Interviewee: Dionna McFerrin
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Interviewer: Charitie V. Hyman
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Background Noise: Some noise from vibrating phones and faint outdoor sounds.

Summary of Interview: Dionna McFerrin explains that she first studied English and still writes fiction. She describes moving to nursing where she had several jobs before going to a county behavioral health program. She describes the interdisciplinary teamwork that she found there. The job was exciting, but also stressful and required overtime. As a Nurse Practitioner, she currently works with patients who have mental health and substance abuse concerns. She aims to open her own mental health clinic that focuses on holistic care and combats stigma.

Time	**Content Description**
0.00.00	Introduction
0.00.39	Grew up in Milwaukee, Wisconsin. Spent some time in other states pre-school; moved around to several different schools because of family moves. Took colleges at UW-Milwaukee after graduating high school early. Took undergraduate degree in English in Jackson, Tennessee. Returned to school for nursing after marrying and beginning family. Went to a direct entry nurse practitioner program in primary care. While in school, worked in mental health as an RN. Worked in hematology and oncology as RN. "I really liked mental health, so I started working in mental health as a nurse practitioner." Decided to get certification to be a psychiatric mental health nurse practitioner. In high school, did some media studies and work.
0.02.45	Originally wanted to—and still want to—be a writer. Media studies in high school led to English degree. But had always loved science and medicine. Grandmother also a nurse, and mother wanted to be a nurse. Talked extensively to grandmother about her nursing experience. And witnessed firsthand: grandmother was often on call and often had her pager with her.
0.03.49	Husband worked in retail as a manager, and initially suggested interviewee might consider returning to work as a pharmacist. Prompted interviewee to get some experience as a pharmacy tech and consider returning to school. But this experience led interviewee to decide against pharmacy. "I said I definitely don't want to be a pharmacist. To me, it was boring because there wasn't enough patient interaction. But while I was doing it, I was taking … science-based credits to get into pharmacy. I said, 'I can't waste this, but I don't want to do this with my life.'" Then found Marquette's direct-entry nursing program and found it much more attractive and exciting.
0.05.05	Marquette's direct entry program lets students with degrees other than RN be admitted direct to the nursing program. Intense program, including summer semesters. Involves some grad courses while doing undergrad, as well as work. Graduated English degree in 2005; and from Marquette in 2016.
0.06.01	Cohort at Marquette from many different backgrounds. Many science-related: e.g., biology and physiology. But also, teachers and others with degrees in

English and business. The variety of students the interviewee found exciting and attractive, even though some stigma about direct-entry students. “Some people were kinda, ‘Direct entry, you guys are not worthy.’ But I think it’s really cool, because you get to bring so many other facets that are important to nursing with you into the program. And I think it adds diversity in the field, and I think it helps you overall with nursing and becoming a nurse practitioner as well.”

0.06.52 First-hand and second-hand experience—including on the internet—about people’s negative attitude toward direct-entry program. “Some people feel you should be a nurse for 15 years before even going back to school to be a nurse practitioner. But it’s a totally different job, so I don’t think that’s true. I think you do have to have some experience, but we had experience too while we were in school.”

0.07.39 Gained clinical experience in school, but also work experience. Had experience in being RN and nursing before finishing program. And even before taking classes in advanced health assessment, already had experience as RNs working. And of course, also had experience as RN before we got to clinicals. “I think if you’re focused enough on what you want to do—I’ve been in school for 10-12 years—I don’t know why [anyone would have a negative attitude].”

0.08.31 Did first set of clinicals for RN at several different hospitals—the Aurora system, St. Joe’s, the VA (where interviewee did her mental health rotation for nursing). For nurse practitioner, interviewee was at the Aurora system (women’s health), geriatrics, and various other clinics, including substance-abuse-focused facilities. Gave interviewee experience of a large number of different patient populations.

0.09.42 First impressions of nursing were “being terrified”. “Even though I had a degree already and I was a mom. I had a degree in English and all the rest, but it was just very different …I don’t think it’s hard necessarily, but it’s work. And you have to do real studying … And then you get to clinicals and it’s real-life patient care. Most people initially aren’t comfortable touching everybody and asking intimate questions of people. So, it’s something you have to learn and build up. And you can’t tell people, ‘I’ve never done this before,’ because that’s going to make people feel weird and vulnerable and uncomfortable.” But after first impressions, interviewee felt much more comfortable after getting used to role.

0.11.02 One of first experience a hemiplegic patient couldn’t move one side of her body. Interviewee had to bathe patient, and interviewee starting ‘pooping’ as patient was being bathed. “That was one of my first experiences, and it was real life—it got real very quickly. But you don’t judge—you have a reaction, but it really makes you understand too how vulnerable are the people you’re taking care of. But also, how much power and control you have in the situation, and that’s something you always have to check.”

0.12.44 Pathophysiology professor was very supportive. “She just made things so easy and was so caring and passionate. That was very inspiring, and thanks to her I got a great understanding of patho [pathology] In that arena, I would say she was the hero of my schooling.” But not a large number of other especially inspiring teachers or mentors.

0.13.49 Worked part-time while at Marquette at Froedtert in hematology and oncology. Got two new jobs because of scheduling difficulties at Milwaukee County

Behavioral Health and Whole Health Clinical Group, the latter focused on mental health in a crisis resource center.

0.14.36 Hema [hematology] was focused on chemo, blood transfusions, IVs, running IV pumps, measuring urine and feces input and output of patients—a lot of hands-on patient care. Since it was an in-patient unit with chemo, many very sick patients. "And death is a part of that—you have to think about and deal with it." In the mental health emergency room, would have people coming in acutely ill with suicidal or homicidal ideation and psychosis. Would perform as an RN a nursing assessment—but not the assessment a nursing practitioner or doctor would do. Interviewee found the doctor/nurse practitioner's responsibility in making these assessments scary, because of the possibility of sending home someone who later would suffer harm. Responsibility included giving psychiatric injections, restraints, making sure patients took care of hygiene, and safety. A very different experience from the first job.

0.16.37 In hematology, not much interaction with doctors and nurse practitioners: lots of standing orders, giving general instructions for patients who meet certain conditions, without a secondary assessment. More socializing and collaborating with other nurses.

0.18.01 Milwaukee County Behavioral Health had own emergency room and behavioral units and long-term care units. Later, started to close units over time (beginning with long-term care units, including for patients who had been involved even in killings) for funding reasons, and transition people into the rooming houses, half-way houses, or into the community "whether that be a good thing or a bad thing", although emergency room maintained. Worked as a step-down process, and now a private organization may be taking over for the city or county's mental health. Private organization has to promise to accept the same patient population, and not to turn people away. "That's a problem now because a lot of the patients can't go" to certain places, sometimes for insurance reasons. "But we'll see what that looks like in practice."

0.21.38 Work in ER unit: a lot of police presence because people come in both voluntarily and involuntarily. Took some getting used to. Had to carry around a large number of keys: had to open a door to get anywhere, because everything is locked. "A lot of vulnerability from the patient side … Nursing, there's a thing of sympathy versus empathy. And we shouldn't have sympathy: you don't need to feel sorry for people; that doesn't help anything. But you should have empathy and try to put yourself in their shoes and understanding. So, I had a lot of empathy towards the patients, and sometimes you take that kind of stuff. So, it was a lot of taking a lot of things home."

0.22.35 Dealing with stress from the job: "Part of it is that I'm a little different now than I was before. I have the ability to listen and take in all this stuff, and kind of shut it off. I did it too much, and you get a lot, not burned out—I don't feel burned out at all—but you build up a little bit of [not internalizing or dwelling on it]. Because I don't feel I would be good to anyone if I did that. Because there's so much pain and a lot of stories."

0.23.31 A typical shift: begins with a report from other nurses. In PCS (the emergency room—'Psychiatric Counselling Services,' maybe) you would sit and wait for

people to come in: could be quite variable. When someone arrives, would often start with giving people food and drink first. And then a "bank-teller" kind of wall. Patients are in booths, and you talk to them. CNAs would take vitals of patients who came in. But first point of contact was security, with 'wanding.' And then a CNA and then a large number of questions from behind the 'bank-teller' wall. Assessment would determine if people were psychotic or manipulative. Would also involve a lot of charting.

0.25.23 Most interactions with nurses and CNA medical assistants, security, police officers, psychiatrists, nurse practitioners, legal (because of the large amount of paperwork associated with people who were being 'chaptered', i.e., coming in involuntarily). There's even a small courthouse. Also, some social work: there was a 'mutt team.' Interviewee felt this may have been an offensive name, but others didn't remark on it. Dealt with many different roles, which interviewee found interesting and exciting. Felt there was a lot of camaraderie in a fast-paced, close-knit environment. Gratifying to see patients who had been in crisis get help and no longer be in crisis.

0.26.54 But sometimes could feel scared, perhaps because of underlying anxiety due to unpredictability of workplace. Another challenge: many mandated shifts, e.g., mandated overtime. So, e.g., if working second shift and someone can't come for scheduled third shift or unexpectedly high census, and then you're required to, which creates challenges for, e.g., childcare and the challenge of working a 16-hour ER shift. Also worked on observations with patients in a unit from 24 to 72 hours, to determine if they could be admitted. Assessment would focus on stabilization and changes in patient's condition over this time: e.g., whether they're taking meds, whether symptoms are improving or disimproving, whether suicidal ideation subsides or continues. Worsening patients would be transferred to another facility. Either patient would be determined to be acute enough to be admitted (if enough beds were available) or safe enough to return to previous environment. So, another reason for admittance might just be lack of safety in returning to previous environment. Unit had capacity of about 14.

0.29.38 Worked at this unit for seven months, although "it seemed like an eternity". The Whole Health crisis resource center—interviewee's next job—was not a hospital and had less acute patients but would help people become stabilized while taking medication every day. Had a lot more downtime in this non-hospital environment. Could be "both a good and a bad thing"—even slightly boring at times. As a residential home, some different kinds of activities: baking cakes, playing games, and doing crafting with people as therapeutic interventions. Some group activities, with one nurse and someone who had a degree in psychology or social work, and a peer support person, and these three would run the groups and often be the only persons on the shift.

0.31.51 Felt comfortable in role as medical point person. Had to be aware of degree of acuity and whether police might have to be called. But having started in the emergency PCS environment, these responsibilities were much more manageable. Spent over a year at this job, until graduation from nurse practitioner program in 2016.

0.32.44 Initially worked after graduation in primary care and internal medicine, in an outpatient clinic. Felt very excited about this and got boards and worked there for a while. But found it wasn't what had expected. Worked with one particular doctor, who was studying for his boards, and so would be absent for much of the day, leaving interviewee self-supporting. Gained experience by doing these tasks herself. Many patients came because of pain-management history of the clinic. But interviewee didn't feel happy about how pain management procedures worked and didn't like writing a large number of prescriptions for opiate medications. So, decided to go into treating opiate addiction, working with Clean Slate and patients who were addicted to opiate pills, heroin, alcohol: "a huge problem in Milwaukee. And then you can have providers exploiting patients and only taking cash payments. And then you have a lot of providers closing down and losing their licenses. And then that puts stigma on other people who are really trying to help. It makes it more difficult, I think. And then there's a lack of people who are doing it and going into it. The medication we use is called Suboxone and nurse practitioners only got a license for that in 2016." Interviewee was among first people in state to take test and get the waiver; highly restricted, and a limit to number of patients who could be on the medication. Can apply to have a larger number of patients on the medication as a nurse practitioner; for doctors, a large maximum number of patients who can be on the medication. However, the total number of people in need of it is higher than these maximums.

0.37.16 Now work for the Professional Services Group Committee. Wanted to broaden—previous job only dealt with substance addiction. But many patients with substance use issues are dual diagnosis with other mental health issues. Couldn't do anything about the latter before. Now do both substance use and mental health issues and can treat both. Most current patients have only mental health issues.

0.38.04 Now do tele-psychiatry, for last year and a half. Patients go to clinic and sees patients in different areas of Wisconsin. These clinics full staffed, e.g., with therapists on site. Patients sit in front of huge screen—"way too huge and way too high definition"—and see people via video link. New technology is also being used not just for mental but for physical health. But easier in psychiatry because there's no physical exam. Allows more flexibility in being able to work from home, especially with children. Also alleviates safety concerns. Has heard of people at other clinics where a patient who had been abusing a prescription came back with a gun after being refused. Violence in mental health a huge issue in general, although interviewee has had few issues in terms of physical violence. Downside is not having face-to-face, in-person contact, and the camaraderie of having other co-workers too.

0.41.13 Goal to open own mental health clinic one day. Husband is now a special education teacher and plans to get master's in social work to become therapist. Plan is to have own family-owned clinic. "There are lot of clinics that don't do it right, and I really care about this population and want to do it right."

0.42.06 Aims for professionalism and high standards in customer service. "And then I'm big just on aesthetics too. I think your environment and the way it looks can dictate how you feel sometimes. So, I just want a nice little pretty clinic that just looks nice and smells nice, and people can just come there and feel a little respite

from the hectic life of real life. And just to show people that they deserve something nice and pretty." Also cares greatly about competence. Many clinics run by psychologists who have less medical background. So important to have someone with that background. But Wisconsin not "full practice authority," so would have to have a collaborating psychiatrist. Nurse practitioners have three different situations—one, full practice authority, where you can practice independently; second, collaborative, where you have to collaborate, and you need a doctor if you need help; and the most restrictive is supervisory, where you have to be regulated by a physician, which comes with many more regulations. "Some people think that nurse practitioners are inferior to them. Some doctors think that. But then they also have lobbying organizations." Also, a shortage of psychiatrists—with many retiring and not as many taking it up. But research shows that nurse practitioners have very good outcomes.

0.45.39 Nurse practitioners have rigorous training and standards. "But then as a nurse, you're bringing a holistic approach—psychosocial measures, etc.—and that's the nursing model rather than the medical model. Although this may be changing now." Thinks of nursing model as holistic care of patients. So, e.g., if a patient presents with chest pain, a nurse will ask how patient is feeling and what's happening in their life. A doctor might see it as a heart issue, as opposed to seeing it more broadly. But this is a generalization, interviewee stresses: some doctors will see things holistically and some nurse practitioners will focus on narrower issues. Also doesn't want to speak to medical school training, since has never attended.

0.47.27 Current nurse practitioner specialty is adult geriatric primary care. This includes dealing with mental health issues, but some nurses deal only with mental issues. Felt that since wants to work only in mental health that, even though not a financial incentive, wanted the extra training and credentials. Taking this course through UW-Milwaukee in first year of new program, with a class of 6. Feels that although more interest, still not much. "There's not a ton of people who want to go into psych … There's a lot of stigma around psych. Like, I wouldn't want to go into cardiology, that's not my thing." Stigma attaches to both patients and nurses. "At least an RN, you'd hear, 'Oh, they're not a real nurse because they're doing psych.' … from other nurses." Thinks perception the result of the different kind of work, and other people not having experience of the work involved—a different skillset involving a lot of assessment and emergency reactions. Uses a different part of nursing skills, doing mental health.

0.50.11 Stigma about patients: "People see them as crazy people and they're afraid of them. People see them as dirty and they don't want physically to be around them. Or they're morally corrupt because things happen to them in their life because they have mental health issues, or they feel that they deserve what they get."

0.50.43 Combat that by treating patients like would treat anyone else. Feels that has to be sterner with some patients—but no different from a diabetic patient whose blood sugar was high because of not following plan—but this compatible with respect and understanding the disease process and what they're going through. Feels like this is part of being a competent provider. Important also that deeply cares about this mental health population.

0.51.48 “I feel like this whole thing got a little preachy on my end already … Just that I think it’s important that more states do get full practice authority for nurse practitioners. It is a big deal, and it is important. And I’m sure that the ones that do, if they looked into patient outcomes and the research on that, I’m sure they would see that it’s not that all of a sudden patients are having these bad things happen to them because the nurse practitioners are without supervision. So, I think we have a role to fulfil, and I think we could be valued a little bit more. And give us some independence.”