Calm Down Collective

by

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Abstract

Calm Down Collective evaluated three established EBPs at the Department of Veteran's Affairs and implemented their strengths into a new program that would supplement the mental health care they currently offer clients. The goal of Calm Down Collective is to help the client learn how to process incoming sensory disruptions to effectively utilize the cognitive work that should follow and alleviate the immediate symptom. The program will use a mixed-method quasi-experimental evaluation with a nonequivalent switched replication design for the participant's portion of the study and a cross-sectional survey for staff respondents. It is hypothesized that more than 50% of participants should be able to self-identify stress or sensory disruptions. The second hypothesis is that they should be able to intervene on their own behalf with the sensory aides provided by the program at least 75% of the time by their final phone interview. Using a paired T-test, pre-test and post-test survey data will be compared to mark a progression in self-regulation as well as assess any change in symptoms using the PSSI-5 PTSD Symptom Scale Interview. The Calm Down Collective will support the dominant treatment plan by providing additional coping skills in the gaps where the client is learning how to self-regulate.

Introduction

Teaching a client to self-regulate and knowing they have the tools and skills to apply it when they are in their world are two very different truths. Addressing the need for additional support while receiving the proper tools and reinforcements is the Calm Down Collective's goal. This paper is providing the background issue and development process of the Calm Down Collective and its descriptions along with the evaluation plan.

The Mental Health segment of the U.S. Department for Veteran's Affairs (V.A.) has a mission "to fulfill President Lincoln's promise 'To care for him who shall have borne the battle, and for his widow, and his orphan" by serving and honoring the men and women who are America's veterans" (va.gov, 2018). To uphold this mission in the face of new mental health challenges, they have coordinated with the National Center for PTSD. They boast being "the world's leading research and educational center of excellence on P.T.S.D. and traumatic stress" (ptsd.va.gov, 2020) for the veteran population. Treatment options include three trauma-focused psychotherapies, also called Talk Therapy, antidepressants, and "suggested treatments with some research support" (ptsd.va.gov, 2020) or any combination of them to choose from. Prolonged Exposure, Cognitive Processing Therapy, Eye Movement Desensitization, and Reprocessing (E.M.D.R.) are Talk Therapies with strong research support. Brief Eclectic Psychotherapy, Narrative Exposure Therapy, Written Narrative Exposure, and Specific Cognitive Behavioral Therapies are four additional trauma-focused psychotherapy options. Each of these programs is a tool to be used to help "trauma survivors [to] feel safe in the world and live happy and productive lives" (ptsd.va.gov, 2020). This evaluation will focus on the E.M.D.R. and Cognitive Processing Therapy. All skills, techniques, and modifications learned during the program are expected to be applied as necessary in their daily lives. Its purpose is to offer a supportive and

supplemental program that aids in reducing P.T.S.D. symptoms with the utilization of tools in addition to clinical therapy options.

Problem Statement

P.T.S.D. is characterized by the inability to self-regulate cognitions and emotions. This can look like the inability to calm oneself or down-regulate, when no immediate threat is present, the need for excessive control, leading to decreased arousal and dissociative symptoms (Zweerings et al., 2018). The risk is in the severity of the diagnosis. The more severe the symptoms, the more impaired their emotional self-regulation, risk-taking, and impulsive behaviors are. This inability to self-regulate makes it difficult for those who suffer from P.T.S.D. to function in their daily life. What would normally have been a simple task becomes paralyzing when their fight or flight response system has kicked in, and they can no longer calm themselves down to know they are safe. Their impulsive and risk-taking behaviors have them seeking other outlets such as drugs, gambling, and sex to compensate or numb themselves from the overwhelming singular emotion they are experiencing. As symptoms become more severe, the sufferer also begins to experience depressive episodes and potential suicidal ideations or actions.

This is significant because, in 2018, seven percent of our population, or 18 million people, identified themselves as veterans (Census.org, 2018). According to Cohen Veteran Bioscience, 8.1 million adults in the United States have a P.T.S.D. diagnosis establishing a 10% to 20% prevalence of P.T.S.D. in post-deployment U.S. infantry personnel. P.T.S.D. is also highly comorbid, meaning it presents with other illnesses at the same time, such as depression, anxiety, and suicidality. The increased long-term risk of these issues coexisting with P.T.S.D. is heart disease, obesity, and many other mental health disorders (cohenveteranbioscience.org, 2020). As P.T.S.D. often takes time to diagnose due to delayed symptom onset and service

members postponing treatment until they get out in order to continue their mission. The U.S. Veteran's Affairs website details 15% of Vietnam-era veterans, 12% of Desert Storm era veterans, and 11%-20% of Operation Iraqi Freedom and Enduring Freedom veterans who have P.T.S.D. (ptsd.va.gov, 2020). It is also important to note that women are more than twice as likely to develop P.T.S.D. as men (Vernor, 2019)

The Homeless Patient Aligned Care Teams Program (H-PACT) acts as a protective factor for this population against mental health and self-regulation for the veteran population and its homeless subset who cannot make it to the V.A. hospital itself. The V.A. established the H-PACT program to address the long-term needs and goals of sustaining all health through housing. Nevertheless, clients are still struggling to cope with the daily symptoms of P.T.S.D. that arise. Those who are still on active duty have instilled protective factors of a tight community, regular daily exercise, peers for social support, and even leadership that ensures they are maintaining their health if they do not have a significant other. The risk comes in their separation.

Once they retire or approach their expiration of time of service (E.T.S.), they begin to lose all their protective factors that came with being an active service member. Learning how to integrate into the veteran community can be stressful. Should a veteran's mental health deteriorate and they can utilize a Domiciliary Residential Rehabilitation Treatment Program (D.R.R.T.P.s) provided by the V.A. Here they receive instant access to 24/7 care for the duration of their stay. The lack of mental health support aids or tools when access to direct and instant care is not possible is a risk for this population. Coping mechanisms only work when one can function to work through them. Unlike medical care, where aids and devices are provided upon

referral (e.g., toilet seat risers, canes), mental health aides such as journals, stress balls, Zen gardens, or fidget devices are required to be obtained by the veteran.

Calm Down Collective

The Calm Down Collective's goal is to help the client learn how to process incoming sensory disruptions to effectively utilize the cognitive work that should follow and alleviate the immediate symptom.

Evidence-Based Program Development Process

All the programs evaluated this far provide generous support in managing mental health issues among the veteran population. Eye Movement Desensitization Reprocessing (E.M.D.R.) boasts a significant decrease in P.T.S.D. symptoms after single-incident trauma memory in 3-6 sessions 77%-100% of the time (Hurley, 2018). However, once a client returns home, they are still required to self-regulate through disorders that can often impair their sensory processing ability (Yeckel, 2018). Calm Down Collective aims to supplement these programs with sensory-based items and training for the client to implement into their daily routine for continued recovery. Calm Down Collective utilizes strengths found in E.B.P.s already provided at the V.A., such as E.M.D.R., H-PACT, and Cognitive Processing Therapy, to supplement their skillsets and help the client learn how to process incoming sensory disruptions to effectively utilize the cognitive work that should follow and alleviate the immediate symptom. The E.M.D.R. program was developed to alleviate trauma symptoms by learning guided responses to emotionally triggering events in short doses. The theory behind E.M.D.R. is that of Adaptive Information Processing (A.I.P.) that says symptoms arise from maladaptively stored memories experienced during a traumatic event (C.E.B.C., 2016). This program's flexibility, the potential for quick results, and client-led approach are great for the military population. It is also cost-effective and

ideal for comorbidity, which has a high occurrence with P.T.S.D. H-PACT's strength is that it is a program the goes to where its client base is. They also use sensory tools and a key element for Calm Down Collective. H-PACT's goal is to sustain health through housing. Calm Down Collective acknowledges that P.T.S.D. symptoms can make housing stability a concern, and the program strives to alleviate them. Cognitive Processing Therapy program often falls under the purview of Cognitive Behavioral Therapy. The theoretical foundation is that Socratic dialogue, or questioning, helps the client to re-examine their beliefs around their traumatic event to further their recovery. The goal is to help the client feel their emotions and not avoid them (C.E.B.C., 2016). A strength Calm Down Collective wants to build on is incorporating mindfulness to bring the client back to the present when de-regulated. All programs aim to improve daily living, and all but H-PACT, which is a come as-needed service, are programs with sessions running 1 to 2 times a week for up to 12 weeks. Calm Down Collective chose to be less rigorous this way.

Calm Down Collective Description

Calm Down Collective is founded in Mindfulness-Based Stress Reduction (M.B.S.R.) and the Recovery Model, a holistic person-centered, strengths-based approach to mental health care (Cole et al., 2015; Yeckel, 2018 & Davidson, 2005). M.B.S.R. has shown effective emotional regulation in veterans with P.T.S.D. (Omidi et al., 2010). This lack of regulation can look like anger, restlessness, trouble concentrating, irritability, and sleep issues. Occupational therapists train in sensory processing and are capable of helping veterans with these needs (Kerr et al., 2020). Recovery, as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA), is “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (SAMHSA, 2012).

The strengths utilized from all previous programs evaluated will enhance Calm Down Collective's efficacy to include being versatile in practice, ease of access, and client-led. Both E.M.D.R. and Cognitive Processing Therapy (C.P.T.) help manage P.T.S.D. symptoms and improve daily living, which is also a goal for Calm Down Collective beyond the treatment facility. Each of these programs is long-term, focusing on the maladaptive beliefs around an event. This new program is much shorter, providing a tangible aid for the client when not working directly with a practitioner. H.P.A.C.T. program strives to meet the SAMHSA's main principles by making all health care accessible and providing social services to help work against homelessness. Calm Down Collective is supplemental and easily incorporated into these established programs for veterans' ongoing care of mental health treatment.

Calm Down Collective would be available through two avenues. The first is through inpatient treatment facilities, where the veteran would go through the program at the end of their stay to prepare them for transitioning back into the community. The second option is through therapist referral to the program. This program will require either a social worker or Occupational Therapist to run the classes. Flexibility comes in class size and location as it can be done in groups or one on one with a therapist if they are trained. The client will attend two classes that teach sensory styles and practical techniques to help self-regulate independently. The course would utilize mindfulness to help the client calm the emotion causing them distress to ease into implementing the treatments they are learning in therapy. Emotional de-regulation is an issue for many suffering from mental health disorders (Yeckel, 2018). Upon completing the program, the veteran would receive a toolkit of their top three preferred sensory items, affectionately called a "Bug Out Bag" (see appendix for examples).

Evaluation Methods

Evaluation Design & Data Collection Procedure

The Calm Down Collective's goal is to help the client learn how to process incoming sensory disruptions to effectively utilize the cognitive work that should follow and alleviate the immediate P.T.S.D. symptom. The intended goal of this evaluation is to determine the effectiveness of the program when applied in daily life beyond treatment. There will be two questions for the process evaluation: 1) if the training was sufficient to help clients self-identify sensory disruptions? 2) if the staff felt prepared to provide the training? To gauge outcome results, there would be three evaluation questions: 1) Did the client utilize their primary sensory response? 2) Has the client's self-regulation improved? 3) Was there a change in the client's P.T.S.D. symptoms? The first hypothesis is that more than 50% of participants should be able to self-identify stress or sensory disruptions. The second hypothesis is that they should be able to intervene on their own behalf with the sensory aides provided by the program at least 75% of the time resulting in a decrease in P.T.S.D. symptoms.

The participant section will be a mixed-method quasi-experimental evaluation with a nonequivalent switched replication design. Both the control and test groups will be surveyed upon entry into the program. Each group will receive the same training for the same amount of time. The control group will receive an order form for the selection of the sensory tools, which will be mailed to them at a later date. The test group will receive their sensory tools before they leave the final class. Data will be collected from both groups at six-week intervals after the class. The control group will receive their sensory items after the first six-week check-in. Self-motivation can be a factor that threatens internal validity. A way to account for this would be replicating the study and creating two groups, the physician referred and self-sought, to see if the

outcomes change. This method was chosen so that participants in both groups not only received training but also received the intervention tools as well. It would allow for data on the immediate outcome of the implementation of skills taught in the class as well as the use of the tools. The delayed intervention of the tool would give insight into the timing of the intervention for optimum outcome. It is the program's hypothesis that all participants would see an increase in their ability to self-identify sensory disturbances and self-regulate in their daily lives.

Sampling

The sample size would be 40 participants, 20 per experimental and comparison group. For the program participant frame, simple random sampling would be used. Ideally, the samples would be selected from the incoming participants and would alternate between being placed into the control or test group. The control group would have class on Monday, and the test group would have class on Wednesday. Each group would take an entrance survey, receive training, then take an exit survey. The control group would fill out an order form to have their sensory intervention tools mailed to them in six weeks where the test group would receive their sensory intervention tools before they left the class. At six weeks, both groups will receive follow-up phone calls where they will be interviewed, and data will be collected. At twelve weeks, with both groups now having their sensory intervention tools, both groups will receive another follow-up phone call to collect additional data.

This study will have a secondary data collection where the program's statistics will be pulled and a cross-sectional survey for staff. As data would be collected from staff and participants, there will be two populations and two sampling frames: the list of employees working directly with clients and the list of incoming program participants. Expert sampling for the staff portion of the evaluation would be used as their input is most needed, and they have the

knowledge base to support their observations. As the program would be small, staff members, such as trainers, occupational therapists, social workers, leads, and program coordinators, would receive surveys.

Measurements

To ensure proper evaluation of this program, the process variable has been identified as the intervention of sensory tools at the end of training or the delayed intervention six weeks post-training. The outcome variable will be improved self-regulation at the second follow-up. An indicator of improved self-regulation would be an increase from their post-test survey to their twelve-week follow-up. An ordinal, five-point Likert scale would be ideal for this measure as the pre and post-test survey. All numbered responses are added up, and their sum is the score (Bhattacherjee, 2012). A survey will be administered at the beginning and end of training and will be a total of 10 questions. It should take no more than 15 minutes to complete. It will be administered on paper and turned into the facilitator when completed. The concern here is the tendency to treat the Likert scale as an interval when it is an ordinal. Ensuring the frequency a person engages in action is difficult as many do not often remember, so allowing the subjective take of each individual's experience with the intervention is going to offer the best feedback. Even though participants already have a diagnosis of P.T.S.D., in order to gauge the extent to which symptoms were alleviated, a 24 question semi-structured P.T.S.D. Symptom Scale Interview will be conducted before training begins and at each follow-up interview (Foa et al., 2016). This scale is one that can be conducted in person and over the phone.

The instrument used for the staff will be a qualitative survey with open-ended questions allowing staff to be detailed in their responses. These surveys will be emailed at random, and each participant will have a week to respond, allowing them time to think over their responses.

Questions will cover topics such as their confidence in their training, the material, team cohesion, client response and engagement, and which sensory tools seem to be the most utilized in sessions. This qualitative approach will be of most help here because we can find expected and unexpected themes that arise when allowing staff room to share their thoughts freely.

The follow-up phone calls for participants will also be a more qualitative approach with a semi-structured interview. This keeps the interview on-topic but still allows for various themes to arise (Bhattacherjee, 2012).

Data Analysis

As this will be a mixed-method design, the qualitative portions will be analyzed using a thematic analysis or open coding in conjunction with software such as NVivo to process through the phone interviews and open-ended questionnaires. For the quantitative portion, the data will be managed in the Statistical Packaging for the Social Sciences program or S.P.S.S. A way to verify positive outcomes is to utilize the paired sample T-test. A final survey after their twelve-week follow-up would be emailed to compare to their pre-test at the beginning of the training to measure sustained improvements.

The findings will be presented best in bar graphs. Breaking it down to its most simple components is important. First shows how many participants across the bottom of the graph and on the left number of times they express experiencing sensory disturbances in a day without interventions. Next to it would be another bar graph showing the same information with a sensory intervention tool post final follow-up. The secondary pulled data could be spruced up and shared in the format it was received. The qualitative data will focus on the themes in the participant responses. These themes will be found through coding and the coding process will be shared with a code book table.

Discussion

The limitations of this evaluation reside in the motivation factor for participants. This is not a program anyone would be forced to attend, so anyone who participates likely wants to be in it. Even with a physician referral to attempt to alleviate that factor, it is still important to note that their arrival suggests some level of motivation. As this is not a mandatory program, it means the potential for the sample size to change is possible. Calm Down Collective is also intentionally created to be supplementary to current standing therapeutic EBPs being offered at the V.A., and the client is to continue in any other treatments they may be in. Knowing if the client results are a direct correlation to this program or another will be difficult as all our goals and objects are very similar. A strength of the program includes an aim towards positive decreases in symptoms for participants alongside other treatment options versus those who only maintain their main source of treatment, proving a valuable vein of future studies. Calm Down Collective also has strengths in its client-led flexibility of care. It is an easy access program that can be taught almost anywhere and ensures the client has the necessary tools upon leaving. With the surveys taken upon beginning and exiting the program and then two follow-up interviews, we can obtain results on the program's efficacy and outcomes with ease. Regular staff surveys are invaluable as well as they often have direct contact with clients and will have useful feedback for any necessary changes as well. Dissemination of findings would be shared in leaflets, and staff meetings as the rollout of the program would begin at this level. It would also be important for them to be shared on the mental health pamphlets provided at the V.A. that share treatment options.

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Appendix A: Fact Sheet

P.T.S.D. is characterized by the inability to self-regulate cognitions and emotions

P.T.S.D. is also highly comorbid with Depression, Anxiety Disorders, and Suicidality

Symptoms can look like→

Alert for Danger Shame ***Loss of Interest*** FLASHBACKS

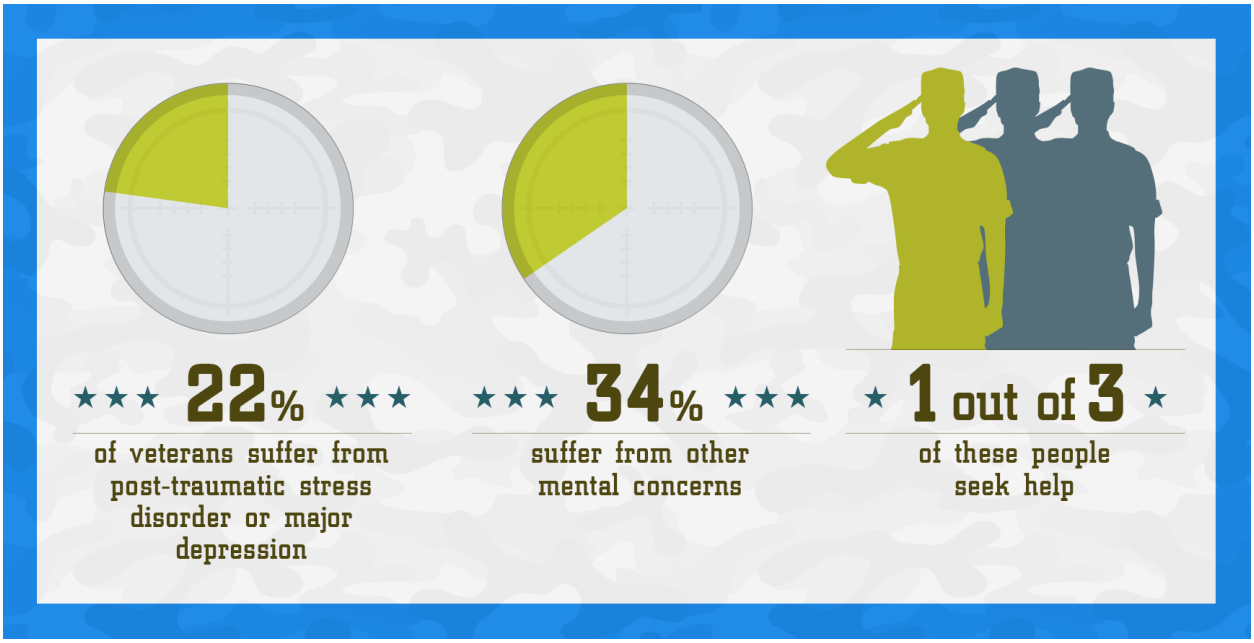
Trouble Sleeping *Hyper Arousal* Fear **Guilt** Feeling Isolated

Panic Attacks **Unable to Complete Daily Tasks**

Serious Mental Illness, Traumatic Stress, & Substance Use

- Women are more than 2x more likely to develop P.T.S.D.
- 70% experience alcohol or other drug abuse problems

70-91% of people with P.T.S.D. struggle to fall asleep



Appendix B: Logic Model

Program Name: Calm Down Collective Logic Model

Goal: To help the client learn how to process incoming sensory disruptions to effectively utilize the cognitive work that should follow and alleviate the immediate P.T.S.D. symptom

Objective: affirm the veteran that they have the skills and tools to self-regulate outside of treatment through mindfulness coupled with sensory tools for additional self-guided calming

INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES	Column2	Column1
Resources:			**INTIAL:**	**INTERMEDIATE:**	**LONG TERM:**
Financial Support	Purchase of sensory tools	***Organization Staff***			
Tax Payers		Staff training			
	Training of additional Social workers and OTs to lead training	Inventory of Sensory tools	understanding of what emotions feel like in their bodies and which sensations aid in calming disruption (primary senory)	improved self regulation at first follow up phone call (self reported, 2 months post class)	decrease in PTSD, or similar, symptoms- (PSSI-5 scale)
possible federal grants					
	purchase & printing of program curriculum (MBSR)	***Participants***			
		two one hour sessions			
Organization Staff	Emotional regulation and Sensory training classes	two follow up phone calls			
Program Director					
Social Work Lead		on-going treatment with primary mental health			
Occupational Therapist Lead	Program Exit Evaluation				
Buyer					
	Receipt of "Bug Out Bag"				
Facilities					
Use of OT space or therapist office-- no additional costs					

Appendix C: Materials for Sensory-Based Intervention

Materials for the sensory-based interventions would be items that create calm for the individual.

For example:

Auditory- rain stick, guided meditation (access to an app)

Tactile- fidget spinner, bubble popper, stress ball

Gustatory- hard candies (fireballs/lemon heads)

Olfactory- essential oils (eucalyptus, spearmint)

Visual- liquid motion bubbler, bubbles (for focus on the breath)

Movement- handballs, yoga mat

Participants would be required to continue care with their primary mental health provider and participate in two follow-up phone calls at two- and four-months post-class.