maximise consumer's view of the mural so that they could see the mural from the unit's communal space.

The ARO who has experience in co-designing and facilitating community mural projects worked with participants to create a safe space where all opinions and ideas were respected and heard. Within the safe group space, participants could engage with the workshop at a level that best suited their needs and ability to concentrate. By providing a flexible safe group space, participants could be directly engaged in the activities or watch and at times both, easing any anxiety or stress they may feel within a group situation.

Cultural responsiveness and representation were key considerations underpinning the mural co-design. The unit's population at that time could be described as having a high proportion of First nations people. Therefore, recognizing, celebrating and responding to the shared cultural identity of consumers was a key design component.

Design

The design step within the co-creation process involves the five, often iterative, phases that include, inviting, sharing, combining, selecting and continuing. The mural project used each of these five phases to arrive at workable design concept. The

process used to arrive at a workable design, one that is still subject to changes, was not linear and at times looped back when design issues or further ideas were incorporated. The co-design of the mural began in February 2023 and continued until May 2023.

The ARO and the unit's activity nurse first discussed the mural project idea with consumers at their regular morning meeting and **invited** consumers, as key stakeholders, to take part in the project. Consumers who were interested in the project formed a breakout participant group. During this initial meeting the ARO outlined the scope of the mural project to the participants and showed them photographs of the mural site.

In the initial stages of the co-design process the ARO presented participants with images of other murals from around their local area. Additional to this set of images, multiple photographs of Australian First Nations people mural artworks were viewed and discussed. The participants were encouraged to **share** their thoughts about the supplied set of mural images and how mural artists' used imagery, colour, and symbolism and what they felt the imagery signified. Participants were then provided with drawing materials and collage materials so they could reproduce their ideas and share them with the group. First Nations people cultural symbols, imagery and stylistic mark making and painting technique ideas were incorporated into the designs produced by individual participants. An example of this is the use the First Nations people flag and the Sand Goanna identified as a First Nations family totem by a participant.

Once finished, participants shared images and their thoughts with the group. The images generated were then **combined** and developed further. The group agreed upon a **selection** of images and with the support of the ARO these images were translated into a preliminary, collective visual story, Figure 3.

At this stage in the co-design process, the ARO and the OT collaborated on ways that the initial design or visual story could be enhanced to enrich the value of the mural to include a therapeutic outcome. The formation of this collaboration created a learning loop, see Figure 2, in the co-creation process that added 'value' to the original visual story and established a therapeutic legacy for current and future unit consumers. The OT's idea of incorporating the Kawa model shifted the design step in the co-creation process by looping back to the invite, share and combine phases where elements of the Kawa model were combined with the original visual narrative. The OT and ARO's ideas took the original snake image that ran through the center of the design and translated it into the Kawa model's river metaphor, with its associated elements of water flow, riverbank, rocks and driftwood (Iwama, 2006). Incorporating this change into the design aligned with the projects aim of creating a mural that was culturally responsive and collaborative.

These new ideas were taken back to the unit's participant group where the group **shared** their opinions of the proposed changes where further refinements were **combined** and **selected**. Some of the participant group found this inclusion of ideas difficult to understand, however with further discussion and negotiation of the proposed changes the group agreed on the changes and the design moved into the **continuing** phase where a final visualization of the mural design was developed.



Figure 3 Illustration of collective visual story

A key line drawing mapping the mural in its entirety was created by the ARO with the assistance of participants. Once completed, sections of the key line drawing were used by the participants to explore and decide upon the use of colour. At this point in the design step of the co-creation process, a fully illustrated version of the mural was created by ARO and participants. To garner support for the next step of the process, a laminated photocopy of the mural illustration was hung in the unit as a way of promoting the project and eliciting help with its painting. Throughout the design step an increase in conversations among unit stakeholders such as consumers, nursing and Allied Health staff and outside community members was created around the project and its objectives. The mural provided a positive topic for the unit's stakeholders could engage with or share an opinion of, outside of notions and conversations of hospitalisation and mental health.

While the design process was still being worked through the ARO was working in the background to complete the safety planning, the purchase of painting materials and the preparation of the project site. Where possible project participants were involved in discussions about paint colour choice, ordering and purchasing of materials.

Realise

Now that the mural design was finalized, the next step in the co-creation process was the realisation or painting of the mural. To finally realise the mural project, project participants were required to engage in the preparation, drafting and painting of the chosen design onto the designated site. Participants in this step of the process needed to have appropriate leave conditions to move beyond the unit's secure boundaries to work on the mural site.

In late May 2023, the cement block retaining wall used for the site of the mural was cleaned by hospital maintenance and participants assisted in the undercoating of the

wall surface. Next the participants assisted the ARO to grid up the wall surface so that the outline of the mural design could be drafted onto the wall, see figure 4. The painting stage of the project which began in June 2023.



Figure 4 Grided mural outline on wall

To maximise the potential wellbeing outcomes of the mural project, the ARO integrated a celebration of the National Aborigines' and Islanders' Day Observance Committee (NAIDOC) into the unit's usual programmed mid-week BBQ. The NAIDOC week event was also an opportunity to celebrate and promote the beginning of the painting phase of the project. The Indigenous Mental Health team was invited to lead the celebration with a smoking ceremony and other cultural activities. Involving the Indigenous Mental Health team at this point in the project helped reinforce the cultural responsiveness utilised in the mural imagery and to improve a sense of identity, belonging, and community among unit consumers. Multiple unit consumers expressed the 'enjoyment' they experienced while attending the BBQ celebration. Observation of consumer and project participants general wellbeing suggest positive feelings were experienced during the NAIDOC week celebration which had a spillover effect on how unit consumers appreciation of the mural.

During the painting of the mural maintaining a flexible approach to translating the illustrated design agreed upon by the stakeholders was an important aspect of the continuing realization of the project. Many design changes evolved over the realization step of the process which involved negotiation between stakeholders and a willingness to trial ideas put forward by the group to solve project challenges. An example of this flexible approach to problem solving and the importance of listening to stakeholder concerns presented itself when one of the unit's consumers was able to raise their concern about an aspect of the design, in this case, the eye colour of the owl who was a dominant character in the mural design. After listening to these concerns, the ARO discussed the issue with project participants. The group agreed that the eye colour be changed from red to yellow to alleviate any concerns that the consumer was experiencing while looking at the mural.

Throughout the six months it took to realise the painting of the mural image, the mural project and the symbolic imagery of the design become a topic for conversation shared between unit stakeholders. Observations of consumer interactions with the ARO, nursing staff, cleaners, support workers, family members and friends suggest that the developing mural provided avenues for the expression of opinions, ideas and a focus outside of consumers mental health diagnosis. Consumers and project participants alike were able to express their feelings of pride, sense of ownership and excitement with others outside of the unit by showing the mural to visiting family members and support workers as well as sharing photographs of themselves in front of the mural. During the painting of the mural participants working directly on the mural and consumers who were inside the unit boundary fence were able to listen to and share music while painting. The mural painting provided the ARO with multiple opportunities to check-in with consumers, develop stronger consumer relationships and discuss a wide range of topics relevant to consumers. Observations of these encounters with consumers suggest that the mural project become a nexus from which the unit stakeholders were able to improve their sense of community, connection and belonging.

To acknowledge their participation in the mural project, consumers placed their handprints on a chosen part of the mural, see Figure 5. Most chose sections of the mural that were meaningful to them so that when they looked upon the mural, they had a direct visual association that links their positive memories of participation and the shared experience of mural's co-creation. Each consumer that was agreeable had their photograph taken in front of the mural. The photograph also become a positive reminder of their personal and shared participation and reinforced their experience of achievement and success. Some consumers included these photographs in Christmas cards to family. By doing so, consumers received positive recognition from family members for their participation and achievement.

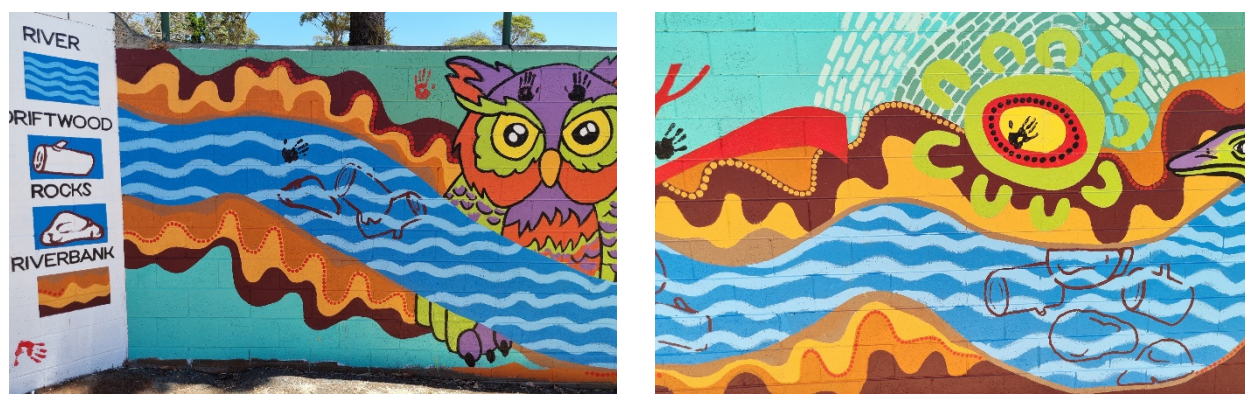


Figure 5 Handprints of consumers on mural

Evaluate

The final step in the co-creation process provided an opportunity for the project stakeholders to reflect on and evaluate the mural project and value created by it. To celebrate the success and assist in the evaluation of the mural project, the ARO created a PowerPoint slideshow of photographs detailing all the steps of the co-creation process. The slideshow was used as a debriefing tool to facilitate small group evaluation discussions with stakeholder groups such as unit nursing staff, consumers, and Allied Health staff. Feedback from small group evaluations suggests that the project was 'valuable', 'improved the visual environment of the unit' and 'improved wellbeing in the unit'.

The ARO also used the PowerPoint slideshow for one-on-one conversations with consumer participants. These conversations provided a space for participants to personally debrief, give feedback on the co-creation process and celebrate personal achievements and contributions to the project. Observations from these consumer debriefing meetings suggest that consumers evaluated the mural project highly and enjoyed the co-creation process from start to finish. Participants expressed their feelings of connection, belonging and wellbeing through their participation in, and contribution to the project. On a personal level, participants also expressed how they experienced a sense of personal achievement each time they view the finished mural.



Figure 6 Completed mural

Discussion and implications

Art interventions like the mural project described in this paper, provide meaningful activity for the psychiatric rehabilitation of adult forensic consumers in a regional setting. Participation in the mural project provided a creative vehicle in which to redirect their focus toward positive experiences that were observed to have improved their self-esteem, sense of identity and ability to mobilise social supports

(other unit stakeholders) and connection (Jensen & Bonde, 2018). Additionally, project participants were observed to have enhanced their overall wellbeing by increasing and nurturing their psychosocial resources (Jensen & Bonde, 2018; Reynolds & Lim, 2007). The finished mural transformed the visual environment of the unit and a created sense of ownership among consumers which improved consumer wellbeing (George & Kasinathan, 2015; Power, 2018).

Observations of possible change mechanisms present in consumer behaviour and mood throughout the project include: intra-personal improvements such as enhanced self-esteem, pride, feelings of accomplishment and the ability to express these feelings; cultural expression of First Nations identity, culture and aesthetic pleasure; cognitive mechanisms such as reminiscence, problem solving, increased attention and memory; and improved social connection through teamwork, sharing of music and discussion of ideas (Dunphy et al, 2019; Van Lith, 2016; Power, 2018).

The mural project had substantial limitations ascribable to its lack of research methodology, descriptive nature and contextualization within a regional, medium security forensic mental health unit (George & Kasinathan, 2015). The positive benefits observed by health service staff and reported by consumers are not able to be confirmed or replicated. Project participants varied throughout the 10-month project due to new consumer admissions, leave requirements and consumer transition back into the community. Project participants also varied in their psychiatric diagnosis and stage within their recovery trajectory.

However, the mural project demonstrated that co-creation is a viable and worthwhile process to use in this highly specialised clinical setting. The stepped co-creation process used throughout the design and painting of the mural, described in Figure 2, was seen to empower consumers and foster agency by permitting consumers to make design decisions and communicate ideas through the imagery chosen. The iterative or cyclic nature of the co-creation process allowed the mural to evolve as it was being realized through the painting process. As adjustments were made to the overall design other design decisions were necessary. Observations of positive improvements in consumer wellbeing and behaviour during the mural co-creation process has relevance for adult and adolescent forensic psychiatric rehabilitation units.

In addition to the positive consumer wellbeing, the utilization of metaphoric imagery derived from the Kawa model embedded within the mural has the potential to be developed into a therapeutic assessment tool for current and future unit consumers. The therapeutic legacy afforded by the mural is evident in the vastly improved aesthetic appeal of the unit environment and the shared metaphoric meanings and common understanding of objects (rocks) and phenomena (river flow) that is culturally responsive to both First Nations people and non-indigenous consumers.

Likewise, the innovative application of the Kawa model embedded within the mural imagery has implications for its application in adult and adolescent forensic psychiatric rehabilitation. The positive outcomes from the mural project greatly added to the recovery journey of consumers who experienced a sense of connectedness and empowerment.

The authors report there are no competing interests to declare.

References

De Koning, J., Crul, M., & Wever, R. (2016, May). *Models of co-creation*. [Conference proceedings] Service Design Geographies. ServDes.2016 Conference, Copenhagen Denmark. Available from:

www.researchgate.net/publication/303541138_Models_of_Co-creation

Dunphy, K., Baker, F., Dumaresq, E., Carroll-Haskins, K., Eickholt, J., Ercole, M., Kaimal, G., Meyer, K., Sajnani, N., Shamir, O., & Wosch, T. (2019) Creative arts interventions to address depression in older adults: A systematic review of outcomes, processes, and mechanisms. *Front Psychol.* Jan 8; 9:2655. doi: 10.3389/fpsyg.2018.02655.

George, O., Kasinathan, J. (2015) Mural art therapy for young offenders hospitalised with a mental illness. *Australasian Psychiatry*; 23 (1):49-53.
doi:10.1177/1039856214563852

Gregg, B., Howell, D., Quick, C. & Iwama, M. (2015) The Kawa River model: Applying theory to develop interventions for combat and operational stress control. *Occupational Therapy in Mental Health*, 31:4, 366-384. doi: 10.1080/0164212X.2015.1075453

Iwama, M., (2006). *Kawa model: Culturally relevant occupational therapy*. Churchill Livingstone, Edinburgh.

Jensen, A., & Bonde, L. (2018). The use of arts interventions for mental health and wellbeing in health settings. *Perspectives in Public Health*, 138 (4), 209-214.

Goodman-Casanova, J., Guzman-Parra, J., Mayoral-Cleries, F., & Cuesta-Lozano, D. (2023). Community-based art groups in mental health recovery: A systematic review and narrative synthesis. *Journal of Psychiatric and Mental Health Nursing*, 00, 1–16. doi:10.1111/jpm.12970

Howells, V., & Zelnik, T. (2009). Making art: A qualitative study of personal and group transformation in a community arts studio. *Psychiatric Rehabilitation Journal*, 32, 215-22. doi:10.2975/32.3.2009.215.222.

Jay, E., Patterson, C., Fernandez, R., & Moxham, L. (2023). Experiences of recovery among adults with a mental illness using visual art methods: A systematic review. *Journal of Psychiatric and Mental Health Nursing*, 30, 361–374. doi:10.1111/jpm.12882

Parr, H. (2006). Mental health, the arts and belongings. *Transactions of the Institute of British Geographers*, 31 (2), 150-166. doi:10.1111/j.1475-5661.2006.00207.x

Power, M. (2018). *Investing in arts and culture positively changes communities: An impact study of RADF supported arts projects in Western Queensland*. [Doctoral Thesis, University of Southern Queensland], doi:10.26192/5c09cef2f0ccb

Reynolds, F., & Lim, K. H. (2007). Contribution of visual art-making to the subjective well-being of women living with cancer: A qualitative study. *The Arts in Psychotherapy*, 34 (1), 1–10. doi:10.1016/j.aip.2006.09.005

Szebeko, D., Tan, L. (2010). Co-designing for society. *Australasian Medical Journal*, 3, 9, 580-590. doi:10.4066 / AMJ.2010.378

Turpin M. & Iwama M. K. (2011). Using occupational therapy models in practice : A field guide. *Elsevier*. Retrieved December 11 2023 from <http://public.ebookcentral.proquest.com/choice/publicfullrecord.aspx?p=1722698>.

Van Lith, T. (2016). Art therapy in mental health: A systematic review of approaches and practices. *The Arts in Psychotherapy*, 47, 9–22. doi:10.1016/j.aip.2015.09.003

Vargas, C., Whelan, J., Brimblecombe, J., Allender, S. (2022) Co-creation, co-design and co-production for public health: A perspective on definitions and distinctions. *Public Health Res Pract*; 32 (2) e3222211. doi:/10.17061/phrp3222211

Doing a PhD

Dr John Gillett | Physician | St Andrews Hospital, Toowoomba
<https://orcid.org/0000-0003-2518-0629>

When you say it quickly it sounds like a dance, “Doing the PhD”, like the Locomotion by Kylie. Well, nothing could be further from the truth. Did I enjoy it? Well that depends. I can just see the sun coming up over the hill so am a little more relaxed about its inevitability but it wasn’t always that way. There have been times in the six years when I thought it will be amazing if I see this thing out. I still won’t be completely settled until I have that scroll in my hand, being congratulated by my supervisors.

As much as the PhD is a journey in itself, my journey had started long before I got to the starting line. I had graduated from medical school at age 23, spent one year training as an RMO before being sent bush. I owed the government a year’s indenture for short funding scholarship to finance me through graduation. I had been academically-minded at school and fair at medical school. My only claim to fame is never failing an exam, except the grade 4 altar boy exam. My father, who expected success in nearly all aspects of life, was not phased by this. So, I didn’t become an altar boy.

Back to being a doctor, I wished to pick up my school studies in Japanese while I was a resident doctor at the Mater Hospital. As the drinking age was 21 when I went to university, grog was not an overwhelming part of my life. I continued attending night classes once or twice a week during that year. Simultaneously, I tried to assemble the skills I thought necessary to survive as a bush doctor. All of us on a government scholarship knew we would be sent rurally and often to towns who could not attract non-indentured doctors. My hospital teachers, senior doctors, were variable in teaching practical skills essential for rural survival. A few thought I was too pushy to get my hand on the scalpel, thinking I overestimated the rural challenge. If anything I had underestimated what I would face.

Being the medical superintendent with right of private practice, I was working during the day seeing a slow trickle of private patients at my small clinic, and public patients at the hospital. While it was not overly busy it was constant, with the only relief coming from a similar second year doctor giving me five days off every thirty. The relieving doctor did this in five rural hospitals then had five days off herself. The blessing was the slowness of people seeking my opinion. People were cautious about attending as the previous medical superintendent had been controversially sacked. I could see a patient with a chronic disease like hypertension, read up on their case in the intervening week and have decided on which anti-hypertensive to give them

when they returned. I read and learned book knowledge, while the patients taught me real world knowledge.

I could see it would be easy to become deskilled quickly in the bush and I hadn't become sufficiently skilled to be deskilled. In the first couple of years I sought out education that would help me treat my new community. Starting simply with learning how to do a curette to treat women who suffered a miscarriage locally, not having to travel 220kms to Toowoomba. I was very cautious about what I treated electively. I had some cowboy skills such as competent horse riding, but I did not want to be a cowboy in medicine practicing on people. As I identified needs of the community, I would seek a teacher in the big smoke to mature my skills to practice safe medicine. Probably the most important skill was the crash course in doing a caesarian section in a month's placement at the Royal Brisbane and Women's Hospital facilitated by the superintendent John Campbell. A very generous act as I had never worked as a doctor at the RBWH, although I had done curette training there two years previously. Now I could truly practice safe obstetrics in Miles. Perhaps John was amazed that I had remained in the bush now four years, non-indentured for three.

I had become fairly skilled with the procedures. Another rural doctor had instructed me on how to do an appendectomy. Getting me to draw the proposed incision with a pen on the anaesthetized patient's abdomen. It was deep end stuff but it was learning in its rawest form. I also realized that the medical needs of patients such as the treatment of asthma, hypertension and diabetes needed attention. Continuing education was now formalized so I enrolled with RACGP with a view to doing the fellowship exam. In those days the qualification was not necessary to practice as a GP. However, I was specially using the study to progress my skills in the treatment of my community.

After six years I was a fairly competent doctor in acute medicine, then I recognized the need to treat chronic painful aging conditions such as osteoarthritis. The only treatment available besides Paracetamol were the NSAIDs. These had the nasty side-effects of causing stomach ulcers with the occasional patient bleeding to death, not a great outcome. Two elderly women in 1984 used to drive to Toowoomba for a weekly acupuncture treatment, being unable to tolerate NSAIDs. That seemed like a good clinical trial to me. I decided there must be something in acupuncture and anything was better than the current treatment. I also learnt from my mother, who managed to get off the 1970's treatment for menopause, Valium, often the cause of long term addiction. With the help of a chiropractor she used herbal medicines to do this. Without realizing from an early age I was learning to be inquisitive, looking at all ways of improving peoples' health.

By now I'm guessing the reader knows the next move. Yes, I went to China and worked with a traditional Chinese doctor learning acupuncture. It was helpful that I had also finished the language degree with majors in Japanese and Chinese. I was by no means fluent but I could easily get myself around and converse with the Chinese patients. This is one of the best skills I have learnt developing a busy acupuncture clinic alongside western medicine. What a joy to be able to use non-drug medicine for some conditions.

My story is about life-long learning, helping people along the way if I could. I have tried to stay faithful to the ethos of fairness, egalitarianism and provision of health services on a basis of disease not wealth. For most of my career I have had the privilege of working in both the public and private sectors simultaneously, allowing me to treat all. The learning has been in traditional western medicine at Queensland and Monash University, also in medicine at the fringes in acupuncture and osteopathy, even in what some people call quackery in Homoeopathy. The drive has always been to not only educate myself but to help my patients safely.

Part of my responsibilities in the bush was my role as a Government Medical Officer or a police doctor. This meant being involved in assessing impaired drivers clinically and taking blood for alcohol and drug assessment. I was also expected to perform forensic examination of deceased motor vehicle crash victims. Whilst this was a legal responsibility, I also considered it a good opportunity to revise my anatomy knowledge as I learnt in a similar way on the generously donated cadavers at the UQ medical school.

Fast forward to 28 years completed in the bush, it was time to move on to a different challenge Palliative Care. I will not bore the reader with how this came about, I was just someone who needed a new challenge in helping others every so often. This is where a kindly health librarian, enters the picture.

I was working as a Senior Medical Officer in Palliative Care at Toowoomba Base Hospital. This was a new medical specialty in which I could see my various skills such as Acupuncture, Homoeopathy and Osteopathy being used alongside my traditional skills of western medicine. The three year specialist training program was fairly unorganized at the time (2007). I had to source my own education and educators. For two days a week I worked at St Vincent's Hospital in Brisbane, going down on a Wednesday morning doing on-call overnight and returning on Thursday evening. With the TBH job, St Vincents job and three children at school, life was busy. Not much time for study. This is when my librarian colleague entered my world. I explained my problem ie I had to be educated in Palliative Medicine and no time to do it in. In a calm way the librarian listened to my story, took a few notes, saying "I'll be in touch". He did ask one salient question "Do you have a CD player in the car?"

Within a few days a couple of CDs were delivered to my office with a note "Try these". What a brilliant idea. Each CD lasted 1 hour, finishing just on the outskirts of Brisbane when I would have to concentrate on city traffic. Two CDs a trip for a year. For a really interesting topic I would listen to the CD twice. What amazed me was the focus of the CDs. Despite a wide focus including hospital talk-back radio in the US, Telomeres, Anesthesiology and Pain control to name a few, all were relevant to Palliative Care. I was taught that the role of the librarian had changed, embracing the new digital world with much greater access to knowledge. I realized that a good librarian was now a keeper on knowledge with skills to link relevant knowledge to the researcher.

Somehow with help from a few other colleagues my training fell into place. Firstly there was the preliminary dissertation on the role of diuretics in ascites (Abdominal Fluid Collection). This involved a literature search on all articles pertaining to the subject, with assistance from the ever-helpful library. Additionally, should any new articles be published on the topic, library staff would have them to my in tray pronto. The librarian was also an experienced teacher on the use of end-note to reference the study. The final product in retrospect could have been published as a comment piece, however we were not into publishing at that time. It was just submitted to the RACP.

Three years passed and it was time to write an article for an international medical journal in order to receive my fellowship. Once again enters library help with literature reviews and brushing up my end note skills. This was more challenging being on Complimentary Medicine as the grey literature had to also be accessed. With the help of my supervisor, Dr Jarad Martin, and the library, I was awarded the best registrar research prize at the 2009 RACP Conference in Auckland. My quest for knowledge was getting explorative, having graduated from course work degrees with proscribed reading lists.

While I was working in Palliative Medicine, I was confronted by a social issue: "Could Palliative Care Cancer Patients drive safely while medicated on opioids?" This raised issues for me as I had spent a lot of my life as a bush GP assessing driving privileges and assessing impaired driving due to alcohol and drugs. The impairing drug in this case was the opioid class of drugs providing necessary pain relief for quality of life. The issue was that opioids can impair driving through cognitive side effects. Palliative Care promises maximizing QoL for the patient and family. Can both these QoL improvements co-exist together whilst maintain safely for both patient and wider community.

This subject of the safety of opioids and driving had rolled around my head for some years. When palliative cancer patients entered the mix, I had to find an answer in order to see this marginalized group of patients treated fairly. I could see

investigating the issue would take some work. From my background I believed the attitudes of GPs and Pharmacists to driving on opioids would have to be explored as GPs prescribed the opioids and Pharmacists dispensed the opioids. These two professions were likely to be advising the cancer opioid medicated patients on driving. Then there was the question of which palliative cancer patients to study. There were more questions, like should it be one cancer or a number of cancers.

Back to the library for a search on driving on opioids in Palliative Care. Only one study done but not relating to opioids. We then knew this was a novel topic worthy of research. With the library's help I broke the topic into its component parts to see if any studies related to my area of interest. Searches were performed on:

1. Opioids and driving (in non-cancer pain patients or healthy volunteers).
2. Opioids in Society (including illicit use and policing in other countries).
3. Doctors and driving (history, road safety, EMST and Mandatory Medical Examinations).
4. Palliative Care (what is it, what promises, research to date).
5. The Car (from T Model, choices, Personalised Plates, relationship, bucket list).
6. Articles were also read on Qualitative Analysis before deciding on an analytical approach.

In the following six years over 1,500 articles have been broadly canvassed during the course of this project.

I now had a fair idea about what I wanted to study but no idea what to do with it. I had spoken to one drug rep who manufactured opioid medication but they showed no interest. I went to Queensland University of Technology as I knew the car accident research unit was there. I went to QUT unannounced to discuss my idea. I had no contacts there but thought I would knock on the door. While wandering from office to office to find the right person, I was lucky to bump into an old colleague from the bush I had not seen for 20 years. She was now the professor of paramedicine. She organised introductions for me and I was on my way. With the funding pressure on academic institutions, my original supervisors have moved on. I am now under a different school with different supervisors for the last two years, who I am well settled with.

I had to decide the exact cancer cohort to study and how to recruit them. Interviewing the GPs and Pharmacists I thought would be relatively easy as these were my professional equals. Ethics approval for interviewing these two groups was quite straight forward, being considered negligible or low risk studies. When it came to interviewing advanced cancer patients ethics to study this group were considered high risk, taking many meetings and a full year to obtain ethics approval. I had considered my profession of medical practitioners as being very ethical so was surprised by the length of time to get approval.

The next issue was whether to study part-time or full-time. I did consider studying full-time and thinking I had an important idea applied for an NHMRC scholarship. Heard nothing, not even an indication of whether my idea was worthy of research. Fortunately QUT were happy with my research proposal and have funded the course fees and a small stipend to cover interview transcription. So part-time it is.

Quantitative or Qualitative, that is the question. As driving on opioids in Palliative Care is sparsely researched, this being exploratory research, it had to be qualitative to see what was happening in this space. Then which qualitative analysis system to use, RTA, TA, GT or CGT? I have made a fist of using CGT and RTA however in retrospect wish I had read about them a little more prior to the research. One must have a solid view about these analytic systems and how to use them. Some of the literature can be confusing when describing these analytical methods. Once again the hospital library came to the fore, getting me books on these topics.

There are two ways to climb the final mountain of writing up a PhD thesis ie by monograph or by publication. I initially thought I would do it by monograph but in doing basically three studies on GPs, Pharmacists and Cancer patients I had not realised how much data I had to analyse. Somehow I had to reign the task in by analysing each study as I went. This resulted in writing a paper on each study and submitting for publication. It made sense to do a last minute change (at the 5.5 year mark) to thesis by publication.

Once again my trusty librarian came to the rescue helping me select which journals to submit to. The quality of the journal had to be high to satisfy the university and for me the journal audience had to be appropriate. I do not want the reader to think my university team of Julie-Anne, Melanie and Mark, previously Vivienne, Lisa and Mark were not advising me. Mark deserves a special mention for continuing on the team even though the uni did not extend his contract. They were. However, when you are researching and studying part-time while still working, it is invaluable to have a colleague locally who can advise, proof read and be a counsellor when one receives the occasional journal knock back or harsh criticism. Having an on-site advisor complemented the fortnightly meetings with the uni advisory team.

Now with two articles published and one about to be submitted to publication I am confident that the end is in sight. Some advice to other non-academic clinicians who wish to attempt a PhD at the end of their careers:

1. Make sure it is a topic you are passionate about researching. This should not be an issue for a senior clinicians.
2. If you can, sort out your supervision properly, in a more formalised way than I did.
3. If you are doing it part-time try to have some local support. In my case it was the librarian. I was lucky as he has also become a good friend.

4. If you are doing qualitative research for the first time read about it. Braun and Clarke, Charmaz etc.
5. Get ready to learn a new language spoken in academia like heuristic, ontology and epistemology.
6. Enjoy trying to do good for others.
7. Buy your wife flowers regularly.

I did think doing a PhD would be my swansong into a slipper and pipe retirement, but already I am having thoughts about the next project (in confidence... don't tell my wife).

John Gillett (28/07/2025, or about 20 years since I walked into a small hospital library and met staff who would go on a journey with me).

Health Library Staff Member Spotlight

Jana Waldmann

Library Manager | The Prince Charles Hospital Library

When did you first start working in a health library?

I started working at The Prince Charles Hospital (TPCH) Library in 2015 and never left.

How/Why did you join health librarianship?

After finishing my library studies, I applied for every possible job available, in every library sector. It took 7 months to even get an interview (I had no previous library experience), but I was then offered 2 jobs in the same week! The call from TPCH came first and I liked that it was a role where you'd get to learn a bit of everything, from client services and training through to cataloguing and collection management.

What was your previous employment background, prior to health libraries?

I worked in magazine publishing in Sydney and London, and then in Aircraft Publications after moving to Brisbane (which had nothing to do with the inflight magazine - the role involved managing and editing updates to the aircraft manuals). It prompted a change in career and I decided to retrain as a librarian.

What do you find most interesting or enjoyable about your current position?

I love the mix of problem solving and customer service that health librarianship provides. There's a wonderful sense of satisfaction when people come to you with an issue and you can help them with the solution. It's also great hearing how the work we've undertaken here at the library has impacted on different areas of the hospital, from facility design through to patient care.

What has been your biggest professional challenge?

I think starting out was a bit of a shock - there was so much to learn, not just from a library sense but also understanding the hospital/health system and all the terminology. I was very fortunate to have a wonderful boss and mentor, and colleagues that supported me as I learned the ropes.

What do you consider the main issues affecting health librarianship today?

Challenging people's assumptions of what we do and what our patrons need is definitely an issue (Oh, you still have print books - isn't everything online? Can't AI do all of that?). Also keeping up with all the developments that will come with AI and how we can work with it and make people aware of its benefits and limitations.

What would you do if you weren't a health librarian?

My dream job is to work for a company like Orbit, Tor or another fantasy/science fiction publisher. I'd happily read the slush pile of unsolicited manuscripts for free.

What is your favourite non-work activity?

Cheering on the mighty Brisbane Lions (or hiding behind the couch, depending on how the game is going), and reading (it was the reason I chose to become a librarian, though I've been told you're not meant to say that in job interviews!).

What have you been reading / watching / listening to of late that you have really enjoyed?

Reading: "The Season" by Helen Garner

Listening: playlists curated by my kids for a road trip. Finding out what resonates with them has been fantastic (lots of Elton John and David Bowie. Too much Imagine Dragons).

Watching: I'm re-watching all the Marvel movies (in chronological order) and just reached Guardians of the Galaxy II, which still gives me all the feels. Also, way too much footy.

