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VAPING: POTENTIAL TO IMPROVE THE PHYSICAL HEALTH OF MENTAL HEALTH CONSUMERS

The growing use of electronic cigarettes, or personal vaporizing devices (PVD) as they are more accurately termed, led to the word "vape" being nominated the Oxford Dictionary's 2014 word of the year. Although they were invented just over a decade ago, the use of PVDs doubled last year and the industry was estimated to be worth $US2 billion, with some predicting sales to eclipse those of tobacco products within the next 10 years.

So what is vaping exactly? Well according the Oxford Dictionary it is the act of inhaling and exhaling the vapour produced by an electronic cigarette or similar device. There are many and varied PVDs on the market today with new models being announced on a weekly basis. These range from simple, often disposable, 'cigalike' devices which closely resemble tobacco cigarettes through to high-powered 'box mods', typically the size and shape of a cigarette packet, with variable power, electronic safety features, LED screens and more.

Some of the wide variety of PVDs available
source: http://www.tampabay.com/news/education/k12/

All e-cigarettes or PVDs share 3 basic components: a battery, an atomizer (basically a small coil of wire surrounded by a wicking material, usually cotton wool) and a tank or container for the e-juice or e-liquid.

Basic components of an e-cigarette or PVD
source: www.biomedcentral.com/1471-2458/11/786/figure/F1?highres=y

The liquid used for vaporizing (E-liquid) typically contains 4 main ingredients: propylene glycol, vegetable glycerin, nicotine and flavouring. The relative proportions of these ingredients are quite variable. Nicotine content varies from nil to 2.4% (usually recommended for heavy smokers), propylene glycol (PG) and vegetable glycerin (VG) percentages vary from 80% PG to almost 100%VG, with flavorings making up only 1-2%. Generally the simpler devices used by new vapers have higher concentrations of PG (typically 80%) with high (1.8-2.4%) nicotine content (to assist with smoking cessation) whereas more experienced users tend to move to higher percentages of VG with low, or even no nicotine. To activate the PVD the user either presses the power button whilst inhaling or simply inhales (on simpler cigalike type devices). This causes the 3.7 volt battery to pass a current through the coil, heating it to a temperature high enough to vaporise the e-liquid, which is then inhaled by the user.

The rapid rise in use of PVDs has led to a frenzy of claims and counter-claims regarding the safety of vaping. The most frequent claims of those who oppose vaping are that the use of PVDs, especially amongst young people, will lead to smoking tobacco cigarettes and that the possibly harmful effects of vaping are unknown. Supporters of vaping argue that PVDs are an effective form of nicotine replacement that helps many smokers to reduce or quit. Unfortunately there is little in the way of strong scientific evidence to support these claims in either direction. Although a full review of the available evidence is beyond the scope of this brief article, the proceedings of the influential US-based Society for Research on Nicotine and Tobacco (SRNT) annual symposium[1] held in February this year highlights some of the emerging findings and research directions in this rapidly growing and changing field. Curtin et al., (2015) reported the findings of the National Tobacco Behavior Monitor for Q12013 & Q12014 (N= 30,136), which found that of 2,618 e-cigarette users the vast majority (89%) were smokers or former smokers and that almost a quarter (23.7%) had successfully quit smoking. Overall, there were estimated to be 15-20 million regular vapers in the US in 2013-14 of whom approximately 4 million were ex-smokers. This represents massive savings in health care costs, smoking-related morbidity and mortality. Although it is far too early to say that vaping is a safe alternative to smoking tobacco, it is almost certainly a safer alternative and one that has had impressive success in helping some smokers to quit.

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VAPING: POTENTIAL TO IMPROVE THE PHYSICAL HEALTH OF MENTAL HEALTH CONSUMERS

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So what does all this have to do with mental health nursing? Well, my first reaction upon discovering vaping was that this could be a solution to the ongoing problem of non-smoking health settings, especially acute inpatient settings where consumers who wish to smoke are often unable to go outside or leave the premises to smoke without an escort. Why not make disposable e-cigs available in our inpatient units as an alternative to other (generally less successful, less acceptable and more expensive) forms of nicotine replacement therapy? One answer to this question is the law. Currently in Victoria it is legal to sell, purchase and use PVDs and e-liquids but it is illegal to sell or supply nicotine in liquid form and (under Commonwealth regulation) to advertise it as NRT. It is, however, legal to purchase and import up to 3 months supply of nicotine liquid for personal use from overseas. Another answer is that we currently know next to nothing about the acceptability or effectiveness of vaping as a replacement for regular cigarette smoking amongst people who have severe mental illness. Although the legislative and regulatory frameworks may take some time and much discussion to resolve, Professor Jayashri Kulkarni of Monash University in Melbourne is embarking on a study that may shed some light on the potential of PVDs within our patient population.

Professor Kulkarni

Professor Kulkarni received a 2014 VicHealth Innovation Research Grant for a study of the acceptability of vaporized nicotine products for smoking reduction or cessation in people with severe and persistent mental illness. There is strong evidence that much of the approximately 20 year reduction in life expectancy of people who have schizophrenia is attributable to chronic physical disorders associated with smoking such as cardiovascular disease, respiratory disease and cancer. Heffner et al. (2015) reported at the SRNT annual symposium[1] that "Smokers with psychiatric disorders represent over 40% of current smokers, consume 45% of cigarettes sold in the US, and quit at rates up to 50% lower than smokers in the general population". These figures, in combination with recent calls for further investigation of nicotine replacement therapies for people with severe and persistent mental illness in light of the finding that smoking appears to have a restorative effect on the loss of neuroplasticity commonly seen in schizophrenia, mean that a thorough investigation of the potential of vaping is much needed.

Specifically, Professor Kulkarni's study will provide information about:

- Relative interest in long-term substitution with Vaporised Nicotine Products (VNP) versus standard care (nicotine patches for short term use + cessation counselling)
- Relative attractiveness of a range of VNP and nicotine patches
- Uptake and duration of use of these products
- Impact on cigarette intake, cigarette cravings, quitting self-efficacy, general health and well-being
- Safety and side effects of use

The success of millions of people around the world in using vaping to help reduce or quit tobacco consumption is very encouraging. We look forward to the outcomes of Professor Kulkarni's research with great interest. It is too early to call but the possibility that vaping may help to reduce the unacceptable gap in mortality rates between people with severe and persistent mental illness and the general population is exciting indeed.

Associate Professor Stephen Elsom
Director, Centre for Psychiatric Nursing

RECOVERY LIBRARY TO BE LAUNCHED AT COLLABORATIVE CONFERENCE

Over the past decade, recovery has become the driving force behind policy, service and practice development internationally. In the paradigm of mental health, the concept of recovery is understood to refer to a unique personal experience, process or journey that is defined and led by each person in relation to their wellbeing.

While recovery is owned by and unique to each individual, mental health services have a role in creating an environment that supports, and does not interfere with, people's recovery efforts. The release of the Victorian Framework for recovery-oriented practice (Department of Health and Human Services, 2011) signalled Victoria's intention to embed recovery approaches in mental health services. The Framework identifies the principles, capabilities, practices and leadership that should underpin the work of the specialist mental health workforce.

The Victorian Department of Health and Human Services contracted the Centre for Psychiatric Nursing, University of Melbourne to develop an online repository of resources to support Victorian mental health services to actively engage with the Framework, to share high-quality resources and to support a service culture of ongoing practice development around recovery values. The resulting product is the Recovery Library. The resources can be accessed on: http://recoverylibrary.unimelb.edu.au/

A diverse range of resources was gathered from clinical and community-managed services that were identified as innovators in relation to recovery-oriented practice. The CPN visited these services and engaged in an iterative and collaborative process of identifying resources that the services routinely used and regarded highly, and which aligned with a set of criteria and values determined by the coproduced project team. These criteria included: the presence of consumer involvement in the selection, adoption or use of the resource, strong themes of self-determination, recognition of a social and familial context, use of strengths-based language and a perspective beyond a biomedical model.

The resources presented in this Recovery Library are mapped against the nine domains of the Framework for recovery-oriented practice. An additional domain pertaining to Growing Consumer Leadership was also developed as part of the formation of the Recovery Library, as this was a gap identified in the process of gathering and collating resources.

The resources are complemented by relevant links and multimedia resources, primarily filmed excerpts of thoughts and reflections of some of Victoria's leading innovative thinkers and change agents in relation to recovery-oriented practice in mental health. Victorian mental health professionals are invited to embrace, utilise and further develop this Recovery Library in an effort to continually improve the quality of people's experiences of using mental health services. This Recovery Library is intended to be a living and dynamic resource. If you have resources you would like considered for inclusion on this website, please forward them to: cpn-info@unimelb.edu.au

Cath Roper
Consumer Academic
Centre for Psychiatric Nursing

A SELF INTRODUCTION

Larissa Limberis

I was stoked on about day 3 of my new job to already be picking up on psych nursing humour. I was in a teleconference with a bunch of psych nurses and when the person on the end of the line complained that they could hear buzzing, someone in the room said "I have a little white pill in my bag which helps to fix that condition" and everyone had a chuckle. Needless to say, I appreciated that moment and instantly warmed to the idea of having 'Psych Nursing' in my new job title!

It is a great pleasure to be writing this and I am thrilled to be CPN's new Programs Officer. I've held similar positions at the University of Melbourne for the past five years or so and during that time I also completed Masters research of my own. Although I haven't previously worked in the area of Mental Health I am very excited by the prospect of engaging with it in this role.

It has been an eventful six weeks since I started, with some pretty major shifts in the landscape such as the University of Melbourne's restructure which has totally transformed it's ways of operating; the loss of the CPN's longstanding staff members - Admin Manager Greg Mutter and Project Manager Imogen Edison; and some significant changes in priorities both in terms of the CPN's research output and training delivery.

As a newcomer I've been intrigued by the range of complex issues that characterize the world of psych nursing and by the unique mediating position that the CPN occupies among the health services, the DHHS, the University of Melbourne, the consumers, the educators and the psych nurses themselves. I've started to learn about some of the conflicts of interest that exist among these different parties and I'm becoming attuned to the challenges inherent to CPN's centripetal location in relation to their respective functions.

At the same time it has been wonderful to learn about the work of my colleagues. Before meeting Cath Roper and Finbar Hopkins I had not heard of Consumer Academics, Coproduction or any of the other therapeutic approaches that they champion, and I am so impressed by these integrative modes of practice. It has also been very inspiring to work alongside Steve Elsom and Natisha Sands, who have done and continue to do such amazing work with their IMI and Triage training programs.

I have been less excited by some of the grimmer realities presented by the field though, such as the restrictive intervention and restraint measures used at some of the services; or the effects of the ice epidemic on psych nursing practice; or the severe shortage of qualified psych nurses; to name a few.

I am hoping to kick start a CPN Facebook page and/or Twitter account soon to facilitate ongoing discussions about these and other pressing topics, which is a journey I hope that you will join me on. There will be announcements and news about these initiatives soon to come.

In the meantime, I look forward to meeting you at the events over the coming months.

Larissa Limberis
Programs Officer, Centre for Psychiatric Nursing

SOME THOUGHTS ON GROUP WORK

Group facilitation is like conducting an orchestra. You want all of the different sections of the orchestra to be in harmony. This means attending to what is happening in the group as well as participating in it by asking questions and ensuring each member's voice is heard. It also means drawing attention to important things that have been said and 'checking in' with its members. You will need to be attuned to how the group develops and changes over time, so knowledge and skills relating to its topic are crucial.

Here are few additional guidelines which might help you to run a group in an inpatient ward.

Planning

It is important to plan for group facilitation. A well planned group will ensure that it runs smoothly and that you can iron out any of the difficulties or challenges before you begin.

It is worthwhile thinking about some of the factors that might impact on your facilitation.

Think about a group you have participated in and think about its processes and content.

Content and Process

In the group you may have noticed that two factors are operating simultaneously. These involve content and process. Content refers to the issue/theme being discussed, as well as what is to be done about it, and how will it be resolved. The group's conversation will revolve around its content.

The less noticeable, but equally important factor is called process. Process refers to how the group works in order to deal with the content. The process is also about how the group works with the content to achieve an acceptable outcome. One useful way of thinking about group process is through Tuckman's Model (1965) *Forming, Storming, Norming and Performing*.

Forming

The 'Forming' stage occurs when the group meets together for the first time. The facilitator/leader can help by initiating introductions, employing ice-breaking activities, and explaining the tasks and purpose of the group.

Storming

At this stage the team members 'jockey' for position as they try to establish their place in the group in relation to other members and group leader. The team tries to focus on its goals but it may get bogged down in cliques and factions and its members may engage in power struggles. The facilitator/leader of the group will need to keep the group on task to achieve its goals and to avoid becoming preoccupied by emotional issues.

Norming

At this stage the group is working towards a consensus about achieving their goals. Decisions are made by group agreement. The group is committed and they are cohesive. There is a relaxed air and members feel comfortable to challenge each other. There is respect for the group leader and some members may start to take on leadership roles. The group leader's role becomes facilitative and supportive.

Performing

This is the working stage of the group. The members are working more strategically and they know their goals and are working to achieve a shared outcome. The members have a shared vision and are also able to work autonomously. The group is able to tolerate disagreements and can positively resolve them. Team members feel confident to ask for help from the group leader around issues relating to a personal development. At this stage the group leader's role is concerned with allocating and directing.

Conclusion

Hopefully some of these thoughts and reflections will help you to establish an inpatient group.

For further information about group work the Centre for Psychiatric Nursing offers a one-day workshop in *Facilitating Therapeutic Groups*.

Please see our website:
http://cpn.unimelb.edu.au/education_and_practice_development/practice_development_workshops

Finbar Hopkins
Lecturer, Centre for Psychiatric Nursing

SAFEWARDS AT NWMH

One of the outcomes of the Victorian state wide Reducing Restrictive Interventions team was the introduction of Safewards. NWMH are part of 7 mental health services across the Victoria who are implementing Safewards.

Safewards is a model developed by Len Bowers a nursing academic and his team from the UK. The model attempts to identify and address the causes of behaviours in staff and consumers that may result in harm, such as violence, self-harm or absconding and reduce the likelihood of this occurring. The Safewards model describes how inherent features of mental health services create potential 'flashpoints', situations where conflict

could arise. Safewards focuses on how staff can act to prevent flashpoints, and how to manage and influence conflict in instances where conflict does arise. A series of 10 interventions have been developed that can be used to prevent/address flashpoints.

NWMH considered the training and how we could implement the 10 interventions into practice; our discussions were around how we could embed the Safewards model into practice. The decision was made to use Action Learning Sets as the mechanism for practice change. We were lucky enough to have Finbar Hopkins from the Centre of Psychiatric Nursing present a day workshop for those involved in Safewards at NWMH; we opened this day up to other members of the Inpatient teams to have a support base for Action Learning Sets to be done on our Inpatient units.

Action Learning Sets differ from other meetings they are focussed on reflection, action and learning and involve every member of the team. They place value in supporting listening and considering knowledge and how that can be actioned.

The Safewards model is an exciting development for Mental Health and in particular nursing, it is hoped that through using the action learning sets we can embed this model into our practice. We look forward at NWMH to having Safewards embedded in practice.

Julie Blackburn
Practice Development Project Officer
NWMH Reducing Restrictive Interventions
