

“The Other” Health

Psychiatric nurse specialists weigh in on the state of **mental health** care in **California**

Sean O'Meara



Care:

The National Institute for Mental Health estimates that 26.2 percent of American adults are affected. The World Health Organization's Global Burden of Disease study, conducted with the support of Harvard University and the World Bank, placed its economic burden in developed nations at 15 percent, which is greater than all cancers combined.

Mental illness. It impacts about one in four Americans, one in 17 severely. But with nearly 60 million people in need of treatment, mental health care is still virtually

absent from the increasingly thorny debate about health care in America. The debate might make for feisty political banter, but in the meantime, chronic underfunding and lack of parity is disabling much of the population.

NWM invited a group of psychiatric nursing specialists in California to come together for a candid, insightful discussion about the "other" health care: what's happening with treatment, how the patient population is changing, and how these professionals see their specialty evolving in an era when patients are increasingly complex.



Rita Haverkamp, MSN, APRN-BC, CNS, is the president of the American Psychiatric Nurses Association (APNA), California Chapter. She has had an advanced practice psychiatric nurse clinical specialty since 1985, and has worked for the Kaiser Permanente system for the last 18 years as an outpatient therapist. Haverkamp was instrumental in the original IMPACT depression care research program and has been a frequent speaker on this care model.



Diane Hickman, MSN, APRN, CNS, provides care at the Veterans' Affairs Medical Center in San Diego. She began her career as a medic for the U.S. Army before earning her BSN and MSN degrees, focusing on nursing education. She later completed her certification as a psychiatric clinical nurse specialist from Point Loma Nazarene University. She is currently pursuing her PhD in nursing from the University of San Diego.



Kathryn Johnson, CNS, NP, APRN-BC, is a board certified adult psychiatric and mental health clinical nurse specialist and adult psychiatric nurse practitioner. She is currently an assistant clinical professor at University of California San Francisco (UCSF). Her areas of interest include psychopharmacologic treatment for adults and adolescents with mood, anxiety, attention and thought disorders.



Kevin McGirr, RN, MS, MPH, is the acting director of quality management for Community Behavioral Health Services, San Francisco Department of Public Health. He obtained his undergraduate nursing degree in Boston and holds graduate degrees in psychiatric nursing from UCSF and public health from University of California Berkeley.



Marlene Nadler-Moodie, MSN, APRN, CNS, is a national board member for the American Psychiatric Nurses Association, and is past president of the California Chapter. She earned her master's degree in adult psychiatric mental health from Hunter College in New York. She is recognized as an expert on restraint reduction, nursing psychopharmacology and psychosocial aspects of general hospital nursing. She is currently at Scripps Mercy Hospital in San Diego.



Cheryl Puntil, RN, MN, is a clinical nurse specialist for geriatric and adult psychiatry at the Resnick Neuropsychiatric Hospital at the University of California Los Angeles. Prior to Resnick, she worked as a staff nurse at Rush Presbyterian Hospital at the Johnston R. Bowman Center in geriatric psychiatry, and at the Mayo Clinic in adult psychiatry. Puntil is widely published on a range of subjects including geriatric psychology, depression and transference.



Loralie Woods, RN, BSc, MSN, is a senior nurse specialist at Sharp Mesa Vista Hospital, the largest privately operated psychiatric hospital in San Diego County. The 149-bed facility became part of the Sharp HealthCare system in 1998. Woods earned her two baccalaureate degrees at Memorial University of Newfoundland in Canada, and her master of science in nursing from San Diego State University.

NWM: Recent statistics suggest that depression is the leading cause of disability in North Americans between the ages of 15 and 44. What's going on? What changes, if any, have you seen in your patient populations, in terms of diagnoses and demographics, over the last five to 10 years?

Hickman: My impression is that any increases over the past decade have to do with the DSM-IV diagnosis of depression as an illness. It's not that it wasn't considered an illness before, but the awareness of depression—and also the SSRI medications for depression—make depression so much more easily diagnosable and more easily treatable today. So, I don't know if

it's more common, but it seems more commonly diagnosed and treated.

Nadler-Moodie: I would tend to agree with that. I think it's more easily identifiable; there is more sophistication among practitioners with an ability to diagnose.

NWM: How would you account for that?

Puntil: They are screening for depression now in the geriatric patient population, and for alcoholism, as well. So, in the primary care setting they are asking if the person has any depressive symptoms, like insomnia, mood changes, anhedonia, those types of

things. And patients are actually being treated in the primary care setting as well. So, I think primary care physicians are little more comfortable identifying depression, assessing it and treating it. But when I did a demographic study on our geropsych unit around 2003-2004 to see what kind of patients we were getting, I thought it was going to be dementia with behavioral disturbance. But in reality it was still depression that was the major [psychiatric] symptom that got people admitted to the hospital.

Johnson: As psychiatric specialists, I think that the patients we're seeing are sicker. They've already been through primary care, perhaps diagnosed and

already undergone one or two or three treatments, but they're not responding.

Nadler-Moodie: Right, exactly.

Johnson: So, by the time they get to us, they're a little more complex.

Puntill: And they're more resistant to treatment, too.

Nadler-Moodie: But also to the point of the 15 to 44 year olds, I think there's just much more in the media. The public is more aware of depression, as well. So, they bring their symptoms more openly to practitioners.

Haverkamp: I work in primary care treating depression, and I think the whole thing is now recognized as an illness that can have treatment. Many of these patients weren't provided treatment in primary care before, and either they weren't willing to go to psychiatry or they weren't identified by the primary care doctors.

Woods: I just want to add that, in regards to post-partum depression, the issue has really hit the media as well, with certain celebrities getting some attention. And the OB/Gyn docs are doing better screening, as are the nurses that work in child and maternal health. Depression can even affect a healthy mother who previously had no symptoms, so the issue is getting more awareness.

Johnson: I'd have to suggest, though, that we have a long way to go in that area.

Woods: True, but I think it's starting to come around.

NWM: *Beyond the media, what do you think accounts for a greater comfort level among primary care physicians to identify and treat depression?*

Hickman: I work at the VA Medical Center in San Diego, and it has become required initial screening along with vital signs. I think this is the case in many hospitals. I also think just by talking about it helps people be more open to it.

NWM: *What about independent practice settings?*

Haverkamp: I think it's becoming known in the independent practice, but it's not required screening like it is in hospitals. But today we have great tools for screening for depression, and it can be done a large scale.

Johnson: I think there is better education all around. If you look at some of the primary care conferences, for example—and this is from a nurse practitioner perspective—very often there are one or two topics on depression, even though it might be a general medicine conference. So, I think practitioners are better informed about depression and how it can affect other illnesses. They're looking for it.

Hickman: Depression has a lot of psychosocial components to it, much more than just medical physiology. And I think for people between the ages of 15 and 44 there are a lot of social stresses that maybe didn't occur before. Higher rates of divorce, unstable circumstances for teenagers and that sort of thing. I think those changes over the last few decades might account for more mood difficulties.

Johnson: I would disagree with you, Diane. I think it's always been there but we're just better at picking it up, and I think people are more comfortable talking about it. I think before when people presented to their doctors with aches and pains, what was really going on many times was depression. And these were the folks that would come back again and again and you could never get a handle on what was going on with them.

Nadler-Moodie: I would agree with that.

Haverkamp: Recently, I heard these primary care docs talking to this older, more experienced physician about his caseload. "How do you handle your patients, how are you getting out on time?" they asked him. And he said, "You know what, if my patients aren't getting better, I figure they might be depressed and get them treatment for the depression." And that's why he thinks his caseload is more manage-

able than the other doctors.

Hickman: Wow.

McGirr: I think the pharmaceutical industry, for better or for worse, has made a significant contribution in making visits, particular to primary care offices, more effective. In my career, we have certainly seen an incredible array of new medications, many of which are more easily tolerated and more effective. They're probably the most prescribed medications in the pharmacy right now. But there are two parts to the first question: Are we seeing more depression or is more depression being treated? I think there has been a lot of work done to better identify various mental disorders, including depression. It's being sensitive to the fact that disability just doesn't come from physical health problems, but in fact mental disorders really lead the burden for individuals around disability.

Puntill: Is it possible now that there are more services to help people qualify for disability because of their depression, and people are just accessing more services than before?

Haverkamp: I think these patients may have already been out in the general population, undiagnosed, and getting disability for other reasons.

Puntill: Or maybe not getting services.

Hickman: That goes into the subject of stigma. In the past you wouldn't have dreamed of saying you had depression as a reason for not going to work.

Puntill: Exactly. You would be told to pull yourself up by your bootstraps and get going.

NMW: *Mental illness does carry an especially powerful stigma. How much of this stigma do you experience among other healthcare providers who are not mental health specialists?*

Nadler-Moodie: I'm a "semi-alone"

mental-health practitioner working throughout a large general hospital; have been in this position for about six months. And there is a bit of stigma. But more than that, there is also quite a bit of ignorance, which is more than just simply stigma. It's very sad that nurses and doctors all throughout the hospital are unable to see some very blatant mental health, psychiatric problems with their patients. Maybe that's kind of a hidden stigma, but they're not really observant. They don't query enough. And they see psychiatric problems as being low on the totem poll when sometimes the most serious problem with the patient is psychiatric based.

Johnson: I couldn't agree with you more. Loralie was talking about postpartum depression. Same thing there. And I think that while we're better as identifying depression, which we'll use as an example, I think it's thought of as just a "psychological problem," and dealing with medical problems takes precedence.

Nadler-Moodie: Right.

Johnson: I saw a woman recently with a 3-month-old child and a life-long history of severe depression. When she got pregnant, her obstetricians advised her to stop her antidepressants—she had been stable for awhile. Well, she got severely depressed about six months into her pregnancy. The obstetrician put her on Zoloft for one month at a low dose, not a therapeutic dose, and she got a little relief from that. When she got into her last trimester, the obstetrician took her off the Zoloft, she got depressed again. Ultimately she delivered her baby, but when she went back for her first check up, she was profoundly depressed, was having intrusive thoughts about hurting herself and the baby, and the obstetrician said to her this is the post-partum blues, it's normal, it will go away.

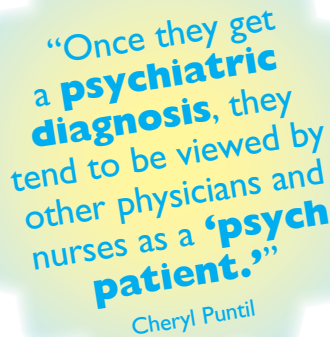
Nadler-Moodie: A new study was just released that says that it's actually pretty safe for pregnant women to take antidepressants.

Johnson: I'm sure this obstetrician thought he was doing what was best for this woman and her baby, but he was discounting the severity of her mental illness.

Nadler-Moodie: Absolutely.

Hickman: I think there is still a lack of knowledge of what's safe and what isn't safe in terms of psychotropic medication during pregnancy.

Puntil: I run several groups on an inpatient adult psych unit, and the patients are very conscious and aware of the stigma that is placed on them. Once they get a psychiatric diagnosis, they tend to be viewed by other physicians and nurses as a "psych patient." And if they go to the ER, for example, they aren't evaluated medically. Some



“Once they get a psychiatric diagnosis, they tend to be viewed by other physicians and nurses as a ‘psych patient.’”
Cheryl Puntil

of the doctors just automatically clear them to come up to our unit—we're a separate hospital at UCLA—but their physical exams are so minimal; sometimes their labs aren't even drawn.

On our unit, which is a med-psych unit as well, we had an 18-year-old female just finishing up high school. She was a straight-A student and she came down with this strange neurological picture. She went to adult neurology because she happened to be 18. They diagnosed her as having a psychiatric problem. They thought it was actually a histrionic conversion reaction, which is an old-time diagnosis. She ended up on our unit. The doctors thought she was doing this intentionally due to stress, to family, pressures to achieve, things like that. But what happen was she had a pediatric autoimmune neuropsychiatric

disorder brought on by a strep infection. They had misdiagnosed her.

Johnson: Oh, my gosh.

Puntil: And it was nursing that conducted a long patient history and found out from her mother that she had a strep infection many months earlier that was never treated. The patient was having delusions, and she had a bizarre gait called Saint Vitus dance. I called the adolescent psychiatrist to come look at her and he knew exactly what it was.

When the internal medicine team saw her, she told them that she thought she was bleeding from her rectum, but actually she was menstruating. When I talked to the doctor, he asked, "Does she just believe that because she's psychotic?" And I said, "No, she's misinterpreting things. She really is experiencing some bleeding, but she doesn't know quite from where." So, there was definitely some stigma there.

McGirr: Was that stigma or ignorance?

Puntil: Well, I think that once someone gets a psychiatric diagnosis, the practitioner minimizes the person's medical problems. That's what I thought happened in this case.

McGirr: This happens a lot. Once someone gets labeled, then they have a very separate identity from the rest of the world, their individuality becomes negated, and everything becomes potentially attributed to their emotional or psychiatric problem.

Nadler-Moodie: I think we're saying we see stigma and ignorance as inter-related.

Puntil: On the other hand, I have seen some general internal medicine docs and geriatric docs who really appreciate and give very good care to psychiatric patients.

Haverkamp: And I think the stigma sometimes applies to us, as well. You know, "How can you work with those

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people?” That kind of thing. But I think there are some changes occurring. In our organization, we have depression classes that are available to the public just like we would offer for diabetes. And as that becomes more available to patients, I think staff will start to learn a little bit more along the way as well.

NWM: So patients will lead the way?

Haverkamp: Right. (General laughter)

Nadler-Moodie: And the professionals will go to the classes after them!

McGirr: I’m primarily located in the public mental health system, and there has been a very strong movement in the last few years to conceptualize mental illness as something one can recover from. So, there’s a renewed affirmation that people, even with severe mental illness, can be mainstreamed, can integrate with society and function.

Johnson: I think one thing that has helped de-stigmatize mental illness was the Decade of the Brain in the 1990s. It used to be that mental illness was always something caused by your mother, or somehow you were neurotic. Now we’ve gone to the other extreme where there aren’t any psychodynamic components—it’s all brain chemistry! Well, not entirely. I’m being a little facetious.

McGirr: There was a lot of that blaming-the-mother thing going on. A lot of blaming.

NWM: We are reading about heightened patient acuity; sicker patients with multiple diagnosis or multiple system issues. (For example, a homeless individual who has diabetes, high blood pressure and suffers from schizophrenia.) What are some of the unique challenges of caring for these

dual- and multi-diagnoses patients, especially in terms of case management and coordination of care with physical medicine specialists? Can you offer some specific examples?

McGirr: While we’re all mental health specialists, we’ve grown up in an era when mental health was separated from the rest of health care, and that has, I think, in some ways hurt us. And we’re trying to re-integrate now so that our client population can, in fact, get some of the primary care that they’re not getting. For a wide variety of reasons, some of which can include the lifestyles of individuals who have severe mental illness, patients have typical issues around the usual things of diet, smoking and lack of exercise. Some of this has to do with the difficulties of getting these clients to comply with the medical regimen, as well as getting them access to medical care providers. These clients can be intensive and need lots of support. So, the issues are complex. Part of my job is to track all the deaths that happen in our client population, and invariably we see that these patients die much sooner than the general population.

Nadler-Moodie: As for the issue of parity, it’s deplorable. As much as we in the field talk about it, it’s not actualized. These patients are very, very sick in terms of medical care. The other piece, the homeless piece, I have to say that there are just no places for these people to go.

Haverkamp: I think what’s occurring right now is co-location and putting mental health people in primary care clinics, which is really making a difference in being able to put all that care together. We really didn’t have that until more recently.

Nadler-Moodie: That’s a positive step.

Haverkamp: That’s what I’m staying.

Nadler-Moodie: But I also think that’s a skewed patient population.

Haverkamp: Actually, that’s happen-

ing around the country in lots of different places.

Nadler-Moodie: Not for the poor or homeless.

Haverkamp: I think it is.

Nadler-Moodie: Then you and I need to talk about where I can send my homeless patients in San Diego.

McGirr: It’s happening, Marlene, but not enough.

Haverstam: No, it’s not enough.

Johnson: I think some of the graduate nursing education programs are trying to address that in their combination of psychiatric clinical nurse specialties and adult nurse practitioners. The goal is to assess the patient more completely and not just look at one aspect of their care.

Hickman: I think that possibly the sicker patients were not even receiving care before, and now there is better access and these patients are able to receive care, and therefore, when we see them, they are sicker.

McGirr: Thirty or 40 years into post-deinstitutionalization, we know one of the advantages of institutionalization was that people with severe and persistent mental illness got total care in 24-hour nursing facilities. Now these patients are left to their own devices, where there is no nurse overseeing whatever health problems they may have, psychiatric or medical. So one of the downsides of deinstitutionalization is a certain abandonment of the more chronic, persistently mentally-ill patients.

Nadler-Moodie: And those patients, Kevin, are sitting on acute-care units.

Puntill: That’s right, they are.

Nadler-Moodie: We see them all the time at Scripps Mercy Hospital, an acute-care inner city hospital unit.

NWM: But the deinstitutionalization

movement was based on the premise that a new model of care would be delivered, and that never really happened.

Nadler-Moodie: Some of that is the NIMBY effect—not in my backyard.

Johnson: I think another group that has been hit even harder, perhaps, are those patients who are working, who might be making minimum wage and can't get Medi-Cal. There are no services for them, and I don't just mean mental health services.

Nadler-Moodie: They don't have insurance and they can't self-pay.

Johnson: And they don't qualify for Medi-Cal.

Woods: United Behavioral Health provides some outpatient, but I'm not sure how much.

Nadler-Moodie: But you have to beg for everything. You go day by day. We have a full-time staff member here who is called a case manager, but who really is a fiscal case manager. This person is essentially on the phone all day with insurers and the government to try to get funds for many of these patients. Does that all day, eight hours a day. It's incredible.

Hickman: And as difficult as it is to get reimbursement from Medicare, Medicare reimburses a whole lot better than Medi-Cal. Medi-Cal reimburses for inpatient acute care and only for a set number of days. I worked at a wonderful outpatient program for clients, and anybody who had Medi-Cal wasn't able to get services because no outpatient treatment was covered. And the provider said what Marlene did: That every single penny had to be bickered for. They would deny the reimbursements two or three times before Medicare would actually cover the expense.

McGirr: In the public mental health system, most of our clients are in fact Medi-Cal funded. And in the California system, mental health is

carved out from the larger Medi-Cal system, which is called specialty mental health services governed by Title IX. In fact, we are compelled to ensure access to services and provide clients with care. In San Francisco, for better or for worse, we are known to provide more services than most of the other counties across the state, supplemented by local funding, of course. In some ways, one could make the case that Medi-Cal beneficiaries are in some instances getting better care than other clients in the system.

Johnson: I think you're right.

McGirr: We have clients with Kaiser benefits who prefer to come to the government to get their services.

Nadler-Moodie: Kevin, I'm putting all my patients on a bus and sending them up to San Francisco. *(General laughter)*

“As for the issue of parity, it's deplorable. As much as we in the field talk about it, it's not actualized.”

Marlene Nadler-Moodie

McGirr: That's our problem in San Francisco! Everyone sends their clients here on a bus!

Hickman: If you don't qualify for government services then I think you do fall into the category of having the least access to care. Unless you're a veteran. I'm a veteran, I work for the VA, so it's more of a “come one, come all.”

McGirr: In our fractured, multi- multi-payer system, which is crazymaking in and of itself, it's the people who are either very rich or very poor who are getting the best care. But it's the big middle, especially the working poor, who really suffer in terms of access to care. And that's where most of the

patients are.

NWM: Mental disorders fall along a continuum of severity. For patients on the higher severity end of the continuum, how much does delayed treatment or barriers to care affect your ability to achieve successful outcomes?

Hickman: I want to say something about recovery. I think that recovery does not necessarily equate with being cured. I don't think the population in general understands the term “recovery” as it applies to addiction disorders and mental health. If you are in “recovery” or are “recovered” it doesn't mean that the illness is gone. It just means you are managing your health, having a better quality of life and are able to live well with the illness.

McGirr: Exactly.

Haverkamp: I think what we all experience when patients don't get the care they need, or they're not able to access the system, is that everything else in their life becomes affected by their illness. Whether it's depression or psychosis or anything, they can lose their livelihoods, their families, become isolated. So, you get many more problems on top of the original disorder.

Hickman: Where I work, people can be in the facility against their will, legally, and a lot of them aren't in the hospital because they were seeking help; they are brought to the hospital. So, that's why we get them as sick as we get them.

Puntill: People with untreated chronic illness seem to take a long time to respond to treatment. I don't know if any of you have seen that, but when we have a patient that has let their psychiatric illness go, have stopped taking their medication—especially people who are psychotic or who have schizophrenia—it takes a long, long time for that person to stabilize.

Nadler-Moodie: Cheryl, don't you

think that some of that is because as they get older they also start to have co-morbid problems?

Punttil: Yes, and I think their mortality is higher, for people who have untreated mental illness.

Johnson: And there's physiological evidence that the brain loses some of its elasticity. There is damage to the brain the longer the patients goes untreated.

McGirr: I have not seen this literature, but sources are saying that people who are diagnosed and treated earlier, especially with the more severe psychiatric disorders, have much better prognosis.

Hickman: In all illnesses, early detection means better prognosis.

Punttil: And better outcomes.

NWM: *Among nurses, statistics suggest that emergency nurses and psychiatric nurses are more prone to be victims of workplace violence. In your view, what can and should be done to help mitigate that?*

Nadler-Moodie: I hate to put the stigma on the patients in general, but I think that we work with people who have symptoms that make them more unstable than others. And therefore, we are a bit at greater risk. But I have been a psychiatric nurse for 35 years and I've never been hurt. I think it has to do with culture with workplaces, the leadership at workplaces. These are the things that help avoid violence. But I do believe there is a lack of training, in general. I will just share with you that the psychiatric unit I work on is in the general hospital, which is true for Cheryl and Diane, and I actually think the psychiatric unit is one of the safer units in the hospital. There is more violence in the other units. People are not managed as well there.

McGirr: What's happening nationwide is professionals in psychiatric units

are looking at the whole practice of seclusion and restraints. And there is a movement to actually make a lot of these inpatient units seclusion and restraint free. That's a cultural and practice change that will clearly take awhile to accomplish.

Nadler-Moodie: It's happening.

Punttil: Yes, it is.

McGirr: In our county hospital, we are just beginning to look at that. And staff does get injured for all kinds of reasons. But what we found was that most of the injuries happened in the process of secluding and restraining patients.

Nadler-Moodie: Absolutely.

McGirr: And since we have changed that practice—it's not entirely eliminated—we have less injuries.

Punttil: It's important to emphasize here the philosophy of management; you're right about that. There is a whole movement to decrease seclusion and restraints, and to manage and intervene earlier with behavioral techniques, with occupational therapy, the sensory interventions that people are using. It takes the management team to educate the staff. For example, we are sending all of our staff to an assaultive behavior management class to learn the techniques to de-escalate patients.

Woods: Not all psychiatric patients are violent. In fact, they are more likely to be victims of violence themselves than be violent. Although we deal with unstable patients at times, as Marlene points out, we shouldn't be labeling psychiatric patients as violent.

Nadler-Moodie: I did another interview recently following the terrible tragedy at Virginia Tech, and the question that coming back was, "What was his diagnosis? What is the one psychiatric diagnosis?" But more often than not, psychiatric patients don't have the wherewithal for violence. I think

Loralie is correct. They are more often the victims than predators. At the time when they are the sickest, they are often not capable of plotting out a violent episode.

Hickman: I would say that 100 percent of the time, when someone is unstable, as Marlene mentions, when the person has a severe episode of psychosis that creates a distorted perception of their reality, they cannot calculate whether or not they are safe around other people or safe in their environment. That's really about the only time I've seen someone behave violently toward staff.

McGirr: Violence is the main category that gets recorded in our incident reporting system. We do know that substance abuse certainly increases the risk. And we have many clients in our system who have severe and persisting mental illness, who are poor and require money management. In these instances the whole issue around comorbidity, and resources and needs are going to decrease a person's frustration tolerance. I think that it is a contributor to a potential for violence.

Haverkamp: I was thinking it might be more of question for people in inpatient units, but I think the higher staffing levels and having more RNs is certainly one of the factors that is helping create the seclusion- and restraint-free environment and leading to less violence.

Nadler-Moodie: I think it helps, but there still are places around the country that have lower staffing than California.

Punttil: I have a friend who works at Atascadero State Hospital, and there's a huge increase in violence against staff because of the lower staffing. Maybe some patients tend to be more violent in state hospitals, but the nurse-patient ratio of 1:6 is not mandated there.*

Nadler-Moodie: I don't know if that's true for all the state hospitals, but it

would be very interesting if the state mandates it but not for its own hospitals.

*(*A spokesperson for the state Department of Mental Health confirmed in July 2007 that, under state licensure, the ratio is 1:8 for staff [psychiatric technicians and nurses] on patient floors. Additionally, the spokesperson provided the following detail regarding the state's consent agreement: For care between 1-60 days, the ratio for enduring treatment team [other patient support professionals including nurses] is 1:15. For care above 60 days, the ratio for enduring treatment team [other patient support professionals including nurses] is 1:25.)*

Puntill: The patients that have been violent on our adult unit are people with a sociopathic diagnosis. And sometimes we forget that the geriatric patient with dementia who wants out of the hospital can get very assaultive. It takes a lot of training and intervention. We've had several nurses who have been scratched, spit on and that sort of thing.

Hickman: That also happens in skilled nursing facilities that are not psychiatric facilities. People with dementia often act that way because they cannot calculate their environment and feel safe.

Nadler-Moodie: The American Psychiatric Nurses Association just completed its revised position on the reduction of seclusion and restraints. It's a beautiful document that moves us further from the first statement from 2000.

NWM: Do you think RN training programs place enough clinical emphasis on mental health?

Nadler-Moodie: No.

Hickman: No.

Puntill: No.

Nadler-Moodie: I think the best pro-

gram that I've heard of is two clinical days a week for an eight-week rotation, one semester. That's not necessarily an emphasis, it's secondary. I think from there it goes down to the worst, which would be non-psychiatric nurse teachers taking students to med-surg units for a half day, one day a week, five times, and talking about communication skills.

Johnson: Many are doing away with specialty training altogether.

Woods: I was educated in Canada. In my undergraduate training, we had a lot of mental health training. We had community-based mental health clinicals that lasted 13 weeks, and we had inpatient psych clinicals. In our last year in the bachelor's program we actually could pick an emphasis, but one of them had to be mental health. You had to do externship with it.

Puntill: I have heard some schools do that externship in the last year and say that it *can't* be in mental health.

Nadler-Moodie: Cheryl, you told me that when you finished your program, you were told to get med-surg experience first, even if you wanted to specialize in psychiatry. But you asked, "How come we don't tell all the nurses that they really need to get a year of psychiatric nursing first?"

Puntill: That's right. The reason I say that is that we can learn skills. Anybody can learn how to catheterize a patient, for example. But it's so hard to learn what's important when you're learning how to do relationship-based care. It's funny because it seems like it's all psychiatric nursing. Not only the relationship with the patient, the relationship with the family, co-workers, to yourself. It's all psychiatric nursing. Everybody needs to know how to connect with a patient, and that's hard to do in the med-surg setting where you've got so many other things to do. Frankly, I think psychiatric nursing is where to start.

NWM: For nurses who aren't in the

specialty now, why would you suggest they consider it?

Hickman: The reason I chose to be in psychiatric nursing is because I think, for me, it's the most interesting type of health care.

Nadler-Moodie: I adore working in psychiatry and have for many years. Much of it is relationship based. You really get to be involved with a patient. It's not a quick visit, a technical issue. It's really getting to know a person.

Puntill: It's also the use of oneself to help a person move toward wellness, mental and physical wellness. We have to use ourselves as the tool. That's why I picked psychiatric nursing to begin with.

Johnson: I've been doing it since 1975, and I have always loved it.

McGirr: It is pretty much the only part of nursing I've ever been interested in. Psychiatric nursing is very, very compelling.

Nadler-Moodie: There is much more use of interpersonal skills and interests. It's fascinating. Working with med-surg nurses everyday, it's very interesting to see how hesitant, how shy or uncomfortable they are at communicating. That doesn't mean they don't have a talent in what they do. But they just don't seem to have the same interpersonal interests.

Haverkamp: When I was in a hiring position for a psych unit, one of things I found was that people who worked in intensive care often like to come over to psych because I think they really wanted to work with patients. In the ICU it was a lot machines.

Woods: I think what would help with new grads coming into the field is having a good preceptor, a good mentor. For me, I had wonderful mental health nurses who were preceptors and mentors. You can tell when a nurse loves their job and loves what they do. And that's so important. **NWM**