Twelve years ago, we wrote an editorial on what was then an emerging controversy over the terminology used to describe advanced practice nursing in child psychiatry (Scahill & Sipple, 1993). In that paper, we argued in favor of the term child psychiatric nurse practitioner and recommended dropping the term clinical nurse specialist. The argument turned on three points. First, like primary care nurse practitioners, advanced practitioners in child psychiatric nursing provide direct care and assume independent clinical responsibility for their patients. Second, mental health assessment and psychiatric diagnosis are counterparts to physical assessment and physical diagnosis in primary care. Third, the use of a single term to describe advanced practice nursing would reduce confusion about roles and expectations for the public and our colleagues in other disciplines. Over the ensuing decade, the field has moved toward the use of a single term with a decided, though not complete, preference for the term nurse practitioner. In the throes of this nearly resolved debate, the controversy about the Doctor of Nursing Practice has now emerged. In this paper, we contend that Doctor of Nursing Practice degree is not a forward direction, but a digression whose time has not yet come.

First, the argument that we advanced 12 years ago still stands. The use of multiple terms to describe independent practice in nursing is potentially confusing to the public and our colleagues in other fields. The introduction of a new term for a doctoral educational level may also threaten the hard-fought gains in third party payment by making it uncertain who is qualified to provide independent direct care.

Second, there are additional issues concerning the Doctor of Nursing Practice that are specific to the field of child mental health. Mental illness in children and adolescents is a major public health problem in the United States. One child in ten has a serious psychiatric condition. Of these, only 20% are receiving appropriate treatment (U.S. Public Health Service, 2001). Clearly, children with serious mental health disorders are an underserved population (Redlener, Grant, & Krol, 2005). The Surgeon General’s Report (U.S. Public Health Service) identified three major barriers to the delivery of quality mental health care in children: recognition, access, and dissemination. Recognition: children with serious mental health problems are not being identified in primary care settings, schools, and juvenile justice facilities. Access: successful identification of children with serious mental health disorders offers little assurance that they can secure competent mental health assessment. Indeed, our colleagues in primary care complain about long waiting lists following referral and poor collaboration following assessment (U.S. Public Health Service). Dissemination: perhaps most alarming, even if a child is identified with a serious psychiatric condition and successfully referred for consultation, there is little assurance that the child will receive appropriate treatment based on evidence. To overcome these formidable barriers in child mental health, we need to train an expanding cadre of practitioners who can provide appropriate, evidenced-based treatment to children with serious mental health conditions. We may also need to change the settings for mental health practice to reduce barriers of access. For example, placing child psychiatric nurse practitioners in primary care settings could improve recognition and facilitate access to care. Doctor of nurse practice programs are unlikely to produce graduates at the pace that can meet the pressing need in child mental health. To be sure, the standard 2-year master's programs will need continuous improvement to prepare graduates for contemporary practice. We
may even need post-master's internships to solidify and expand the clinical skills learned in the formal didactic program.

Third, we need more researchers in child mental health. Nurses educated at the doctoral level are in high demand because schools of nursing correctly perceive that research funding is critical for growing the educational capacity of the school (Dracup, Cronenwett, Meleis, & Benner, 2005). Involvement of students in faculty research projects is also the time-honored method of helping students understand the role of research in clinical care. Moreover, active research programs in schools of nursing are the best way to attract the next generation of research scientists. With its focus on clinical care, it is not clear that the doctor of nursing practice will promote the research environment. In child mental health, the research needs are manifold. To meet the pressing public health needs in child psychiatry, research will increasingly involve multidisciplinary teams including neuroscientists, geneticists, pharmacologists, statisticians, epidemiologists, and clinical scientists. Schools of nursing must maintain a level of rigor in doctoral programs to make certain that our graduates are ready to participate in these multidisciplinary research teams. Therefore, at least for the present and near future, we favor master's level training for practitioners and doctoral level training for researchers.

In closing, the Doctor of Nursing Practice degree is premature—especially for the field of child mental health. Among the most pressing needs in child mental health are improved access to mental health services and better dissemination of empirically supported treatments—both pharmacological and psychosocial. Through continuous improvement of our master's programs in child psychiatric nursing, we can contribute to the national shortage of child mental health clinicians and ensure that our graduates provide up-to-date clinical care informed by evidence. Schools of nursing can contribute to meeting the research needs in child mental health by steadily enhancing the rigor of our doctoral programs to ensure that graduates are ready to participate in an increasingly complex multidisciplinary milieu.

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