2017

An educational program about living with depression

Ngozi Gloria Okoro
Walden University

Walden University

College of Health Sciences

This is to certify that the doctoral study by
Ngozi Okoro

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Cassandra Taylor, Committee Chairperson, Nursing Faculty
Dr. Barbara Niedz, Committee Member, Nursing Faculty
Dr. Dana Leach, University Reviewer, Nursing Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University

Abstract

An Educational Program about Living with Depression

By

Ngozi Okoro

MSN, South University, 2013

Project study submitted in partial fulfillment of the requirements for the degree of

Doctor of Nursing Practice

Walden University

May, 2017

Abstract

Depression is a common and disabling mental illness, but the loneliness, isolation, and poor quality of life associated with depression may improve with treatment. Depressive patients adhere to their treatment and experience better outcomes when their family members are involved with their treatment. At the project mental health facility, patients with depression had the highest non-compliance rate to treatment and no educational program existed for their families. This observation led to the current practice-focused question which examined how an evidenced-based educational program can be developed for family members or caregivers of patients diagnosed with depression. The purpose of this project was to assemble a team of experts to develop and plan an educational program about living with depression for family members or caregivers of patients diagnosed with depression. This project was guided by Jean Watson's theory of human caring and the view of health as harmony of mind, body, and soul. The educational program was planned using reviewed research studies with the input of a team of local experts consisting of a psychiatrist, a licensed therapist, a mental health nurse practitioner, registered nurses, and medical assistants. The project resulted in a four session educational program, a manual of policies and procedures, and recommendations for implementation and evaluation of the education. The educational program resulting from this project has the potential to improve the health and well-being of patients with depression and their families, decrease the stigma they face, and contribute to positive social change.

An Educational Program about Living with Depression

By

Ngozi Okoro

MSN, South University, 2013

Project study submitted in partial fulfillment of the requirements for the degree of

Doctor of Nursing Practice

Walden University

May, 2017

Acknowledgements

I dedicate this project to my family who stood by me throughout the years I have been in school. I also dedicate this project to my children, Micheal, Ashley, Racheal and Isaac, who had to endure several weeks of fast food because mommy was not able to cook, and to my parents who encouraged me to continue when it seemed I was about to give up.

To Dr. Taylor whose insightful criticisms and patience has guided me throughout my journey as a DNP student, and to Dr. Moss and Dr. McGinnis, I say thank you for all your help and assistance when I needed you.

Table of Contents

Section 1: Nature of Project ... 1

- Introduction ... 1
- Problem Statement ... 2
- Nature of the Doctoral Project ... 3
- Significance ... 5
- Summary ... 8

Section 2: Background and context ... 9

- Conceptual Models ... 9
- Relevance to Nursing Practice ... 11
- Local Background and Context ... 21
- Role of the DNP Student ... 22
- Project Team ... 24
- Summary ... 24
- Practice-Focused Question ... 25
- Definition of Terms ... 25
- Depression: An Overview of Diagnosis and Treatment ... 27
- Types of Depression ... 28
  - Mild Depression ... 28
  - Moderate Depression ... 28
  - Severe Depression ... 28
  - Bipolar Disorder ... 29
  - Dysthymic Disorder ... 29

        Cyclothymic Disorder 29
        Seasonal Affective Disorder 30
    Sources of Evidence 30
    Analysis and Synthesis 31
        Team Member’s Workshop Evaluation 32
        Team Members’ Evaluation of DNP Student’s Project 33
    Summary 35
Section 4: Findings, Discussions and Implications 36
    Introduction 36
    Findings and Implications 36
    Recommendations and Implementations 40
    Contributions of the Doctoral Project Team 41
    Strengths and Limitations 42
Section 5: Dissemination Plan 43
    Analysis of Self 44
    Summary 45
References 46
Appendix A: Sample Workshop Evaluation 52
Appendix B: Sample Team Evaluation 56
Appendix C: Table of Scores 57
Appendix D: Distributed Flyer 58

Section 1: Nature of Project

Introduction

Depression is a common mental health problem affecting one in 10 Americans at some point in their lives, and the number of patients diagnosed with depression goes up by about 20% each year (National Institute of Mental Health, 2015). Depression affects people of all ages; however, women are nearly twice as likely as men to have depression (Mayo Clinic, n.d.). Moreover, it is estimated that nearly one in five Americans over the age of 65 struggles with depression (AARP, n.d.). If researchers rated diseases according to severity, depression would be among the top (Leford, 2014). Depression is so debilitating that it is one of the prominent causes of disability, and as many as two-thirds of people who commit suicide have this condition (Leford, 2014).

Depression is a serious mental health problem that, left untreated, can lead to disabling symptoms and negatively affect one’s quality of life. Symptoms of depression include feelings of sadness, loneliness, irritability, worthlessness, hopelessness, agitation, and guilt. Some may escalate to suicidal and homicidal ideations. Practitioners make a diagnosis of depression when these symptoms are present for 2 weeks or longer. Depression can be a debilitating and life-threatening condition that can result in social isolation, illness, and a negative disposition (AARP, n.d.), resulting in a patient who is often suffering alone, and in silence.

Problem Statement

The deinstitutionalization of mental healthcare in the Western world brought about family involvement to help shoulder some of the burden of caring for mentally ill patients (Anderson & Cannova, 2015). Most patients with mental illness depend on their family members for financial support, emotional support, housing, and advocacy (Leggatt, 2002). The term caregiver refers to someone not professionally trained but is taking care of the individual receiving mental health treatment. This term can include family members such as parents, siblings, children, partners, or even friends. Family involvement in a mental health setting can take different forms depending on the level of care required, ranging from a basic function to a more complex level of caring. However, the Health Insurance Portability and Accountability Act (HIPPA) forbids health care professionals from disclosing pertinent medical information without consent. Unlike people with physical conditions, patients with mental illnesses need help making decisions about their health and conditions because their judgement is often impaired. Many mental health providers do not understand what they are allowed to say under HIPPA law, and as a result, they often shut caregivers out even in circumstances in which they should be included.

Family involvement can lead to better patient outcomes, such as fewer in-patient admissions and shorter in-patient stays (Easson, Giacco, Dirik, & Priebe, 2014). Despite the benefits, providers underutilize family members when caring for patients (Easson et al., 2014). The target mental health facility had no educational program for patients' family members and caregivers, creating a gap in practice. This purpose of this project was to assemble a team of experts to develop and plan an educational program about living with depression for family members or caregivers of patients diagnosed with depression. While individuals have the ability to attain good mental health, they require support to achieve and maintain it. Caregivers play a vital role in the care of their loved ones by providing a significant portion of their care. Involving family members may be one of the best ways to help these patients. Families can encourage patients to engage with treatment plans, be able to recognize and act fast at the earliest sign of relapse, as well as assist during crisis episodes. This project addressed the identified gap in practice by helping develop and plan an educational program that will educate families and caregivers of people with depression. Since this program is solely for caregivers without involvement of actual patients, there is no violation of HIPPA law. Implementation will occur after project completion, and other practitioners will facilitate the implementation. The goals of the educational program are to examine ways to have the following:

- Better communication between family participants and their loved ones,
- Improved satisfaction in their interactions with their loved ones, and
- Better understanding about depression.

Nature of the Doctoral Project

Depression requires treatment just like any other medical condition. However, because some of the symptoms such as insomnia, irritability, fatigue, lack of concentration, and body pains are vague, people tend to dismiss these symptoms until they are unable to do daily activities (Krucik, 2016). Depression is one of the most commonly treated conditions in primary care, but it remains underdiagnosed and undertreated (Saver, Van-Nguyen, Keppel, & Doescher, 2007). Family involvement is crucial to the speedy treatment and maintenance of mental health because these patients feel alone and vulnerable (Leggatt, 2002). Families can encourage, provide emotional support, engage with treatment plans, and recognize and respond to early signs and symptoms of relapse. The participants of this educational program will be adult family members and other caregivers of depression patients who are willing to enroll in an educational program to learn how to better care for and support their loved ones.

Examples of topics that were included in this study include:

- Different types of depression and causes,
- Symptoms of depression and impact on the family,
- Effective communication between patients and loved ones, and
- Stress management.

Patients will not play any role in this program. The program is solely an educational program targeting adults with loved ones or family members suffering from depression. The team of experts planned this program. They are from Georgia Behavioral Health Center in Smyrna, Georgia. In addition to my participation, the team of experts that helped plan this educational program included a psychiatrist, a licensed therapist, a mental health nurse practitioner, registered nurse, two medical assistants, and two additional nurses. I planned this program with the assistance of these experts. Each expert contributed according to his/her expertise. They also presented their parts to their peers during meetings. We deliberated and agreed on what should be included on the handout for the program/workshop.

Significance

Stakeholders are groups of people who have an interest or concern in an organization or community. Patients, providers, and families are key stakeholders in evaluating the effectiveness of their treatment plan. From my experience, people suffering from mental illnesses like depression require support from family members to cope with their illnesses. People with bipolar depression may also have mood swings. This is a dangerous time for such people because they typically have irrational thoughts during the manic phase (American Psychiatric Association, 2013). While providers may adjust patient medications to alleviate their symptoms during these periods, family members can physically monitoring their symptoms. Consequently, it is important to educate family members on what to do in these situations and how to identify when patients need a higher level of care (Leggatt, 2002).

Nurses must recognize and respond to complex healthcare challenges and diverse patient populations (Institute of Medicine, 2010). Mental health practitioners must be sensitive to the need of people with mental illness. It takes an empathetic practitioner to care for people with mental illness, because the patient's illness is not physical and can be difficult to assess especially when the judgement of the patient is impaired. It is crucial for all nurses, not just mental health nurses, to obtain information about mental health problems. My experience is that most of my patients start out in a primary care setting and then receive a referral for a specialist. Planning this program with other providers helped improve the sensitivity of the participants toward their patients, increased empathy, and improved assessment and awareness about mental illness. Nurses serve crucial roles in healthcare. As such, it was important that a nurse lead this educational program. King and Hanson-Turton (2010) documented that patients trust nurses more than other healthcare professionals do. Additionally, Nurses also have been an enabling force for change in healthcare, such as facilitating cost-effective treatment along many dimensions (Aiken, Cheung & Olds, 2009). Ultimately, the leader of the program needed to be a trusted member of the medical team.

My nursing contribution helped improve this educational program. My vast nursing experience helped envision the program parameters not just from a mental health standpoint but also from a holistic standpoint. I understood the need to involve the patient's support system. I also recognized that untreated mental illness could affect the individual's physical health. Therefore, I was able to foster beginning the program by making sure information included in the handout would help individuals living with mental illness obtain support from people closest to them.

This educational program may shed light on the positive contributions of nurses in healthcare, as many of the participants are nurses. During the course of the program, participants may see how nurses protect, promote, and optimize the health of those in their care. States underutilize nurses by not allowing them to practice at the fullest extent of their education (Institute of Medicine, 2010). Professional resistance is one of the reasons why nurses do not practice at the fullest extent of their education (Institute of Medicine, 2010). This program may highlight the value of nurses. Exposing nurses to leadership roles among other medical professionals may help reduce this resistance. This doctoral project demonstrated the professional competence of nurses as educators, mentors, and providers.

Due to the need to educate caregivers about depression, there are many opportunities to transfer this educational program to additional locations. Depression is the most common mental illness in United States; however, due to lack of public knowledge, people endure the pain for a long time (Parle, 2012). Due to the recognition that primary care providers treat most patients with depression (Sharp & Lipsky, 2002), some healthcare organizations are incorporating specialized mental healthcare into primary practice. When depression manifests in early adolescence, both patients and parents receive patient education. However, adult patients often do not get this benefit (Sharp & Lipsky, 2002). Johnson et al. (2008) suggested educating family members about their loved one's illness to help improve patient outcomes. In my local practice, several caregivers have verbalized interest in participating in an educational program. Their interest has centered on the desire to support their loved ones by helping them understand and cope with depression.

When family and caregivers are involved in the care of patients with depression, management is more effective and patients achieve improved mental health. Education provides family caregivers with skills regarding communication and supportive community resources. Education may help family members embrace the importance of taking care of themselves. When family members are educated as to their loved one's illness, such education provides them knowledge and skills to improve the quality of life of their loved ones and their entire family, contributing to positive social change.

Summary

Depression interferes with an individual's daily life, causing pain to both the individual and family members. Despite the benefits of involving family members of patients with depression, providers underutilize family members when caring for patients. The target mental health facility had no educational program for patients' family members and caregivers.

This purpose of this project was to assemble a team of experts to develop and plan an educational program about living with depression. The participants are families and caregivers of patients diagnosed with depression. The administrator of the healthcare organization assembled a team of expert stakeholders to provide input and feedback during the development of the educational program. There will be an implementation and evaluation of the education program after the completion of this project.

Section 2: Background and context

Depression is a serious mental health problem and, if left untreated, can lead to disabling symptoms that affect an individual's quality of life. Clinicians must use the resources available, including family members whenever appropriate, to help improve the patient's outcome. Despite the benefits of involving family members of depression patients, providers underutilize family members when caring for patients. The target mental health facility had no educational program for patients' family members and caregivers. This purpose of this project was to assemble a team of experts to develop and plan an educational program about living with depression for families and caregivers of patients diagnosed with depression.

Conceptual Models

The Jean Watson theory of human caring focuses on the patient as a whole unit (Watson, 2008). The caregivers using the theory will help the patient gain a higher degree of harmony with the mind, body, and soul. Unlike some theories that focus solely on physical being, the theory of human caring is a good fit for issues related to mental health. This theory has four major components:

- Human beings: An individual who is valued, cared for, nurtured, and worthy of respect;
- Health: The connection between the mind, body, and soul. The mind, not just the physical body, has to be healthy;
- Nursing: Professionals in nursing who influence knowledge about health and illness. They incorporate caring with ethical care interactions; and

- Environment: A person’s environment is crucial to his or her well-being. For most patients, the environment will be their homes. Caregivers must receive proper education on how to care for their loved ones (Watson, 2008)

This purpose of this project was to assemble a team of experts to develop and plan an educational program for family and caregivers that could equip family members with the information needed to care for loved ones with depression. With the theory of human caring as the stating point, the caregivers may learn by doing, meaning that the interaction between them and their loved ones could foster caring. Including “health” as part of the four major components may help the caregivers understand that harmony within mind, body, and soul is associated with total well-being, not just the absence of physical illness. Including “Nursing” as part of the four major components may help signify that caregiving is part of the science of human health. Caregivers may learn how to cultivate a good relationship with the mental health professionals caring for their loved ones. Including “Environment” as part of the four major components may help caregivers reflect on creating a loving atmosphere that fosters healing.

Watson (2008) stated that individuals must learn caring. As such, each generation does not simply transfer caring to the next generation. Providing this educational program to family members or caregivers may improve their knowledge about depression and improve their decision making. For example, caregivers will learn signs and symptoms of depression that may help them communicate with providers on the symptoms their loved ones continue experiencing. Doing so may help providers know whether to increase dosage of current medications, or start different ones. Jean Watson’s theory promotes holistic health, not just physical health. Health is a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity (World health organization, 1984).

Relevance to Nursing Practice

Depression is one of the most common mental illnesses in United States. According to the World Health Organization (2011), persons with major depression are more likely to be disabled than those with other mental or behavioral disorders. The World Health Organization predicted that, by the year 2020, major depression would be second only to ischemic heart disease as a cause of disability (Gabriel, 2010). Stressing the prevalence and characteristics of depression in older adults, Gellis, Kenaley, and McCracken (2014) observed that nearly 5 million of the 31 million Americans over 65 suffer from clinically significant depressive syndromes. The researchers further revealed that adults 65 and above with depression in primary care are more likely to die than their counterparts without depression (Morrell et al, 2011). Morrell et al. (2011) added that 28% of older adults with depression living in nursing homes have received ineffective treatment or no treatment at all. Contending that the etiology of depression is often unclear, Gellis et al. (2014) stipulated that depression is not a normal experience of growing older; rather, older adults are at increased risk for experiencing this disorder. Good mental health is essential to maintain a healthy quality of life in the community and the society in general.

Effective management of depression is not just a patient goal; it is a family goal. The behaviors and mood of depressed patients affect the family and people around them (Marano, 2011). This can disrupt the family social balance, which may lead to a hostile environment. Marano (2011) also stated that an atmosphere of highly expressed emotion multiplies the chance of relapse by two to three times.

At the same time, families can be major forces of care, comfort, and cure. Family education helps tackle this issue in the context of depression. Stevens, Kinmonth, Peveler, and Thompson (1997) described the development of a comprehensive educational program for recognition and management of depressive illness. Educating family members and significant others about their loved one's condition cannot only help alleviate some of the burdens but can also help change the perceptions everyone has about this illness.

In a world of growing distrust of healthcare providers, good communication among patients, families, and providers is essential (Leggatt, 2002). The healthcare system faces several challenges. The financial burden is so overwhelming that the care of patients is sometimes compromised, often creating a disparity in healthcare (U.S. Bureau of Disease Collaborators, 2013). My experience is that there are disparities in family/caregiver involvement. Many caregivers do not know about their loved one's illness, and as a result, they are unable to help them. The inclusion of caregivers in the daily treatment of their loved ones with depression may lead to consistent positive outcomes. My experience is also that patients with mental illness are usually not consistent with their treatment regimen due to lack of monitoring. Consequently, family members should be included in their care to achieve the best clinical outcome (Rowe, 2013).

There needs to be a redesign of the healthcare system to reflect current issues and challenges facing the system. People now need collaborative efforts of patients, families, providers, government agencies, healthcare administrators, and policymaker. Several educational programs are available for people struggling with depression, such as the Depression and Bipolar Support Alliance (DBSA). They offer education and support to family members of patients with depression to deal with their illness. DBSA is peer-led. Most of their staff and board members live with a mood disorder. The fact that these individuals live with a mood disorder makes the alliance unique. The goal of educating family members and/or loved ones is to stop mentally ill patients from relapsing, help them return to the community, and allow them to live a normal life. To achieve these goals, family educational programs provide family members the skills needed to equip them in caring for their loved ones (Korn, 2015). The skills acquired may also help family members deal with the arduous task of caring for their loved ones and, thereby, promote the well-being of the whole family.

Wright (2008) examined the use of family/caregiver education in mental health. She stated that, in New Zealand, the people view Western culture as having a negative influence on family life. The use of a family/caregiver group conference in New Zealand engages both the professionals and the caregivers to help manage their clients' conditions. Wright also noted that such education promoted social inclusion and decreased the stigma often seen concerning mental health issues. She observed that this approach cultivated mutual trust among nursing professionals, people with mental illness, and their loved ones. Dixon et al. (2001) conducted a pilot study to explore the effectiveness of a family-to-family educational program. In this study, the National Alliance for Mentally Ill (NAMI) developed a structured 12-week program. Thirty-seven family members participated in this study in Baltimore, Maryland. Thirty (84%) of the participants were women. Thirty (81%) were Caucasian, seven (19%) were African American, and 21 (57%) were parents. Participants mean age was 55, with a *SD* of +/- 11.72 years, and their mean years of education was 14.9, with a *SD* of +/- 1.85 years.

Dixon et al. (2001) used a 51-item questionnaire as a tool to collect data. The caregiver interview included 24 questions from the Family Experience Interview Schedule (FEIS), which has well-established reliability and validity. The researchers also used a modified version of the Center for Epidemiological Studies-Depression (CES-D) scale to ask 25 questions on depression. The CED-D is a 20-item measure used by caregivers to rate how often symptoms associated with depression such as insomnia and agitation were experienced over the previous weeks (Dixon et al, 2001). Finally, they used a Family Empowerment Scale containing 27 questions. The researchers read the questionnaire to the participants over the phone. The phone interviews lasted 30 to 45 minutes each.

Findings suggested that the program increased the participants' knowledge about the causes and treatment of mental illness, their understanding of the mental health system, and their overall well-being. The researchers used a paired *t*-test (one-tailed) to compare baseline assessments with completion assessments. Additionally, the researchers intended to address the hypothesis that family/caregiver educational programs improve their knowledge about mental illness and empower them to care for their loved ones after the training. To determine whether the results at completion were sustained after 6 months, the researchers performed a paired *t*-test (two-tailed) between assessment at completion and at a 6-month follow up. The researchers also used a Bonferroni correction to minimize the possibility of Type 1 Error and required a *p* value of .004 or less. The scores indicated a greater level of empowerment from baseline to completion comparison: $t = 4.78$, $df = 36$, $p < .001$. A survey of the participants after the program supported this hypothesis. Based on post-education survey, the study supported the research that the caregivers are significantly less displeased and are more concerned about their family member who has mental illness after completing the program. Affective displeasure scores from baseline to completion comparison indicated the following result: $t = 3.46$, $df = 36$, $p < .001$. The researchers found that the results still existed 6 months after the program.

Dixon et al. (2001) used the Family Empowerment Scale to assess the family, community, and service. These subscales were rated on a scale of 1-5 with higher scores indicating greater sense of empowerment. The results showed that the Family Empowerment Scale mean score at baseline was 2.52, with a *SD* of .76, the mean score at program completion was 3.05, and the *SD* was .85. The mean score at a 6-month follow up was 3.01, with a *SD* of .70. The post-education survey showed that participants felt more empowered to care for their loved ones than they did at baseline; however, the authors acknowledged that the study was limited due to its small size and lack of control group. This study suggested that the educational program enhanced and empowered the family members' knowledge about mental illness, as well as how to care for their loved ones. The study concluded that the educational program improved patients' outcomes.

Carter-Gasque and Curlee (1999) studied a randomly selected sample of family members at a South Carolina hospital. The participants took a telephone survey to identify their needs for education, skill building, and support. There were 80 family members in this study. The researchers asked these family members about information and support needs in different areas. The researchers conducted the study to understand patients' families and their need for education and support. According to this study, support groups for family members of people with mental illness have inconsistent attendance due to a cultural norm of not "airing out dirty linen" in front of others.

To increase family member participation, Carter et al. (1999) conducted their study in a hospital setting. This is because it is easier to conduct the study while the participants are in the hospital visiting their loved ones. The majority of the participants expressed that they would not be able participate outside the hospital due to time constraints. The researchers used a 52-item survey to obtain information about the patients and their caregivers. The survey included several questions about the demographic data, information on the length of current hospitalization, and the effect of the illness on the family's lifestyle. The researchers also used a 13-item survey to gain information about family members' educational, skill building, and support needs. The number of times the patients had been hospitalized within the last 6 months served as a measure of the family's involvement with the patient. The researchers used this opportunity to educate the family members and identify needs in several areas. The family members expressed the most interest in individualized sessions with providers. Seventy-eight percent of respondents identified advocacy as the greatest need. The researchers explained advocacy to participants as acting or speaking on behalf of their family members to professionals. Education about mental illness, treatment, rehabilitation, and medication compliance issues were areas of second greatest need (76%), followed by education about side effects of medications (75%). Twenty-eight participants (35%) reported desiring more time with mental health providers. The results clearly showed that caregivers/family members are in need of education regarding mental illness and caregiving. The research also showed that family members are eager to learn, which means that mental health professionals have to engage caregivers when appropriate. The study concluded that mental health professionals should continue to make efforts to engage family members for the benefit of the patients.

The NAMI examined the outcome of an educational program on mental illness. This program was a 12-week course offered by NAMI for family members of adults with mental illness (Lucksted et al., 2011). This study, which evaluated the effectiveness of an educational program about mental illness, included 318 participants from five Maryland counties: the Baltimore metropolitan region, as well as Howard, Frederick, Montgomery, and Prince George’s counties. Trained volunteer family members taught classes using NAMI locations and schedules. Participants, randomly assigned to the class, were between the ages of 21 to 80 years of age and agreed to participate in the program. The researchers interviewed them during enrollment and 3 months later (at the end of study) regarding problem and emotion-focused coping, subjective illness burden, and distress.

The researchers used a linear mixed effects multilevel regression model to test for significant changes over time between intervention conditions (Lucksted et al., 2011). They evaluated problem-focused coping with empowerment and knowledge scales. The family empowerment scale has three subtitles: family (12 items), community (10 items), and service system empowerment (12 items). The researchers assessed knowledge about mental illness using a 20-item true/false questionnaire of accurate information (available from authors) covering material from the curriculum. Emotion-focused coping was measured using a 4-item COPE subscale measuring four dimensions: (a) seeking social support, (b) positive reinterpretation and growth, (c) acceptance, and (d) denial. Researchers have demonstrated good reliability and validity of the COPE scale with similar populations (Lucksted et al., 2011).

The researchers also evaluated subjective illness burden using the FEIS (Family Experience Interview Schedule) worry and displeasure scales (Lucksted et al., 2011). These measure the displeasure on an 8-item displeasure scale by rating it from zero to 10. They measured family functioning with the Family Assessment Device (FAD) and the Family Problem-Solving Communication Scale (FPSC). The FAD evaluates how the family functions and how they relate to each other. Researchers have widely used these scales to see how families respond to medical and/or physical illness. Researchers have established the reliability and validity of the scale. The findings showed that comparing participants who attended the family class (*n* = 116) with those in the control group revealed that the differences between both groups observed in the completer analysis persisted.

In addition to the previously noted findings for Lucksted et al. (2011), this narrower sample also showed significantly reduced depression as measured by the CES-D scale, Family to Family (FTF) baseline of 8.7 +/- 7.4, control group baseline of 9.1 +/- 7.4; FTF 3-month follow-up of 7.1 +/- 6.6, control group 3 month follow-up of 8.5 +/- 6.8 ; B +/- *SE* = -1.43 +/- 65; *t* = -2.19, *df* = 98, *p* = .031), and reduced overall distress as measured by the Brief Symptom Inventory (BSI) Global Severity Index (FTF baseline 51.9 +/- 9.1, control group baseline 52.3 +/- 9.4 ; FTF 3-month 49.6 +/- 8.4, control group 3-month 51.9 +/- 9.1 ; B +/- *SE* = -2.01 +/- 93 ; *t* = -2.17, *df* = 98, *p* = .032). The result of this randomized trial provides data to support the idea that brief family/caregiver-driven educational programs merit consideration as an evidenced-based practice. The result also showed significant improvement in problem-focused coping as measured by increased acceptance of their loved one's illness, as well as reduction in distress and improved problem-solving skills. The study concluded that family education is effective in enhancing and empowering families of persons with mental illness with the skills needed to care for their loved ones, thereby reducing undue distress and hospitalization. An independent research team of trained family assessors evaluated the families prior to the program, after completing the program, and 6 months after the program. Participants were assessed and measured on their knowledge on depression, assistance with daily living, social network, and attitudes towards professional.

Nurses play a vital role in promoting preventive health to patients and their families. The current state of practice in the treatment of depression is the use of psychotropic drugs. While it is easy to write a prescription to treat depression, according to recent studies, taking antidepressants alone is not the best therapeutic way of treating this illness (Olfson & Marcus, 2009). This is not to say prescribing antidepressants is an ineffective treatment. Every situation is different and has to be treated differently. However, providing education to caregivers about the illness seems to improve compliance with treatment regimens (Casey, Lal, & Wada, 2012). The researchers also had educational sessions on promoting family involvement in mental health. They found out that the idea of involving family members in mental healthcare is evolving, stipulating that the shift is due to three factors:

- Family advocacy and overwhelming evidence supporting positive effects of family involvement,
- Positive outcomes of individuals with mental illness, and
- Valuable contributions of families'/caregivers' service towards mental healthcare delivery.

Consequently, the Kirby commission in Canada started an effort to involve caregivers, and it improved the outcome of patients within a Canadian regional mental healthcare system (Kirby, 2008).

The Mental Health Services Research Program (MHSRA) addresses how education and support programs help family members and caregivers of people with mental illness. This program, called the Journey of Hope (JOH) family education course, examines the effectiveness of family/caregiver-led educational programs in improving their relative's mental illness. Some members of the NAMI founded JOH in 1993. This program was founded on the belief that families/caregivers are best suited to offer education and support to their relatives who suffer from mental illness.

The JOH teachers are trained volunteer family members who have relatives with mental illness. They volunteer their time to teach program participants different types of mental illness. They require all participants be family members or caregivers of a relative with mental illness. Since the beginning of this program, participants have noted the positive effects of participating in this educational program. They have stated that they gained knowledge about the causes of mental illness and better ways to manage their relatives' difficult behaviors. They also stated that it helped their relatives' health outcomes because it decreased hospitalization rates.

Local Background and Context

This project will focus on educating the family members/loved ones of patients with depression and improving communication between them and their loved ones. The fact that this program is free to participants and open to the public is a significant advantage of a program like this. Patients are not involved or connected to the program. The program will give the participants a broad knowledge about different types of depression, symptoms, what to expect, how to support their loved ones, and how communicate effectively. There will be no need for patient consent since the goal of the program is to impart knowledge, and the workshop will not use any patient's medical record. My observation is that providers in my practice setting rarely involve family members in the care of their adult loved ones due to concerns about privacy and confidentiality. Health Insurance Portability and Accountability laws make limit discussion of patients' illnesses without their consent, and state laws are even more stringent. In the practice that is the setting for this DNP project, family involvement in patient's care is not being used as a standard of care. Many patients are reluctant to include family members in their care. They complain their family members are not supportive and use derogatory names like "crazy" and "weird" to describe them. In this practice setting, the patients who do involve their family members in their care seem to do better overall. This is one of the reasons for this project. My experience is also that the patients often will not seek professional help until symptoms are worse, thereby resulting in being admitted in a residential setting.

Role of the DNP Student

Doctor of Nursing Practice practitioners are expected to comply with professional standards. They are also supposed to care for their patients while maintaining confidentiality. Nurse practitioners who are prepared at the doctoral level use evidence-based knowledge and apply it into clinical practice, thereby improving the health outcomes of their patients. Many mental health nurse practitioners do not include family members, even though they often hold the key to many unanswered questions (National Alliance on Mental Illness, 2017a).

As a provider, I find it fulfilling to see patients go from their worst to their best. There are several success stories, but one particular patient comes to mind whenever there is a discussion of the importance of family involvement and education. This 20-

year-old female had been struggling with ADHD and depression with psychotic features. Since she was an adult, she did not need parental consent or anybody to be present during visits. While she seemed knowledgeable \the first time she came to the clinic two years ago, because of her ADHD diagnosis, she forgot much of the educational instructions given to her regarding depression. She would forget to take her medication for days and then go into a psychotic episode. Even when the instructions were written down, she still would forget. She attempted suicide four times in a year and had to be placed in an inpatient setting during those times. One day she was asked to bring someone with her when coming for her next visit, and she agreed. A portion of her time during each visit was used to educate her parents on depression and ADHD, what to look for, when to be concerned, and what to do when she got into a psychotic phase. Within 3 months of educating the family, this patient became more stable, and the frequency of her psychotic episodes drastically reduced, keeping her out of the hospital. She ended up graduating from college one year earlier than anticipated. This patient is grateful that her family was involved in her care. She also initially expressed that she did not know the role of nurse practitioners and was reluctant to receive treatment from a nurse practitioner. However, her opinion changed during the length of her treatment. This case study is an important example of how this project can add value to the primary care setting in the management of patients with depression.

Educating the family members of depression patients brings the stakeholders closer to ending the stigma associated with mental illness. Mental health professionals need to involve family members or loved ones when caring for the patient. Research has shown that patients whose loved ones were involved in their care have a better outcome than those whose loved ones were not involved (Dixon et al., 2001).

Project Team

In addition to my participation, the team of experts that helped plan this educational program included a psychiatrist, a licensed therapist, a mental health nurse practitioner, registered nurse, two medical assistants, and two additional nurses. As a student, I developed and planned this program; it does not include implementation or data collection. Other practitioners will be implement and evaluate the program after completion of this project.

Summary

Generally, caring has often been synonymous with nursing, so it is only proper that a nurse would conduct this educational program for families/caregivers of persons with depression. DNP students possess the knowledge and leadership skills to conduct an educational program that will benefit people with mental illness, and advance nurse clinicians can engage in decision making about our current healthcare challenges. Since the caregiver’s ability to recognize early signs and symptoms of depression is dependent on their level of knowledge about this illness, educational programs for caregivers can increase awareness and facilitate early identification of a relapse. This free seminar will help family members and/or caregivers learn about depression and discover ways to help their loved ones.

Section 3: Collection and Analysis of Evidence

Depression is a serious medical problem that affects the entire body. Depression can lead to disabling symptoms that affects one's quality of life (Allen, 2005). There are many treatment options available, but people are often ashamed to seek treatment. Despite the benefits of involving family members of depression patients in caregiving, family members are underutilized. The target mental health facility is Georgia Behavioral Health Center in Smyrna, Georgia. The center does not have an educational program for patients' family members and caregivers. This purpose of this project was to assemble a team of experts to develop and plan an educational program about living with depression for families and caregivers of patients diagnosed with depression.

Practice-Focused Question

Family involvement helps treatment and has benefits, but the local facility, Georgia behavioral healthcare center underutilizes family members. The practice-focused question that guided this project was as follows: How can an evidence-based educational program be developed for family members and caregivers of patients with depression? The planning process of this educational program included a critical literature review in order to provide evidence-based education. An expert team from the local facility contributed input and feedback that was incorporated into the educational program.

Definition of Terms

Caregiver: This is someone who provides daily care such as bathing, cooking, cleaning, and medication administration without pay. This can be a parent, spouse, friend, neighbor, or any relative. Unmarried heterosexual and homosexual couples could also be caregivers for this program.

Depression: Depression is a mood disorder that negatively affects the way the person feels. It is a serious medical problem affecting the brain. There are various causes of depression, including genetic, psychological, environmental, and biochemical.

Education: Education is an act of acquiring knowledge through a learning process (“Education,” n.d.). Such a process can occur through reading or listening to a tutor. Education is a tool needed to help individuals to make better choices. The purpose of education is to give people the opportunity to learn about certain situations or acquire skills they would not ordinarily have.

Family: A family is the basic social unit consisting of parents and their children (“Family,” n.d.). This is also known as a traditional or nuclear family. There are other kinds of family. The single parent family consists of an unmarried adult together with his or her children. Blood relatives, such as uncles, aunt, cousins, nieces, and nephews are extended family.

Mental Illness: Mental illness involves any psychiatric condition that impairs the way someone thinks, reacts, or behaves. Depression is the most common cause of mental illness.

Stigma: Stigma is a perceived negative trait that causes people to degrade or think less of another human being. Stigma brings about shame, blame, hopelessness, distress, misrepresentation by the media, and reluctance to seek help (Parle, 2012). Selfstigmatization occurs when a stigmatized person starts to believe what people think about him or her.

Support Education: Support education is an approach used by mental health professionals to partner with family members or loved ones to impart knowledge about mental illness. It will help lay the groundwork for what the future will be for their loved ones (National Alliance on Mental Illness, 2017a).

Depression: An Overview of Diagnosis and Treatment

This educational program will address the different types of depression, symptoms, causes, and individual differences in experience of depression. The *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM) offers clinicians information and standards for classifying and treating mental disorders (American Psychiatric Association, 2013). Mental health providers assume that depression is because of a chemical imbalance (National Institute of Mental Health. (2015). This notion brought about the development of selective serotonin-reuptake inhibitors (SSRI), such as Prozac, Paxil, and Zoloft (National Institute of Mental Health, 2015). However, research has yielded little or no evidence to support this concept (Burns, 2014), and these medications do not work on everyone with depression. Moreover, even when they do work, it takes about 6 to 8 weeks for the patient to feel the effects, which makes researchers wonder whether serotonin imbalance is actually responsible for depression (Wall, 2014).

Types of Depression

Severity is one classification of depression: mild, moderate, or severe. Extensive clinical judgement is required to differentiate the severity of this illness. In addition to severity, there are several other specifically defined types of depression. The following section outlines a list of depression types.

Mild Depression

Symptoms of mild depression include insomnia, guilt, irritability, sadness, loss of interest, weight changes, fatigue, hopelessness, worthlessness, appetite changes, and suicide ideation. People with mild depression often go undiagnosed because their symptoms are not considered severe enough. However, prompt diagnosis and treatment of depression can prevent the condition from getting worse.

Moderate Depression

Symptoms of depression mentioned above are worse in moderate depression. Usually, patients are diagnosed with moderate depression if they have at least three symptoms of depression.

Severe Depression

This class of depression causes the most distress and agitation because symptoms are considerably worse (Gabriel, 2010). A person with this type of depression experiences most of the symptoms of depression. Suicide ideation is a concern with someone with this kind of depression.

Bipolar Disorder

Because of the alternating highs (manic moods) and lows (depressive moods), this type of depression is also known as “maniac depression.” People with this disorder have various mood swings. There are two forms of bipolar disorder: bipolar disorder 1 and bipolar disorder 2. Bipolar disorder 1 involves a longer period of mania and psychotic episodes, and bipolar disorder 2 has a shorter period of mania and no psychotic episode. Symptoms of mania include decreased need for sleep, pressured speech, racing thoughts, impulsivity, feelings of grandiosity, and excess energy (American Psychiatric Association, 2013).

Dysthymic Disorder

Long-term and on-going depression characterizes dysthymic disorder. Dysthymia does not hinder individuals from doing everyday routines even though the disorder is severe enough to disrupt relationships and responsibilities. Symptoms include sadness for no reason, apathy, irritability, and lethargy. Sufferers may also experience social withdrawal, anger, pessimistic attitude, and loss of libido (Krucik, 2016).

Cyclothymic Disorder

This disorder usually develops during early adulthood leading to chronic mood swings. This type of depression can last for several months, then stabilize, and then change again. People with this kind of depression rarely seek medical treatment due to the mildness of this disorder. Symptoms include change in appetite, self-confidence, and interest. This type of disorder is common in relatives of people who suffer from bipolar disorder (American Psychiatric Association, 2013).

Seasonal Affective Disorder

This type of depression affects most people throughout their life even though they may not know it. Practitioners observe seasonal affective disorder more where there is less sunshine. Winter is the most common time of the year people slip into this type of depression. People who suffer from this type of depression tend to eat and sleep more and may also experience weight gain and fatigue (American Psychiatric Association, 2013).

Sources of Evidence

In addition to my participation, the team of experts that helped plan this educational program included a psychiatrist, a licensed therapist, a mental health nurse practitioner, registered nurse, two medical assistants, and two additional nurses. Each expert contributed according to the area of expertise. A search of literature using research databases helped identify materials that cover the area of focus. The nursing database CINAHL has the ability to narrow a search to specific practice areas, evidence-based practice, and to search using medical subject headings. I searched for the right theory for the program using key concepts. I also used information from support groups about depression to gather information about the literature review.

This purpose of this project was to assemble a team of experts to develop and plan an educational program about living with depression for family members or caregivers of patients diagnosed with depression. I presented the results of the literature review to the team of experts. Meetings were held several times, discussions occurred, and feedback was provided. I compiled the feedback and brought the results back to the team.

Analysis and Synthesis

Each expert professional used a PowerPoint presentation to discuss relevant areas of expertise. I wrote down the minutes during meetings and presentations. After the team of experts finished their presentations, the team deliberated on each expert’s presentation, asked questions, and added missing information. The team agreed that the compiled information could address the practice-focused question: How can an evidence-based educational program be developed for family members and caregivers of patients with depression?

In addition to my participation, the team of experts that helped plan this educational program included a psychiatrist, a licensed therapist, a mental health nurse practitioner, registered nurse, two medical assistants, and two additional nurses. The team conducted regular meetings to review the project as it was being developed, evaluated the literature findings, made decisions about how the program fit into institutional processes, and made suggested changes as needed. Each expert teammate was involved where appropriate. For example, the therapist was involved in designing the topic on good communication skills. Each person presented ideas on assigned tasks during the meeting, and the team decided which materials to add. The team deliberated and made the final decision. I included a written record of the meeting results in the project final report to serve as a process evaluation of the project. The project included the development of program evaluation materials including pre- and posttests of participants’ knowledge of depression and the use of structured communication to convey information to their loved ones. This assessment may also help validate the ability of the program host in communicating effectively with their audience of family members. During post-test evaluation, family members will be expected to explain the signs and symptoms of depression, what to do when their loved ones are in crisis, and what to do in case of emergency. They will also be expected to verbalize their perception of their ability to communicate effectively. I collected the summative project evaluation of my performance at the end of the project (see Appendix B).

Team Member's Workshop Evaluation

The evaluation of the workshop was three-fold: planning the workshop as evaluated by team members, the team members' evaluation of each other's presentations, and participants' evaluation of the actual program (this last was not part of this project; for the sample workshop evaluation see Appendix A). Team members agreed that the content of the material met the needs of the workshop. Team members also agreed on the length of the course. Initially, they wanted to make it a 4-hour course facilitated over two days; however, they decided on an 8-hour course facilitated on one day instead because of the possibility of participants not returning the next day. Team members expressed that they liked the interactive nature of the presentation and the sense of comradery among team members. The team members did not like that the meeting ran over a few times. The team members agreed that only the common types of depression would be included if the workshop were to be repeated. Finally, the team members evaluated each other's presentations. Overall, the team members agreed that the presentations were well organized and provided useful information.

Team Members' Evaluation of DNP Student's Project

The team members evaluated me based on the planning of the workshop (see Appendix B). The team members agreed that I sent out agendas in a timely manner. They also agreed that I submitted the minutes in a timely manner. They agreed that meetings were held at the allotted time frame except for two incidents, when the meeting ran later than allotted due to starting late. Team members agreed that the meetings were productive. The team members agreed that they felt a sense of accomplishment in contributing to the planning of the workshop. The team members noted several areas in which they thought I excelled. One member stated that I was meticulous in my planning process; another noted that it was a "well thought out" project. Others echoed the same sentiments by stating that I was effective in facilitating the planning of the workshop. The team suggested that facilitating a workshop on depression and anxiety would be ideal since both illnesses often coexist.

Project Deliverables

Key deliverables for this DNP project included the informational/educational program in four sessions and a "how-to" manual for members of the primary care practice project team in the form of policies and procedures, which included criteria for participants to assure a good fit. The team developed a plan for implementation of the program and included it in the deliverables. In addition, the team members devised a full evaluation plan for the educational sessions, including tips for the program team members to analyze and synthesize feedback from participants to guide future educational sessions. I developed educational material describing these types of depression as part of the project. To validate the acquisition of knowledge, participants will be required to demonstrate, explain, and corroborate the information they receive. Participants (on the day of implementation) will be given educational materials on depression to help them understand the risk factors and warning signs to look for to assist in caring for their loved ones and to learn how to communicate effectively with their loved ones. The curriculum consists of several skill-building exercises that will help family members of patients with depression gain knowledge on how to listen, communicate, handle crisis and relapses, cope with worry and anxiety, and receive financial and respite support from the community. The curriculum consists of four 2-hour sessions. The goal for this program will be to encourage the following:

- Better communication between family participants and their loved ones,
- Improved satisfaction in their interactions with their loved ones, and
- Better understanding about depression.

The target audience includes family members or caregivers of patients with depression. The audience is not limited to family members/caregivers of people who come to the local facility; rather, it is open to the public. Members of the team will post flyers at medical centers within five miles of the facility. Participants will commit to coming to all five sessions. They cannot miss more than 10% of the information taught during these sessions. In addition to my participation, the team of experts available to implement this educational program includes a psychiatrist, a licensed therapist, a mental health nurse practitioner, registered nurse, two medical assistants, and two additional nurses. Team members were aware of their roles throughout the planning phase. As a

DNP student, I developed this program, which includes a plan for implementation and evaluation. However, other practitioners will implement and evaluate the program after completion of this project. The researcher sent a flyer to recruit team members and volunteers for the planning of the workshop (see Appendix D). The program was not implemented.

Summary

This project examined the following question: How can an evidence-based educational program be developed for family members and caregivers of patients with depression? In order to answer the question, the researcher completed a thorough literature search and obtained the input of a team of experts to create an evidence-based program regarding depression for family members. The deliverables of this project were the educational program materials and plans for implementation and evaluation of the program.

Section 4: Findings, Discussions and Implications

Introduction

Despite the evidence that involved family members can have a beneficial influence on the management of patients with depression, the participating facility, Georgia Behavioral Health Center did not have a program targeted to family members, creating a gap in practice. The practice-focus question that guided this project was the following: How can an evidence-based educational program be developed for family members and caregivers of patients with depression? This purpose of this project was to assemble a team of experts to develop and plan an educational program for people living with depression. I developed this educational program after a thorough review of the literature and input from a team of local experts.

Findings and Implications

Findings from the literature review showed that educating caregivers about mental illness improved the lives of their loved ones and decreased social isolation and stigma (Wright, 2008). The expert team used NAMI's national guidelines as a guide in the development of this educational program. NAMI's support group follows a structured model, which includes the following characteristics:

- Free to all participants,
- Involves caregivers of individuals (18+) with mental illness,
- Meets weekly or monthly,
- Maintains confidentiality,

- Usually led by family members/caregivers of individuals living with mental illness, and
- Makes no medical or therapy endorsements (National Alliance on Mental Illness, 2017b).

In addition to my participation, the team of experts that helped plan this educational program included a psychiatrist, a licensed therapist, a mental health nurse practitioner, registered nurse, two medical assistants, and two additional nurses. These experts met with me to plan the program, and I coordinated the meetings. A schedule of potential time frames was made and the team picked times that worked best with their schedules. During the meetings, the teammates used PowerPoint presentations to facilitate discussion regarding how people with depression can manage their illness and live a fulfilling life. The team also discussed how incorporating psychotherapy and pharmacotherapy could ultimately improve the individual's outcome. The team agreed that involving a trusted loved one in the care of an individual with depression improves the life of the individual suffering from depression. After each meeting, team members evaluated the contents of the workshop and my performance as a coordinator (see Appendices A and B). The team of professionals created the educational program to address this gap in practice using their expertise to provide knowledge, tools, and coping skills to help the caregivers care for their loved ones. The team of experts attended bi-weekly meetings.

According to area of expertise, the team members developed handouts for the potential participants of this educational program. The content of the material is an evidence-based teaching method on depression. Team members used PowerPoint presentation to present the content of the material. The content of the material is consistent with NAMI guidelines for support groups.

The results of the facilitated team meetings were the deliverable work products of this project. These deliverables included the informational/educational program in four sessions and a "how-to" manual for members of the primary care practice project team in the form of policies and procedures, including criteria for participants to assure a good fit. Team members developed an implementation plan of the program included in the deliverables, along with a plan for evaluating the educational sessions. At the completion of the project, I handed over the deliverables to the facility, at which time the team and stakeholders at the organization approved the educational program and related materials.

The results of the project evaluation from the team of experts were positive. They agreed that the program content met their needs. The length of the workshop meetings received mixed reviews, as some team members felt that the length of the meetings was too long while others thought it was adequate. The team members unanimously expressed their interest in the topic of the project. They felt that it would help many families deal with this mental health issue. The team also agreed that if the course were to be repeated, it should focus on only the major and more common types of depression, such as major depression and bipolar depression. The team also strongly agreed that the meeting objectives were met and each team member's presentation in the area of expertise was organized, thoughtful, and clearly stated. Team members were responsive to questions asked, the use of PowerPoint presentations, and collaborative teaching style.

I gave evaluation questionnaires with 12 questions (see Appendix A) to 15 team members. Twelve questionnaires were completed; of these 12 received, 10 of them gave a perfect score of 100% to the questions. Of the remaining two, there was a 10% deduction (score of 90%) for the length of the course. The deduction was due to the meetings lasting longer than stated a few times.

During the workshop meeting, there was a mild disagreement between the psychiatrist and the mental health nurse practitioner. The nurse practitioner stated that she normally does not treat seasonal affective disorder depression with medication since it only affects individuals during certain times of the year (mostly winter). Instead, the nurse practitioner treats individuals with this disorder with light therapy, which involves sitting in front of a light box for a period each day. The psychiatrist, on the other hand, uses antidepressants to treat these individuals. Both parties resolved this disagreement in agreeing that each individual’s response to treatment is different and requires different treatment.

Findings during the meeting also included improvement in professional skills. Team members stated that they learned from each other. After the team members agreed on the content of the project, the team presented the materials to the administrators who then presented them to the senior leaders. The process took about 3 weeks. Finally, the project was approved for implementation. The administrators of the organization expressed their appreciation for the team members’ hard work in putting the program together. They complimented me on my leadership skills. Overall, they concluded that the planning and development of this project was a success.

The team members evaluated my performance as a facilitator and a student. They agreed that agendas for the meetings were sent out in a timely manner, that minutes were submitted on time, that meetings were on time (with a few exceptions), that the purpose of the meetings was achieved each time met, that each team member contributed to the success of the workshop, and that the student was diligent in coordinating the workshop.

The implications of these findings include the overall well-being of the individuals with depression or mental illness, as well as decreased stigma of mental illness among the community and institutions. Probably the most important of all is the decrease in hospitalization. Potential implications of positive change include collaboration between primary care providers and mental health providers to offer better care for individuals with depression. Because symptoms of depression are controlled, sufferers can maintain gainful employment that helps their economic status. Conversely, the workshop promoted interdisciplinary collaboration among providers in mental health settings that could also improve patients' health outcomes.

Recommendations and Implementations

As noted, a gap exists in practice wherein caregivers are not involved in the care of their loved ones with mental illness. According to the literature, caregivers need training to help understand the etiology of depression, to support their loved ones, and to involve medical professionals when necessary (Leggatt, 2002). Members of the expert panel at the center plan to have about 25 caregivers of individuals suffering from depression come to a mental health fair for the program. It will be an 8-hour day with an hour lunch break. Members of the expert panel will serve as speakers for a section that pertains to their areas of expertise. At the end of the workshop, the facilitators will use an evaluation tool to evaluate the effectiveness of the program, the tools used, and the content of the materials (see Appendix A). There will be a 6-month follow-up on the participants of the program to see if they retained knowledge instilled in them during the program.

Upon completion of the development of this educational program, team members went through the material and agreed on the final content. After that, the material went to the stakeholders of the organization for approval. Upon approval, other practitioners will implement this program after I complete the DNP degree. The team members will disseminate the program evaluation to the participant to fill out at the conclusion of the program (see Appendix B).

Contributions of the Doctoral Project Team

In addition to my participation, the team of experts that helped plan this educational program included a psychiatrist, a licensed therapist, a mental health nurse practitioner, registered nurse, two medical assistants, and two additional nurses. The psychiatrist and mental health nurse practitioner shared their roles and responsibilities. They talked about several pharmacological treatment options on depression. The licensed therapist talked about how to use coping skills to deal with depression. The registered nurse talked about how caregivers can show care by using therapeutic touch, open-ended question and the use of empathy when interacting with their loved ones. The two medical assistants and two additional nurses will help with nonmedical needs like directing the participants on what to do, answering phone calls, arranging seats, serving food, and answering non-medical questions. Because of the success of the planning of this project, the organization suggested that the team plan similar projects for parents with children suffering from attention deficit hyperactive disorder (ADHD).

Strengths and Limitations

A strength of this project was the involvement of expert mental health professionals in its planning and development stages. Another strength was the content of the project, as the content follows NAMI guidelines on caregiver support. The third strength is that this educational program is free of charge to adult caregivers of people with depression. A limitation of this program is the narrowing of the content of the program to only depression. Even though depression is the most common type of mental illness (National Institute of Mental Health, 2015), there are other common mental illnesses, such as anxiety, that could have been added in the program.

Section 5: Dissemination Plan

This purpose of this project was to assemble a team of experts to develop and plan an educational program about living with depression. The participants of the workshop will be caregivers of people with depression. The result of the findings and the content of this educational program will be shared with other staff members at a designated time before implementation. In addition to my participation, the team of experts that helped plan this educational program included a psychiatrist, a licensed therapist, a mental health nurse practitioner, registered nurse, two medical assistants, and two additional nurses. These team members had several bi-weekly meetings, some in person and some by conference calls, to discuss the content of the material, which included handouts for dissemination to the participants. Each professional contributed using individual expertise. During the meetings, the professional presented their assigned parts, making amendments according to suggestions by team members. At the end of each meeting, all team members agreed on the content of the agenda for that day and the schedule for the next meeting. After the completion of the program development, team members sent the completed program to the stakeholders of the organization for approval and set aside a day for implementation. Upon completion of this DNP project, the team will have the educational handouts to proceed with implementation. Other practitioners will implement the plan after I complete the DNP degree.

The participants will be caregivers of people with depression. The venue will be a mental health facility in the southern United States. The participants will evaluate the implementation team after the program. The findings of this project suggest that persons living with depression can live a fulfilling life if they take care of themselves using their treatment regimen and surround themselves with caring loved ones. I communicated these findings to the stakeholders of the facility. They agreed that this topic receives little attention or discussion. The researcher's employer and co-workers were also pleased with the outcome of the educational program and wants me to plan one for the facility next year. Educating loved ones about depression will help them care for their family members or friends, which helps them better cope with their illness. The workshop was a good experience for the professionals. They were able to learn from each other. Because of the positive response to this workshop by the team members, the researcher will likely develop and present a poster presentation on this topic at a national conference.

Analysis of Self

The word *scholar* involves life-long learning. One of the reasons why I pursued a doctorate was to acquire more knowledge that would be beneficial to my patients. The scholar-practitioner model presents an opportunity for self-renewal, sustaining the zeal or passion of learning, even as one experiences changes (Herbet, 2006). As an effective nurse leader, people often describe me as being a visionary, one who has plans to direct a team to a specific goal. As nurses, we always strive to do our best for our patients. As a practitioner, I seek to improve care for my patients since I am able to do more for them as a provider.

Leadership roles are different from managerial functions. Management is doing things right; however, leadership is doing the right things (Covey, 2006). Another quality of a good nurse leader is having collaborative leadership skills. This kind of leadership is effective when leading people who are motivated and able to work hard without coercion. A good leader must be familiar with different leadership styles and use each style according to each kind of subordinate.

As a DNP student and a leader, I know it is important to adapt to the ever-changing healthcare system. Nurse leaders have to lead and deliver top-notch care, often in challenging and changing environments. Throughout this project, I used the leadership skills acquired throughout the program to work and collaborate with other professionals to develop this program. With strategic solutions, I could understand my own abilities and limitations and effectively confront obstacles. A long-term professional goal will be to assist the team members to implement this program after graduation. I used a project evaluation for the analysis of self after every meeting (see Appendix B).

Summary

This purpose of this project was to assemble a team of experts to develop and plan an educational program about living with depression. The participants will be caregivers of people with depression. Based on the literature review and the NAMI guidelines for support groups, an evidence-based program and PowerPoint presentations were created. Implementation of this education program may help caregivers/family members support their loved ones’ compliance with their treatment regimen, which, in turn, improves their outcomes and decreases hospitalization. When family members are educated as to their loved one’s illness, it gives them the knowledge and skills to improve quality of life of their loved ones and their entire family, contributing to positive social change.

References

AARP. (n.d.). Chronic conditions among older Americans. Retrieved from https://assets.aarp.org/rgcenter/health/beyond_50_hcr_conditions.pdf

Aiken, L. H., Cheung, R. B., & Olds, D. M. (2009). Education policy initiatives to address the nurse shortage in the United States. *Health Affairs, 28*(4), w646–w656. https://doi.org/10.1377/hlthaff.28.4.w646

Allen, J. G. (2005). *Coping with depression*. Houston, TX: The Menninger Clinic.

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Anderson, M., & Cannova, L. (2015). 50 years of mental health hope and struggle: 1957-2007. Retrieved from http://www.crimeandjustice.org/councilinfo.cfm?pid=54

Burns, D. (2014). Is clinical depression the result of a chemical imbalance or something else? [Blog Post]. Retrieved from https://www.quora.com/Is-clinical-depression-the-result-of-a-chemical-imbalance-or-something-else

Carter-Gasque, K., & Curlee, M. B. (1999). The educational needs of families of mentally ill adults: The South Carolina experience. *Psychiatric Services*, *50*(4), 520–524. https://doi.org/10.1176/ps.50.4.520

Casey, R., Lal, S., & Wada, M. (2012). Promoting a culture of family involvement in mental health. *Occupational Therapy Now*, *14,* 8–10.

Centers for Disease Control and Prevention (2011). *Mental health basics*. Retrieved from http://www.cdc.gov/mentalhealth/basics.htm

Covey, S. (2006). *The seven habits of highly effective people*. New York, NY: Free Press.

Dixon, L., McFarlane, W., Lefley, H., Lucksted, A., Cohen, C., Falloon, I., . . . Sondheimer, D. (2001). Evidence-based practices for services to family members of people with psychiatric disabilities. *Psychiatric Services*, *52*(7), 903–910. https://doi.org/10.1176/appi.ps.52.7.903

Easson, E., Giacco, D., Dirik, & A., Priebe, S. (2014). Implementing family involvement in the treatment of patients with psychosis: A systematic review of facilitating and hindering factors. *British Medical Journal, 4*(10), 1–12. https://doi.org/10.1136/bmjopen-2014-006108

Education. (n.d.). In *Merriam-Webster's online dictionary.* Retrieved from https://www.merriam-webster.com/dictionary/education

Family. (n.d.) In *Oxford Advanced Learner's Dictionary*. Retrieved from http://www.oxfordlearnersdictionaries.com/us/definition/english/family_1?q=family

Gabriel, A. (2010). Depression literacy among patients and the public. A literature review. *Primary Psychiatry, 17*(1), 55–64.

Gellis, Z. D., Kenaley, B. L., McCracken, S. G. (2014). Depressive disorders literature review. Retrieved from http://cswediamaxsite.cswe.org/default.aspx?id=27895

Herbet, T. R. (2010). The scholar-practitioner concept and its implications for self-renewal: A doctoral student's perspective. *Scholar-Practitioner Quarterly*, *4*(1), 33–41.

Institute of Medicine. (2010). *Forum on the future of Nursing: Care in the community.* Washington DC: The National Academics Press.

Johnson, B., Abraham, M., Conway, J., Simmons, L., Edgman-Levitan, S., Sodomka, P., . . . Ford, D. (2008). *Partnering with patients and families to design a patient and family-centered healthcare system*. Cambridge, MA: Institute for Family-Centered Care.

King, S. E., & Hanson-Turton, T. (2010). Nurse-managed health centers. In E. M. Sullivan-Marx, D. O. McGivern, J. A. Fairman, & S. A. Greenberg (Eds.), *Nurse Practitioners: The evolution and future of advanced practice* (pp. 183–198). New York, NY: Springer.

Kirby, M. (2008). Mental health in Canada: out of the shadows forever. *Canadian Medical Association Journal*, *178*(10), 1320-1322.

Korn, M. L. (2015). A psychoeducational program for the chronically mentally ill. Retrieved from http://www.medscape.org/viewarticle/418620.

Krucik, G. T. (2016, August 29). Symptoms of depression [Blog Post]. Retrieved from http://www.healthline.com/health/depression/symptoms

Ledford, H. (2014). Medical research: If depression were cancer. *Nature, 515*(7526), 182–184. https://doi.org/10.1038/515182a

Leggatt, M. (2002). Families and mental health workers: The need for partnership. *Journal of the World Psychiatric Association 1*(1), 52–54.

Lucksted, A., Dixon, L. B., Medoff, D. R., Burland, J., Stewart, B., Lehman, A. F., … Swank, A. (2011). Outcomes of a randomized study of a peer-taught family-to-family education program for mental illness. *Psychiatric Services*, *62*(6), 591–597. https://doi.org/10.1176/ps.62.6.pss6206_0591

Marano, E. H. (2011, March). Depression: A family matter. *Psychology Today.* Retrieved from https://www.psychologytoday.com/articles/200203/depression-family-matter

Mayo Clinic. (n.d.). Depression in women: Understanding the gender gap. Retrieved from http://www.mayoclinic.org/diseases-conditions/depression/in-depth/depression/art-20047725

Morrell, C. J., Curran, S., Topping, A., Shaik, K., Muthukrishnan, V., & Stephenson, J. (2011). Identification of depressive disorder among older people in care homes- a feasibility study. *Primary Health Care Research and Development*, *12*(3), 255–265. https://doi.org/10.1017/s1463423611000144

National Alliance on Mental Illness. (2017a). Family members and caregivers. Retrieved from https://www.nami.org/Find-Support/Family-Members-and-Caregivers

National Alliance on Mental Illness. (2017b). NAMI Family support group. Retrieved from https://www.nami.org/Find-Support/NAMI-Programs/Nami-Family-Support-Group

National Institute of Mental Health. (2015). Major depression among adults. Retrieved from https://www.nimh.nih.gov/health/statistics/prevalence/major-depression-among-adults.shtml

Olfson, M., & Marcus, S. C. (2009). National patterns in antidepressant medication treatment. *Archives of General Psychiatry*, *66*(8), 848–856. https://doi.org/10.1001/archgenpsychiatry.2009.81

Parle, S. (2012). How does stigma affect people with mental illness? *Nursing Times, 108*(28), 12–14.

Rowe, J. (2013). Is mental healthcare a family affair? Retrieved from http://www.open.edu/openlearn/body-mind/health/nursing/mental-health-care-family-affair

Saver, B. G., Van-Nguyen, V., Keppel, G., & Doescher, M. P. (2007). A qualitative study of depression in primary care: Missed opportunities for diagnosis and education. *Journal of the American Board of Family Medicine, 20*(1), 28–35. https://doi.org/10.3122/jabfm.2007.01.060026

Sharp, L. K., & Lipsky, M. S. (2002). Screening for depression across the lifespan: A review of measures for use in primary care settings. *American Family Physician, 66*(6), 1001–1008.

Stevens, L., Kinmonth, A. L., Peveler, R., & Thompson, C. (1997). The Hampshire Depression project: Development and piloting of clinical practice guidelines and education about depression in primary health care. *Medical Education, 31*(5), 375–379. https://doi.org/10.1046/j.1365-2923.1997.00670.x

U.S. Bureau of Disease Collaborators. (2013). The state of US health, 1990 – 2010: Burden of diseases, injuries, and risk factors. *Journal of American Medical Association*, *310*(6), 591–608. https://doi.org/10.1001/jama.2013.13805

Wall, T. (2014, September 9). Rethinking serotonin’s role in clinical depression [Blog Post]. Retrieved from http://www.huffingtonpost.com/teagan-wall/rethinking-serotonins-role-in-clinical-depression_b_5781664.html/

Watson, J. (2008). *Nursing: The philosophy and science of caring*. Boulder, CO: Colorado University Press.

World Health Organization. (1984). *The spiritual dimension in the global strategy for health for all by the year 2000.* Retrieved from http://apps.who.int/iris/bitstream/10665/160950/1/WHA37_R13_eng.pdf

World Health Organization. (2011). *Global status report on non-communicable diseases*. Retrieved from http://www.who.int/chp/ncd_global_status_report/en/

Wright, T. (2008). Using family group conference in mental health. *Nursing Times, 104*(4), 33-34.

Appendix A: Sample Workshop Evaluation

A. Course Design (Circle the number to indicate your level of agreement/disagreement with each of the aspects of course design.)

		Strongly agree				Strongly disagree
1.	The program content met my needs.	1	2	3	4	5
2.	Length of the course was adequate	1	2	3	4	5

3. What did you like most about the course?

4. What specific things did you like least about the course?

5. If the course was repeated, what should be left out or changed?

B. Course objectives (Circle the number to indicate your level of agreement/disagreement with the degree to which course objectives were met.)

Strongly agree Strongly disagree

1. Understanding of prevalence of depression 1 2 3 4 5

2. Skills development in the area of communication with loved ones
1 2 3 4 5

3. Increase knowledge in the area 1 2 3 4 5
of types of depression

4. Awareness of available psychological and 1 2 3 4 5
pharmacological treatment of depression
    1. Information on how to support their loved ones emotionally
1 2 3 4 5

6. Knowledgeable of responsibilities of a caregiver 1 2 3 4 5

7. Knowledge of available support groups for families and
Caregivers of mentally ill persons 1 2 3 4 5

8. Increase knowledge of policy issues that affect people with mental illness
1 2 3 4 5

C. Evaluation of each team member presenter in stated area:

		Strongly agree				strongly disagree
1.	Content was presented in an organized	1	2	3	4	5
2.	Content was presented clearly and effectively	1	2	3	4	5
3.	Was responsive to questions/comments	1	2	3	4	5
4.	Teaching aids/audiovisuals were used effectively	1	2	3	4	5
5.	Teaching style was effective	1	2	3	4	5
6.	Content met stated objectives	1	2	3	4	5
7.	Content presented was applicable to my practice	1	2	3	4	5

D. As a result of attending this course, I see the value to me in the following ways (check all that apply):

___I gained one or more specific ideas that I can implement at home with my family member

___I learned a new approach to addressing mental health issues with my loved one

___It may help me do a better job.

___I do not see the impact of this course on my role as a caregiver.

___Other

E. By attending this course, I believe (check all that apply):

___I was able to update my skills.

___I acquired new and/or advanced skills.

___I have better knowledge upon which to base my decisions/actions when caring for my loved one (s).

___I am reconsidering my views toward the topic(s) presented.

___The topic presented was appropriate, but I am undecided as to my own views.

___Other

E. Facilities/Arrangements (Circle the appropriate number to indicate your level of satisfaction or circle NA if the item is not applicable to you.)

	Unsatisfactory			Satisfactory		
1. Lodging	1	2	3	4	5	NA
2. Food Services	1	2	3	4	5	NA
3. Meeting rooms and facilities	1	2	3	4	5	NA
4. Restrooms	1	2	3	4	5	NA
5. Day of week	1	2	3	4	5	NA
6. Time of day	1	2	3	4	5	NA
7. Location	1	2	3	4	5	NA

Comments:

Overall, I would rate this workshop as:

___Excellent

___Good

___Average

___Poor

Other learning needs: (List any other topics you would be interested in for the future

Appendix B: Sample Team Evaluation

Stakeholder/Team member Evaluation of DNP Project

Problem:

Q6 Were meeting agendas sent out in a timely manner? ___ ___ ___ ___ ___

Q7 Were meeting minutes submitted in a timely manner? ___ ___ ___ ___ ___

Q8 Were meetings held to the allotted time frame? ___ ___ ___ ___ ___

Q9 Would you consider the meetings productive? ___ ___ ___ ___ ___

Q10 Do you feel that you had input into the process? ___ ___ ___ ___ ___

Q11 Please comment on areas where you feel the DNP student excelled or might learn from your advice/suggestions.

Appendix C: Table of Scores

Team members	**The program content met my needs.**	**Length of the course was adequate**	**What did you like most about the course ?**	**What specific things did you like least about the course ?**	**If the course was repeated , what should be left out or changed?**	**Content was presented in an organized 1 2 3 4 5**	**Content was presented clearly 1 2 3 4 5 and effectively**	**Was responsive to questions/comments 1 2 3 4 5**	**Teaching aids/audiovisuals were used effectively 1 2 3 4 5**	**Teaching style was effective 1 2 3 4 5**	**Content met stated objectives 1 2 3 4 5**
Member #1											
Member #2											
Member #3											
Member #4											
Member #5											
Member #6											
Member #7											
Member #8											
Member #9											
Member #10											
Member #11											
Member #12											
Member#13											
Member #14											
Member #15											

Appendix D: Distributed Flyer

Family and caregiver education day planning
Committee sign up

When: November 20th 2016 from 3pm to 7pm

Location: Georgia Behavioral Health Center

Address: 4015 South Cobb Drive, Smyrna GA Suite 115

Signing up does not guarantee participation. Chosen professionals and volunteers will be notified by phone

Who may participate: Mental health professionals and volunteers.

Childcare is not provided. There is no cost to attend and dinner is included.

Topics will include signs and symptoms of depression, what is depression, types of depression, treatment of depression (psychotherapy and pharmacotherapy), family support and planning

Contact Ngozi Okoro at 678-361-0116 for further information