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State Programs Annual Report

National Guard Bureau Warrior Resilience and Fitness

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March 2023
Approved for public release;
distribution unlimited.
IDA Document NS D-33216
Log: H 23-000358

INSTITUTE FOR DEFENSE ANALYSES
730 East Glebe Road
Alexandria, Virginia 22301

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About This Publication
This work was conducted by the Institute for Defense Analyses under contract HQ0034-19-D-0001, project DZ-6-4421, "Evidence-Based Leadership Framework for Suicide Prevention" for the National Guard Bureau. The views, opinions, and findings should not be construed as representing the official position of either the Department of Defense or the sponsoring organization.

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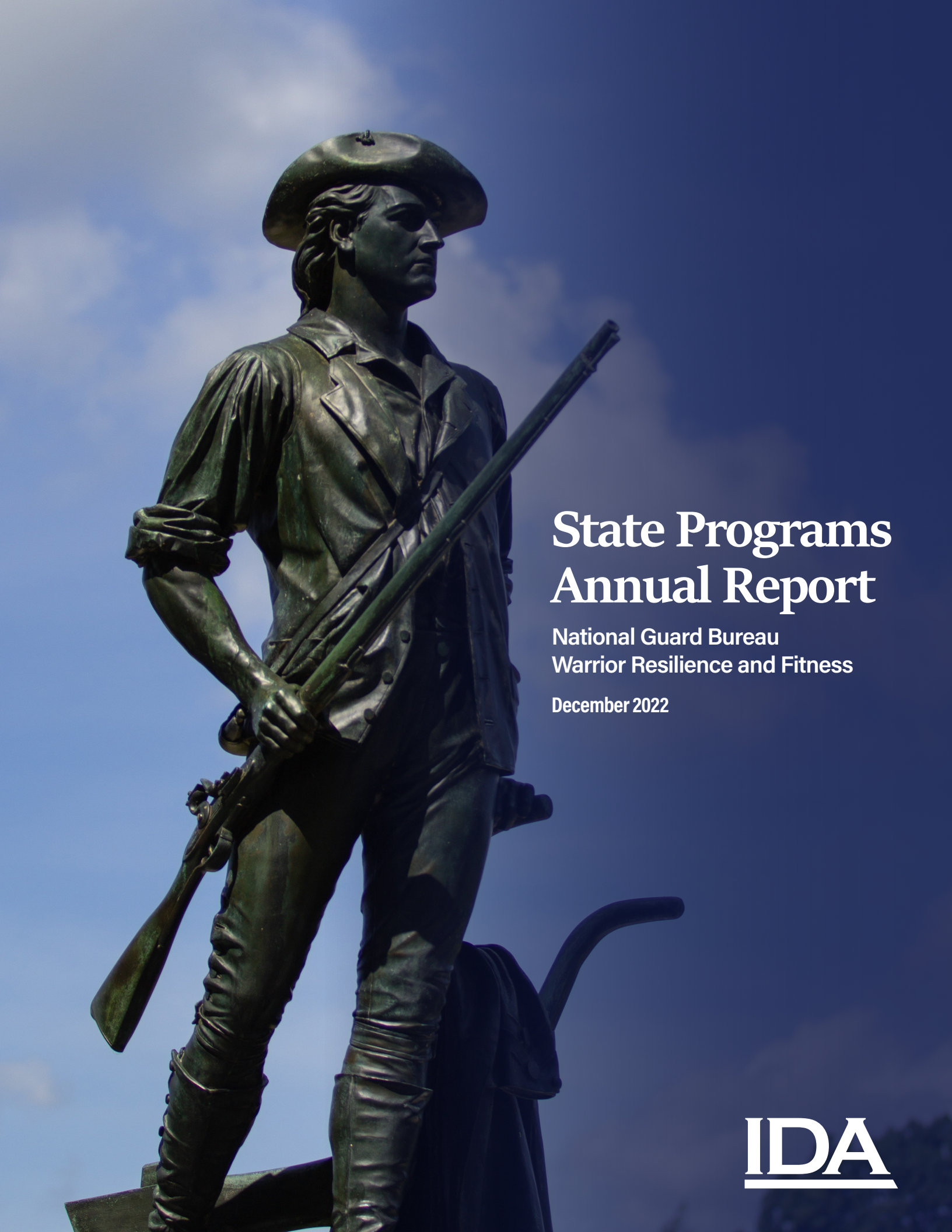

State Programs Annual Report

National Guard Bureau Warrior Resilience and Fitness

December 2022

IDA

Executive Summary

Since 2019, the Institute for Defense Analyses (IDA) has supported the implementation of the National Guard Bureau (NGB) Warrior Resilience and Fitness Division's (WRF's) prevention innovation process, which aims to identify, evaluate, and disseminate promising practices developed in National Guard (NG) states and territories to prevent harmful behaviors and promote wellbeing among service members (SMs). The ultimate goal of this process is to allow other NG states and territories to learn from the experiences of WRF-supported programs as they implement their own prevention activities and to facilitate uptake of best practices across the NG. In support of that goal, this report is organized to focus on two areas. The first summarizes the challenges and successes of 32 state programs supported since fiscal year 2019 as well as lessons learned from those programs to inform future program implementation across the NG states and territories. The second details the results of nine specific programs that have demonstrated effectiveness.

IDA provided technical assistance to state programs to facilitate the development and execution of robust evaluation plans. As the states/territories implemented and evaluated their programs, IDA reviewed the monthly updates and quarterly reports submitted to WRF, facilitated monthly conference calls among all programs, and held ad hoc meetings with individual states/territories. These activities enabled IDA to understand their progress and assist with challenges. IDA then drew broad lessons learned and recommendations for the implementation and evaluation of state-led prevention programs. The following table summarizes these findings according to three areas of implementation and evaluation: 1) Early planning and start-up, 2) Program implementation and sustainment, and 3) Process and outcome evaluation.

Summary of Best Practices and Lessons Learned from State Programs

Area	Challenges	Key Recommendations for Program Managers
Early planning and start-up	■ Challenges securing contracts or identifying appropriate contracted programs ■ Difficulty recruiting program participants	■ Coordinate closely with state contracting and legal personnel during contracting process ■ Secure and display leadership support for program ■ Offer programs while SMs are in a paid status and/or incorporate programs into existing processes
Program implementation and sustainment	■ Disruptions due to mobilizations and deployments ■ Lack of leadership support ■ Limited personnel and staff time to implement and evaluate programs	■ Develop contingency plans with alternative courses of action and consider the impact of implementation disruptions in program evaluation ■ Use evaluation findings to advocate for program and analyze return on investment to demonstrate value ■ Test alternative program approaches that fit current staffing resources
Process and outcome evaluation	■ Failure to establish or execute a rigorous evaluation plan ■ Lack of access to adequate data	■ Incorporate evaluation planning into implementation planning ■ Build evaluation planning and execution into budget, implementation, and staffing plans ■ Leverage internal or external sources of support for program evaluation, e.g. university partners or SMs with research experience ■ Create brief, easy-to-access data collection tools and communicate importance of program evaluation to program participants ■ Use historical comparisons, follow-up surveys, administrative data, and logic models to strengthen evaluation designs and understanding of program effects

IDA conducted quantitative analyses of the data that program teams collected during their evaluations; in cases where programs had local support for data analysis, IDA reviewed results. Typically, IDA's analyses consisted of 1) calculating descriptive statistics to summarize participant experiences and outcomes, 2) conducting statistical tests (e.g., t-tests, linear regression) examining differences in outcomes across two time-points, and 3) calculating effect

sizes (e.g., Cohen's d) to understand the potential real-world impact of results. Based on the results, IDA determined which programs had demonstrated effectiveness in improving key SM outcomes or prevention processes. Nine programs addressing the domains of Integrated Prevention, Sexual Assault, Substance Misuse, and Suicide were determined to have evidence of effectiveness, as summarized in the following table.

Overview of Successful State Programs

Integrated Prevention	
First Line Leader Relational Leadership Training	Training to improve First Line Leaders' individual counseling and leadership skills. Improved knowledge and attitudes related to counseling and relationship-building from pre- to post-training
Work for Warriors Georgia (GA)	Screening and referral to NG resources for SMs, veterans, and spouses through an online platform. Facilitated over 19,000 referrals since 2019
Behavioral Health Primary Prevention and Retention	Screening new recruits to identify and proactively address risk factors. Reduced rates and acuity of behavioral health issues, compared to projections based on historical trends

Sexual Assault	
Buddy Aid	Sexual assault prevention and response training designed to prepare all SMs to respond to disclosures of sexual assault. Improved knowledge of, and confidence in, how to identify and provide first-line support to victims of sexual assault from pre- to post-training

Substance Misuse	
Substance Abuse Subtle Screening Inventory (SASSI)-4	Online screening administered to self-referrals and positive urinalysis cases to facilitate referral to care. Decreased participants' intentions to use alcohol/drugs to cope with stress from pre- to post-screening

Suicide	
Start	Online gatekeeper training distributed to leadership, SMs and spouses, and community partners to improve ability to identify and respond to SMs at risk for suicide. Improved participants' confidence in their ability to recognize and respond to signs someone is considering suicide from pre- to post-training
Together Strong	Virtual role-play training to teach SMs how to identify and respond to those at risk for suicide and increase awareness of behavioral health resources. Improved participant preparedness, likelihood, and confidence to recognize and respond to signs of distress from pre- to post-training
SafeUTNG	Mobile app offers live chat with local University of Utah clinicians during times of crisis. Since 2019, app was downloaded over 3,600 times and facilitated over 350 crisis chats
Crisis Response Plan	Training to enable Behavioral Health Officers (BHOs) and Chaplains to provide a brief evidence-based and client-centered intervention for SMs at risk of suicide. Improved participant knowledge of and confidence in conducting crisis response planning with SMs from pre- to post-training

Contents

1. Introduction

Since 2019, the National Guard Bureau (NGB) Warrior Resilience and Fitness (WRF) Division has implemented an innovation process that aims to identify, evaluate, and disseminate state-developed best practices to prevent harmful behaviors and promote wellbeing among service members (SMs) in the National Guard (NG). The Institute for Defense Analyses (IDA) developed this process and facilitated its deployment and refinement, as detailed in IDA's 2019[1] and 2021[2] reports. As of the 2021 fiscal year (FY), WRF had funded 32 state programs in over 30 states and territories. An additional 21 state programs were funded in the 2022 and 2023 FYs; results of these programs will be discussed in a future report.

Over the course of their participation in the WRF innovation process, WRF and IDA have worked closely with each state program to ensure that they develop rigorous evaluation plans, conduct robust data collection and analyses, and draw actionable lessons learned from the results of their implementation and evaluation efforts. In line with the key aims of the WRF innovation process, this document highlights broader lessons learned from the implementation and evaluation of state programs to inform prevention activities at the state level (Chapter 2), and provides details of successful programs to facilitate their dissemination to NG throughout the 54 states and territories (Chapter 3).

A. Methodology

The findings presented in this document are drawn from state programs' evaluation and reporting activities between 2019 and 2022. These activities broadly consisted of three efforts:

1. Develop an evaluation plan. As a condition of WRF funding, all state programs are required to develop and implement an evaluation plan to assess the effectiveness of their interventions. IDA worked closely with the programs to develop these plans; technical assistance activities included:

a) **Educational presentations** to build program managers' understanding of best practices for evaluation design and data collection and analysis.

b) **A spreadsheet of recommended metrics** tailored to each program. Programs were encouraged to select from these suggested metrics and/or identify metrics independently using the Catalogue of WRF Metrics and Measures.[3] IDA also provided feedback to ensure that selected metrics were relevant to the program's objectives and key evaluation questions, included both *process* and *outcome* metrics,[4] and measured *intermediate outcomes* (i.e., changes expected to occur immediately following the intervention, such as help-seeking intentions) as well as *long-term outcomes* (e.g., service utilization).

c) **Recommended data collection strategies and tools.** Programs are asked to employ, at a minimum, pre-/post-test evaluation designs, with data collection occurring immediately before and after the intervention. To strengthen their designs, programs are encouraged to collect follow-up data (e.g., on skill/knowledge retention, behavior change) a number of months after the intervention and/or to analyze administrative data to measure downstream impacts on behavioral outcomes. They are also encouraged to identify control or comparison

The Catalogue of WRF Metrics and Measures lists and defines over 100 metrics, along with associated survey measures or administrative data sources, to support evaluation design.

To access the Catalogue, **click here** or visit https://apps.dtic.mil/sti/pdfs/AD1169548.pdf

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

2 Dina Eliezer, Ashlie M. Williams, Dave I. Cotting, Heidi C. Reutter, and Rachel D. Dubin, *National Guard Suicide Prevention and Resilience Innovation Framework*, IDA Paper P-22668 (Alexandria, VA: Institute for Defense Analyses, July 2021).

3 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, February 2021).

4 Process metrics (i.e., measures of performance) provide information about the scope and quality of program activities and are used for monitoring program implementation. Outcome metrics (i.e., measures of effectiveness) provide information on the changes that occur as a result of program activities.

groups against which they can compare the intervention's effects. Most state programs collected primary data using evaluation questionnaires or surveys. The *Catalogue of WRF Metrics and Measures* provides validated survey measures for collecting data on each metric. IDA worked with the programs to compile these measures into paper or electronic questionnaires and advised on how to administer the questionnaires.

2. Collect and analyze data. Equipped with the evaluation plan, programs were expected to deploy it concurrently with their program implementation activities. While state programs collected data independently, IDA offered recommendations for troubleshooting issues related to data collection (see Chapter 2). Following collection, IDA also analyzed the data for program teams lacking the local capacity to do so. Analyses typically sought to answer five broad questions, as summarized in Table 1-1:

Table 1-1: Evaluation Questions and Related Analytic Methods

Evaluation Questions	Analytic Methods
How did participants perceive the intervention (i.e., participant satisfaction, perceived usefulness/relevance)? To what extent did outcomes differ (e.g., attitudes, behavior, knowledge) before the intervention versus after the intervention?	Calculation of descriptive statistics, e.g., ■ Average scores at each timepoint of data collection ■ Percentage of participants selecting a particular answer choice
Were changes in outcomes from before the intervention to after the intervention statistically significant (i.e., not due to chance)?	Statistical tests examining differences in outcomes across two time-points, e.g.: ■ Paired t-tests ■ Wilcoxon signed-rank tests ■ McNemar's tests
Did other factors (e.g., implementation factors such as different individuals delivering the intervention; participant characteristics such as different units receiving the intervention) significantly affect the observed outcomes?	Multivariable statistical analyses, e.g.: ■ Linear or logistic regression ■ Analysis of Variance (ANOVA) or Analysis of Covariance (ANCOVA)
Was the magnitude of changes in outcomes from before the intervention to after the intervention practically meaningful (i.e., the intervention could produce meaningful real-world changes in outcomes)?	Calculation of effect sizes to determine the magnitude of the observed change., e.g.: ■ Cohen's d ■ Cohen's f ■ Odds ratio

Note: Results were considered statistically significant given a *p-value* of less than 0.05. Effect sizes were considered meaningful given a *d* of 0.2 or greater or an *f* of 0.1 or greater.

IDA provided details of these results in Excel workbooks and gave in-depth briefings to program teams to ensure understanding. Programs then summarized and interpreted these results in formal quarterly reports, drawing on relevant experiential and contextual information to inform conclusions about their program's process and outcome effectiveness. These reports, along with IDA's independent assessment of the strength of the findings, informed selection of programs featured in Chapter 3.

3. Document progress, challenges, and findings. Throughout program implementation, all programs were required to document their progress in short monthly updates and more detailed quarterly reports. In the quarterly reports, they were asked to report details of new and ongoing activities, to include process metrics; efforts to ensure high-quality implementation and evaluation; challenges related to implementation, management, administration, or evaluation of the intervention; and strategies used or resources/support needed to address these challenges. In addition, IDA and WRF held monthly community calls with all state programs and ad-hoc meetings with individual state programs to discuss these topics. The summary of best practices and lessons learned presented in Chapter 2 reflect the information gathered through these means.

2. Summary of Best Practices and Lessons Learned

Regardless of their impact on service member outcomes, each state program's implementation and evaluation experience provided a valuable opportunity to learn about challenges and best practices for applying prevention activities. This chapter describes these lessons learned, with the aim to inform future efforts at the state level and highlight areas where additional resources or attention may be needed to address more intractable issues.

The following discussion details common challenges, strategies used to address them, and recommendations for future consideration. Findings are divided into three sub-sections: early planning and start-up; program implementation and sustainment; and process and outcome evaluation.

A. Early Planning and Start-up

While some state programs had already established their program prior to receiving WRF support, many were in very early stages of planning. Among the latter group, challenges frequently arose related to contracting for services and securing program participants. Table 2-1 provides an overview of these challenges and associated lessons learned and recommendations.

Table 2-1: Summary of Early Planning and Start-up Lessons Learned and Recommendations

Challenges	Best practices and lessons learned	Recommendations for program managers
Challenges securing contracts or identifying appropriate contracted programs	■ WRF added contracting guidance to the FY21 call for submissions (e.g., complying with sole source contracting regulations, identifying contractors)	■ Coordinate closely with the state Contracting Office, Budget Analyst, and/or legal counsel in early planning stages ■ Explore databases of evidence-based programs and/or identify programs in use elsewhere in the military (e.g., active duty) to identify promising contracted programs
Difficulty recruiting program participants	■ Programs incorporated activities into drill time or placed participants on orders ■ Programs reached participants through referrals and/or warm hand-offs from other resources ■ Leaders communicated support for voluntary participation in programs and/or created policies requiring participation	■ Develop recruitment materials and messaging in a variety of formats to advertise the program to target audiences ■ Secure support from a variety of stakeholders who can reinforce recruitment messages

Contracting issues. Programs that depend on the use of a particular contractor encountered issues complying with sole-source regulations, while some of those that had not yet identified a specific contractor struggled to identify one that met their needs. Program managers should coordinate closely with resources in their states, such as the Contracting Office, United States Property and Fiscal Officer, Budget Analyst, and/or legal counsel and review policies related to contracting prior to taking steps to establish a contract. To assist in identifying contracted services, states can also review existing databases of evidence-based programs (e.g., Clearinghouse for Military Family Readiness,[5] Repository of Best Practices[6]) to identify those who have already demonstrated evidence of effectiveness and/or relevance to military populations.

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

6 Dina Eliezer et al., *National Guard Suicide Prevention and Resilience Innovation Framework*.

Participant recruitment challenges. Many newly-established programs experienced difficulty securing service member participation. This occurred most commonly among programs in which participation was voluntary and/or separate from drill. Referral-based programs and programs embedded into existing processes or during drill had more success in recruitment. For those that were unable to leverage drill time, putting participants on orders also facilitated participation. Additionally, sustained marketing and outreach efforts can be effective for securing voluntary participation. Some programs saw increases in participation following email or in-person communications that highlighted NG leadership support for, or encouragement to participate in, the program.

B. Program Implementation and Sustainment

Over time, many programs encountered challenges related to implementing and sustaining their programs. Some of these challenges were periodic disruptions, such as mobilizations; others, such as lack of staff time and/or leadership support, hindered the ability of program managers to sustain activities over the long term. Table 2-2 summarizes findings in these areas.

Table 2-2: Summary of Program Implementation and Sustainment Lessons Learned and Recommendations

Challenges	Best practices and lessons learned	Recommendations for program managers
Disruptions due to COVID-19, mobilizations, and deployments	■ WRF requested programs describe contingency plans related to COVID-19 in the FY21 call for submissions ■ Implementation shifted to virtual platforms, when feasible	■ Implementation planning should include contingency plans, e.g., alternative timelines and courses of action for working with units or SMs affected by mobilizations or deployments ■ Evaluation should assess process and outcome effectiveness in units with various mobilization/deployment schedules
Lack of leadership support due to turnover or shifting priorities	■ Managers used evaluation findings to advocate for their programs ■ Programs aligned programs with leadership priorities and emergent NG needs	■ Analyze return on investment to demonstrate the value of new programs ■ Invite NGB/WRF engagement with state-level leaders
Limited personnel and staff time to implement and evaluate programs	■ Programs utilized contractors to provide additional staff time[a]	■ Early implementation planning should assess availability of state resources to cover staffing augmentation ■ Test alternative program approaches that fit current staffing resources

Notes:
a) WRF was unable to provide personnel/pay and allowance funding in FY2020 and FY2021, which necessitated increased reliance on contractors. Personnel funding was provided in FY2019.

Disruptions due to mobilizations or deployments. Between 2019 and 2022, implementation of many state programs was disrupted due to the COVID-19 pandemic response and mobilizations related to civil unrest. While many programs adapted to COVID-19 conditions by shifting to virtual platforms, states/territories should address broader contingencies in their longer-term implementation plans, considering how scheduling and staffing resources might adjust to ensure continuity during future activations. Further, evaluation activities should measure differences in outcomes given participant duty status to ensure that programs achieve their objectives given a variety of service member experiences and mobilization/deployment schedules.

Limited staffing resources. Program managers commonly implemented their programs and evaluation plans as an additional duty, which made it difficult to sustain over time given competing priorities. Programs that were able to secure funding for additional staff (contracted or organic) had greater success carrying out quality implementation and evaluation activities. Before adopting any new program, managers should consult with resources within and external to their state to ensure that their staffing plans are realistic and that resources will be available to fill them.

Lack of leadership support. Lack of support from local leadership, to include high-level leadership (e.g., adjutants general, assistants to the adjutant general, flag officers) as well as mid-level leaders and stakeholders from other programs, caused difficulty for several programs. Further, turnover or shifting priorities could make it difficult to sustain support over time. This affected other prerequisites for successful program implementation and sustainment, such as securing adequate staffing and service member participation. Evaluation findings demonstrating the program's effects on service member outcomes were helpful to securing leadership support. In the future, analyzing return on investment, such as long-term cost savings resulting from implementing a program, could bolster these efforts. Engagement with NGB or WRF is also important to communicating program priorities.

C. Process and Outcome Evaluation

IDA provided education and assistance to state programs to support local capacity for program evaluation. However, many factors, such as staff time, access to data, and access to program participants, affected the degree to which state programs were successful in carrying out their evaluations. Table 2-3 summarizes challenges, lessons learned, and recommendations related to evaluation activities.

Table 2-3: Summary of Process and Evaluation Lessons Learned and Recommendations

Challenges	Best practices and lessons learned	Recommendations for program managers
Failure to establish or execute a rigorous evaluation plan	■ Managers revised weak evaluation plans after beginning program implementation ■ Managers leveraged internal or external sources of support for program evaluation, e.g. university partners or SMs with research experience	■ Build evaluation planning and execution into implementation and staffing plans ■ Develop an evaluation plan prior to beginning program implementation ■ Allocate 5 to 10% of program budget to evaluation activities
Few responses to evaluation questionnaires	■ Managers asked SMs to complete forms during program activities (e.g., immediately before and after a training) or other in-person events ■ Managers used technology (QR codes, electronic data collection) to make forms easy to complete ■ Managers worked to shorten lengthy questionnaires	■ Develop recruitment materials and messaging in a variety of formats to reach participants ■ Communicate the importance of program evaluation to participants ■ Share evaluation results with key stakeholder groups ■ If feasible, call unresponsive participants to complete questionnaires over the phone
Inability to access control/comparison groups or measure longer-term outcomes	■ Managers pursued other strategies to strengthen evaluation (e.g., historical comparisons, follow-up surveys) ■ Managers measured intermediate outcomes directly tied to their intervention	■ Use data from Department of Defense (DOD) surveys and administrative sources to compare participant and non-participant outcomes and examine long-term outcomes ■ Develop theories of change and/or logic models to understand potential program impacts

Challenges	Best practices and lessons learned	Recommendations for program managers
Lack of access to administrative and service utilization data (e.g., to assess whether intervention had an impact on retention or utilization of helping resources)	■ Managers leveraged internal NG data (e.g., physical fitness test (PFT) results, alcohol incidents)	■ Secure buy-in from multiple levels of state leadership to facilitate data-sharing across programs

Failure to establish or execute an evaluation plan. Some programs lacked the staff time or resources to conduct evaluation-planning activities (e.g., developing an evaluation plan, creating or administering data collection tools). Other programs began/continued evaluation activities that were not sufficiently rigorous (e.g., surveys distributed at the end of training that measure satisfaction with program but not improvement in outcomes; failure at pre- and post-intervention data collection to collect unique identifiers necessary for paired statistical analyses). Although IDA provided direct assistance to programs for analyzing data and developing/revising evaluation plans, data collection tools, and survey deployment strategies, we could not directly assist with execution. Programs that had existing partnerships with external research entities, such as local universities, or included service members and/or civilians with research/evaluation experience on their program teams had greater success carrying out robust evaluations. Staffing plans should budget time and resources needed for evaluation; the CDC[7] and World Health Organization[8] recommend that programs budget 10% of staff time to program evaluation. Further, many resources exist to build internal capability of program evaluation where it may be lacking. See, for example, the RAND Suicide Prevention Program Evaluation Toolkit[9] and the U.S. Army's Ready and Resilient Program Evaluation Process Guide.[10]

Lack of access to adequate data. Programs commonly struggled to collect or obtain access to the data required for a robust program evaluation. This was commonly due to receiving too few responses to evaluation questionnaires. Administrative and service utilization data was also a key component of some programs' evaluations. Some programs lacked access to this data, however. Difficulty obtaining responses to evaluation questionnaires and/or administrative data affected not only evaluation of the immediate effects of the intervention itself, but also created challenges related to employing more robust evaluation designs that included control/comparison groups (i.e., comparing program participants to non-participants) and to measuring longer-term outcomes (e.g., effects on service utilization or rates of behavioral health issues).

Administering questionnaires immediately before and after an intervention (e.g., at the start and end of a training) was a best-practice for achieving higher response rates. Where this is infeasible, some programs had success calling participants to complete questionnaires over the phone. Conducting marketing and outreach that encourages participation in the evaluation may also improve response rates; this may be more impactful if messages communicate leadership support for and/or the utility of the program evaluation.

Securing buy-in from leadership, other program managers, and other key stakeholders in the state could assist in facilitating access to administrative and service utilization data, which would enable comparison across participants and non-participants and analyses of effects on longer-term outcomes. In the future, programs should also pursue

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7 Goldie MacDonald, 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, November 2001), https://stacks.cdc.gov/view/cdc/23472.

8 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.

9 Joie D. Acosta, Rajeev Ramchand, Amariah Becker et al., *RAND Suicide Prevention Program Evaluation Toolkit* (Santa Monica, CA: RAND Corporation, 2013), http://www.rand.org/pubs/tools/TL111.html.

10 U.S. Army Health Promotion and Wellness Directorate, *U.S. Army's Ready and Resilient Initiative Evaluation Process Guide* (Washington, DC: Department of the Army, 2019), https://phc.amedd.army.mil/PHC%20Resource%20Library/TG382_IEPGuide2019.pdf.

the use of existing survey data, such as the Defense Organizational Climate Survey or Status of Forces Survey, to facilitate comparisons. Many measures included in the WRF Catalogue of Metrics and Measures are drawn from such surveys.

Often, it may not be feasible for states to employ comparison groups or to measure long-term outcomes. In the absence of long-term measures, theories of change or logic models (which map the relationship between program inputs, outputs, intermediate outcomes, and longer-term impacts)[11] can help conceptualize how intermediate outcomes may impact longer-term outcomes. When informed by the evidence-base regarding prevention of harmful behaviors, these can offer useful insights for prevention.[12] However, interpretation of evaluation results should always consider the limitations of designs lacking control/comparison groups and longer-term measurements.

D. General Considerations and Recommendations

In addition to the lessons learned presented above, we conclude with general considerations for program implementation and evaluation. These are relevant to implementation of future efforts and should be kept in mind when reviewing the nine successful programs featured in Chapter 3.

- Some programs may be effective in certain settings but unsuccessful in others. As discussed in Section B, states considering implementation of any program should examine how their states' staffing resources, policies, and force structure may affect the feasibility and effectiveness of the program. Programs shown to be effective elsewhere may need to be adapted to suit a particular context; rigorous and continuous evaluation should accompany this adaptation.
- Many programs employ strategies to improve long-term sustainability. When working with contracted programs, for example, employing train-the-trainer models that develop organic capability to run the program can help to reduce long-term costs. States implementing train-the-trainer models should assess fidelity (i.e., adherence to implementation protocols) and outcomes across trainers. Developing curricula or other program approaches within the NG is also a promising approach, though states may have greater success adapting existing evidence-based practices rather than starting from scratch.
- Time is prerequisite to determining longer-term effects. As discussed in Section C, programs were often unable to measure whether their effects were sustained over time and/or whether they affected more distal behavioral outcomes. Often, they measured short-term changes in intermediate outcomes, such as intentions to use behavioral health services. Longer-term evaluations (e.g., assessment of outcomes several months after program completion) are needed to determine whether reinforcement of, or repeated participation in, the interventions is necessary to retain and/or sustain program effects.
- Many behavioral outcomes, such as suicidal behavior or substance misuse, are affected by myriad different factors. A single program or intervention is unlikely to be sufficient to substantially impact such behaviors. When establishing a new program, states should consider how the intervention complements other programs or resources available in the state to develop an effective portfolio of activities. Refer to the WRF Prevention Framework for more information about the elements of a comprehensive approach to prevention.[13] In many cases, evaluations that seek to assess broad behavioral outcomes like suicide should consider the impact of a portfolio of activities, rather than a single program.[14]

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11 "Logic Models," Centers for Disease Control and Prevention Website, last reveiwed December 18, 2018, https://www.cdc.gov/evaluation/logicmodels/index.htm.

12 While IDA's metric recommendations were informed by theories of change and logic modeling, programs were not asked to develop formal logic models. In the future, managers should consider developing these tools as part of their early evaluation planning.

13 Dina Eliezer et al., *National Guard Suicide Prevention and Resilience Innovation Framework*.

14 Kerry L. Knox, 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 (December 2010): 2457-2463, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2978162/.

3. Overview of State Programs

The following sections provide an overview of state programs that have demonstrated evidence of effectiveness during state-level implementation and evaluation. These programs address a range of behavioral areas, including sexual assault, suicide, and substance misuse. Some programs constitute "integrated prevention," meaning they **address multiple harmful behaviors in a cohesive manner.**

In the overviews of programs below, you will find information about the *prevention level*[15] and *prevention approach*[16] relevant to each program. See Appendix A for more information about prevention levels and approaches.

To learn more about an program, click its name in the table below to navigate to its overview page. At the bottom of each navigation page, you will find a link to an appendix with supplemental information about the program.

Integrated Prevention			
Program		**Prevention Level**	**Prevention Approach**
First Line Leader Relational Leadership Course OH Army National Guard (ARNG)	**Build trust through counseling and relationship skills training for first-line leaders.** Advanced training for conducting effective individual counseling with SMs, building professional relationships with subordinates, and facilitating unit cohesion.	Primary	Improve life-skills, relationships, and connectedness Change culture to promote help-seeking
Work for Warriors Georgia GA ARNG/Air National Guard (ANG)	**Streamline employment support services using online platform.** Screening and referral to employment services and other NG resources for SMs, veterans, and spouses through an online platform that has built-in reporting capabilities to inform program efforts.	Primary	Identify populations at risk Create protective environments
Behavioral Health Primary Prevention and Retention (BHPPR) ND & SD ARNG/ANG	**Proactively screen new recruits for pre-existing risk factors and provide preventative support to at-risk SMs.** Screening for SMs during Recruit Sustainment Program to identify risk factors and provide proactive case management.	Primary and secondary	Identify populations at risk Provide care and treatment

15 Public health frameworks outline three levels of prevention: primary, secondary, and tertiary. "Violence Prevention Fundamentals," Centers for Disease Control and Prevention Website, published July 22, 2019, https://vetoviolence.cdc.gov/apps/main/prevention-information/47.

16 Prevention approaches are detailed in the WRF Prevention Framework: Dina Eliezer et al., *National Guard Suicide Prevention and Resilience Innovation Framework*.

Sexual Assault			
Program		**Prevention Level**	**Prevention Approach**
Buddy Aid SD ARNG	**Operationalize sexual assault first response.** Sexual assault prevention and response training designed to prepare all SMs to respond to disclosures of sexual assault and treat the threat of sexual assault as equally destructive as other common military threats.	Secondary and tertiary	Identify populations at risk Change culture to promote help-seeking

Substance Misuse			
Program		**Prevention Level**	**Prevention Approach**
SASSI-4 OK ARNG	**Facilitate substance abuse referrals through online assessment.** Online version of the Substance Abuse Subtle Screening Inventory (SASSI)-4 administered to self-referrals and positive urinalysis cases facilitates referral process.	Secondary	Identify populations at risk Provide care and treatment

Suicide			
Program		**Prevention Level**	**Prevention Approach**
Start SC ARNG	**Expand gatekeeper skills through online suicide prevention training.** Online gatekeeper training distributed to leadership, SMs and spouses, and community partners to improve ability to identify and respond to SMs at risk for suicide.	Secondary	Identify populations at risk
Together Strong ND ARNG	**Teach risk reduction communication skills through online training.** Virtual role-play training to teach participants how to identify and respond to those at risk for suicide and increase awareness of behavioral health (BH) resources.	Primary and secondary	Identify populations at risk
SafeUTNG UT ARNG/ANG	**Reduce barriers to care through crisis intervention mobile app.** A mobile app offers live chat with local clinicians, in partnership with the University of Utah, during times of crisis.	Tertiary	Provide care and treatment
Crisis Response Plan TX ARNG	**Train Behavioral Health Officers (BHOs) and Chaplains on crisis response and lethal means safety counseling.** Training to enable BHOs and Chaplains to provide a brief evidence-based and client-centered intervention for SMs at risk of suicide.	Tertiary	Create protective environments

First Line Leader Relational Leadership Course

Training to Improve Counseling and Connection

What is the FLL Relational Leadership Course and why is it needed?

The First Line Leader (FLL) Relational Leadership Course aims to improve leaders' ability to support their subordinates. It develops relationship-building and counseling skills among leaders O1-O3 and E4 and above. These FLLs are required to conduct quarterly individual counseling with their subordinates, but receive limited training on key counseling skills.

If FLLs are able to use counseling and relationship-building to identify their subordinates' needs, they can help address upstream risk factors, such as workplace issues or financial challenges, for harmful behaviors.

> "It is essential that First Line Leaders truly know their soldiers. Effective leaders know their Soldier's challenges and successes. It is a cornerstone of the leader's role to take care of Soldiers."[17]

Is the program effective?

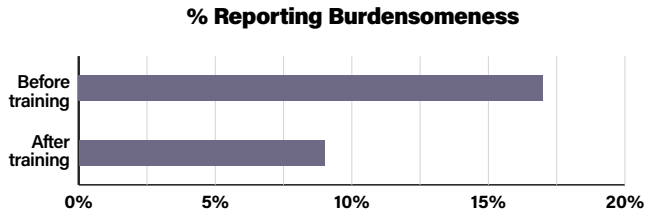
Since 2020, over 1,358 FLLs received the Relational Leadership Course. After the training, these participants demonstrated improvement in:

- *Attitudes* about the importance of leaders building relationships with their subordinates, and
- *Knowledge* of concepts related to counseling (e.g., knowledge of behavioral health resources).

These outcomes address two key barriers FLLs reported to building relationships: prioritizing time for, and inexperience providing, soldier care.

Future evaluations should assess whether the training reduces rates of harmful behaviors in units in the long term.

Beyond preparing participants to be more effective FLLs, data suggests that **the course directly benefitted the participants** by reducing the percentage who felt like a burden on others. *Burdensomeness* increases risk for suicide.



81% of participants believed the course would help them improve relationships with their subordinates.

How does the program work?

The Relational Leadership Course is implemented using internal NG resources:

- Ohio's Family Programs staff conduct the four-hour course. A train-the-trainer curriculum also prepares new facilitators to lead the course. OH ARNG policy requires all FLLs to complete the course annually.
- Minimal internal resources (e.g., printing handbooks, training space) are needed. Ohio developed a spend plan outlining costs of implementing the training in other NG states/territories.
- After taking the course, FLLs gain access to a Teams channel, which stores specific tools and exercises they can use to counsel and build relationships with subordinates

Contact: SFC Ronald Fry, Administrative Manager, OH ARNG, ronald.f.fry.mil@army.mil

Click here for First Line Leader – Relational Leadership Training Supplemental Information and Materials

17 Ohio Army National Guard, *Rucksack Essentials* (Columbus, OH: Ohio Army National Guard, 2022), https://www.ong.ohio.gov/programs/transition-assistance/resources/rucksack-essentials.pdf.

Work for Warriors Georgia

Connecting SMs with Support Services and Job Opportunities

What is Work for Warriors and why is it needed?

Work for Warriors Georgia (WFWGA) streamlines referrals to resources and service providers. The program requires SMs to complete a Wellness Poll during Soldier Readiness Processing, Yellow Ribbon, and other group events to indicate their needs. They can also complete the poll online at any time. Less than 72 hours later, a service provider contacts the SM.

Beyond employment assistance, SMs can request assistance for finances, behavioral health, legal needs, Veterans Affairs and health care benefits, education, and more. Centralizing outreach and referrals is a best practice for supporting access to care, and facilitating quality job opportunities is critical to reducing suicide risk related to financial issues.

Is the program effective?

Facilitated Resource Referrals

Since it began operating in 2019, WFWGA has polled over 22,500 SMs to identify resource needs. This has facilitated over 19,000 service referrals, including:

- **3,610** referrals to employment assistance
- **1,155** referrals to financial assistance
- **777** referrals to behavioral health services
- **13,625** referrals for other services (e.g., TRICARE, legal resources, education benefits)

Secured Employment

As of 2022, WFWGA had helped 2,326 individuals gain employment.

Among a sample of WFWGA users, 79% said they were satisfied with the job they found through WFWGA.

> *There is such a broad range of services that Work For Warriors Georgia offers. They helped me a lot with this transition to the civilian sector. (WFWGA participant)*

How does the program work?

1) *Support from the Work for Warriors Coalition:* WFWGA is a member of the Work for Warriors Coalition, which provides guidance and support for implementing the program.
2) *Creation of an online database:* The program uses an online platform to run the Wellness Poll and coordinate marketing and referrals.
3) *Outreach and marketing efforts:* WFWGA reaches most SMs during Soldier Readiness Processing, Yellow Ribbon events, and other unit briefs.

Note: Among a sample of WFWGA users, 54% were unfamiliar with the program before WFWGA started working with them. Proactive outreach and online marketing are critical to supporting the reach of this program.

Contact: Lacy Turner, Program Director, GA ARNG, lacy.p.turner.nfg@army.mil

WWW.W4WGA.ORG

Click here for Work for Warriors Supplemental Information and Materials

Behavioral Health Primary Prevention and Retention (BHPPR)

Proactive Support to New Recruits

What is BHPPR and why is it needed?

BHPPR proactively identifies SMs with social determinants of health (SDOH) needs and supports those at risk. A 15-20 minute questionnaire completed during recruit sustainment program (RSP) identifies SMs with life stressors, such as legal, financial, or relationship issues. It provides low-touch, proactive case management to address these issues, or transfers those with acute problems to more intensive services.

The program aims to prevent acute behavior health (BH) issues, which may otherwise limit readiness and retention, and provides a systematic way to do so at time of entry into the military.

Social Determinants of Health:

Conditions in living and working environments that affect a person's health and quality of life

Is the program effective?

Improving Behavioral Health Outcomes

During its first year, BHPPR's risk identification process showed evidence for reducing negative BH outcomes among new recruits. Compared to projections based on historical trends, the program found:

- **78%** reduced incidence of BH issues arising during RSP compared to projections based on historical trends
- **31%** lower severity (rated on a 4-point scale) when issues were identified

This suggests that proactive case management provided to new recruits may facilitate early intervention better than standard RSP processes.

Reaching New Recruits

Participation rates suggest that the BHPPR program is highly acceptable to new recruits:

- **75%** of the 475 new recruits who started RSP during program implementation completed the voluntary SDOH screening questionnaire.
- **100%** of those identified as having unaddressed needs participated in the voluntary proactive case management provided to them.

Future evaluations should assess effects on retention and rates of behavioral health issues over a longer period of time.

How does the program work?

The NM ARNG developed a Standard Operating Procedure (SOP) for BHPPR. This SOP includes step-by-step guidance for running the program during RSP and/or Student Flight School. Basic materials are required for implementation:

- SDOH screening questionnaire (detailed in SOP)
- Electronic survey software to administer the questionnaire

When adapting the program, states may consider resource-intensive or low-resource implementation options.

Resource intensive: Requires a large staff of case managers to directly contact (via telephone) and provide support to at-risk SMs. This is the original design of BHPPR, but it requires significant staff time.

Low resource: Use "caring contacts" (emails or letters) offering resources and support to at-risk SMs to reduce demands on staff time. However, the effectiveness of this approach has not yet been tested.

Contact: 1LT Michelle McDaniel, Chief of Behavioral Health, NM ARNG, michelle.a.mcdaniel5.mil@army.mil

Click here for Behavioral Health Primary Prevention and Retention Supplemental Information and Materials

Buddy Aid

Sexual Assault First Response Training

What is Buddy Aid and why is it needed?

Buddy Aid is first response for sexual assault disclosures. It is taught through a 1.5-hour training designed to prepare all SMs to respond to disclosures of sexual assault and to treat the threat of sexual assault as equally destructive as other common military threats. SMs learn:

- How to identify signs a peer may have experienced a sexual assault
- "One thing" to say as a first response to a sexual assault disclosure
- How to help victims access further support, when they're ready

Appropriate first line response can help increase use of support services and lessen impacts of sexual assault on military readiness.

> One Supportive Thing to Say:
>
> **I believe you.**
>
> **It's not your fault.**
>
> **You didn't deserve that.**
>
> **I'm here to get you the help you want.**

Is the program effective?

95% of Buddy Aid participants said their training was clear and they felt comfortable sharing personal thoughts during the training.

"I liked how it was put in tactical terms that can be applied to a wound on the battlefield." (ARNG participant)

Buddy Aid training has shown consistent evidence of improving short-term outcomes among over 1,800 participants, including their:

- *Likelihood* to identify and respond to signs a peer may have experienced a sexual assault
- *Knowledge* of "one thing" to say in response to a sexual assault disclosure
- *Rejection of rape myths*, like the notion that sexual assault is mainly a "female issue"

Before the trainings, only **2 in 10** participants knew one supportive thing to say to a sexual assault victim.

After the trainings, **8 in 10** knew one supportive thing to say.

Future evaluations should assess whether participants maintain improved knowledge and attitudes and apply their skills over a longer period of time after the training.

How does the program work?

1) *Attend a Train-the-Trainer course:* Victim Advocates and Sexual Assault Response Coordinators apply to attend a 5-day train-the-trainer course at the NG Professional Education Center (PEC) to become certified facilitators for their states
2) *Schedule trainings in units:* Once certified, facilitators conduct the training in person with groups of 20-30 SMs

- The training follows a standardized PowerPoint presentation
- Facilitators need a classroom with screen/projector, a tourniquet, and their Service's First Aid Field Manual to run the training

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Click here for Buddy Aid Supplemental Information and Materials

SASSI-4

Streamlined Screening for Substance Use Disorders

What is the SASSI-4 and why is it needed?

The Substance Abuse Subtle Screening Inventory (SASSI-4) is an online screening to identify individuals that require treatment for substance use disorders. It is provided to SMs who test positive on urinalyses, have alcohol incidents, or who self-report substance use concerns. Based on the results, SMs receive counseling and referral to appropriate resources (e.g., Alcohol and Substance Abuse Training (ASAP) training or community-based treatment). The Oklahoma ARNG provides the screening:

- Online, so SMs can take it at convenient times
- At no cost to the SM (the OK ARNG covers the fee)

This aims to reduce barriers to accessing preventative care and treatment, and in turn prevent risky substance use from continuing or worsening into a clinical disorder.

Did you know?

Community-based drug and alcohol assessments cost $50 to $350 in Oklahoma, with higher prices common in rural areas.

This can make it hard for SMs to get care for substance use concerns.

Is the program effective?

Implementation of SASSI-4 in the OK ARNG has been effective, but not without challenges.

As of April 2022, 186 SMs had completed the SASSI-4. **Participants had positive views of the screening**. They:

- Said the screening was easily accessible and understandable
- Believed their results were accurate
- Would recommend the screening to other SMs who have substance use concerns

The program has had some **coordination challenges:**

- Delays in notifying SMs about positive urinalyses, which created a backlog of assessments
- SM failure to contact the Risk Reduction Coordinator (RRC) to gain access to the SASSI-4
- After the screening, SM failure to participate in post-screening counseling on their results

Short-term outcomes show promise: Among participants who completed evaluation questionnaires, data showed a significant decrease in intentions to use alcohol/drugs to cope with stress, comparing responses before each participant completed the SASSI-4 to their responses after they completed it and received counseling on their results.

Key outcomes are unknown. Future efforts should evaluate the effects of the screening process on substance misuse recidivism rates over time.

How does the program work?

1) *Purchase licenses.* The Oklahoma ARNG purchased SASSI-4 licenses in bulk using G1 Medical Detachment funding.
2) *Complete required training.* To disperse the assessments, a licensed clinician (e.g., LPC, LCSW) must first complete an 8-hour training. For more information about costs and required trainings, see https://sassi.com/sassi-4/
3) *Develop a process to coordinate between readiness NCOs and RRCs.* In Oklahoma, readiness NCOs notify SMs of positive urinalyses results and instruct them to contact the RRC to access the screening online.
4) *Provide post-screening counseling and referral.* After the SM completes the training, the RRC walks the SM through his or her results and refers to appropriate resources (ASAP training and/or community treatment services).

Contact: Amber McCoy, Risk Reduction Coordinator, OK ARNG, amber.r.mccoy2.ctr@mail.mil

Click here for SASSI-4 Supplemental Information and Materials

Start

Gatekeeper Training for Suicide Prevention

What is Start and why is it needed?

Start trains participants to identify and support SMs who may be considering suicide. It teaches four key steps to mitigate suicide risk and includes simulations in which participants practice their skills. After completing the 1.5-hour training, participants gain access to a database of helping resources to seamlessly connect at-risk SMs with support. Participants learn how to:

- Tune into signs a SM may be considering suicide
- Directly ask whether a SM is considering suicide
- Support the SM in immediately contacting helping resources

The brief, virtual format of the training enables it to reach a broad audience of military and civilian NG personnel, families, and community partners, **building a protective community around SMs** experiencing high risk of suicide.

Is the program effective?

Among over 1,400 NG participants, Start has shown evidence for **improving confidence in gatekeeper skills** immediately after the course, including in their ability to:

- Recognize the signs someone might be considering suicide
- Know how and where to get help for someone considering suicide
- Help someone who may be considering suicide

1 in 4 Start participants said they already had someone in mind with whom they could use their new skills.

97% of participants said that if they were struggling with thoughts of suicide themselves, they would know how to use the helping resources Start provided.

Future evaluations should assess whether participants retain their improved knowledge and confidence, and whether they actually apply their skills, over a longer period of time after the training.

How does the program work?

1) *Purchase Start licenses:* LivingWorks provides Start training licenses at a cost.
2) *Distribute licenses:* Once purchased, in-state program managers distribute Start licenses to individuals interested in participating. The training is completed entirely online. It takes approximately 1.5 hours and can be completed across multiple sessions, in the participant's own time
3) *Marketing:* States should consider unit-level outreach and marketing to support participation. Some states have also allowed SMs to use drill time for the training to encourage completion.

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Click here for Start Supplemental Information and Materials

Together Strong

Gatekeeper Training for Suicide Prevention

What is Together Strong and why is it needed?

Together Strong is virtual gatekeeper training for suicide prevention, tailored to the NG. Through avatar-based role-plays, participants interact with SMs in crisis, experimenting with different response options to learn to:

- Recognize signs of distress in their peers
- Use motivational interviewing techniques to find out what their peers need
- Refer peers to support services

Together Strong was developed in collaboration with the Veteran's Health Administration and tailored to the North Dakota NG to improve its relevance to SMs. It aims to reinforce and supplement in-person suicide prevention trainings that teach similar gatekeeper skills.

Is the program effective?

In its first year, 1,550 North Dakota ARNG members enrolled in the training, and 77% (1,193) completed it. This represents about 40% of the total force.

Over the short term, Together Strong improved participants' preparedness, likelihood, and confidence to use gatekeeper skills with someone showing signs of distress, e.g.:

- Discussing their concerns with the person
- Motivating the person to seek help
- Recommending support services to the person

Beyond improving gatekeeper skills, Together Strong i**mproved participants' own help-seeking intentions**.

Before the trainings, only **5 in 10** participants said they would be likely to seek help from NG resources if faced with a stressful situation.

After completing the training, **7 in 10** said they would.

Future evaluations should use survey and administration data to assess whether Together Strong training increases use of support services among members of the NG.

How does the program work?

1) *Purchase Together Strong licenses:* The North Dakota ARNG purchased a training package in bulk from Kognito.
2) *Distribute licenses:* Once purchased, licenses were distributed to units in coordination with the G3 and unit training NCOs.
3) *Complete training:* Together Strong is entirely virtual and takes less than one hour. Units scheduled time for members to complete it in lieu of Annual Suicide Prevention training in FY2022. In the future, they plan to have only new recruits complete the training.
   - North Dakota also planned for a 90-minute unit debrief led by Suicide Intervention Officers to follow the training. This was ultimately not implemented due to lack of drill time.
4) *Reinforce leadership support:* Senior leaders helped encourage SMs to complete the training, if they had not done so in their unit. Marketing materials can also be purchased from Kognito.

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Click here for Together Strong Supplemental Information and Materials

SafeUTNG

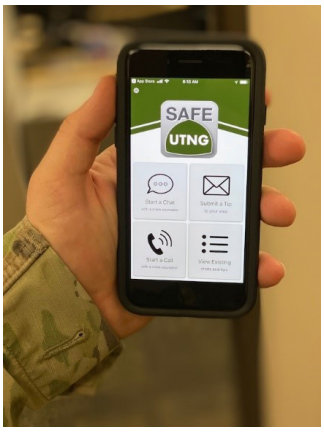
Crisis Intervention Mobile App

What is SafeUTNG and why is it needed?

SafeUTNG provides 24/7/365 access to confidential crisis intervention through a mobile app. Using the app, SMs, civilians, and family members can reach a licensed mental health professional at the University of Utah via live chat or a voice call. They help users through crises related to suicidality, domestic violence, and other challenges.

To reduce barriers to care, the app and its services are:

- Entirely free to download and use
- Confidential, with follow-up only for imminent risk of harm
- Staffed by clinicians trained in military cultural competency



Is the program effective?

In the Utah NG, evaluation of the SafeUTNG app has focused on reach and utilization. To protect user privacy, the Utah NG does not track data on outcomes of crisis chats.

Marketing and outreach efforts showed promise for increasing use of the app over time:

- **2019:** In the first 2 months after launch, 1,337 users downloaded the app.
- **2020:** A force-wide survey found that awareness of the app was low among males, enlisted SMs, and those with lower levels of social support.
- **2021-2022:** After redoubled marketing efforts, downloads and use of the app increased when comparing similar periods between 2021 and 2022, and quarter to quarter in 2022.

Since 2019, the app has been **downloaded over 3,600 times.**

To date, users have engaged in over 350 crisis chats and, on average, exchanged 30 messages with crisis-line clinicians during each chat.

How does the program work?

1) **Download:** The SafeUTNG app is free and available to download through the Apple and Google Play stores. However, crisis chat services are not currently available outside of Utah. The SafeUTNG team is exploring avenues to expand to additional states.

2) **Partner:** Currently, clinicians from the University of Utah staff the app's crisis chat services. With increased use, the app will require additional licensed mental health professionals. New partnerships with local universities could facilitate expansion of services in additional states/territories.

3) **Train:** External partnerships are important to ensuring user confidentiality but may require NG personnel to train civilian providers on military cultural competency.

4) **Market:** Promoting awareness and utilization of the app among SMs may require additional NG staff time (e.g., presentations to SMs and leadership, integrating information into suicide prevention briefs). Measuring awareness, such as through a marketing survey, can help direct these efforts.

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Click here for SafeUTNG Crisis Intervention App Supplemental Information and Materials

Crisis Response Plan

Mitigating Risk during Suicidal Crises

What is Crisis Response Plan and why is it needed?

Crisis Response Plan (CRP) is a client-centered approach to reduce immediate suicide risk among SMs. The program trains Chaplains and Behavioral Health Officers (BHOs) to collaborate with SMs during counseling sessions to develop a personalized plan for managing suicidal crises and improving firearm safety. To do so, it incorporates:

- Motivational interviewing
- SMs' personal values
- SMs' self-identified warning signs and resources

Chaplains and BHOs have inconsistent access to training on evidence-based approaches to manage suicide risk during outpatient care. CRP training aims to increase SM access to care during high risk periods.

Evidence-based practice

Clinical trials . . .

among active duty Soldiers with acute behavioral health risks found that Crisis Response Planning reduced suicide attempts by 76%.[18]

Is the program effective?

Effective Skill-building

Among 37 participants from the Texas NG said the training improved knowledge of the core components of a CRP. It also improved their confidence to:

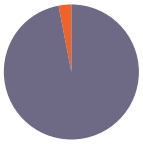
- Work with SMs experiencing heightened suicide risk
- Conduct suicide risk assessments
- Provide counseling to service members experiencing emotional crises or suicide risk

Need for Follow-up and Outreach

Four months after training, few participants had used CRP:

- 38% said that few SMs with suicide risk sought counseling from them
- 14% said the SMs they counseled were uninterested in partaking in CRP and/or lethal means counseling

Longer-term follow-up is necessary to assess retention and use of CRP skills among chaplains and BHOs. Future efforts could also couple CRP training with targeted marketing and outreach to increase SMs' help-seeking.



97% of participants said the CRP training enhanced their professional experience. They liked that the training was highly interactive – with live presentations, videos, breakout sessions, and roleplay excercises to help them build competence within a community of peers.

How does the program work?

Train Chaplains and BHOs

1) *Contracted training:* Training was provided by the University of Texas Health Science Center San Antonio's (UTHSCSA) Strong Star Training Program.
2) *Virtual implementation:* Groups of about 20 participants joined one, 8-hour virtual training session led by UTHSCSA facilitators.
3) *Case consultation:* After receiving training, participants received access to a resource portal and case consultation sessions to support longer-term skill retention and development.

Provide CRP Intervention

Once trained, Chaplains and BHOs provide the CRP intervention as needed to SMs with high suicide risk. The intervention can be delivered virtually and takes about 30 minutes.

Contact: Shandra Sponsler, J1 Personnel Services Division Chief, TX NG, shandra.b.sponsler.civ@army.mil

Click here for Crisis Response Plan Supplemental Information and Materials

18 Craig J. Bryan, Jim Mintz, Tracy A. Clemans et al., "Effect of Crisis Response Planning vs. Contracts for Safety on Suicide Risk in US Army Soldiers: A Randomized Clinical Trial," *Journal of Affective Disorders* 212 (2017): 64-72, https://pubmed.ncbi.nlm.nih.gov/28142085/.

Appendix A. Prevention Levels and Approaches

Prevention level. Public health frameworks outline three levels of prevention: primary, secondary, and tertiary. [19]

- *Primary prevention* activities intervene before negative outcomes occur. These interventions typically target broad populations to reduce risk factors and increase protective factors. For more information about specific risk and protective factors related to harmful behaviors, see the CDC's Connecting the Dots[20] and Violence Prevention websites.[21]
- *Secondary prevention* activities address risks early to prevent them from leading to worse outcomes. These activities typically target populations known to be at higher risk for negative outcomes.
- *Tertiary prevention* activities manage or mitigate the effects of negative outcomes that have already occurred.

Prevention approach. Effective prevention programs incorporate the six domains of evidence-based practices outlined in the WRF Prevention Framework, shown in Figure 1 below. Domains include activities spanning primary, secondary, and tertiary prevention levels.

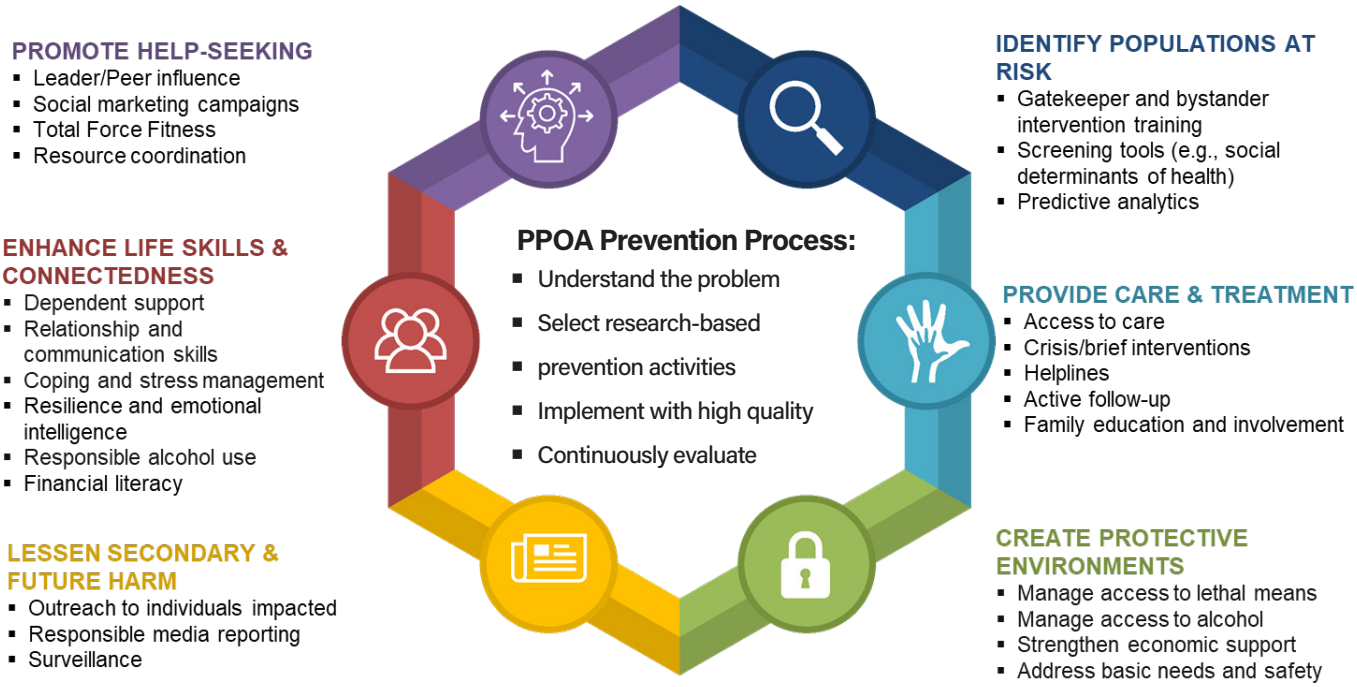


Figure 1: WRF Prevention Framework

For more information about the approaches and activities summarized in the WRF Prevention Framework, see the National Guard Suicide Prevention Innovation Framework companion report.[22]

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19 "Violence Prevention Fundamentals," Centers for Disease Control and Prevention Website, published July 22, 2019, https://vetoviolence.cdc.gov/apps/main/prevention-information/47.

20 "Connecting the Dots," Centers for Disease Control and Prevention Website, published November 7, 2017, https://vetoviolence.cdc.gov/apps/connecting-the-dots/.

21 "Violence Prevention Fundamentals," Centers for Disease Control and Prevention Website, published July 22, 2019, https://vetoviolence.cdc.gov/apps/main/prevention-information/47.

22 Dina Eliezer et al., *National Guard Suicide Prevention and Resilience Innovation Framework*.

Appendix B. Supplemental Information and Materials

First Line Leader – Relational Leadership Training

Description: Four-hour course designed for NCOs ranking E4+ and Platoon Leaders to improve FLLs skills for conducting quarterly individual counseling and building relationships with subordinates.

Justification: FLLs have limited training for conducting required individual counseling with their subordinates; improved counseling enables FLLs to identify and help address suicide risk related to workplace and personal issues among their subordinates.

Evidence of effectiveness: *Evidence of process and outcome effectiveness.* As of January 2022, FLLs in 113 units (1,031 SMs total; 68% of state) had received training. Participants indicated high satisfaction with the program: 95% felt the training information was useful, 81% felt the training would help improve leadership relationships, and 73% felt the training would improve unit cohesion. Outcome data showed statistically significant positive changes in interpersonal skills, knowledge, and connectedness measures from pre- to post- training. IDA used a linear regression model (examining effects across Battalions) and McNemar's tests[23] to assess significance of training effects and calculated Cohen's *f* to assess effect size. From pre- to post-test, participants showed improved:

- **Attitudes** about the importance of leaders building relationships with their subordinates ($p<.01$, f=1.87)
- **Knowledge** of concepts related to counseling (e.g., from 68% correct on knowledge of behavioral health resources prior to the training, to 88% correct after the training).
- Indicated a greater **sense of connectedness** (e.g., from 17% indicating feeling like a burden before training to 9% after training) ($p<.001$, f=3.47)

Feasibility: Implementation of the program utilizes existing staff resources. The curriculum was developed by the program team and requires minimal resources to conduct (printing materials, training space). Wide- scale implementation was achieved in the Ohio ARNG as a result of a state policy requiring all FLLs to complete the training. Even so, some units delayed sending leaders to the training, which necessitated additional outreach and leadership engagement. The program plans to conduct annual follow-on trainings with all units. This will facilitate follow-up data collection to measure whether participants retain and apply the counseling skills.

23 McNemar's tests used when outcome data was dichotomous.

Work for Warriors Georgia

Description: Streamlines connection to helping services, including employment, by screening SMs during Soldier Readiness Processing (SRP) and Yellow Ribbon/other group events to facilitate referral using an online platform that has built-in reporting capabilities.

For more information about Work for Warriors GA, visit https://workforwarriorsga.org/

Justification: The NG lacks employment assistance programs for active Guardsmen; current employment programs focus on retiring or separating SMs. By facilitating employment and connection to other helping services, the program may reduce suicide risk, as well as reduce attrition, related to financial issues and other stressors.

Evidence of effectiveness: *Evidence of process and outcome effectiveness*. Since August 2019, the program has polled over 22,500 SMs to identify resource needs. This has facilitated over 19,000 service referrals, including:

- 634 referrals for behavioral health assistance
- 2,403 referrals for employment assistance
- 960 referrals for financial assistance
- 11,582 referrals for other types of assistance (e.g., legal resources, education resources, Veterans benefits, TRICARE)

WFWGA's employment assistance has facilitated 2,326 new full-time hires with a median annual salary of $30-40k.

Feasibility: A customer satisfaction service completed by some WFWGA service recipients found that awareness of the program was low (below 50%) before the respondents started working with WFWGA. This highlights the importance of the program's marketing and direct outreach efforts. The program requires dedicated staff to conduct outreach during SRP and other events, as well as for provision of employment services. In GA, these services have been supported by Yellow Ribbon funding. The program's automated referral process and detailed tracking of metrics also requires a license for Salesforce.

A white paper detailing WFWGA's efforts is available upon request.

Behavioral Health Primary Prevention and Retention

Description: By screening new recruits during recruit sustainment program (RSP) for SDOH-related needs, the program proactively identifies soldiers at risk for deployment- and retention-limiting conditions. It mitigates those risks by providing proactive case management consisting of follow-up contact and screening at six-month intervals, and transferring those who develop more acute problems to standard of care case management.

Justification: Training pipeline losses are frequently due to behavioral health issues exacerbated by life stressors in new recruits. These losses affect readiness. NG does not have a program to systematically identify and address risk factors, including legal, financial, and relationship issues, before crises occur.

Evidence of effectiveness: *Evidence of process and outcome effectiveness*. In the first year of implementation, evaluation found that early screening and proactive case management, when compared with standard of care practices that do not include early screening:

- Reduced the incidence of mental health, substance use, and psychosocial issues requiring standard of care case management (69 projected based on historical trends; 15 actual)
- When these issues did occur, facilitated identification and intervention at low levels of severity (on a 4-point scale, projected a 2.32 average severity rating based on historical trends; 1.6 actual).

While proactive case management participants completed basic training and advanced individual training at high rates, data are not yet available to assess longer term outcomes related to retention.

In addition to screening for SDOH-related needs, BHPPR also administered assessments of Adverse Childhood Experiences, personality, and behavioral health history. Analyses suggested that scores on these measures predicted some SMs' behavioral health outcomes during RSP, suggesting that these assessment tools may also facilitate early intervention to prevent adverse outcomes. The Independent Review Commission on Sexual Assault described these findings in their 2021 report and included an associated recommendation to screen for Adverse Childhood Experiences, modeled after the program's approach, as part of sexual assault prevention activities.[24]

Feasibility: In NM, program implementation began with ARNG RSP members in April 2019. The program achieved high rates of participation in the voluntary screening process among new recruits. This process was implemented both in-person and (as a result of COVID-19) virtually. The team developed an SOP to facilitate expansion of the program, and in May 2020 it expanded to include the NM ANG and the SD ARNG. However, implementation of both the screening and case management components of the program required investment of significant staff resources, including the availability of a Behavioral Health Officer (BHO) to administer assessments during RSP and case managers to conduct ongoing proactive case management. This led to issues with feasibility over time in both NM and SD. With lower staffing resources, states could potentially adapt the program using a "caring contacts" approach in lieu of proactive case management (i.e., send e-mails or letters to at-risk service members offering resources and support rather than contacting them by phone). However, a caring contact approach to the program has not yet been evaluated.

24 Independent Review Commission on Sexual Assault, *Hard Truths and the Duty to Change: Recommendations from the Independent Review Commission on Sexual Assault in the Military* (Washington, DC: IRS, 2021), https://media.defense.gov/2021/Jul/02/2002755437/-1/-1/0/IRC-FULL-REPORT-FINAL-1923-7-1-21.PDF/IRC-FULL-REPORT-FINAL-1923-7-1-21.PDF.

Buddy Aid

Description: Sexual assault prevention and response training to prepare all SMs to respond to disclosures of sexual assault and treat the threat of sexual assault as equally destructive as other common military threats.

Justification: Sexual assault prevention and response training is focused primarily on awareness and does not include comprehensive training on first line response. Appropriate first line response can help to increase use of support services and lessen secondary impacts of sexual assault on the workplace environment.

Evidence of effectiveness: *Evidence of process and outcome effectiveness.* Over 1,852 SMs had received Buddy Aid training as of 20 July 2022. Participants completed pre- and post-tests immediately before and after each training to measure satisfaction and outcomes. Approximately 95% of participants said the training was clearly presented, the facilitator was knowledgeable, and they felt comfortable expressing personal thoughts during the training. Over 60% of training participants demonstrate improved preparedness in responding to sexual assault. IDA conducted paired t-tests, Wilcoxon tests,[25] and McNemar's tests[26] to assess significance of changes in attitudes after the training, compared to attitudes before training. IDA also calculated Cohen's d to examine effect sizes (i.e., the magnitude of the change from pre- to post-training).[27] Significant improvements were seen on several metrics:

- Rejection of rape myths ($p<0.01$, $d=0.22$)
- Belief that sexual assault is the most likely threat that soldiers face ($p<0.01$, $d=0.85$)
- Belief that units should practice sexual assault response in field training ($p<0.01$, $d=0.45$)
- Confidence that the participant has "one thing" to say in response to a disclosure of sexual assault ($p<0.01$, $d=0.75$)
- Demonstrated knowledge of "one thing" to say in response to a disclosure ($p<0.01$)
- Likelihood to ask another SM if someone had hurt them ($p<0.01$, $d=0.68$)
- Participants' confidence in their own ability to respond to a disclosure ($p<0.01$, $d=0.50$)
- Belief that members of unit would disclose sexual assault victimization to a buddy ($p<0.01$, $d=0.30$)

Feasibility: The program has developed a sustainable train-the-trainer process to prepare new Buddy Aid facilitators. As of this writing, 75% of sessions have been facilitated by newly-credentialed trainers and continue to demonstrate outcome effectiveness. Statistical analyses comparing sessions led by the program manager/developer to sessions led by other facilitators found no evidence of trainer effects (i.e., facilitators certified through the train-the-trainer process are just as effective at delivering Buddy Aid training as the program manager/developer).

25 Wilcoxon tests used instead of t-tests when data was not normally distributed.

26 McNemar's tests used instead of t-tests when outcome data was dichotomous (i.e., "correct" or "incorrect").

27 Effect sizes were not calculated when data was dichotomous.

SASSI-4

Description: An online version of the SASSI-4 (developed by the SASSI Institute) identifies SMs who require treatment for substance use disorders in accordance with AR 600-85. The screening is administered free of charge to SMs who test positive on urinalysis tests, have alcohol incidents, or self-report substance use concerns.

For more information about SASSI-4, visit https://sassi.com/sassi-4/

Justification: NG lacks an internal, no-cost substance use assessment. SASSI-4 reduces barriers to care by keeping the assessment process internal to the NG and providing referrals to community-based treatment. By facilitating access to care, the process may reduce suicide risk related to legal/administrative, financial, workplace, and relationship issues arising from substance misuse.

Evidence of effectiveness: *Moderate evidence of process effectiveness*. As of April 2022, 186 SMs had completed the SASSI-4. Participants provided positive feedback on the assessment; on average, they believed the SASSI-4 results were accurate, found the screening accessible/understandable, and would recommend it to other SMs who have substance use concerns. Statistical analyses of pre- and post-assessment survey data from a subset of participants show a significant decrease in intentions to use alcohol/drugs to cope with stress ($p=0.023$) following completion of the SASSI-4 and receipt of counseling on the results of the assessment. The program plans to examine effects of the program on substance misuse recidivism rates, but data on this key outcome are not yet available.

Feasibility: Implementation of the program utilizes existing staff resources and state funding for purchase of SASSI-4 administrations. The Risk Reduction Coordinator (RRC) distributes SASSI-4 licenses directly to the SM following referral from a Drug Testing Coordinator, unit leader, self-referral, or other source. After the SM completes the SASSI-4, the RRC counsels him or her on the results over the phone. The RRC also shares the results with the Drug Testing Coordinator and unit representative and refers the SM to required counseling services.

In the OK ARNG, the program has experienced several coordination challenges. Delays in units' notification of SMs about positive urinalyses created a backlog of assessments and referrals. Some SMs who did receive notification of a positive urinalysis also failed to complete the SASSI-4. The RRC is currently working with Command and Readiness NCOs to address these issues.

Start

Description: Online gatekeeper training for suicide prevention (adapted from LivingWorks programs ASIST and Suicide to Hope) is distributed broadly to service members, family care staff, leadership, service members and their spouses, and community partners.

For more information about Start, visit https://www.livingworks.net/start

Justification: The NG lacks a comprehensive virtual suicide prevention training that is accessible to geographically dispersed NG SMs. The training equips SMs to identify suicide risk in individuals struggling with common NG risk factors, including financial, legal, and relationship problems.

Evidence of effectiveness: *Evidence of process and outcome effectiveness.* As of January 2022, over 1,400 individuals completed the training across 13 states. Participants indicated high satisfaction. The program shows evidence of effectiveness for building skills for identifying and responding to suicide risk. IDA conducted paired t-tests/Wilcoxon tests to assess significant changes in attitudes from pre-to post-training, and calculated Cohen's d for effect size. From pre- to post-training, participants significantly increased their confidence (as measured on a 5-point scale) that they could:

- Recognize the signs someone might be considering suicide, $p<.001$; $M\ (pre)=3.25$, $M\ (post)=3.68$, $d=0.68$
- Know how and where to get help for someone considering suicide, $p<.001$; $pre=3.33$; $post=3.66$, $d=0.55$
- Help someone who may be considering suicide, $p<.001$; $pre=3.43$, $post=3.71$, $d=0.46$

Feasibility: The training is virtual but may require outreach/socialization to facilitate participation at the unit level. States implemented varied approaches to offering the training, including using drill time to complete the training or allowing SMs to complete the training at home. Access to the training requires purchase of user licenses from LivingWorks but otherwise requires minimal investment of existing staff resources.

Together Strong

Description: Online gatekeeper training for suicide prevention developed by Kognito, in collaboration with the Veterans Affairs departments of New York and New Jersey and tailored for use in the North Dakota ARNG. Members of the North Dakota ARNG were required to complete the training in lieu of annual suicide prevention training in 2022.

For more information about Together Strong, visit https://kognito.com/solution/together-strong/

Justification: Peer support is a critical component of preventing suicide and reducing stigma related to mental health challenges. However, NG members have limited opportunities for interactive, skills-based training that is accessible in virtual formats. Together Strong equips SMs to provide peer-to-peer support and increase help-seeking using motivational interviewing techniques.

Evidence of effectiveness: *Evidence of process and outcome effectiveness.* In one year of implementation, 1,550 North Dakota ARNG members enrolled in the training, and 77% (1,193) completed it. They expressed high satisfaction and demonstrated significant improvements in gatekeeper skills and attitudes. IDA conducted paired Wilcoxon tests to assess significance of changes from pre- to post-training and calculated Cohen's d for effect size. From pre- to post-training, participants significantly increased their:

- *Preparedness* to recognize signs of distress, discuss concerns with the person, motivate the person to seek help, and recommend support services, $p<0.001$, $d=0.44$
- *Likelihood* to discuss their concerns with the person, motivate the person to seek help, and recommend support services, $p<0.001$, $d=0.34$
- *Confidence* in their own ability to recognize and discuss signs of distress and suicide, actively and compassionately listen to the person, help someone who is suicidal, and recommend support services, $p<0.001$, $d=0.41$

Additionally, the training improved participants' own help-seeking intentions, were they to feel trapped or stuck in a stressful situation from pre- to post-training:

- Likelihood to contact helping resources within the NG, $p<0.001$, $d=0.49$
- Likelihood to contact helping resources outside of the NG, $p<0.001$, $d=0.47$

These results are consistent with published literature examining the effectiveness of Together Strong in civilian populations.[28]

In North Dakota, the program was unable to collect follow-up data to measure use and retention of gatekeeper skills. The evaluation also measured effects of the program on mental health stigma but found no significant changes.

Feasibility: The training is virtual and takes approximately one-hour to complete. Access to the training requires purchase of user licenses from Kognito. The North Dakota ARNG developed a policy requiring the training and provided time during drill weekends for SMs to complete it. However, they experienced some difficulty accessing the training from NG computers, though this issue was addressed with help from Kognito. The program also leveraged unit leadership to encourage participation at the unit level.

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28 Daniel Coleman, Natasha Black, Jeffrey Ng, and Emily Blumenthal, "Kognito's Avatar-Based Suicide Prevention Training for College Students: Results of a Randomized Controlled Trial and a Naturalistic Evaluation," *Suicide and Life-Threatening Behavior* 49, no. 6 (December 2019): 1735-1745, https://onlinelibrary.wiley.com/doi/abs/10.1111/sltb.12550.

SafeUTNG Crisis Intervention App

Description: SafeUTNG is a mobile app that connects service members (SMs), significant others, and civilian contractors to crisis intervention services 24/7 via live chat or voice calls. The services are provided by licensed mental health professionals trained in military cultural competency at the University of Utah.

For more information about SafeUTNG, visit https://safeut.org/national-guard

Justification: Reduces barriers to care for SMs and their families in need of crisis intervention services by providing anonymous access to a licensed professional at no cost to the user.

Evidence of effectiveness: *Evidence of process effectiveness.* Since December 2019, there have been over 3,600 downloads of the app and a total of 356 chat conversations, averaging 21 individual messages per conversation. The program implemented a baseline survey to assess awareness of and satisfaction with the app in 2021; results showed low awareness and intention to use the app among males, enlisted SMs, and those with lower levels of social support. This highlighted the need for additional outreach and marketing. The program conducted outreach presentations to SMs and leadership, integrated SafeUTNG information into existing suicide briefs, and worked with the Family Readiness Group leadership to ensure that family members were made aware of SafeUTNG. Utilization of the app increased from 2021 to 2022 and continued to increase in 2022.

Feasibility: Within the Utah NG, the program identified a need to increase availability of licensed mental health providers to staff the app, as increased use by SMs over time may overwhelm existing staff availability. Promoting awareness/utilization of the app also required moderate investment of staff time internal to the NG.

While the app is openly available to download from the Apple and Google Play stores, it is intended for use in Utah. The SafeUTNG app was adapted from another app, SafeUT, developed with support from state resources for civilian students and their parents. Other states may be able to develop similar apps based on the SafeUTNG model.

Crisis Response Plan

Description: Virtual training offered to Chaplains and Behavioral Health Officers to build skills for crisis response planning and lethal means counseling during interactions with SMs experiencing distress or suicidal ideation. The program aims to reduce immediate risk of suicide and increase use of evidence-based practices among service providers.

Justification: NG Chaplains and BHOs often have inconsistent access to training on evidence-based practices for managing suicidal ideations among SMs. Further, providers more broadly may lack training on counseling on access to lethal means, an effective approach to reducing immediate risk of suicide by firearms and medications.

Evidence of effectiveness: *Evidence of process and outcome effectiveness.* CRP training was delivered to 37 service providers, including chaplains and behavioral health officers, in the Texas ARNG and ANG. Participants indicated high satisfaction with the training program. The program shows evidence of effectiveness for improving knowledge of Crisis Response Planning for suicide prevention and confidence in counseling practices. IDA used McNemar's tests to assess changes in knowledge of Crisis Response Planning and found significant effects on demonstrated knowledge of the core elements included in Crisis Response plans from pre- to immediately post-training. Knowledge tests were not re-administered at four-month follow-up. Items on which participant knowledge improved included:

- "Crisis Response Plan includes a contract for safety" [true or false question]; $p<0.001$
- "Crisis Response Planning has been shown to reduce suicidal behaviors by approximately…" [multiple choice question]; $p=0.02$
- "The suicidal mode includes…" [multiple choice question]; $p<0.01$
- "Narrative assessments in Crisis Response Planning specifically focus on all but which of the following?" [multiple choice question]; $p=0.03$
- "The Crisis Response Plan includes which set of components?" [multiple choice question]; $p<0.001$
- Knowledge that Crisis Response Planning prioritizes internal strategies for solving a crisis [multiple choice question]; $p=0.02$

IDA also conducted paired t-tests/Wilcoxon tests to assess changes in participants' confidence from pre- to immediately post-training, and calculated Cohen's d for effect size. From pre- to post- training, participants significantly increased their confidence that they could:

- Work with service members with suicide risk, $p=0.003$; $M\ (pre)=3.81$, $M\ (post)=4.38$, $d=0.69$
- Conduct suicide risk assessments, $p=0.03$; $M\ (pre)=3.85$; $M\ (post)=4.31$, $d=0.53$
- Provide counseling to service members with emotional crises or suicide risk, $p=0.02$; $M\ (pre)=3.77$, $M\ (post)=4.21$, $d=0.45$

Follow-up surveys administered four months following initial trainings showed no significant decreases in confidence compared to surveys administered immediately following the training.

Four months after training, participants completed follow-up surveys assessing their use of CRP with SMs showing suicide risk. At that time, few participants had used CRP:

- 38% said that few SMs with suicide risk sought counseling from them
- 14% said the SMs they counseled were uninterested in partaking in CRP and/or lethal means counseling

The evaluation did not include pre-post measures related to the lethal means safety components of the training. However, in open-ended responses, a few participants said they learned skills related to firearm safety and/or conducted lethal means counseling with service members at four-month follow-up. Future efforts to train providers in CRP could concurrently conduct targeted marketing and outreach to increase SMs' help-seeking behaviors.

Feasibility: The program was implemented virtually through a contract with the University of Texas Health Science Center San Antonio's (UTHSCSA) Strong Star Training Program. Initial trainings were held virtually in November 2021 and February 2022 (participants attended one of these trainings), with effective reach of intended participants. While the training demonstrated outcome effectiveness, some participants reported that they would prefer an in-person format with more guided role-play activities. To support skills retention and development, case consultations were offered to participants through July 2022, but few took part in these sessions. Participants reported encountering few opportunities to apply their skills in their work, which may have limited their need for these near-term follow-up consultations. However, a portion of participants identified SMs' disinterest in receiving lethal means counseling as a barrier to applying the practice.

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Appendix D. Abbreviations

ANOVA	Analysis of Variance
ANCOVA	Analysis of Covariance
ANG	Air National Guard
ARNG	Army National Guard
ASAP	Alcohol and Substance Abuse Training
BH	Behavioral Health
BHO	Behavioral Health Officer
BHPPR	Behavioral Health Primary Prevention and Retention
CRP	Crisis Response Plan
DOD	Department of Defense
FLL	First Line Leader
FY	Fiscal Year
IDA	Institute for Defense Analyses
NG	National Guard
NGB	National Guard Bureau
PEC	Professional Education Center
PFT	Physical Fitness Test
RRC	Risk Reduction Coordinator
RSP	Recruit Sustainment Program
SASSI-4	Substance Abuse Subtle Screening Inventory-4
SM	Service Member
SOP	Standard Operating Procedure
SRP	Soldier Readiness Processing
UTHSCSA	University of Texas Health Science Center San Antonio
WRF	Warrior Resilience and Fitness
WFWGA	Work for Warriors Georgia

Appendix E. Illustrations

Tables

Figures

IDA

REPORT DOCUMENTATION PAGE	Form Approved OMB No. 0704-0188

1. REPORT DATE (DD-MM-YY)	2. REPORT TYPE	3. DATES COVERED (From – To)
xx-03-2023	Final	

4. TITLE AND SUBTITLE

State Programs Annual Report
National Guard Bureau Warrior Resilience and Fitness

5a. CONTRACT NO.
HQ0034-19-D-0001

5b. GRANT NO.

5c. PROGRAM ELEMENT NO(S).

6. AUTHOR(S)
Ashlie Williams
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5d. PROJECT NO.

5e. TASK NO.
DZ-6-4421

5f. WORK UNIT NO.

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)
Institute for Defense Analyses
730 E.Glebe Rd
Alexandria, VA 22305

8. PERFORMING ORGANIZATION REPORT NO.
IDA Document NS D-33216
Log: H 23-000358

9. SPONSORING / MONITORING AGENCY NAME(S) AND ADDRESS(ES)
NGB
111 S George Mason Dr.
Arlington, VA 22204

10. SPONSOR'S / MONITOR'S ACRONYM(S)
NGB

11. SPONSOR'S / MONITOR'S REPORT NO(S).

12. DISTRIBUTION / AVAILABILITY STATEMENT
Approved for public release; distribution unlimited.

13. SUPPLEMENTARY NOTES

14. ABSTRACT

In 2019, the Warrior Resilience and Fitness (WRF) Division within the National Guard Bureau (NGB) implemented a process to identify, select, evaluate, and disseminate state-level programs to prevent suicide and promote resilience. This process was based on that outlined in the Institute for Defense Analyses' (IDA) 2019 report. A central goal of the process is to identify local programs with evidence of effectiveness that can be expanded and applied across the National Guard. Over the past three years, IDA has worked closely with WRF and state-level programs to design and implement program evaluation plans, synthesize results, and document lessons learned. This report documents the implementation progress and evaluation results of the initial cohorts of state programs.

15. SUBJECT TERMS
Program evaluation; suicide prevention; resilience; capacity building; technical assistance; innovation

16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NO. OF PAGES	19a. NAME OF RESPONSIBLE PERSON
a. REPORT	b. ABSTRACT	c. THIS PAGE			LTC Andy Shepherd
U	U	U	U	36	19b. TELEPHONE NUMBER (Include Area Code) 703-601-7758

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