The Advanced Psychiatric Nurse Practitioner in the School Setting:

Role Identification, Development, and Implementation

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Abstract

In recent years, both public and private school systems have been challenged to deal with and manage a growing population of students with mental health needs. Many administrators, teachers, and staff lack sufficient training and understanding of behavioral and emotional symptoms exhibited by students in the classroom. The management of mental health needs and disruptive behaviors are among the struggles and stressors that school systems face daily. Mental health needs and disruptive behaviors can compromise the classroom environment, deter from student achievement in educational objectives, and create an environment of chaos and conflict. Advanced psychiatric nurses (PMH APRN) offer unique expertise and skills in the evaluation and management of mental health issues for students at-risk. The advanced psychiatric nurse may also provide support and consultation to administrators, teachers, and staff in the development and implementation of programs to reduce disruptive behaviors, improve classroom management, and facilitate treatment and intervention for at-risk students when indicated. This synthesis paper will discuss the role of the psychiatric mental health nurse practitioner in the school setting and articulate this role within the context of Institute of Medicine’s report for the advancement of nursing practice for the 21st century.

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Public and private school systems at all levels have experienced a significant increase in mental health needs among student populations over the last several years. Administrators, teachers, and staff in the school setting are often ill prepared to manage the emotional and behavioral disturbances presented by at-risk students (Galassi & Akos, 2004). When students engage in disruptive behaviors and present with severe emotional disturbances in the classroom, teachers may often feel overwhelmed, inadequate, and less confident in their abilities to manage the environment and are unable to provide for the education of their students. These behaviors may include any behavior that results in disruption of the educational process and interfere with the general objectives and academic achievement for everyone involved. The mental health needs of students and management of behaviors often becomes the primary focus of the classroom rather than teaching and learning. The result is emotionally frustrating for the school system, parents, and students alike (Clunies-Ross, Little & Kienhuis, 2008).

Disruptive Behaviors and Mental Health Needs

Disruptive behaviors in the school setting may include students’ exhibiting defiant behaviors, refraining from adherence to classroom and school rules and regulations, and demonstrating acts of verbal and physical aggression toward peers and teachers (Baloglu, 2009). Students may also express self-destructive behaviors such as suicidal ideations or engage in self-harm such as mutilation of themselves. These at-risk students are more prone to substance abuse, depression, and anxiety, and are often subjected to peer pressures and bullying. These
stressors not only negatively impact student performance, but also result in negativity from teachers and school personnel as well. Teachers may often lose control of the classroom and respond with reactive, emotional responses rather than proactive measures (Baloglu, 2009).

Not all students who participate in disruptive behaviors or conduct issues have an underlying mental disorder. Secondary gains and environmental factors may contribute to student behavior problems as well (Bjorkland & Rehling, 2010). However, the management of student behaviors and differentiating mental health concerns are tasks many school officials acknowledge that they have little or insufficient training in. Minimum preparation and the inability to problem solve and structure the classroom environment lead to increased stress and dissatisfaction throughout the educational institution, among staff, parents, and students. Additionally, when emotional and mental health needs of students are left unattended or are inadequately addressed, the community at large suffers (Small & Tetrick, 2001).

The Role of the PMH APRN in the School Setting

Kratochwill, Sheridan, Rotto & Salmon (1991) identified that a behavioral consultant is an individual who specializes in the identification and analysis of a problem and has the ability to implement an evidence-based intervention. In educational setting, this role may be characterized by the use of a collaborative, methodical activity intended for the resolution of disruptive behaviors. The behavioral consultant may deliver a service directly or indirectly to both the student and teacher. Additionally, the consultant is equipped to evaluate the effectiveness of interventions and to recommend modifications to enhance effectiveness over time (Elliot, Busse, Zins & Kratchowill, 1993).
The American Academy of Child and Adolescent Psychiatry (AACAP) has recognized the importance of school-based mental health intervention which consist of “clear classroom rules and procedures, managing transitions without undue interruption, improving time on task, communicating competently and improving achievement and behavior with contingent awards” (Walter & Berkowitz, 2005, p. 1079). Classroom management programs developed by a behavioral consultant such as a mental health clinician may add a significant component to the structure of the school setting (Walter & Berkowitz, 2005).

Advanced psychiatric nurse practitioners are particularly suited to meet this growing need and assuming the role of behavioral consultant within the school setting. The diagnostic, interventional, and management skills possessed by the PMH APRN have the potential to provide improvement within the school system by facilitating and motivating both teachers and students to pursue positive change. As transformational leaders, the PMH APRN can improve outcomes and bring a much-needed resource to the educational environment (Higgins, 2003). The ANA’s (2007) Psychiatric Mental Health Nursing: Scope and Standards of Practice recognizes the PMH APRN as having particular skills in needs assessment within various at-risk populations. As a behavioral consultant, the PMH APRN can develop interventions and programs to meet needs that extend into the community. The advanced psychiatric nurse can impact the school setting by “providing psycho-education to individuals, families, and groups to promote knowledge, understanding, and effective management of mental health problems” (American Nurses Association [ANA], 2007, p. 50).

By serving in a consultative role, the PMH APRN may provide services within the school setting that are consultee centered and administratively centered. The ANA (2007) defines the consultee centered role as “psychosocial or educational-skill development issues related to
patient care” and the administratively centered role as “attainment of expertise in either management of staff or program development” (p. 50). The PMH APRN is well positioned to meet recommendations set forth by the AACAP for behavioral interventions for students to achieve specific behavioral goals, which may include appropriate communication and emotional expression, self-control, and appreciation for consequences (Walter & Berkowitz, 2005). The advanced nurse practitioner can implement techniques to effectively neutralize disruptive behaviors and promote self-awareness without compromising the safety of the environment, teaching and learning.

**Dialectical Behavior Therapy (DBT): A Framework for Intervention**

In the 1990’s, Marsha M Linehan, PhD at the University of Washington developed a multimodal cognitive behavioral treatment (CBT) model applicable to working with personality disorders. Her model, known as Dialectical Behavior Therapy (DBT), borrowed from the traditions of CBT and Young’s conceptual applications of guided imagery, rescripting, and cognitive restructuring to work with what many might consider a more challenging and difficult subgroup of character pathology often referred to as “Cluster B” personality disorders (i.e. anti-social personality, borderline personality, histrionic personality, and narcissistic personality). DBT has also been applied more specifically with patients who demonstrate Cluster B personality traits and co-occurring/existing substance abuse disorders and eating disorders (Clevenger, 2014).

Linehan observed that traditional cognitive-behavioral approaches were not as successful in working with more difficult-to-treat patients who were also prone to self-harm, suicidal ideation, and often engaged in destructive behaviors. Linehan believed that these difficult
patients engaged in such behaviors because they lacked appropriate coping skills and were influenced by positive and negative reinforcements that interfered with their ability to function appropriately (Dimeff & Linehan, 2001).

DBT recognizes that patients who engage in self-harm or struggle with persistent suicidal ideations often lack important interpersonal, self-regulation (particularly emotion regulation) and distress tolerance skills. These individuals also tend to have multiple personal and environment factors that block and/or inhibit the use of behavioral skills that contribute to and reinforce dysfunctional behaviors and relationships. Linehan applied the term dialectical to emphasis a synthesis of opposites. DBT allows this synthesis to occur by helping individuals to recognize that there are different ways of viewing their world and to replace rigid, dichotomous thinking that drives destructive behaviors. Therapists using the DBT model recognize that the patient is doing the best that he or she can and works to bring validation and acceptance of the patient “as he/she is” while simultaneously supporting them to change (Dimeff & Linehan, 2001).

Basic principles of the DBT theory are very applicable to the school environment with at-risk students. These students are often concrete thinkers with a tendency to view their circumstances as black or white, fair or unfair…good or bad. Because they enter into these judgmental positions and states of mind, they lack the ability to communicate their needs and emotions effectively. They often struggle with an ability to gain the perspective of others and create conflict for themselves internally and externally because of these distortions. Students prone to disruptive and self-destructive behaviors are reactive and lack the ability to “pull back” from stressful events and emotional situations to develop alternative coping techniques or to establish contingencies. As a result, they tend to take rigid and uncompromising positions in
both their attitudes and behaviors leading to crisis in the classroom, at home, and in the community.

In the school setting, the PMH APRN can extrapolate the DBT theory, technique and application to provide a structured program for the recognition of and intervention with at-risk students, who may appropriately be characterized as “difficult-to-manage.” Comprehensive intervention in the DBT model is based on the following five functions:

- Enhancing behavioral capabilities
- Improving motivation to change by modifying inhibitions and reinforcing contingencies
- Assuring that new skill development can be generalized to the natural environment
- Structuring intervention in ways that support both teacher and student abilities
- Enhancing teacher knowledge, motivation, and ability to intervene with and manage more difficult students effectively (What is DBT?, 2016).

The objectives of the DBT model can be generally perceived as occurring in stages and represent a system’s approach to change:

- Stage 1: To stabilize the student and to achieve behavioral control and symptoms management
- Stage 2: To replace quiet desperation and emotional lability with non-traumatic emotional experiences and regulation of emotional response
- Stage 3: To achieve a sense of normalcy and reduce ongoing conflict in interpersonal relationships and problems within the educational environment
• Stage 4: To promote a sense of well-being and joy and to resolve the overwhelming sense of incompleteness in emotional needs and desires surrounding student, peer, and teacher relationships and behaviors within the environment (What is DBT?, 2016).

The PMH APRN is tasked with teaching and promoting skills for both the students and school personnel to avoid chronic crisis and ongoing conflict. This is accomplished by assisting the students and school personnel to develop two fundamental skills: Acceptance and Change (Holmes, George & Liles, 2005). Acceptance in the DBT model includes *mindfulness* (e.g. attention to the present moment, assuming a non-judgment stance, and focusing on effectiveness). It is important to validate the student experiences as “real” without attempting to label behaviors, thoughts, or emotions as distorted or irrational (as in traditional CBT techniques), but to acknowledge the student perspective for what it is (Holmes, et. al, 2005). Change in the DBT model occurs through the behavioral analysis of maladaptive behaviors and application of problem-solving techniques. The PMH APRN may include skills training for both teachers and students, contingency management (i.e. evaluation of reinforcers and punishments), cognitive modification, and distress tolerance strategies (Holmes et. al, 2005).

Acceptance may be conceptualized as the “WHAT” skills:

• Drawn from principles of eastern Zen and western contemplative practices --- **MINDFULNESS**
• Emphasizes the capacity to pay attention, non-judgmentally, to the present moment
• Teaches the student and teacher to pause in the moment to more fully experience emotions and senses without reaction --- **GAIN PERSPECTIVE**
• Develops the ability to let feelings and experiences pass without allowing those emotions to dominate the moment in reaction, thoughts, or behaviors (Dietz, 2003).

Change is conceptualized as the “HOW” Skills:

• Based on principles of learning and crisis theory

• Focuses on recognizing and describing facts, not thinking about what is “good or bad”, “fair or unfair”….these are judgments, not factual understandings

• Takes circumstances in small pieces and understands the situation. Does not allow the mind to stray into emotion or reaction before a clear perception is formed.

• Emphasizes to simply do what works to effectively address the present moment. Do not respond or react based on emotions, thoughts or perceptions about the past or future events. Recognizes immediate consequences and deals only with that reality (Dietz, 2003).

As the behavioral consultant, the PMH APRN assists the teacher and student to recognize that the relationship does not have to be based upon an adversarial nature. The teacher does not have to play “bad cop…good cop” in order to motivate the student to change nor do the students have to resort to disruptive or self-destructive behaviors to have needs met and to express themselves. In applying the DBT model, the PMH APRN can model these techniques and encourage both teachers and students to recognize that the process requires flexibility and compromise for everyone. Both teachers and students are engaged as active participants.
Implementation Challenges, Support, and Future Directions

The Institute of Medicine (IOM) in partnership with the Robert Wood Johnson Foundation (RWJF) published *The Future of Nursing, Leading Change, Advancing Health* and this ground-breaking report recognized the significant contribution of advanced practice nurses to the future of health care delivery systems across the country. The report emphasized the quality of care and value of advanced practice nurses as transformational leaders, particularly in the development of community primary care models (Institute of Medicine, 2010). The IOM report recommended that nurses should practice to the full extent of their education and training and should be recognized as full partners with physicians and other healthcare professional in redesigning health care in the United States (Institute of Medicine, 2010, pp. 1-3). Advanced practice nurses have the ability to achieve tremendous results and produce positive outcomes through grassroots efforts and community based care-like public and private school systems.

In spite of strong evidence, research and recognition from various organizations such as the Institute of Medicine, advanced practice nurses continue to struggle with a clearly delineated scope of practice nationally. States still independently determine the requirements and regulate the recognition of advances practice nurses within the healthcare community. Opposition still exists in many circles, particularly among certain physician groups, to allow advanced practice nurses autonomy in their practice. The Consensus Model for Advanced Practice Nursing developed by the APRN Joint Dialogue Group Report (2008) urged the adoption of consistent standards nationally to allow boards of nursing the full authority to regulate advanced nursing practice within each state. The model emphasized that in order for nursing to continue to advance, there must be clear role definition, requirements, and congruent standards and scopes of practice nationally.
Advanced practice nurses have long been willing to serve populations and in areas deemed less desirable or underprivileged. Historically, APRN’s have been willing to take less in terms of financial reimbursement, perform tasks that physicians have abandoned or delegated as lesser than medicine, and carved a niche by providing care to those that would otherwise be left out. Advanced practice nurses can continue to excel by demonstrating their worth and value in creating models of care and community service such as the one proposed in this paper. Active participation, program development, and producing outcomes can help APRN’s to receive the recognition and rewards for their contributions. As health care costs continue to rise and resources continue to decrease, meeting the needs of individuals and communities “where they are” will be paramount to health care delivery in this country. Advanced nurse practitioners are poised to be the front line of a 21st century delivery model engaged in preventative care, chronic disease management, and intervention. Mental health needs are certainly among the many concerns that will shape the future of wellness going forward.

In evaluating the challenges and supports of the local implementation of a school based mental health program and consultation service, it is important to realize the impact of financial constraints to the process. The implementation of the DBT model, as outlined, emphasizes the utilization of existing resources and training school system staff to better manage at-risk student populations. The proposal serves to reach a greater number of students without adding additional costs. To that end, the proposal may be better received and gain the support of administration and community leadership necessary to fully develop the model.

Teachers, parents, and school officials alike must buy-in to the concept that public and private school systems are tasked with not only delivering the basics of education (reading, writing and arithmetic), but for many of today’s youth the only safe, structured and secure
environment that these children will know. Without serving the emotional and psychological needs of these students, education will fail. Creating an environment that recognizes and allows teachers to do what they are trained to do—teach—without the constrains of also requiring them to be counselors and mental health professionals is essential to reducing teacher burn-out and to retaining good teachers within the system. By providing a behavioral consultation program, the PMH APRN within the school system can alleviate the stressors and conflict faced by teachers and students to promote an environment that engages everyone in social-emotional learning.

The PMH APRN is perhaps the best qualified and suited to meet these growing needs. The training in psychopharmacology, diagnostic evaluation, and understanding of treatment planning and coordination are unique to the advanced practice nurse and skills that other mental health professionals may not necessarily have. By emphasizing a multi-disciplinary approach and through collaboration, the PMH APRN as a behavioral health consultant can guide access to community resources, education constituencies regarding the mental health needs of the student populations, and promote greater community wellness. The emotional and physical health of our children today will dictate the emotional and physical wellbeing of our communities tomorrow.
RESOURCES


