Gretchen Anderson
Anoka State Hospital Oral History Project
28 March 2014
[0:41:55]

[Music playing]

Neal: Good morning.

Gretchen: Good morning.

Neal: I am Neal Holtan. I am here with the Anoka County Historical Society's Oral History Project for Anoka State Hospital.

Gretchen: That is great.

Neal: And, I am here with you, Gretchen Anderson.

Gretchen: Yes.

Neal: Thank you for coming in.

Gretchen: Thank you.

Neal: Could you tell us a little bit about yourself, where you grew up and what your family was like?

Gretchen: Sure. I grew up in Elbow Lake, Minnesota. My dad was a dentist in Elbow Lake. My mom worked as his dental assistant. Very small community. We were very aware of Fergus Falls. Regional Treatment Center then was called the Fergus Falls State Hospital. I kind of got my first interest in mental health when we were seniors in high school, and we went to visit the Fergus Falls State Hospital. And, I was struck by everybody sitting around in dayrooms, languishing, smoking cigarettes, drooling, pacing. And, I thought, I knew I wanted to be a nurse and I thought I would really like to be in psychiatric nursing and help those people.

Neal: And, how about school?

Gretchen: I went to a three-year nursing program initially at Hennepin County General Hospital, and receive my diploma in nursing in 1974. And, I continued my education over the years, a rather circuitous route, getting a four-year degree from Metro State in nursing, a Master's in nursing from Bethel, and my nurse practitioner in mental health, psychiatric nursing from the U of M, yeah.

Neal: Wow. And, what years did you work at Anoka State?

Gretchen: I started working at Anoka in June of 1988, and I worked there until I retired in October of 2011.

Neal: And, what position did you hold at the hospital?

Gretchen: I started as a staff nurse. I interviewed for a position. I had been working at a local community hospital. I was a single parent at the time. I had two very small children. I was aware that the state had better insurance benefits that I could get at the community hospital. And, I applied for a job. I was assured that I would be on a straight day position. I started the job, and I was immediately put on the second shift, and I thought, oh, no. I have left a position at a hospital I liked and went to the State Hospital, because I thought the benefit package would be really excellent. But, now I am on lates, I have children at home, and it was fortunate that the head nurse walked in the nursing office about two days after I started. And, she decided she was going to quit immediately and she walked out the door, she quit. And, they asked me if I would take the job as the head nurse. So, within a week of my hire, I was the head nurse of the cottage nine that I worked in. And, I maintained that position for a long time. Within our moving, and the state was always changing and trying to make things better with administration changes. I became a nurse administrator, then I went back to school and I became a psychiatric nurse practitioner, so I was not the head nurse. But, I had direct responsibility for the care of patients on the unit, and then units that I was assigned for as well as the staff.

Neal: And, how did your work change when you got the nurse practitioner?

Gretchen: My work, it changed because I had more of the direct contact with the patients. And, I had a collaborative agreement with a psychiatrist that I could check in with. But, I had 25 patients that I provided psychiatric care for on my own.

Neal: And, how long did you do that?

Gretchen: I did that for about 11 years.

Neal: I will ask you more about that in a few minutes. When you worked at the hospital, did you live nearby in the community?

Gretchen: At the time, initially, I lived in Brooklyn Center, and then drove up to Anoka. And, eventually moved to Ramsey to make it easier to get to work.

Neal: Okay. Do you think that your training equipped you to be a nurse at Anoka State Hospital?

Gretchen: Yeah, I do. I trained at the old General, and we had, we came out of that three-year diploma program ready to run those units, no matter what unit it was, whether it was med/surg or OB, pediatric, we came out very prepared to take charge and run a unit. I was very well trained.

Neal: I can verify that. I was an intern there, same year you graduated.

Gretchen: Okay, yeah.

Neal: And, the nurses that trained there certainly well equipped to manage large wards and spaces. So, you saw that directly applied at Anoka.

Gretchen: Oh, yeah, um-hmm.

Neal: Was there a nursing director?

Gretchen: There was a nursing director. When I came, the nursing director was Carolyn Torp [PH] and she was the nursing director for quite a while, and then she retired and she was replaced by Peg Gimmel [PH].

Neal: And, what role did the nursing director have?

Gretchen: Her role, we would meet with her weekly and she would go over how things were going on the units. We would problem solve any difficult situations as a group. She was in charge of making sure the standards were met on all of the units.

Neal: Did she do the hiring?

Gretchen: Yep, she did the hiring at that time. And, she did hire me, um-hmm.

Neal: Okay. How many nurses were there all together, would you say?

Gretchen: On my unit, or at the hospital?

Neal: Well, at the hospital.

Gretchen: Oh, my gosh, there were not that many registered nurses. There were, at the time that I started, I think there were four registered nurses on the unit, and I was the fifth one, and we covered three shifts. Our staffing pattern was a lot different than it was now. For a 45-bed unit, there were probably four staff on, very few staff, very different provision of care at that time. Standards were different, yeah.

Neal: Did you supervise the staff in your unit then?

Gretchen: Yep, I would come in early every morning about 6:00 so I could work with the night staff, hear any concerns that they had, any difficulties that patients had on nights. I made all the patient assignments for the day, who was going to spend the day in the medication room, and we would have treatment teams once a week. If there were any orders to be gotten, I would get the order. We would transcribe them. A variety of people, we had a secretary that would help with transcription, LPNs or the RNs would do it. But, I did direct supervision of all three shifts. So, I came in early and I stayed late so I could have the involvement with the three shifts so I knew what was going on.

Neal: Okay. So, there were sign-out rounds between each shift.

Gretchen: Yep. We came on, I did a round with the nurse that was on in the morning. We went around, make sure everyone was in bed, breathing, and at the end of the shift we would make a sign-off round as well. So, the next RN coming on would take her shift knowing where the patients might be, and I say that because they might be off, down by the river. They might have checked off

the unit, they might have wondered over to the liquor store. It was totally a different time, a lot freer than it is now.

Neal: What kinds of programs would you report out, typically?

Gretchen: Oh, what kind of problems? If somebody, and this was of course in the, '88, was before we had the medications that we do now to treat psychosis and depression. So, maybe somebody we would suspect was not taking their medication, then we would start talking about, we would have to think about maybe putting them in a seclusion room the next day and getting a bunch of staff over and put a NG tube down their nose so we could get their meds down into their stomach. We would force it. We did not have injectables that we could give for force med backup like we do today. So, we would do NG tube the next day. So, we would start talking about that, or somebody had gone off for a two-hour pass into Anoka and they had not come back. Where did we think they were? Or, somebody checked off the unit and they went over and they brought beer back to the unit and we had to take the beer away and call the security officer to come and take it.

Neal: How did you come into contact with the patients when they were admitted?

Gretchen: They would be usually admitted down to the Miller Building, there we had an admission unit at the time. Sometimes, they came directly to the cottage I worked with, which was MICD, which was a mentally ill chemical dependent unit, sometimes they would come. It was infrequent that we got a patient admitted to the hospital, because people came and they stayed for long periods of time. So, if somebody was being discharged from one of the units, the whole hospital knew. Everybody knew the patients very well in all the units, because they were there so long. And, when they got better and were out walking around, we would who was who and how they were doing. Just everybody watched everybody, and if they saw something going on, they would call the unit that they came from and they would say, "You know, there's a problem with your patient. He's out on a pass, but this is what he's doing." So, everybody very reported to everybody.

Neal: Did you have any safety concerns for yourself or other staff?

Gretchen: Oh, sure, constantly.

Neal: And, how did you manage that?

Gretchen: We would, a lot of times a person could escalate very quickly, because they would be responding to auditory hallucinations and maybe they were not taking their medication, or their medication was not working, and we would call the security for backup. And, we would have to maybe seclude them, restrain them. I have been chased down the hall by patients with knives and run into the nursing office and slammed the door and called for help. I have been part of a situation on the unit where one patient tried to murder another patient and hit her in the head at night with a rock in a sock. It was a very, at times, unsafe situation.

Neal: And, did the staff kind of take that in stride and expect that?

Gretchen: Yeah. Everybody just expected it, part of the job, and you just tried to make sure everybody was doing the best they could, and you were aware of your safety at all times, and watchful of your environment. The staff bathroom, the level, building I worked in was four levels. The staff bathroom was downstairs, so if you had to run down to the bathroom, you hoped nobody followed you down the stairs, yeah.

Neal: And, how about the tunnel system? Did you use that?

Gretchen: Oh, yeah, the tunnels, yeah, they were great. The tunnels were very much used when I first started at Anoka in 1988. We would take patients through the tunnels in the winter, or if it was raining really hard or bad stormy weather, to the dining room. We would go as a group through the tunnels. People that had higher privileges could be on their own in the tunnels. You never knew what you could encounter in those tunnels. They were dark, they were very poorly lit, and you would find people sleeping in the tunnels, having sex in the tunnels. It was a wild experience, the tunnels. I tried to avoid the tunnels, yeah.

Neal: Were there ever unexpected pregnancies that resulted in that sort of thing.

Gretchen: Yep, there were.

Neal: What would happen in that case?

Gretchen: We had a patient who got pregnant in the stairwell, and I went with her over to Mercy for confirmation of her pregnancy. And, even though she was psychotic, she was overjoyed that she was going to be a mother. The state absorbed this cost. She did have this baby and I see her occasionally in the community. The child grew up, is an adult now. I do not know, but it was taken care of. I mean, the baby was born.

Neal: Was the baby born at Anoka State?

Gretchen: No, this baby, she was discharged. The baby was born at Mercy, yeah. And, we would moms come in that were expecting, and when they got close to delivery, or we were very worried, their prenatal care was through community obstetrician service and they would delivery at Mercy, their babies.

Neal: Was birth control an option for the patients?

Gretchen: It would be offered as part of the family practice, doctors' involvement with the patients. A lot of times it was something they did not care to participate in, birth control.

Neal: And, would that be the pill mainly?

Gretchen: The pill mainly, people did not care to take the pill, yeah.

Neal: And, why do you think that was?

Gretchen: I think in 1988, a lot of women had concerns about the pill and even though they were mentally ill patients, they were not interested in it. And, a lot of patients could not remember to take their antipsychotic medication, so they would not remember to take the pill anyway, so it would not be an effective manner of birth control for them.

Neal: So, the psychiatric medications, were those given out to the patients and then observed them taking it?

Gretchen: Yes, yeah, yep, the patients would come to the med window. The med room was a very small room, very poorly lit. How we ever got those meds dished out correctly is amazing, but we did, and the patients would take the meds in front of you, so you saw them take their medication.

Neal: Did they ever like cheat their medicines?

Gretchen: Yeah. We would check their mouth, we would say, "Open your mouth, lift up your tongue." And, then we would say, "No, no, you did not do it good enough." We would put on a pair of gloves and you would say, "Open up your mouth," and you would dig around in their to make sure. They would stand there with their mouth open. Nobody ever bit down on you. They were pretty easy-going, yeah.

Neal: And, did patients tend to get better over time?

Gretchen: They did get better over time. They came for a period, which was a long period of time, sometimes six months, sometimes at year, at that time, sometimes longer even. The stays were maybe 500 days, and they would gradually get better. Now, whether that was the medication, whether it was somebody constantly working with them that they cared about, that they knew cared about them, that they had formed a relationship with. They would get better.

Neal: And, what other kinds of treatments did they get?

Gretchen: Sometimes, people, like today, still would go over to Mercy for ECT treatments, electroshock treatments. We had rehab services. We had, at that time, we had a man who was very instrumental with a gardening program. The farm was closed when I got there. They did not have the farm that they used to have, although it was still standing. But, he had a gardening activity, and the people liked that. He was very involved with helping people to plant seeds, flowers, teaching them about flowers, and people really liked that. At that time, we had rehab services where people could be involved with doing something on the unit. It would be maybe sweeping the floor, emptying the garbage. They would get a small payment. They liked that, they liked being involved with doing something for the unit, and they did get a very small amount of money. And, we do not have that anymore.

Neal: And, who formulated the treatment plan?

Gretchen: The treatment plan was formulated by the treatment team, with every discipline putting in their interventions. The doctor would have his interventions, whether it was medication, modalities, giving the meds, seeing if they were effective. The nurses' interventions might include

getting a patient up every day, making sure they were dressed in clean clothes, helping with their grooming, teaching them, always teaching, teaching about their medications, teaching them about the importance of taking their medications, teaching them about side effects, things to watch for. Rehab put in their interventions, what they were going to do with a person, maybe take them out in the blue bus for an activity, maybe taking them to the mall for, down to North Town for an activity, maybe going to Anoka for coffee.

Neal: And, what kind of records were kept?

Gretchen: Oh, the records were the paper records, not the electronic like we have today. We had a chart system, and the chart system was unique in that everybody fought for the chart, because one person could write in the chart at a time and everybody wanted to write. And, if the doctor came, he got the chart, because, of course, he had very limited time and he had orders to put in. So, a lot of, we tried to get all our charting done each shift.

Neal: So, there was charting…

Gretchen: Every shift.

Neal: …on every patient, every shift.

Gretchen: Not every patient, every shift. We would sometimes just say, "Patient slept," and sign your name, or "Patient on the unit," and sign your name. It was very brief, and then it became more detailed charting over the years.

Neal: And, were these records kept sorted here at the hospital?

Gretchen: They were on each unit for each patient. They were stored, and then after the patient was discharged, they were taken to medical records. The chart was disassembled and kept in storage for when they came back, because they would come back. It was a revolving door system, and so then you would have to go get the big box of all the old charts, so you could look back to past hospitalization to see what medication might have worked, might have helped them when they were discharged the last time.

Neal: In regard to the treatment plan, were people pretty much in agreement all the time, or were there disagreements about what should happen?

Gretchen: Oh, they were pretty much in agreement, because the unit I worked on was mentally ill and chemically dependent, we had a CD focus, chemically dependent focus, where the push was to get people to chemical dependency to understand how CD impacted their lives, whether it was alcohol and, that was, in the years before, methamphetamine. So, our main CD problems at that time were alcohol and cannabis, marijuana use.

Neal: And, what other diagnoses did they have?

Gretchen: The diagnoses, the people would come in with schizophrenia, whether it was paranoid schizophrenia, a non-differentiated type, a first-even schizophrenia. Sometimes, we would get very young people in with a first psychotic break, maybe they were 18 years old and they would be coming in for a first hospitalization. The other diagnoses would be depression, bipolar illness, mania was not uncommon.

Neal: And, when you were working as a nurse practitioner, did you do diagnoses?

Gretchen: Yes, yep, um-hmm.

Neal: How did people monitor the progress of the patients overall, in regard to the treatment plan.

Gretchen: The overall progress was, we would look at the treatment plan each week in treatment plan, and we would have goals written for the patient. For example, take their medications every day without arguing, and that was just an example. The next week when we would have treatment team, we would say, "When they took their meds this week, did they take them? Did they throw a fuss? Did they cheek their meds? Did they go to water fountain? Did they spit their meds? Did they go to the waste basket and spit their meds out? Did they drink a lot of water after they took their meds, you know, is there a question?" So, we would check to see if they trying to make their goals possible. We would talk to the patients. We would have the patients come in to treatment team each week, and we would say, "How are you doing? How do you think you're doing? What have you learned? What has helped you? What isn't helpful? How can we make this a better stay for you?" We would ask people.

Neal: And, what kind of feedback would they give you?

Gretchen: Oh, it would depend if they were taking their meds or not. They were genuinely, if they were on medication, pretty open to saying how they were doing. They would frequently say, "I don't like these medications." That was a common theme. "I don't like meds." And, it is today. "I don't like taking these meds. The meds make me feel funny. The antidepressants make me feel numb. I don't feel emotion on them." I mean, you would hear the complaints, and then you would talk to them about, "If you take the meds and you still have the side effects, you don't have the depression, or you don't have the voices. You're not seeing things," you know, to try and work with what they were saying with what the meds could offer.

Neal: What do you think the average length of stay, how long did the average patient…

Gretchen: At that time?

Neal: Yeah.

Gretchen: Oh, my goodness, I wish I had kept the, all, we had so many sheets on length of stay. The different units had different lengths of stay. We had a geriatric unit, which had a longer length of stay. Sometimes, it was harder to get people discharged, older people. It was easier at that time to discharge into nursing homes than it is today, with the regulations have changed with mentally ill being accepted. It is more paperwork. So, I think the length of stay sometimes would go maybe a

year, maybe nine months. You got to know their family pretty well. You got to know who had somebody call them on the phone, because they would talk about. You knew who came to visit, if anybody had visitors. A lot of people came, they had no visitors, nobody called them, I mean, they had no patient family involvement, not uncommon.

Neal: You mentioned elderly. Were there, we have heard that some of the elderly residents and patients really were not that mentally ill, but did not have any other options, is that…

Gretchen: Yeah, that is…

Neal: …would you agree with that?

Gretchen: …yeah, that is true, I do believe that is true. And, that does continue. It is just like where are they going to go, who is going to take them? Some of them have, you know, rather strange behaviors and people will not tolerate it in the community. In a mental health state hospital setting, they do tolerate that. That is normal, that is the normal. It is like, "Oh, he's doing this," you know. "Okay. That's how it is."

Neal: And, so some of them would be placed in regular nursing homes at that time?

Gretchen: Yes, yes they were. They were discharged out to nursing homes.

Neal: And, would that be in the community that they came from?

Gretchen: Hopefully. They tried to get them back into the community they came from as often as possible.

Neal: And, what kind of geographic spread did you have among the patients?

Gretchen: Oh, at that time, because we had all the state hospitals up and running, not like today, where they have been closed. So, our area was the counties around Anoka. Anoka, Hennepin, Hennepin County, Ramsey County, Washington County, this immediate Twin City county area.

Neal: And, you mentioned Mercy Hospital a couple of times. So, you had close ties with them?

Gretchen: We did. If things would go bad with a patient, or they had to by ambulance over to Mercy, they would be taken there. A lot of our, some of our moms who did deliver, delivered down at Hennepin County, just because of the nature of their pregnancy was a higher risk with Children's close by, so they were taken downtown.

Neal: And, what kind of events would lead to ambulance rides?

Gretchen: Oh, people would overdose on a chemical substance on the unit, or you would find them unresponsive. Or, you would find a person trying to self-injure, injure themselves, cut themselves really badly and have to go in for, although the docs would suture them up, maybe they would lacerate themselves a lot and they would have to go in for some suturing up in the ER over at

Mercy. The docs over in the ER were pretty cross with our patients. It was hard for them to, because they were trying to treat life threatening injuries, and then our patients would afflict abuse on themselves and be brought in. So, a lot of times our relationship with the community hospital was not the best, because of the nature of what the people did to themselves.

Neal: And, did you do surgery at Anoka State Hospital?

Gretchen: They did, but not when I was there.

Neal: How long did, before you arrived…

Gretchen: Oh, my gosh.

Neal: …did they stop?

Gretchen: You know, I do not know the answer to that, but I know we were not doing any surgery.

Neal: What kind of equipment did you have? Did you have like EKG machines, or…

Gretchen: They had a portable EKG machine over in the clinic. We had a central clinic at that time. The patient could go over, it was old equipment, everything was old.

Neal: Was it just a one-room…

Gretchen: Clinic.

Neal: …clinic?

Gretchen: At that time, I believe it was, and then they tried to improve it and get a larger work area.

Neal: Did it have just walk-ins or appointments?

Gretchen: No, we had, then they went to, shortly after I started, a system where we had a family practice doc assigned to each unit. And, the doc would come to morning report, and hear about any problems on the unit. And, then we had a treatment room on the unit, equipped. So, they could do most things there. But, if there was like a heart problem, they would frequently send them out to a community specialist.

Neal: Did you have tuberculosis testing?

Gretchen: We did, we did when people came in. They were tested and I do not remember anybody have a positive compared to now, different, where you have to send them out of the treatment center now, because we do not have the special room with the air circulation.

Neal: And, what was the diet like for the patients.

Gretchen: Well, we put out a lot of peanut butter cups for snacks. That was just one part that I do remember well, because the patients loved those peanut butter, little med cups, 30 cc med cups with peanut butter, because they put them out for the squirrels. And, we had literally squirrels all over, squirrels all over the campus. They were eating well off the peanut butter and getting quite fat. We had a lot of food for the patients. There was no limit on what they could eat. They had meat and potatoes, vegetable, desert, over in the central dining room. It was infrequent that somebody needed a tray to be delivered to the unit in the food truck, but that did happen. We tried to get everybody over to eat. And, at the end, after everybody had gone through the serving line, they would call out, "Seconds," and then everybody would come back and eat some more. Today, it is, people are more aware of the amount of calories that they serve the patients, so the food is not as abundant in amount that is served. It was not uncommon then for people to gain weight, but they gain weight today, too, because of the side effects from the meds.

Neal: Did the patients complain about the food, or they liked it?

Gretchen: It depended. Most people liked the food, and they ate pretty well. The staff would go over and eat the meals, too. That was, if you had to go with the patients to the meal, then you had the mean and you sat down and ate, too. I thought it was great. I liked to go.

Neal: And, could most of the patients feed themselves, eat by themselves?

Gretchen: Oh, yeah, yes, oh, yeah, they did. Yeah, and then take food out of the central dining room for the squirrels, yeah. And, once in a while, they would horde food up in their rooms, because you would have to do a room search, because you would suspect something was going on, because the room would stink, and there would be all kinds of food rotting. Or, they had put bread in a can in the dayroom, and they would be having, starting some hooch. I mean, they would get some booze started in the dayroom.

Neal: Wow. And, did it ever actually turn into drinkable alcohol?

Gretchen: I do not know. You know, that was in the day, I am sure they did drink some of it, but that was in the day when there was smoking in the hospital, indoors. The patients all smoked, and the staff smoked. The staff smoked in the cottage at the nursing desk, in the halls. The patients smoked, you would go out of the nursing office where the air was blue into the hallways where it was very blue, into the dayrooms where it was even bluer. You had to kind of hold your breath, because you would go in there and do your rounds and you would count to make sure everybody was there on your checklist. So, sometimes things sort of did not noticed that might be in the corner, because you did not, people, round after round would not necessarily go too far in that dayroom. But, the janitors would and you would hear a report, "Say, did you know," and you would go, "No."

Neal: Could you say something about the doctors? Who were they, did they work full-time, just come in part-time?

Gretchen: Our docs worked full-time. We were very fortunate on our unit. In the other units, they had full-time psychiatrists and full-time family practice docs that were dedicated to the assigned cottages, and they got to know the patients very well. They were not docs coming in from an agency, from a national agency to provide in times of low coverage. They were people, that was their job, that was their one job, was to come work at the State Hospital.

Neal: Okay. Just a few questions about kind of the big picture.

Gretchen: Okay.

Neal: What do you think the surrounding community in Anoka, the town of Anoka, what were attitudes like toward the hospital?

Gretchen: I know from the talk that we would have in the office that the community was not happy having our patients wandering the streets of Anoka, wandering into their shops, helping themselves to items. We knew that. We would get calls back from store people. They did not want our patients to come down into their shops. There was a particular patient who would come in and cause a ruckus. They did not want that person to come back. I knew attitudes were not good. People did not like them wandering freely. And, at that time, if a patient was a high enough privilege level, they would just simply leave the unit. I mean, they could go and be back in four hours or eight hours. So, they had a lot of time to get themselves into trouble if that was their mission, I guess.

Neal: And, how did you handle those situations?

Gretchen: When they came, when the patient came back, we would…

Neal: Or, if you heard from…

Gretchen: Oh, we would assure them, we would try and keep the patient on the campus. And, then we would talk with the patient and say, "You cannot go, when you go back on pass, you can't go downtown Anoka. You can't go in this store." And, then, of course, they probably would say, "Okay," and then the next thing you know we would get the call again that they had gone back down. It was hard to contain people. Today, they do not have that free ability to check off the unit. They are in the hospital pretty much from the time they are there. If they are off, they are escorted with staff and that was not what was going on in 1988.

Neal: I am sorry, did you say you retired?

Gretchen: In 2011.

Neal: Just three years ago. Have you maintained any ties to mental health organizations or treatment?

Gretchen: Oh, yeah. Yep, well, I still teach for Bethel University. I am an adjunct faculty in their nursing department. So, this semester I have two groups of students at Anoka. On Tuesday, I

have a full day, and Thursday a full day there, so I still see the units and I know a lot of people from years of working with people. So, I pretty much have the pulse of the unit, the hospital.

Neal: And, what is in your course for the students?

Gretchen: For the course, they are undergraduate nursing. They are in the four-year bachelor's of science program, and so their expectation is to go onto the unit, begin to have a relationship, form a relationship with somebody, get to know them, get to know the meds they are taking, have an understanding of the psychiatric meds that are prescribed for them. Do some patient teaching, begin to form their assessment skills, if the patients are responding to treatment, watch the RNs. They get to shadow RNs frequently for their safety. I have them shadow with one of the staff RNs throughout the day if possible.

Neal: Do they consider the psychiatric nursing different from their other courses?

Gretchen: Yeah, yeah, big time. And, then they get to go to community hospitals where they are just flying around, using all kinds of machinery and different styles of nursing care. But, like I say to them, "You're always going to see mental health dynamics, whether it is home care," or they have a hospice part of the semester where they are in hospice. One day they have home care, they have some community support, whether it is going out into an open AA meeting, or like a women's support group. You will always see mental health, whether it is anxiety or depression, or you are looking at person who is grieving. You can recognize where they are at, what they are doing.

Neal: What would you say your top goals or messages to those students would be regarding psychiatric nursing?

Gretchen: My main goals are to them to be aware of the dynamics of mental illness. I mean, it is all over. It is in your family, it is in my family. Be aware of when people are not doing as well, and just kind of gauge your response to them. And, always in the nursing setting, just know when somebody comes off and a family member starts a tirade against you, not to take that personally. It is where that person is at, just be aware, maybe sensitivity of what is going on with them.

Neal: Big broad question here. Do you think attitudes in society in general have changed over time regarding mentally ill people?

Gretchen: Slowly. I think we are coming to have a better acceptance of people with mental illness. There is still a lot of stigma attached.

Neal: And, if you had any advice for advocates for the mentally ill, what would you tell them?

Gretchen: Keep working, keep doing your job. You are doing great. I think the advocates are really helping.

Neal: Do you interact with them currently, or not?

Gretchen: I do at times. Yesterday, when we were leaving, one of the advocates was coming in from Hennepin County and she said, "Oh, a group of nursing students." And, I go, "Yeah." I did not know her, but she could just tell by the group leaving that they were students, and she just spoke really highly of nursing students and gave them each her card and told them if they had any questions about her role, they would be free to call her.

Neal: And, does that person work for the county, or…

Gretchen: She works for Hennepin County, and she was coming in to see a patient.

Neal: And, what role do they have?

Gretchen: The advocate role, it can depend on whether it is somebody in the community or at the state level, advocating for legislative changes.

Neal: What have we forgotten to talk about?

Gretchen: I cannot think of anything. We covered a lot.

Neal: Well, thank you. You did a great job.

Gretchen: Oh, thank you.

Neal: Thanks for coming in today.

Gretchen: Thank you.

[Music playing]

[End of audio]