An Introductory Clinical Core Course in Psychiatric Management: An Innovative Lifespan Course Blending All Nurse Practitioner Majors

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TOPIC. *The prevalence of anxiety, depression, substance abuse, and suicidal ideation is significant in primary care settings across the country. Nonpsychiatric nurse practitioners must be able to recognize symptoms of common psychiatric disorders, know how to treat less complex mental illnesses, and know when to refer to psychiatric mental health nurse practitioners (PMHNPs).*
PURPOSE. *This article describes the course content, assignments, and teaching strategies used in a clinical core course in the nurse practitioner (NP) curriculum that is required for all NP majors at the University of Texas at Arlington. Psychiatric Management for Advanced Practice provides the foundation for later PMHNP major specific clinical courses.*
SOURCES. *Development of the course content was based on NONPF Domains and Competencies for the NP, input from graduate NP faculty using a modified Delphi approach, NP student feedback, review of curriculum from other schools, and review of the literature on depression, suicide, anxiety, and substance abuse disorders in primary care settings.*
CONCLUSIONS. *Since 1999, students from the eight different NP programs at the University of Texas at Arlington have been required to take this course. Student, faculty, and graduate feedback about this course have been consistently positive. Many NP students comment on feeling much more comfortable assessing for depression, suicide, and substance use.*
Search terms: *Introductory clinical course, psychiatric management for the advanced practice nurse, core course*

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Introduction

The Psychiatric Mental Health Nurse Practitioner (PMHNP) program at the University of Texas at Arlington School of Nursing (UTA) includes an entry-level clinical course focusing on the identification, screening, treatment, and referral for common and less severe mental illnesses such as major depression, all of the anxiety disorders, and chemical dependencies. This first clinical psychiatric management course is called Psychiatric Management for Advanced Practice. Further course work for the PMHNP student includes a course focusing on individual, group, and family therapies. An additional course, which builds on this entry-level core course, focuses on advanced medication management for more chronic and complex psychiatric disorders such as schizophrenia, schizoaffective disorder, treatment-resistant depression, bipolar disorder, treatment-resistant anxiety disorders, autistic spectrum disorders, complex developmental and childhood disorders, personality disorders, and the interactions of these psychiatric illnesses with complex medical comorbidities. In this paper, we will discuss the introductory clinical course for the PMHNP majors. What makes this course unique is that we have blended the content of this course to meet the needs of all nurse practitioner (NP) majors in addition to the PMHNP majors in this required core clinical course.

Why a Clinical Core Course in Psychiatric Management for All NP Majors?

The prevalence of anxiety, depression, chemical dependency, and suicidal ideation is significant in primary care settings across the country. Mental illness

ranked second in burden of disease worldwide in the global burden of disease study of 1990, depression ranked second only to ischemic heart disease in terms of disability and years lost, while alcohol abuse ranked fourth and bipolar disorder ranked sixth (Murray & Lopez, 1996). In a sample of over 2,000 primary care patients who were screened for common mental illnesses, the prevalence of suicidal ideation was 6.1%, substance use disorders 13.8%, major depressive disorder over 18%, and panic disorder over 6% (Pilowsky et al., 2006). In a study screening patients who had chronic lung disease, over 65% were screened and later diagnosed with depression but only 31% received treatment (Kunik et al., 2005).

Mood disorders are also highly prevalent in chronic medical disorders such as coronary artery disease, diabetes, many types of cancer, and Alzheimer's disease. Depression worsens the morbidity and mortality in individuals with these comorbid conditions (Evans et al., 2005). It is clear that nonpsychiatric providers must be able to recognize symptoms of common psychiatric disorders, know how to treat, and when to refer to psychiatric providers if we are to reduce both morbidity and mortality.

The Surgeon General's 1999 report, *Mental Health: A Report of the Surgeon General* (Department of Health and Human Services [DHHS], 1999), recommended that we no longer look at a split between mental and physical health and that we should integrate mental health into the mainstream of health care. Strategies for improving the mental health of all Americans included overcoming stigma, improving public awareness of effective treatments, ensuring the supply of mental health providers, and facilitating entry into treatment. We have implemented these strategies in our PMHNP program at UTA in a number of creative ways. First and foremost, we are educating highly qualified PMHNPs who can function in a variety of settings, whether private or public, in the hope of facilitating better mental health treatment and better accessibility to care. Secondly, through our Psychiatric Management (PM) clinical core course, we are raising awareness and reducing the stigma of mental illness by reinforcing the need for screening, assessment, and treatment of suicidal ideation, depression, anxiety disorders, and substance use disorders, to primary care and acute care NP students. The goal for all NPs, regardless of their specialty, is to "spread the word" that mental healthcare treatments are effective and available. Our goal is that no NP will "miss" the suicidal older adult with diabetes who stops her medicine, nor will the NP discharge the young man who overdoses on diphenhydramine but instead will refer for immediate psychiatric treatment.

Blurred Boundaries or Defining Our Roles?

The current trend of primary care providers being the entry point for access to care and often being the first to recognize mental illnesses has opened the door to a much-needed dialogue on scope of practice issues for PMHNPs who recognize physical health concerns in their patients and for primary care NPs who recognize mental health problems in their patients. Two noted authors discussed the issue of these blurred practice boundaries in advanced nursing practice (McCabe & Burman, 2006). These authors used examples of the family nurse practitioner who identifies a patient with depression and the PMHNP who rules out or diagnoses hypothyroidism in a patient being followed for depression. The question is raised as to whom should treat the multiplicity of problems, especially when patients are poor and have limited access to care. The authors state that "In the real world, APNs are faced daily with issues that flirt with the line of their scope of practice and the reality is that there is limited consensus on where the line is and what to do when faced with the need to cross the line" (McCabe & Burman, p. 6). We have attempted to conceptualize some of these scope of practice issues in both lecture and in clinical experiences, focusing on when to treat and when to refer in "real life" practice settings for common and certainly less complex psychiatric disorders.

Course Content

In 1999, the NP faculty revised the curriculum to include three clinical core courses for NP students across all majors that would provide better consistency and continuity in content foundational for the specialty courses of each major. In addition to the Psychiatric Management (PM) course described in this article, the other core clinical courses included a Pediatric Management course and an Adult Management course. A modified Delphi approach was used to survey NP faculty across majors to rank didactic content for the three courses. Survey results for the PM course included the ranking of psychiatric disorders and mental health problems that faculty were seeing in large numbers in their own NP practices. Later, outcome objectives were written for this course matching them to specific entry level National Organization of Nurse Practitioner Faculty (NONPF) Competencies for Nurse Practitioners (NONPF, 2002).

When the two credit hour Psychiatric Management course began in 1999, course content included screening, assessment, and treatment of major depression, anxiety disorders, attention deficit/hyperactivity disorder (ADHD), and the identification of delirium, dementia, and depression in the elderly, substance use screening, violence prevention, and the use of complementary therapies. Based on overwhelming feedback from students and graduates as well as full support of the graduate faculty, the course was expanded to a three credit hour course in 2005, increasing the didactic portion from 15 to 30 hours.

A modified Delphi survey of the faculty was again used to determine expansion and addition of content for the 3-hour course. As a result of the survey and subsequent discussions, we added content on screening and assessment of postpartum depression, grief, end-of-life issues, legal and ethical issues about the right to refuse treatment and use of appropriate documentation, and specific mental status assessment techniques across the lifespan. Additional changes included an expansion of the topic of suicide, and screening and referral of childhood and adolescent depression, eating disorders, and bipolar disorder. The neurobiology for each disorder, including genetics and epidemiology, are now covered for each disorder.

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The major foci of this course are the destigmatization of mental illness, the need to screen for mental health issues in all medical settings, and when to refer to psychiatric providers. The interactions of physical and mental illnesses are discussed throughout the course, but a specific lecture on psychiatric disorders in chronic medical illness reinforces the need to screen for mental illness. Severe psychiatric disorders such as schizophrenia and schizoaffective disorders are briefly described, especially the risk of diabetes with antipsychotic medications, but the assessment and management of these more complex disorders are covered only in the PMHNP major courses.

Assessment

Prior to taking this course, the PMHNP and other NP students demonstrate the ability to complete a medical history, mental status exam, and physical examination in the Advanced Health Assessment course. Building on these skills, we teach students in Psychiatric Management to use valid and reliable screening tools and methods to identify individuals across the lifespan at risk for or experiencing depression, anxiety, chemical dependency, eating disorders, ADHD,

sexual/physical abuse/violence, suicide, and homicide. We review the unique assessment strategies to use with children and with elderly patients. As each topic is discussed in class through case studies, lecture, and discussion, we review the *DSM IV* criteria required to make a diagnosis and practice doing psychiatric assessments, determining the differential diagnosis and how to rule out physical causes of the problem behavior.

Suicide

The topic of suicide is a major focus in this course. Most students are highly anxious about discussing suicide and role-playing is used to elicit myths and stereotypical thinking. Two faculty members demonstrate a patient expressing suicidal ideation being interviewed by the NP. A third faculty member provides a commentary about the rationale for the interview techniques used and the focus on promoting safety. Students then discuss the verbal and nonverbal communication in the role play and ask questions such as "What would you do if she did have a gun?" Following this discussion students are divided into groups of three, with one student role playing the suicidal patient, another student role playing the NP doing the intervention, and the third student observing and giving feedback to the "NP." Each group acts out three different crisis scenarios from real-life primary care settings. We provide a nonthreatening atmosphere for the student to ask questions about suicide and to practice skills in suicide prevention and intervention and develop confidence in asking appropriate questions and providing interventions for safety (Jeffries, 2005). Again, the focus is on screening, assessment, brief intervention, and referral to psychiatric providers.

Assessment and Treatment versus Screening and Referral

Screening and brief interventions for problem use of drugs and alcohol are essential skills for nurse practitioner students across all settings. All students in the Psychiatric Management course spend a clinical day learning what goes on in addiction treatment programs. They attend groups, do a substance abuse assessment, and experience the hope and challenges of addiction recovery. For example, pediatric and acute care pediatric NP students attend groups at an adolescent outpatient addictions program. It is a challenge to place all these students each semester, but the recovery community is very willing to accommodate students so that they can better assess and refer future patients in need of treatment.

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Students practice screening, assessment, and differentiating drug or alcohol abuse versus dependency. In the didactic portion of the course, we provide an overview of the signs and symptoms of withdrawal, standard protocols for safe detoxification, and the science of addiction, but the emphasis is on screening, brief interventions, and referral in primary care. An exception is the new treatment for opiate dependence with Suboxone that is being mainstreamed into primary care office settings where certified physicians can prescribe this medication. We discuss the value of the 12-step program for recovery as well as evidence-based psycho-educational and psychotherapeutic types of treatment. In-depth diagnostic criteria, detoxification protocols, comorbidity, and more advanced chemical dependency management are covered in the PMHNP major specific courses.

A significant amount of classroom time is spent discussing the screening, assessment, and treatment for

major depression and anxiety disorders. Screening postpartum mothers for depression and teaching diagnostic reasoning skills of differentiating depression from normal grief, normal "baby blues" in the postpartum period, and bipolar disorder is critical to safe care. This content was timely in its addition in that it coincided with the deaths of several children in Texas by mothers with postpartum depression. We discuss suicide risks with antidepressants at great length. For the nonpsych majors, this will be the only time they have this content, so it is an expected outcome that the NP student demonstrate the appropriate assessment and treatment of less complex depressive and anxiety disorders as well as recognize when to refer to psychiatric providers. Referral for cognitive behavioral therapy (CBT) for depressive and anxiety disorders is taught as a best practice based on recognized clinical guidelines for evidence-based practice. For the PMHNP student, this content lays the groundwork for their specialty practice, but antidepressant failures, when to augment or switch medications, treatment-resistant depression, and decision-making for patients with more complex comorbidity are discussed at length in future PMHNP clinical courses.

The screening, assessment, and treatment of common childhood psychiatric illnesses such as depression, anxiety disorders, and ADHD are taught in this beginning level course. We use case scenarios to facilitate collaborative learning, such as how to help parents weigh the risks and benefits of antidepressants with the increased risk of suicide. We discuss the complexity of diagnosing and differentiating childhood depression from bipolar disorder and ADHD with the emphasis on referral. More complex childhood and adolescent psychiatric disorders such as the pervasive developmental disorders, tic disorders, oppositional defiant, and conduct disorders are described. Students in the pediatric psychiatry clinical areas often see these patients, but the full assessment, diagnosis, and treatment of these complex disorders are not expected until later clinical coursework for the PMHNP students.

In this introductory course, additional content is presented to assist the NP student to differentiate delirium, depression, and dementia in an older adult. We ask the students to demonstrate critical-thinking skills in discussing risks and benefits of pharmacologic treatments in patients with dementia. More advanced competencies related to treatments in more complex older adult patients are not expected until later clinical courses for the PMHNP.

Teaching Strategies

Teaching strategies in this course include frequent use of role-playing and "actors" to simulate patients, a "live" psychiatric evaluation put on DVD to be used and studied at home to facilitate the development of interviewing skills, "live" simulations of suicidal patients needing crisis intervention, and faculty–student interactive exercises stressing assessment, diagnostic reasoning, differential diagnoses, and options for treatment of patients developed in a case scenario format (Gibbons et al., 2002; Jeffries, 2005). Case studies are used during each lecture to highlight the screening and assessment of each specific disorder and to assist the students in developing diagnostic skills and clinical reasoning skills, such as how to decide which antidepressant drug would be the best choice and why.

At the end of the course we evaluate the student's demonstration of a complete psychiatric evaluation. The student must assess appropriate subjective and objective data, and determine differential diagnoses and recommendations for pharmacologic and nonpharmacologic treatment using a simulated patient "actor" with a common psychiatric problem such as depression, panic disorder, or alcohol abuse. Scenarios are written for each student appropriate to their NP major. For example, the acute care NP students have a scenario of a hospitalized "patient" and emergency room NP students have a "patient" in the emergency room setting.

Students also complete a formal paper called "the SOAP note," describing a patient that was seen during

the clinical experience. Students summarize and analyze the subjective and objective data, develop the differential diagnosis and determine the plan of care, gaining experience writing an initial psychiatric evaluation of a new patient. Students write "clinical decision-making papers" (CDMs), writing up specified case studies as SOAP notes. They organize the material that is given, determine what questions must be asked for both the subjective and objective assessment, and determine the full Axis V diagnoses (APA, 2000). They then develop a plan and provide rationale based on their analysis and decision-making skills. An example of a CDM is a scenario about a young woman with significant weight loss and sad mood. We select scenarios such as this one to reinforce the student's ability to assess and manage depression.

Thirty-two clinical hours in a psychiatric area and 8 hours of addiction clinical experience provide "hands on" practice in developing beginning-level competencies. An additional 5 "clinical" hours are incorporated in classroom experiential activities focusing on suicide intervention and other interviewing skills. With the help of a Graduate Clinical Coordinator, we choose psychiatric providers at clinical sites specific to the student's NP major. For example, we use PMHNPs in public mental health clinics, private psychiatry practices and Veteran's Administration psychiatry clinics for adult, geriatric, and family NP majors; Psychiatric Consult Liaison Clinical Nurse Specialists, PMHNPs, or psychiatrists in general medical hospitals and psychiatric emergency rooms for acute care and emergency room nurse practitioner students; and PMHNPs at child psychiatric outpatient and partial hospitalization programs for the PNP and acute care PNP students. We select more complex clinical sites for the PMHNP majors such as public mental health Assertive Community Treatment (ACT) clinics or prison settings where many of the severely mentally ill are residing.

Students are expected to keep a journal of their clinical objectives, including a summary of their clinical experiences, describing how their objectives were met or not met. As hoped for, the most common observations have been the students' changed perceptions of mental illness and treatment by the end of the course. Other teaching strategies such as videotaping role-playing activities and then having students self-critique their interview styles are being considered for the future.

Nonpharmacologic Treatments

Motivational interviewing (MI) is introduced as an evidence-based therapy to assess readiness for change and to reduce resistance to change with such issues as medication compliance, smoking, and use of drugs and alcohol. Complementary therapies are introduced with an overview of the theories explaining their benefit, the most commonly used types of alternative therapies, and how to advise patients who are using or considering using complementary therapies. Students review the evidence supporting the use of a selected complementary therapy and present this in an informal presentation to other students.

Ethics

One of the outcome objectives for this course is for the student to demonstrate ethical decision-making in advanced nursing practice. Ethical theory is introduced earlier in the nursing theory course. We build on this content through small group discussions of ethical dilemmas such as patients' rights to refuse treatment, telling patients the diagnoses of dementia, schizophrenia, or cancer, and the reporting of possible parent/child abuse. We help the students explore and understand why and how he or she is making these ethical decisions. Further content on ethical decision-making is taught in the later practicum courses.

Summary

We have received positive feedback from faculty and students in all of the NP majors regarding the value of this course for practice. Many non-PMHNP students have described patients they have cared for in later clinical

courses noting that "I knew more than my preceptor" in terms of depression screening, addiction screening, and medication treatment of common psychiatric disorders in medical settings. Several faculty members have expressed a desire to take this course, stating that their original NP education did not prepare them to care for the large numbers of depressed and anxious patients that they see in their faculty practice. Feedback from the PMHNP students is always "I need more time," including more in-depth discussion of complex patients seen in the public mental health clinics. As this course has evolved, the later PMHNP major specific courses have expanded their depth and scope to meet the needs of the students and the population that they serve.

The faculty–student interactive approach to student learning about psychiatric disorders has facilitated the reduction of stigma of both mental illness and the mentally ill. Frequent feedback from NP students (other than PMHNP students) is that they entered the course not wanting to take it and finished the course very satisfied with their additional knowledge and skills. An interesting sidebar has been the frequent questions about how students' families and patients can access psychiatric care and stories of how these students have advocated for their current patients, now that they "understand what's going on," such as when a suicidal patient is ignored in a medical emergency room, or a depressed elder is given a dementia diagnosis without evaluation for depression.

The beginning level Psychiatric Management course provides a foundation for the management of individuals with common and less complex psychiatric problems and disorders across the lifespan for PMHNP and other NP students. The collaboration with other NP major faculty in designing the course, the recognition of this content as essential for all NP students, and the challenging yet essential inclusion of clinical experiences have made this course a positive learning opportunity for both students and faculty and an identified strength of our overall nurse practitioner program at the University of Texas at Arlington.

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