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Stop, Meditate, and Listen: A Treatment Modality for Iraqi Refugees with Depression

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UNIVERITY OF SAN DIEGO
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DOCTOR OF NURSING PRACTICE PORTFOLIO

by

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Abstract

Purposes: To implement a mindfulness meditation program with Arabic speaking clients as an adjunctive treatment of depression

Background: Depression rates among Iraqi refugees are between 28.3 and 75% compared to 8.6% in the general population (Slewa-Younan, Guajardo, Heriseanu, & Hasan, 2015). Treatment options are limited at Neighborhood Healthcare in El Cajon due to budget limitations, cultural beliefs and language barriers, among other reasons. Individual therapy is intended to be a brief intervention due to limited staffing. Many middle eastern refugees decline group therapy due to stigma surrounding mental health treatment and concerns about privacy. Even though traditional treatment options are effective in many cases, there is also a gap in care. Numerous patients continue to exhibit significant depression with the current interventions in place. Mindfulness interventions are shown to have a medium to large effect size for the treatment of depression. In addition, mindfulness interventions are easy to teach and can be practiced by the patient independently.

Methods: The nurse practitioner met with six clients for individual sessions in order to teach clients how to meditate. Inclusion criteria are a Patient Health Questionnaire 9 (PHQ-9) score greater than 10 and primary language of Arabic. The nurse practitioner instructed clients regarding guided meditation and mindfulness. The patients had access to meditation tracks and were calls by clinic staff to encourage practice at home during the initiation of treatment. Quality of Life Scores (QoL) were measured at the first and last session. PHQ-9 scores were measured at all sessions.

Outcomes Achieved: Three of six patients completed the program with partial adherence to treatment. Patients experiences a 9% to 58% increase in QoL. One patient experienced an improvement in PHQ-9. Patients reports positive outcomes subjectively and planned to continue meditating.

Conclusions: Meditation is a treatment option already widely used in western cultures. Although meditative practices are used in some religious practices, most Middle Eastern patient have little exposure to meditation. Recently, resources for meditation in Arabic were developed in Australia and have already shown to be effective in the treatment of depression for people from the Middle (East South Eastern Sydney Local Health District, 2017).

Stop, Meditate, and Listen: A Treatment Modality for Iraqi Refugees with Depression

Neighborhood Healthcare (NHC) is a system of Federally Qualified Healthcare Centers (FQHC) in southern California. NHC works under a model of integrated care and provides many services, including primary care, women's health care, mental health care, chiropractic care, and dental care. NHC services low-income families with Medi-Cal and Medicare insurance plans. NHC also offers services to people without insurance as part of their core value to provide healthcare regardless of someone's ability to pay. There are a large number of middle eastern patients at the NHC location in El Cajon.

According to the California Department of Social Services, San Diego County admitted the most refugees in California compared to other counties (California Department of Social Services, 2017). Between 2012 and 2016; about 75% of the thirteen thousand refugees who arrived in San Diego during this time period were from Iraq (California Department of Social Services, 2017). El Cajon has become one of two areas in the United Stated where Iraqi refugees are settling in large numbers; a Los Angeles Times article reports that 60,000 Chaldeans (Iraqi Christians) live in El Cajon and that many Syrian refugees are following suite.

Around sixty percent of the patient served at NHC El Cajon are Arabic speaking. Many of the patients are Iraqi refugees suffering with depression, anxiety, and post-traumatic stress disorder. In a recent meta-analysis, the prevalence rate of depression among Iraqi refugees was between 28.3% and 75% compared to 8.6% in the general population of the United States (Slewa-Younan, Guajardo, Heriseanu, & Hasan, 2015). There are many stressors for the Iraqi patients, including significant trauma history, acculturation, separation from family, lack of community, and other stressors common to

all people. There are multiple services currently available to patients with mental health disorders at NHC El Cajon.

First, the patient will see a primary care provider to treat their medical conditions and the provider will make appropriate referrals. Then, the patient is referred to mental health services within NHC when the person is identified as having a mental health disorder which requires more specialized care. Then, the patient will meet with a psychologist for individual therapy. Most clients are only able to have thirty-minute sessions every four to six weeks due to a limited number of psychologists and space within the facility. Many middle eastern clients are not willing to attend group therapy.

There is a stigma associated with getting mental health treatment within the middle eastern culture. Furthermore, many middle eastern patients do not believe the other patients in the group will keep information confidential. In fact, one patient shared in group and later learned another patient had disclosed her information within the community. There are other reasons clients do not want to attend group therapy. Many clients do not want to be around other people due to depression, anxiety, and hyperarousal. Furthermore, some of our patients have limited transportation. Lastly, there can be barriers to developing a therapeutic alliance, such as a lack of in-person interpretation services in some cases.

As part of individual therapy sessions, the psychologist will generally screen patients to determine if they also need medication management services from a psychiatric provider. The psychiatric provider will prescribe pharmaceuticals based on symptoms and choose medications based on current evidence. The clients generally come in for follow-up appointments once every two to three months depending on the provider’s

schedule and acuity of symptoms. There are also barriers specific to medication management of mental disorders.

Medication compliance can be difficult with middle eastern patients because often patients quit taking medication when they feel better, or the patient may only take it on the days they are noticing symptoms. Furthermore, not all pharmacies write labels in Arabic causing the patients to not take the medication as instructed. In addition, many middle eastern patients at NHC suffer from Helicobacter pylori infections and will not take their medications if they are feeling nauseous. In addition to medication, both the psychologist and psychiatric providers encourage lifestyle modification.

A few people will go for walks, but the majority of patients are not willing to exercise. It is also difficult to get patients to change their diet. Many patients sit and watch Arabic television most of the day, and this can trigger depression and trauma since news of the middle east shows between television programs. Many of the clients are not ready to incorporate lifestyle modifications, but this problem is not unique to one group of people. Some of the patients do improve, but there are many with treatment resistant depression.

NHC currently monitors Patient Health Questionnaire - 9 (PHQ-9) scores to track depression in the patients. In 2017, NHC had a total of 3,655 Arabic speaking patients. Of those patients, 11.8% had a PHQ-9 score greater than 10. The goal of the nurse practitioner project is to incorporate another therapeutic intervention to help the middle eastern patients with treatment resistant depression.

Background

The nurse practitioner considered interventions that would be patient centered and culturally sensitive to privacy needs when identifying other treatment options. The

chosen therapeutic modality needed to overcome some of the barriers of the current treatment options. Ideally, the interventions would involve minimal effort for the clients and one patients are able to do at home.

Currently, mindfulness is the new frontier of mental health treatment. “Mindfulness refers to paying attention deliberately in the present moment with a non-judgmental attitude” (Klainin-Yobas, Cho, & Creedy, 2012, p. 110). Meditation is one form of a mindfulness-based intervention. Meditation is “a broad set of psychosomatic practices that involve training and regulating attention towards interoceptive or exteroceptive foci, or intentionally created mental images, while observing or redirecting attention from distracting thoughts” (Jain, Walsh, Eisendrath, Christensen, & Rael Cahn, 2015, p. 2). Examples of interoceptive foci include one’s breathing or sensations of one’s body. Exteroceptive foci are usually some sort of object on which a person will focus. Meditation is a practice people are able to do alone in any setting. For those new to meditation, it is usually easier to begin by using some form of guided meditation.

PubMed and CINAHL were used when searching for evidence to support using mindfulness meditation. The search terms used were depression, meditation, and mindfulness. Several meta-analyses were available. Forty-three articles were reviewed and ultimately four were used as the key sources of evidence informing the decision to move forward with implementing a mindfulness meditation intervention. Upon review of the data, there was strong evidence to show that meditation was an effective treatment strategy for depression.

A large effect size was shown in a meta-analysis of studies using mindfulness

meditation protocols for the treatment of depression (Khoury, Lecomte, Fortin, Masse, Therien, Bouchard, et al., 2013). Additionally, another meta-analysis of randomized control trials demonstrated that meditation also had a significant effect on patient with an acute episode of Major Depressive Disorder and those in partial remission (Jain, Walsh, Eisendrath, Christensen, & Rael Cahn, 2015). A third meta-analysis showed a large effect size of mindfulness-based stress reduction centered around meditation (Klainin-Yobas, et al., 2012). Last, another meta-analysis of randomized control trials showed moderate to large effect size for the use of mindfulness-based interventions (MBI) for the treatment of depression (Strauss, Cavanagh, Oliver, & Pettman, 2014). Meta-analyses are considered the highest level of evidence (Melnyk & Fineout-Overholt, 2015).

Evidence Based Intervention

Mindfulness based interventions have become increasingly popular for the treatment of depression, anxiety, and other mental health disorders. The primary intervention of the project was to introduce patients to meditation at the clinic in a one on one setting. The clients then meditated at home as well.

There are currently many meditation applications available in English and other languages which people can download to their phone. Mindfulness meditation resources in Arabic are limited, and some of the meditation tracks available are not translated well into Arabic. The treatment team found one well-made resource after an extensive internet search. The South Easter Sydney Local Health District (SESLHD) developed guided meditations in Arabic and put the meditation tracks on their website so others might be able to use them freely. The aim of the evidenced-based project was to introduce clients to mindfulness meditation through the tracks produced by SESLHD. The goal of this

brief intervention was to decrease PHQ-9 scores by five points in each participating patient and to improve QoL.

All clients were offered four individual sessions in which the meditation tracks were introduced, and the client practiced meditation. Prior to starting the track, the clients completed a PHQ-9 to measure the level of depression over the past two weeks (Sawaya, Atoui, Hamadeh, Zeinoun, & Nahas, 2016). In addition to practicing meditation, the clinician evaluated state of other mental health disorders and adjust medications as it was appropriate. Between appointments, the staff then called clients to encourage them to use tracks at home.

There was complete buy-in after introducing the idea of mindfulness meditation in Arabic to the behavioral health team at NHC El Cajon. Other staff members also want to be involved with implementing the project. Although many were excited to start the project, there were some potential barriers.

Establish Benchmarks

Multiple publications identified similar gaps in evidence for mindful based therapies. First, studies need to have better designs with a more homogenous control group (Jain, et al., 2015). Also, study sizes need be larger with improved control over extraneous factors (Klainin-Yobas, et al., 2012). In addition to short-comings with study design, there are also gaps subject areas of mindfulness.

There is a need for more studies that show how mindfulness interventions fit in with other therapies (Khoury, et al., 2013; Jain, et al., 2015). The current research does not study ways of incorporating mindfulness-based interventions with medication

management and other psychotherapies. The available body of evidence also lacks studies that explore ways for sustaining meditation practices and long-term studies of meditation (Klainin-Yobas, et al., 2012). In addition, the nurse practitioner was able to find few publications regarding implementation of meditation or mindfulness-based programs in Arabic-speaking patients. There were no meta-analyses on the subject of Arabic meditation.

PICO Questions

P: In Arabic speaking clients with PHQ-9 scores greater than or equal to 10

I: Does mindfulness meditation

C: Compared to current practice (medication and psychotherapy alone)

O: Decrease PHQ-9 scores

T: Within 2 months

In Arabic speaking client at Neighborhood Healthcare El Cajon with a PHQ-9 score greater than or equal to ten does mindfulness medication compared to current practice decrease PHQ-9 scores over a 2-month period?

EBP Model

The Iowa Model was used as a guide to implement the project. The Iowa model is intended for a multidisciplinary team (Melnyk & Fineout-Overholt, 2015). The Iowa model is a well-established tool, and it has multiple feedback loops, which offer opportunities to reflect on the direction of the project (Melnyk, et al., 2015). The model is also very details, and it is organized in a linear fashion (Melnyk, et al., 2015). The Iowa model helped ensure the team did not miss important steps while developing and evaluating the evidence-based project.

The Iowa model first has users identify a "trigger" based on new/more current knowledge or a problem that has been recognized in the healthcare setting (Melnyk, et al., 2015). The user later develops a team of multidisciplinary professionals after determining that the trigger is a priority for the setting (Melnyk, et al., 2015). Then, the team synthesizes and critiques the evidence available (Melnyk, et al., 2015). If there is sufficient evidence the team will develop a pilot project (Melnyk, et al., 2015). If there is not enough evidence the team will have to conduct research (Melnyk, et al., 2015). After the pilot is complete, the team decides whether or not the organization should change practice and then disseminates the results (Melnyk, et al., 2015).

Process Plan and Evaluation

Stakeholder Identification

The process stakeholders on the project included the therapists and psychiatrists who also want to use mindfulness interventions with their Arabic-speaking clients. These process stakeholders were present on sight in El Cajon. The nurse practitioner kept the stakeholders updated and engaged by giving periodic updates at meetings. Additionally, the nurse practitioner's faculty chair was kept informed on the progress of the project by periodic e-mails or meetings.

The outcome stakeholders are the medical director, behavioral health director, and other administrators. The nurse practitioner kept outcome stakeholders updated by sending periodic e-mails since most of these stakeholders were off-site.

Process Indicators Data Monitoring

First, the patients at the clinic already have documented PHQ-9 scores which are a valid and reliable measure of depression severity in Arabic-speaking patients (Sawaya,

2016). PHQ-9 scores are tracked every two to three months as a quality measure. The nurse practitioner continued to track PHQ-9 scores over the course of the project.

The nurse practitioner also measured Quality of Life (QoL) scores. QoL is defined as "a person's sense of well-being that stems from satisfaction or dis-satisfaction with the areas of life that are important to him/her" (Ferrans, 1990). The QoL instruments examines four areas of life theorized to be important to QoL: "health and functioning, socioeconomic, psychological/spiritual, and family" (Halabi, 2006).

After getting buy-in from the six patients that participated in the pilot study, the nurse practitioner presented the basic concepts of meditation and mindfulness during individual sessions. Then, the nurse practitioner presented a guided meditation track in Arabic. There were four sessions offered to each patient in the pilot. The purpose of presenting the information in a private, individualized setting was a strategy used to help motivate the patients to meditate at home.

The patients was provided with a compact disc (CD) of the meditation tracks and they were also be provided with the website from which the tracks could be streamed. The nurse practitioner asked the patients to meditate three times a week. Research shows patients are half as likely to experience a relapse of depression if they practice mindfulness at least three times a week during treatment for depression (Crane et al., 2014). The Arabic-speaking staff at the clinic periodically called to check on the patients' progress at home.

Outcome Indicators Data Monitoring

As indicated above, PHQ-9 scores were measured at the four meditation sessions to note differences in severity of depression. The clients also completed QoL screenings at the first and last session offered to the patient.

Data Analysis

The nurse practitioner tracked PHQ-9 scores to see if there is a change over the 2-month intervention period. The QoL scores were calculated using available tools to see if there is a difference in scores pre-intervention and post-intervention.

Cost Benefit Analysis

The additional cost required for the project was limited. No additional staff were needed to implement the meditation sessions at the clinic. The only additional cost was for the CD which will be given to the clients participating with mindfulness sessions. The psychologist will be able to bill for therapy sessions at the clinic for each patient to whom they introduce mediation. Each patient that completes meditations sessions at the clinic will bring a profit as shown in the table below.

Table 1

Cost Benefit Analysis of Meditation Sessions

Cost		Benefit	
CDs	$7	$64 per session (Medi-Cal), 40 sessions (4 each for 10)	$2,560
		Expected profit per patient	$256

(California Department of Health Care Services, n. d.)

Dissemination

First, the nurse practitioner gave a presentation at the University of San Diego Hahn School of Nursing in March 2018. Then, the results were shown at a poster presentation at the Western Institute of Nursing 50th Annual Communicating Nursing Research Conference in April 2018. The the key stakeholders at NHC heard the nurse practitioner present the findings of the pilot in April 2018. Finally, the University of San Diego Hahn School of Nursing hosts a poster presentation day each spring and the nurse practitioner presented her findings there in May 2018.

Sustainability

The nurse practitioner implemented the pilot at NHC El Cajon and had a vested interest in continuing the project to wider implementation and sustainability. The behavior health team at NHC met. They planned to use meditation in Arabic on a larger scale. Meditation will be incorporated into group therapy for Arabic-speaking patients. All the clinicians will begin offering meditation instruction to patients identified as appropriate for mindfulness interventions. The nurse practitioner will continue to make sure meditation CDs are available at the clinic for Arabic speaking clients. The idea is that this mindfulness intervention will be one tool available to clinicians at NHC, especially for clients unwilling to participate with group therapy. The clinicians will periodically check in with the clients who have completed the meditation sessions to encourage the clients to continue meditating at home.

Evaluation of Evidence-Based Interventions and Outcomes

The pilot was implemented from January 2018 until March 2018. There were six patients who express interested in participating with the pilot. Half of the patient completed the mediation program, and all patient missed at least one appointment during

the pilot. Some patients were able to reschedule missed appointments. The other half of the patients did not complete the pilot for various reasons such as a death in the family or getting the flu. One patient did say she was "too stressed out to meditate."

The three patients completing the study had between 9% and 58% improvement in QoL. One patient demonstrated a drop in PHQ-9 score from 24 to 16 over a two-month period of time. Those who adhered mostly closely to appointments and practice at home showed the most improvement in outcome scores. Although not everyone experienced improvements in PHQ-9 scores, everyone did report qualitative improvements and an improvement in QoL.

One patient reported sleeping much better. Another patient stated he was "looking at life differently" and indicated he was viewing stressful life situations in a more positive mindset. The last patient noticed she felt "comfortable psychologically, my breathing is regular, body relaxed, pressure in my head down." Also, a few of the patients had difficulty with finding a comfortable way of meditating and felt the individualized instruction was helpful in resolving difficulties. Although the patients reported qualitative and quantitative improvements, some of the patients did have critiques for the pilot.

A few of the patients reports concerns over privacy. Different interpreters were contacting the patients to check-in on how the meditation was working and to remind the patients to practice three times per week. The patients would have preferred that the same interpreter contact them each time to decrease the number of people aware they were meditating. One patient stated that at first, she "did not believe in" meditation, and she indicated public knowledge of her meditating would portray her in a negative way within her community.

Implications for Clinic Practice

Meditation is one way of improving qualitative and quantitative outcomes for Arabic-speaking patients. The pilot indicated meditation is an effective and brief intervention that empowers patients to be more active in their own mental health treatment. Meditation can improve both QoL and PHQ-9 scores when practiced regularly. In addition to being beneficial for the patient, mindfulness is a billable service which can add additional avenues for revenue at the clinic. Last, more access to treatment could be created if the team is able to stabilize people more efficiently.

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Final DNP Exemplars

AACN DNP Essentials/NONPF Competencies/USD DNP Program Outcomes Exemplars

Semester	Clinical Hours
MSN Hours	500
Fall 2016	310
Spring 2017	348
Summer 2017	214
Fall 2017	245
Spring 2018	210
Total	**1327**

AACN DNP Essentials & NONPF Competencies	USD DNP Program Objectives	Exemplars Provide bulleted exemplars that demonstrates achievement of each objective
DNP Essential I: Scientific Underpinnings for Practice **NONPF: Scientific Foundation Competencies** *The scientific foundation of nursing practice has expanded and includes a focus on both the natural and social sciences including human biology, genomics, science of therapeutics, psychosocial sciences, as well as the science of complex organizational structures. In addition, philosophical, ethical, and historical issues inherent in the development of science create a context for the application of the natural and social sciences.*	**2.** Synthesize nursing and other scientific and ethical theories and concepts to create a foundation for advanced nursing practice.	Fall 16, Spr 17, Sum 17, Fall 17, Spr 18- Leininger's theory of cultural congruent care Fall 16, Spr 17, DNP project- new practice approaches for tx resist. depression Spr 17- Complete Literature Review on Mindfulness Spr 17, Sum 17, Fall 17, Spr 18- Utilize IOWA Model for Program Planning Sum 17- Utilize driver diagram for Strategic Planning of DNP project
DNP Essential II: Organizational & System	**5.** Design, implement, and evaluate ethical health care	Spr 17, Sum 17, Fall 17, Spr 18- DNP project will

Leadership for Quality Improvement & Systems Thinking **NONPF: Leadership Competencies/Health Delivery System Competencies** *Advanced nursing practice includes an organizational and systems leadership component that emphasizes practice, ongoing improvement of health outcomes, and ensuring patient safety. Nurses should be prepared with sophisticated expertise in assessing organizations, identifying system's issues, and facilitating organization-wide changes in practice delivery. This also requires political skills, systems thinking, and the business and financial acumen needed for the analysis of practice quality and costs.*	delivery systems and information systems that meet societal needs and ensure accountability for quality outcomes.	measure PHQ-9 scores to measure improvements in depression Fall 16, Spr 17, Sum 17- Developing cost-effective interventions for NPO with limited resources Fall 16, Spr 17, Sum 17, Fall 17, Spr 18- Participate with provider meetings, interdisciplinary meetings to design better delivery system Sum 17- Presentation for propsed DNP project given to behavioral health team at NHC Spr 18- Implement pilot Spr 18- Stakeholder presentation of Arabic meditation pilot Spr 18- Sustainability planning of Arabic meditation programming
DNP Essential III: Clinical Scholarship & Analytical Methods for Evidence-Based Practice **NONPF: Quality Competencies/Practice Inquiry Competencies** *Scholarship and research are the hallmarks of doctoral education. Although basic research is viewed as the first and most*	**4.** Incorporate research into practice through critical appraisal of existing evidence, evaluating practice outcomes, and developing evidence-based practice guidelines.	Fall 16, Spr 17 - Complete literature search on mindfulness Fall 16, Spr 17- Utilize A3 framework to analyze clinical problems Fall 16, Spr 17, Spr 18- Maintain clinical standards by attending conferences.

essential form of scholarly activity, an enlarged perspective of scholarship has emerged through alternative paradigms that involve more than discovery of new knowledge. These paradigms recognize: (1) the scholarship of discovery and integration "reflects the investigative and synthesizing traditions of academic life"; (2) scholars give meaning to isolated facts and make connections across disciplines through the scholarship of integration; and (3) the scholar applies knowledge to solve a problem via the scholarship of application that involves the translation of research into practice and dissemination and integration of new knowledge.		Fall 16, Spr 17, Sum 17, Fall 17, Spr 18- Using EBP to improve health literacy Sum 17- Utilize 3-year financial prospectus to evaluate expected financial outcomes of DNP project Spr 18- Evaluate results of Arabic meditation pilot Fall 17- Training for Medication Assisted Treatment program at clinic to treat opiate addiction
DNP Essential IV: Information Systems/Technology & Patient Care Technology for Improvement & Transformation of Health Care **NONPF: Technology & Information Literacy Competencies** *DNP graduates are distinguished by their abilities to use information systems/technology to support and improve patient care and health care systems, and provide leadership within healthcare*	**7.** Incorporate ethical, regulatory, and legal guidelines in the delivery of health care and the selection, use, and evaluation of information systems and patient care technology.	Fall 16, Spr 17, Sum 17, Fall 17, Spr 18- Utilize electronic medical record (eWC) for charting Educating patients on portal to increase number of people accessing service and improve communication Sum 17- evaluated current meditation apps available in Arabic for patient to use

systems and/or academic settings. Knowledge and skills related to information systems/technology and patient care technology prepare the DNP graduates apply new knowledge, manage individual and aggregate level information, and assess the efficacy of patient care technology appropriate to a specialized area of practice along with the design, selection, and use of information systems/technology to evaluate programs of care, outcomes of care, and care systems. Information systems/technology provide a mechanism to apply budget and productivity tools, practice information systems and decision supports, and web-based learning or intervention tools to support and improve patient care.		
DNP Essential V: Health Care Policy for Advocacy in Health Care **NONPF: Policy Competencies** *Health care policy, whether created though governmental actions, institutional decision-making, or organizational standards, creates a framework that can facilitate or impede the delivery of health care services or the ability of the provider to engage in*	**3.** Demonstrate leadership in collaborative efforts to develop and implement policies to improve health care delivery and outcomes at all levels of professional practice (institutional, local, state, regional, national, and/or international).	Fall 16, Spr 17, Sum 17, Fall 17, Spr 18- Weekly provider meeting at NHC Fall 16- Voting in election for props effecting healthcare Fall 16, Spr 17, Sum 17, Fall 17, Spr 18- Member of AANP, ANA, CANP Fall 16, Spr 17, Sum 17, Fall 17, Spr 18- Educate public on role of nurse practitioner

practice to address health care needs. Engagement in the process of policy development is central to creating a health care system that meets the needs of its constituents. Political activism and a commitment to policy development are central elements of DNP practice.		Sum 17- evaluate current NHC policies as team for possible revisions
DNP Essential VI: Interprofessional Collaboration for Improving Patient & Population Health Outcomes **NONPF: Leadership Competencies** *Today's complex, multi-tiered health care environment depends on the contributions of highly skilled and knowledgeable individuals from multiple professions. In order to accomplish the IOM mandate for safe, timely, effective, efficient, equitable, and patient-centered care in this environment, health care professionals must function as highly collaborative teams. DNPs have advanced preparation in the interprofessional dimension of health care that enable them to facilitate collaborative team functioning and overcome impediments to interprofessional practice. DNP graduates have preparation in methods of*	**1.** Demonstrate advanced levels of clinical practice within defined ethical, legal, and regulatory parameters in designing, implementing, and evaluating evidenced-based, culturally competent therapeutic interventions for individuals or aggregates. **3.** Demonstrate leadership in collaborative efforts to develop and implement policies to improve health care delivery and outcomes at all levels of professional practice (institutional, local, state, regional, national, and/or international).	Fall 16, Spr 17, Sum 17, Fall 17, Spr 18- Collaborating with multi-disciplinary team (psychiatrist, psychologists, MFTs, MDs, PAs, managers) to develop culturally sensitive treatment options Fall 16, Spr 17, Sum 17, Fall 17, Spr 18- Provider meetings Fall 16, Spr 17- DNPC 648 Health Policy Fall 16, Spr 17, Sum 17, Fall 17, Spr 18- Multidisciplinary approach when implementing DNP project Fall 16, Spr 17, Sum 17, Fall 17, Spr 18- Use integrated care model to provide primary care/mental health services Spr 18- Met with stakeholders to provide

effective team leadership and are prepared to play a central role in establishing interprofessional teams, participating in the work of the team, and assuming leadership of the team when appropriate.		results of pilot and plan for sustainability
DNP Essential VII: Clinical Prevention & Population Health for Improving Nation's Health **NONPF: Leadership Competencies** *Consistent with national calls for action and with the longstanding focus on health promotion and disease prevention in nursing, the DNP graduate has a foundation in clinical prevention and population health. This foundation enables DNP graduates to analyze epidemiological, biostatistical, occupational, and environmental data in the development, implementation, and evaluation of clinical prevention and population.*	**6.** Employ a population health focus in the design, implementation, and evaluation of health care delivery systems that address primary, secondary, and tertiary levels of prevention.	Fall 16, Spr 17, Sum 17, Fall 17, Spr 18- Developing tertiary prevention strategies for PTSD in immigrants from Middle East Spr 17- Webinar on developing primary prevention strategies in mental health Fall 16- Completed DNP 625 Epidemiology and Biostatistics Fall 16, Spr 17, Fall 17, Spr 18- Increase awareness of importance of flu vaccine Sum 17, Fall 17- Increase awareness of Hepatitis A outbreak and available vaccines in San Diego

DNP Essential VIII: Advanced Nursing Practice **NONPF: Independent Practice/Ethics Competencies** *The increased knowledge and sophistication of healthcare has resulted in the growth of specialization in nursing in order to ensure competence in these highly complex areas of practice. The reality of the growth of specialization in nursing practice is that no individual can master all advanced roles and the requisite knowledge for enacting these roles. DNP programs provide preparation within distinct specialties that require expertise, advanced knowledge, and mastery in one area of nursing practice. A DNP graduate is prepared to practice in an area of specialization within the larger domain of nursing.*	**1**. Demonstrate advanced levels of clinical practice within defined ethical, legal, and regulatory parameters in designing, implementing, and evaluating evidence-based, culturally competent therapeutic interventions for individuals or aggregates.	Fall 16- Help develop values of NHC Spr 17- Completed DNPC 610: Philosophy of Reflective Practices Fall 16, Spr 17, Sum 17- Use Jean Watson's theory of caring for assessment/planning Fall 16, Spr 17, Sum 17, Fall 17, Spr 18- Implement culturally specific DNP project- mindfulness for Arabic speaking clients Fall 16, Spr 17, Sum 17, Fall 17, Spr 18- Practicing within the scope of my license as governed by state board of registered nursing Sum 17, Fall 17- Go through IRB process

Appendix A: Evaluation Instruments & Tools

استبيان عن صحة المرضى - 9 (PHQ-9)

خلال الأسبوعين الماضيين، كم مرة عانيت من أي من المشاكل التالية؟ *(ضع علامة "✓" للإشارة لجوابك)*	ولا مرة	عدة أيام	أكثر من نصف الأيام	تقريبا كل يوم
1. قلة الاهتمام أو قلة الاستمتاع بممارسة بالقيام بأي عمل	0	1	2	3
2. الشعور بالحزن أو ضيق الصدر أو اليأس	0	1	2	3
3. صعوبة في النوم أو نوم متقطع أو النوم أكثر من المعتاد	0	1	2	3
4. الشعور بالتعب أو بامتلاك القليل جداً من الطاقة	0	1	2	3
5. قلة الشهية أو الزيادة في تناول الطعام عن المعتاد	0	1	2	3
6. الشعور بعدم الرضا عن النفس أو الشعور بأنك قد أخذلت نفسك أو عائلتك	0	1	2	3
7. صعوبة في التركيز مثلاً أثناء قراءة الصحيفة أو مشاهدة التلفزيون	0	1	2	3
8. بطء في الحركة أو بطء في التحدث عما هو معتاد لدرجة ملحوظة من الآخرين / أو على العكس من ذلك التحدث بسرعة وكثرة الحركة أكثر من المعتاد	0	1	2	3
9. راودتك أفكار بأنه من الأفضل لو كنت ميتا أو أفكار بأن تقوم بإيذاء النفس	0	1	2	3

_____ + _____ + _____ + *0* = **Total Score:** _____ **(FOR OFFICE CODING)**

إذا أشرت إلى أيّة من المشاكل أعلاه، فإلى أية درجة صعّبت عليك هذه المشاكل القيام بعملك، الاعتناء بالأمور المنزلية، أو الانسجام مع أشخاص آخرين؟

ليست هناك أي صعوبة	هناك بعض الصعوبات	هناك صعوبات شديدة	هناك صعوبات بالغة التعقيد
☐	☐	☐	☐

(Spitzer, Wiliams, & Kroenke, 1999)

مقياس نوعية الحياة Quality of Life Index

(النموذج العام Generic Version III)

الجزء الأول: يرجى وضع دائرة حول الإجابة الملائمة لكل مما يلي وفقا لما تراه مناسبا لوصف **مدى رضاك** عن نواحي مختلفة من حياتك. الرجاء وضع دائرة حول الرقم الذي يمثل رأيك علما بأنه لا توجد إجابة صحيحة أو خاطئة.

كم أنت راض عن:	غير راض جدا	غير راض بشكل متوسط	غير راض قليلا	راض قليلا	راض بشكل متوسط	راض جدا
1. صحتك؟	1	2	3	4	5	6
2. الرعاية الصحية التي تتلقاها؟	1	2	3	4	5	6
3. مقدار الألم في حياتك؟	1	2	3	4	5	6
4. مدى طاقتك على القيام بالنشاطات اليومية؟	1	2	3	4	5	6
5. قدرتك على رعاية نفسك بنفسك؟	1	2	3	4	5	6
6. مدى سيطرتك على حياتك؟	1	2	3	4	5	6
7. فرصك لعيش الفترة الزمنية التي تتمناها؟	1	2	3	4	5	6
8. صحة عائلتك؟	1	2	3	4	5	6
9. أطفالك؟	1	2	3	4	5	6
10. سعادة عائلتك؟	1	2	3	4	5	6
11. حياتك الجنسية؟	1	2	3	4	5	6
12. زوجك أو شريك حياتك؟	1	2	3	4	5	6
13. أصدقاؤك؟	1	2	3	4	5	6
14. الدعم المعنوي الذي تتلقاه من عائلتك؟	1	2	3	4	5	6
15. الدعم المعنوي الذي تتلقاه من الآخرين خارج عائلتك؟	1	2	3	4	5	6

يرجى الذهاب إلى الصفحة التالية

(Ferrans & Powers, 1995)

كم أنت راض عن:	غير راض جدا	غير راض بشكل متوسط	غير راض قليلا	راض قليلا	راض بشكل متوسط	راض جدا
16. قدرتك على القيام بالواجبات العائلية؟	1	2	3	4	5	6
17. مدى فائدتك للآخرين؟	1	2	3	4	5	6
18. مقدار الضغط النفسي أو القلق الذي تعانيه في حياتك؟	1	2	3	4	5	6
19. جيرانك؟	1	2	3	4	5	6
20. بيتك أو منزلك أو مسكنك؟	1	2	3	4	5	6
21. عملك (إذا كنت تعمل)؟	1	2	3	4	5	6
22. عدم حصولك على عمل (إذا كنت لا تعمل، أو متقاعد، أو غير قادر على العمل)؟	1	2	3	4	5	6
23. تحصيلك العلمي؟	1	2	3	4	5	6
24. قدرتك على تدبير أمورك المالية؟	1	2	3	4	5	6
25. الأنشطة التي تسلي بها نفسك؟	1	2	3	4	5	6
26. فرصك لتحقيق مستقبل سعيد؟	1	2	3	4	5	6
27. راحة بالك أو استقرارك النفسي؟	1	2	3	4	5	6
28. إيمانك بالله عز وجل؟	1	2	3	4	5	6
29. تحقيقك للأهداف الشخصية؟	1	2	3	4	5	6
30. سعادتك بشكل عام؟	1	2	3	4	5	6
31. حياتك بشكل عام؟	1	2	3	4	5	6
32. مظهرك الشخصي؟	1	2	3	4	5	6
33. نفسك بشكل عام؟	1	2	3	4	5	6

(يرجى الذهاب إلى الصفحة التالية)

(Ferrans & Powers, 1995)

الجزء الثاني: يرجى وضع دائرة حول الإجابة الملائمة لكل مما يلي وفقا لما تراه مناسبا لوصف **مدى أهمية** كل من النواحي التالية من حياتك. الرجاء وضع دائرة حول الرقم الذي يمثل رأيك علما بأنه لا توجد إجابة صحيحة أو خاطئة.

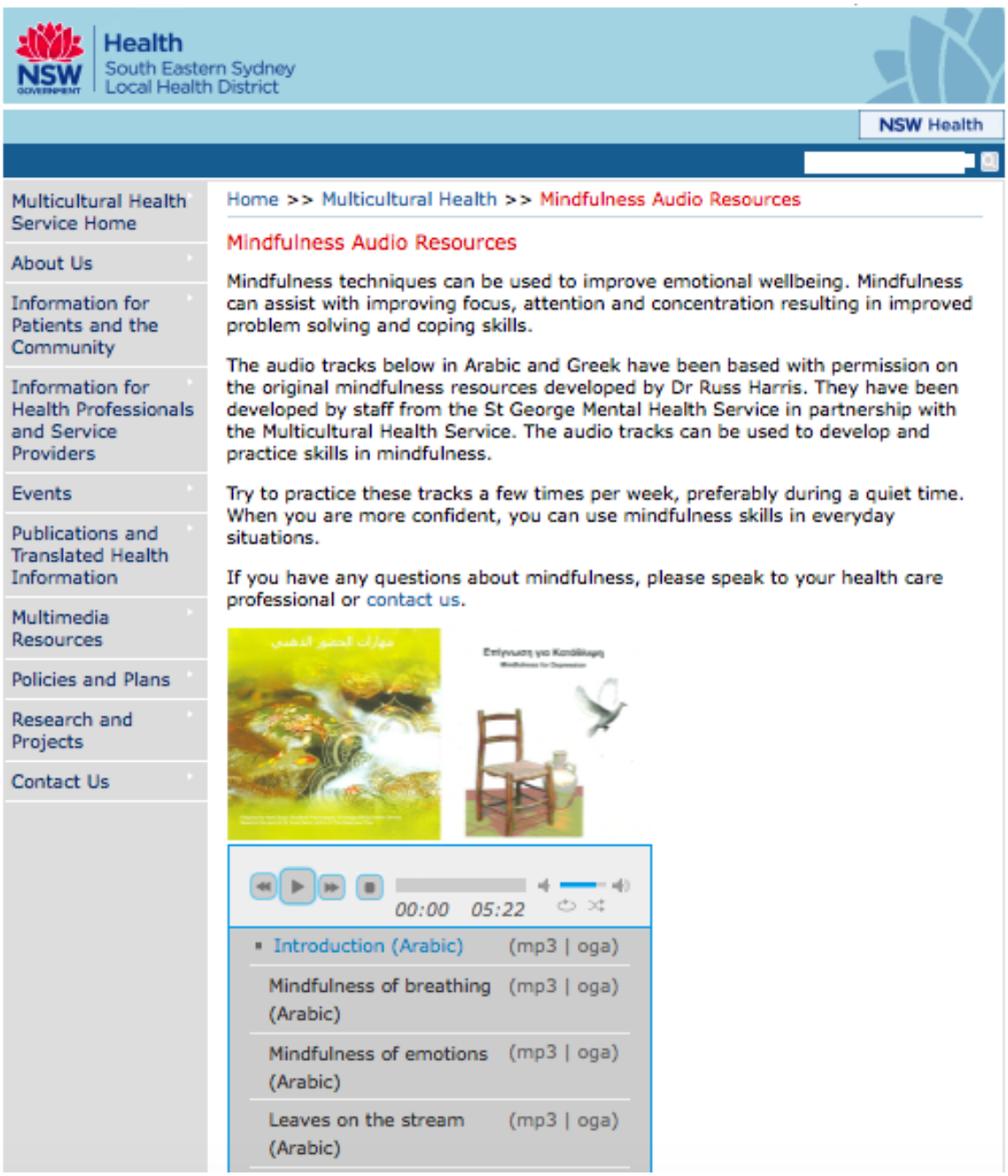
كم هو مهم بالنسبة لك:	مهم جدا	مهم	متوسط الأهمية	غير مهم	غير مهم أبدا	
1. صحتك؟	1	2	3	4	5	6
2. الرعاية الصحية التي تتلقاها؟	1	2	3	4	5	6
3. خلو حياتك من الألم؟	1	2	3	4	5	6
4. توفر طاقة كافية لديك للقيام بالنشاطات اليومية؟	1	2	3	4	5	6
5. رعاية نفسك بنفسك؟	1	2	3	4	5	6
6. القدرة على ضبط أمور حياتك؟	1	2	3	4	5	6
7. العيش للفترة الزمنية التي تتمناها؟	1	2	3	4	5	6
8. صحة عائلتك؟	1	2	3	4	5	6
9. أطفالك؟	1	2	3	4	5	6
10. سعادة عائلتك؟	1	2	3	4	5	6
11. حياتك الجنسية؟	1	2	3	4	5	6
12. زوجك أو شريك حياتك؟	1	2	3	4	5	6
13. أصدقاؤك؟	1	2	3	4	5	6
14. الدعم المعنوي الذي تتلقاه من عائلتك؟	1	2	3	4	5	6
15. الدعم المعنوي الذي تتلقاه من الآخرين خارج عائلتك؟	1	2	3	4	5	6

(يرجى الذهاب إلى الصفحة التالية)

(Ferrans & Powers, 1995)

كم هو مهم بالنسبة لك:	غير مهم جدا	غير مهم بشكل متوسط	غير مهم قليلا	مهم قليلا	مهم بشكل متوسط	مهم جدا
16. القيام بالواجبات العائلية؟	1	2	3	4	5	6
17. أن تكون مفيداً للآخرين؟	1	2	3	4	5	6
18. خلو حياتك من الضغوطات النفسية؟	1	2	3	4	5	6
19. جيرانك؟	1	2	3	4	5	6
20. بيتك أو منزلك أو مسكنك؟	1	2	3	4	5	6
21. عملك (إذا كنت تعمل)؟	1	2	3	4	5	6
22. حصولك على عمل (إذا كنت لا تعمل، أو متقاعد، أو غير قادر على العمل)؟	1	2	3	4	5	6
23. تحصيلك العلمي؟	1	2	3	4	5	6
24. القدرة على تدبير أمورك المالية؟	1	2	3	4	5	6
25. القيام بأنشطة ترفيهية؟	1	2	3	4	5	6
26. حصولك على مستقبل سعيد؟	1	2	3	4	5	6
27. راحة بالك أو استقرارك النفسي؟	1	2	3	4	5	6
28. إيمانك بالله عز وجل؟	1	2	3	4	5	6
29. تحقيق أهدافك الشخصية؟	1	2	3	4	5	6
30. سعادتك بشكل عام؟	1	2	3	4	5	6
31. أن تكون راضيا عن حياتك؟	1	2	3	4	5	6
32. مظهرك الشخصي؟	1	2	3	4	5	6
33. نفسك بالنسبة إليك؟	1	2	3	4	5	6

(Ferrans & Powers, 1995)



(South Eastern Sydney Local Health District, 2017)

Appendix C: Poster Abstract and Letter of Acceptance

Title: Stop, Meditate, and Listen: A Treatment Modality for Iraqi Refugees with Depression

Background: Depression rates among Iraqi refugees are between 28.3 and 75% compared to 8.6% in the general population. Treatment options are limited at Neighborhood Healthcare in El Cajon due to budget limitations, cultural beliefs, and language barriers, among other reasons. Individual therapy is intended to be a brief intervention due to limited staffing. Many middle eastern refugees decline group therapy due to stigma surrounding mental health treatment and concerns about privacy. Even though traditional treatment options are effective in many cases, there is also a gap in care. Numerous patients continue to exhibit significant depression with the current interventions in place. Mindfulness interventions are shown to have a medium to large effect size for the treatment of depression. In addition, mindfulness interventions are easy to teach and be practiced by the patient independently.

Purpose of Project: To implement a mindfulness meditation program in Arabic as an adjunctive treatment of depression

Framework/EBP Model: Iowa Model of Evidence Based Practice

Evidence-based Intervention/Benchmarks: The nurse practitioner will meet with the clients for individual sessions. Inclusion criteria are a Patient Health Questionnaire 9 (PHQ-9) score greater than 10 and primary language of Arabic. The nurse practitioner will instruct clients regarding guided meditation and mindfulness. The patients will have access to meditation tracks and will get reminder calls from clinic staff encouraging practice at home during the initiation of treatment. Quality of Life Scores (QOLS) and PHQ-9 scores will be measured at each session and at three months after sessions have ended.

From: win@confex.com
Subject: 2018 WIN Conference: Poster Presentation - Action Required
Date: December 6, 2017 at 1:12 PM
To: kgoehring@sandiego.edu

Dear Katherine R. Goehring,

Congratulations! Your abstract, "Stop, Meditate, and Listen: A Treatment Modality for Iraqi Refugees with Depression," has been accepted for a Poster presentation at the Western Institute of Nursing's 51st Annual Communicating Nursing Research Conference to be held April 11-14, 2018 at the Davenport Grand Hotel in Spokane, Washington.

Your poster session is scheduled for Saturday, April 14, 2018 from 8:00 AM - 12:00 PM.

Please notify any additional authors on your paper of this good news. Conference registration and the conference program will be available on the WIN website at www.winursing.org in the upcoming weeks.

Poster presentations are less formal, but not less rigorous or substantive, than podium presentations. Poster authors present their work interactively to groups of interested individuals with the aid of a visual display that summarizes research findings or project outcomes. Posters are displayed in a central location for four-hour blocks of time so attendees can peruse the visual displays and talk with the authors. The WIN Program Committee has set aside one hour of time during each poster session solely for attendees to view posters. We ask that presenters stand by their posters during this hour, which will be listed in the conference program. **Poster boards are 4' x 8'.** Please visit the Presenter's Corner on the WIN website for valuable tips on presenting your poster.

As the Presenting Author, we ask that you log into the "Presenter Information Center" (link is below) to provide the following information by January 5th:

1. Give your consent to present (see the "Consent to Participate" module);
2. Complete any missing information on the CE bioform (via the disclosure form) and/or the Content Objectives Grid.

Poster presenters do not need to upload presentation files, so please disregard that module in the Presenter Information Center.

Your place on the conference schedule will not be considered as final until all of these responses are completed and received no later than 5:00 PM Pacific Time on FRIDAY, JANUARY 5, 2018. By giving your consent to participate, the Program Committee is asking that you make a commitment to present your poster on the date and at the time assigned. As indicated in the Call for Abstracts, all presenters are required to pay the applicable registration fee and to cover their own travel expenses.

If, for any reason, you are unable to attend due to last minute matters, you are asked to send a representative to present your poster. If you do not present or have someone present for you, and you do not notify WIN in time to have your abstract pulled from the proceedings, you will be charged $60. In addition, an errata sheet will be circulated with the proceedings.

The link to the Presenter Information Center is:
http://win.confex.com/win/2018/posters/extra/index.cgi?username=12878&password=468561&EntryType=Paper

If prompted for login information:
Username: 12878
Password: 468561
EntryType: Abstract (Paper)

To reserve a room at the Davenport Grand Hotel, please click here.

We look forward to an excellent conference and to your participation. If you have questions, please contact Bo Perry by email at perrybo@ohsu.edu.

Sincerely,

Anthony McGuire, PhD, CCRN, ACNP-BC, FAHA
Chair, WIN Program Committee

Appendix D: Support Letters

SAN DIEGO - NORTH

RAY M. DICKINSON WELLNESS CENTER & MAIN ADMINISTRATION
425 N. Date St. #203
Escondido, CA 92025
(760) 520-8300
Dental Services
(760) 520-8330
Behavioral Health
(760) 520-8340

ESCONDIDO
460 N. Elm St.
Escondido, CA 92025
(760) 520-8100

GRAND
1001 E. Grand Ave.
Escondido, CA 92025
(760) 520-8200

PAUMA VALLEY
16650 Hwy. 76
P.O. Box 655
Pauma Valley, CA 92061
(760) 742-9919
Dental Services
(760)742-0672

PEDIATRICS & PRENATAL
426 N. Date St.
Escondido, CA 92025
(760) 690-5900

VALLEY PARKWAY
728 E. Valley Pkwy.
Escondido, CA 92025
(760) 737-6900

SAN DIEGO - EAST

EL CAJON
855 E. Madison Ave.
El Cajon, CA 92020
(619) 440-2751

LAKESIDE
10039 Vine St.
Lakeside, CA 92040
(619) 390-9975
Dental Services
(619) 390-9135

RIVERSIDE

HEMET
903 E. Devonshire Ave., Ste. D
Hemet, CA 92543
(951) 216-6100

MENIFEE
26926 Cherry Hills Blvd., Ste. B
Menifee, CA 92586
(951) 216-2200

TEMECULA
41840 Enterprise Circle N.
Temecula, CA 92590
(951) 225-6400

NEIGHBORHOOD HEALTHCARE
a californiahealth+center

Agency Approval Letter for Data Use

To: Institutional Review Board, University of San Diego

From: Wendi Vierra, Ph.D.
Director of Behavioral Health Operations

Re: Use of Clinical Data

Katherine Goehring, NP has our support to begin her scholarly practice project at Neighborhood Healthcare as part of her coursework for the DNP Program at the University of San Diego. Ms. Goehring has agreed to cleanse all data of any patient or institutional identifiers, as we understand that she will request to use data from this experience for publications and professional presentations.

Sincerely,

Wendi Vierra, Ph.D.
Director of Behavioral Health Operations
Neighborhood Healthcare

5998 Alcala Park, San Diego, CA 92110-2492

www.sandiego.edu/nursing

October 5, 2017

To: Institutional Review Board, University of San Diego

From: Michael Terry, DNP, FNP, PMHNP
Clinical Professor, Hahn School of Nursing and Health Science

I am serving as Faculty Advisor / Mentor for the DNP Project Titled: "Stop, Meditate, and Listen: A Treatment Modality for Iraqi Refugees with Depression" conducted by Katherine Goehring, PMHNP-BC, DNP Student in the Hahn School of Nursing and Health Science. I approve of this timely and important project and will be advising these students throughout the process.

Sincerely,

Michael Terry, DNP, FNP, PMHNP
Clinical Professor & Coordinator
Psychiatric Nurse Practitioner Program

Appendix E: IRB Letter

Nov 15, 2017 3:53 PM PST

Katherine Goehring
Hahn School of Nursing & Health Science

Re: Exempt - Initial - IRB-2018-144, Stop, Meditate, and Listen: A Treatment Modality for Iraqi Refugees with Depression

Dear Katherine Goehring:

The Institutional Review Board has rendered the decision below for IRB-2018-144, Stop, Meditate, and Listen: A Treatment Modality for Iraqi Refugees with Depression.

Decision: Exempt

Selected Category: Category 4. Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

Findings: This should be a Category 4 study.

Research Notes:

Internal Notes:

Note: We send IRB correspondence regarding student research to the faculty advisor, who bears the ultimate responsibility for the conduct of the research. We request that the faculty advisor share this correspondence with the student researcher.

The next deadline for submitting project proposals to the Provost's Office for full review is N/A. You may submit a project proposal for expedited or exempt review at any time.

Sincerely,

Dr. Thomas R. Herrinton
Administrator, Institutional Review Board

Office of the Vice President and Provost
Hughes Administration Center, Room 214
5998 Alcalá Park, San Diego, CA 92110-2492

Appendix F: Poster

Stop, Meditate, and Listen: A Treatment Modality for Iraqi Refugees with Depression

Katherine Goehring, MSN, PMHNP-BC, Faculty Mentor: Dr. Michael Terry, DNP, FNP, PMHNP
Clinical Mentor: Dr. Dorothy Liu, MD

Background

- ✓ Statistics
  - ✓ Depression rates among Iraqi refugees between 28.3-75% in western countries compared to 8.6% in the general population
  - ✓ 2012-2016: 9,024 Iraqi refugees settled in San Diego County
  - ✓ Neighborhood Healthcare (NHC) treated 431 Arabic speaking patients with Patient Health Questionnaire - 9 (PHQ-9) score >10 in 2017
  - ✓ Total number of Arabic speaking patients at NHC: 3655 (18 and older)
  - ✓ 11.8% of Arabic speaking patients at NHC with moderate to severe depression
- ✓ Many middle eastern refugees decline group therapy due to stigma surrounding mental health treatment/privacy concerns
- ✓ Limited resources in Federally Qualified Health Center setting
- ✓ Untreated depression associated with diabetes, heart disease, dementia, and other medical conditions
- ✓ Mindfulness interventions are shown to have a medium to large effect size for the treatment of depression
- ✓ Half as likely to have symptom relapse if meditating 3 times per week

Purpose

- ✓ To implement a mindfulness meditation program in Arabic as an adjunct for the treatment of depression
- ✓ Focus is to create intervention which is patient centered
- ✓ Empower patients

EBP Model/Framework

- ✓ Iowa Model of Evidence Based Practice

Project Plan Process

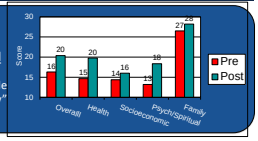
- ✓ NHC approval for project
- ✓ University of San Diego, Institutional Review Board approved
- ✓ Initiate individual meditation sessions with Arabic speaking clients with depression at NHC in El Cajon, California
  - ✓ 4 total sessions teaching use of guided meditations
  - ✓ Quality of Life Scale (QOLS) at first and last session
  - ✓ PHQ-9 scores at each session
  - ✓ 3 or 6 patients completed program
- ✓ Follow up calls between sessions to encourage meditation at home at least 3 times a week
- ✓ Stakeholder presentation
- ✓ Disseminate results

Implications for Clinical Practice

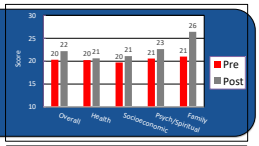
- ✓ Improved access to care
- ✓ More culturally sensitive treatment options
- ✓ Increased patient empowerment
- ✓ Increase revenue for non-profit organization
  - ✓ Mindfulness therapy is a billable service
- ✓ Potential to improve health outcomes, as depression is correlated to many costly medical conditions, including dementia and diabetes

Results

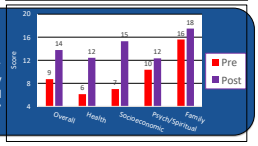
Patient 1 QOLS
25% Improved
"I feel comfortable psychologically"



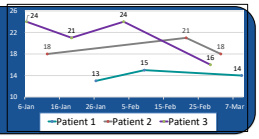
Patient 2 QOLS
9% Improved
"easier to fall asleep"



Patient 3 QOLS
58% Improved
"Useful…especially for depression and anxiety."



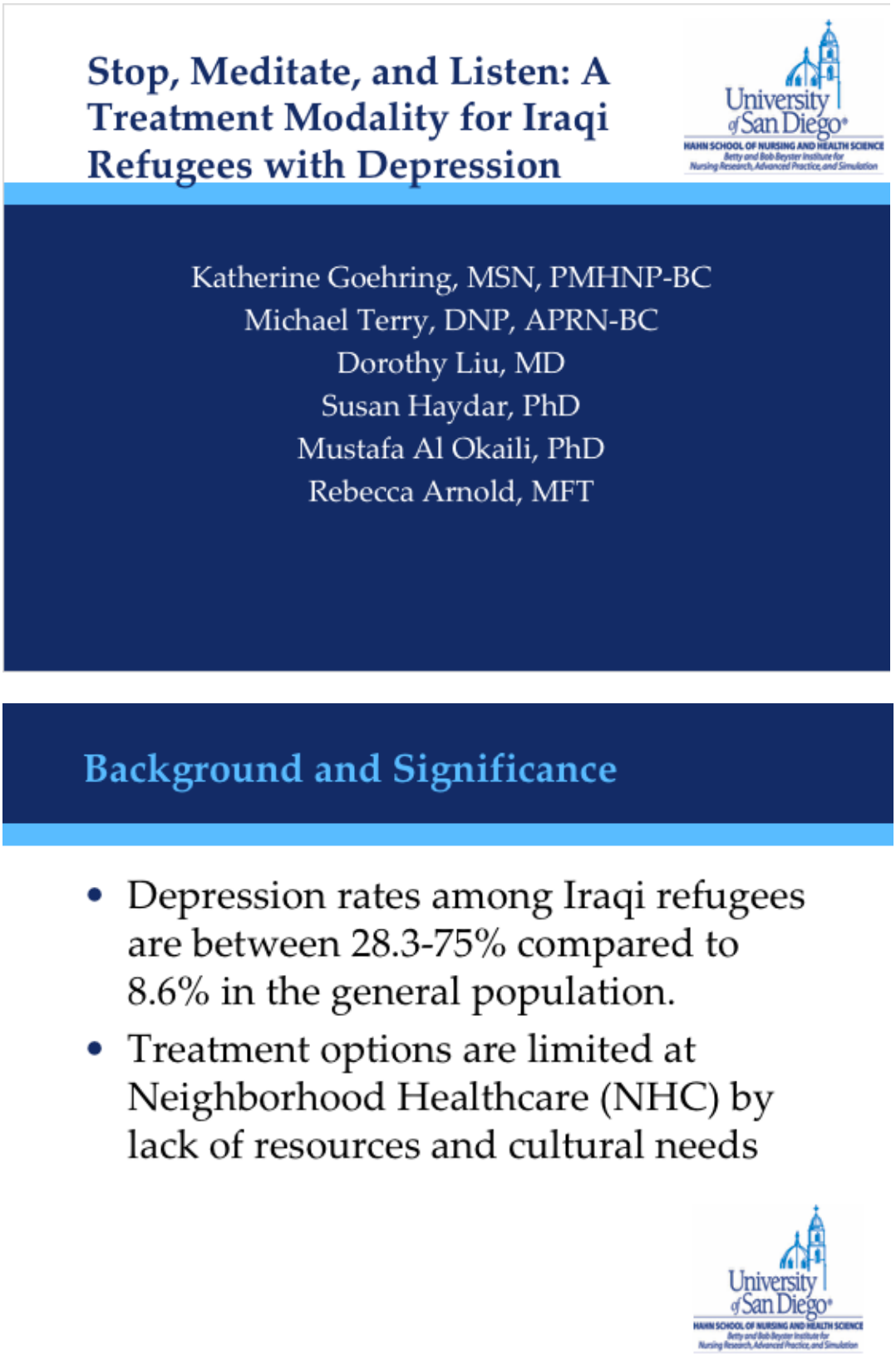
PHQ-9 Scores



Conclusions

- ✓ Teaching guided meditation to patients with depression is a brief intervention
- ✓ Effective intervention in setting where therapy resources are limited
- ✓ Meditation is a helpful treatment options for patients unable to participate in group therapy
- ✓ Culturally sensitive to those requiring more privacy
- ✓ Adherence to treatment remains problematic
- ✓ Improved QOLS with partial adherence to recommendations
- ✓ Can improve severity of depression

Appendix G: Stakeholder Presentation



Needs Assessment

- 2012-2016: 9,024 Iraqi Refugees settle in San Diego County
- NHC treated 431 Arabic speaking patients with Patient Health Questionaire-9 (PHQ-9) score > 10 in 2017
- Total number Arabic speaking patients 3655 (18 and older)
- Percentage of adult Arabic-speaking patients with moderate to severe depression is 11.8%

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Purpose/Aims

- Purpose is to implement a pilot for a mindfulness meditation program in Arabic as an adjunctive treatment for depression
- Focus is to create an intervention which is patient centered and culturally congruent
- Empower patients

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Framework/EBP Model

Iowa Model of Evidence Based Practice

- Meant for multidisciplinary team
- Well established tool
- Multiple feedback loops

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Synopsis of the Evidence

- Mindfulness interventions have a medium to large effect size as a treatment for depression
- Effective for acute depression and depression in partial remission
- Half as likely to have symptom relapse if meditating 3 times per week at home

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Project Plan Process

- 6 patients agreed to participate
- Each patient offered four session of meditation instruction and practice
- Medication adjustments continued as necessary
- Patients were called between sessions to encourage meditation at home

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Project Plan Process

- PHQ-9 scores were measured at each session
- Quality of Life (QoL) scores were measured at the start of the pilot and at the end of session four

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Timeline

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Results

- 3 patient completed
- 3 dropped out or stopped coming to appointments
  - Flu, stress, no show to last appointment

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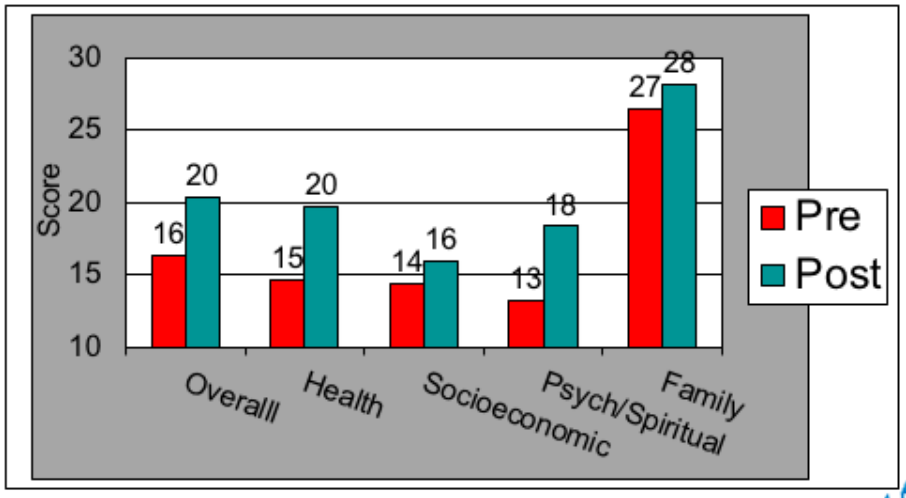
Patient 1 QoL



25% Change Overall

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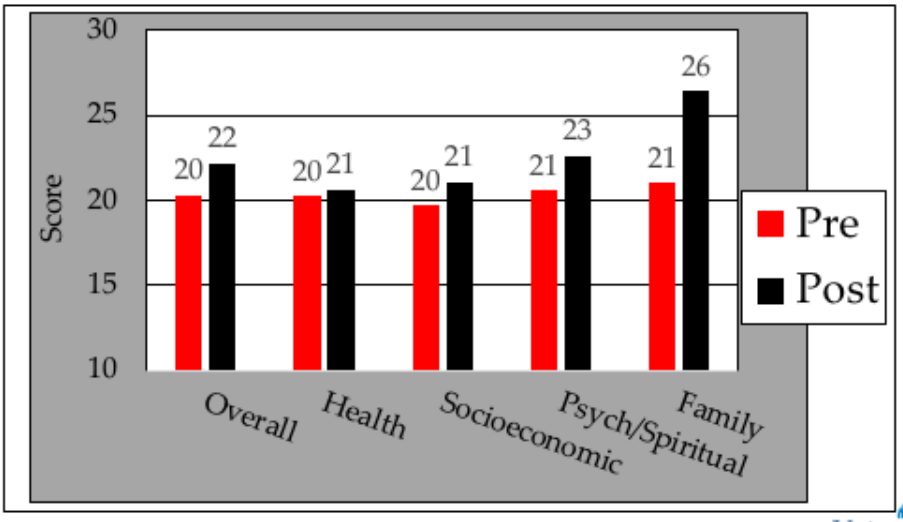
Results: Patient 2 QoL



9% Change Overall

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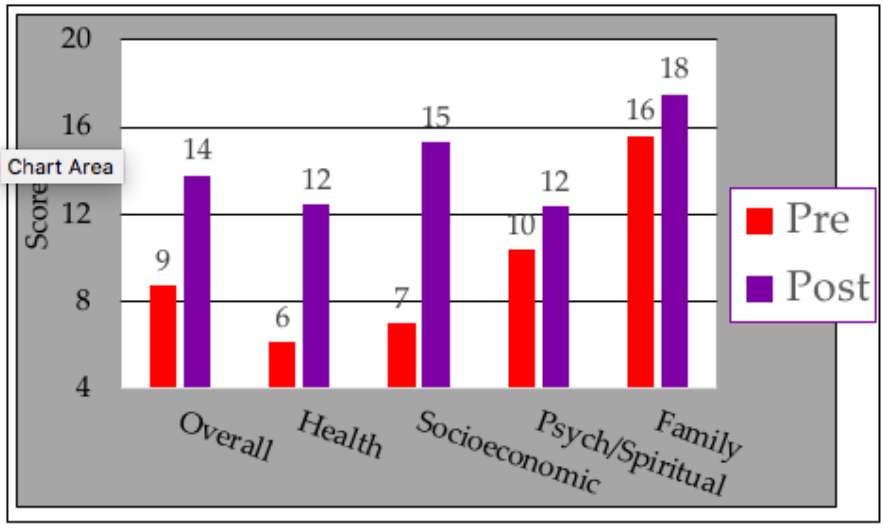
Results: Patient 3 QoL



58% Change Overall

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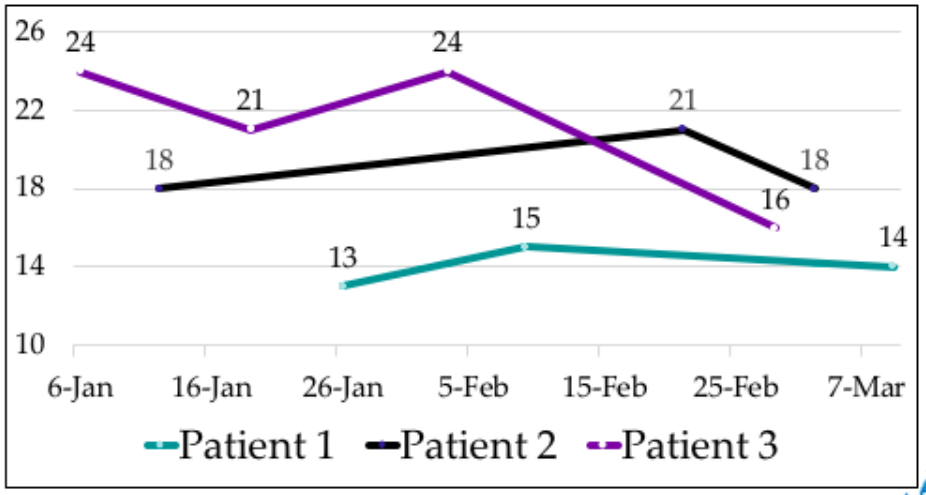
Results: PHQ-9 Scores



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Conclusions

- Benefits
  - Meditation improved QoL scores
  - Regular meditation did improve PHQ-9 in one patient
  - Patients found it helpful
  - Short/effective Intervention
  - Easy to learn

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Conclusions

- Barriers
  - Adherence difficult
  - Many cultural stigmas regarding meditation
  - Privacy
  - Technology

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Cost-Benefit Analysis

Cost

- CD's	$10 (pack of 50)

Benefit

- Sessions billed to Medi-Cal	$ 64
- 4 sessions per client	$ 256
- 6 patients	$1536

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Implications for Clinical Practice

- Improved access to care by stabilizing depression more efficiently
- Increased patient empowerment
- Potential to improve health outcomes, as depression is correlated to many costly medical conditions, including dementia and diabetes

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Implications for Clinical Practice

- Improved QoL and potentially depression
- Increase revenue for non-profit organization
  - Mindfulness therapy is a billable service for psychologists

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