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National Guard Suicide Prevention and Resilience Innovation Framework

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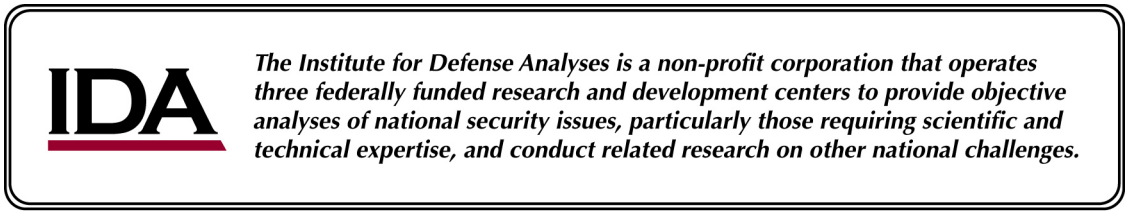

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Executive Summary

In 2019, the Warrior Resilience and Fitness (WRF) Division within the National Guard Bureau (NGB) implemented the WRF Innovation Incubator (WRFII), based on the process the Institute for Defense Analyses (IDA) outlined in its 2019 report.* The WRFII is a process to identify, select, evaluate, and disseminate state-level pilot programs to prevent suicide and promote resilience. A central goal of the WRFII is to identify local pilots that can be expanded and applied across the National Guard (NG). Over the past two years, WRF asked IDA to advise and assist in deploying and refining each step of the WRFII process. IDA has since expanded WRF's strategic prevention framework (i.e., the Compendium of WRF Strategies), facilitated and refined the pilot program selection process, provided technical assistance to ensure that pilot programs develop rigorous evaluation plans, and outlined the three-year trajectory for pilot program implementation and dissemination. The current report documents the revised WRFII process as well as the products and tools IDA developed to support the process, as detailed in Table ES-1.

Table ES-1. Overview of the WRFII Process and Supporting Products

WRFII Step	Description	Supporting Products
 Assess Needs & Gaps	Survey the landscape to assess the needs of NG Soldiers and Airmen and determine related gaps in WRF services and programs	• Compendium of WRF Strategies (Figure 1) • Response/Recovery Leadership Integrated Engagement Framework (Figure 2)
 Invite Submissions	Invite submissions for innovative pilot programs from across the NG; designate priority areas based on current needs and related gaps	• Proposal Template (Chapter 3, section A)
 Select Pilots	Evaluate and select pilots for funding using rigorous criteria ✓*Addresses priority area* ✓*Based on a requirement* ✓*Suitable for population* ✓*Feasible* ✓*Effective* ✓*Robust evaluation plan* ✓*Novel*	• Reviewer Guide (Appendix D) • Facilitator Guide (Appendix E) • Evaluation Criteria (Table 5 and Appendix F) • Synthesis of Reviewer Feedback (Table 6)

* Dina Eliezer, David R. Graham, and Susan Clark-Sestak, *National Guard Suicide Prevention Innovation Framework*, IDA Paper P-10468 (Alexandria, VA: Institute for Defense Analyses, March 2019).

WRFII Step	Description	Supporting Products
Evaluate Effectiveness	Provide technical assistance to selected pilots to enable teams to evaluate program effectiveness	• Welcome Packet (Appendix G) • Suggested Metrics (Appendix H) • Evaluation Plan Worksheet (Appendix I) • Quarterly Report Template (Appendix J) • Catalogue of Metrics (separate publication)
Disseminate & Implement	Disseminate information about pilot outcomes and implement effective programs throughout NG states and territories	• Final Report on WRFII Pilot Program Processes and Outcomes (future IDA report)

A. Assess Needs and Gaps

IDA developed the Compendium of WRF Strategies to help guide and organize the NG's portfolio of activities to prevent high-risk behavior and promote resiliency. Adapting existing prevention frameworks** to the NG context, the Compendium specifies six broad domains of activity necessary for a comprehensive approach to prevent and respond to harmful behavior. Figure ES-1 summarizes the Compendium, and an accompanying spreadsheet, provided separately, details evidence-based and research-informed programs that fall under each domain (see Appendix C for examples).

Figure ES-1. Compendium of WRF Strategies

** CDC's Suicide Prevention Technical Package and SPRC's Comprehensive Approach to Suicide Prevention.

WRF uses the Compendium to identify gaps in existing initiatives and prioritize future programming to fill those gaps (e.g., through selection of WRFII pilots). Further, as a repository of best practices, states/territories can use the Compendium to select evidence-based programs that meet their local needs.

IDA developed the Compendium to span across harmful behaviors, including suicide, substance misuse, and sexual assault. Although the prevention programs IDA reviewed can be organized under common categories since they utilize parallel approaches (e.g., peer influence, screening tools, brief intervention), individual programs and practices typically target a single high-risk behavior (e.g., sexual assault prevention through bystander intervention training). However, a subset of activities appears to be integrative/cross-cutting in that a single program could potentially impact multiple harmful behaviors (e.g., policy to reduce access to alcohol, training on coping and relationship skills, economic support, and promotion of help-seeking). Further, IDA's review of prevention programs reveals important opportunities to apply approaches developed for one high risk behavior to another high-risk behavior (see Table 3).

B. Invite Submissions and Select Pilots

IDA uses the Compendium of WRF Strategies to identify gaps in NGB's prevention approach and recommend priority areas for the pilot program selection process. WRF then disseminates a call for proposals throughout the NG and specifies priority areas based on IDA's recommendations and leadership priorities (e.g., lethal means management, integrative approaches to prevent harmful behavior). Once pilot program submissions are received, WRF convenes Expert Review Panels (ERPs) to review proposals according to established evaluation criteria (i.e., addresses priority area, suitable for population, novel, feasible, based on a requirement, effective, robust evaluation plan). IDA facilitates the ERPs and compiles reviewer evaluations and feedback to highlight the strengths and weaknesses of each proposal. Using these summaries, WRF leadership then engages in programmatic review, assembling the portfolio of proposals that best aligns with WRF priorities and can be feasibly implemented with the funding available.[***]

C. Evaluate Effectiveness

Once pilot programs are selected for participation in the WRFII, they are required to evaluate their program as a condition of participation. To facilitate robust evaluation and align measurement across pilots, IDA provides technical assistance to each pilot program. The technical assistance process begins with new pilot orientation, to include: a welcome packet, conference call with an overview of the program, presentations on program evaluation, and individual calls with each program to gain an understanding of their objectives. IDA then works with each pilot program to

[***] IDA modeled the selection process after the Military Operational Medicine Research Program (MOMRP) and the National Institutes of Health's (NIH) processes for peer review.

help them select metrics, develop their evaluation plan, and design measurement instruments to assess program outcomes. As pilots begin implementation and evaluation, IDA monitors pilot program progress and emerging needs through brief updates provided by pilot programs on a monthly basis, detailed reports provided on a quarterly basis, and community calls with all pilots to discuss shared challenges. As needed, IDA also assists with data analysis and interpretation. Through the technical assistance and pilot reporting processes, IDA identified critical implementation and evaluation challenges, as well as recommended steps WRF can take to address them:

Table ES-2. Pilot Program Challenges and Associated Recommendations

Challenge	Recommendations for WRF
Interruptions due to COVID-19 restrictions	Consider extending time in the program for pilots greatly impacted by COVID-19
Delayed program start-up due to contracting and other approval processes	Offer "seed funding" one year prior to commencement of official participation in the WRFII to support promising submissions that are likely to have lengthy start-up delays
Difficulty recruiting program participants	Invite expert reviewers to serve as mentors to new pilots to assist with implementation and evaluation
Lack of leadership support due to turnover or shifting priorities	Engage with state-level leaders and provide formal memorandums of support
Limited staff time for implementation and evaluation	To the extent possible, provide military pay and allowance funding to pilots that require staffing augmentation and/or assist pilots in requesting funding from relevant offices
Barriers to program evaluation (e.g., low response rates on evaluation questionnaires, difficulty securing comparison groups)	To expand pilot evaluation capacity, suggest that pilot program submissions include at least one team member knowledgeable about program evaluation and allocate 10% of a program's budget/team members' time for program evaluation

Despite implementation and evaluation challenges, most pilot programs demonstrated that their programs are feasible to implement and acceptable to participants. Further, several pilot programs demonstrated preliminary evidence of outcome effectiveness and expanded their pilots to other states and/or services. Table ES- provides examples of pilot achievements, based on data available to date; these results should be considered preliminary as evaluation is ongoing.

Table ES-3. Evidence of Outcome and Implementation Effectiveness

Evidence of outcome effectiveness (measures of effectiveness)
• *Behavioral Health (BH) Primary Prevention and Retention (New Mexico Army National Guard (ARNG)):* Screening and proactive case management reduced the incidence of mental health, substance misuse, and psychosocial issues requiring BH care. Only 15 participants required BH care as compared to 69 people projected to need care, based on historical averages

- *Buddy Aid (South Dakota ARNG):* Buddy Aid training improved preparedness to respond to sexual assault disclosures for 66% of participants (i.e., increase in knowledge, likelihood to act, confidence in skills, and supportive attitudes from pre- to post-test)
- *Start (South Carolina ARNG):* Start training improved participants' self-assessed confidence in their ability to help those at risk for suicide (25-35% highly confident before training compared to 65-75% highly confident after training)

Evidence of implementation effectiveness (measures of performance)

- Across four pilots, screened over 10,000 service members to assess needs and identify those at risk
- Across seven pilots, provided training to over 8,000 service members to prevent harmful behavior and promote holistic fitness
- Across three pilots, coordinated resources, information, and support, reaching out to over 11,000 service members and/or family members

D. Disseminate and Implement

A central goal of the WRFII is to identify local pilots that can be expanded and applied across the NG. To achieve this end, IDA recommended a three-year trajectory for pilot programs entering into the WRFII, from proof of concept (year 1), to local evaluation (year 2), and concluding with a broader evaluation across multiple states (year 3).[****] At the end of three years, pilots that address key leadership priorities and demonstrate evidence of effectiveness across multiple states may be recommended for national implementation. Most pilots, however, will not be appropriate for Guard-wide implementation, but could still be funded at the state-level for local use. WRF engages in a range of dissemination activities to ensure that NG states and territories can leverage effective pilot programs that meet the needs of their service members. Current dissemination activities include leadership briefings, WRF website and newsletter publications, and media engagements. Future dissemination activities should provide more in-depth information about pilot outcomes and implementation guidance, to include training events/workshops on pilots for program managers and forums to allow pilots to present to state and national leaders.

Moving forward, as NG selects pilots to implement nationally, it should develop a process and identify corresponding resources to bring pilot programs to scale, including continued evaluation to assess large-scale feasibility and effectiveness. Further, as states/territories adopt pilots locally, WRF should ensure that they have a means to monitor program activities and evaluate outcomes. Ultimately, a sustained and deliberate approach to program evaluation will allow NGB to assess the long-term value of WRFII programs, identify programs that should be discontinued or modified as service member needs shift, and determine areas of continued need to inform selection of new pilot programs.

[****] Loosely based on tiered evidence grant models, as described in GAO-16-818, "Tiered Evidence Grants: Opportunities Exist to Share Lessons from Early Implementation and Inform Future Federal Efforts," U.S. Government Accountability Office, Sept. 21, 2016. https://www.gao.gov/products/gao-16-818.

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1. Introduction

A. IDA Task

In 2018, the National Guard (NG) Studies Program asked the Institute for Defense Analyses (IDA) to develop a systematic process to identify, select, and deploy evidence-based suicide prevention practices, as described in IDA's 2019 report.[1] The Warrior Resilience and Fitness (WRF) Division has since implemented the process IDA developed through the WRF Innovation Incubator (WRFII) and asked IDA to advise and assist in deploying and refining the process. Over the past two years, IDA has provided technical assistance to 32 pilot programs to ensure that they develop rigorous evaluation plans, facilitated and refined the pilot selection process for Fiscal Year 2020 (FY20) and Fiscal Year 2021 (FY21), and expanded the Compendium of Suicide Prevention Strategies[2] to apply to a broader range of prevention and response activities in line with WRF's integrative approach to risk and resiliency. The current report documents the revised WRFII process as well as the products and tools IDA developed to support the process.

B. Overview of WRFII Process

The WRFII provides a means for the NG to identify, select, evaluate, and disseminate the most effective local practices for preventing suicide and promoting psychological wellbeing and resiliency among service members (SMs) throughout the NG. A central goal of the WRFII is to identify local pilots that can be expanded and applied across the NG. Until the implementation of the WRFII, the NG lacked a systematic means through which to identify and disseminate strategies developed at the state level to promote resiliency and prevent harmful behavior. Through the WRFII, NG has provided funding to support 11 pilots for its inaugural cohort (selected in FY19), 11 pilots in its second cohort (selected in FY20), and 10 pilots in its third cohort (selected in FY21).[3] WRFII currently aligns with a Congressional funding cycle, thus pilots first started receiving funding at the end of the second quarter or beginning of the third quarter of the FY in which they were selected. The table below outlines the key steps of the WRFII process along with associated products IDA developed to support the process. The subsequent chapters of this report align with the WRFII process steps: Assess Needs and Gaps (Chapter 2), Invite Submissions and

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1 Dina Eliezer, David R. Graham, and Susan Clark-Sestak, *National Guard Suicide Prevention Innovation Framework*, IDA Paper P-10468 (Alexandria, VA: Institute for Defense Analyses, March 2019).

2 Ibid.

3 Each pilot is eligible to receive funding and technical assistance for up to three years.

Select Pilots (Chapter 3), Evaluate Effectiveness (Chapter 4), and Disseminate and Implement (Chapter 5). The report concludes with recommendations for WRF (Chapter 6).

Table 1. Overview of the WRFII Process and Supporting Products

WRFII Step	Description	Supporting Products
 Assess Needs & Gaps	Survey the landscape to assess the needs of NG Soldiers and Airmen and determine related gaps in WRF services and programs	• Compendium of WRF Strategies (Figure 1) • Response/Recovery Leadership Integrated Engagement Framework (Figure 2)
 Invite Submissions	Invite submissions for innovative pilot programs from across the NG; designate priority areas based on current needs and related gaps	• Proposal Template (Chapter 3, section A)
 Select Pilots	Evaluate and select pilots for funding using rigorous criteria ✓*Addresses priority area* ✓*Based on a requirement* ✓*Suitable for population* ✓*Feasible* ✓*Effective* ✓*Robust evaluation plan* ✓*Novel*	• Reviewer Guide (Appendix D) • Facilitator Guide (Appendix E) • Evaluation Criteria (Table 5 and Appendix F) • Synthesis of Reviewer Feedback (Table 6)
 Evaluate Effectiveness	Provide technical assistance to selected pilots to enable teams to evaluate program effectiveness	• Welcome Packet (Appendix G) • Suggested Metrics (Appendix H) • Evaluation Plan Worksheet (Appendix I) • Quarterly Report Template (Appendix J) • Catalogue of Metrics (separate publication)[4]
 Disseminate & Implement	Disseminate information about pilot outcomes and implement effective programs throughout NG states and territories	• Final Report on WRFII Pilot Program Processes and Outcomes (future IDA report)

[4] Ashlie M. Williams, Dina Eliezer, and Rachel D. Dubin, *Catalogue of Warrior Resilience and Fitness Metrics and Measures*, IDA Paper NS P-18430 (Alexandria, VA: Institute for Defense Analyses, 2021), https://www.ida.org/research-and-publications/publications/all/c/ca/catalogue-of-warrior-resilience-and-fitness-metrics-and-measures.

2. Assess Needs and Gaps

Before the NG can determine which local best practices it should support and evaluate through the WRFII, it must understand current gaps in NG's approach to preventing harmful behaviors and promoting resiliency. In other words, NG must compare its current approach to the state of the science with respect to evidence-based practices for preventing harmful behaviors. This chapter describes recommended strategies for identifying both evidence-based practices and the NG's current approach to prevent harmful behaviors and promote resiliency.

A. Compendium of WRF Strategies

To specify an evidence-based approach to suicide prevention, IDA developed the Compendium of Suicide Prevention Strategies, as described in IDA's 2019 report.[5] The Compendium, based on the Center for Disease Control's (CDC) and Suicide Prevention Resource Center's (SPRC) models and tailored for the NG, denotes the essential elements of a comprehensive approach to suicide prevention and provides corresponding examples of programs with evidence of effectiveness in a variety of military and civilian contexts.

In the current report, IDA extended the Compendium of Suicide Prevention Strategies to apply to a broader range of prevention activities, henceforth referred to as the Compendium of WRF Strategies (Figure 1). To do so, IDA compiled programs and practices to prevent and respond to sexual assault and substance misuse and added to and updated the programs to prevent and respond to suicide. A sample of evidence-based suicide, sexual assault, and substance misuse prevention and response programs is provided in Appendix B. A spreadsheet, provided separately to WRF, provides the full list of programs, categorized by the strength of the evidence for their effectiveness. Although some of the compiled programs are currently used in the NG or Department of Defense (DOD) (as noted in the spreadsheet and the text below), other programs are typically used in civilian contexts and have not been evaluated for their applicability to military populations.

[5] Dina Eliezer, David R. Graham, and Susan Clark-Sestak, *National Guard Suicide Prevention Innovation Framework*, IDA Paper P-10468 (Alexandria, VA: Institute for Defense Analyses, March 2019).

Figure 1. Compendium of WRF Strategies

The Compendium is meant to be an evolving document and should be regularly expanded as the NG develops new strategies through the innovation incubator process and as the broader literature on evidence-based programs progresses. The Compendium can serve several key functions for the NG:

- Overarching strategy to guide and organize the NG's portfolio of activities to prevent high-risk behavior and promote resiliency.
- Repository of best practices to help states and territories select specific programs that meet their local needs.
- Tool to compare current practices to best practices and identify gaps that can be addressed through new programs selected for the innovation incubator.

1. Methodology

As described in IDA's 2019 report, IDA selected the categories of the Compendium to parallel existing frameworks (CDC's Suicide Prevention Technical Package[6] and SPRC's

[6] Deb Stone, Kristin Holland, Brad Bartholow, and et al., *Preventing Suicide: A Technical Package of Policies, Programs, and Practices* (Atlanta, GA: Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2017), https://www.cdc.gov/violenceprevention/pdf/suicidetechnicalpackage.pdf.

Comprehensive Approach to Suicide Prevention[7]) but slightly altered category names and combined categories to better fit a NG context (see Appendix A for an explanation). To adjust the Compendium to be inclusive of sexual assault and substance misuse programs, IDA also reviewed frameworks in these areas from the CDC,[8] Substance Abuse and Mental Health Services Administration (SAMHSA),[9] and World Health Organization.[10] Based on the review of the prevention frameworks and evidence-based programs, we maintained the original categories of the Compendium, with a few modifications in category names to make them more generalizable.

To compile examples of evidence-based and research-informed programs, we searched a range of databases of evidence-based practices (e.g., Clearinghouse for Military Family Readiness (CMFR),[11] Culture of Respect,[12] and the County Health Rankings and Roadmaps' Curated Strategy Lists).[13] We added additional programs based on literature searches or inclusion in technical packages/frameworks. The databases IDA reviewed employed varying methodologies for rating the evidence-level of programs. As such, we devised our own methodology to apply a uniform approach across programs, based on existing guidance.[14] Appendix B provides a detailed description. Broadly, we specified programs as evidence-based or research-informed, but within each domain we included specific sub-categories. Evidence-based programs ranged from robust experimental designs (A – strong evidence), quasi-experimental designs (B – moderate evidence), and single-group designs that measured outcomes before and after program participation (pre-/post-tests) (C – some evidence). We did not rank order sub-categories of research-informed

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7 "Resources and Programs," Suicide Prevention Resource Center, accessed November 1, 2018, https://www.sprc.org/resources-programs. https://www.sprc.org/resources-programs.

8 Kathleen C. Basile, jones S DeGue, K.K. Freire, and et al., *Stop SV: A Technical Package to Prevent Sexual Violence* (Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2016), https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf.

9 Substance Abuse and Mental Health Services Administration, *Substance Misuse Prevention for Young Adults* (Rockville, MD: National Mental Health and Substance Use Policy Laboratory, Substance Abuse and Mental Health Services Administration, 2019), https://store.samhsa.gov/sites/default/files/d7/priv/pep19-pl-guide-1.pdf.

10 World Health Organization, Global Strategy to Reduce Harmful Use of Alcohol (Geneva, Switzerland: World Health Organization), https://www.who.int/substance_abuse/alcstratenglishfinal.pdf.

11 "Programs," Clearinghouse for Military Family Readiness, Penn State University, accessed November 1, 2018, https://militaryfamilies.psu.edu/programs-review.

12 "Culture of Respect: Ending Campus Sexual Violence," NASPA, accessed June 2, 2021, https://cultureofrespect.org/.

13 "What Works for Health Curated Strategy Lists," Take Action to Improve Health, County Health Rankings & Roadmaps, accessed May 27, 2021, https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/curated-strategy-lists.

14 OCEBM Levels of Evidence Working Group, "The Oxford 2011 Levels of Evidence," Oxford Centre for Evidence-Based Medicine, http://www.cebm.net/index.aspx?o=5653.

programs, but noted the specific reason for the designation (e.g., weak evaluation evidence, has not been evaluated, evaluation in progress).

In the sections that follow, we provide an overview of the six Compendium domains and highlight differences and commonalties in existing evidence-based and research-informed programs and practices across the three harmful behaviors reviewed (suicide, sexual assault, and substance misuse). We then discuss opportunities for integrated or cross-cutting prevention across harmful behavior domains (Chapter 2, section A.3).

2. Strategies to Prevent and Respond to Suicide, Sexual Assault, and Substance Misuse

In the sections that follow (A2a-f), we review the six Compendium categories and provide specific examples of evidence-based or research-informed programs to prevent or respond to suicide, sexual assault, and substance misuse (as summarized in Figure 2). Some programs discussed are used in the military and/or NG (e.g., current WRFII pilot programs), and some are used in civilian contexts but could be relevant for the military. For a more comprehensive list of evidence-based programs see Appendix C and the accompanying spreadsheet, provided separately. For a description of all current WRFII pilot programs, see the pilot fact sheet on WRF's website.[15]

[15] Department of Defense National Guard Bureau, *Warrior Resilience & Fitness Division*, (n.p.: Department of Defense National Guard Bureau, 2021), https://www.nationalguard.mil/Portals/31/Documents/J-1/WRF/WRFII%20Pilots_12MAR2021.pdf.

Table 2. Compendium of WRF Strategies: Commonalities and Differences across Suicide (SP), Sexual Assault (SA), and Substance Misuse (SU) Prevention/Response Programs

Identify People in Need

Gatekeeper and bystander intervention training
- Training content varies, but all focus on identifying and responding to risk
- SA bystander training has broader focus on culture change

Screening tools
- Screening is more common for SP and SU than for SA
- SU approaches are unique in their use of self-assessments

Predictive analytics
- Prediction is better-developed for SP than for SA and SU; clinical application still rare

Provide Care & Treatment

Access to care
- Common approaches to expand access, but treatment is specific

Crisis/brief intervention and helplines
- Brief interventions are behavior-specific; helplines are specific and general

Active follow-up
- Contact through transitions in care for SP and SU; victim advocacy for SA

Family education and involvement
- Couples therapy and family education; SA approaches often focus on adolescents

Create Protective Environments

Manage access to lethal means
- Mainly of relevance to SP but also for SU (e.g., prevent overdose)

Reduce access to alcohol
- Common approach to implement policies that regulate alcohol sales/prices

Provide economic support
- Common approach to provide employment support and reduce financial distress

Change the Culture to Promote Help-Seeking & Reduce Harm

Leader/Peer influence
- Strategies vary: bystander (SA), support groups (SU), peer-to-peer support (SP)

Social marketing campaigns
- Norms addressed vary: MH stigma (SP), norms that support violence (SA), normalization of excessive alcohol use (SU)

Total Force Fitness
- Common approach to promote holistic health

Resource coordination
- Common approach to reduce barriers by centralizing resources

Enhance Life Skills, Resiliency & Connectedness

Coping and stress management
- Common approach to improve coping skills, often combined with behavior-specific content

Family and relationship programs
- Common approach to improve communication, parenting, and relationship skills

Behavior-specific skill-building
- Empowerment training to build SA resistance skills
- Education and behavior change skills to reduce SU

Lessen Secondary & Future Harm

Outreach to individuals impacted
- Comprehensive postvention approaches most developed for SP

Responsible media reporting
- Guidelines on safe reporting for SP and SA; SU media materials provide general education

Surveillance
- Data relevant to SP, SA, and SU often stored in separate systems, limiting integration of surveillance

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a. Identify People in Need

Approaches to identify individuals in need vary by harmful behavior type, but typically encompass: 1) gatekeeper/bystander intervention training to teach leaders, gatekeepers, and peers how to identify those in need/at risk, 2) screening/risk assessment tools, and 3) predictive analytics leveraging administrative data.

1) Gatekeeper and Bystander Intervention Training

Across harmful behaviors, there are a range of evidence-based programs focused on teaching peers, leaders, and community gatekeepers how to intervene when someone is at risk for suicide (e.g., Applied Suicide Intervention Skills Training (ASIST);[16] Question, Persuade, Refer[17]), behavioral health problems (e.g., Mental Health First Aid[18]), or sexual assault (e.g., Bringing in the Bystander, Green Dot). In general, the focus of gatekeeper programs tends to be on suicide risk and the focus of bystander intervention programs tends to be on sexual assault or related harmful behaviors (e.g., sexual harassment). However, some gatekeeper programs discuss behavioral health more generally including substance misuse, and some bystander intervention programs discuss intervention strategies for risky alcohol use (e.g., My Student Body: Alcohol[19]).

Although gatekeeper training and bystander intervention approaches have similar objectives to teach people skills to intervene in high-risk situations, they differ in key respects. Gatekeeper training tends to specifically focus on assisting individuals at risk of suicide whereas bystander intervention approaches are more broadly focused on cultural change (for this reason we cross-reference bystander intervention approaches under the Change Culture domain). Bystander intervention training teaches skills to identify risky situations but also skills to counteract social norms that may be supportive of sexual violence. Suicide gatekeeper training approaches may benefit from an expanded focus on intervention to counteract stigmatization of mental health

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[16] Madelyn S. Gould, et al., "Impact of Applied Suicide Intervention Skills Training on the National Suicide Prevention Lifeline," *Suicide and Life-Threatening Behavior* 43, no. 6 (December 2013): 676–691, doi:10.1111/sltb.12049.

[17] Monica M. Matthieu, et al., "Evaluation of Gatekeeper Training for Suicide Prevention in Veterans," *Archives of Suicide Research* 12, no. 2 (2008): 148–154, https://doi.org/10.1080/13811110701857491; Glenn Albright, et al., "Using an Avatar-Based Simulation to Train Families to Motivate Veterans with Post-Deployment Stress to Seek Help at the VA," *Games for Health Journal* 1, no. 1 (February 2012): 21–28, https://doi.org/10.1089/g4h.2011.0003.

[18] Betty A. Kitchener and Anthony F. Jorm, "Mental Health First Aid Training: Review of Evaluation Studies." *Australian & New Zealand Journal of Psychiatry* 40, no. 1 (January 2006): 6-8, https://doi.org/10.1038/mp.2017.23.

[19] Emil Chiauzzi, Traci Craig Green, Sarah Lord, Christina Thum, and Marion Goldstein, "My Student Body: A High-Risk Drinking Prevention Web Site for College Students." *Journal of American College Health* 53, no. 6 (2005): 263-274, https://doi.org/10.3200/jach.53.6.263-274.

challenges and/or help-seeking; the Air Force has taken this approach by extending its sexual assault bystander intervention training, Green Dot, to suicide. Conversely, bystander intervention approaches could benefit from a greater focus on teaching response skills once an individual has been victimized; one WRFII pilot, Buddy Aid, takes this approach.

2) Screening Tools

Screening tools are commonly used in the military to assess both risk for suicide and substance misuse behavior, including universal screening administered to an entire population (e.g., the Periodic Health Assessment) as well as more detailed screening once some level of risk is identified (e.g., Adult Substance Abuse Subtle Screening Inventory – 4 (SASSI-4); Columbia-Suicide Severity Rating Scale[20]). Screening tools/protocols are also available to assess previous sexual assault victimization[21] as well as risk for sexual assault perpetration[22] but tend to be used less frequently.[23] Unique to substance misuse screening approaches are programs that allow individuals to complete self-assessments, often online, and receive personalized feedback about their risk and strategies to reduce substance misuse (for this reason we cross-reference these programs under the Enhance Life Skills domain, e.g., Electronic Check-Up-to-Go,[24] Check Your Drinking[25]).

Other programs use screening to target specific interventions. For example, a WRFII pilot, Behavioral Health Primary Prevention and Retention, screens for adverse childhood experiences and current psychosocial and behavioral health problems to provide proactive case management

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[20] K. Posner, et al., *Columbia-Suicide Severity Rating Scale (C-SSRS)*, (New York, NY: The Research Foundation for Mental Hygiene, Inc., 2008), https://vtspc.org/wp-content/uploads/2016/12/C-SSRS-LifetimeRecent-Clinical.pdf.

[21] National Sexual Violence Resource Center, *Assessing Patients for Sexual Violence: A Guide for Health care Providers*, (n.p.: National Sexual Violence Resource Center, 2011), accessed April 7, 2021, https://www.nsvrc.org/sites/default/files/Publications_NSVRC_Guides_Assessing-patients-for-sexual-violence.pdf.

[22] National Sexual Violence Resource Center, "Assessment and Treatment for Individuals who Commit Sexual Assault," SART Toolkit Section 7.3, accessed May 28, 2021, https://www.nsvrc.org/sarts/toolkit/7-3.

[23] National Sexual Violence Resource Center, *Assessing Patients for Sexual Violence*, (n.p.: National Sexual Violence Resource Center, 2011), accessed April 7, 2021, https://www.nsvrc.org/sites/default/files/Publications_NSVRC_Guides_Assessing-patients-for-sexual-violence.pdf.

[24] Diana M. Doumas, Christina M. Kane, Tabitha B. Navarro, and Jennifer Roman, "Decreasing Heavy Drinking in First-Year Students: Evaluation of a Web-Based Personalized Feedback Program Administered During Orientation," *Journal of College Counseling* 14, no. 1 (December 2011): 5-20, https://doi.org/10.1002/j.2161-1882.2011.tb00060.x.; John T. P. Hustad, Nancy P. Barnett, Brian Borsari, and Kristina M. Jackson, "Web-Based Alcohol Prevention for Incoming College Students: A Randomized Controlled Trial," *Addictive Behaviors* 35, no. 3 (March 2010): 183-189, https://doi.org/10.1016/j.addbeh.2009.10.012.

[25] John A. Cunningham, T. Cameron Wild, Joanne Cordingley, Trevor Van Mierlo, and Keith Humphreys, "A Randomized Controlled Trial of an Internet-Based Intervention for Alcohol Abusers," *Addiction* 104, no. 12 (November 2009): 2023-2032, https://doi.org/10.1111/j.1360-0443.2009.02726.x.

for individuals at risk. Targeting of interventions for those at risk of sexual assault victimization is less common; one exception is the Sexual Communication and Consent program (SCC), currently under evaluation in the Air Force. SCC is administered to a general audience of Airmen, but provides personalized content based on level of risk for sexual assault (based on prior experiences).[26]

3) Predictive Analytics

Gatekeeper training and screening tools are limited by their reliance on self-disclosure or third-party perceptions of risk. Predictive analytic approaches bypass the need for self-report or individual judgement by relying on available administrative data (e.g., electronic health records) or other sources of text (e.g., social media).[27] The Veterans Health Administration (VHA) is one of the few organizations to apply predictive analytics to clinical operations by analyzing electronic health records to identify patients at risk of suicide (REACH VET)[28] or opioid overdose (STORM).[29] Overall, research on predictive analytics is more commonly focused on suicidal behavior, with fewer applications to sexual assault or substance misuse.

b. Provide Care and Treatment 

Access to high-quality, evidence-based behavioral health care is of central importance to preventing suicide, preventing and treating substance misuse, and treating trauma associated with sexual assault. Although the specific treatment type varies by harmful behavior, the general strategies are consistent, including: 1) access to behavioral health care, 2) crisis/brief interventions and helplines, 3) active follow-up at periods of heightened risk, and 4) family education/involvement throughout the treatment process.

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[26] Marian (Becky) E. Lane, Nichole Scaglione, Randy Eckhoff, Revecca Macy, et al, "Development and Implementation of Innovative, Tailored Sexual Assault Prevention Interventions: An Mhealth Example from the US Air Force," abstract, *Prevention Science* (May 2019), https://spr.confex.com/spr/spr2019/webprogram/Paper27648.html.

[27] Qijin Cheng, and Carrie SM Lui. "Applying Text Mining Methods to Suicide Research," *Suicide and Life-Threatening Behavior* 51, no. 1 (February 2021): 137-147, https://onlinelibrary.wiley.com/doi/epdf/10.1111/sltb.12680.

[28] U.S. Department of Veterans Affairs, "VA REACH VET Initiative Helps Save Veterans Lives: Program Signals When More Help Is Needed for At-risk Veterans," press release, April 3, 2017, (Washington, DC: Office of Public and Intergovernmental Affairs), https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2878.

[29] Elizabeth M. Oliva, Thomas Bowe, Sara Tavakoli, Susana Martins, Eleanor T. Lewis, Meenah Paik, Ilse Wiechers, et al. "Development and Applications of the Veterans Health Administration's Stratification Tool for Opioid Risk Mitigation (STORM) to Improve Opioid Safety and Prevent Overdose and Suicide," *Psychological Services* 14, no. 1 (February 2017): 34-49, https://doi.org/10.1037/ser0000099.

1) Access to Care

Since military health care is typically unavailable to traditional NG members (unless in a mobilized status), the NG has established a number of partnerships to expand access to care. Notably, the VHA deploys Mobile Vet Centers to every drill weekend and Star Behavioral Health Providers trains community providers on military cultural competence. Although NG Directors of Psychological Health (DPHs) and Behavioral Health Officers (BHOs) cannot provide behavioral health care directly, they must refer Guard members to community providers who provide evidence-based therapeutic approaches. For example, cognitive behavioral therapy (CBT) approaches are effective for suicide prevention, substance misuse, and sexual assault-related trauma.[30] The DOD is currently evaluating a program (Chaplains CARE) to train chaplains in the use of cognitive behavioral strategies to reduce suicide risk.[31] If effective, this training could potentially be broadened to improve chaplains' response to sexual assault and substance misuse as well. Computer-based therapeutic interventions are also available to treat depression, substance misuse, and trauma[32]; these approaches, along with virtual counseling services, may be particularly promising for geographically dispersed NG members who may not have access to regular behavioral health care.

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[30] Deb M. Stone, Kristin M. Holland, Brad Bartholow, Alex E. Crosby, Shane Davis, and Natalie Wilkins, *Preventing Suicide: A Technical Package of Policies, Programs, and Practices*, (Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2017). https://www.cdc.gov/violenceprevention/pdf/suicidetechnicalpackage.pdf.; Kathryn R. McHugh, Bridget A. Hearon, and Michael W. Otto, "Cognitive Behavioral Therapy for Substance Use Disorders," *Psychiatric Clinics of North America* 33, no. 3 (September 2010): 511-525, https://doi.org/10.1016/j.psc.2010.04.012.; Kathleen C. Basile, Sarah DeGue, Kathryn Jones, Kimberley Freire, Jenny Dills, Sharon Smith, Jerris Raiford, *STOP SV: A Technical Package to Prevent Sexual Violence*, (Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2016), https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf.

[31] Under Secretary of Defense For Personnel and Readiness, *Annual Suicide Report Calendar Year 2019* (n.p.: Department of Defense, 2020), https://www.dspo.mil/Portals/113/Documents/CY2019%20Suicide%20Report/DoD%20Calendar%20Year%20CY%202019%20Annual%20Suicide%20Report.pdf?ver=YOA4IZVcVA9mzwtsfdO5Ew%3D%3D.

[32] Patrick L. Dulin, and Vivian M. Gonzalez. "Smartphone-Based, Momentary Intervention for Alcohol Cravings Amongst Individuals with an Alcohol Use Disorder," *Psychology of Addictive Behaviors* 31, no. 5 (2017): 601-607, https://doi.org/10.1037/adb0000292.; Deborah A. Levesque, Deborah F. Van Marter, Robert J. Schneider, Mark R. Bauer, David N. Goldberg, James O. Prochaska, and Janice M. Prochaska, "Randomized Trial of a Computer-Tailored Intervention for Patients with Depression," *American Journal of Health Promotion* 26, no. 2 (November 2011): 77-89, https://doi.org/10.4278/ajhp.090123-quan-27.; Devika Fiorillo, Caitlin McLean, Jacqueline Pistorello, Steven C. Hayes, and Victoria M. Follette, "Evaluation of a Web-Based Acceptance and Commitment Therapy Program for Women with Trauma-Related Problems: A Pilot Study," *Journal of Contextual Behavioral Science* 6, no. 1 (January 2017): 104-113, https://doi.org/10.1016/j.jcbs.2016.11.003.

2) Crisis/Brief Interventions and Helplines

In situations of crisis and immediate need, DPHs, BHOs, Sexual Assault Response Coordinators (SARCs), Sexual Assault Prevention and Response (SAPR) Victim Advocates (VAs), Alcohol Drug Control Officers (ADCOs), chaplains, and leaders provide critical support and connection to care. Upon identification of risk through gatekeepers or screening tools, brief interventions are often recommended to respond to acute risk, followed by referral to longer-term care (i.e., Screening, Brief Intervention, and Referral to Treatment (SBIRT)).[33] Although BHOs, ADCOs, SARCs/VAs, and other gatekeepers facilitate screening and referral to treatment, it is unclear whether they systematically apply brief interventions. Common brief interventions include cognitive-behavioral or motivational interviewing strategies for substance misuse,[34] safety planning interventions for suicidal behavior,[35] and early trauma-focused CBT[36] or interventions to reduce intrusive memories[37] for trauma survivors.

DOD provides several helplines to directly connect individuals in crisis with support at any time (e.g., Military OneSource for any need, Safe Helpline for sexual assault, YouCanQuit2 for smoking cessation). A WRFII pilot, SafeUTNG, provides a crisis intervention mobile app for NG SMs, family members, and civilian staff. The app connects users to licensed mental health professionals through chat or a phone call and also allows users to anonymously report high-risk behavior of others.

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[33] Thomas F. Babor, Bonnie G. McRee, Patricia A. Kassebaum, Paul L. Grimaldi, Kazi Ahmed, and Jeremy Bray, "Screening, Brief Intervention, and Referral to Treatment (SBIRT) Toward a Public Health Approach to the Management of Substance Abuse," *Substance Abuse* 28, no. 3 (2007): 7-30, https://doi.org/10.1300/j465v28n03_03.

[34] Richard Saitz, "Screening and Brief Intervention Enter Their 5th Decade," *Substance Abuse* 28, no. 3 (2007): 3-6, https://doi.org/10.1300/j465v28n03_02.

[35] Marjan Ghahramanlou-Holloway, et al., "Safety Planning for Military (SAFE MIL): Rationale, Design, and Safety Considerations of a Randomized Controlled Trial to Reduce Suicide Risk Among Psychiatric Inpatients," *Contemporary Clinical Trials* 39, no. 1 (September 2014): 113–123, https://doi.org/10.1016/j.cct.2014.07.003.

[36] Hege Kornør, Dagfinn Winje, Øivind Ekeberg, Lars Weisæth, Ingvild Kirkehei, Kjell Johansen, and Asbjørn Steiro, "Early Trauma-Focused Cognitive-Behavioural Therapy to Prevent Chronic Post-Traumatic Stress Disorder and Related Symptoms: A Systematic Review and Meta-Analysis," *BMC Psychiatry* 8, (September 2008), https://doi.org/10.1186/1471-244x-8-81.

[37] Lalitha Iyadurai, Simon E. Blackwell, Richard Meiser-Stedman, Peter C. Watson, Michael B. Bonsall, John R. Geddes, Anna C. Nobre, and Emily A. Holmes, "Preventing Intrusive Memories after Trauma via a Brief Intervention Involving Tetris Computer Game Play in the Emergency Department: A Proof-of-Concept Randomized Controlled Trial," *Molecular Psychiatry* 23, no. 3 (March 2017): 674-682, https://doi.org/10.1038/mp.2017.23.

3) Active Follow-up

Behavioral health patients are at especially high risk of suicidal behavior[38] during transition periods in care (i.e., transition from inpatient to outpatient). Active follow-up approaches ensure that individuals are supported and connected to care through these transition periods. For example, the caring contact intervention provides brief messages from hospital staff (e.g., e-mails, letters) to patients after hospitalization to express support and share resources.[39] This approach has only been applied to patients recovering from suicidal behavior, but could potentially be extended to different behavioral health challenges. Notably, risk for suicide increases after substance misuse treatment,[40] suggesting another window of opportunity for intervention to prevent both suicide, overdose, or relapse. It should be noted that evidence supporting the effectiveness of the caring contact intervention in a military population is not yet robust (i.e., findings mixed/inconsistent); further research is warranted given the promise and high feasibility of this intervention.[41] For sexual assault survivors, victim advocacy services provide ongoing support throughout all phases of the response process, including navigating behavioral health treatment and investigative/judicial processes.

4) Family Education and Involvement

Family members may play an important role in identifying risk for suicidal behavior and substance misuse and helping loved ones follow through with coping strategies and treatment approaches. Several evidence-based family approaches are available for substance misuse and behavioral health, including therapy that includes significant others (e.g., Alcohol Behavior Couple Therapy[42]) and training that educates family members, develops their coping skills, and helps them motivate their loved ones to change their behavior and seek care (e.g., Community

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38 Daniel Thomas Chung, et al., "Suicide Rates after Discharge from Psychiatric Facilities: A Systematic Review and Meta-Analysis," *JAMA Psychiatry* 74, no. 7 (July 2017): 694–702, doi:10.1001/jamapsychiatry.2017.1044.

39 Mark A. Reger, et al., "Implementation Methods for the Caring Contacts Suicide Prevention Intervention," *Professional Psychology: Research and Practice* 48, no. 5 (October 2017): 369–377, https://doi.org/10.1037/pro0000134.

40 Office of the Surgeon General (US), and National Action Alliance for Suicide Prevention (US), *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention* (Washington, DC: U.S. Department of Health & Human Services (US), 2012), https://www.ncbi.nlm.nih.gov/pubmed/23136686.

41 Katherine Anne Comtois, Amanda H. Kerbrat, Christopher R. DeCou, David C. Atkins, Justine J. Majeres, Justin C. Baker, and Richard K. Ries, "Effect of Augmenting Standard Care for Military Personnel with Brief Caring Text Messages for Suicide Prevention: A Randomized Clinical Trial," *JAMA Psychiatry* 76, no. 5 (May 2019): 474-483, doi.org/10.1001/jamapsychiatry.2018.4530.

42 Barbara S. McCrady, Adam D. Wilson, Rosa E. Muñoz, Brandi C. Fink, Kathryn Fokas, and Adrienne Borders, "Alcohol-Focused Behavioral Couple Therapy," *Family Process* 55, no. 3 (July 2016): 443-459, 443–59. https://doi.org/10.1111/famp.12231.

Reinforcement and Family Training[43] and the National Alliance on Mental Illness (NAMI) Family to Family Education Program[44]). Family-based approaches for sexual assault aim to prevent perpetration among adolescents at risk by involving their family in therapy and improving parent-child relationships.[45]

c. Create Protective Environments 

To fully address risk factors for suicide, substance misuse, and sexual assault, interventions should not only aim to change individual behavior but also the environments in which they reside. Strategies to create environments that minimize the risk for suicide, substance misuse, and sexual assault include: 1) manage access to lethal means for individuals at risk, 2) reduce access to alcohol, and 3) provide economic support.

1) Manage Access to Lethal Means

A significant body of evidence suggests that interventions can reduce suicide by limiting access to the means by which individuals typically attempt suicide (e.g., firearms, drugs, and public suicide "hotspots"). Given the high fatality rate of suicide attempts through firearms,[46] lethal means interventions are often aimed at reducing access to firearms in particular. Community-based approaches seek to educate community members, firearm retailers, and other stakeholders on suicide risk and firearm safety (e.g., the Gun Shop Project[47]) or broadly distribute firearm locks to enable safe storage.[48] Interventions targeted to individuals at risk of suicide often include lethal means counseling and education to improve safe storage practices (e.g., Counseling on Access to

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43 Hendrik G. Roozen, Ranne De Waart, and Petra Van Der Kroft, "Community Reinforcement and Family Training: An Effective Option to Engage Treatment-Resistant Substance-Abusing Individuals in Treatment," *Addiction* 105, no. 10 (September 2010): 1729-1738, https://doi.org/10.1111/j.1360-0443.2010.03016.x.

44 Jason Schiffman, et al., "Outcomes of a Family Peer Education Program for Families of Youth and Adults with Mental Illness," *International Journal of Mental Health* 44, no. 4 (2015): 303–315, doi:10.1080/00207411.2015.1076293.

45 Kathleen C. Basile, et al., *STOP SV* (Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2016), https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf.

46 Deb M. Stone, et al., *Preventing Suicide* (Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2017), https://www.cdc.gov/violenceprevention/pdf/suicidetechnicalpackage.pdf.

47 "Gun Shop Project," Means Matter, Harvard T.H. Chan School of Public Health, accessed December 2, 2018, https://www.hsph.harvard.edu/means-matter/gun-shop-project/.

48 Ali Rowhani-Rahbar, Joseph A. Simonetti, and Frederick P. Rivara, "Effectiveness of Interventions to Promote Safe Firearm Storage," *Epidemiologic Reviews* 38, no. 1 (1 January 2016): 111–124, https://doi.org/10.1093/epirev/mxv006.

Lethal Means[49]) as well as provision of safe storage options that go beyond gun locks (e.g., storage of firearms outside of one's home). WRFII pilot, Crisis Response Plan, trains chaplains and BHOs on a brief intervention to reduce suicide risk, including lethal means safety counseling.

Beyond firearm restriction interventions, creating barriers on public sites that have been used for suicide (e.g., bridges, tall buildings, train tracks) also reduces suicide.[50] Related strategies to reduce the risk of fatal overdose include the use of blister packs for medications,[51] collection/disposal of unused opioid prescriptions,[52] and harm reduction techniques to prevent overdose, such as expanding access to naloxone.[53] Restricting access to drugs could also reduce the incidence of drug-facilitated sexual assault; interventions focused on reducing alcohol access in particular (as described below) may prove effective as alcohol is the most common substance involved in sexual assault.[54]

2) Reduce Access to Alcohol

State and local policy interventions that regulate alcohol sales and pricing not only have the potential to reduce substance misuse but also sexual assault and suicide as alcohol is often involved in these incidents. In particular, research suggests that higher alcohol prices and/or lower density of establishments selling alcohol in a given region are associated with lower sexual assault

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49 Elizabeth Sale, Michelle Hendricks, Virginia Weil, Collin Miller, Scott Perkins, and Suzanne McCudden, "Counseling on Access to Lethal Means (CALM): An Evaluation of a Suicide Prevention Means Restriction Training Program for Mental Health Providers," *Community Mental Health Journal* 54, no. 3 (November 2017): 293-301, https://doi.org/10.1007/s10597-017-0190-z.

50 Georgina R. Cox, et al., "Interventions to Reduce Suicides at Suicide Hotspots: A Systematic Review," *BMC Public Health* 13, (March 2013): 214, https://doi.org/10.1186/1471-2458-13-214.

51 J. L. Turvill, A. K. Burroughs, and K. P. Moore, "Change in Occurrence of Paracetamol Overdose in UK after Introduction of Blister Packs," *The Lancet* 355, no. 9220 (June 2000): 2048-2049, https://doi.org/10.1016/s0140-6736(00)02355-2.

52 Kavita M. Babu, Jeffrey Brent, and David N. Juurlink, "Prevention of Opioid Overdose," *The New England Journal of Medicine* 380, no. 23 (June 2019): 2246-2255, https://doi.org/10.1056/NEJMra1807054.

53 Kathryn F. Hawk, Federico E. Vaca, and Gail D'Onofrio, "Reducing Fatal Opioid Overdose: Prevention, Treatment and Harm Reduction Strategies," *The Yale Journal of Biology and Medicine* 88, no. 3 (September 2015): 235-245, https://europepmc.org/backend/ptpmcrender.fcgi?accid=PMC4553643&blobtype=pdf.

54 J. A. Hall, and C. B. T. Moore, "Drug Facilitated Sexual Assault–A Review," *Journal of Forensic and Legal Medicine* 15, no. 5 (July 2008): 291-297, https://www.sciencedirect.com/science/article/pii/S1752928X08000024.

victimization,[55] lower suicide rates,[56] and diminished alcohol consumption.[57] Alcohol-density restrictions can be established through policies that allocate a maximum number of alcohol licenses per area or set a minimum distance between establishments.[58] Increased alcohol pricing is most often achieved through greater excise/sales tax on alcoholic beverages. Notably, alcohol prices at military bases are significantly lower than alcohol prices at civilian establishments, potentially increasing SMs' risk of alcohol misuse and associated harmful behaviors.[59] Other strategies that may be effective in reducing alcohol consumption include restrictions on alcohol promotions (e.g., restrictions on happy hour times, banning unlimited drink specials)[60] and limiting days of alcohol sales (e.g., Sunday bans).[61]

3) Provide Economic Support

Financial distress and unemployment are risk factors for suicide, interpersonal violence, and substance misuse. Financial distress is commonly experienced prior to suicide attempts; further, financial challenges often lead to relationship conflict which may increase risk for suicide[62] and domestic violence, including sexual assault.[63] Substance misuse is also linked to financial

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55 Caroline Lippy, and Sarah DeGue, "Exploring Alcohol Policy Approaches to Prevent Sexual Violence Perpetration," *Trauma, Violence, & Abuse* 17, no. 1 (November 2014): 26-42, https://doi.org/10.1177/1524838014557291.

56 Ziming Xuan, Timothy S. Naimi, Mark S. Kaplan, et al., "Alcohol Policies and Suicide: A Review of the Literature," *Alcoholism: Clinical and Experimental Research* 40, no. 10 (September 2016): 2043-2055, https://doi.org/10.1111/acer.13203.

57 Alexander C. Wagenaar, Matthew J. Salois, and Kelli A. Komro, "Effects of Beverage Alcohol Price and Tax Levels on Drinking: A Meta-Analysis of 1003 Estimates from 112 Studies," *Addiction* 104, no. 2 (January 2009): 179–190, https://doi.org/10.1111/j.1360-0443.2008.02438.x.

58 Peter Anderson, Dan Chisholm, and Daniela C. Fuhr, "Effectiveness and Cost-Effectiveness of Policies and Programmes to Reduce the Harm Caused by Alcohol," *The Lancet* 373, no. 9682 (June-July 2009): 2234-2246, https://doi.org/10.1016/s0140-6736(09)60744-3.

59 Julie A. Pechacek (Lockwood), James M. Bishop, P.M. Picucci, Alexandra M. Saizen, Amrit K. Romana, and John A. Vig, *Understanding Alcohol Use in the Military: Assessing Civilian and Commander Retail Alcohol Market Interventions*, IDA Document NS D-8607 (Alexandria, VA: Institute for Defense Analyses, July 2017).

60 "Drink Special Restrictions," Take Action to Improve Health, County Health Rankings & Roadmaps, accessed April 11, 2021, https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/drink-special-restrictions.

61 Adam Sherk, Tim Stockwell, Tanya Chikritzhs, et al., "Alcohol Consumption and the Physical Availability of Take-Away Alcohol: Systematic Reviews and Meta-Analyses of the Days and Hours of Sale and Outlet Density," *Journal of Studies on Alcohol and Drugs* 79, no. 1 (January 2018): 58-67, https://doi.org/10.15288/jsad.2017.79.58.

62 Caitlin A. Goodin, Daniel M. Prendergast, Larry D. Pruitt, et al., "Financial Hardship and Risk of Suicide Among U.S. Army Personnel," *Psychological Services* 16, no. 2 (May 2019): 286-292, https://doi.org/10.1037/ser0000201.

63 P. H. Niolon, M. Kearns, J. Dills, K. Rambo, S. Irving, T. Armstead, and L. Gilbert, *Preventing Intimate Partner Violence Across the Lifespan: A Technical Package of Programs, Policies, and Practices*, (Atlanta, GA:

challenges with substance misuse both leading to financial distress and occurring as a result of financial distress.[64] As citizen-soldiers, NG SMs face unique challenges in balancing their civilian employment with their NG duties. National programs, including the Joint NG Employment Support Program and the Employer Support of the Guard and Reserve (ESGR) program provide key resources. Additionally, NG states and territories have their own programs to provide direct employment support (e.g., WRFII pilot Work for Warriors Georgia).

d. Change Culture to Promote Help-Seeking and Reduce Harm 

Cultural change to destigmatize and normalize help-seeking is at the heart of efforts to prevent suicide, sexual assault, and substance misuse. Cultural change efforts also seek to shift social norms specific to each harmful behavior; suicide prevention initiatives aim to reduce stigma associated with suicide and mental health disorders, sexual assault programs aim to counteract norms supportive of violence and harassment, and substance misuse programs aim to reduce normalization of excessive substance use. Specific strategies to change culture and social norms include: 1) Leader/peer influence approaches, 2) Awareness/social marketing campaigns, 3) Total force fitness and related holistic health approaches, and 4) Centralized resource coordination. Total force fitness and resource coordination approaches typically promote help-seeking in general while awareness/social marketing campaigns and leader/peer influence approaches focus on a wider range of norms in addition to promoting help-seeking.

1) Leader/Peer Influence

Social influence approaches enlist peers and leaders to challenge harmful social norms and provide support and resources to those at risk. A key tenet of the Air Force's Suicide Prevention Program is leadership support; leaders are closely involved in suicide prevention activities, including messaging to the force from the highest-levels.[65] In the ANG, leaders receive quarterly talking points relevant to suicide prevention to foster discussions within their units. Across the Services, suicide and sexual assault prevention and response training is included in professional military education at all leadership levels.

National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2017), accessed June 1, 2021, https://stacks.cdc.gov/view/cdc/45820.

64 Wilson M. Compton, Joe Gfroerer, Kevin P. Conway, and Matthew S. Finger, "Unemployment and Substance Outcomes in the United States 2002–2010," *Drug and Alcohol Dependence* 142 (September 2014): 350-353, https://doi.org/10.1016/j.drugalcdep.2014.06.012.

65 Knox, Kerry L., Steven Pflanz, Gerald W. Talcott, Rick L. Campise, Jill E. Lavigne, Alina Bajorska, Xin Tu, and Eric D. Caine, "The US Air Force Suicide Prevention Program: Implications for Public Health Policy," *American Journal of Public Health* 100, no. 12 (September 2011): 2457-2463, https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2009.159871.

Although leaders play a central role in prevention in the military context, specific programs developed to change social norms in civilian contexts often focus on peers and/or peer leaders. Bystander intervention approaches, most commonly used for sexual assault prevention, aim to change culture by teaching individuals how to recognize and challenge harmful attitudes and behaviors (e.g., victim-blaming comments, sexual harassment) and intervene in situations where individuals may be at risk for sexual assault. Of all the sexual assault programs reviewed, bystander intervention approaches were the most common evidence-based approach (e.g., Green Dot[66] and Bringing in the Bystander[67] have both been used in the military).

Although sexual assault bystander intervention programs often include content on risky substance use, bystander intervention approaches for substance misuse may be a promising approach that warrants further attention. One program that applies a bystander approach to substance misuse is PeerCare, which seeks to transform workplace culture by teaching participants how to intervene with colleagues engaging in risky substance use behavior.[68] More frequently, substance misuse programs engage peers by convening support groups as part of the therapeutic process for those with substance use disorder (e.g., Twelve Step Facilitation Therapy[69]) and/or provide a network of peers also aiming to change their substance use behavior (e.g., Checkup and Choices and Moderation Management[70]).

Peer support for behavioral health more broadly includes programs that train peer leaders to connect individuals at risk with resources (e.g., Buddy-to-Buddy in Michigan ARNG).[71] Resources Exist, Asking Can Help (REACH), currently under evaluation by the DOD, uses a

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66 Ann L. Coker, Bonnie S. Fisher, Heather M. Bush, et al., "Evaluation of the Green Dot Bystander Intervention to Reduce Interpersonal Violence Among College Students Across Three Campuses," *Violence Against Women* 21, no. 12 (August 2014): 1507-1527, https://doi.org/10.1177/1077801214545284.

67 Mary M. Moynihan, Victoria L. Banyard, Alison C. Cares, et al., "Encouraging Responses in Sexual and Relationship Violence Prevention: What Program Effects Remain 1 Year Later," *Journal of Interpersonal Violence* 30, no. 1 (May 2014): 110-132, https://doi.org/10.1177/0886260514532719.

68 Rebecca S. Spicer, and Ted R. Miller, "Impact of a Workplace Peer-Focused Substance Abuse Prevention and Early Intervention Program," *Alcoholism: Clinical & Experimental Research* 29, no. 4 (May 2006): 609-611, https://doi.org/10.1097/01.alc.0000158831.43241.b4.

69 Richard Longabaugh, Philip W. Wirtz, Allen Zweben, and Robert L. Stout, "Network Support for Drinking, Alcoholics Anonymous and Long-Term Matching Effects," *Addiction* 93, no. 9 (September 1998): 1313-1333, https://doi.org/10.1046/j.1360-0443.1998.93913133.x.

70 Reid K. Hester, Harold D. Delaney, and William Campbell, "ModerateDrinking.com and Moderation Management: Outcomes of a Randomized Clinical Trial with Non-Dependent Problem Drinkers," *Journal of Consulting and Clinical Psychology* 79, no. 2 (April 2011): 215-224, https://doi.org/10.1037/a0022487.

71 John F. Greden, Marcia Valenstein, Jane Spinner, et al., "Buddy-To-Buddy, a Citizen Soldier Peer Support Program to Counteract Stigma, PTSD, Depression, and Suicide," *Psychiatric and Neurologic Aspects of War* 1208, no. 1 (October 2010): 90–97, https://doi.org/10.1111/j.1749-6632.2010.05719.x.

group-discussion format to help individuals overcome barriers to help-seeking.[72] As discussed previously, peer approaches for suicide prevention most often focus on gatekeeper skills rather than broader cultural change; one exception is Source of Strength, a program in which peer leaders promote attitude change regarding suicide and help-seeking.[73]

2) Social Marketing Campaigns

Awareness/social marketing campaigns are a key universal strategy to change cultural norms that deter people from seeking help or that promote harmful behavior. For example, DOD's Real Warriors Campaign, which provides testimonials from SMs, reframes help-seeking as an act of strength and may normalize mental health treatment. Social marketing campaigns can also serve as companion approaches to bystander intervention training. The Know Your Power campaign, used in parallel with Bringing in the Bystander training, provides a series of images portraying bystander behavior to increase awareness about strategies to intervene.[74]

Substance misuse awareness campaigns often utilize a social norms approach by challenging misperceptions about peer alcohol use. Young adults tend to overestimate the extent to which their peers engage in excessive alcohol consumption, and this inaccurate perception may drive excess drinking.[75] Social marketing campaigns that provide accurate norms and statistics about the extent to which peers consume alcohol can correct social norms about drinking behavior and thereby

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[72] Under Secretary of Defense For Personnel and Readiness, *Annual Suicide Report Calendar Year 2019* (n.p.: Department of Defense 2020), https://www.dspo.mil/Portals/113/Documents/CY2019%20Suicide%20Report/DoD%20Calendar%20Year%20CY%202019%20Annual%20Suicide%20Report.pdf?ver=YOA4IZVcVA9mzwtsfdO5Ew%3D%3D.

[73] Peter A. Wyman, Hendricks Brown, Mark LoMurry, et al., "An Outcome Evaluation of the Sources of Strength Suicide Prevention Program Delivered by Adolescent Peer Leaders in High Schools," *American Journal of Public Health* 100, no. 9 (September 2010): 1653–1661, https://doi.org/10.2105/ajph.2009.190025.; Although this program is developed for high school students, it has been adapted for the Georgia NG, according to CMFR.

[74] Sharyn J. Potter, and Jane G. Stapleton, "Translating Sexual Assault Prevention from a College Campus to a United States Military Installation: Piloting the Know-Your-Power Bystander Social Marketing Campaign," *Journal of Interpersonal Violence* 27, no. 8 (November 2011): 1593-1621, https://doi.org/10.1177/0886260511425795.

[75] Lotte Vallentin-Holbech, Birthe Marie Rasmussen, and Christiane Stock, "Effects of the Social Norms Intervention The GOOD Life on Norm Perceptions, Binge Drinking and Alcohol-Related Harms: A Cluster-Randomised Controlled Trial," *Preventive Medicine Reports* 12 (December 2018): 304-311, https://www.sciencedirect.com/science/article/pii/S2211335518302560..; James Turner, H. Wesley Perkins, and Jennifer Bauerle, "Declining Negative Consequences Related to Alcohol Misuse Among Students Exposed to a Social Norms Marketing Intervention on a College Campus," *Journal of American College Health* 57, no. 1 (2008): 85-94, https://doi.org/10.3200/jach.57.1.85-94.; Substance Abuse and Mental Health Services Administration, *Substance Misuse Prevention for Young Adults*. (Rockville, MD: National Mental Health and Substance Use Policy Laboratory, Substance Abuse and Mental Health Services Administration, 2019), https://store.samhsa.gov/sites/default/files/d7/priv/pep19-pl-guide-1.pdf.

reduce excessive alcohol use.[76] Some social norms approaches also provide personalized feedback about how one's own drinking behavior compares to peers.[77] Although social norms approaches are most often used to target alcohol use,[78] there is some limited evidence for their use for the prevention of other harmful behaviors (e.g., accurate information about peers' willingness to seek mental health care[79] or men's low endorsement of predatory sexual behavior[80]). Application of the social norms approach to promote help-seeking more broadly or to counteract norms that may promote violence may be an important direction to consider for future social marketing campaigns.

3) Total Force Fitness (TFF)

By championing the interdependence between physical and psychological health, DOD's TFF framework reframes psychological health as an inextricable and essential part of one's total health; Army's holistic health and fitness (H2F) approach and Air Force's Comprehensive Airman Fitness approach have the same intent. Several WRFII pilot programs adopt a TFF approach by integrating physical fitness with resiliency and lifestyle training. For example, Warrior F.I.T. and AXE provide physical fitness and nutrition coaching, augmented through a focus on resiliency, sleep, and stress management. Although the effect of the TFF approach has not been directly evaluated,[81] research suggests a close link between physical and psychological outcomes[82] (e.g., chronic disease is associated with death by suicide).[83] Additional work is needed to evaluate

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76 Ibid.

77 Melissa A. Lewis, and Clayton Neighbors, "Social Norms Approaches Using Descriptive Drinking Norms Education: A Review of the Research on Personalized Normative Feedback," *Journal of American College Health* 54, no. 4 (2006): 213-218, https://doi.org/10.3200/jach.54.4.213-218.

78 Paulius Yamin, Maria Fei, Saadi Lahlou, and Sara Levy, "Using Social Norms to Change Behavior and Increase Sustainability in the Real World: A Systematic Review of the Literature," *Sustainability* 11, no. 20 (2019): 5847, https://doi.org/10.3390/su11205847.

79 Kami J. Silk, Evan K. Perrault, Samantha A. Nazione, Kristin Pace, and Jan Collins-Eaglin, "Evaluation of a Social Norms Approach to a Suicide Prevention Campaign," *Journal of Health Communication* 22, no. 2 (January 2017): 135-142, https://doi.org/10.1080/10810730.2016.1258742.

80 Alan D. Berkowitz, "Applications of Social Norms Theory to Other Health and Social Justice Issues," *The Social Norms Approach to Preventing School and College Age Substance Abuse: A Handbook for Educators, Counselors, and Clinicians*, ed. H. Wesley Perkins (San Francisco, CA: Jossey-Bass, 2003), 259-279, http://www.alanberkowitz.com/articles/norms_applications.pdf.

81 For a proposed methodology see: Joan A. Walter, Ian Coulter, Lara Hilton, et al., "Program Evaluation of Total Force Fitness Programs in the Military," *Military Medicine* 175, no. 8 (August 2010): 103-109, https://doi.org/10.7205/milmed-d-10-00279.

82 Hannah Dale, Linsay Brassington, and Kristel King, "The Impact of Healthy Lifestyle Interventions on Mental Health and Wellbeing: A Systematic Review," *Mental Health Review Journal* 19, no. 1 (March 2014): 1-26, https://doi.org/10.1108/mhrj-05-2013-0016.

83 Renee D. Goodwin, Andrej Marusic, and Christina W. Hoven, "Suicide Attempts in the United States: The Role of Physical Illness," *Social Science & Medicine* 56, no. 8 (April 2003): 1783–1788, https://doi.org/10.1016/S0277-9536(02)00174-0.

whether the TFF framework, and programs modeled after this approach, are successful in their intent to reduce stigmatization of mental illness and promote help-seeking.

4) Resource Coordination

DOD and the National Guard Bureau (NGB) provide a vast range of services to support SMs; however, awareness and utilization of these resources is often limited. Programs like Military OneSource, which centralize resources, not only reduce structural barriers to access support but may also change attitudes by normalizing help-seeking (although the latter assumption has not been evaluated). Several NG states have smartphone applications that centralize resource information; past and present WRFII pilots have also taken this approach. Embedded Resiliency Teams provide integrated mental health, physical health, and fitness services, One Stop Shops provides a central location in each Congressional district of South Carolina for a range of services, and CSF2 Resource Text Line provides automated resource information through a text line.

e. Enhance Life Skills, Connection, and Resiliency 

Programs that improve life skills, relationships, and resiliency may prevent suicide, sexual assault, and substance misuse by enhancing people's ability to cope with stressors that could trigger harmful events and by addressing risky behavior before it escalates to a clinical problem or a crime. Specific approaches include: 1) Social/emotional learning programs to teach coping skills, 2) Family/relationship programs to build communication skills, and 3) Behavior-specific skills such as sexual assault resistance and substance misuse behavior change.

1) Coping and Stress Management

By enhancing coping skills, problem solving, and emotion regulation, social-emotional learning programs may improve individuals' ability to cope with stressors and reduce the impact of potential triggers to harmful behavior. Defender's Edge,[84] Battlemind,[85] and Life Guard,[86] are all evidence-based/informed programs developed specifically for the military to teach psychological skills that promote resiliency, enhance performance, and improve adjustment after

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84 Craig J. Bryan, and Chad E. Morrow, "Circumventing Mental Health Stigma by Embracing the Warrior Culture: Lessons Learned from the Defender's Edge Program," *Professional Psychology: Research and Practice* 42, no. 1 (2011): 16-23, https://doi.org/10.1037/a0022290.

85 Amy B. Adler, Paul D. Bliese, Dennis McGurk, Charles W. Hoge, and Carl Andrew Castro, "Battlemind Debriefing and Battlemind Training as Early Interventions with Soldiers Returning from Iraq: Randomization by Platoon," *Sport, Exercise, and Performance Psychology* 1, no. 3 (August 2011): 66-83, https://doi.org/10.1037/2157-3905.1.s.66.

86 Dean Blevins, J. Vince Roca, and Trey Spencer, "Life Guard: Evaluation of an ACT-Based Workshop to Facilitate Reintegration of OIF/OEF Veterans," *Professional Psychology: Research and Practice* 42, no. 1 (February 2011): 32–39, https://doi.org/10.1037/a0022321.

deployment. Notably, however, only Battlemind is still in use as part of the Army's Deployment Cycle Resilience Training. Interventions focused on reducing substance misuse typically incorporate general training on coping and stress management along with content on alcohol abuse (e.g., Healthy Workplace[87]). Sexual assault and related domestic violence prevention programs tend to focus on skills to manage anger and enhance empathy, as well as general coping skills (e.g., Dialectical Psychoeducational Workshop[88]).

2) Family/Relationship Programs

Relationship conflict, inadequate social support, and/or social isolation are common risk factors for suicide[89], substance misuse[90], and sexual assault[91]. Programs that strengthen family and significant other relationships thus have the potential to improve outcomes across harmful behaviors. For example, programs focused on improving parenting skills are also associated with reduced suicidal ideation (After Deployment Adaptive Parenting Tools[92]) and substance misuse among youth (Promoting School-community-university Partnerships to Enhance Resilience[93]). Other programs aim to improve intimate partner relationships by teaching communication and conflict resolution skills (e.g., Strength at Home – Couple's Program[94]). WRFII pilot, Electronic

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87 Royer F. Cook, Rebekah K. Hersch, Anita S. Back, and Tracy L. McPherson, "The Prevention of Substance Abuse Among Construction Workers: A Field Test of a Social-Cognitive Program," *The Journal of Primary Prevention* 25, no. 3 (November 2004): 337-357, https://doi.org/10.1023/b:jopp.0000048025.11036.32.

88 Mary M. Cavanaugh, Phyllis L. Solomon, and Richard J. Gelles, "The Dialectical Psychoeducational Workshop (DPEW) for Males at Risk for Intimate Partner Violence: A Pilot Randomized Controlled Trial," *Journal of Experimental Criminology* 7, no. 3 (March 2011): 275-291, https://doi.org/10.1007/s11292-011-9126-8.

89 Till, Benedikt, Ulrich S. Tran, and Thomas Niederkrotenthaler, "Relationship Satisfaction and Risk Factors for Suicide," *Crisis: The Journal of Crisis Intervention and Suicide Prevention* 38, no. 1 (2017): 7-16, https://econtent.hogrefe.com/doi/abs/10.1027/0227-5910/a000407?journalCode=cri

90 Kenneth J. Gruber, and Melissa Floyd Taylor, "A Family Perspective for Substance Abuse: Implications from the Literature," *Journal of Social Work Practice in the Addictions* 6, no. 1-2 (2006): 1-29, https://www.tandfonline.com/doi/abs/10.1300/J160v06n01_01.

91 Andra Teten Tharp, Sarah DeGue, Linda Anne Valle, Kathryn A. Brookmeyer, Greta M. Massetti, and Jennifer L. Matjasko, "A Systematic Qualitative Review of Risk and Protective Factors for Sexual Violence Perpetration," *Trauma, Violence, & Abuse* 14, no. 2 (April 2013): 133-167, https://journals.sagepub.com/doi/10.1177/1524838012470031.

92 Abigail H. Gewirtz, David S. DeGarmo, and Osnat Zamir, "Effects of a Military Parenting Program on Parental Distress and Suicidal Ideation: After Deployment Adaptive Parenting Tools," *Suicide and Life Threatening Behavior* 46, no. S1 (April 2016): S23–S31, https://doi.org/10.1111/sltb.12255.

93 Richard Spoth, Mark Greenberg, Karen Bierman, and Cleve Redmond, "PROSPER Community–University Partnership Model for Public Education Systems: Capacity-Building for Evidence-Based, Competence-Building Prevention," *Prevention Science* 5, no. 1 (March 2004): 31-39, https://doi.org/10.1023/b:prev.0000013979.52796.8b.

94 Casey T. Taft, Suzannah K. Creech, Matthew W. Gallagher, Alexandra Macdonald, Christopher M. Murphy, and Candice M. Monson, "Strength at Home Couples Program to Prevent Military Partner Violence: A Randomized

Relationship Education, is evaluating the evidence-based program, ePREP (Prevention and Relationship Education Program) for Couples[95] in a NG context. Relationship programs with a more specific sexual assault or domestic violence focus also educate participants about consent or reducing physical and psychological aggression (e.g., Brief Motivational Interviewing for Dating Aggression[96]).

3) Behavior-Specific Programs: Sexual Assault Resistance and Substance Misuse Behavior Change

In addition to building general coping and communication skills, programs to prevent harmful behavior also include training on specific skills necessary to resist victimization or reduce risky substance use behavior. As noted in the sections above, programs often include a combination of general life skills (e.g., coping with stress) and harmful behavior-specific life skills (e.g., understanding consent). Unique to sexual assault, empowerment training teaches individuals verbal and physical techniques to resist victimization (e.g., Enhanced Assess, Acknowledge, Act Sexual Assault Resistance Education Program[97]). Substance misuse programs focus on educating participants about safe use of substances, consequences of heavy use and addiction, and strategies to reduce risky substance use and avoid relapse. Several WRFII pilots, including Alcohol and Drug Abuse Prevention Training-Guard (ADAPT-Guard), Prime for Life, and Risk Reduction Psychoeducation, provide education on substance misuse risks and behavior-change skills. Notably, these programs fill a gap in the ARNG's approach to substance misuse by providing support to individuals who were identified as a substance abuse concern (e.g., through urinalysis) but do not meet diagnostic criteria for a substance use disorder.

f. Lessen Secondary and Future Harm 

Suicide, sexual assault, and substance misuse not only have a profound impact on the lives of individuals directly involved, but may also harm those indirectly involved through their relationships with people who died by suicide, experienced or perpetrated sexual assault, or engaged in substance misuse. This section addresses strategies to prevent "secondary and future"

Controlled Trial," *Journal of Consulting and Clinical Psychology* 84, no. 11 (November 2016): 935-945, https://doi.org/10.1037/ccp0000129.

95 Scott R. Braithwaite, and Frank D. Fincham, "ePREP: Computer Based Prevention of Relationship Dysfunction, Depression and Anxiety," *Journal of Social and Clinical Psychology* 26, no. 5 (May 2007): 609-622, https://doi.org/10.1521/jscp.2007.26.5.609.; Scott R. Braithwaite, and Frank D. Fincham, "Computer-Based Prevention of Intimate Partner Violence in Marriage," *Behaviour Research and Therapy* 54 (March 2014): 12-21, https://doi.org/10.1016/j.brat.2013.12.006.

96 Erica M. Woodin, and K. Daniel O'Leary, "A Brief Motivational Intervention for Physically Aggressive Dating Couples," *Prevention Science* 11, no. 4 (April 2010): 371-383, https://doi.org/10.1007/s11121-010-0176-3.

97 Charlene Y. Senn, Misha Eliasziw, Paula C. Barata, et al., "Efficacy of a Sexual Assault Resistance Program for University Women," *New England Journal of Medicine* 372, no. 24 (June 2015): 2326-2335, https://doi.org/10.1056/nejmsa1411131.

harm, targeted at individuals who were not directly involved in a harmful behavior incident but could be impacted through their awareness of the event or relationships with individuals directly involved. Although sexual assault prevention frameworks often include support for survivors in a tertiary prevention category similar to this one, we limit this category to "secondary" harm to better integrate with suicide prevention frameworks. Thus, we categorize behavioral health and victim advocacy support for sexual assault survivors under "Provide Care and Treatment" together with care for individuals with substance use disorder and those at risk for suicide.

Postvention describes a range of strategies implemented in the wake of a suicide attempt or death to provide support to loved ones, friends, and colleagues and reduce risk of harm among vulnerable individuals aware of the incident. DOD developed a toolkit that provides detailed guidance on postvention for leaders and response personnel, including a phased approach to support individuals grieving, information about roles/responsibilities and managing potential burnout, and direction on terminology to discuss suicide safely.[98]

Although the term postvention often refers to suicide, similar approaches can be applied in the aftermath of a sexual assault incident (e.g., to prevent retaliation against victims, to reduce risk among children who witness violence at home[99]) or to support family members coping with a loved one's substance misuse or overdose. For example, guidelines for the media on safe and non-stigmatizing reporting practices are available for suicide[100] and sexual assault.[101] Guidelines for the media on substance misuse tend to provide broad education rather than specific guidance for language-use.[102] Additionally, surveillance approaches are applied across harmful behavior domains to monitor incidents and provide information on trends and risk factors to inform prevention and response approaches. However, information on incidents of sexual assault, suicide, and substance misuse are stored on separate NG data systems, limiting the ability to understand these problems in a more integrative manner. Overall, strategies to prevent secondary and future harm are available for all harmful behaviors reviewed, but comprehensive postvention approaches to address secondary harm are most well-developed for suicide prevention.

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98 U.S. Department of Defense, *Postvention Toolkit for a Military Suicide Loss*, 1st ed. (n.p.: U.S. Department of Defense, n.d.), https://www.dspo.mil/Portals/113/Documents/PostventionToolkit.pdf.

99 Kathleen C. Basile, et al., *STOP SV* (Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 2016), https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf.

100 "Reporting on Suicide," Reporting on Suicide, accessed April 21, 2021, http://reportingonsuicide.org/about/.

101 "Reporting on Sexual Violence," Media and Press, National Sexual Violence Resource Center, accessed April 21, 2021, https://www.nsvrc.org/sexual-violence-reporting-tools.

102 National Institute on Drug Abuse, National Institutes of Health, and U.S. Department of Health and Human Services, *The National Institute on Drug Abuse Media Guide: How to Find What You Need to Know About Drug Use and Addiction*, (n.p.: U.S. Department of Health and Human Services, revised 2018), accessed April 21, 2021, https://www.drugabuse.gov/sites/default/files/media_guide.pdf.

3. Opportunities for Integration and Cross-Cutting Prevention

Suicide, sexual assault, and substance misuse prevention programs utilize many parallel approaches (e.g., peer influence, screening tools, brief intervention); however, individual programs and practices are often targeted to a single domain (e.g., bystander intervention for sexual assault). Relatedly, evaluations of programs often examine only a single harmful behavior, limiting researchers' ability to understand the impact of any given program on multiple high-risk behaviors. A notable exception is the evaluation of the Air Force's suicide prevention program, which demonstrated an impact on suicidal behavior as well as family violence, homicide, and accidental death.[103] Greater coordination of program evaluation across different harmful behaviors is critical to determine whether programs, practices, or policies prevent multiple high-risk behaviors.

A subset of activities reviewed here appear to be integrative/cross-cutting in that a single approach could potentially impact multiple high-risk behavior domains. For example, strategies to reduce access to alcohol through policies that regulate sales and pricing have demonstrated effectiveness in reducing the incidence of suicide, sexual assault/domestic violence, and substance misuse.[104] Further, programs that directly address common risk factors and/or provide skills to overcome common triggers of high-risk behavior could also prevent multiple harmful behaviors, including: teaching coping and stress management, family and relationship programs, and economic support. Programs that seek to reduce stigma and promote help-seeking more generally may also have an impact across harmful behaviors by encouraging early intervention and recovery. These integrative approaches in particular should be prioritized for evaluation of outcomes across multiple harmful behaviors.

More commonly, the programs and practices reviewed here have a specific area of focus, as is necessary to prevent/respond to harmful behavior in a targeted manner. Nonetheless, examining the commonalities, or lack thereof, between suicide, sexual assault, and substance misuse programs reveals important areas for future program development as approaches used to prevent one harmful behavior could be applied to prevent another. These opportunities for cross-behavior application are highlighted throughout the preceding sections and summarized in Table 3.

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[103] Kerry L. Knox, Steven Pflanz, Gerald W. Talcott, et al., "The US Air Force Suicide Prevention Program: Implications for Public Health Policy," *American Journal of Public Health* 100, no. 12 (December 2010): 2457-2463, https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2009.159871.

[104] Caroline Lippy, and Sarah DeGue (2014). "Exploring Alcohol Policy Approaches to Prevent Sexual Violence Perpetration," *Trauma, Violence, & Abuse* 17, no. 1 (November 2014): 26-42, https://doi.org/10.1177/1524838014557291.; Ziming Xuan, Timothy S. Naimi, Mark S. Kaplan, et al., "Alcohol Policies and Suicide: A Review of the Literature," *Alcoholism: Clinical and Experimental Research* 40, no. 10 (September 2016): 2043-2055, https://doi.org/10.1111/acer.13203.; Alexander C. Wagenaar, Matthew J. Salois, and Kelli A. Komro, "Effects of Beverage Alcohol Price and Tax Levels on Drinking: A Meta-Analysis of 1003 Estimates from 112 Studies," *Addiction* 104, no. 2 (January 2009): 179–190, https://doi.org/10.1111/j.1360-0443.2008.02438.x.

Table 3. Opportunities for Cross-cutting/Integrative Prevention

Integrative/cross-cutting approaches (i.e., a single intervention may prevent multiple harmful behaviors):

- Reduce access to alcohol (i.e., policies to regulate sales and prices)
- Economic support
- Coping and stress management
- Family and relationship programs (i.e., teach communication skills)
- Programs to promote help-seeking (e.g., resource coordination, TFF)

Approaches/programs that could be adapted from one harmful behavior to apply to another harmful behavior:

- Apply gatekeeper training approaches to bystander intervention and vice-versa (e.g., expand gatekeeper training to teach skills for counteracting stigma of mental health and expand bystander training to teach skills for responding to survivors)
- Apply bystander intervention approaches to substance misuse to a greater extent
- Promote greater use of sexual assault victimization and perpetration screening and targeted intervention based on screening
- Apply caring contact approach for suicide risk to other areas (e.g., after discharge from substance misuse treatment)
- Apply social norms marketing approaches typically used for substance misuse (i.e., present accurate information about peer drinking to counter misconceptions) to encourage help-seeking and counteract norms that may promote violence
- Develop more comprehensive postvention approaches to lessen secondary harm related to sexual assault and substance misuse-related incidents

B. Response/Recovery Enhanced Leadership Integrated Engagement Framework (RELIEF)

With the onset of the COVID-19 pandemic, NGB asked IDA to develop a framework specifically focused on response and recovery from current and future national crises or disasters. To do so, IDA adapted the prevention-oriented Compendium of WRF Strategies to crisis response, leveraging existing frameworks and guidance from the Inter-Agency Standing Committee[105] and the Center for the Study of Traumatic Stress.[106] Further, rather than pairing each category with evidence-based strategies, as done for the Compendium, IDA compiled available government resources to support SMs and their families and organized them under each category of the RELIEF model (Figure 2).

[105] Inter-Agency Standing Committee, *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, (Geneva, Switzerland: Inter-Agency Standing Committee, 2017), https://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf.

[106] "Disasters," Fact Sheets, Center for the Study of Traumatic Stress, accessed April 21, 2021, https://www.cstsonline.org/fact-sheet-menu/disasters.

Figure 2. Response/Recovery Enhanced Leadership Integrated Engagement Framework (RELIEF)

Like the Compendium, the RELIEF model provides a unified strategy for the NG and specifies key activities necessary for a comprehensive approach to crisis preparation, response, recovery, and mitigation. The model serves as a guide for leaders to understand how to focus their efforts in response to crisis situations, provides NGB/NG state program staff with an understanding of how their program fits into the broader NG strategy and where they can collaborate with related programs, and provides NG SMs and family members with a streamlined source for resource information. The RELIEF model is currently featured on WRF's web-page and allows users to click on the categories to navigate to a list of example resources.[107]

C. Gap Analysis

While the Compendium of WRF Strategies and the RELIEF model provide important information about the state of the science with respect to evidence-informed prevention and response, WRF also requires a means to assess the "current state" of NG activities in order to identify gaps in strategies to address SM needs. WRF is currently compiling and documenting prevention and response activities at the headquarters level but does not have a systematic process to compile activities at the local level. Rather, WRF learns about local activities in an ad-hoc

[107] Department of Defense National Guard Bureau, *Response/Recovery (RE) Leadership Integrated Engagement Framework (RELIEF)*, n.p.: Department of Defense National Guard Bureau, n.d. https://www.nationalguard.mil/Portals/31/Documents/J-1/WRF/WRF_RELIEF_Framework%2030%20July%202020.pdf.

manner. Submissions to the WRFII provide some information about current activities; however, submissions are not representative of the full scope of state/territory activities. WRF should consider developing a process to request basic information about existing NG wellness and resiliency programs from NG states and territories in order to identify promising programs not submitted to the innovation incubator. With this information, WRF can compare current NG activities to the Compendium to assess gaps in current prevention programs/practices and provide better support and guidance to the field.

D. Conclusion

The Compendium of WRF Strategies is a flexible prevention framework that can be applied across harmful behaviors and adopted to meet other emerging needs (e.g., crisis response/recovery). Importantly, the Compendium serves as a tool for WRF to organize their current prevention and response initiatives, identify gaps in existing initiatives, and prioritize future programming to fill those gaps. A key application of the Compendium is to guide the innovation incubator selection process. As described in Chapter 3, WRF uses the Compendium to determine priority areas for the pilot selection process and guide their programmatic review of submissions.

3. Invite Submissions and Select Pilots

IDA's 2019 report[108] described a process for the selection of innovative local pilot programs to prevent high risk behavior and promote resilience. Over the past two years, IDA worked with WRF to implement and refine the process through the FY20 and FY21 selection cycles and the upcoming FY22 cycle. IDA also assisted in the inaugural FY19 selection process, but this process was implemented on an abbreviated timeline and has since evolved considerably. This chapter describes the selection process for *new* proposals in its current iteration, as planned for the upcoming FY22 selection process. Chapter 5 describes the full three-year trajectory of pilot programs and the criteria for proceeding to subsequent years of funding.

The WRFII pilot submission and selection process spans 5-6 months with selection decisions announced ahead of the Congressional funding cycle (i.e., prior to the start of the calendar year). WRF disseminates a call for proposals and provides a two-month period for receipt of submissions from NG states and territories. Once submissions are received, WRF convenes Expert Review Panels (ERP), facilitated by IDA, to review proposals according to established evaluation criteria. WRF leadership then engages in programmatic review, assembling the portfolio of proposals that best aligns with WRF priorities and can be feasibly implemented with the funding available (Figure 3). IDA modeled the selection process after the Military Operational Medicine Research Program (MOMRP)[109] and the National Institutes of Health's (NIH)[110] processes for peer review.

[108] Dina Eliezer, David R. Graham, and Susan Clark-Sestak, *National Guard Suicide Prevention Innovation Framework*, IDA Paper P-10468 (Alexandria, VA: Institute for Defense Analyses, March 2019).

[109] Ray Santullo, Personal conversation, December 13, 2019.

[110] U.S. Department of Health and Human Services, National Institutes of Health, and 2019 Office of Extramural Research, *NIH Peer Review: Grants and Cooperative Agreements* (n.p.: National Institutes of Health, n.d.) https://grants.nih.gov/grants/peerreview22713webv2.pdf.

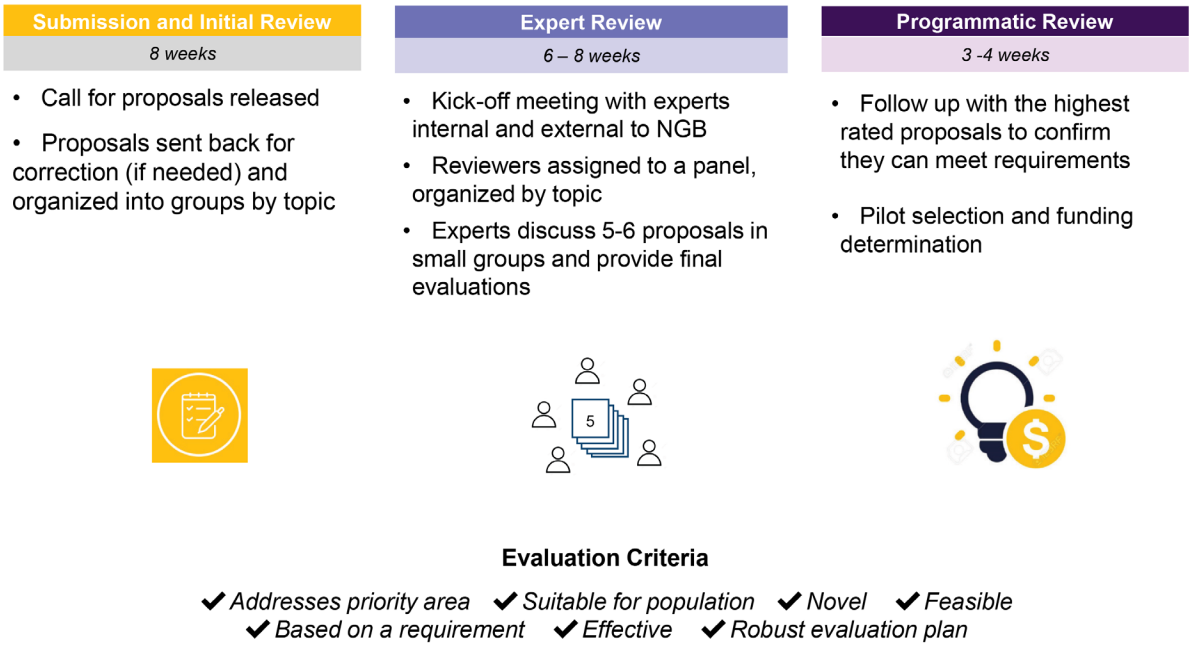


Figure 3. WRFII Submission and Selection Process Overview

A. Submission and Initial Review

WRF releases a call for proposals each year and specifies priority topics and methods to encourage states/territories[111] to submit programs that best meet SM needs. To inform WRF's priority area selection, IDA conducts a gap analysis, aligning current WRFII pilot programs to the domains of the Compendium of WRF Strategies (Chapter 2) and identifying domains that are not extensively covered by existing pilots. IDA also considers broader WRF programmatic activities and emerging needs; for example, mobile apps and virtual services emerged as a priority area in FY21 due to the social distancing restrictions imposed by the COVID-19 pandemic. Priority topics over the past two selection cycles (FY20 and FY21) and upcoming selection cycle (FY22) are highlighted in Table 4. After the FY20 cycle, IDA recommended fewer priority topics, with greater specificity, to better differentiate between submissions. The topics in FY20 were so broad and wide-ranging that nearly all submissions fit under one of the areas.

IDA also recommends priority methods to encourage use of evidence-based programs and robust evaluation methods; as such these priority methods have remained fairly consistent over the years. For the upcoming FY22 selection process, priority methods will include: program evaluation designs with control or comparison groups that measure outcomes before and after

[111] WRFII has received submissions from a variety of program offices, e.g., Chaplaincy; Family Readiness; Psychological Health; Resilience, Risk Reduction, and Suicide Prevention; Sexual Harassment/Assault Response and Prevention.

program participation, multiple component or joint Army National Guard (ARNG)/Air National Guard (ANG) programs, and evidence-based programs that have not yet been used in the Guard.

Table 4. WRFII Priority Topics FY20-FY22

FY20	FY21	FY22
• Addressing barriers to care and resource utilization • Integrated approaches to destructive behavior • Promoting connectedness • Management of lethal means • Support during transitions/reintegration	• Management of lethal means • Mobile apps and virtual services	• Management of lethal means • Integrative approaches to prevent harmful behavior • Reintegration and/or postvention

In addition to designated priority topics and methods, the call for proposals includes a submission template to standardize information received. IDA designed the proposal template to align with the evaluation criteria reviewers consider when assessing submissions (Table 5). In addition to general information about the program specifics, project team, and proposed budget, the proposal also requests information about the program's suitability for use in the NG, evidence of effectiveness, and evaluation plan. The template contains short and detailed questions instead of requiring broad narrative descriptions in order to make it more accessible for program managers who typically do not have a research or evaluation background. Nonetheless, over the past two cycles of the process, the quality of submissions varied greatly and reviewers often had difficulty understanding program descriptions. As such, IDA recommended the following processes to improve submission quality, including:

- Allowing early submission of draft proposals to receive feedback from IDA (FY21 and FY22);
- Specific language in the call for proposals indicating that submissions should be complete and clearly-written (FY22); and
- An initial filtering process to remove incomplete, unclear, and/or redundant proposals from consideration (FY22).

WRF has also extended the submission period to allow for more time to complete proposals.

Once proposals are received, IDA provides feedback on proposals received by the early deadline and requests corrections or additional information, as needed, from remaining proposals. IDA then organizes proposals by topic to prepare for the expert review process; for example, FY21 topics included access to resources/connectedness, leadership and unit climate, screening for and reducing risk, prevention of suicide and substance misuse, and physical fitness and nutrition. IDA

designates topic areas based on the content of proposals submitted in a given year and to ensure that categories include no more than six proposals.

B. Expert Review

Each year, WRF convenes ERPs comprised of about 30 reviewers internal and external to NGB. In past review cycles, experts within NGB spanned across J-1 offices (e.g., SAPR, Behavioral Health, Office of Air Surgeon/Army Surgeon, Drug Reduction, Family Programs, Diversity and Inclusion, Suicide Prevention, Transition Assistance). External experts included DOD offices (e.g., Defense Suicide Prevention Office, Office of People Analytics, Military-Civilian Transition Office), MOMRP, and other federal agencies (e.g., Veterans Health Administration, SAMHSA).

WRF and IDA assign about five reviewers to each topic based on their area of expertise and to ensure an even distribution of internal and external experts and military and civilian representation. WRF and IDA then convene a kick-off meeting with all reviewers to explain the review process. After the meeting, reviewers receive an invitation to their review session, a reviewer guide describing the process (Appendix D), and proposals for their topic area. WRF instructs reviewers to read all proposals in their topic area and preliminarily evaluate each on a global dimension (excellent, good, fair, poor). WRF also assigns reviewers two proposals to read in greater depth so that they can begin the discussion of their assigned proposals during the review session.

WRF convenes the four-hour expert review sessions in-person, if feasible, or on Microsoft Teams (as done in FY21 and FY22 due to COVID-19). IDA facilitates the review sessions, as detailed in the facilitator guide (Appendix E). Reviewers discuss each proposal, focusing on the extent to which the proposal meets the evaluation criteria. Reviewers record their evaluations in a designated spreadsheet after the discussion of each proposal but are given the opportunity to update their evaluations at the end of the session and submit final evaluations through an online survey link. At the end of the session, reviewers also complete a feedback form about the review process. Feedback from past review sessions has been instrumental in refining the review process. For example, IDA streamlined the ERP evaluation criteria (summarized in Table 5; full description in Appendix F) based on reviewer feedback (i.e., removed *acceptable to participants* because it was too similar to *suitable for the population* and removed *impactful* because it was too similar to *effective*).

Table 5. ERP Evaluation Criteria

Criteria	Description
Addresses WRF priority area	Does the program fit into one or more of the WRF priority topics AND one or more of the priority methods?
Suitable to the target population	Is the proposed program both suitable for the intended population and culturally appropriate?

Criteria	Description
Novel	Is the program unique/novel (not redundant with existing DOD programs)?
Based on a requirement	Does the program fulfill the intent of a requirement specified in DOD or subordinate service-level regulation, policy, or guidance documents [for programmatic review only]
Feasible	Can the program requirements (e.g., for additional staff, contractors, funding, and participation time) reasonably be met on a long-term basis
Effective	Is there evidence of the proposed program's effectiveness?
Robust evaluation plan	Does the proposal clearly articulate plans for a reliable evaluation of the pilot?
Global evaluation	What is your overall assessment of this proposal?

C. Programmatic Review

After the review session, IDA compiles reviewer evaluations and feedback to highlight the strengths and weaknesses of each proposal as well as any areas for clarification. These summaries directly inform programmatic review. An excerpt from a FY21 pilot, Mental Health First Aid, is provided in Table 6.

Table 6. SSP 105: Rhode Island – Mental Health First Aid

Feedback statement: Reviewers agreed that this program has the potential to meet an important need for integrated training that prepares Guard members to recognize and intervene in a broad range of behavioral health issues, rather than addressing issues in siloes. They were impressed with the body of evidence supporting the training's effectiveness in veteran populations and saw great benefit in testing it in the NG. They noted that a virtual version of Mental Health First Aid training was recently developed, which may be more feasible for Rhode Island to implement given COVID restrictions.	
Strengths:	• Evidence-based program that is culturally competent with a version tailored for veterans • Unique program that combines education, screening, and next steps/referrals – rare for a program to combine all these components • Capability to implement Mental Health First Aid virtually (this was not stated in the proposal, but one of the reviewers noted this)
Weaknesses:	• May be difficult to fit in during drill weekend if they intend to train a broad population, however, would be feasible if they train in stages • Evaluation plan could be strengthened (e.g., functional outcomes to see if people end up using the skills they learned)
Areas for clarification:	• None

If reviewers note any areas for clarification, particularly for a highly rated pilot, WRF follows up with the program to request further detail. The WRF leadership team then convenes to review the proposals; IDA is not involved in this review session. During programmatic review, WRF leadership focuses on the most highly rated proposals and discusses alignment with priorities and

programmatic needs as well as other practical considerations including funding availability, geographic diversity and balance of ANG and ARNG programs, and geographic diversity. WRF then contacts its initial selection of pilot programs to ensure the programs are able to obligate funds within the FY. Once selection decisions and funding amounts are finalized, NGB sends an e-mail announcing the selected pilots to NGB and state leadership. Finally, WRF provides everyone who submitted a proposal with individualized feedback about selection decisions, including a statement describing reviewer feedback (see "feedback statement" in Table 6).

4. Evaluate Effectiveness

Pilot programs selected for participation in the WRFII are required to evaluate their program as a condition of their participation. Pilot program managers, however, often lack program evaluation experience and have limited time and, absent the WRFII, access to funding or technical assistance (TA) necessary to conduct an evaluation. Even when quality evaluations do occur, the measures they use may vary widely, hindering comparison of results across programs addressing similar prevention domains. The WRFII aims to address these challenges by offering funding and TA for evaluation activities. In the WRFII's "Evaluate Effectiveness" phase, IDA's TA efforts thus focus on building evaluation capacity among pilot program managers through consultation and provision of TA support tools. This chapter describes the current TA process and associated products as well as lessons learned through TA provided to the FY19 and FY20 pilot programs. WRFII currently aligns with a Congressional funding cycle, thus pilot programs first start receiving funding at the beginning of the first quarter or end of the second quarter of the FY in which they were selected. FY21 pilots have only recently begun and are just starting to receive TA, so they are not discussed in this chapter.

A. Technical Assistance Process and Products

To facilitate robust evaluation and align measurement across pilot programs, WRFII provides TA to each pilot team throughout their participation in the WRFII. This TA includes regular communication with all pilot teams, collecting and reviewing pilot reports, and providing informational materials and evaluation tools. This section describes TA processes and products for both (1) new pilot program orientation and start-up and (2) on-going support and deliverables. Table 7 summarizes each TA product and the timeframe of their use.

Table 7: Technical Assistance Support Tools

Product	Description	Timeframe
Welcome Packet (Appendix G)	A document with basic information about the WRFII, key contacts, and procedures/expectations of participation	WRF sends to each pilot upon confirmation of pilot participation in the WRFII
Evaluation Essentials Presentation	A briefing on basic evaluation designs and best practices for high-quality evaluation	IDA presents one month after WRFII kick-off
Introductory TA Discussion Guide	A guide for introductory TA call between IDA and individual pilot teams	IDA begins scheduling calls within one month of WRFII kick-off
Suggested Metrics Spreadsheet (Appendix H)	A list of recommended metrics and data collection methods tailored to each pilot	IDA provides to pilots one month after introductory TA discussion

Product	Description	Timeframe
Catalogue of WRF Metrics and Measures[112]	A collection of metrics and associated survey measures to inform development of pilot evaluation plans	WRF sends to pilots prior to WRFII kick-off
Evaluation Plan Worksheet (Appendix I)	A template in which pilots record their selected metrics, measures, and data collection plans	Pilots submit the template for IDA feedback after receiving the suggested metrics spreadsheet
Monthly Update Spreadsheet	A template in which pilots briefly describe their accomplishments, current activities, and needs for support from WRF/IDA	Pilots complete on a monthly basis
Quarterly Report Template (Appendix J)	A template in which pilots describe implementation progress/challenges, provide raw de-identified evaluation data, and interpret results/findings	Pilots complete on a quarterly basis

1. New Pilot Orientation and Start-up

Once new pilot programs confirm their participation in the WRFII, they begin an orientation process to learn about the benefits and expectations of participation in the WRFII. Pilots receive a Welcome Packet (Appendix G) upon confirmation of participation. This document provides an overview of the WRFII, participation requirements and deliverables, and key contact information for IDA and WRF team members. Pilots also receive information about funding disbursements and contracting procedures from WRF.

After pilots receive funding disbursements, WRF and IDA hold an inaugural community call teleconference with the full cohort of new pilots to orient them to program processes and expectations and introduce pilots to each other and the WRF and IDA teams. Following this call, IDA begins scheduling individual TA calls with each pilot team. The purpose of these calls is for IDA to gain a clear understanding of the nature of the pilot program and the pilot team's TA needs and to build rapport. The call covers the following topics:

- Overview of the program, including goals and objectives
- Current status of the program (start-up, early implementation, ongoing implementation)
- Plans for evaluation design, data collection, and metrics
- Challenges related to implementation/evaluation and need for technical assistance
- Relevant documents the pilot team can provide (e.g., work plan, list of metrics, survey tools, reports)

Following this call, pilots begin developing or refining their evaluation plans, which they ultimately document on the Evaluation Plan Worksheet (Appendix I). This worksheet requires

[112] Williams, et al., *Catalogue of Warrior Resilience and Fitness Metrics and Measures,* IDA Paper NS P-18430 (Alexandria, VA: Institute for Defense Analyses, 2021).

each pilot to select process and outcome metrics and to describe the data and methods they will use to track these metrics, along with any TA they will need to do so. In FY19 and FY20, pilots required varying degrees of support to complete this worksheet. To assist them in selecting metrics, IDA developed a spreadsheet with recommended metrics and data collection methods tailored to each pilot program (see Appendix H for an example) based on the introductory TA discussion, the pilot proposal, and any other supporting documents provided. Pilots are encouraged to select from this spreadsheet to form their evaluation plans, though they are not required to use the recommendations.

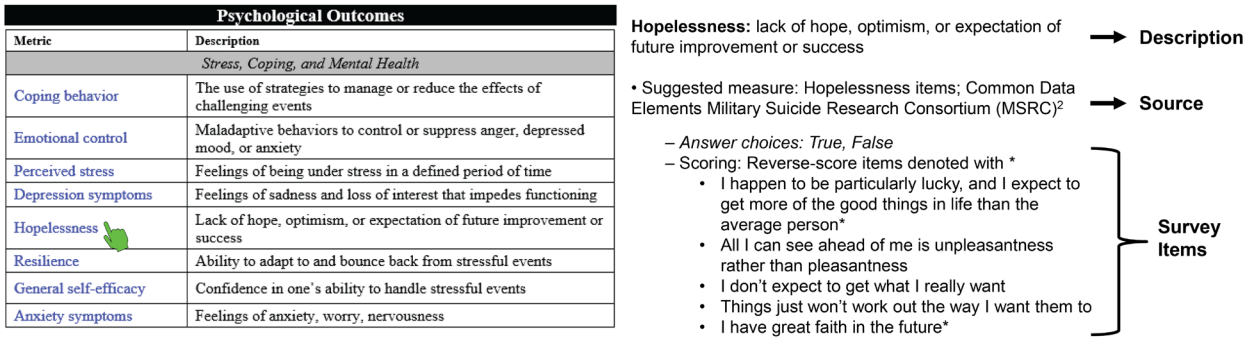
In addition to selecting a comprehensive set of metrics, pilot programs are also encouraged to employ pre/post (or baseline/endline) designs and control/comparison groups to gather robust evidence of effectiveness. Pilots detail these methods in the Evaluation Plan Worksheet. After each team completes their worksheet, IDA reviews the document and provides feedback. As pilots prepare to implement their evaluation plans, IDA also assists with designing or refining evaluation questionnaires/surveys and provides information about data collection and analysis software options.

To inform their metrics selections and design of evaluation tools, all pilots receive the Catalogue of WRF Metrics and Measures,[113] a document that lists and defines approximately 100 metrics. The catalogue includes recommended survey measures and administrative data sources for each metric and is organized according to TFF domains: Psychological, Social, Ideological/Spiritual, Financial, Physical/Medical, and Nutritional. Figure 4 provides an overview of the catalogue's contents overlaid on a TFF model:

Figure 4. Sample Metrics Included in the WRF Catalogue of Metrics and Measures

[113] Williams et al., *Catalogue of Warrior Resilience and Fitness Metrics and Measures,* IDA Paper NS P-18430 (Alexandria, VA: Institute for Defense Analyses, 2021).

To use the Catalogue, pilot teams identify the TFF domains and outcome subcategories relevant to their pilot, then browse the metrics listed under each. Once the user has identified a metric to include in the pilot's evaluation plan, clicking the name of the metric will bring the user to the associated survey measure or administrative data source. Figure 5 illustrates this process.



Psychological Outcomes

Metric	Description
Stress, Coping, and Mental Health	
Coping behavior	The use of strategies to manage or reduce the effects of challenging events
Emotional control	Maladaptive behaviors to control or suppress anger, depressed mood, or anxiety
Perceived stress	Feelings of being under stress in a defined period of time
Depression symptoms	Feelings of sadness and loss of interest that impedes functioning
Hopelessness	Lack of hope, optimism, or expectation of future improvement or success
Resilience	Ability to adapt to and bounce back from stressful events
General self-efficacy	Confidence in one's ability to handle stressful events
Anxiety symptoms	Feelings of anxiety, worry, nervousness

Note: The user clicks "Hopelessness" in the metrics table (left) and navigates to a survey measure (right).

Figure 5. Example Metrics Selection Process

The purpose of the Catalogue is to not only assist individual pilot teams in developing their evaluation plans, but also better align program evaluation across pilot programs. By linking each metric to a validated survey measure or data source, the Catalogue helps to ensure that pilots that track the same outcome metrics use the same measures to do so. When developing their evaluation plans, pilots are also encouraged to track a certain set of priority WRFII metrics. In FY20, these metrics included "connectedness" and "help-seeking intentions," with measures drawn from the Defense Equal Opportunity Climate Survey and Status of Forces Survey, respectively. These priority metrics and measures enable WRF to evaluate the aggregate effects of the WRFII across all pilot programs.

Depending on the nature of the evaluation design, some pilots may require approval by an Institutional Review Board (IRB) and/or Human Research Protections Office (HRPO). IDA is unable to consult with pilot programs on whether IRB/HRPO approval will be necessary as it is outside the scope of IDA's statement of work and not appropriate for IDA, as a non-DOD organization, to advise NGB on compliance with DOD policies. IDA informs pilot teams of this limitation and refers them to WRF and their state leadership for guidance on policies related to program evaluation, research, and information collections. To ensure pilots receive support in navigating lengthy IRB and HRPO approval processes, WRF should seek to develop resident expertise on IRB/HRPO processes and a regular line of communication with the service offices responsible for executing these processes.

2. Ongoing Support and Deliverables

IDA provides ongoing TA for pilot teams' evaluation activities through conference calls, review of deliverables, and individual follow-up on an as-needed basis. All pilot teams are required to provide written monthly and quarterly reports and participate in monthly calls. These reports

enable IDA to respond to pilots' TA needs, provide information which WRF may brief to key stakeholders, and promote information-sharing among pilot teams and with non-WRFII states. To facilitate improved access by each of these parties, WRF should consider storing all reports and resources in an accessible, centralized repository in the future.

Each month, all pilot teams fill out the Monthly Update Spreadsheet with a short summary of their implementation and evaluation progress and challenges over the past month. The purpose of this summary is to inform WRF and IDA of each program's activities and facilitate outreach for TA. The spreadsheet also includes space for the pilot team to update a statement of the pilot's key accomplishments to date. WRF includes these key accomplishments in briefings to NGB leadership, Congress, and other external audiences. IDA compiles each pilot's updates into a single Excel workbook, with each month on a separate worksheet, to allow all pilot teams to read each other's updates.

IDA and WRF host a community call with all pilot teams once a month. The purpose of the community calls is to share WRFII updates, socialize TA resources, and identify areas in which the pilots may need further assistance or support. The attendance on and structure of these calls changes from month to month. Initially, new pilot programs attend community calls with only their cohort of new pilots to learn about WRFII processes. Once new pilots are oriented, they attend community calls with pilots that began in previous years. On larger calls, with multiple cohorts of pilots, WRF and IDA occasionally divide the pilots into smaller breakout groups to better facilitate discussion among similar programs. At least one point of contact from each pilot team is expected to attend one community call per month.

Each quarter, all pilot teams complete a quarterly report using the Quarterly Report Template (Appendix J). In this report, pilot teams document their implementation progress and any related challenges, creating a record that will inform future efforts by other states/territories to replicate or adapt the program. Pilot teams also provide their de-identified raw data, present a summary of their process and outcome metrics, and write a brief narrative discussing their evaluation findings or other lessons learned. This document not only allows IDA and WRF to monitor the progress of each pilot, but also creates a record that pilot teams and WRF can share with NG and other external stakeholders, facilitating broader dissemination.

While IDA provides feedback on each pilot team's deliverables, pilot teams are encouraged to proactively seek out IDA's support for efforts such as developing data collection tools, trouble-shooting data collection or data quality issues, conducting data analyses, and reporting on metrics. In the past, the degree of IDA's engagement with each pilot varied according to the pilot teams' need for external support. The experiences of three pilot programs, as described below, illustrate the impact of the WRFII and IDA-led TA on state-level activities.

- **Buddy Aid (South Dakota and Wyoming ARNG):** Buddy Aid is a sexual assault first responder training taught in the style of first aid or suicide prevention gatekeeper training. IDA worked closely with the pilot team to identify appropriate metrics and

measures for inclusion in pre- and post-training assessments and a follow-up survey. To support analysis, IDA created an Excel workbook to calculate descriptive statistics of all training data. IDA summarized these results and conducted statistical analyses to determine the statistical significance of changes from pre- to post-training. IDA also created a separate Excel workbook in which the pilot team tracks administrative metrics, such as number of participants in each Buddy Aid training and number of sexual assault disclosures following training. Leveraging evaluation data demonstrating effectiveness of the training, Buddy Aid secured endorsement from the Adjutant Generals (TAGs) in South Dakota and Wyoming for state-wide roll-out and support from ARNG SAPR to pursue further expansion and institutionalization (see section C of this chapter for detail).

- **Embedded Clinician (Connecticut ARNG):** Through a partnership with the Connecticut Department of Mental Health and Addiction Services (DMHAS), a community agency embeds mental health providers during drill weekends to provide services and referrals to SMs. Although this partnership predated the WRFII, the pilot team struggled to obtain access to reliable administrative data on community provider support to SMs. IDA reviewed the available community provider reports to identify data quality issues and the pilot team raised these issues with the community agency to improve performance and accountability. To supplement community provider reports, the team also developed a questionnaire to determine SMs' awareness of, utilization of, and satisfaction with the program. They used measures from the Catalogue of WRF Metrics and Measures to develop the questionnaire, and IDA provided feedback to improve clarity. The questionnaire revealed limited awareness and utilization of the program, prompting the team to initiate efforts to spread awareness. Although the program experienced significant challenges, the pilot's experience demonstrates the utility of evaluation for identifying needed process improvements and may provide key lessons learned for those hoping to implement a similar program in their state.
- **Start (South Carolina ARNG):** Start is an online gatekeeper training for suicide prevention developed by LivingWorks. As originally developed, the Start training included brief pre- and post-training assessments in the training interface; however, they were largely marketing-oriented. In FY19, IDA recommended the addition of several measures of gatekeeper knowledge, skills, and behaviors, as well as a longer-term follow-up assessment. LivingWorks ultimately included one scale of self-reported measures in the pre- and post-training assessments. In FY21, IDA worked with LivingWorks to develop a follow-up assessment that included additional measures of knowledge and behavior (i.e., actions to help individuals at risk). Starting in the fall of 2021, this follow-up training assessment will be sent to participants two months and six months after training completion. Start evaluation data will be compared to two FY21 pilots using similar gatekeeper training approaches (Mental Health First Aid and

Together Strong); IDA is working with the new pilots to align their assessment tools with Start's training assessments.

B. FY19 and FY20 Pilot Program Challenges

Pilot programs commonly experienced difficulties in implementing and evaluating their programs. Challenges related to the COVID-19 pandemic, SM and staff time, leadership support, and data collection delayed many pilots' activities and, in some cases, limited their ability to assess the implementation and outcome effectiveness of their programs. Lessons learned from navigating these challenges can help inform, prepare, and guide future pilot programs. Table 8 summarizes common challenges and strategies through which WRF or pilot programs may address them. The discussion that follows the table provides details on each of these common challenges.

Table 8. Common Challenges Experienced by FY19 and FY20 Pilot Programs

Challenge	Mitigation strategies in use	Recommendations
Interruptions due to COVID-19 restrictions	• Pilots shifted to virtual platforms • WRF requested information on effects of COVID restrictions in all FY21 pilot proposals	• WRF should consider extending time in the program for pilots greatly impacted by COVID-19
Delayed start-up due to contracting and other approval processes	• WRF added contracting guidance to the FY21 call for proposals	• Prior to Year 1, WRF could provide seed funding to pilots likely to have start-up delays
Difficulty recruiting program participants	• Pilots secured participants by incorporating programs into drill or other existing processes	• WRF should encourage pilots to share program recruitment materials and messaging to identify best practices • Invite expert reviewers to serve as mentors to new pilots to assist with implementation and evaluation
Lack of leadership support due to turnover or shifting priorities	• Pilots used evaluation findings to advocate for their programs	• Pilots should analyze return on investment to demonstrate the value of their programs • WRF should directly engage with state-level leaders and provide documentation of WRF support for pilots

Challenge	Mitigation strategies in use	Recommendations
Limited staff time for implementation and evaluation	• Pilots utilized contractors as contracting costs are covered by WRFII funding	• WRF should review pilot proposals to ensure selected pilots have adequate staffing plans • WRF should aim to provide military pay and allowance funding to pilots that require staffing augmentation and/or assist pilots in requesting funding from relevant program offices
Few responses to evaluation questionnaires	• Pilots asked SMs to complete forms during program activities (immediately before and after training) or other in-person events • Pilots used technology (QR codes, electronic data collection) to make forms easy to complete • Pilots worked with IDA to shorten lengthy questionnaires	• WRF should encourage pilots to share messaging and other strategies to secure participation
Lack of access to comparison groups	• Pilots pursued other strategies to strengthen evaluation (e.g., historical comparisons, long-term follow-up assessments)	• Pilots should use data from DOD surveys and administrative sources to compare participant and non-participant outcomes
Lack of access to administrative and service utilization data	• Pilots leveraged internal NG data (e.g., physical fitness test (PFT) results, alcohol incidents)	• Pilots should secure buy-in from multiple levels of state leadership to facilitate data-sharing across programs

1. COVID-19

Many pilot programs experienced delays or interruptions due to COVID-19 restrictions and state activations. When pandemic restrictions began in the spring and summer of 2020, most states stopped holding monthly in-person weekend drills. In states that did hold in-person drills, social distancing requirements limited the number of participants in pilot activities. Some states continued implementation unabated through use of virtual platforms. In Georgia, for example, the Work for Warriors pilot was already structured to provide remote services, allowing for uninterrupted implementation. Likewise, COVID-19 did not impact online Start training; rather, it led to the expansion of the program as many other states sought virtual offerings. Other states needed to adapt implementation to accommodate COVID-19 restrictions. Michigan, for example, shifted from testing an in-person experiential couples education course (PREPx) to an entirely virtual one (ePREP), and Oregon's Embedded Resiliency Teams "embedded" in units' virtual drills to provide psychoeducation and information about available services. In addition to

pandemic-related restrictions, activations and deployments for responses to the pandemic and civil unrest limited the ability of personnel in several states to continue managing their pilot for much of the year. Given ongoing pandemic-related restrictions, WRF required all new pilot proposals (beginning in FY21) to describe how restrictions would affect their implementation plans, and ERPs considered this information when assessing the feasibility of each pilot.

2. Start-up

While COVID-19 had significant impacts on most programs, several programs struggled with long start-up times for other reasons. Contracting presented an issue for some pilot programs. In particular, pilots that had identified a specific contractor prior to receiving funding experienced difficulties complying with sole source contracting regulations. However, pilots that waited to identify a contractor until after selection into the WRFII also encountered start-up delays. These challenges are to some extent unavoidable, and WRF must maintain close communication with states to manage this process.

To prepare potential pilots to set up contracts, WRF now includes guidance on contracting in its call for proposals. In the past, WRF has also offered a small amount of seed funding to promising pilots for one year to assist with navigating lengthy start-up processes, with the expectation that the program begins full participation in Year 1 WRFII activities the following year; this option for start-up funds could be expanded to a greater number of pilots. Furthermore, WRF and other stakeholders should take the actual length of time each state has been implementing its pilot program into consideration when examining evaluation results, rather than solely considering the year the program began receiving funding.

3. Service Member Participation

Several pilot teams noted difficulties securing SM participation in their programs. This was often due to limited time available during drill as well as to limited funds to put SMs on orders to participate in activities outside of drill. Programs in which participation in program activities is voluntary and separate from drill, such as Michigan's Electronic Couples Relationship Education Program and Connecticut's Risk Reduction Psychoeducation Group, seem to face the greatest difficulty in recruitment. Referral-based programs and programs embedded into existing processes, including Georgia's Work for Warriors, Massachusetts's Warrior F.I.T., New Mexico's Behavioral Health Primary Prevention and Retention, and Oklahoma's SASSI-4 programs, have relatively greater success in consistently attracting participation, even when voluntary. Programs scheduled into drill, including South Dakota's Buddy Aid, California's Supportive Services Council, and Ohio's First Line Leader Course, may have the greatest success securing participants; however, scheduling these sessions may rely upon relationships with unit commanders, which some pilots may struggle to obtain.

4. Leadership Support

Leadership support is critical to the success of WRFII pilot programs; it can affect the program's ability to implement, secure participants, and conduct an evaluation, as well as the long-term sustainability of the program. Multiple states noted challenges maintaining leadership support due to leaders' competing priorities, turnover, and skepticism about the program's value. For example, one pilot team experienced pushback from a new commander who believed the program was negatively affecting recruitment and retention outcomes. The pilot team was able to use data to demonstrate that the commander's perception was inaccurate. However, the team noted that state-developed programs are often supported through informal agreements with commanders; without mandates from higher levels of leadership, the programs are vulnerable to being altered or discontinued given command turnover or shifting priorities. Pilot teams must actively work to gain leadership support through building relationships with commanders and using evaluation data to advocate for the program. To assist in this advocacy, IDA presented on methods for calculating return on investment during one community call; such an analysis may enable pilots to show cost savings and cost effectiveness associated with their programs. WRF could further assist states in gaining leadership support by engaging directly with state leadership, providing documentation of briefings with NGB leadership to demonstrate the high-visibility of the program, and providing official memorandums of WRF's support for the pilot programs.

5. Staff Time

In several states, limited staff time hindered both program implementation and evaluation. Currently, the Congressional allocation used to fund WRFII pilots does not provide funding for military pay and allowances; thus, staff time cannot be augmented through WRFII participation (unless contracted). Consequently, pilot teams often performed WRFII activities as an additional duty. This structure made it particularly difficult to prioritize the data collection and reporting activities that participation in the WRFII demands. Even where pilot teams did manage their pilots as a primary duty, they still experienced time constraints. The leader of South Dakota's Buddy Aid program, for example, is on full-time orders to run the pilot; however, as the pilot scaled up implementation to additional states after its first year, demand on staff time has increased beyond a single full-time effort, putting pressure on both implementation and evaluation activities. Several pilots noted that additional administrative support and staffing would improve their team's capability to implement and evaluate their pilot. While the proposal submission materials clearly describe the implementation, evaluation, and reporting requirements of participation in the WRFII, pilots may underestimate the time intensity of these requirements. As such, WRF should closely review new pilot proposals to verify that the budget requests and staffing plans are realistic for meeting all requirements. Further, if feasible, WRFII should seek to provide funding for military pay and allowances for pilots that require staff augmentation and/or assist pilots in requesting funding from relevant program offices.

6. Program Assessment Participation

While most pilots that asked participants to complete program/training assessments developed robust measures and data collection plans, some struggled with low response rates, especially when administered outside of a training or other in-person setting. In Georgia, for example, the Work for Warriors program emailed an evaluation questionnaire to all employment assistance recipients but received very few responses. The state ultimately called recipients over the phone, enabling them to collect more responses but requiring an unsustainable amount of staff time. Several programs that delivered in-person trainings or built the program assessments into their program delivery had less difficulty achieving higher response rates. Other states, however, found that data collection took away from their program activities. One program, for example, found that administering assessments before and after participation took too much time and was not well received by participants. To save time, they only implemented a post-event training assessment, which weakened the quality of their evaluation. IDA worked with pilot teams to shorten lengthy data collection tools and develop feasible data collection schedules. Multiple states also identified innovative solutions to data collection challenges. For example, Connecticut's Embedded Clinician program provided SMs waiting in line for their periodic health assessments with a quick response (QR) code linking to an electronic form, Ohio's Support System Coordinator created a video encouraging newsletter recipients to respond to the pilot's biannual feedback tool, and Oregon's Embedded Resiliency Team worked with information technology staff to automatically prompt all Wing members to complete an evaluation questionnaire upon logging into their NG laptops.

7. Comparison Groups

Most states are unable to collect data from individuals apart from the direct beneficiaries of their program. This posed a challenge to including comparison groups in pilots' program evaluations, as states would need to rely on commanders or staff of other programs to facilitate access to individuals not participating in the pilot program. Multiple pilot programs attempted to work with other offices in their states to identify potential comparison groups, but have not yet succeeded. To facilitate comparison with program non-participants, IDA has recommended the use of existing DOD survey data (e.g., Unit Risk Inventory (URI), Defense Equal Opportunity Climate Survey (DEOCS)) and administrative data. In Ohio, for example, the Support System Coordinator will assess the effects of Start training by comparing URI results in units that received Start training versus those that did not. In New Mexico, the Behavioral Health Primary Prevention program is able to compare trends in service utilization and behavioral health outcomes between program participants and non-participants using prior years' administrative data.

8. Service Utilization Data

Access to service utilization data posed a challenge for several pilots, especially when working with partner organizations or NG programs not directly involved in the pilot. In various

states, pilot programs have been unable to access certain data relevant to their evaluations because partners have refused to provide it or simply did not collect the requested data. In one state, the program struggled to obtain de-identified data from the private organization that staffed the program. When the organization eventually did provide this data, the data quality was poor, limiting its utility. While it may ultimately not be possible to obtain service utilization data from private entities, states may be better able to utilize internal administrative data; states typically had easier access to data on outcomes such as fitness test results, alcohol incidents, and engagement with NG behavioral health services. Still, some states had difficulty obtaining requisite data from NG programs and staff not directly involved in the pilot. In one state, the pilot team found that NG service providers were not tracking the referral or usage statistics the program needed to determine whether the pilot affected service utilization, while in another state, the pilot team found some programs unwilling to share data. This highlights the importance of securing buy-in for the pilot from multiple levels of state leadership.

C. FY19 and FY20 Pilot Program Achievements

As the WRFII has progressed, the quality of pilots' evaluation plans has improved. Whereas most pilots in the first cohort initially collected limited data on SM outcomes, IDA worked with them to form pre/post data collection plans and/or plans to compare outcomes to historical trends using existing administrative or existing survey data. In order to strengthen the quality of evaluation among future pilots, IDA recommended that WRF require pilots to describe their evaluation plans in their WRFII proposal submissions. WRF then considered the feasibility of conducting a robust evaluation in its FY20 pilot selections, and once the FY20 pilots joined the WRFII, they had already started planning evaluation activities. The vast majority of pilots in the FY19 and FY20 cohorts have implemented or planned robust evaluations. Almost all are collecting data on program participants at multiple time points, including before and after program participation. Some are conducting time-series analyses to examine changes in trends, such as in substance use recidivism rates, PFT pass rates, retention rates, or URI results. Despite the challenges described in the previous section, several pilots are additionally planning to incorporate comparison or control groups.

Several pilots have begun expansions to additional states/territories and joint Army/Air NG implementation. In South Dakota, the Start program expanded to include Ohio in its first year and added several additional states in its second and third years. The Buddy Aid program gained the support of TAGs in South Dakota and Wyoming to pursue state-wide roll-out in both of those states during the second year of the program and has trained Buddy Aid facilitators in over 10 states. Buddy Aid, WRF, and ARNG SAPR are now working with the Professional Education Center (PEC) to establish monthly offerings of Buddy Aid train-the-trainer (T3) and Level 10 training at PEC. New Mexico's Behavioral Health Primary Prevention and Retention Program, initially an ARNG program, has expanded to include the New Mexico ANG, the South Dakota ARNG and ANG, and the Arkansas ARNG. WRF also shared information about the program with

the Independent Review Commission on Sexual Assault, which is now considering making recommendations based on the screening approach the New Mexico pilot team developed. These scale-up activities may be beneficial to evaluating the pilot programs. Increasing the number of participants and including participants from multiple contexts may provide useful information related to the program's applicability or need for adaptation in various settings.

While it is too early for many pilots to draw conclusions about the outcomes of their programs, five states in the first cohort of pilots have found promising evidence of effectiveness:

- *Behavioral Health Primary Prevention and Retention (New Mexico ARNG):* Demonstrated that screening and proactive case management (CM), when compared with no screening and standard of care, 1) reduce the incidence of mental health, substance use, and psychosocial issues requiring standard of care CM and, 2) when these issues do occur, facilitate identification and intervention at low levels of acuity. Based on historical data, the program projected 69 participants would develop behavioral health issues; only 15 did so, and at low levels of acuity.[114]
- *Buddy Aid (South Dakota and Wyoming ARNG):* Demonstrated evidence of effectiveness for preparing SAPR VAs and SARCs to lead Buddy Aid and for improving sexual assault response preparedness among SMs more broadly. Ninety-two percent of T3 participants and 66% of Buddy Aid participants showed increased preparedness for appropriately responding to disclosures of sexual assault (improvement in knowledge, likelihood to act and confidence in response skills; and attitudes supportive of sexual assault prevention and response). These improvements were statistically significant.[115]
- *Start (South Carolina ARNG):* Demonstrated preliminary evidence of effectiveness for building gatekeeper skills for suicide prevention. In aggregate, the 1,934 participants reported higher self-assessed confidence in their ability to help those at risk immediately following the training (65-75% highly confident) compared to pre-training (25-35% highly confident). [116]
- *Warrior F.I.T. (Massachusetts ARNG):* Demonstrated evidence that the program's didactic workshops were effective in improving fitness test scores among SMs with previously failing scores or height/weight flags. The program found a statistically

[114] Brian Pilgrim, "Behavioral Health Primary Prevention and Retention Program Quarterly Report" (unpublished report, submitted to NGB (WRF), February 27, 2021), Microsoft Word file.

[115] Bridget Flannery, "Buddy Aid Quarterly Report" (unpublished report, submitted to NGB (WRF), May 5, 2021), Microsoft Word file.

[116] LivingWorks, "LivingWorks Start Course Survey" (unpublished report, submitted to NGB (WRF), September 9, 2020), Microsoft Word file.

significant increase in Army Physical Fitness Test (APFT) scores after workshop participation. Further, among 93 workshop participants, 60 participants lost body fat and 18 successfully came off of APFT or height/weight flags.[117]

- *Work for Warriors (Georgia ARNG):* Demonstrated evidence of effectiveness for identifying SMs in need and connecting them with services. The screening and referral process in particular appeared to be an effective and highly feasible tool for streamlining service provision. Among the 9,984 individuals screened in FY20-FY21, the program received 1,115 requests for employment assistance and facilitated 286 new full-time hires.[118]

Although only a few pilot programs have had sufficient time to demonstrate program effectiveness, many pilot programs have data available to demonstrate the reach of their program to provide services and support for SMs. Examples are provided below.

- Across four WRFII pilots, screened over 11,500 SMs to assess needs and identify those at risk for adverse outcomes
  - Screened 9,984 SMs to assess need for support services (Work for Warriors)
  - Screened 528 new recruits to identify SMs at risk for retention-limiting conditions (Behavioral Health Primary Prevention and Retention)
  - Screened 73 self-referrals and positive urinalysis cases with the online SASSI-4 (SASSI-4)
  - Screened 995 SMs on body composition and injury risk to tailor physical readiness plans (Warrior F.I.T.)
- Across seven WRFII pilots, provided training to over 9,000 SMs to prevent harmful behavior and promote holistic fitness
  - Deployed online gatekeeper training, completed by over 2,600 individuals (Start)
  - Held 4 T3s and 13 sexual assault first responder training sessions, including 539 participants in total (Buddy Aid)
  - Held two-day trainings for 52 individuals referred for drug and alcohol-related incidents (ADAPT-Guard)
  - Provided leadership training for 71 units (740 individuals) on effective counseling (First Line Leader Course – Relational Leadership)

[117] Meghan Garvey, "FY20 Q4 Warrior FIT data analysis," (unpublished report, submitted to NGB (WRF), n.d.), Microsoft Word file.

[118] Lacy Turner, "Work for Warriors GA Quarterly Report," (unpublished report, submitted to NGB (WRF), May 1, 2021), Microsoft Word file.

  - Held physical readiness workshops with 151 participants (Warrior F.I.T.)
  - Held 4 camps for 87 soldiers on nutrition and fitness fundamentals (AXE)
  - Conducted targeted prevention training with 115 at-risk units, with 5,061 participants in total (Support Services Council)
- Across three WRFII pilots, coordinated resources, information, and support; in total, the programs reached out to over 11,000 SMs and/or family members
  - Sent informational newsletters to SMs and their families (5,432) and mailed 566 gun locks (Support Systems Coordinator)
  - Disseminated crisis intervention app, downloaded by 1,539 individuals (SafeUTNG)
  - Provided "one-stop-shop" services to 4,328 unique individuals (One Stop Shops)

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5. Disseminate and Implement

A central goal of the WRFII is to identify local pilots that can be expanded and applied across the NG. To achieve this end, IDA recommended a three-year trajectory for pilot programs entering into the WRFII, from proof of concept (year 1), to local evaluation (year 2), and concluding with a broader evaluation across multiple states (year 3). At the end of three years, pilots that address key leadership priorities and demonstrate evidence of effectiveness across multiple states may be recommended for broader implementation across NG states and territories. Most pilots, however, will not be appropriate for Guard-wide implementation but could still be funded at the state level for local use. WRF engages in a range of dissemination activities to ensure that NG states and territories can leverage effective pilots that meet the needs of their SMs. As the final stage of the WRFII process, dissemination and implementation activities are just beginning. Thus, this chapter presents the intended way forward, but refinement of this process is expected as the first cohort of pilots (FY19) complete their final year with the WRFII (third year will conclude by March 2022).

A. Pilot Trajectory

IDA recommended a three-year trajectory for WRFII pilots, loosely based on tiered evidence grant models, as described in GAO-16-818.[119] Tiered evidence grant models provide varying levels of funding to programs depending on their level of evidence. Innovations without robust evidence are given relatively less funding to demonstrate feasibility while programs with evidence of effectiveness are given more funding to demonstrate generalizability across sites or for different populations. The VHA uses a similar tiered approach for their innovation process, with "spark" awards to support pilot program development/proof of concept, "seed" to support evaluation of pilot projects in one location, and "spread" to support evaluation of pilot programs across multiple locations ("diffusion of innovation").[120] Since WRFII's pilot program submissions are nearly all at the earliest stage of development (proof of concept), IDA recommended a tiered approach distributed across time (Figure 6).

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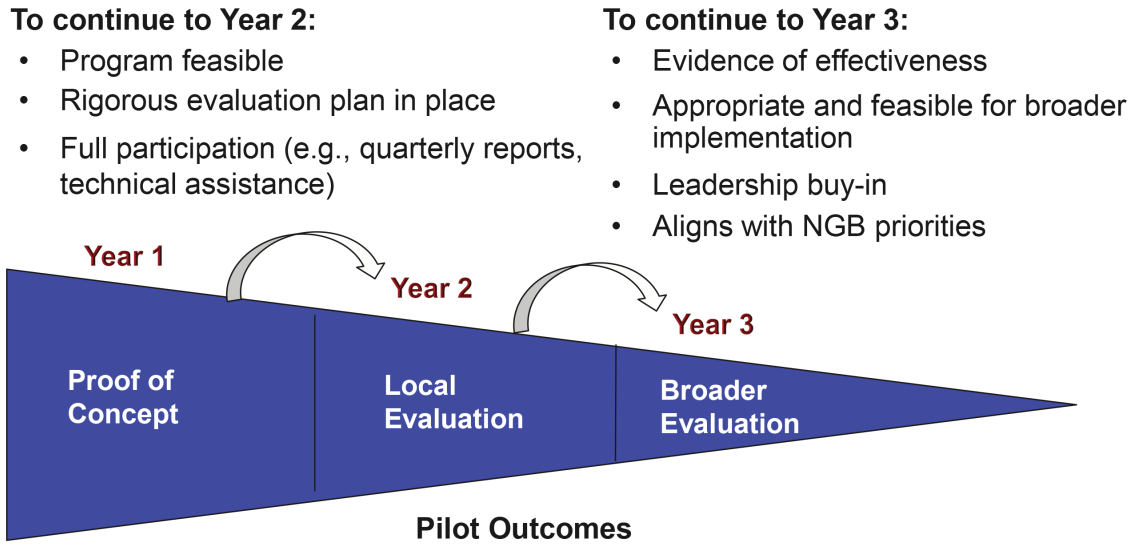
[119] United States Government Accountability Office, *Tiered Evidence Grants: Opportunities Exist to Share Lessons from Early Implementation and Inform Future Federal Efforts*, (n.p.: United States Government Accountability Office, September 2016), https://www.gao.gov/assets/gao-16-818.pdf.

[120] "Innovators Network Spark-Seed-Spread Investment Program" Solutions, VHA Innovation Ecosystem, accessed May 5, 2021, https://www.va.gov/INNOVATIONECOSYSTEM/views/solutions/spark-seed-spread.html#:~:text=What%20is%20Spark%2DSeed%2DSpread,families%2C%20caregivers%2C%20and%20employees.

The intent is for most pilots to progress through the tiers in three years. However, not all pilots will be selected for continuation, and the pace of progression through the three tiers may vary. As described in Chapter 4, some pilots have lengthy start-up times to set up contracts or secure necessary approvals; these pilots will likely need the full three years to proceed through each tier. Conversely, other pilot programs which are able to begin immediately upon selection and/or are relatively simple to implement (e.g., online program) may proceed through the tiers in less than three years.



- Documentation only: Pilots that do not proceed past Year 1 or that lack evidence of effectiveness are not disseminated for implementation, however, lessons learned from these pilots are recorded and shared broadly
- Dissemination only: Pilots found to be effective after Year 2 or Year 3 will be: included in the Compendium, spotlighted in dissemination activities, and may be locally funded
- Dissemination and implementation: Pilots found to be effective after Year 3 will be spotlighted in dissemination activities and connected with relevant NGB programs offices to be considered for Guard-wide implementation

Figure 6. Three-year Trajectory for WRFII Pilot Programs

At the time of selection, most WRFII pilots have not yet implemented their program, while others are just beginning implementation but do not have a plan for evaluation in place. At a minimum, the key tasks for first-year pilots are to begin implementation to demonstrate the feasibility of their program and to establish a strong evaluation plan with the support of the technical assistance team (see Chapter 4). Pilots that do so, and demonstrate their reliability as partners through participation in WRFII activities, will be selected for a second year of funding.

The key aim for second-year pilots is to fully evaluate their program in a single state to determine effectiveness in improving SM outcomes. Programs that do not demonstrate evidence

of effectiveness by the end of their second year will typically not receive a third year of funding, though their outcomes and lessons learned will be included in certain dissemination materials (described below). Furthermore, not all pilots that demonstrate effectiveness will proceed to a third year. To progress to a third year of funding, pilots must not only demonstrate effectiveness in their initial local evaluation, but also show promise of feasibility for broader implementation (e.g., applicable/relevant for a national population, not cost prohibitive) and alignment with NGB and leadership priorities, particularly among leaders of the programmatic domain most relevant to their pilot (e.g., Resilience, Risk Reduction, and Suicide Prevention (R3SP) for a suicide prevention pilot, SAPR for a sexual assault prevention pilot). Given that not all effective pilots will meet these additional criteria, effective pilots that do not proceed to a third year may still be disseminated by WRF and selected by individual states for local implementation. In some circumstances, pilots that do not meet all these criteria may still receive funding in their third year to complete local evaluation started in the second year.

The goal of the third and final year of pilot participation is to implement and evaluate the program across multiple states. Pilots selected for a third year of funding have often already begun implementation across multiple states, or at least conversations with potential partners. To assist pilots in deciding on partner states, WRF and IDA developed the following guidance (Table 9).

Table 9. Considerations for Pilot Programs Selecting Partner States for Expansion

Key aim for year 3 pilots is to expand evaluation to other states; however, pilots should prioritize quality of implementation over quantity of participating states. Pilots should consider the following criteria when selecting new states:	
Essential criteria:	• **Leadership buy-in** – does state leadership support the pilot? • **Feasibility** – can the state implement with fidelity (according to the guidance provided by the lead state)? • **Evaluation capability** – is the state willing/able to participate in the evaluation?
Additional considerations:	• **Risk level** – is the state at high risk for the problem the pilot addresses? • **Geographic diversity** – is the state in a region not covered by other participating states?

Third-year pilots also participate in dissemination activities to a greater extent than in previous years; WRF often shares initial results of these pilots with leadership or features information about the pilots in newsletters. WRF also ensures that third-year pilots are socialized with the programmatic office in which they could potentially reside. At the end of the three-year trajectory, WRF may recommend a limited number of effective pilots for broader implementation throughout the Guard, most likely directed through the relevant programmatic office. As described

below, effective pilots that are not ultimately recommended for broad implementation will still be featured in WRF dissemination activities.

B. Dissemination

The full benefits of the WRFII cannot be achieved without broad dissemination of pilot outcomes. Through a robust dissemination process, the innovations developed through the incubator can directly inform local practices to improve SM wellbeing. Importantly, dissemination activities must not only feature effective programs, but also programs that were not feasible or effective to avoid duplication of flawed practices. Further, lessons learned from all pilots should be passed on to program managers and leaders at the state level to help them refine their current practices and inform development of new approaches. To date, WRF has a number of dissemination activities in place, mainly focused on effective or promising pilots. In the sections that follow, we highlight current activities along with recommendations for future activities to enhance dissemination (summarized in Table 10). Moving forward, IDA recommends expanding the nature of information shared in dissemination activities to extend beyond program achievements to include challenges and lessons learned.

Table 10. Current and Recommended Dissemination Activities

Disseminate to leaders	• Present pilot information at leadership briefings and forums* • Include senior leaders outside of WRF in the programmatic review process or convene a General Officer Advisory Council (GOAC) to inform decision-making • Hold a virtual forum to allow effective pilots to present to state and national leaders • Disseminate quick guides on pilot outcomes
Disseminate to program managers and general audiences	• Include pilot information on the WRF website* • Feature pilots in media engagements* • Include information about pilots in DOD newsletters* • Invite pilots to present at communities of practice • Hold training events/workshops to provide in-depth information on pilots • Convene an annual forum to announce new pilots and feature continuing pilots • Disseminate a guidebook to describe pilot programs, implementation strategies, and evaluation results.

Note: * refers to dissemination activities currently taking place.

1. Dissemination to Leaders

WRF disseminates information about pilot outcomes to leaders through a variety of forums, including periodic briefings and discussions in leadership forums (e.g., briefing to the Director of the J-1, Suicide Prevention Task Force). These briefings, however, typically only inform a limited set of leaders, mainly at the NGB level. WRF should consider expanding dissemination to inform

a broader selection of senior leaders. To do so, WRF could involve senior leaders in programmatic selection decisions or convene a General Officer Advisory Council to weigh in on pilots most appropriate for Guard-wide implementation. Additionally, WRF could develop a forum to inform state-level leaders, including TAGs, about promising pilots that they could consider implementing in their states/territories. The forum could take place as a virtual conference with presentations from select pilots. Additional "quick guides" with promising pilot descriptions and outcomes could be disseminated to state and national leadership. WRF could also present to TAGs at existing forums (e.g., Resilient Forces Readiness Advisory Council (RFRAC), Adjutants General Association of the United States).

2. Dissemination to Program Managers and General Audiences

WRF's current dissemination activities extend broadly to key stakeholders, program managers, and even general audiences beyond DOD. WRF includes a fact sheet about pilot programs on its public-facing website and engages with the media periodically to highlight WRFII and specific pilots. Additionally, WRF publishes an internal newsletter which includes information about pilots and submits highlights about pilot programs to other DOD newsletters (e.g., Army Resilience Directorate newsletter).

Moving forward, WRF should consider platforms to provide more in-depth information about pilots to local program managers who may seek to implement a pilot in their own state/territory. WRF could present information about pilot programs through existing communities of practice/conferences or hold a WRF-sponsored event to highlight promising pilots. For example, instead of simply disseminating a memo to announce pilot-selection decisions, WRF could hold a virtual event to announce new pilots and showcase pilots selected for their third year of funding. WRF could also sponsor workshops and invite pilots to provide details about implementing their program, to include resources required and strategies for overcoming common challenges.

To assist with the dissemination process, IDA provides quarterly summaries of pilot program progress, based on the information submitted in their quarterly reports. IDA's next report will provide consolidated information about pilot outcomes as well as implementation-relevant information. The intent is to serve as a resource to inform program managers and leaders at all levels about pilots that may have relevance in their state. This material could be incorporated into a pilot guidebook that details each program's challenges, achievements, and for those with evidence of effectiveness, implementation guidance for distribution across the NG.

C. Continued Implementation and Evaluation

As NG selects pilots to implement nationally, it should develop a process and identify corresponding resources to bring pilot programs to scale. The WRFII process only supports pilot programs through the implementation and evaluation process, but additional support may be needed to ensure that the most promising pilot programs can be transitioned to Guard-wide

implementation. National implementation plans should also include evaluation to assess large-scale feasibility and effectiveness.

For pilot programs that are implemented locally (i.e., selected for the "dissemination only" outcome at the end of year three, for state leaders to implement on an as-needed basis), WRF should ensure that states/territories have a means to monitor implementation quality and evaluate program outcomes. At a minimum, pilot programs can provide their evaluation tools to states/territories hoping to implement their program. WRF can also provide direct TA to states/territories, disseminate evaluation support tools (including the Catalogue of WRF Metrics and Measures), and hold capacity-building seminars on program evaluation.

Ideally, NGB should develop a process to collect and centralize data on program processes and outcomes as pilot programs are implemented more widely, whether on a national or local level; WRF's SPRINGBoard could serve as a potential platform to do so. Through a centralized system to collect and aggregate program data, NGB can monitor programs to ensure that states/territories have sufficient resources, programs are implemented with fidelity, and they have a positive impact on SM wellbeing. A centralized system will also allow NGB to identify programs that should be discontinued or modified as SM needs and resource-availability shift over time. Ultimately, a sustained and deliberate approach to program evaluation will allow NGB to assess the long-term value of programs developed through the innovation incubator and determine areas of continued need to inform selection of new pilots.

6. Recommendations

Throughout the first two years of implementation of the WRFII, IDA has identified areas in which process refinements could better enable WRF to achieve its goals of identifying and disseminating the most effective local strategies for promoting resiliency and preventing harmful behaviors. This chapter summarizes recommendations for improving each step of the WRFII process, as described in the previous chapters.

A. Assess Needs and Gaps

- Develop a process to request basic information about existing NG wellness and resiliency programs in order to identify promising programs not submitted to the innovation incubator and better understand the current state of NG prevention and response activities.
  - Although WRF learns about many existing programs through the innovation incubator, some programs not in need of funds or without the time or resources to complete a submission may go unnoticed.
- Prioritize integrative/cross-cutting programs for evaluation of multiple harmful outcomes and consider applying prevention approaches successful in one harmful behavior domain to other harmful behavior domains (see Table 3).

B. Invite Submissions and Select Pilots

- To expand pilot evaluation capacity, suggest that pilot submissions should include at least one team member knowledgeable about program evaluation and allocate 10% of a program's budget/team members' time for program evaluation, as recommended by the CDC[121] and the World Health Organization.[122]

[121] MacDonald, Goldie, Gabrielle Starr, Michael Schooley, Sue Lin Yee, and Karen Klimowski, *Introduction to program evaluation for comprehensive tobacco control programs*, (Atlanta, GA: Centers for Disease Control and Prevention, 2001), https://stacks.cdc.gov/view/cdc/23472.

[122] World Health Organization, *Health Promotion Evaluation: Recommendations to Policy-Makers: Report of the WHO European Working Group on Health Promotion Evaluation*, (Copenhagen, Denmark: World Health Organization, 1998), https://apps.who.int/iris/bitstream/handle/10665/108116/E60706.pdf?sequence=1&isAllowed=y.

- Offer "seed funding" one year prior to commencement of official participation in the WRFII to support promising submissions that are likely to have lengthy start-up delays due to contracting or IRB/HRPO reviews.
- Include senior leaders outside of WRF in the programmatic review process, particularly when considering pilots for their third-year, in order to identify pilots that align with Guard-wide priorities and that hold the greatest promise for national application.

C. Evaluate Effectiveness

- To support pilots that may need to undergo IRB and HRPO reviews, hire or identify internally an individual with experience managing or conducting human subjects research to provide guidance.
- Invite ERP reviewers to serve as mentors to new pilots to provide subject-matter expertise on the pilot's program area and to assist with the development and implementation of evaluation plans.
- Assist in pilot teams' efforts to secure state-level leadership support early in the WRFII trajectory, such as by providing formal memorandums of support for the pilot program, increased documentation and sharing of WRF's leadership briefings on the WRFII, and targeted engagement with TAGs in states with promising pilots.
- To the extent possible, provide military pay and allowance funding to pilots that require staffing augmentation and/or assist pilots in requesting funding from relevant program offices.

D. Disseminate and Implement

- Expand dissemination activities to include not only effective programs, but also programs that are not feasible or effective; share information about program outcomes *and* implementation challenges/lessons learned.
- Consider whether additional resources are needed to bring programs to scale once they have successfully completed the three-year WRFII cycle; national implementation plans should include evaluation to assess large-scale feasibility and effectiveness.
- Once effective pilots are implemented nationally or in new states/territories, promote continued program evaluation through technical assistance and capacity building and collect program data in a centralized database to assess long-term outcomes.

Appendix A.
Comparison of Compendium of WRF Strategies to CDC Suicide Prevention Framework

CDC Suicide Prevention Framework	Compendium of WRF Strategies	Rationale for Change
Identify and Support People at Risk	Identify People in Need	Created a distinct category for identifying individuals at risk; this is a key area of focus for the NG since traditional Guard members do not receive health care through the military.
Identify and Support People at Risk; Strengthen Access and Delivery of Care	Provide Care and Treatment	Simplified to combine all behavioral health treatment and support in one category.
Create Protective Environments; Strengthen Economic Support	Create Protective Environments	Combined categories because economic support ensures individuals have their basic needs met and is thus a foundation of creating protective environments.
Create Protective Environments (*includes culture)*	Change Culture to Promote Help-seeking and Reduce Harm	Created a distinct category for culture change as it is a key goal of WRF and essential for integrative prevention. The CDC's sexual assault prevention framework also includes a separate category for culture change.
Teach Coping and Problem-solving Skills; Promote Connectedness	Enhance Life Skills, Connection, and Resiliency	Merged categories because evidence-based programs often combine coping skills and connectedness (e.g., relationship training to enhance communication skills).
Lessen Harms and Prevent Future Risk	Lessen Secondary and Future Harm	Changed to *secondary* harm to reference individuals not involved in the primary incident. This facilitates a more integrative prevention approach (e.g., behavioral health care for sexual assault survivors and those at risk of suicide can be included in the same category - "Provide Care and Treatment")

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Appendix B.
Evidence Level Grades Applied to Prevention Approaches

Level	Type of evidence
I+	• Systematic reviews/meta-analysis of random controlled trials (RCTs)
I	• RCTs • Experimental designs
II+	• Quasi-experimental designs (comparison group) with pre-/post-tests or time series
II	• Quasi-experimental designs (comparison group) with post-test only • Non-experimental designs (single group) with times series • Non-experimental designs (single group) with pre-/post-tests
III	• Non-experimental designs (single group) with post-test only
IV	• Qualitative design only • Sound theory • Expert opinions/interviews

Grade	Evidence level	Qualifying evidence	Implications for use
A	Strong evidence	Level I+ or I evidence or generally consistent findings from multiple studies of levels II+	Program can be adopted with confidence
B	Moderate evidence	Levels II+ evidence or generally consistent findings from multiple studies of level II	Program can be adopted with relative confidence
C	Some evidence	Levels II evidence or generally consistent findings from multiple studies of level III	Program can be adopted when there is no grade A or B alternative program AND a clear and compelling rationale can be offered for its execution
D	Weak evidence	Levels III evidence or generally inconsistent findings from multiple studies of levels I-III	Program should only be considered for adoption when there is no grad A-C alternative program AND a clear and compelling rationale can be offered for its execution
F	No empirical evidence	Level IV evidence	Program should be evaluated before consideration for adoption

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Appendix C.
Example Evidence-based Programs

Program	Description	Method	Domain
	Identify People in Need		
Kognito Family of Heroes	One hour online role-playing training for families of SMs who have returned from deployment. Training focused on recognizing warning signs and motivating family members to access resources. Evidence of effectiveness for improving preparedness to recognize signs of risk and provide Veterans Health Administration (VHA) referral information. Has been used in the military. *https://www.continuum.militaryfamilies.psu.edu/program/fact_sheet_1479*	Gatekeeper Training	Suicide
Columbia-Suicide Severity Rating Scale (C-SSRS)	Universal tool that can be administered by non-clinicians, with minimal training, and is effective at detecting a range of suicidal behavior. The C-SSRS is used by some Army National Guard (ARNG) states and territories and by all Air National Guard (ANG) Directors of Psychological Health (DPHs). *http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/cssrs-for-communities-and-healthcare/#filter=.general-use.english*	Screening/ Risk Assessment	Suicide
Green Dot	Bystander intervention program that teaches participants how to identify and respond to situations in which people could be at risk for abuse or that promote norms accepting of violence. Used by the Air Force for sexual assault and suicide. Evidence of effectiveness for preventing sexual assault victimization and perpetration. *https://www.continuum.militaryfamilies.psu.edu/program/fact_sheet_1981*	Gatekeeper Training	Sexual assault and Suicide

Drinker's Check-up	An online alcohol-reduction program. Participants take a self-assessment of their drinking and are given a range of strategies to select from to reduce their alcohol consumption. Has been used in the military. Evidence of effectiveness for reducing the frequency/quantity of alcohol consumption. *https://www.continuum.militaryfamilies.psu.edu/program/fact_sheet_1046*	Screening/ Risk assessment	Substance misuse
Provide Care and Treatment			
Crisis Response Planning	Brief 30-minute intervention in which individuals at risk for suicide collaboratively work with clinician to identify warning signs, coping skills, and social support resources. Can be administered as a stand-alone intervention or paired with treatment. Evidence of effectiveness for reducing suicide attempts in a military population (Army). *https://crpforsuicide.com/*	Crisis/Brief Intervention	Suicide
Cognitive Processing Therapy (CPT)	PTSD treatment program for sexual assault and trauma survivors that adapts CBT for trauma. Evidence of effectiveness for reducing levels of PTSD and depression. Military/veteran version available. *https://www.apa.org/ptsd-guideline/treatments/cognitive-processing-therapist.pdf*	Access to Care	Sexual assault
Strength at Home Men's Program	Program for active-duty and former military personnel who have perpetrated intimate partner violence (IPV). Participants learn about trauma and IPV in weekly, two-hour therapy sessions. Evidence of effectiveness for lowering the rate of psychological/physical aggression. Has been used in the military. *https://www.continuum.militaryfamilies.psu.edu/program/fact_sheet_2157*	Access to Care	Domestic violence (including sexual assault)
Alcohol Behavior Couple Therapy (ABCT)	Alcohol-abstinence program for individuals with alcohol-use disorders and their partners. Participants learn how to create an environment to encourage abstinence and strong relationships. Evaluated for use with veterans. Evidence of effectiveness for days of abstinence, relapse duration, and relationship satisfaction. *https://www.continuum.militaryfamilies.psu.edu/program/fact_sheet_923*	Family involvement and education	Substance misuse
Create Protective Environments			
Safe firearm storage devices	Systematic review of clinic- or community-based means restriction found that provision of free safe storage devices improved gun safety practices. Counseling alone or economic incentives were not as effective. The military services distribute gun locks. *https://doi.org/10.1093/epirev/mxv006*	Manage Access to Lethal Means	Suicide
Counseling on Access to Lethal Means (CALM)	One-session training for mental health clinicians on how to provide counseling to individuals at risk for suicide to reduce access to lethal means, with a particular focus on firearms. Compared to baseline, clinicians who received the training increased lethal means counseling behavior and had greater self-efficacy. *https://link.springer.com/article/10.1007/s10597-017-0190-z*	Manage Access to Lethal Means	Suicide

Alcohol outlet density restrictions	State and municipality strategy for regulating alcohol sales via licensing and zoning of bars, restaurants, liquor stores, and grocery stores. Evidence of effectiveness for lowering the rate of alcohol consumption, intimate partner violence, and suicide. *https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/policies/alcohol-outlet-density-restrictions*	Policy to Reduce Alcohol Access	All
Change Culture to Promote Help-seeking and Reduce Harm			
Sources of Strength	Program involves peer leaders to improve norms and attitudes about suicide. Although designed for teenagers, the Georgia National Guard (NG) has adapted and used the program. Evidence of effectiveness for increasing help-seeking behavior and improving coping among high school students. *https://www.continuum.militaryfamilies.psu.edu/program/fact_sheet_1451*	Peer Influence	Suicide
Respect in the Workplace	Online, interactive program for employees that educates them on workplace bullying, harassment, and discrimination. Participants learn how to recognize bullying, harassment, and discrimination, and how to report and document it. The program has a mix of slides, animated scenarios, and questions and answers. Evidence of effectiveness for increasing perceived civility in the workplace. *https://redcrosselearning.ca/RespectintheWorkplace.php*	Peer Influence	Sexual Assault
Social norms marketing approaches	Corrects misperceptions about peer alcohol consumption by providing accurate norms and statistics. Evidence of effectiveness for changing perceptions about peer drinking and reducing alcohol consumption across some, but not all, studies. Effectiveness may depend on the quality of the social marketing campaign. *https://store.samhsa.gov/product/Substance-Misuse-Prevention-for-Young-Adults/PEP19-PL-Guide-1*	Social marketing/ awareness	Substance misuse
Enhance Life Skills, Resiliency, and Connectedness			
Virtual Hope Box	Department of Defense (DOD) smartphone app where individuals can compile photos and videos of loved ones, learn about relaxation techniques and available resources, and receive reminders about reasons for living. Developed for use as a supplement to therapy. Evidence of effectiveness in improving coping skills among a sample of veterans *https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201600283*	Coping and Stress Management	Suicide
Electronic Prevention and Relationship Education Program (ePREP) for Couples and PREP for Strong Bonds	Online program (ePREP) or in-person program (paired with Strong Bonds couples retreat in the military) to enhance relationships. Teaches communication and problem-solving skills to assist in conflict resolution. Evidence of effectiveness for reducing physical and psychological aggression (ePREP) and improving marital quality and lowering risk of divorce (PREP). *https://www.continuum.militaryfamilies.psu.edu/program/fact_sheet_2632*	Family and Relationship Programs	All

Enhanced Assess, Acknowledge, Act (EAAA) Sexual Assault Resistance Education Program	Training developed for female college students that teaches skills to prevent victimization (e.g., identify and acknowledge risk, directly respond to risk through verbal and physical techniques). Evidence of effectiveness for reducing sexual assault victimization. *https://evidencebasedprograms.org/document/eaaa-sexual-assault-resistance-program-evidence-summary/*	Empowerment training	Sexual assault
MyStudentBody: Alcohol	Participants receive online motivational feedback and learn about alcohol-related risks, risk reduction strategies, bystander intervention, state laws, and communication skills. Evidence of effectiveness for reducing average, peak, and total alcohol consumption. *https://www.tandfonline.com/doi/abs/10.3200/JACH.53.6.263-274*	Education and behavior change skills	Substance misuse
Lessen Secondary and Future Harm			
Connect Suicide Postvention	Training designed to build capacity of organizations to respond to a suicide death, based on best practice protocols. The program has been used in the New Hampshire Army National Guard (ARNG). Compared to pre-participation attitudes, program participants felt more prepared to help those in need and were less likely to endorse attitudes that stigmatized help-seeking. *https://www.sprc.org/resources-programs/connect-suicide-postvention-training*	Postvention	Suicide
Guidelines for Media Reporting on Sexual Assault	Set of recommendations for the media on how to report on sexual assault in a safe and non-stigmatizing manner (e.g., using language that avoids victim blame and ensures accuracy) as well as education about what constitutes sexual violence and consent. Research-informed, but has not been evaluated. *https://www.nsvrc.org/sexual-violence-reporting-tools*	Media Guidelines	Sexual assault

Appendix D.
FY21 ERP Reviewer Guide

1. 20 OCT 1300-1400: Kick-off teleconference

2. 20 OCT – 3 NOV: Individual review of submissions

- Read proposals and preliminarily evaluate: Reviewers will receive an e-mail with all submissions in their topic area and will preliminarily evaluate each proposal using the enclosed spreadsheet. Of the submissions in their topic area, each reviewer will also be assigned 2 proposals to read in greater depth; reviewers should be prepared to begin the discussion on these proposals by sharing their initial assessment of its strengths and weaknesses.
    - *Preliminary evaluation*:
        1. **Excellent**: Outstanding proposal that should have the highest priority for support
        2. **Good**: High quality proposal that should be supported but may not be considered a priority
        3. **Fair**: Proposal has significant weaknesses that should be addressed before final consideration
        4. **Poor**: Proposal has critical flaws and should not be supported
    - Reviewers should record their preliminary evaluation in the enclosed excel file - column C (Initial Global Assessment). Reviewers will complete the remaining fields during the ERP meeting.
- Review evaluation criteria: Reviewers should review all the evaluation criteria (section Attachment 5 PDF) to prepare for the ERP meeting.
    - *Priority topics/methods:* Priority areas referenced in Criteria 1 are included here (see Attachment 1 PDF)
    - *Current pilots:* To assist in assessing the novelty of the FY20 submissions (Criteria 3), reviewers should review the descriptions of current pilots (see Current pilot PDF)

3. 3 NOV – 13 NOV: ERP Meeting (4 hours)

- There will be a separate ERP meeting for each topic area; reviewers will only attend the meeting for their topic area.
- At the ERP meeting, reviewers will discuss each proposal in turn.
- At the end of the discussion, all reviewers will document their final evaluations of the proposals.
- Using the evaluations compiled at the ERP meeting, WRF leadership will make final selection decisions.

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Appendix E.
FY21 ERP Facilitator Guide

1. Before the panel

- Make sure the following materials are attached to the meeting invite:
    - Proposals
    - Reviewer Guide
    - NGB WRFII Reviewer Ratings excel spreadsheet
    - Evidence summary

2. Introduction [beginning only] – *5 minutes*

- WRF introduction
    - Explain where files are located in Outlook and Teams (screen share to show).
    - Note that the chat function is not enabled for some of us on the panel. If you have a question or comment and do not want to interrupt the conversation, you can use the hand-raise button.
    - Note these are O&M and not R&D funds; pilots are program evaluation instead of research, and proposals are not written by researchers.
- Let's start with reviewer introductions – please tell us who you are, where you work, and what you focus on.
- Facilitator introduction (IDA)
    - Goal: The goal of the Expert Review Panel is to collectively assess the quality of each proposal. The objective is not to select a specific number of proposals, but rather to evaluate each proposal so WRF leadership can use that information in their selection decisions. *You may decide that all of the proposals are great or none of them are, or somewhere in between.*
    - Process: We will begin by discussing each proposal, one by one. After the discussion, each of you will record your evaluations for the proposal in your Excel spreadsheet, and any additional comments. At the end of the session today, you will have the chance to amend any of your evaluations. Then we will ask you to input your final evaluations into SurveyMonkey. *The discussions may help you make your evaluation decisions, but you do not have to come to a consensus as a group in your final evaluations.*
    - Does anyone have any questions before we begin?

3. Background information [for each proposal] – *5 minutes each*

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- In the outlook meeting invite or in the files section in Teams, you will find all the proposals attached. Please open proposal [X] and take a few minutes to refresh your memory and look at any notes/comments you jotted down in your Reviewer Rating excel file.
    - For those of you assigned this proposal, we will ask for your initial thoughts to begin our discussion shortly.
- [*Screen share the evidence summary for that pilot*] On the screen share, you will see a summary WRF's research team put together to describe the evidence for the pilot. You can also find this document, called WRFII Fall 2020 Proposals_Evidence Summaries, in the invitation or within Microsoft Teams. Take a minute to read that over and click on the hand icon to raise your hand when you are done.
- [*If applicable, screen share the FY19/FY20 pilots and highlight the one that's relevant*] Now I have put up the list of current pilots. Just take a minute to read through the one I highlighted here as it is similar to the proposal you will be discussing.

4. Group discussion [for each proposal] – *20 minutes each, longer for the first proposal*

- Let us go ahead and begin our discussion. [X and X], this was your assigned proposal - can one of you start us off and tell us about your initial impressions?
- [*For the first proposal. Screen share evaluation criteria to start*] Now let us go through the evaluation criteria one by one and discuss how the proposal does in each of those areas. You can find detailed descriptions of the evaluation criteria in section 2 of the proposal template.
    - [*Make sure to explain the criteria and go through one by one, if they skip around just come back around to get through all the criteria.*]
    - [*Tell them we are skipping the "Based on a Requirement" criteria, that will be assessed through programmatic review.*]
- [*For the subsequent proposals*]: What are your thoughts about this proposal? How well does it meet the criteria? [*Open discussion, but ask about specific criterion as prompts to keep the conversation going and make sure they address all the areas.*]
    - [*May need to remind them that just because a proposal does not meet a particular criterion, it does not mean it is out of consideration entirely, especially if the proposal is strong in other areas.*]
- Are you all ready to evaluate this proposal? Remember that you can come back at the end and change your evaluations. Go ahead and record your evaluations in the excel spreadsheet. It is the same document where you recorded your preliminary ratings – in the reviewer guide, and attached to the meeting invite (NGB WRFII Reviewer Ratings).

5. Discussion of all proposals together – *10 minutes*

- Now that we have gone through all the proposals, are there any that we would like to revisit and discuss again? [*Open discussion*]

- Please take a look at each of your evaluations again and make any change you feel is needed.
- If you had to rank the proposals, which ones would come out on top?

6. Submit your reviews and ERP feedback – ***10 minutes***

- Now to submit your final evaluations, we are going to send you a survey link where you can enter in your ratings along with any additional feedback. WRF will use your ratings to help them decide which proposals to select across all the topic areas.
    - Additionally, at the end of the survey, you'll find a link to an *anonymous* survey with questions about the ERP process. Please let us know how the process went so we can improve it for next year. But please feel free to talk to us after this session or send us an e-mail with any other feedback.
    - Go ahead and stay on the meeting as you complete the survey in case you have any questions along the way. Once you are done, you can go ahead and leave.
    - [*Screen share the survey link; share the link through chat.*]
        - Ratings: https://www.surveymonkey.com/r/ERP_ratings21
        - Feedback: https://www.surveymonkey.com/r/ERP_feedback21

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Appendix F.
ERP Evaluation Criteria

Instructions: Assess each program using the criteria below. Priority should be offered to programs with a higher number of "Yes", relative to "Partial" or "No" responses while giving consideration to their fit with current WRF priorities.

1. ***Addresses WRF priority area:*** Does the program fit into one or more of the WRF priority topics and methods?

   - ☐ **Yes**
     The program directly addresses one or more of the WRF priority areas or methodological approaches
   - ☐ **Partial**
     The program indirectly or partially addresses one or more of the WRF priority areas or methodological approaches
   - ☐ **No**
     The program does not address any of the WRF priority areas or methodological approaches
   - ☐ **Need more information**

2. ***Suitable to target population:*** Is the proposed program suitable for the intended population and culturally appropriate?

   - ☐ **Yes**
     It was developed or adapted for military members, Veterans, or civilians in similar demographic groups, and is in line with National Guard (NG) culture and/or sub-cultures that are at higher risk (e.g., young Guard members, Guard members in rural locations).
   - ☐ **Partial**
     It was developed for a general U.S. population and there is no perceived obstacle to its adaptation for the intended population and NG culture.
   - ☐ **No**
     There are obstacles to its adaptation for the intended population and NG culture.
   - ☐ **Need more information**

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3. ***Novel:*** Is the program unique/novel (not redundant with existing Department of Defense (DOD) programs)?
   - ☐ **Yes**
     There are no other known DOD programs with the same goals, functions, and intended outcomes.
   - ☐ **Partial**
     There are similar DOD programs, but the current program offers meaningful improvements (e.g., better tailored to the Guard, more efficient, fewer resources needed).
   - ☐ **No**
     There are similar DOD programs that function well and the current program offers no meaningful improvement.
   - ☐ **Need more information**

4. ***Based on a requirement:*** Does the program fulfill the intent of a requirement specified in DOD or subordinate service-level regulation, policy, or guidance documents (e.g., National Defense Authorization Act (NDAA), Chief National Guard Bureau Instruction (CNGBI), Department of Veterans Affairs/DOD Clinical Practice Guidelines)?
   - ☐ **Yes**
     The program directly fulfills the intent of a DOD requirement (e.g., requirement specifies programs of this exact type).
   - ☐ **Partial**
     The program indirectly meets the intent of a DOD requirement (i.e., fulfills requirement when interpreted broadly).
   - ☐ **No**
     The program does not relate to any specific requirement stated in law or policy.
   - ☐ **Need more information**

5. ***Feasible:*** Can the program requirements (e.g., for additional staff, contractors, funding, and participation time) reasonably be met on a long-term basis?
   - ☐ **Yes**
     The requirements (e.g., for additional staff, contractors, funding, and participation time) can reasonably be met on a long-term basis (*preference given here to programs with existing funding mechanisms or research partnerships*).
   - ☐ **Partial**
     The requirements (e.g., for additional staff, contractors, funding, and participation time) can reasonably be met in the short term, but not over time.
   - ☐ **No**
     The requirements (e.g., for additional staff, contractors, funding, and participation time) cannot reasonably be met.

- ☐ **Need more information**

6. ***Effective:*** Is there evidence of the proposed program's effectiveness (e.g., demonstrated positive change in relevant attitudes and/or behavior as measured before and after implementation)?
   - ☐ **Yes**
     There is at least one study indicating effectiveness, and no study indicates that it is ineffective.
   - ☐ **Partial**
     There is at least one study indicating effectiveness, but other studies indicate that it is ineffective, OR
     It has not been evaluated for effectiveness, but it is research-informed and promising.
   - ☐ **No**
     It has not been evaluated for effectiveness *and* is not research-informed, OR
     It has been evaluated but studies have indicated that is ineffective.
   - ☐ **Need more information**

7. ***Robust evaluation plan:*** Does the proposal clearly articulate plans for a reliable evaluation of the pilot (e.g., includes both process and outcome metrics, uses a pre-post tests and/or control/comparison groups, objectives are clearly defined and measurable, evaluation is feasible and timely)?
   - ☐ **Yes**
     The evaluation plan includes all necessary elements and includes a robust design.
   - ☐ **Partial**
     The evaluation plan is lacking in some areas, but a robust evaluation will be possible with technical support.
   - ☐ **No**
     The evaluation plan is lacking significant elements, and a robust evaluation is unlikely even with technical assistance.
   - ☐ **Need more information**

8. ***Global assessment:*** What is your overall assessment of this proposal?
   - ☐ **Excellent:** Outstanding proposal that should have the highest priority for support.
   - ☐ **Good:** High quality proposal that should be supported but may not be considered a priority.
   - ☐ **Fair:** Proposal has key weaknesses that should be addressed before further consideration.
   - ☐ **Poor:** Proposal has serious flaws and should not be supported.
   - ☐ **Need more information**

Recommended action: What is your recommendation for this proposal?

- ☐ **Fund:** Fund this proposal
- ☐ **Technical assistance:** Provide technical assistance but no funding
- ☐ **No action**

Appendix G.
WRFII Welcome Packet (Excerpt)

Congratulations on your selection for the Fiscal Year (FY) 2021 WRFII cohort. Over the next year, you will join and interact with a cohort of innovative pilots and receive personalized technical assistance. The results of your program will be briefed up to the highest levels, from NGB leadership, including the Chief of the National Guard Bureau, to Congressional stakeholders.

This document provides information to orient you to WRFII activities, expectations, contacts, and resources. The table below provides a brief overview of the enclosed information.

Required activities*	Support provided	Key contacts
• Monthly community call • Individual meetings on an as-needed basis • Evaluation plan • Monthly updates • Quarterly reports • Financial status updates	• Implementation advice • Connection with stakeholders and advisors • Metric development • Evaluation questionnaire design • Data collection planning • Data analysis support	MAJ Emily Vernon WRF Pilots and Studies Lead SFC Chris Allen WRFII PM Ashlie Williams, MPH, MSW Technical Assistance (IDA) Dina Eliezer, PhD Technical Assistance (IDA)

Note: Receipt of a second year of funding for pilots is contingent on completion of the required activities stated above. WRF will work with pilots to ensure they have the resources needed to complete these activities and that timelines for completion are feasible.

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Appendix H.
Suggested Metrics Spreadsheet (Example)

OK: SASSI-4				
Recommended Evaluation Design				
Data sources: metrics described below assessed through program administrative data, questionnaires, Drug and Alcohol Testing Management Information System (DAMIS), and other personnel data sources Timing of questionnaires: Immediately before the screening and again after screening completion Comparison or control group: No control or comparison group possible. However, could compare some of the intermediate outcomes listed below to historical data before the SASSI-4 was offered				
Recommended Metrics				
Activity	**Evaluation Question**	**Type of Metric**	**Name of Metric** NOTE: These are suggested metrics but it is entirely up to your team to decide which metrics are appropriate for your pilot. If there are metrics that you would like to measure but are not on this list or in the Catalogue of Measures, please let us know and we can assist you in locating relevant measures.	**Notes**
SASSI-4	Is the screening reaching	Process	# briefings delivered on SASSI-4	You can break this out by type of briefing - command, unit, one-on-one
		Process	# individuals referred for required screening	

	Service members?	Process	# individuals referred for voluntary screening	You can also look at the reasons for the referrals (i.e., urinalysis screens, alcohol incidents) and sources of referrals (Army Substance Abuse Program, Behavioral Health, chaplain, self-referral)
		Process	Source of referral	I.e., ASAP, BH, Chaplain, self-referral. Is there a way for BH/Chaplains to refer people for the screening, or would that just come through as a self-referral?
		Process	Reason for referral	I.e. drug positive, alcohol incident, etc.
		Process	Time to follow up	I.e., referral date to date sent
		Process	Time to completion	I.e., date sent to date completed
		Process	# invalid assessment responses	
		Process	Service member satisfaction with screening	It may be difficult to make this anonymous, but you can make it confidential by storing the data with codes
	Did the availability of SASSI increase use of screening and subsequent counseling among Service	Intermediate	# of individuals who self-refer for screening	Could compare these numbers to historical data before SASSI-4 to see if the use of an online screening tool improves these outcomes
		Intermediate	# individuals who complete screening	
		Intermediate	# individuals who receive referral for counseling	
		Intermediate	# individuals referred for counseling who attend counseling	
		Intermediate	Time from referral for screening to start of counseling	
		Intermediate	Intention to stay in the National Guard	

	members at high-risk?	Intermediate	Perceived norms - help-seeking/stigma related to help-seeking	If you want to assess these types of outcomes, as well as satisfaction questions, you could implement a questionnaire they take both before and after the screening
		Intermediate	Connectedness and/or social support	
		Long-term	Repeated drug positives	You can measure longer-term changes such as in recidivism, retention, and resource utilization by comparing DAMIS and other administrative data across years. Because the program may have secondary effects on climate and other outcomes, it may also be useful to examine any changes in URI results.
		Long-term	Repeated alcohol incidents	
		Long-term	Resource utilization	
		Long-term	Retention (from administrative records)	

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Appendix I.
Evaluation Plan Worksheet

INSTRUCTIONS

In the two sections below, please list the metrics you have selected for evaluating your pilot. To assist you in this process, please see the Catalogue of WRF Metrics and Measures with specific measures you can select from. Note that it is entirely up to your team to decide which metrics are appropriate for your pilot; however, the technical assistance team will provide feedback on your completed worksheet to strengthen your evaluation plan. The goal is to select metrics that will measure the effectiveness and value of your pilot. Pilots may also be asked to report on a common set of outcome metrics to assess impact across the WRFII.

After selecting metrics, please describe your data collection plans. Examples are provided in italics. If you are unsure of your metrics, measures, or data collection plans, please reach out to IDA for any assistance that you need.

PROCESS

Name of metric

Example: number of participants

Example: participant satisfaction

How, when, and from whom will you collect this data? (e.g., administrative data collected on an ongoing basis, data shared by service providers on a monthly basis, sign-in sheets collected at each event)

Do you have the resources you need to collect, store and analyze this data? If not, what additional resources or assistance will you require? (e.g. access to a SurveyMonkey account, reporting forms, statistical analysis software/skills)

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OUTCOMES

Provide the name of the metric and whether or not you are using a measure from the Catalogue of WRF Metrics and Measures

Name of metric	Are you using a measure from the Catalogue?	If not, what measure will you use instead?
Example: # referrals made through app	*No*	*Administrative data*
Example: Self-efficacy to help individuals at risk	*Yes*	*N/A*
Example: Intention to stay in the National Guard	*Yes*	*N/A*
Example: Perceived social support	*No*	*Multidimensional Scale of Perceived Social Support (Zimet et al, 1988)*

How, when, and from whom will you collect this data? (e.g., administrative data collected on an ongoing basis, questionnaire administered immediately before and after program participation as well as a follow-up survey emailed to all participants 3 months later, Unit Risk Inventory (URI) data collected once a year). **Evaluations should measure outcomes both before and after program completion (i.e., pre/post assessment) *and* compare outcomes to a control or comparison group, if possible.**

Do you have the resources you need to collect, store and analyze this data? If not, what additional resources or assistance will you require (e.g., access to a SurveyMonkey account, reporting forms, statistical analysis software/skills)**?**

Appendix J.
Quarterly Report Template

Program Information

A. Program Overview and Objectives: *Provide a brief overview of your program and list the specific objectives your program aims to achieve. You may copy this section from your WRFII proposal submission.*

B. Program Team: *Provide a list of the members of your program team and a brief description of their role. You may copy this section from your WRFII proposal submission.*

Program Implementation

A. Implementation Progress and Quality: *Describe your progress in planning and/or implementing your program, including descriptions of both new activities this quarter and ongoing activities. In your response, describe how you have sought to ensure high-quality implementation.*

B. Implementation and Management Challenges: *Provide a brief description of any implementation, management, or administration challenges you experienced this quarter. Include challenges relating to activity implementation, staffing, contracting, finances, etc. In your response, describe how you intend to address these challenges.*

C. Plans for Next Quarter and Needs: *Provide a brief description of planned project and evaluation activities in the upcoming quarter. In your summary, include any anticipated challenges, resource needs, or technical assistance needs.*

Results

A. Data Sources and Methods: *Briefly describe your data sources, the tools you used to collect data, and the timing of your data collection this quarter (e.g. assessment administered among training participants before and after each training, administrative data reported monthly by program staff). In your description, be sure to discuss any limitations or challenges in your data collection efforts.*

B. Raw Data: *Please provide your raw data in an Excel spreadsheet. In your spreadsheet, please clearly define all variables and remove all personally identifiable information (PII). See the sample Excel template, "Example Raw Data."*

C. Description of Results to Date*: Provide a summary of your results for this quarter for each of your process and outcome metrics using the tables below. If you do not have a full*

quarter of data, include your results thus far and indicate the date range. If you have more than a full quarter of data, include your results to date in a second column and indicate the date range.

Process Metrics - *Example metrics and data are filled in for your reference.*

Metric name	Description of analysis	Q1 Oct-Dec '19	Cumulative results to date
Implementation	Total number of trainings held	3	
Satisfaction	Average level of satisfaction with the program (mean score on 1 to 4 scale)	3.21	N/A
Satisfaction	Percentage of participants who said they were "very satisfied" with the program	57%	N/A
Resources downloaded	Average number of files downloaded per participant	1.7	N/A
Resources downloaded	Total number of files downloaded across all participants	300	N/A
Utilization	Total number of participants	200	N/A

Outcome Metrics - *Example metrics and data are filled in for your reference.*

Metric name	Description of metric	Q1 Oct-Dec '19 – change from pre to post survey	Cumulative results to date
Knowledge of signs of suicide	Percentage of participants who answered incorrectly before program participation, but answered correctly after participation	50%	N/A
Stress	Percentage of participants indicating lower levels of stress on the post-survey than on the pre-survey	36%	N/A
Stress	Average change in stress from the pre-survey to the post-survey (average score on stress scale on the pre-survey subtracted from average score on the stress scale on the post-survey)	1.2	N/A

Employment	Percentage of program participants securing employment within 3 months	82%	N/A

D. Findings and Interpretation: *Describe what you learned about your program from your analyses, drawing on relevant experiential and contextual information to inform your interpretation. If your findings are unclear, describe additional data you may need or strategies you may adopt to gain greater insight.*

E. Success Story (optional): *Provide a narrative of one or more success stories related to your project goals and objectives from this quarter. Do not include individuals' real names or other PII.*

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Appendix L.
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Appendix M.
Abbreviations

ABCT	Alcohol Behavior Couple Therapy
ADAPT	Alcohol and Drug Abuse Prevention Training
ADCO	Alcohol and Drug Control Office
ANG	Air National Guard
APFT	Army Physical Fitness Test
ARNG	Army National Guard
ASIST	Applied Suicide Intervention Skills Training
BH	Behavioral Health
BHO	Behavioral Health Officer
CALM	Counseling on Access to Lethal Means
CBT	Cognitive Behavioral Therapy
CDC	Centers for Disease Control and Prevention
CM	Case Management
CMFR	Clearinghouse for Military Family Research
CNGBI	Chief National Guard Bureau Instruction
C-SSRS	Columbia-Suicide Severity Rating Scale
DAMIS	Drug and Alcohol Testing Management Information System
DEOCS	Defense Equal Opportunity Climate Survey
DMHAS	Department of Mental Health and Addiction Services
DOD	Department of Defense
DPH	Director of Psychological Health
EAAA	Enhanced Assess, Acknowledge, Act
ERP	Expert Review Panel

ESGR	Employer Support of the Guard and Reserve
FY	Fiscal Year
GOAC	General Officer Advisory Council
H2F	Holistic Health and Fitness
HRPO	Human Subjects Research Protection Office
IDA	Institute for Defense Analyses
IPV	Intimate Partner Violence
IRB	Institutional Review Board
MOMRP	Military Operational Medicine Research Program
NAMI	National Alliance on Mental Illness
NDAA	National Defense Authorization Act
NG	National Guard
NGB	National Guard Bureau
NIH	National Institutes of Health
PEC	Professional Education Center
PFT	Physical Fitness Test
PII	Personally Identifiable Information
PREP	Prevention and Relationship Education Program
R3SP	Resilience, Risk Reduction, and Suicide Prevention
RCT	Randomized Control Trial
REACH	Resources Exist, Asking Can Help
RELIEF	Response/Recovery Enhanced Leadership Integrated Engagement Framework
RFRAC	Resilient Forces Readiness Advisory Council
SARC	Sexual Assault Response Coordinator
SA	Sexual Assault
SAPR	Sexual Assault Prevention and Response
SAPR VA	Sexual Assault Prevention and Response Victim Advocate

SAMHSA	Substance Abuse and Mental Health Services Administration
SASSI-4	Substance Abuse Subtle Screening Inventory – 4
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SCC	Sexual Communication and Consent program
SM	Service member
SP	Suicide Prevention
SPRC	Suicide Prevention Resource Center
SU	Substance Use
T3	Train-the-Trainer
TA	Technical Assistance
TAG	The Adjutant General
TFF	Total Force Fitness
URI	Unit Risk Inventory
VHA	Veterans Health Administration
WRF	Warrior Resilience and Fitness
WRFII	Warrior Resilience and Fitness Innovation Incubator

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14. ABSTRACT

In 2018, the National Guard Studies Program asked the Institute for Defense Analyses (IDA) to develop a systematic process to identify, select, and deploy evidence-based suicide prevention (SP) practices, as described in IDA's 2019 paper, P-10468, *National Guard Suicide Prevention Innovation Framework*. The Warrior Resilience and Fitness (WRF) Division has since implemented the process IDA developed, through the WRF Innovation Incubator (WRFII), and asked IDA to advise and assist in deploying and refining the process. Over the past two years, IDA has provided technical assistance to ensure that selected pilot programs develop rigorous evaluation plans (11 FY19 pilots and 12 FY20 pilots), facilitated and refined the pilot program selection process for FY20 and FY21, and expanded the Compendium of SP Strategies to apply to a broader range of prevention and promotion activities, in line with WRF's integrative approach to risk and resiliency. The current paper documents the revised WRFII process, as well as the products and tools IDA has developed to support the process.

15. SUBJECT TERMS

Suicide prevention; resiliency; total force fitness; program evaluation; capacity-building; technical assistance; innovation

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