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ABSTRACT

The aim of this clinical training site innovation is to develop accessible pediatric mental health clinical training sites for psychiatric mental health nurse practitioner (PMHNP) students. Mental health services in school settings provide treatment in the child's community and create opportunities for innovation and collaboration with teachers, school counselors, and school psychologists. School settings provide opportunities for early recognition of anxiety symptoms and accessible treatment that can help close the gap in clinical training sites for this population. Mild and moderate symptoms of anxiety often go untreated and may affect academic performance negatively. Cognitive behavioral play therapy is an effective treatment modality provided by PMHNP students and supports the roles of school personnel.

Elementary school-based cognitive behavioral play therapy groups: A psychiatric mental health nurse practitioner intervention

Mental health services in an elementary school setting provide treatment in the child's community and create opportunities for innovation and collaboration with teachers, school counselors, and school psychologists. Psychosocial interventions for anxiety contribute to improved overall academic performance (Nail et al., 2015). Cognitive Behavioral Play Therapy (CBPT) is a front-line intervention that may reduce the negative effect of anxiety over time (Lee, Victor, James, Roach, & Bernstein, 2016).

Approximately, 20% of the child and adolescent population in the United States will be affected by mental health disorders during their lifetime, with symptoms of anxiety disorders often emerging by age six (HealthyPeople.gov, 2014), yet many children with emotional disorders are not identified and receive no treatment (Stallard, 2013). A connection exists between a child's mental health and his/her capacity for academic achievement; specifically, stress, worry and anxiety interfere with a child's ability to learn (Souers & Hall, 2016). Reduced concentration, distractibility, and overall underachievement are outcomes of excessive anxiety (Nail et al., 2015). Poor academic achievement can be predicted in children who manifest anxiety in the school setting (Sawyer & Nunez, 2014).

Anxiety prevention programs are effective by fostering resilience and providing a buffer effect against additional stressors (Sawyer & Nunez, 2014). CBPT is the recommended first-line treatment for children with mild to moderate anxiety and is the most frequently used modality in programs addressing symptoms of anxiety (Lee, Victor, James, Roach, & Bernstein, 2016).

Although much is known about the effects of anxiety on their academic achievement, children continue to be underserved with inadequate access to mental health services. There is a dire shortage of mental health professionals who provide accessible care to pediatric populations (Mental Health American, 2017). Psychiatric mental health nurse practitioners (PMHNPs) with adequate training in pediatric mental health interventions may have a valuable role in increasing mental health services for youth in need of quality and accessible care.

Psychiatric mental health nurse practitioner role–lifespan focus

Psychiatric mental health nurse practitioner (PMHNP) programs have undergone major changes in recent years. The APRN consensus model with its mandate for a lifespan focus introduced a significant change in psychiatric mental health nurse practitioner education (APRN Consensus Work Group, 2008). Despite the challenges of the transition to a lifespan focus, the goal of PMHNP programs is to prepare more practitioners to treat children and adolescents, particularly in rural areas (AACAP, 2014). With the lifespan focus, all PMHNP students are required to have clinical experiences with the child and adolescent population to earn the Master of Science in Nursing degree or the post-Master's certificate. However, development of clinical sites providing child psychotherapy experiences is particularly challenging, and is a problem nationally because of the lack of child psychiatry services across the United States (Weber, Delaney, & Snow, 2016).

The scope of practice for a PMHNP includes assessment of psychiatric symptoms, diagnosis of mental health/illness,

provision of psychoeducation/therapy for individuals, groups and families, and medication management across the lifespan (NPPMHNPC, 2003). Specific competencies of the PMHNP role include assumption of complex and advanced leadership roles to initiate and guide change and use of best available evidence to continuously improve quality of clinical practice (Weber et al., 2016). While learning this comprehensive set of PMHNP skills, students – with preceptor supervision – expand the capacity to address the gap in access to mental health services.

School systems as clinical sites

School-based prevention and intervention initiatives are increasingly common methods for offering mental health services for children and adolescents (Grossman et al., 2007). School settings are practical and convenient because they offer regular contact with the majority of children and adolescents (Stallard, 2013). Prevention and early recognition of symptoms are more easily accomplished when patients and treatment sites are accessible, which is the case in schools. Furthermore, this approach is feasible because school system leaders strive to increase mental health services in schools. School-based mental health services have no associated direct costs to families, and minimize common barriers to access of these services (e.g., transportation). Mental health services, then, can occur in children's natural environment, markedly reducing disruption to learning and minimizing stigma (Cappella, Frazier, Atkins, Schoenwald, & Glisson, 2008).

Interprofessional education

Interprofessional practice is a competency required of PMHNP students; school settings provide clinical experiences with opportunities for students to meet this competency, in addition to other core competencies (e.g., collaboration, conflict resolution, consultation, team building) (NONPF, 2017). Collaboration with school staff is essential in planning services to meet clinical requirements for PMHNP students in the setting, as well as targeting the mental health needs of children and adolescents in a specific school. Furthermore, through collaboration, school staff is educated about the role of the PMHNP; currently school counselors, school psychologists, and school social workers provide the vast majority of school-based mental health services (NASP, 2016).

Comprehensive mental health services are most effective when provided through a multi-tiered system of supports (MTSS) by school-employed mental health professionals. The MTSS is an overarching term for an initiative in which a variety of school-wide approaches are employed to improve student learning and behavior (Sink & Ockerman, 2016). MTSS encompasses the continuum of need, enabling schools to promote mental wellness for all students, identify and address problems before they escalate or become chronic, and provide increasingly intensive, data-driven services for individual students as needed. Access to adequate staffing of school-employed mental health professionals is essential to the quality and effectiveness of these services (NASP, 2016). This approach allows students to be placed in one of three tiers so their needs may be addressed effectively. Tier 1, the primary tier, refers to prevention efforts focused on the entire student body. Tier 2, the secondary tier, refers to typically small, group-based interventions for at-risk students. Tier 3, the tertiary tier, refers to significant support (e.g., weekly individual therapy provided within the school setting) for students who have not responded to earlier interventions (Harrington, Griffith, Gray, & Greenspan, 2016).

PMHNP students can provide a resource for comprehensive mental health services by augmenting the prescribed roles for school personnel involved with assessment and treatment of children's and adolescents' mental health issues. Ideally, school psychologists and licensed clinical social workers in the school setting serve as preceptors for the psychotherapy-related competencies for the child and adolescent population. Use of interdisciplinary preceptors for PMHNP students in child and adolescent psychotherapy experiences is a creative strategy used by some graduate programs (Weber et al., 2016).

The specialized focus of the school setting provides PMHNP students with exposure to other professionals and the mental health issues facing children and adolescents. These clinical experiences facilitate networking with professionals who are key in evaluation and treatment of the children and adolescents. Additionally, clinical experiences in schools allow PMHNP students an opportunity to learn about the school system and the influence of school on children's or adolescents' mental health. This knowledge is valuable for PMHNP students in treatment planning and consideration of transitions of care.

Innovation: Elementary school-based cognitive behavioral play therapy group

Given the challenges related to accessible mental health care for school-age children and the need for more pediatric mental health clinical training sites for PMHNPs, our team sought to engage in a partnership with the local school system to develop an elementary school-based clinical site for the Family/Group Psychotherapy Course in the local PMHNP program. PMHNP students in this initiative provided a cognitive behavioral play therapy (CBPT) group for children in grades two through four who were having difficulty with stress, worry, and anxiety. PMHNP students conducted the CBPT group using a curriculum developed from CBPT principles and activities based on evidence for best practice (Drewes, 2009).

Through this school-based group therapy intervention co-led by PMHNP students, we initially intended to implement a program developing a local school as a clinical site. We planned for subsequent phases in which we gradually added elementary and middle schools as additional clinical sites, locally and across the state. The number of school-based sites would be contingent on available preceptors at the school and geography of PMHNP students in the program.

Phase 1 (Year 1)

Setting

We implemented the pilot program at a local Spanish immersion elementary school (grades K-5) with approximately 500 students. We identified this school as a strong candidate for the

initial program because it has a tradition of community engagement with the nearby university where the School of Nursing was located and their receptivity to participating in the Pilot Program.

Group member recruitment

The school's assistant principal, school counselor, and school social worker served as the MTSS team and determined which students would participate in the groups. The *Student Risk Screening Scale (SRSS) & Student Internalizing Behavior Screening Scale (SIBSS)* is administered to each student annually (MIBLSI, ND), and students' scores determined their placement in one of the three tiers. Students assigned to Tier 2 (small group-based intervention) were placed in the CBPT group.

Process

We held an initial meeting at the school with the MTSS team, led by the principal, to discuss elementary student mental health needs and possible interventions PMHNP students might provide. We agreed that a group intervention to address symptoms of anxiety was a good fit for the school and also met competency and clinical requirements for the PMHNP students. Additionally, we met with division-level personnel who had oversight for all nurse-led initiatives in the entire school system. Elementary school personnel and faculty from the PMHNP program mutually determined logistics for the group (i.e., time-frame for the group sessions; meeting space; school personnel contact; group schedule) and agreed on the nature of the group (based on identified student needs), and treatment modality to be used. The MTSS team identified students in Tier 2 who could benefit from additional socio-emotional support in acquiring stress management skills. A faculty member and school counselor developed a brief paragraph describing the purpose of the group in non-clinical terms, sending it via email from the school counselor to parents whose children had been referred to the group. Parents provided their permission for the child to participate. In an effort to provide treatment for as many students as possible, the PMHNP students held two 30-minute group sessions consecutively. The MTSS team determined the length of the group session.

Boys and girls were placed in groups according to grade level, with a third-grade group of six and a fourth/fifth grade group of eight. A co-leader model was used by the two PMHNP students to guide the groups, which shared a curriculum with a few adaptions for the older children. Using CBPT as the theoretical foundation for the curriculum, we adapted techniques for a six-session intervention and developed a template for the group structure (Appendix I). This template ensured consistency and assisted PMHNP students' learning. The elementary students completed a brief evaluation of the group on the last day.

A change in preceptor occurred in the subsequent semester, with a faculty member (author) who is credentialed as a child and adolescent psychiatric clinical nurse specialist serving as the preceptor. This faculty member was highly instrumental in the curriculum development and also served as clinical supervisor for the PMHNP students who were the co-leaders; therefore,

it was not a challenge to assume the preceptor role. Of note, neither of the preceptors were employees of the school system. A benefit of PMHNP course faculty serving as preceptor for the initial program was the opportunity to shape further the experience as a strong clinical placement for this specialized setting. The second time the groups were offered, there were fewer children who met Tier 2 eligibility, with four students in each of the two groups.

At the conclusion of the second round of group session, we (preceptor, PMHNP students) met with the MTSS team to discuss the program and discuss feasibility for moving forward. Everyone involved in the process strongly supported continuing the CBPT group-based intervention with the PMHNP students, with specific recommendations to develop the pilot program further, described below.

Phase 2 (Year Two) – continued development

The general framework established during the first year worked well and will continue, including the co-leader model, CBPT model, 30-minute sessions, and preceptor's presence in the group. Recommendations for phase two include additional group meetings because the elementary student group participants overwhelmingly requested more sessions. The total number of groups for the subsequent semester was increased from 6 to 14. The MTSS team requested increased engagement of PMHNP students in the school setting. Specifically, the team requested that the PMHNP students would observe group members in classroom, attend the monthly MTSS student review and that outcomes be measured. These recommendations serve to broaden the clinical experience of the students as well as meet the mission of the school more effectively. The commitment of the elementary school facilitated planning in the PMHNP program. The broadening of the experience during the second semester of the program solidified the partnership with the school and mutually benefited the elementary school/PMHNP program collaboration, and enhanced the potential for the school to continue serving as a clinical training site during the following school year. For example, at the end of the first year, we determined that the number of PMHNP students who could receive clinical experience at the elementary school-based site would increase from two to four students, thereby meeting a challenge of the program requirement for a lifespan focus.

Challenges/barriers – sustainability

Perhaps the single most challenging factor for determining of a clinical site is the availability of a preceptor who meets the criteria established by AACN (AACN, 2006). These criteria, in addition to the shortage of mental health providers for children and adolescents, increase the difficulty of securing preceptors. Specifically, in the school setting, preceptors who may seem qualified through education and experience may not possess the exact licensure credentials currently required in PMHNP programs.

The demands on school employees to provide a safe, stimulating, compassionate learning community may leave little time for participation in additional initiatives. Time requirements for

planning and discussion may be difficult. The space required for the group sessions, as well as clinical discussions between students, preceptor, and MTSS team members, is often at a premium

Finally, school personnel are often unfamiliar with the expanded role of the PMHNP student, and seem to consider medication management as the primary function. Continued education of school leaders about the scope of PMHNP practice, as well as their observation of the contributions PMHNP students make will strengthen recognition of the value of this collaboration.

Recommendations

As a result of the lifespan focus and frequent shortage of clinical sites, meeting the required competencies for PMHNP students means that critical thinking, creative solutions, and persistent advocacy are required to continue to develop clinical settings, such as in schools, effectively. A focus on collaboration such as the one we have described here encourages the development of additional sites, as well as gives PMHNP students exposure to multi-disciplinary preceptors with expertise in the care of children and adolescents. This promotes the interprofessional education that prepares PMHNP students for interprofessional practice, a collaboration that provides a bridge for academic institutions and the community.

An established network between the school setting and the PMHNP program increases the potential for opportunities for collaboration beyond the actual clinical intervention. Evidence-based clinical practice in the school setting provides a new opportunity for scholarly work at the graduate level. Program evaluation, needs assessments, and quality improvement initiatives can promote services provided for children and adolescents who may benefit from high quality, accessible mental health treatment.

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Appendix I

Template School-Based Group

Date:

Group Name/Focus: (Children my like to name group)

Group Session Number _____:

Overall Group Goals (example):

1. Identify and recognize feelings associated with stress/worry/fear
2. Describe differences in healthy and unhealthy stress
3. Learn and practice coping skills
4. Identify situations at home and school to use coping skills

Session Goals

1.
2.
3.

Supplies Needed:

Review of Group Rules (White Board):

  1.

  2.

  3.

  4.

Introduction to Group (Content focus for this session)

-
-

-
-

Activities/Procedure (Handouts; materials):

Conclusion (3-minute warning):

Back-up Plan (too few participants, supplies missing, etc.)