### How to Obtain Contact Hours by Reading Articles in This Issue

**Instructions**

4.0 contact hours will be awarded by Vindico Medical Education upon successful completion of the posttest and evaluation. To obtain contact hours:

1. Read the following articles carefully, noting the tables and other illustrative materials, which are provided to enhance your knowledge and understanding of the content:

   **Integrated Physical and Mental Health Care at a Nurse-Managed Clinic: Report from the Trenches**
   Deena Nardi, PhD, PMHCNS-BC, FAAN, on pages 28-34.

   **Providing Nursing Leadership in a Community Residential Mental Health Setting**
   Frances A. Hughes, RN, DNurs, ONZM, FNZCMHN, FACMHN; and Anita Bamford, DNurs, RN, on pages 35-42.

   **Simulation to Enhance Care of Patients with Psychiatric and Behavioral Issues: Use in Clinical Settings**
   Joan S. Grant, DSN, RN, CS; Norman L. Keltner, EdD, RN; and Greg Eagerton, DNP, RN, on pages 43-49.

2. Read each question and record your answers on the CNE Registration Form on page 51.

3. Complete all sections of the CNE Registration Form, including indicating the total time spent on the activity (reading articles and completing quiz). Forms and quizzes cannot be processed if this section is incomplete. All participants are required by the accreditation agency to attest to the time spent completing the activity.

4. Forward the completed form with your check or money order, drawn on a US bank, for $16 (USD) made out to JPN-CNE. CNE Registration Forms must be received no later than July 31, 2013.

**Contact Hours**

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This is a Learner-Paced Program. Answers to the posttest will be graded, and you will be advised that you have passed or failed within 60 days of receipt of your completed test. A score of 70% or above will comprise a passing grade. A certificate will be awarded to participants who successfully complete the test. A contact hour is 60 minutes of instruction. Contact hour verification can be awarded only at the completion of a program.

**Activity Objectives**

1. Describe factors that influence the success of nurse-managed health clinics.
2. Apply characteristics of successful nurse leadership.
3. Identify essential elements of successful simulation activities.

**Author Disclosure Statements**

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- Dr. Grant, Dr. Keltner, and Dr. Eagerton disclose that they have no significant financial interests in any product or class of products discussed directly or indirectly in this activity, including research support.

**Commercial Support Statement**

All authors and planners have agreed that this activity will be free of commercial bias. There is no commercial support for this activity. There is no non-commercial support for this activity.
ABSTRACT

The Health and Wellness Center (HWC), located in Joliet, Illinois, is a nurse-managed universally accessible primary health care center funded by a grant from the Health Resources and Services Administration. The goals of the HWC are to improve access to quality primary health care services for all patients, including those who are uninsured and underserved, and to develop and implement a model of nurse-managed primary health care that integrates both physical and mental health assessment and treatment. After 5 years of developing and using this model, it is clear that integration requires strategic supports from the financial, political, and professional sectors to be considered a cost-effective model of health care delivery. Recommendations for policy and practice change are offered based on the author’s experiences of providing integrated health care at the HWC and the health care industry’s responses to uninsured or underinsured patients’ needs.
he American Academy of Nursing (n.d.) created the Edge Runners® recognition in 2007 as part of its Raise the Voice campaign to showcase innovative nursing-led models that transform and improve health care service delivery in the United States. The University of St. Francis Health and Wellness Center (HWC), one of 66 such models in the country, was designated an Edge Runner by the American Academy of Nursing in 2008 for exemplifying a new nursing model of affordable holistic primary care services, with integration of mental and physical care, regardless of patients’ employment status or income. The HWC was developed by a team of advanced practice nurses (APNs) to address the growing need for universally accessible health care, including mental health care, in Illinois. The goals of the HWC are to improve access to quality primary health care services for those who are poor and uninsured, and to develop and implement a model of nurse-managed primary health care, integrating both physical and mental health assessment, treatment, and follow-up services.

THE UNIVERSITY OF ST. FRANCIS HEALTH AND WELLNESS CENTER

The HWC founders created what they thought would be an innovative solution to the access-to-care problem. Their population base is primarily the working poor and those who are uninsured, as well as place-bound older adults and people with disabilities and victims of domestic violence. The HWC offers walk-in scheduling and evening hours for greater accessibility. Patients without insurance pay on a sliding scale based on income. Special arrangements are made for residents of local homeless and domestic violence shelters. The HWC provides a “one-stop” approach to meeting health needs. Each patient is screened for depression by the primary care providers at the initial visit, and onsite counseling, psychotherapy, psychiatric evaluations and assessments, prescriptive services, consultation, and medication monitoring are also provided by the three mental health providers affiliated with the center. It is a recognized Blue Cross and Blue Shield, Humana, Medicare, and Medicaid provider, receiving 5% of its income from private insurance, 10% from Medicare, 13% from cash payment, and 72% from the State of Illinois.

All uninsured patients needing expensive medications are helped to apply for prescription assistance through pharmaceutical companies. This represents a projected cost savings of $2,880 annually for a patient taking one tablet daily of a medication such as quetiapine (Seroquel®, $8.00/tablet, http://www.drugstore.com, June 6, 2011). The HWC social worker enrolls child patients who are uninsured in the State of Illinois Healthcare for All Kids insurance program, intended for the 250,000 children in Illinois without health insurance (State of Illinois, 2011). The HWC providers also received the Innovation Award from the Illinois Nurses Association in 2007 for “implementing an innovative model of health care delivery that increased access while promoting high quality, cost-effective health care” (Connolly, Lindsey, Maragos, Nardi, & Wilson, 2007).

HWC providers are completing their fifth year of providing primary health care services to primarily poor, low income, uninsured, and underserved patients. The center operates three sites: a domestic violence shelter, the main clinical site on the ground floor of a Housing Authority building, and a new walk-in student outreach site close to student services at the university. It is also a clinical site for practicum and clinical rotations of students in programs such as Doctor of Nursing Practice, Bachelor and Master of Science in Nursing, and Master of Social Work.

I practice at the HWC only 1 day per week, but more than 350 of its 7,200 patients (4.6%) have been referred to me for mental health services, which include psychiatric evaluations and developmental screenings, brief or directed psychotherapy, counseling, prescriptions, medication management, and social services. The most frequent conditions diagnosed or treated at this center are hypertension, diabetes, hyperlipidemia, obesity, sexually transmitted diseases, and chronic pain; however, patients referred to me are also struggling with major depressive disorder (36.6%), bipolar disorders (13.3%), anxiety and eating disorders (12.5%), substance abuse (11.4%), and posttraumatic stress disorders (4.4)—to name the most common diagnoses.

Although originally funded through a grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration, the co-founders are working toward financial independence and sustainability of the center, primarily through health insurance reimbursement agreements. These agreements are still difficult to arrange for the APNs who run nurse-managed clinics in Illinois and other parts of the United States. Although the Affordable Care Act was passed in 2010, APNs still have a long way to go before they are routinely considered as fully reimbursable providers of medical services and the medical home by federal and state governments, medical boards and Chief Financial Officers of hospitals and clinics, and third-party insurance payers.
THE NEED FOR AN INTEGRATED SYSTEM OF HEALTH CARE

In addition to having a psychiatric-mental health APN onsite who diagnoses, prescribes, and treats, there is also a licensed mental health therapist and a licensed social worker who link patients with outside social services and also provide therapy. Despite having these specialty providers seeing patients on 4 separate days per week, there is a 3-month waiting list for our mental health services, and the center manager is searching for another psychotherapist so more patients can be treated in a timely manner. The need for more psychiatric-mental health services for the center’s primary care patients is acute and reflects the national need for specialized health care services for uninsured patients, such as psychiatry, neurology, gastroenterology, endocrinology, and surgery.

The need is also critical for access to the most effective pharmacological agents to treat bipolar disorders in this population. The atypical antipsychotic medications that are also used as mood and impulse stabilizers and anti-manic agents, such as quetiapine and aripiprazole (Abilify®), have price tags of approximately $300 to $500 per month (http://www.drugstore.com, June 6, 2011), which is more than the average monthly income of many HWC patients. Prescription assistance is an option we use regularly, but there is no guarantee from the pharmaceutical companies that these medications will continue to be delivered indefinitely to those who cannot afford them. Patients must wait 6 to 12 weeks for each refill from the pharmaceutical company, so providers and patients must always plan several months in advance to prevent interruption of pharmacotherapy.

Many HWC patients come to the center because they have lost their health insurance, usually because they were fired, laid off, or aged out of their parents’ insurance. Some people in this predicament can attend college, join the military, or find other jobs to regain health insurance, which is a lifeline for so many. However, uninsured individuals with both chronic mental health conditions, such as Asperger’s syndrome, severe bipolar disorders, psychoses, learning disorders, and substance abuse, and medical illnesses, such as diabetes mellitus, chronic obstructive pulmonary disease, dementias, arthritis, and chronic pain, have limited employment options, and continued unemployment further alters their lives.

Another common reason uninsured patients seek mental health care via the HWC is their primary care provider, most often a physician but also family nurse practitioners, directs them to seek treatment from a psychiatrist for their clinical depression, bipolar disorders, or adult attention-deficit/hyperactivity disorder (ADHD), rather than integrate treatment for these conditions into their regular, primary health treatment. However, these patients often cannot get past the psychiatrist’s front desk and may be told, for example, “The doctor is not taking any more Medicare/Medicaid/et cetera patients at this time.”

RECOMMENDATIONS TO INCREASE FULL ACCESS TO MENTAL HEALTH TREATMENT

Our goal at the HWC is to collaborate with hospitals, medical centers, and a number of public and private agencies to meet the health care needs of our patients. The need for a level playing field for all patients, regardless of income or circumstance, is crucial. President Obama has made health care reform a key component of his administration, but until this reformed redesign is implemented and evaluated, I would like to suggest some reforms of my own to more directly meet the health care needs of many consumers, including our patients at the HWC. Each reform listed below is accompanied by an example or description of how it might work or why it is needed, based on the patients and providers I have worked with over the past 5 years. Please note that identifying details have been changed and pseudonyms have been used.

Work Out a Payment Plan for Newly Uninsured Patients

Third-party insurance continues to be a “golden ticket” to access and continue receiving comprehensive health care, especially the psychiatric, pharmacological, surgical, physical therapy, rehabilitation, sports medicine, and other specialty care that supports quality of life for many individuals. At the HWC, we have seen patients whose chronic conditions had been well managed by their primary and specialty care providers, but who lose their trusted providers after they lose their jobs and insurance. These patients go into a downward spiral, as they can get no longer refill their medications. They...
are then bounced from clinic to clinic; they panic; their stress levels rise and symptoms worsen; and their ability to function deteriorates.

The Patient Protection and Affordable Care Act (2010) supports the formation of accountable care organizations (ACOs), where providers can network to improve care and reduce costs of patient care (Cleary, Trautman, & Wilmuth, 2011). However, a closer look at these ACOs shows that their interests are in market share, market power, antitrust violations, competition, governance, risk adjustments, and ownership (Greaney, 2011). Racial and ethnic disparities in health care are created simply due to where the ACOs are created. ACOs in low-income neighborhoods have fewer resources to use for patient care than ACOs located in more affluent neighborhoods (Pollack & Armstrong, 2011).

A better level of care can be easily achieved for a sizable number of unemployed individuals if physicians and psychiatrists would instruct their front desk personnel to work out a payment method for their newly unemployed long-time patients that will allow these patients to continue to see their trusted provider if they lose their insurance. This payment plan could include referral to low- or no-cost clinics for more general health care needs, such as immunizations, wellness checkups, and screenings, but patients would continue to see their usual provider for ongoing management of long-standing but treatable disorders.

Update and Humanize Emergency Department Discharge Procedures

Emergency department (ED) providers can update and humanize their discharge procedures for fragile patients with a history of mental illness and no recent provider, who show up at the ED in a panic and suicidal. These patients with no insurance are kept in the ED for hours, given a short-acting benzodiazepine, often alprazolam (Xanax®), and then assessed for level of suicidality. By the second time they are assessed, the patient is usually out of peak crisis, at least regarding imminent threat, and is discharged with instructions to see a psychiatrist for follow up. When these patients are not admitted, but calmed down and discharged, many of them will contact the HWC afterward, with a week’s worth of benzodiazepines and no refills, reemerging symptoms, no health records, no medical card, no income, no way to pay for any medications, and rising anxiety. Many patients tell us they are given a psychiatrist’s name on a discharge sheet, but when they call and say they have no insurance, they are told that the doctor will not take new patients without insurance.

This situation can be avoided with an updated system of referring patients with no insurance to specialists (in this case, a psychiatrist) who could agree to taking turns seeing a set number of these patients, so no one provider’s practice is overwhelmed with uninsured patients. This system of turn taking has been successful in the Project Access model used in many cities, such as Spokane, Washington, and Asheville, North Carolina, to provide wrap-around, comprehensive health care services to underserved populations. This prevents burning out a few provider volunteers who wish to provide charity care yet are quickly overwhelmed by the numbers who are referred to their practice and by the severity of their disorders. The Project Access model is discussed in more detail below.

Adapt the Project Access Model to Fit Community Population Needs

The HWC is a member of the National Nursing Centers Consortium, which provides primary health care to more than 250,000 patients each year. Unfortunately, the state-managed Medicare and Medicaid payment systems of many states deny full reimbursement or prospective payment reimbursements to non-physician providers for their services. Many of these centers cannot cover costs of treatment to patients who are under- or uninsured unless the centers continue to be federally grant funded. Although they provide cost-effective, quality health care, these centers continue to face many reimbursement and policy barriers (Hansen-Turton, 2007). However, the burgeoning need for primary care services and providers necessitates a new way of planning for meeting these needs, especially considering that the country expects a shortage of more than 124,000 primary care physicians within the next 15 years (Stringer, 2010). One such way is Project Access, which originated in Appalachia in 1996 through a Robert Wood Johnson Foundation grant.

Project Access was first developed by a team of physicians in Buncombe County, North Carolina, as a network of primary care and specialty providers who agree to see a certain number of uninsured patients each year (i.e., physicians see 10, specialists see 20), either at one of their Project Access Safety Net Clinics or at their own offices (Baker, McKenzie, & Harrison, 2005; Buncombe County Medical Society, n.d.). The Project Access model of health care has been adopted by more than 22 communities nationwide (Spokane County Medical Society, n.d.). Documented outcomes of the Buncombe County Project Access include increased uninsured patient access to specialty care; reduced costs of charity care; reduced patient visits to EDs with corresponding projected ED cost reductions; and improved health status of uninsured patients (Baker et al., 2005; Buncombe County Medical Society, n.d.).

It is time for a Project Access-like commitment from health care
Report from the Trenches.


1. Integrated health care provides both mental and physical health assessment, treatment, and follow-up services in one setting, managed by the patient’s health care provider.

2. The Project Access model can be used to offer comprehensive health care services to underserved groups and meet community population needs.

3. Health care disparities and lack of access to affordable, quality health care continue to be a growing problem. Quality universal health care that is cost effective, affordable, and accessible, such as that provided by the Health and Wellness Center, is an important solution to this problem.

4. The collaborative practice and supervision agreements tied to advanced practice nurses’ (APNs’) licensing requirements in many states should be abolished as they curb and control psychiatric APNs’ ability to engage in free trade in the marketplace.

Do you agree with this article? Disagree? Have a comment or questions?
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providers, medical centers, and clinics, so that patients with chronic mental illness, as well as those who are medically fragile, can be treated, followed, referred to specialists when indicated, receive first-line medications, and access the health care they need. This would require recognition that limited access to comprehensive health care is a growing problem in this country, regardless of the new Affordable Care Act, and a willingness by the nation’s medical societies to engage in the strategic planning necessary to create the provider-to-provider agreements that make Project Access a success.

**Use AAFP Guidelines for Primary Care Patients with Mental Health Disorders**

In its position paper on mental health, the American Academy of Family Physicians (AAFP, 2001) emphasizes the integral role that mental health services plays in family practice and encourages family physicians to provide such services as part of their general practice. Low-income patients with no insurance who have prior histories of mental illness can be treated effectively by family physicians using the AAFP guidelines for mental health. This integration of mental and physical health treatment by primary care providers could provide more holistic health care to the approximately 70% to 85% of children and adolescents (approximately 15 million) who currently do not receive treatment for their mental and behavioral health disorders (American Psychological Association Task Force on Evidence-Based Practice with Children and Adolescents, 2008; Centers for Disease Control and Prevention, 2006).

Approximately 10% of patients referred to me have symptoms of postpartum depression, including the fatigue, sense of isolation, uncontrolled crying, suicidal ideations, and resentments that can last for years if left untreated. Lynda, a 32-year-old woman referred to me by the Department of Children & Family Services for a mental health assessment, was one of these patients. She had three children younger than 5 and an often-absent boyfriend. She came to the HWC because she felt overweight and depressed; she said she had these feelings since the birth of her first child; “I need help…. I’ve lost control of myself since his birth…. I don’t get out.” She, like so many of my patients referred for depression after giving birth, could have been assessed and treated for postpartum depression by her obstetrician, gynecologist, or primary care provider. This alone would have prevented 5 years of clinical depression and decreased quality of life for Lynda, decreased risk to the development of her children associated with maternal depression, and freed up some of the backlog at HWC for appointments with psychiatric-mental health providers.

**Increase Access to County/Community Mental Health Center Programs**

Lynda came to see me because she needed a mental health assessment and was told there was a 1-year wait for such an assessment at the county mental health center. The county mental health center is necessary to the public health of the community, but its services fail to reach too many individuals with chronic mental illness. Services such as bus pick up for appointments, prescription services and medication monitoring, day programs, psychoeducation, and support and guidance groups are sorely needed. However, resources are scant, and treatment programs are locked in the “1980s mode” of staff-led groups scheduled at certain times, with meeting rooms left empty at other times.

It is time for county mental health departments to partner with APNs to design ways to more effectively use the mental health providers, time, and space at these centers, and to strategically plan to build on existing services. For example, community self-help groups for disorders and illnesses such as autism, ADHD, substance abuse, cancer, and grief could be contacted and invited to use those empty rooms for
their open meetings, which would address the supportive counseling needs of many.

Collaborate to Develop Referral Systems

Psychiatrists and other mental health specialists should collaborate with primary care providers to develop referral and treatment systems for their uninsured patients with complex mental health problems. For example, George was a long-term survivor of HIV who had been seeing a psychiatrist for years for panic disorder and night terrors. He was a cooperative patient, and his panic attacks had been under control with a course of medication, journaling, ziprasidone (Geodon®), and low-dose alprazolam as needed. Due to his deteriorating health, George lost his job, his means of transportation, and his insurance, finally receiving Social Security Disability Insurance. When his psychiatrist retired, his long-time primary care provider would not renew the psychiatric medications prescribed by the psychiatrist. George said his doctor felt uncomfortable prescribing psychiatric medications and told him a psychiatrist would have to do so. George called every psychiatrist listed in the online telephone book, but none would take a new patient who was not insured with third-party private insurance. George walked into the HWC after months of trying to find a psychiatrist who would consent to see him and had already been without his psychiatric medications for some time.

If his psychiatrist had only asked his staff to locate and arrange for a mental health treatment program to which to transfer George, his stable treatment could have progressed seamlessly. Instead, this patient was handled like an unwanted guest, an unwanted commodity—another patient with a chronic mental health disorder and no means to pay the full fee for a psychiatrist’s services.

Abolish the Collaborative Practice and Supervision Agreements Required for APN Licensing in Certain States

The collaborative practice and supervision agreements tied to advanced nursing practice licensing requirements in many states curb and control APNs’ ability to engage in free trade in the marketplace. To fulfill APN licensing requirements in Illinois, for example, psychiatric-mental health APNs must arrange for monthly face-to-face meetings at the collaborative physician’s convenience. This supervision requirement prevents APNs from opening practices in rural areas or areas where there are shortages of specialist providers, such as psychiatrists, because of the time, costs (i.e., the collaborative meetings are not free), and travel distance required to meet with physicians who may forget, cancel, or reschedule. These agreements limit APNs’ careers, income, access to populations, and professional progress, but the practice will continue until there is a united and sustained groundswell against it from all APNs.

Consider that physician supervision, forced collaboration, and mandated monthly meetings with physicians are not a part of APN education, clinical requirements, state nursing education program approvals, or National League for Nursing Accrediting Commission or Commission on Collegiate Nursing Education accreditation requirements. However, after APNs in many states have earned their graduate degrees and received APN board certification, they must then submit these agreements with members of another profession (medicine) to the state department of professional registration to complete their APN license applications in those states.

Since these collaborative agreements are in no way connected to accreditation, certification, or education, perhaps it is time for our national nursing organizations to enlist their legal counsels to explore the advisability of a class action suit to end this enforced regulation of APN practice by another profession and the hand-in-glove relationship between legislators and the medical lobby. It is time to end the monopoly of medicine on the business of health care. This major restriction to full APN practice must be eliminated to increase access to qualified mental health providers for patients with unrecognized mental health disorders and those seeking treatment but who cannot receive care due to lack of psychiatric-mental health specialists.

CONCLUSION

The practice roles of APNs are evolving because the nature of health care providers, delivery, and funding has changed in the United States. The HWC model of integrated care by a team of APNs demonstrates that APNs can be universally recognized primary health care providers in the near future and should have fully reimbursable status by all insurance providers, including Medicaid, in all 50 states. The data show APNs provide integrated mental and physical health care that is as high in quality as that provided by physicians and osteopaths (Bauer, 2010). However, health care disparities and lack of access to affordable, quality health care continue as a growing problem in this country and is no longer a problem of the poor. Quality universal health care (i.e., nobody out, everybody in) that is cost effective, affordable, and accessible, such as that provided by the HWC, is an important solution to this problem.

For this to happen, APN point-of-care service delivery must be recognized as fully reimbursable, and all encumbrances to full practice by APNs must be eliminated. Physicians, hospitals, and community health agencies must welcome APNs and their independent prac-
policies to the table as full partners as they design more comprehensive health care programs that provide wrap-around services of specialist referral, case management, community support services, appropriate diagnostic tests, and timely hospitalization—especially for patients with chronic mental illness experiencing acute episodes.

Health care providers can actively advocate for recognition, parity, and inclusion of mental health services into all areas of health care education, delivery, legislation, and insurance/payment systems. Professional and specialty nursing organizations, such as the American Nurses Association, the International Society of Psychiatric-Mental Health Nurses (ISPN), and the National Association of Pediatric Nurse Practitioners, are advocating for universal access to quality health care, which includes a full menu of mental health care across the life span (Dimarco & Melnyk, 2009; ISPN, n.d.; Vallina, 2009).

The president of ISPN has encouraged providers to learn the health care reform playing field (Delaney, 2009). My playing field is this nurse-managed center, our state and federal legislative bodies, and its members who equivocate about changing an entrenched system, with disappearing providers, desperate uninsured patients, and the labyrinthine reimbursement systems for basic mental health services. Certainly, this is the time, during the nation’s focus on operationalizing health care reform, to formally recognize that comprehensive health care for episodic, acute, and chronic mental and physical illnesses is a basic right of all human beings, tied to our right to life, liberty, and the pursuit of happiness. This nation can only provide universal access to integrated mental and physical health care if and when it fully recognizes APNs—including specialty providers such as psychiatric-mental health APNs—as fully credentialed providers of these services, who are able to sit on panels, granted hospital admitting privileges, and free to open a practice where it is needed and financially supported.

REFERENCES

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Providing Nursing Leadership in a Community Residential Mental Health Setting

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ABSTRACT
The worldwide burden of mental illness is increasing. Strong leadership is increasingly emerging as a core component of good mental health nursing. The aim of this article is to demonstrate the ways in which nurses can provide strong and consistent leadership in a values-based practice environment that embodies respect for individuals’ dignity and self-determination within a community residential mental health service, which provides a structural foundation for effective action. This is accomplished through the presentation of two vignettes, which highlight how the seemingly impossible becomes possible when an economic paradigm such as agency theory is exchanged for a sociological and psychological paradigm found in leadership as stewardship at the point of service. It is through stronger nursing leadership in mental health that stigma and discrimination can be reduced and better access to treatments and services can be gained by those with mental illness. Nurse leadership in mental health services is not new, but it is still relatively uncommon to see residential services for “high needs” individuals being led by nurses. How nurses meet the challenges faced by mental health services are often at the heart of effective leadership skills and strategies.
With mental health being a critical area of health and disability around the globe and the growth in evidence surrounding the burden of disease and disparities of health status among those who have mental illness, it is important that nurses take a more active role in addressing this key health issue. Nurses are an important component of the workforce, and in many countries, they provide the bulk of care (World Health Organization [WHO], 2007). Thus, nurses are ideally placed to tackle the issues facing mental health consumers.

Mental health nursing combines professional therapeutic “people” skills with technical skills. This combination involves specialized, evidence-based knowledge, skills, and attitudes in patient observation, assessment, individual and group interventions, and care. Nurses also provide support to families within a therapeutic environment and work with other disciplines within a wider health care team.

MENTAL HEALTH NURSING LEADERSHIP

Strengthening mental health nursing leadership is imperative to tackling health and social issues for consumers. There is consensus that leadership is an essential practice, but it remains a concept that has different meanings depending on the particular nursing discipline in which one works. Effective nursing leadership is a critical part of the ways in which nurses address issues facing people with mental illness, as well as the ways mental health services are developed and delivered. Leadership as a nurse is not without challenges, but its contribution to informing the behavior of others allows visions to be realized and potential to be seen (Cook, 2001; Mahoney, 2001).

Leadership is not always associated with a formal title (e.g., manager) and can happen within or between services, between and among colleagues, and external to formal management or accountability structures. At its most narrow definition, leadership is reliant on formal hierarchical structures and provides little scope for the development of excellence. However, at its best, leadership has the potential to stimulate and maintain positive change and growth of individuals and services.

Nursing leadership is also contextual. The culture and formal structure within which leadership is exercised influences the leader’s ability to be effective. Alignment with the mission, vision, and values of an organization is imperative for the collective well-being of those being served and the self-actualization of the leader. By creating environments that promote values-based practices, respect for the person’s dignity, self-determination, fairness, and equity (Murphy & Roberts, 2008) are more likely to be realized.

A useful definition of leadership involves understanding that it is “a process ordinary people use when they are bringing forth the best from themselves and others” (Canadian Nurses Association [CNA], 2005). In this context, leadership is not reliant on formal structures but is based on a series of themes, including courage, change, vision and goal setting, enabling and inspiring, enlisting others to get things done, relationships, honesty and integrity, and fostering leadership in others (CNA, 2005).

With regard to mental health nursing, there is also a focus on recovery—one of the most important themes of leadership in mental health services. Recovery is defined as “the ability to live well in the presence or absence of one’s mental illness (or whatever people choose to name their experience)” (Mental Health Commission, 2001, p. 1). These principles are reflected in the stewardship paradigm,

Effective nursing leadership is a critical part of the ways in which nurses address issues facing people with mental illness, as well as the ways mental health services are developed and delivered.

MENTAL ILLNESS AND SERVICE USE

All around the globe, mental health services struggle to address
the complex needs of those with mental illness. The worldwide burden of mental illness is increasing. Mental illness and neurological conditions account for 30.8% of years lived with disability, and depression is estimated to account for almost 12% of all disability (WHO, 2010). Mental illness affects millions of people, but although we have means of effective treatment, only a small minority receive even the most basic treatment (WHO, & World Organization of Family Doctors, 2008).

People who use mental health services—in particular those with a diagnosis of schizophrenia or bipolar disorder—are at increased risk for a range of physical illnesses and conditions, including coronary heart disease, diabetes, infections, respiratory disease, and greater levels of obesity (Department of Health, 2006). In many cases, weight gain is a clear side effect of medication (Department of Health, 2006). They are almost twice as likely to die from coronary heart disease as the general population and four times more likely to die from respiratory disease (Department of Health, 2006).

People with mental health conditions are among the most marginalized and most vulnerable individuals. They often experience violations of their human rights, exclusion from social and economic activities, and are frequently denied opportunities for education and employment (WHO, 2010). This is despite the fact that tackling mental illness is cost effective—similar in impact to the provision of antiretroviral drugs and glycemic control of diabetes (WHO, 2010).

The evidence is now compelling for mental health nurses, as well as primary care nurses, to be skilled in providing choices and assessment, as well as supporting healthy options and interventions, when working with mental health consumers. However, there is a shortage of skilled health professionals, often in the poorest countries with the greatest burden of disease (WHO, 2006). Nurses are the core health care providers in the mental health area, an area often forgotten and neglected among health services (WHO, 2007).

As the largest professional workforce, nurses have a leadership role to play to fight stigma and discrimination and to provide care to those with mental illness. Articulate, informed nurse leaders can help raise issues of human rights, prevent inhumane practices, and galvanize communities to improve the rights of those with mental illness. Nurse leaders have a great deal to offer (Hughes, 2010).

LEADERSHIP IN COMMUNITY MENTAL HEALTH SERVICES

The “Cinderella status” (i.e., achieving recognition after a period of obscurity) of mental health services contributes to a lack of recognition of mental health nurses as leaders (Hughes, 2008). This is by no means an excuse for poor leadership, and it is despite this that mental health nurses are emerging as leaders in service provision, policy making, and education (Hughes, Duke, Bamford, & Moss, 2006).

A range of factors have led to this high standard of leadership in mental health nursing. Some of these factors are within nursing itself, while others reflect changes in the ways in which mental health services are provided. Mental health nurses have traditionally had to work extra hard to gain recognition and inclusion, resulting in one of two attitudes: (a) a defensive and entrenched position whereby nurses feel “the world is against us,” or (b) a belief that mental health nurses need to be “out there” supporting their colleagues and seeking continuous improvement of services for mental health consumers. For the most part, mental health nurses take the latter view. This view fosters leadership and has resulted in the mental health nursing workforce developing a style of leadership that is often further developed than that of other nursing disciplines (Hughes, Grigg, Fritsch, & Calder, 2007).

However, mental health nurses are not always well recognized by other nurses. This is possibly a reflection of the deeply ingrained prejudices toward people with mental illness that includes those involved in their care or a reflection that general nurses are not well trained in mental health. There are a number of examples of this, from the policy level where mental health nurses were excluded from a working group on primary health (Bennis & Nanus, 1985) to inpatient surgical facilities where nursing staff feel incapable of “managing” a patient whose needs in that facility are surgical but who also has a mental illness (Hughes, 2008). These attitudes demand our response as mental health nurses. Although it might be argued that it is the responsibility of nursing leaders in those disciplines to show leadership, the very lack of such leadership requires us to take action.

In view of the factors influencing mental health nurse leadership, how best might mental health nurses promote and improve existing skills in this regard? Returning to the introduction of this article, it is critical to remember that true leadership occurs across, within, and between organizations, and is not necessarily dependent on hierarchy (although managers should,
of course, be expected to exhibit leadership). The competencies for mental health nurses articulated by Te Ao Maramatanga (New Zealand College of Mental Health Nurses, 2004) reflect the themes of leadership listed above, thus strongly indicating that leadership is expected of all mental health nurses.

Having a clear understanding of leadership and formulating expectations of mental health nurses are important in developing services. However, there is a corresponding need to ensure that formal training is available to enable nurses to practice and take advantage of their leadership skills in the provision of independent mental health services (O’Neil & Morjikian, 2003).

Internationally and recently in New Zealand, moves toward enabling nurses to become independent nurse practitioners has been a significant contribution to the development of nurse-led services. The competencies for nurse practitioners set out by the Nursing Council of New Zealand (2008) include a specific focus on leadership and require nurse practitioners to “demonstrate nursing leadership that positively influences the health outcomes of client/population group and the profession of nursing” (p. 5). This clearly indicates the expectation that nurses can, and should, provide leadership, including in an independent practitioner role.

New Zealand has also responded to this need through the development of formally recognized training. For example, Te Pou o Te Whakaaro Nui (The National Centre of Mental Health Research, Information and Workforce Development) has delivered (2004-2007) the first national mental health leadership and management development programme for District

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**VIJNETTE 1: MRS. T.**

Mrs. T. has a long history of bipolar disorder and type 2 diabetes for which she is insulin dependent. She has lived at home with her family and in other residential care facilities; however, over the years the combination of managing her bipolar symptoms and diabetes has been challenging. She has had many different primary care providers, making management difficult. She continues to have a compulsory treatment order under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

Mrs. T. came into the mental health service 8 months ago with no permanent primary health provider. She was 25 kg (55 pounds) overweight and taking 56 units of insulin in the morning and 22 units in the evening. Her blood sugar average was 18.6 mm/L. Her mental state was labile and volatile, and she spent long periods of time in a distressed state. Her diet consisted largely of processed foods and soft drinks. She had a long history of using as-needed medication to manage her acute symptoms.

On entry to the mental health service, the RN established, in consultation with Mrs. T., a lifestyle and care plan involving regular assessment and monitoring with the mental health team and her family. Mrs. T. enrolled with a local primary health care provider and had access to a diabetes nurse specialist and full physical reviews by her general practitioner. Day-to-day care involves RNs and community mental health support workers. As a result, Mrs. T. is now experiencing the benefits of integrated mental and physical health care. The principal challenge throughout Mrs. T.’s time with the service has been her everyday lifestyle choices, particularly related to diet, weight management, and exercise. This has been greatly helped by daily in-home support to assist her with lifestyle choices throughout her mental health recovery process.

Mrs. T. now lives in a house with three other women and from the day of arrival has experienced a change in her dietary regimen in being introduced to fresh foods. She has been encouraged to take responsibility for her diet by helping determine what to grow in the vegetable garden and by shopping with staff at the local market. Access to a wide variety of healthy food and increased exercise have been successful in stabilizing her diabetes. Within 6 weeks of her placement with the service, Mrs. T.’s insulin was reduced to 24 units in the morning and 10 units in the evening. Her blood sugar average is now 8.5 mm/L, and she successfully lost 10 kg (22 pounds) within 10 weeks. As a result of lowering her blood sugar, Mrs. T.’s mental state has improved and she has become less agitated, demanding, and aggressive in her engagement with others.
Health Board and nongovernment organization (NGO) managers, and clinical and service use leaders. Te Pou believes there are only two programs of this kind in the world—programs that see leaders who are service users and health professionals learning alongside each other.

Mental health nursing has come a long way, and the changes have been even more rapid in recent times. Mental health nurses now take an active role in service provision and continue to lead service development. The expansion of services in the community has both enabled and been enabled by nurses’ ability to provide leadership in the care and recovery of people with mental illness. Mental health services are now predominantly provided in the community rather than inpatient settings, and nurses are often at the forefront of the delivery of these services. Such services range from clinic-based services (e.g., antipsychotic intramuscular injection) to the provision and management of residential services in the community. Of course, this is not unique to New Zealand, with nurse-led mental health services being provided in the United Kingdom, Canada, Australia, and increasingly in developing countries where there are few doctors.

At this juncture, it is useful to note that the focus of this article on nurse-led services is not intended to argue against a range of other services delivered by other providers, including service users/consumers. The focus on appropriate service delivery should ideally be sufficiently broad to ensure a range of services that meet the needs and wishes of all consumers.

The increased ability of NGOs to provide services in the community has also been a driving force in the development of nurse-led mental health services. An example of this kind of service is a residential mental health service in a community north of Wellington, New Zealand.

**VIGNETTE 2: MR. X.**

Mr. X., in his late 50s, has a long-standing forensic mental health history and treatment under different aspects of New Zealand’s mental health legislation. He had previously been living in the community with 6 hours per day of support worker input but required more oversight and active support. His team was multidisciplinary, but no nurses were involved.

On Mr. X’s arrival at the mental health service residence, his documents outlined his mental health support requirements and risk and relapse plan, but little information was included about his daily living needs and physical concerns. The RN discussed this with his prior care team and noted that the team was unclear about the mental and physical aspects of Mr. X’s daily living. Despite his apparently having had very close supervision, Mr. X. arrived at the service in a physically neglected state. He had multiple fungal infections, calloused and infected feet, untreated infected burns, severe constipation, and high blood sugar. He had trouble walking, and his mental health appeared to be deteriorating.

The RN worked with Mr. X. and other health providers to resolve his issues and established a supportive, supervised activities of daily living program. Mr. X. no longer needs his walking stick, no longer buys and applies his own enemas, receives regular input from podiatry professionals, enjoys trips into the community, and enjoys his meals. He recently commented that he had not had this kind of support before. His mental illness has stabilized to the point where he has been discharged from compulsory status under mental health legislation. This caused Mr. X. some anxiety about the possibility of losing his current residence and the care that has made such a profound difference in his quality of life. Regardless of his legal status, Mr. X. remains in the care of this service and will continue to require ongoing care and close supervision to retain his current level of mental and physical health.
The service demonstrates effective nurse leadership in the delivery of a residential mental health service that is part of its community. A range of services are provided, including those related to acute recovery, and the service has been successful in transitioning residents back into their communities, without subsequent intervention from acute mental health services. The service has established extensive relationships with the surrounding community, the local Primary Health Organization, other mental health NGOs, the local mental health team, and the Regional Forensic Mental Health Service.

The residents of this service come from many sources, including other NGO providers for which residents were no longer suitable, forensic medium-secure units, and acute inpatient units. This means that the service is experienced in supporting and managing residents with complex needs, including people who (a) have compulsory treatment orders under the Mental Health (Compulsory Assessment and Treatment) Act 1992, (b) have complex physical and aged-related conditions, and (c) are dying and chose to stay in familiar surroundings (with the support of district nurses). Although the residence was originally an all-male facility, it now includes five women. Residents are a mixture of cultures—Eastern Bloc European, British, Irish, and New Zealand European and Maori.

The vignettes described in the Sidebars on pages 38 and 39 demonstrate how nurses can provide strong and consistent leadership in a values-based practice environment. These vignettes clearly demonstrate the contrasting paradigms of the agent versus the stewardship style of leadership. They also show how the concept of leadership in mental health includes a strong focus on recovery and, as part of that, there is a need to constantly advocate that all residents be respected and treated fairly. Both vignettes provide an accurate reflection of the concept of recovery; that is, both residents are able to live well in the presence of mental illness.

Recovery principles are apparent in that service residents have few admissions to inpatient mental health. For example, in August 2006, five residents were welcomed to the service from their previous accommodation that had its license revoked. All of these residents were successfully transitioned into the service and have not needed intervention from the acute mental health services since that time.

Sadly, there are also instances that provide stark contrast between the leadership demonstrated by many mental health nurses and those working in other services. There are many examples of how other health services can fail to meet the needs of people with mental illness (Hughes, 2008). How can this be? One explanation could be a difference in the philosophical underpinnings of the governance and leadership approach in these services. For some, care provision is seen as purely a business, and managers act as agents trying to maximize their utility, which can be at the expense of the consumer when consumers are not seen as people but rather as economic units. Agency theory tends to depict people as “individualistic and utility maximizers” (Davis, Schoorman, & Donaldson, 1997, p. 38), whereas stewardship theory depicts people as “collective self actualizers who achieve utility through organizational achievement” (Davis et al., 1997, p. 38). This demonstrates the extent to which those working in mental health services have an obligation to continually extend our leadership as stewards into other services.

The vignettes described here clearly demonstrate how nurses can provide strong and consistent leadership within a community-based, high-needs mental health service when the leadership is underpinned by the stewardship model and serves to restore the dignity and self-determination of the people in that service. Both Mrs. T. and Mr. X. had been cared for by other community teams but both were physically and mentally at risk of further serious illness.

The focus on leadership at this service includes continuous quality improvement, designed to enhance the lives of staff and residents. This involves strong clinical support and supervision for residents and a proactive approach to all health-related areas of residents’ lives—screening, monitoring, and early intervention. Furthermore, it involves a belief that its residents should

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The expansion of services in the community has both enabled and been enabled by nurses’ ability to provide leadership in the care and recovery of people with mental illness.
CONTINUING TO DEVELOP LEADERSHIP AMONG MENTAL HEALTH NURSES

Having determined the value and active presence of strong leadership among mental health nurses, it is equally as important to ensure such leadership continues to grow and develop (CNA, 2005). One of the strengths of effective leadership is its ability to identify and respond to challenges. It is tempting to perceive challenges as being negative and requiring some sort of struggle to overcome. Rather, challenges are inevitable and may be positive in nature, for example, the availability of a new medication, preparing a service user for transition into a new environment, and taking on a new role or establishing a new service. The emergence of a robust mental health consumer movement in New Zealand is a challenge and a delight—and has resulted in better services. The strength of mental health nurses as leaders is reflected by our ability to adapt to change and to foster leadership in others.

As noted in the preceding discussion, there is a need for formal training and recognition of leadership, as well as a common understanding of its principles and purpose. There is also a need for leadership to be an active process. Part of the role of nursing leaders and service providers is to continue the debate on leadership and to articulate what we expect from those involved in establishing training policy, competencies, and standards (Hughes, Duke, et al, 2006).

In terms of developing nurse-led services, nurses who are prepared to understand the business aspect of health services and who have a sense of entrepreneurship are necessary. Perhaps this is yet a further theme that can be added to those outlined previously.

CONCLUSION

The continuing development of strong and effective leadership by mental health nurses is a critical factor in the emerging provision of nurse-led services, including an increasing number and range of residential services for people with mental illness. Mental health nurses can exhibit the skills needed to lead within mental health services; these skills are not only valuable, but are critical in ensuring that services (including health, disability, and social services) meet the needs of the people using them. Effective leadership also ensures that staff are well supported and able to participate as leaders in their own right, regardless of their job title or position within an organization.

This article highlights some of the ways in which a nurse-led mental health service can provide effective residential services for people with long-term mental health and disability issues. The WHO (2010) specifically recognizes that people with mental illness are a vulnerable population and notes that people who are vulnerable due to other causes (e.g., illness, disability, poverty) are at increased risk for mental illness. Nurses have the opportunity to use their skills to build the strength and resilience of those who are vulnerable. Leadership within this context is not solely about management or ownership; rather, it is about enabling other people to perform at their best, toward common goals in a practice environment that respects the dignity of each person and offers the opportunity for self-actualization. Furthermore, it includes advocacy and the courage to tackle discrimination and stigma—both of which are often well entrenched in other health services. Goodwin and Happell (2006) recognized that social stigma attached to mental illness is often more debilitating than the illness itself.

As leaders, nurses working in mental health must have the courage to respond to such challenges and build the resilience.
needed to ensure timely and appropriate responses. Challenges can arise at all levels—policy, legislation, service delivery, and through relationships with clients and various communities. Nurses should be prepared to address these many challenges, have sufficient strength to welcome them, the honesty and integrity to face them, and the courage to address them.

REFERENCES


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Simulation to Enhance Care of Patients with Psychiatric and Behavioral Issues

Use in Clinical Settings

Joan S. Grant, DSN, RN, CS; Norman L. Keltner, EdD, RN; and Greg Eagerton, DNP, RN

ABSTRACT
Nurses with a medical-surgical clinical focus often care for patients with psychiatric and behavioral issues in acute care hospitals. This article describes how hospital staff and nursing and theater department faculty joined forces to develop realistic simulated psychiatric scenarios for use by practicing nurses.
As patient acuity levels increase, nurses must frequently manage patients with multiple diagnoses. Given this complexity, however, nurses may feel uncomfortable managing the care of patients with a variety of psychiatric and behavioral issues. Little practical advice exists on how to accomplish this in the real world. In this article, we show how we drew on the expertise of practicing nurses in conjunction with nursing and theater department faculty to develop and participate in simulated scenarios using medical patients with a variety of psychiatric and behavioral diagnoses.

BACKGROUND
Simulation and Its Components

Although a unified definition of simulation does not exist in the literature, the National Council of State Boards of Nursing (2005) defines simulation as an educational process. Jeffries (2005) further expanded on this process, stating that simulations are activities that mimic the reality of the clinical environment and are designed to demonstrate procedures, decision making, and critical thinking through role-playing and the use of devices such as interactive videos and mannequins.

Major components of simulation in education include student and teacher factors/interactions, educational practices, design characteristics, and debriefing (Jeffries, 2005; Jeffries, McNelis, & Wheeler, 2008). The teaching role in simulation assumes either a learning or evaluative objective: If learning, teachers facilitate and provide support throughout the learning process; if evaluative, teachers assume the role of observer. Student self-direction and motivation drive good simulation. If the simulation involves role-playing, especially when working in groups, one student may play the role of the patient while another observes.

Principles of educational practices used to guide simulation design and implementation include active learning, feedback, student-faculty interaction, and collaboration. High expectations, allowing for diverse styles of learning, and sufficient time on task are critical components. These principles are applied across a variety of simulation experiences that exist on a continuum. For example, case scenarios, simulations of clinical problems, patient role-playing with actors, vignettes, and critiquing videorecordings of selected skill performance can be used to achieve clear objectives (Chickering & Gamson, 1987; Jeffries, 2005; Shepherd, McCunnis, Brown, & Hair, 2010).

Design characteristics address objectives, fidelity, complexity, cues, and debriefing. The design should correspond to the level of problem solving and decision making expected of the student. Objectives should be clear and match the learner’s knowledge and experience. Clinical simulations should mimic clinical reality (i.e., fidelity), maintaining authenticity and including as many realistic environmental factors as possible. Simulations extend from simple to complex, thus progressively challenging the learner. During a simulation, teachers—and even patients—can provide cues to assist movement through simulations (Jeffries et al., 2008).

Debriefing (i.e., scenario feedback) is the most important feature of simulation-based education and can be as important as the simulation itself. The debriefing session provides an accurate account of events intended to stimulate learning and discussion in a nonthreatening and organized way (Issenberg, McGaghie, Petrusa, Gordon, & Scalese, 2005). Debriefing is most effective when initiated immediately following the simulation and should focus on positive aspects of the simulation and areas for improvement (Reese, Jeffries, & Engum, 2010). The instructor must focus on a few critical performance issues during the debriefing process and provide supportive feedback with objective indicators of successful performance (Salas et al., 2008). Both individual- and team-oriented feedback should be provided. Conclusions should be made and goals should be set during the debriefing to facilitate feedback during future sessions (Salas et al., 2008). Examples of desirable outcomes of simulation include an increase in knowledge, improved skill performance, satisfaction, enhanced critical thinking, and greater self-confidence in the clinical setting.

USING SIMULATION TO ADDRESS PSYCHIATRIC AND BEHAVIORAL DIAGNOSES

Nursing care of patients with psychiatric and behavioral diagnoses requires expert knowledge and strong communication skills; therefore, effective communication is a critical component of psychiatric clinical practice. The ability to create a therapeutic relationship with patients with mental illness is not a skill nurses develop automatically (Dearing & Steadman, 2009).

Journaling, video and audio vignettes of impaired patients, the use of consumer advocates, and small group discussions with patients have been used successfully to improve em-

Simulations...mimic the reality of the clinical environment and are designed to demonstrate procedures, decision making, and critical thinking through role-playing and the use of devices.
pathy in nursing and medical practitioners when caring for patients with psychiatric and behavioral problems (Dearing & Stedman, 2009; Lee-Hsieh, Kuo, Turton, Hsu, & Chu, 2007; Wald & Reis, 2010). In examining the empirical literature, we found that high-fidelity simulation (Sleeper & Thompson, 2008) and objective structured clinical examination (O'Sullivan, Chao, Russell, Levine, & Fabiny, 2008) have been used to enhance therapeutic communication and interpersonal skills. Further, two studies demonstrated good outcomes when standardized patients were used with psychiatric-mental health nurse practitioners and undergraduate nursing students (Becker, Rose, Berg, Park, & Shatzer, 2006; Shawler, 2008). Specifically, this simulation model facilitated development of participants’ interviewing, assessment, and diagnostic skills with patients with psychiatric and behavioral diagnoses (i.e., anxiety, depression, alcohol dependence, schizophrenia, and eating disorders). Important simulation elements used in these studies included:

- Scenarios depicting real-life clinical situations relevant to a specific population.
- Nursing tasks (i.e., obtaining a medical history, explaining a diagnosis and prognosis, providing therapeutic instructions, and counseling).
- Training of standardized patients.
- Clear objectives for the scenario.
- Bidirectional evaluations by both the “patient” and the evaluator.
- A standardized tool.
- A checklist depicting critical tasks performed by the person role-playing the health care practitioner.

**Academic Sources of Simulation**

Beyond these basic approaches, there is evidence of yet other types of simulation to educate mental health professionals in both nursing and medicine (Hilty et al., 2006; Srinivasan, Hwang, West, & Yellowlees, 2006). Three major health science centers have developed simulation approaches beneficial to psychiatric training: Virginia Commonwealth University (VCU), Oregon Health and Science University (OHSU), and New York University (NYU) School of Medicine (Atkinson, n.d.; Aull, n.d.; Brown, 2008).

Psychiatric nursing faculty at VCU developed a variety of simulation activities to use with nursing students. Basic psychiatric nursing skills found to be amenable to the simulation model included therapeutic communication, crisis management, in-terdisciplinary collaboration, medication administration, and use of a symptom assessment tool (Brown, 2008). Simulation exercises VCU faculty use to teach or enhance these basic skills include (Brown, 2008):

- Role-play for reinforcement.
- Videorecorded vignettes for illustration.
- Nurse-patient interactions to facilitate self-awareness.
- Medication administration for patient safety.
- SimMan® scenarios for alcohol detoxification.
- Clinical competence evaluation using a standard test.

**Non-Academic Sources of Simulation**

Private companies also produce psychiatric simulations. SymptomMedia (http://symptommedia.com) developed short video segments demonstrating psychiatric disorders, treatments, and ethical issues. A multidisciplinary team of behavioral health experts consisting of a psychiatrist, psychologist, social worker, and a psychiatric nurse practitioner

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**Basic psychiatric nursing skills found to be amenable to the simulation model included therapeutic communication, medication administration, and use of a symptom assessment tool.**

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In 1994, NYU established a medical humanities website (http://medhum.med.nyu.edu), a dedicated resource for scholars, educators, students, patients, and others interested in the work of medical humanities. The largest section of this medical humanities website is the literature, arts, and medicine database, which holds annotations of works of literature, art, and film relevant to the illness experience, medical education, and practice. Site visitors can search by keywords, such as alcoholism, depression, communication, and dementia. As such, these vignettes and other materials can be used to develop and enhance psychiatric nursing skills.

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Larry Smith is a 62-year-old veteran from the Vietnam era who has been hospitalized for complications from his diabetes. He developed a foot wound 2 months ago and did not seek medical care, and is consequently admitted for treatment of his wound, with possible amputation. He has a longstanding diagnosis of posttraumatic stress disorder. When the nurse walks in, Larry tells her to get out of his room, that she doesn’t know anything about him or his illness, and that she is just a leech—taking from men like him who actually fought for this country.

<table>
<thead>
<tr>
<th>UNSUCCESSFUL INTERACTION</th>
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<tr>
<td>Larry: “Get out of here. You don’t know nothin’ and you don’t care anyway.”</td>
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<tr>
<td>Nurse: “Pardon me. Who do you think you are talking to? Do you think it is any fun coming in here and taking care of someone like you?”</td>
</tr>
<tr>
<td>Larry: “Get out.”</td>
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<tr>
<td>Nurse: “I’ll get out when I’m finished. I have a job to do, you know.”</td>
</tr>
<tr>
<td>Larry: “A job. All you people do is sit around and talk about other nurses. Nobody answers the call button when I push it. I guess you’re too busy talkin’ about each other.”</td>
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<tr>
<td>Nurse: “Hold it there. I’m the professional here. I work hard, very hard, and I don’t need criticism. This job is more than enough.”</td>
</tr>
<tr>
<td>Larry: “You don’t know what hard work is. I worked in the mines for 30 years. I would have given anything to have had a job like yours. You are ungrateful.”</td>
</tr>
<tr>
<td>Nurse: “You have to have an education to do this job. I just wish it were as easy as you think.”</td>
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<tr>
<td>Larry: “Just leave and don’t come back.”</td>
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<th>SUCCESSFUL INTERACTION</th>
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<tr>
<td>Larry: “Get out of here. You don’t know nothin’ and you don’t care anyway.”</td>
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<tr>
<td>Nurse: “Mr. Smith, I’m Nancy Jones and I am the nurse who is taking care of you today. Tell me what is going on. You seem upset. I would like to know why you are so troubled.”</td>
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<tr>
<td>Larry: “You don’t care. Get out.”</td>
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<tr>
<td>Nurse: “I do care, and I want to know what is upsetting you right now. (The nurse keeps the patient in the present moment to decrease anxiety. She reinforces what her role is and what realistic expectations he should have for her now.)”</td>
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<tr>
<td>Larry: “All this is to you is a job. All you people do is sit around and talk about other nurses.”</td>
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<tr>
<td>Nurse: “Mr. Smith, I’m here now to take care of your foot ulcer but you seem so upset that I think we need to talk about that first.”</td>
</tr>
<tr>
<td>Larry: “This damn foot ulcer reminds me of when I got shot in Vietnam.”</td>
</tr>
<tr>
<td>Nurse: “I’d like to hear about that, and I have a few minutes. It must be scary to be in a hospital and be thinking about Vietnam again. (The nurse helps him connect his thoughts and then his thoughts to his feelings.)”</td>
</tr>
<tr>
<td>Larry: “I went to ‘Nam when I was 17 years old…”</td>
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Figure. Example scripts of psychiatric simulations, both unsuccessful and successful interactions.
collaborate in the film production. These videos are available for an annual subscription cost.

Another example of a non-academic source is the Hearing Voices Curriculum: Complete Training and Curriculum Package (Deegan, 2006), which includes the simulation “Hearing Voices That Are Distressing,” in which participants use headphones for listening to a specially designed recording. During this simulated experience of hearing voices, participants undertake a series of tasks, including social interaction in the community, engaging in a psychiatric interview, cognitive testing, and participating in an activities group at a day treatment program. The simulation experience is followed by a debriefing and discussion period. The curriculum also includes a 1-hour recorded lecture (Deegan, 2006). Hamilton Wilson et al. (2009) found that this tool helped students understand the challenges posed by hearing voices. In their qualitative analysis, all participants supported the use of the “Hearing Voices” simulation and identified feeling distracted and uncomfortable while also being more aware of the impact of hearing voices on their comfort and ability to carry out activities. Students gained a new sense of respect for those who lived with the challenge of auditory hallucinations. Further, students described the experience as transformative, resulting in them abandoning preconceived notions of mental illness and achieving a new awareness of the need for understanding, patience, and empathy for people who hear voices (Hamilton Wilson et al., 2009).

### TABLE

**RUBRIC FOR PSYCHIATRIC SIMULATIONS**

| Video 1: An unsuccessful interaction | - Context/background  
|                                      | - Other salient information  
|                                      | - Actions: Nonverbal and verbal communication by the nurse  
|                                      | - Actions: Nonverbal and verbal communication by the patient  
| Video 2: Expert panel                | - Effects of nonverbal and verbal communication on the nurse (positive, negative, unsure)  
|                                      | - Effects of nonverbal and verbal communication on the patient (positive, negative, unsure)  
|                                      | - Effects of nonverbal and verbal communication on others in the environment (positive, negative, unsure)  
| Video 3: A successful interaction    | - Actions: Nonverbal and verbal communication by the nurse  
|                                      | - Actions: Nonverbal and verbal communication by the patient  
| Live: BVAMC educator/facilitator     | - Evaluation of outcomes for the nurse (positive or negative)  
|                                      | - Outcomes for the patient (positive or negative)  
|                                      | - Outcomes for others in the environment (positive or negative)  

*Note. BVAMC = Birmingham Veterans Affairs Medical Center.*

simulation use is increasing dramatically in education, it also has potential value in the practice setting. Implementing simulation must be systematic, in which desired competencies (Srinivasan et al., 2006), facility construction or renovation, equipment, educator training and development, and buy-in by administrators and staff are examined (Seropian, Brown, Gavilanes, & Driggers, 2004). Cost is inherent in these factors. It is important to identify and prioritize potentially troublesome areas and then determine the feasibility of using simulation to enhance nurse-patient interactions.

The Birmingham Veterans Affairs Medical Center (BVAMC) is a large acute tertiary care facility, situated across the street from the University of Alabama at Birmingham School of Nursing (UAB SON). These two health care entities collaborated to write and submit a Veterans Affairs Nursing Academy (VANA) grant that would not only increase the number of graduating nurses familiar with caring for veterans, but would also allow the sharing of human resources in doing so. One of the goals of this grant is the development of psychiatric simulations to assist nurs-
KEYPOINTS

1. As patient acuity levels increase, nurses frequently manage the care of patients with a variety of psychiatric and behavioral diagnoses.

2. The world of simulation has grown substantially in recent years to develop useful simulations that mimic the reality of the clinical environment.

3. In this article, we discuss how we drew on the expertise of practicing nurses in conjunction with faculty to develop and participate in simulated scenarios using medical patients with a variety of psychiatric and behavioral diagnoses.

4. Videorecorded nurse-patient interactions presented by professional nurse educators/facilitators may be a useful approach to enhance simulation in psychiatric nursing.

Do you agree with this article? Disagree? Have a comment or questions?
Send an e-mail to the Journal at jpn@slackinc.com.

In this collaboration, the BVAMC not only linked to a school of nursing but also to other departments within the university. Therefore, the help of the University’s Theatre Department was enlisted early on, generating a wellspring of ideas. Further, by collaborating with theater faculty and students, a polished product that introduced and reinforced appropriate nurse-patient interactions while promoting greater awareness of salient issues was acted out and directed by professionals in the drama field. A structured three-phase simulation activity was developed, depicting a:

- Video of an unsuccessful nurse-patient interaction (approximately 2 to 3 minutes).
- Structured response by an expert panel (UAB SON faculty members, BVAMC staff) and feedback from staff nurses regarding identification of (a) primary points/issues made by the patient in the interaction, (b) ineffective therapeutic communication techniques used by the nurse, (c) important or more desirable therapeutic communication techniques/principles that the nurse may use, and (d) actual versus more desirable outcomes from the patient’s and nurse’s responses.
- Video portraying a successful repeat of the interaction, followed by a structured response by the expert panel and feedback from staff nurses regarding identification of (a) primary points/issues made by the patient in the interaction, (b) effective therapeutic communication techniques used by the nurse in the interaction, (c) alternate effective communication principles/techniques that could be used in the interaction, and (d) positive outcomes from the patient’s and nurse’s responses.

These videos are realistically scripted (Figure) and are appropriate to present to nursing staff on all shifts by BVAMC nurse educators/facilitators. The nurse educators/facilitators are given a rubric (Table)

Providing Quality Care to Veterans With Both Medical and Psychiatric Diagnoses
Faculty met with BVAMC nurses to explore how to provide quality care to veterans experiencing medical-surgical illnesses as well as psychiatric and medical problems. After meeting, the group prioritized and identified several areas that were potentially amenable to video simulations, including:

- How to manage patients with alcoholism and substance abuse who signed out of the hospital against medical advice.
- Early signs of agitation and how to diffuse it in these patients.
- Care for patients who felt a sense of entitlement to specific care.
- Appropriate and inappropriate methods of communication and management of psychiatric patients with behavioral problems as well as paranoia and delusions.
- How to work with patients who accuse nurses of stealing from or lying to them.

Given these pervasive issues, a planning group was appointed by the nursing leadership of each institution. The directive was the development of psychiatric simulations to reach all BVAMC nurses on all shifts. Simulation is embraced at the UAB SON, with abundant simulation resources and frequent use by faculty, especially in medical-surgical and pediatric nursing courses. A strategic plan is in place to integrate simulation throughout the curriculum, and psychiatric simulations are currently in the early stages of development. The group decided to develop videorecorded scenarios that could be viewed, responded to, and critiqued by nurses on any shift.
to guide the post-viewing discussion, to ensure consistent delivery of important principles and content among staff nurses. Formative evaluations by nursing staff regarding the usefulness of the videos in meeting objectives and managing specific patient issues are important, both immediately following and several weeks after viewing. It is also essential to determine whether nursing staff are incorporating strategies from these simulations into practice. Further, patient satisfaction scores regarding nurse-patient interactions during their hospitalization experience will be reviewed for improvement.

CONCLUSION

The world of simulation has grown substantially in recent years (Reese et al., 2010), and psychiatric nursing is working hard to develop useful simulations that mimic the reality of the clinical environment. Desirable outcomes are increased knowledge, improved skill performance, increased satisfaction, enhanced critical thinking, and greater self-confidence in the clinical setting as a result of participating in the simulation. Video-recorded nurse-patient interactions presented by professional nurse educators/facilitators may be one other useful approach to enhance simulation in psychiatric nursing and thus improve patient care.

REFERENCES


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Questions #1-7 refer to the article about providing integrated physical and mental health care services at a nurse-managed clinic by Nardi on pages 28-34.

1. A characteristic of accountable care organizations is that they:
   A. are reimbursed by Medicare.
   B. consist of providers who network to improve care and reduce costs of patient care.
   C. consist of a network of providers who are reimbursed by Medicaid and Medicare.
   D. are maintained by providers who receive monthly flat fees from third-party payers.

2. The system of turn taking, successfully used in the Project Access model, provides:
   A. wrap-around, comprehensive health care services to populations with supplemental insurance.
   B. limited health care services to underserved populations.
   C. wrap-around, comprehensive health care services to underserved populations.
   D. complete outpatient health care services to those receiving Medicare.

3. The National Consortium of Nurse-Managed Centers provides primary health care to more than _____ patients each year.
   A. 100,000.
   B. 175,000.
   C. 250,000.
   D. 300,000.

4. If mental and physical health treatment were integrated by primary care providers, the percentage of children and adolescents who could begin receiving treatment for mental and behavioral disorders would be:
   A. 18% to 22%.
   B. 30% to 46%.
   C. 50% to 65%.
   D. 70% to 85%.

5. Within the next 15 years, the United States expects a shortage of more than _____ primary care physicians.
   A. 10,000.
   B. 56,000.
   C. 124,000.
   D. 210,000.

6. The Project Access model has been adopted by more than:
   A. 22 communities worldwide.
   B. 168 communities worldwide.
   C. 12 countries worldwide.
   D. 30 states within the United States.

7. Low-income patients with no health insurance who have prior histories of mental illness can be treated by family physicians using the:
   A. American Academy of Family Physicians guidelines for mental health.
   B. Northern Physicians Organization guidelines for mental health.
   C. American Medical Association guidelines for comprehensive health care services.

Questions #8-13 refer to the article about providing nursing leadership in a community residential mental health setting by Hughes and Bamford on pages 35-42.

8. In order for a leader to achieve self-actualization:
   A. alignment with the mission, vision, and values of an organization is imperative.
   B. formal leadership practice must occur at all times.
   C. alignment to an internal hierarchical structure must be maintained.
   D. experience in an administrative capacity must have occurred for at least 10 years.

9. Respect for the person’s dignity, self-determination, fairness, and equity are more likely to be realized by creating environments that:
   A. promote values-based practices.
   B. involve mentorship and peer review.
   C. encourage competition.
   D. stimulate goal-directed activity.

10. A characteristic of the stewardship paradigm is:
    A. the opportunity for patients to spend time away from family members.
    B. the ability to draw strengths from the practitioner.
    C. dependency on the health care system when needed.
    D. a strong focus on the individuals and environment external to the nurse.

11. _____ is estimated to account for almost 12% of all disability.
    A. Schizophrenia.
    B. Substance abuse.
    C. Bipolar disorder.
    D. Depression.

12. When compared to the general population, people who use mental health services, and particularly those with a diagnosis of schizophrenia or bipolar disorder, are almost:
    A. twice as likely to die from respiratory disease.
    B. four times more likely to die from respiratory disease.
    C. three times more likely to die from respiratory disease.
    D. three times more likely to die from respiratory disease.
13. Characteristics of true leadership include:
   A. assisting others to recognize negative attributes in themselves.
   B. a strict adherence to the hierarchy within the organization.
   C. providing leadership across, within, and between organizations.
   D. encouraging consumers to be autonomous in tackling health and social issues.

Questions #14-20 refer to the article about simulation to enhance caring for patients with psychiatric and behavioral issues by Grant, Keltner, and Eagerton on pages 43-49.

14. Major components of simulation in education include student and teacher factors/interactions, educational practices, and:
   A. integration of theoretical concepts and debriefing.
   B. pre-testing and debriefing.
   C. design characteristics and debriefing.
   D. video enhancement and debriefing.

15. When the teaching role in simulation assumes an evaluative objective, teachers:
   A. assume the role of observer.
   B. provide support throughout the learning experience.
   C. facilitate the learning process.
   D. provide prompts for direction throughout the simulation.

16. Principles of educational practices used to guide simulation design and implementation include:
   A. active learning, prompting, and debriefing.
   B. participant observation, active learning, and collaboration.
   C. participant observation, feedback, and student/faculty interaction.
   D. active learning, feedback, student/faculty interaction, and collaboration.

17. When designing a simulation experience, the objectives should be:
   A. clear and match the learner’s knowledge and experience.
   B. clear, increasingly complex, and goal-directed.
   C. slightly more complex than the learner’s current ability to perform.
   D. bi-directional and pertaining to the teacher and learner.

18. Simulations progressively challenge the learner by:
   A. extending from simple to complex.
   B. varying in levels of complexity to mimic real-life situations.
   C. offering situations that involve at least two senses of all participants.
   D. being able to make mistakes without harming a patient.

19. Debriefing is most effective:
   A. when positive and negative aspects of the simulation are discussed.
   B. when initiated 24 hours following the simulation.
   C. when participants recognize and discuss barriers to learning.
   D. when initiated immediately following the simulation.

20. During the debriefing process, feedback should be:
   A. unidirectional from the teacher to learners.
   B. provided only by learners.
   C. individual- and team-oriented.
   D. team-oriented only.

CNE REGISTRATION

Please register me for the Learner-Paced program for 4.0 contact hours.

Print or Type
Name
Address
City State Zip Telephone number (in case we have questions)
Date of Birth (used for tracking contact hours only)
Education Level (Circle highest): Diploma, ADN, BSN, MSN, PhD Other (Please specify)_
Work Setting:
Position:

EVALUATION: Must be completed for contact hour certificate to be awarded.

1. The content of the articles was accurately described by the learning objectives:  
   Yes  No
   • Describe factors that influence the success of nurse-managed health clinics.
   • Apply characteristics of successful nurse leadership.
   • Identify essential elements of successful simulation activities.

2. The content met my educational needs.
3. The content was relevant to my nursing practice.
4. How much time was required to read the articles and take the quiz?  
   240 265 290 315 340 (minutes spent)

5. Please list topics you would like to see future activities address:

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