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State Programs Annual Report

National Guard Bureau Warrior Resilience and Fitness

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State Programs Annual Report

National Guard Bureau
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IDA

Executive Summary

Since 2019, the Institute for Defense Analyses (IDA) has assisted the National Guard Bureau (NGB) Warrior Resilience and Fitness Division (WRF) in identifying, evaluating, and disseminating state- and territory-led programs that show potential to fill National Guard (NG) needs related to the prevention of harmful behaviors. This Annual Report summarizes the activities and results of these programs through Calendar Year 2023. It reiterates and expands upon the State Programs Annual Report for Calendar Year 2022.* Both reports describe best practices and recommendations that NG states and territories can apply to their own program implementation and evaluation.

State program teams develop and execute evaluation plans, informed by IDA's technical assistance efforts, alongside their program implementation. They provide written monthly updates and quarterly reports to the WRF management team. IDA reviewed these documents and notes from monthly conference calls and other conversations with state program teams to derive the content of this report.

This report summarizes challenges and lessons learned in the areas of early program planning and start-up, program implementation and sustainment, and process and outcome evaluation. Additionally, the report recommends best practices and considerations for improving the success of prevention activities more generally. The table below summarizes these recommendations to address challenges identified.

Summary of State Programs Challenges and Recommendations

Area	Challenges	Key Recommendations for Program Managers
Early planning and start-up	▪ Delayed funding ▪ Challenges securing contracts or identifying appropriate contracted programs ▪ Program elements not clearly delineated ▪ Difficulty recruiting program participants	▪ Coordinate closely with state contracting and legal personnel during contracting process ▪ Explore databases of evidence-based programs and/or identify programs in use elsewhere in the military to identify promising contracted programs and curricula ▪ Develop a logic model to strategically outline the relationship between a program's activities, population, and goals ▪ Secure and display leadership support for program ▪ Offer programs while service members (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 ▪ Expansion of the program before sufficient evaluation and preparation ▪ 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 ▪ Set realistic expectations with leadership about what results can be achieved in a given time ▪ Test alternative program approaches that fit current staffing resources
Program evaluation	▪ Failure to establish or execute a rigorous evaluation plan ▪ Few responses to evaluation questionnaires ▪ Limited access to 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 evaluation surveys and communicate importance of program evaluation to program participants ▪ Use historical comparisons, follow-up surveys, and administrative data to strengthen evaluation designs

* Ashlie M. Williams, Dina Eliezer, Juliana Esposito, and Emily A. Fedele, *State Programs Annual Report: National Guard Bureau Warrior Resilience and Fitness*. IDA Document NS D-33216 (Alexandria, VA: Institute for Defense Analyses, 2023).

The report highlights 13 programs that have demonstrated success in achieving key program milestones and two that are still in the early phases of implementation and evaluation. It additionally details seven programs that showed limited success against program milestones after more than a year of WRF support, and/or for which IDA had limited documentation. Broadly, we defined "success" as a program's ability to be conducted in a reasonable and timely manner (i.e., feasible), positively impact its short- and long-term outcomes of interest (i.e., effective), and secured support from NG stakeholders (i.e., appropriate to the NG). To assess outcome effectiveness, IDA conducted quantitative analyses (e.g., calculating descriptive statistics and effect sizes, statistical tests of significance) using raw data that state program teams were required to report. In some cases, IDA independently reviewed analyses these teams conducted. NG states and territories may consider adopting or adapting these programs to fill gaps in their prevention plans.

The following table summarizes all 22 programs described in this report and is organized according to prevention strategy areas.

Overview of State Programs

Enhance Life Skills and Connectedness	
YogaShield Success: Limited	Trauma-informed curriculum trains NG members to provide yoga courses to peers to improve mental and physical resiliency. Program trained 40 Guardsmen during initial implementation.
Operational Stress Management Success: Moderate	Virtual 10-day course to improve service members' (SMs') self-care, coping, and behavioral health (BH). Participants improved self-reported knowledge, self-efficacy, and service awareness from pre- to post-training.
Couples Online Relationship Education (ePREP) Success: Moderate	Online program for couples to develop conflict resolution and communication skills to improve relationship satisfaction. Participants indicated reduced stress from pre- to post-training.
Connectedness and Relationship Education Success: High	Training to improve First Line Leaders' interpersonal communication and leadership skills. Participants reported improved knowledge and attitudes related to counseling and relationship-building from pre- to post-training.
Purple Resolve Success: Moderate	Annual organizational training for enhancing connectedness and collective resiliency. Service members reported improved life purpose from pre- to post-training.
Ready and Resilient Warrior Workshop Success: Limited	Virtual, 7-day group counselling program to develop self-esteem, belonging, and resilience in recently deployed service members. Trained 45 Soldiers.
MyPrime Success: High	Online, self-paced course to reduce alcohol and drug misuse. Participants showed improvements in perceived harm of substance misuse and risk perception from pre- to post-training.
Risk Reduction Psychoeducation Success: Limited	In-person course to reduce risky alcohol use among high-risk SMs. Participants demonstrated improvements in alcohol- and behavior-change related knowledge and awareness of NG resources/programs.

Identify Populations at Risk	
Buddy Aid Success: High	Sexual assault prevention and response training designed to prepare all SMs to respond to disclosures of sexual assault. Participants improved knowledge of, and confidence in, how to identify and provide first-line support to victims of sexual assault from pre- to post-training.
Mental Health First Aid Success: Moderate	In-person gatekeeper training to enhance individuals' behavioral and mental health intervention skills. Participants showed improved gatekeeper knowledge, self-efficacy, and intentions from pre- to post- training.
Start Success: High	Online gatekeeper training for leaders, SMs and spouses, and community partners to improve ability to identify and respond to SMs at risk for suicide. Participants improved self-efficacy to recognize and respond to signs someone is considering suicide from pre- to post-training.
Together Strong Success: High	Virtual role-play training to teach SMs how to identify and respond to those at risk for suicide. Participants showed improved preparedness, likelihood, and confidence to recognize and respond to signs of distress from pre- to post-training.
VReal Success: High	Interactive virtual reality training to improve ability to effectively identify and talk with distressed Airmen and connect them with resources and support. Participants indicated increased self-efficacy to recognize and support at-risk peers.
Behavioral Health Primary Prevention and Retention Success: High	Screening new recruits during Recruit Sustainment Program and Student Flight to identify and proactively address risk factors. Participants experienced reduced rates and acuity of BH issues, compared to projections based on historical trends.
SASSI-4 Success: Moderate	Online screening with follow-up counseling administered to self-referrals and Soldiers following an alcohol incident or positive urinalysis to facilitate referral to care. Participants showed decreased intentions to use alcohol/drugs to cope with stress from pre- to post-screening.
Provide Resources and Support	
Military Support Embedded Clinician Program Success: Limited	Mental health providers embed in units during drill weekends to deliver support services, care, and referrals, in partnership with a state government agency. Embedded clinicians provided 161 consultations and 67 referrals during FY2020 Q3.
Crisis Response Plan Success: High	Training to enable BH personnel and Chaplains to provide a brief 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.
SafeUTNG Success: Moderate	Mobile app offers live chat with local University of Utah clinicians during times of crisis. Between 2019 and 2022, app was downloaded over 3,600 times and used for over 350 crisis chats.
Create Protective Environments	
CALM & Collect Success: Limited	Online training teaches Suicide Intervention Officers (SIO) to help SMs at risk of suicide reduce access to lethal means by using on-base firearm storage locations. As of February 2024, 65 SIOs received the CALM training; evaluation results are not yet available.
EADS Suicide Awareness and Firearm Education Success: Limited	In-person hunter safety class with suicide prevention focus to spread awareness of mental health, increase use of safe storage practices, and create a supportive community. Trained 23 Airmen.
Firearm Risk Mitigation Success: Limited	Group training to change attitudes about safe storage of lethal means. Participating firearm owners reported higher likelihood of talking with a loved one about safe storage, compared to SMs that did not attend the training.
Work for Warriors Georgia Success: High	Screening and referral to NG resources for SMs, veterans, and spouses through an online platform. Facilitated over 40,000 referrals since 2019.

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1. Introduction

Since 2019, the Institute for Defense Analyses (IDA) has assisted the National Guard Bureau (NGB) Warrior Resilience and Fitness (WRF) Division with identifying, evaluating, and disseminating best practices for preventing harmful behaviors among service members (SMs) in the National Guard (NG). As part of this effort, NGB has supported state-led programs, and IDA has provided technical assistance for the evaluation of these programs.[1] As of the 2023 fiscal year (FY), WRF had funded 55 state programs in over 35 states and territories.

This Annual Report summarizes the activities and results of these programs that were active during the 2023 Calendar Year. It updates and expands on content from IDA's 2022 *State Programs Annual Report*.[2] It provides lessons-learned and recommendations that NG states and territories can apply to their own program implementation and evaluation. NG states and territories may learn from implementation challenges (Chapters 2 and 3) to strengthen their own prevention efforts and/or consider adopting the successful programs listed in this report (Chapter 3).

A. Methodology

This report describes the challenges, best practices, and evidence of effectiveness for each program based on the results of state-led evaluation activities and descriptions of implementation activities provided in program reports. The findings presented in this document are drawn from state programs' evaluation and reporting activities between 2019 and 2023. As presented in IDA's *2022 State Programs Annual Report,*[3] these activities can be summarized into four steps:

The *WRF Evaluation Primer and Catalogue of Metrics* lists and defines over 140 metrics, along with associated survey measures or administrative data sources, to support evaluation design.

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 *WRF Evaluation Primer and Catalogue of Metrics,* which is currently in the final stages of development (this will be referred to as the *Evaluation Primer* during the remainder of this report). 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

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1 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).

2 Ashlie M. Williams, Dina Eliezer, Juliana Esposito, and Emily A. Fedele, *State Programs Annual Report: National Guard Bureau Warrior Resilience and Fitness*. IDA Document NS D-33216 (Alexandria, VA: Institute for Defense Analyses, 2023).

3 Ashlie M. Williams, Dina Eliezer, Juliana Esposito, and Emily A. Fedele, *State Programs Annual Report: National Guard Bureau Warrior Resilience and Fitness*. IDA Document NS D-33216 (Alexandria, VA: Institute for Defense Analyses, 2023).

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 *Evaluation Primer* 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:

Table 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 our assessment of program success. Section B of this chapter describes our approach to categorizing programs' degree of success.

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.

4. Accomplish milestones required for program expansion. IDA and WRF established eight milestones for state programs to systematically assess their progress and determine if and when programs are ready for expansion to other states and/or national implementation. IDA assembles quarterly score cards to indicate programs' progress on each milestone as well as track participation in community calls and submission of monthly and quarterly reports. Criteria for progress on each milestone is provided in Appendix C. WRF adds information about each programs' remaining budget.

Table 2 provides an explanation of the milestones. Although milestones are not necessarily sequential, programs often progress through the milestones in the order presented below. The first two milestones (planned evaluation and initial implementation) establish proof of concept, that the program is viable for implementation and evaluation. The next three milestones demonstrate process and outcome effectiveness and obtain leadership buy-in, are often achieved at the local level (i.e., one or two states) and preliminarily show that the program is effective and feasible.[5] The final three milestones, disseminate results, secure interest from other states, and develop an expansion plan, are all critical for expansion beyond the initial state(s). Depending on the nature of the program and its progress on the previous milestones, this expansion could extend to a few additional states or to the entire 54. To determine viability for expansion, the program should first assess process and outcome effectiveness in a few additional states with varied conditions and resources.

Table 2. Milestones for State Programs to Proceed from Local Implementation to Expansion across Multiple States/Territories

Milestone	Description
Robust evaluation plan	Developed a comprehensive, detailed evaluation plan, including relevant process and outcome evaluation metrics, a pre-post design (or similarly robust design), and a strategy for obtaining data (e.g., collection through questionnaires or access to administrative data)
Established initial implementation	Since receipt of funding, completed the steps necessary to initially implement the program (e.g., secured contracts, hired personnel, finalized materials, scheduled activities)
Demonstrated process effectiveness	Demonstrated evidence of effectiveness on key process metrics, suggesting feasibility in the short- and long-term. Process metrics will vary by initiatives, but examples include: reached 100% of the target number of participants, held 100% of the target number of sessions, participant satisfaction is high, demonstrated fidelity to protocol (e.g., similar results across trainers).
Demonstrated outcome effectiveness	Demonstrated evidence of outcome effectiveness on key metrics. This is typically defined as showing statistically significant effects (e.g., positive change from pre- to post-test, $p < .05$) with meaningful effect sizes ($d > .2$).
Obtained leadership buy-in	Initiative supported by local NG leadership, demonstrated by receiving at least partial funding from the state/territory and/or receiving a direct expression of leadership support (e.g., letter of support, communication with WRF/NGB leaders)

[5] Note: Programs in this report typically used pre-post evaluation designs, in line with the criteria for meeting the milestones "Robust evaluation plan" and "Demonstrated outcome effectiveness." This design most closely corresponds to "Minimal" or "Moderate" evidence levels described in IDA's 2021 report. State programs may experience practical challenges executing more advanced (e.g., quasi-experimental) designs. Repeated pre-post evaluations and analyses of longer-term outcomes can strengthen evaluation designs (consistent with the "Moderate" evidence level); we recommend this for most programs in this Annual Report.

Milestone	Description
Disseminated results	Produced, released, and/or presented results demonstrating its implementation and effectiveness to broad audiences (e.g., during Community Calls, at The Adjutant General (TAG) forums)
Developed expansion plan	Developed resources to facilitate expansion into partner locations (i.e., other states), including: implementation guidance and/or Standard Operating Procedure (SOP), evaluation guidance and data collection strategy for partner locations, and a cooperative management plan for coordinating implementation and evaluation
Secured interest from additional states	Demonstrated relevance and interest for implementation in new partner locations (i.e., additional states, territories, DC) and has confirmed plans to expand to at least one partner location

B. Classification of Programs in This Report

Based on programs' progress across the milestones to the current date, IDA classified the programs' success as high, moderate, or limited. Broadly, we defined "success" as a program's ability to be conducted in a reasonable and timely manner (i.e., feasible), positively impact its short- and long-term outcomes of interest (i.e., effective), and secure support from NG stakeholders (i.e., appropriate to the NG). For each milestone, states could receive full, partial, or no completion.

- *Highly successful programs* developed a robust evaluation plan, implemented the program in a timely manner, demonstrated process and outcome effectiveness, and acquired leadership buy-in.
- *Moderately successful programs* developed a robust evaluation plan and implemented in a timely manner. However, they only made partial progress on achieving any of the following: process effectiveness, outcome effectiveness, and leadership buy-in.
- Lastly, programs with *limited success* were unable to fully implement and/or collect data that demonstrated process or outcome effectiveness. These can either be new programs that are in the early stages of implementation (i.e., Guam's CALM & Collect program and New York's EADS SAFE program), programs that were unable to transform the founding idea into a functioning program, or operating programs with an insufficient evaluation plan and/or partial implementation.

Some successful programs have expanded to multiple states and territories, while others operate only in specific states or units/Wings. Although many view expansion as an indicator of success, that is not always accurate. Some programs may effectively serve the needs of the local state population but would not be appropriate or feasible for broader expansion. Other programs may expand prematurely, without sufficient preparation, or before they are able to demonstrate feasibility or effectiveness. This may happen when a program addresses an urgent need or receives an influx of funding or leadership interest. To avoid misrepresenting a program's evinced progress, we did not include milestones related to program expansion to new states/territories (i.e., Developed expansion plan and Secured interest from additional states) in this report's criteria for rating "success."

It is important to note that to review programs' success, IDA relied on information that states provided. This included data and updates from monthly and quarterly reports, technical assistance requests, and conversations. While IDA and WRF frequently communicate with the state programs, there are some that do not complete required reporting. Therefore, IDA was unable to determine success in some areas. Further, it is important to note that success is not stationary. State programs' success can change, both positively and negatively, as they continue to document their plans, implement their program, and collect data.

2. Summary of Best Practices and Recommendations

Programs' successes and failures alike contribute to a knowledge base that can support future efforts to implement prevention programs in the NG. In this chapter, we describe common challenges, best practices, and recommendations synthesized across programs with varying levels of success, as well as IDA's recommendations to program managers for overcoming or averting future challenges. We organize this discussion into three sections: early planning and start-up; program implementation and sustainment; and process and outcome evaluation.

A. Early Planning and Start-up

Most state programs that WRF supports are in very early stages of planning at the time they apply for funding. These programs commonly encounter issues with executing funding and/or contracts, detailing specific program elements or implementation plans, and securing program participants. Table 3 provides an overview of these challenges and associated best practices and recommendations.

Table 3. Summary of Early Planning and Start-up Best Practices and Recommendations

Challenges	Best practices	Recommendations for program managers
Delayed funding	▪ Program managers proactively notified responsible offices on the name, amount, and expected date of program funding delivery ▪ Program team began developing the curriculum, recruitment strategy, and evaluation plan while waiting for funding	▪ Coordinate closely with the Contracting Office, Budget Analyst, and WRF leadership ▪ Begin development on subsequent elements of the program to allow for quicker implementation once funding arrives
Challenges securing contracts and identifying or working with contractors	▪ WRF added contracting guidance to the call for submissions (e.g., complying with sole source contracting regulations, identifying contractors) beginning in FY21 and required state legal approval of submissions beginning in FY23 ▪ Program managers selected programs that were developed specifically for military populations and used companies with a history of implementing programs in the military	▪ 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
Broad and poorly defined goals, curriculum, and target population	▪ Program managers developed simple, well-organized programs with a small set of goals ▪ Program managers selected and clearly defined a target population based on the state's needs ▪ Programs utilized existing evidence-based curriculum and/or integrated new content into existing curriculum ▪ Programs delayed implementation until the curriculum was finalized	▪ Identify or use a conceptual/theoretical model to guide goals, curriculum development ▪ Develop Specific, Measurable, Achievable, Relevant, Time-bound, Inclusive, and Equitable (SMART-IE) goals to guide program planning ▪ Clearly delineate the program's activities, target population, and goals prior to implementation (e.g., in a logic model) ▪ Explore databases of evidence-based programs and/or identify programs in use elsewhere in the military (e.g., active duty) and peer-reviewed literature to identify promising curricula ▪ Invite subject matter experts to review newly developed materials or adaptations of existing materials

Challenges	Best practices	Recommendations for program managers
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 ▪ Programs advertised incentives and/or other forms of encouragement during outreach ▪ Programs expanded outreach to SMs with needs similar to the original target population, when appropriate to the program	▪ 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 ▪ Coordinate with legal and/or other involved offices to offer appropriate monetary (e.g., gift cards) or nonmonetary incentives and other forms of encouragement (e.g., child care, training credits) to participants ▪ Use the program objectives and a logic model to inform program outreach expansion

Funding delays. Many new programs experienced significant delays in receiving funding, due to federal-level processes. States should anticipate delays and advise appropriate state resources, such as the Contracting Office and Budget Analyst, on the anticipated funding and its expected arrival. Regular communication with WRF leadership is also beneficial to receive updates on funding status. Programs that depend on contracted services should especially discuss anticipated funding timelines with WRF; if WRF anticipates extended funding delays, states may need to consider deferring their plans to the next fiscal year. To facilitate rapid implementation upon the delivery of funding, programs that do not depend on contracting should use this time to finalize their program. Delegating responsibilities across the team, finalizing curriculum, working with the Contracting Office, creating recruitment materials, and developing a robust evaluation plan are some examples.

Contracting issues. Programs that depended on the use of a particular third-party contractor encountered issues complying with sole-source regulations, and/or issues identifying a specific contractor that met 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,[6] Repository of Best Practices[7]) to identify those who have already demonstrated evidence of effectiveness and/or relevance to military populations.

Broad, unclear program elements. During early development, programs commonly struggle to distill the program's focus into specific programmatic activities and goals. Programs with clear, specific, and narrow goals typically experienced fewer challenges finalizing program plans, creating concise evaluation surveys, and achieving outcome effectiveness. To create a well-defined single program, states should use Specific, Measurable, Achievable, Relevant, Time-bound, Inclusive, and Equitable (SMART-IE)[8] criteria to describe specific, well-defined goals and develop a logic model to outline a program's path to reach these goals. Effective program managers start with goals and work backwards through outcomes and outputs to develop a program or set of activities that will reach these goals. Purposeful selection of a specific target audience, based on their needs and characteristics, should directly tie into program goals and activities.

Developing training curricula can be particularly challenging and resource-intensive. Programs should consult with subject matter experts during this process (e.g., university partners, external agencies, or internal NG advisors); WRF may consider connecting programs with experts involved in WRF's initial program review and

6 Clearinghouse for Military Family Readiness, Penn State University, "Search Programs," accessed November 1, 2018, https://www.continuum.militaryfamilies.psu.edu/search.

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

8 DoD SPARX Knowledge, "Course PREV-0005: Developing a Comprehensive Integrated Primary Prevention Plan", 2023, https://jkodirect.jten.mil/Atlas2/page/desktop/DesktopHome.jsf.

funding determination processes and/or with experts from the Integrated Prevention Program or other program offices. Programs that adopted or incorporated elements from existing curricula were less likely to encounter issues with initial start-up and more likely to achieve outcome effectiveness. To identify existing promising curricula, states can review databases of existing evidence-based programs (e.g., Clearinghouse for Military Family Readiness[9], Repository of Best Practices[10]) and peer-reviewed literature.

States commonly attempt to design programs to address several complex behavioral outcomes, such as suicidal behavior and substance misuse. Recognizing that many factors influence these complex behaviors, some programs attempt to address a multitude of risk and protective factors within a single intervention (i.e., integrated prevention). Without careful research and theory-informed program design, doing so can result in a program that is overly broad or poorly aligned with specific objectives. In many cases, states should consider how a proposed intervention complements other programs or resources available in the state and the extent to which evaluation activities may overlap.[11] This comparison may complement current efforts of the Integrated Prevention Workforce (IPW), who are tasked with creating Comprehensive Integrated Prevention Plans.[12] Refer to the WRF Prevention Framework for more information about the elements of a comprehensive approach to prevention.[13]

Participant recruitment challenges. Many newly established programs experienced difficulty securing SM participation, occurring 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. Sustained marketing and outreach efforts can also 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. Incentives or efforts to remove barriers to participation, partnered with effective marketing and program communication,[14] can also stimulate recruitment. Offering gift cards, child care, training credits, snacks, or obtaining approval to use a new program as a replacement for an existing required training, can improve participation.

Although expanding program recruitment to a larger group of SMs may increase participation, some programs expanded recruitment based on convenience (e.g., to full-time personnel when a program originally targeted M-Day SMs), rather than characteristics that aligned with the program's original purpose. Some programs that included SMs with very different needs or baseline characteristics (e.g., SMs with a history of substance use issues participating in a behavior change training together with service providers) struggled to achieve outcome effectiveness. Only populations that share characteristics or risk factors important to the program should be considered. When expanding recruitment, programs managers should ensure that the selected population aligns with the program's goals and is appropriate to receive the intervention.

B. Program Implementation and Sustainment

Once established, many programs had difficulty sustaining high-quality program implementation over time. Activations and deployments unavoidably disrupted some programs. Other challenges, such as lack of staff time and/or leadership support, also hindered programs' continued implementation following the initial launch. Table 4 summarizes findings in these areas.

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9 Clearinghouse for Military Family Readiness, Penn State University, "Programs."

10 Eliezer, Williams, Cotting, Reutter, and Dubin, *National Guard Suicide Prevention and Resilience Innovation Framework*.

11 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): 2457–63, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2978162/.

12 Office of the Under Secretary of Defense for Personnel and Readiness, DoDI 6400.09: DoD Policy on Integrated Primary Prevention of Self-Directed Harm and Prohibited Abuse or Harm § (2020), https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/640009p.pdf.

13 Eliezer, Williams, Cotting, Reutter, and Dubin, *National Guard Suicide Prevention and Resilience Innovation Framework*.

14 E.g., Behavioral economics principles have shown promise for improving recruitment. See https://www.science.org/doi/10.1126/scitranslmed.aaf0946.

Table 4. Summary of Program Implementation and Sustainment Best Practices and Recommendations

Challenges	Best practices	Recommendations for program managers
Disruptions due to mobilizations or deployments	▪ Programs adjusted timelines to reach SMs before or after the mobilization/deployment ▪ Programs assigned different personnel to lead activities, as needed ▪ Staff traveled to units' locations to deliver the program	▪ 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 and/or states and territories affected by natural disasters) ▪ 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 goals with leadership priorities and emergent NG needs ▪ Requested concrete forms of leadership support (e.g., funding, policies to support program implementation, encouragement of participation)	▪ Analyze return on investment to demonstrate the value of new programs ▪ Invite NGB/WRF engagement with state-level leaders ▪ Tie program and evaluation to Department of Defense (DoD)/military directives and operational readiness
Expansion to new states or populations without sufficient evaluation or planning	▪ Program recruitment expands minimally, only to appropriate populations ▪ Staff compiled and distributed documentation of program processes in preparation for future expansion	▪ Set realistic expectations with leadership about what results can be achieved in a given time ▪ Programs should expand to new states only after they demonstrate proof of concept and process and outcome effectiveness in the originating state(s) ▪ Ensure new populations align with program goals and are appropriate to receive the intervention
Limited personnel, staff time, and expertise to implement and evaluate programs	▪ Programs utilized contractors to provide additional staff time in the absence of pay and allowance funds[a] ▪ Program managers created interdisciplinary teams of personnel to support implementation and evaluation activities ▪ Program managers developed programs that are adjacent to their duties and/or background	▪ Early implementation planning should assess availability of state resources to cover staffing augmentation ▪ Test alternative program approaches that fit current staffing resources ▪ Select a sustainable staffing approach that balances staff time restraints and the need for implementation fidelity. Cross train staff when possible ▪ Develop a plan that delineates each member's responsibilities related to the program

Disruptions due to mobilizations or deployments. Between 2019 and 2023, implementation of many state programs has been disrupted due to mobilizations and deployments. Similar to how programs that launched during the COVID-19 pandemic made plans to shift to virtual platforms or reduce participant numbers at in-person events, states/territories should address 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 SM experiences and mobilization/deployment schedules.

Lack of leadership support. State program managers commonly emphasize the importance of leadership support, 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, to the success of their efforts. A best practice is to work closely with leaders from the start of a program and to identify specific leadership actions necessary to

successful implementation and evaluation within a state. Positive leadership actions have included providing funding, supporting policies that allow programs to operate as intended (e.g., policy needed to create firearm safe storage locations), allowing programs to serve as a replacement for a similar required training, formally and informally encouraging SMs to participate in the program and/or mandating participation, and eventually providing opportunities for the program to disseminate findings. However, leadership turnover or shifting priorities made it difficult for some states to sustain support over time, which affected other prerequisites for successful program implementation and sustainment, such as securing adequate staffing and SM participation. Evaluation findings demonstrating the program's effects on SM outcomes were helpful to securing leadership support in some states. In the future, analyzing return on investment, such as long-term cost savings resulting from implementing a program, could bolster these efforts. Alignment of program goals with Department of Defense (DoD) and NGB policy requirements, as well as engagement with WRF or other NGB-level stakeholders, is also important to communicating program priorities.

Premature expansion. New programs that align closely with leadership priorities and show initial proof of concept garner attention from NG leadership in other locations and have been asked or given opportunities to expand. Several new programs have attempted to expand to joint services within the state or across multiple states, and/or to include new program activities, behaviors, and goals either before or soon after initial implementation. Small-scale initial implementation (i.e., within one or only a few states; among one or a few narrowly-defined target populations) is an important step. It allows program managers to iron out curriculum, implementation, and data collection challenges and make tweaks to set the program up for success. Skipping or accelerating this process can cause challenges within the team, as they may lack the experience or capacity to operate on a larger scale. Similarly, programs shown to be effective elsewhere may need to be adapted to suit a particular context. Rapid expansion may overlook this important step, resulting in wasted resources spent in implementation and unfavorable evaluation results. Rigorous and continuous evaluation should accompany program expansion and adaption to new contexts to monitor process and outcome effectiveness across settings. Further, program managers and their leadership should have realistic expectations (e.g., pre-defined and agreed upon with leadership) about the planning and resources required to maintain high-quality program implementation and about the timeframes necessary to assess whether a program's results warrant expansion. Presenting leadership and other interested parties with findings and accurate explanations of the evaluation's strengths and weaknesses, describing how the program was developed to achieve intentionally defined goals and objectives, and specifying the contexts and populations for which the program has shown suitability may help keep leadership and other interested stakeholders engaged while simultaneously guiding an informed program expansion approach. A logic model and SMART-IE objectives are important to reference during this process.

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. Even without funding for additional staff, programs that were conducted by a team, rather than an individual, were more successful and more likely to avoid delays from staffing disruptions. Teams with limited personnel time commonly preserved their resources by implementing train-the-trainer (T3) programs. In programs following a T3 model, participants complete a training and then are encouraged to teach the new skills to their unit. Although this approach uses minimal resources, is sustainable over time, and develops organic capability to train desired skills, states implementing T3 models should rigorously assess fidelity (i.e., adherence to implementation protocols) and outcomes across trainers. Decentralized strategies, such as T3 models, allow more opportunities for divergencies in implementation. To ensure high program fidelity, a traveling training team may be an appropriate alternative. Another approach to overcoming limited staffing resources is to cross-train staff, when possible (e.g., train staff to perform multiple roles), which eliminates bottlenecking implementation to one person. Selecting an approach that balances resource restraints with the desire for program fidelity is an important consideration. 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, as well as to examine how their staffing resources, policies, and force structure may affect the feasibility and effectiveness of the program.

C. Process and Outcome Evaluation

State programs typically plan simple evaluation designs, consisting of pre- and post-surveys or other data collections among program participants only (i.e., single-group designs). Staff time, access to relevant data, and adequate survey response rates are necessary to the success of these evaluations. Internal evaluation expertise and/or use of external technical assistance resources (e.g., academic, community, and/or nonprofit organizations) can also improve the quality of evaluation activities. Table 5 summarizes challenges, best practices, and recommendations related to evaluation activities.

Table 5. Summary of Process and Outcome Evaluation Best Practices and Recommendations

Challenges	Best practices	Recommendations for program managers
Failure to establish or execute a rigorous evaluation plan	▪ Revised weak evaluation plans after beginning program implementation ▪ Used objective questions and measures from validated scales ▪ Leveraged internal or external sources of support for program evaluation, e.g., university partners or service members (SMs) with research experience	▪ Develop an evaluation plan prior to beginning program implementation ▪ For externally sourced programs, review evaluation plans with contractors and tailor the content to the target population ▪ Align program evaluation plan and data collection to the program's logic model and program goals ▪ Search existing military surveys, peer-reviewed literature, and program evaluations for established survey measures ▪ Build evaluation planning and execution into implementation and staffing plans ▪ Allocate 5 to 10% of program budget to evaluation activities ▪ Coordinate with IDA, DoD Technical Assistance Centers, and state Integrated Primary Prevention Workforces before and during implementation to establish a robust evaluation plan
Few responses to evaluation questionnaires	▪ Asked SMs to complete surveys during program activities (e.g., immediately before and after a training) or other in-person events ▪ Used technology (QR codes, electronic data collection) to make forms easy to complete ▪ Worked to shorten lengthy questionnaires ▪ Included unique identifiers on surveys to link questionnaires completed at different timepoints	▪ 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 ▪ Offer incentives for completing follow-up surveys
Inability to access control/comparison groups or measure longer-term outcomes	▪ Pursued other strategies to strengthen evaluation (e.g., historical comparisons, follow-up surveys) ▪ 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 research-informed theories of change and/or logic models to understand potential program impacts

Challenges	Best practices	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)	▪ 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 ▪ Consult the Integrated Prevention Program to understand data available within a state

Failure to establish or execute an evaluation plan. Some programs lacked the staff time (e.g., staff are dual-hatted or oversee the program as an informal additional duty) or resources to conduct evaluation activities (e.g., developing an evaluation plan, creating or administering data collection tools, establishing fidelity assessments). Some managers also lacked the necessary knowledge and skills to plan and execute a proper evaluation. Other programs began/continued evaluation activities that were not sufficiently rigorous. Insufficient evaluation practices included distributing surveys at the end of training to measure satisfaction with the program but not changes in outcomes, failure to use unique identifiers necessary for paired statistical analyses of pre- and post-intervention data, and use of subjective survey questions and/or questions not derived from validated measures. More broadly, programs did not always have clearly defined goals, which hindered the creation of evaluation plans directly tied to those goals.

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 SMs and/or civilians with research/evaluation experience on their program teams had greater success developing and carrying out robust evaluations. For those without external research support, program teams should consult the *Evaluation Primer*, existing DoD surveys (i.e., Status of Forces Survey, Workplace and Gender Relations Survey of Military Members (WGRS, Defense Organizational Climate Survey (DEOCS)), published evaluations of similar programs, and peer-reviewed literature when developing surveys to identify robust, validated outcome measures. States with contracted programs should be active in the program evaluation process even if it is carried out by the contractor, to ensure that program evaluation plans meet the needs of the NG (e.g., DoD integrated prevention policy requirements regarding program evaluation[15]). States should request information on the organization's evaluation plan well before implementation begins and provide recommendations to ensure it is robust, appropriate for the target population, and relevant to their needs.

Staffing plans should budget time and resources needed for evaluation; the Centers for Disease Control and Prevention (CDC)[16] and World Health Organization[17] recommend that programs budget 10% of staff time to program evaluation. Further, many resources exist to build internal capability for program evaluation where it may be lacking. See, for example, the RAND Suicide Prevention Program Evaluation Toolkit[18] and the U.S. Army's Ready and Resilient Program Evaluation Process Guide.[19]

Few responses to evaluation questionnaires. Programs oftentimes struggled to collect complete survey data from program participants (i.e., having all participants submit their pre- and post-surveys), especially at follow-up surveys (e.g., 6 months after program participation). SMs experience survey fatigue and, depending on the format of the program (e.g., online, long workshops, service utilization), are not inclined to complete evaluation surveys. Collecting

15 Office of the Under Secretary of Defense for Personnel and Readiness, DoDI 6400.09: DoD Policy on Integrated Primary Prevention of Self-Directed Harm and Prohibited Abuse or Harm.

16 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.

17 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://iris.who.int/bitstream/handle/10665/108116/E60706.pdf?sequence=1.

18 Joie D. Acosta, Rajeev Ramchand, Amariah Becker, Alexandria Felton, and Aaron Kofner, *RAND Suicide Prevention Program Evaluation Toolkit* (Santa Monica, CA: RAND Corporation, 2013), http://www.rand.org/pubs/tools/TL111.html.

19 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://ph.health.mil/PHC%20Resource%20Library/TG382_IEPGuide2019.pdf.

complete survey data is especially important for smaller programs with fewer participants; if small programs fail to collect evaluation questionnaires, statistical analysis to evaluate outcome effectiveness is unreliable or infeasible. Administering questionnaires immediately before and after 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, however; this may be more impactful if messages communicate leadership support for and/or the utility of the program evaluation. Other best practices include shortening lengthy surveys and incorporating technology (e.g., QR codes) into the program to make surveys easier to access. Managers also incorporated unique identifiers to match individual-level data pre- and post-program participation, making all collected data useful. To get buy-in from participants, managers can communicate the importance of collecting evaluation data, follow-up with unresponsive participants (given staff bandwidth), and share the results with participants. For follow-up surveys, providing participants with an incentive (e.g., a discount code) for completed surveys can lead to higher response rates.

Inability to access control/comparison groups or measure longer-term outcomes. Most programs implement a simple pre/post evaluation design where they administer evaluation surveys to participants immediately before and after program participation. Often, they measured short-term changes in intermediate outcomes, such as intentions to use behavioral health (BH) services. States were often unable to measure whether program effects were sustained over time and/or whether they affected more distal behavioral outcomes. A more robust evaluation design that leads to stronger statistical support for outcome effectiveness includes comparison groups to assess causality and/or follow-up surveys to assess longer-term outcomes. Implementing an evaluation design with a comparison group can be logistically complex for some programs, but employing a wait-list design (i.e., collecting current pre-post data from groups scheduled to participate in the future) as a program nears expansion may be possible. In the absence of comparison groups, a best practice for successful programs was using historical data (e.g., DoD surveys and administrative data) for comparison between participant and non-participant outcomes. Successful programs also implemented follow-up surveys that directly assessed program interventions to capture longer-term outcome data. When it is not feasible for states to employ comparison groups or to measure long-term outcomes, theories of change or logic models[20] 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.[21] However, interpretation of evaluation results should always consider the limitations of designs lacking control/comparison groups and longer-term measurements.

Lack of access to administrative data. Programs commonly struggled to collect or obtain access to the data required for a robust program evaluation. While programs commonly lacked adequate responses to pre-post or follow-up evaluation questionnaires, administrative and service utilization data were also key components of some programs' evaluations. Some programs, however, lacked access to this data. Difficulty obtaining 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 BH issues).

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 the use of existing survey data, such as the DEOCS or Status of Forces Survey, to facilitate comparisons. Many measures included in the *WRF Catalogue of Metrics and Measures* are drawn from such surveys. Working closely with the state's Integrated Prevention Program, which is tasked with incorporating such data into needs assessments and command climate assessments, may also be a productive avenue to facilitate access to data.

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

21 While IDA's metric recommendations were informed by theories of change and logic modeling, programs were not asked to develop formal logic models. Current policies require the Integrated Prevention Workforce to develop program logic models. Other program managers should also consider developing these tools as part of their early evaluation planning.

3. Overview of State Programs

The following sections highlight state programs that have demonstrated successful state-level implementation and evaluation. These programs address a range of behavioral areas, including sexual assault, suicide, and substance misuse. Many programs cohesively address upstream risk and protective factors that influence multiple harmful behaviors, which is one approach to integrated prevention. The table below categorizes programs by prevention strategy (e.g., Enhance Life Skills and Connectedness) and note the factors addressed, the prevention level (i.e., primary, secondary, or tertiary) at which the program works, and its implementation status. See Appendix A for an overview of prevention strategy areas and levels, as outlined in the Prevention Framework.

To learn more about a program, click its name in Table 6. For programs with *high* or *moderate* success, the link will navigate to a program overview page. At the bottom of each overview page, you will find a link to an appendix with supplemental information about the program. Programs that demonstrated *limited* success do not have overview pages; clicking the program name in Table 6 will take you directly to the supplemental information in Appendix B.

Table 6. WRF State Programs

Enhance Life Skills and Connectedness				
Name	**Description**	**Risk/ Protective Factor**	**Prevention Level**	**Implementation Status**
Coping and Stress Management				
YogaShield Success: Limited	**Create healthy and high-performing Guardsmen through resiliency and mindfulness training**. Six-week mental and physical resiliency and stress management program brings yoga philosophy and somatic and cognitive exercises (e.g., breathing techniques, mindfulness) to a military population.	Stress and coping	Primary	Operating at state level, IA ANG/ARNG
Operational Stress Management Success: Moderate	**Improve behavioral health (BH) through a self-care and stress management train-the-trainer (T3) course.** Service members (SMs) develop skills for their own self-care and coping skills and are trained to bring these skills back to their units to improve overall stress management, resiliency, and BH.	Stress and coping	Primary	Concluded implementation in the IL ARNG
Relationship and Communication Skills				
Couples Online Relationship Education (ePREP) Success: Moderate	**Develop conflict resolution and communication skills to improve relationship satisfaction.** Couples strengthen their problem-solving skills through an online program to improve marital quality and prevent divorce.	Social support/ social engagement	Primary and Secondary	Operating at state level, MI ARNG/ANG
Connectedness and Relationship Education Success: High	**Foster trust within units by training first-line leaders in relationship-building and risk-identification.** Advanced training for learning effective communication skills to build professional relationships with subordinates and facilitate unit cohesion.	Communica-tion skills	Primary	Operating at state level, OH and ID ARNG/ANG; national-level implementation in progress
Resilience and Emotional Intelligence				
Purple Resolve Success: Moderate	**Enhance connectedness and collective resiliency.** Annual, three-day organizational-level training that aims to drive culture change.	Social connected-ness	Primary	Operating at state level, NV ANG/ARNG

Ready and Resilient Warrior Workshop Success: Limited	**Strengthen belonging, self-esteem, and resiliency through post-deployment counselling.** Seven-session, group counseling workshop for high-risk and recently deployed SMs that builds self-esteem across a range of topics (e.g., communication, lifestyle, finances).	Stress and coping	Primary	Concluded implementation in the HI ARNG
Responsible Alcohol Use				
MyPrime Success: High	**Reduce individual alcohol and drug use through online adaption of an evidenced-based curriculum.** SMs learn to change their individual alcohol and drug use through a non-judgmental, motivational course.	Substance Misuse	Tertiary	Operating at state level, ND ARNG; national-level implementation in progress
Risk Reduction Psychoeducation Group Success: Limited	**Improve coping skills and reduce risky alcohol use among at-risk SMs.** In-person, two-day course for Alcohol and Substance Abuse Program (ASAP) or self-referrals to improve their knowledge and coping skills related to drug use.	Substance Misuse	Secondary and Tertiary	Operating at state level, CT ARNG

Identify Populations at Risk				
Name	**Description**	**Behavior**	**Prevention Level**	**Implementation Status**
Gatekeeper and Bystander Intervention Training				
Buddy Aid Success: High	**Operationalizes first response for sexual assault disclosures.** 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.	Active intervention; past trauma	Secondary and Tertiary	Operating at state level, SD ARNG; national-level implementation in progress
Mental Health First Aid Success: Moderate	**Enhance prevention and intervention skills for behavioral and mental health issues**. One-day gatekeeper training that teaches participants to engage in supportive conversations and to recognize the signs of distress and intervene by referring to support resources.	Active intervention; substance misuse	Primary and Secondary	Operating at state level, RI ARNG
Start Success: High	**Expand participants' abilities to identify and support SMs who may be considering suicide.** 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.	Active intervention	Secondary	Operating at state level, SC ARNG; national-level implementation in progress
Together Strong Success: High	**Teach risk reduction communication skills for suicide prevention through an online training tailored to the NG.** Virtual role-play training to teach participants how to identify and respond to those at risk for suicide and increase awareness of BH resources.	Active intervention	Primary and Secondary	Concluded implementation in the ND ARNG
VReal Success: High	**Build SMs' skills to recognize and respond to Airmen with suicidal ideation.** VReal provides 45-minute interactive suicide prevention gatekeeper training delivered through virtual reality headsets. SMs role-play in realistic situations and speak with distressed Airmen.	Active intervention	Primary and Secondary	Concluded implementation in the NE ANG

Screening Tools				
Behavioral Health Primary Prevention and Retention Success: High	**Proactively identify new recruits with social determinants of health (SDOH) needs and support those at risk.** Screening for SMs during Recruit Sustainment Program to identify risk factors and provide proactive case management.	Basic needs; Safety; Mental health	Primary and Secondary	Operating at state level, SD and NM ARNG/ANG; national-level implementation in progress
SASSI-4 Success: Moderate	**Identify and refer individuals that require treatment for substance misuse disorders.** Online version of the Substance Abuse Subtle Screening Inventory (SASSI)-4 administered to self-referrals and positive urinalysis cases facilitates referral process.	Substance Misuse	Secondary	Operating at state level, OK ARNG

Provide Care and Treatment				
Name	**Description**	**Behavior**	**Prevention Level**	**Implementation Status**
Access to Care				
Military Support Embedded Clinician Program Success: Limited	**Deliver in-unit mental health support services, referrals, and care during drill weekend.** Licensed mental health providers are embedded to deliver confidential services and referrals to resources in coordination with the full-time NG BH team.	Mental health	Secondary and Tertiary	Operating at state level, CT ANG/ ARNG
Crisis/brief Interventions				
Crisis Response Plan Success: High	**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.	Active intervention	Tertiary	Concluded implementation in the TX ARNG
SafeUTNG Success: Moderate	**Reduce barriers to care 24/7/365 through a confidential crisis intervention mobile app.** A mobile app offers live chat with local clinicians, in partnership with the University of Utah, during times of crisis.	Active intervention	Tertiary	Operating at state level, UT ARNG/ANG

Create Protective Environments				
Name	**Description**	**Behavior**	**Prevention Level**	**Implementation Status**
Manage Access to Lethal Means				
CALM & Collect Success: Limited	**Establish a safe place to deposit firearms and teaches Suicide Intervention Officers (SIOs) to counsel SMs on storage of lethal means.** Program that intends to reduce suicides and firearm violence by training SIOs to identify and counsel SMs at-risk and providing a place for SMs to store their firearms when their suicide risk is elevated.	Firearm safety	Secondary and Tertiary	Operating at state level, GU ANG/ARNG
EADS SAFE (Suicide Awareness and Firearm Education) Success: Limited	**Teach suicide awareness from a hunter safety lens and build supportive community.** EADS SAFE integrates suicide awareness content into existing Hunter Safety curriculum and encourages mental health awareness and safe storage practices to the community.	Firearm safety	Primary, Secondary, and Tertiary	Operating at state level, NY ANG

Firearm Risk Mitigation Success: Limited	**Develop personalized firearm safety plans to minimize access to lethal means.** In-person, structured psychoeducational brief on firearm risk mitigation and suicide. Participants receive support using shared decision-making to develop a personalized firearm safety plan.	Firearm safety	Tertiary	Operating at state level, IL ANG
Strengthen Economic Support				
Work for Warriors Georgia Success: High	**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.	Financial strain; Employment	Primary	Operating at state level, GA ANG/ARNG; national-level implementation in progress

Operational Stress Management (OSM)

Resiliency and Self-Care Training

Status: Concluded **State and Service**: IL ARNG **Demonstrated Success:** Moderate

What is OSM and why is it needed?

Improves BH through self-care and stress management T3 course. Among SMs in highly mobilized units, the OSM training teaches skills, tools, and resources for individual resiliency, stress management, and coping. Using a T3 method, it also equips SMs to disseminate their skills among other member of their units to prevent BH issues at the unit level.

Resilience trainings are often implemented during low operational tempo (OPTEMPO). OSM, instead, targets units in the weeks before their deployment to proactively strengthen resilience before they need to use them.

Click here to watch a video about OSM: https://www.youtube.com/watch?v=8Ub3fJwZwls.

Is the program effective?

Awareness and Skill-building

The 30 participants from the Illinois NG demonstrated significant improvement in their confidence to:

- *Understand and be aware* of stress, resilience, and coping resources
- *Manage* their individual stress
- *Teach others* about stress and resilience and assist others in managing their stress.

Tools and Resources

The program covered many tools and resources that SMs can employ to teach others how to effectively manage their stress.

95% of participants indicated being likely or very likely to use the tools and resources when teaching others.

Further evaluations should include objective knowledge and skills assessment questions to complement measures of confidence and self-efficacy. A follow-up survey could assess actual use of the taught stress-management behaviors and use of tools/resources with other unit members. Longer term, administrative data and surveys could assess unit-level changes in incidence of harmful behavior.

How does the program work?

Train Soldiers

1) *Contracted training:* Training was provided by NATAL Global Resilience, which adapted the curriculum from a training for first responders.
2) *Virtual implementation*: 30 participants joined ten, eight-hour sessions led by NATAL facilitators.
3) *Individual skill- building*: In the first five sessions, participants learned how to understand and manage their own resilience and stress.
4) *T3:* In the final five sessions, participants learned how to bring their skills back to their unit through teaching and assisting their peers.

Train the Unit

Once trained, Soldiers share what they have learned with their units by developing and providing operational stress management trainings and/or informally discussing relevant skills on a need-by-need basis.

Resource Intensive

Although only implemented in one cohort, OSM required significant staff-time for participants (eighty hours over two weeks) during a high-stress time already busy with preparations for deployment.

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Click here for Operational Stress Management Supplemental Information and Materials

Connectedness and Relationship Education (CARE)

Training First Line Leaders (FLLs) to Improve Communication Skills

Status: Scaling **Implementing Office**: NGB/WRF **Demonstrated Success:** High

What is CARE and why is it needed?

Fosters trust within units by training first-line leaders (FLLs) in relationship-building and risk-identification. The FLL Relational Leadership Course aims to improve leaders' ability to support their subordinates. It develops communication skills and knowledge of risk mitigation practices among leaders O1-O3 and E4 and above. These FLLs have close contact with subordinates through individual counseling and ongoing informal interactions, but receive limited training on key communication and risk-identification skills.

If FLLs are able to use communication and relationship- building skills 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."**

Ohio ARNG, *Rucksack Essentials* (Columbus, OH: Ohio ARNG, 2022), https://www.ong.ohio.gov/members/oharng/transition-assistance/resources/rucksack-essentials.pdf.

Is the program effective?

Since 2020, over 2,100 CARE participants completed evaluation surveys. Immediately after the training, participants demonstrated improvement in:

- *Attitudes* about the importance of leaders building relationships with their subordinates,
- *Knowledge* of effective communication concepts, and
- *Confidence* in their ability to apply skills related to communication and risk-mitigation (e.g., identify risk behaviors).

83% of participants believed the course would help them improve relationships with their subordinates.

Beyond preparing participants to be more effective FLLs, CARE ultimately aims to improve outcomes among all SMs within a unit. These outcomes include:

- Reducing risk behaviors,
- Increasing resource utilization, and
- Strengthening connectedness and unit belonging.

The link between CARE's short, intermediate, and long-term outcomes reflects its *theory of change:*

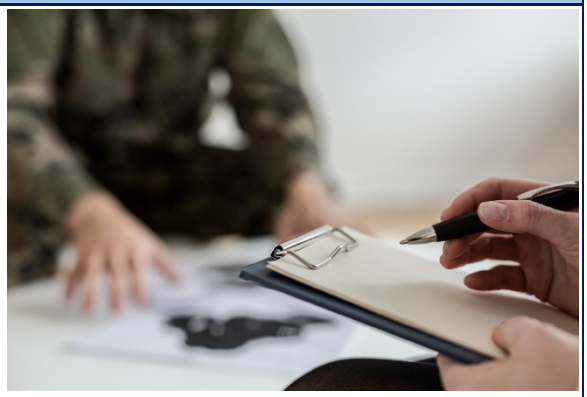
FLLs learn relationship-building skills → FLL apply skills to address SMs' risk factors → Units have reduced risk, increased protective factors

Future evaluations should use follow-up surveys to measure intermediate outcomes (retention and application of training content over time). They could use administrative data to assess longer-term changes in connectedness and rates of harmful behaviors at the unit level.

How does the program work?

CARE uses internal NG resources:

- Trainings for trainers (T4Ts) prepare new facilitators to lead the course. States select their own personnel to send to the T4Ts.
- States must sign a memorandum of agreement to add the course to their unit training schedules and complete program evaluation activities. All FLLs in the unit take the eight-hour, in-person course together.
- Minimal internal resources (e.g., printing handbooks, training space) are needed to deliver the training in a state.
- 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, CARE Program Manager, ronald.f.fry.mil@army.mil

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

MyPrime

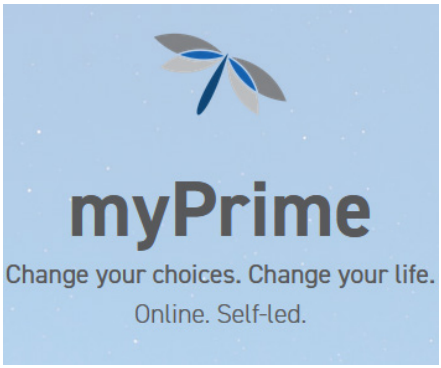
Alcohol and Drug-Abuse Prevention and Intervention Program

Status: Operating **Implementing Office**: NGB/WRF **Demonstrated Success:** High

What is MyPrime and why is it needed?

Reduces individual alcohol and drug use through online adaption of an evidenced-based curriculum. MyPrime is the online, self-paced version of Prime for Life (PFL). MyPrime/PFL is an intervention program that aims to change high-risk alcohol and drug-related behaviors by affecting individuals' beliefs, attitudes, risk perception, motivation, and knowledge. The program includes a self-assessment to measure individual substance addiction and a three-module behavior-change curriculum.

Substance misuse interventions are commonly in-person. By being virtual, self-paced, and accessible in any location, MyPrime allows SMs to complete requirements in a timely manner.



Prevention Research Institute, "MyPrime," https://www.primeforlife.org/programs/myprime.

Is the program effective?

Among 66 participants in the North Dakota NG, MyPrime has shown evidence for improving short-term outcomes. From pre- to post-training, participants showed:

- *Reduced intentions* to use alcohol in the next 90 days
- *Increased perception of risk* from drinking and substance-use behavior
- *Increased perceived harm for others and themselves* when engaging in alcohol and substance use

As of 2023, only one SM who had successfully completed MyPrime early intervention training has demonstrated recidivism.

Participant Satisfaction

Satisfaction rates suggest that the MyPrime program is highly acceptable for participants:

91% agreed or strongly agreed that programs like MyPrime are useful for people who have experienced alcohol and/or drug problems

Future evaluations should use a follow-up survey to assess whether participants maintain these improvements over time, as well as administrative data to evaluate longer-term effects on substance misuse recidivism. Collecting data from a comparison group would also strengthen evaluation data.

How does the program work?

Target Populations

The program targets three audiences of service members:

- Individuals who are drug positive, as indicated by a positive urinalysis
- Individuals who receive an alcohol violation
- Individuals who self-identify as struggling with drug or alcohol use

Enrollment and Completion

To receive access to MyPrime, SMs can either submit a leadership or personal request or be enrolled in the Alcohol and Substance Abuse Program.

SMs who receive a violation must complete MyPrime to fulfill Alcohol and Substance Abuse Program requirements.

Contact: Amy Ruff, R3SP, ND ARNG, amy.l.ruff4.civ@army.mil

Click here for MyPrime Supplemental Information and Materials

Buddy Aid

Sexual Assault First Response Training

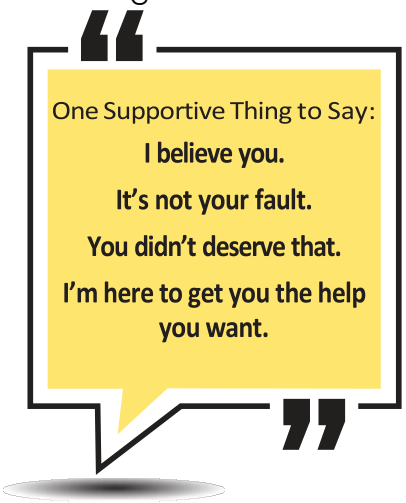
Status: National **Implementing Office**: NGB/SAPR **Demonstrated Success:** High

What is Buddy Aid and why is it needed?

Operationalizes 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.



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)

During its first 3 years of implementation, Buddy Aid training showed 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.

Data collected as the program has scaled to new states show similar results, with no significant differences observed between new trainers and the original training team.

Future evaluations should employ follow-up surveys to 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, Sexual Assault Response Coordinators, Integrated Prevention Professionals and others apply to attend a five-day mobile-training-team style 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 twenty to thirty 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

Click here to watch a video about Buddy Aid: https://www.dvidshub.net/video/877645/ep-44-understanding-buddy-aid-with-maj-flannery.

Contact: MAJ Bridget Flannery, Buddy Aid Manager, bridget.a.flannery2.mil@army.mil

Click here for Buddy Aid Supplemental Information and Materials

Mental Health First Aid (MHFA)

Prevention and Intervention for Mental Health Issues

Status: Operating **State and Service**: RI ANG **Demonstrated Success:** Moderate

What is MHFA and why is it needed?

Enhances prevention and intervention skills for behavioral and mental health issues. MHFA is an in-person, evidence-based intervention that teaches individuals to identify, understand, and assist someone who may be experiencing psychological distress, substance misuse, or suicidal ideation.

Gatekeeper trainings typically focus on current suicide risk. MHFA takes a preventative approach by targeting identification of upstream risk factors (e.g., substance misuse or psychological distress) through peer intervention and resource referrals.

> **"I now feel more confident as a leader to engage with and identify service members who may be showing signs of mental distress."**
>
> *– MHFA Participant*

Is the program effective?

Among 110 participants in the RI ANG, MHFA has demonstrated significant improvements across numerous outcomes:

- *Help-seeking self-efficacy*, including confidence in one's ability to recognize signs of mental health challenges in others and assist someone in distress
- *Help-seeking intentions*, including future use of appropriate coping mechanisms to respond to a stressful situation
- *Awareness of existing military support services*, including Military and Veteran Crisis Lines, Vet Center, Soldier and Family Assistance Center, Transition and Employment Assistance, and Chaplain Services.

Participant Satisfaction

Overall, participants indicted high satisfaction with the MHFA training:

> **I thought this was an excellent course and should be offered to all soldiers to encourage looking out for your buddy.**

- More than **97%** of participants thought the course was helpful and/or prepared them to use these skills professionally in their job
- **89%** of the participants thought the course materials represented Veterans well

Future evaluations should use a follow-up survey to assess whether participants maintain these improvements and apply their new skills over a longer period of time.

How does the program work?

1) License and Purchase: Program manager must be certified in MHFA to be able to teach others. Certification requires three hours of self-paced work and a three-day interactive training taken either in-person or virtually. After certification, states must purchase course materials.

2) Schedule: MHFA can be delivered in one eight-hour session or two four-hour sessions. Since NG personnel deliver the training, unit commanders can select the option that works best for their unit training schedule.

3) Adapt content: MHFA has multiple modules available that tailor the content to a particular audience (e.g., Veterans, adults, teens). Each module adjusts its explanation of mental health's relevance, risk and protective factors, selected scenarios, and mental health resources based on its intended population.

Contact: Rebecca Sanderson, Primary Prevention Specialist, Rebecca.K.Sanderson.civ@army.mil

Click here for Mental Health First Aid Supplemental Information and Materials

Start
Gatekeeper Training for Suicide Prevention

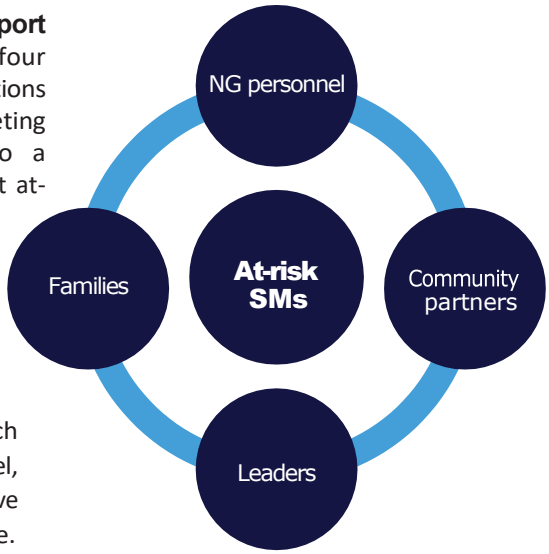
Status: Scaling **Implementing Office**: NGB/WRF **Demonstrated Success:** High

What is Start and why is it needed?

Expands participants' abilities 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 in to signs an SM may be considering suicide
- Directly ask whether an 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.

LIVINGWORKS Start

"LivingWorks Start", *LivingWorks,* https://livingworks.net/training/livingworks-start/.

Contact: SGT Travis Duncan, travis.e.duncan3.mil@army.mil

Click here for Start Supplemental Information and Materials

Together Strong
Gatekeeper Training for Suicide Prevention

Status: Concluded **State and Service**: ND ARNG **Demonstrated Success:** High

What is Together Strong and why is it needed?

Teaches risk reduction communication skills for suicide prevention through an online training 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 aimed to reinforce and supplement in-person suicide prevention trainings that teach similar gatekeeper skills.

> **It was brilliant and effective and I'd love to see this kind of training used to teach and train us on other topics and subjects.**

> **I think everything in this simulation is realistic, even down to the type of language used. It felt more humanized than robotic.**

Was the program effective?

Between August 2021 and June 2022, 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 **improved 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.

Evaluations of Together Strong conducted in university student populations used survey and administration data to assess longer-term outcomes among participants, including whether the training increased their use of support services. One found that training participants went on to seek counseling services at twice the rate of non-participants.* While North Dakota was unable to assess long-term outcomes in its evaluation, future efforts could adopt a similar evaluation design.

** Source:* 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 (2019): 1735–745.

How did the program work?

The Kognito brand was sunset in 2023, so Together Strong licenses are no longer available for purchase. States may learn from the ND ARNG's implementation approach to inform use of other online trainings:

1) *Purchase and distribute Together Strong licenses:* The North Dakota ARNG purchased a training package in bulk from Kognito. Once purchased, the program manager distributed the licenses to units in coordination with the G3 and unit training NCOs.
2) *Complete training:* Together Strong was entirely virtual and took less than one hour to complete. Units scheduled time for members to complete it in lieu of Annual Suicide Prevention training in FY2022.
3) *Reinforce leadership support:* Senior leaders encouraged SMs to complete the training, if they had not done so in their unit.

North Dakota also planned for a ninety-minute unit debrief led by SIOs to follow the training. This was ultimately not implemented due to lack of drill time. In the future, similar online gatekeeper training programs could test whether a unit debrief influences key training outcomes.

Contact: Amy Ruff, R3SP, ND ARNG, amy.l.ruff4.civ@army.mil

Click here for Together Strong Supplemental Information and Materials

VReal
Suicide Prevention Virtual Reality

Status: Concluded **State and Service**: NE ANG **Demonstrated Success:** High

What is VReal and why is it needed?

Builds SMs' skills to recognize and respond to Airmen with suicidal ideation. VReal is a forty-five-minute interactive suicide prevention gate-keeper training, developed by Moth + Flame, delivered through virtual reality headsets**.** SMs role-play in realistic situations with distressed Airmen.

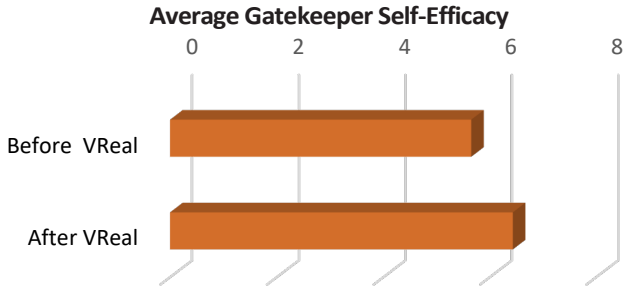
Suicide prevention gatekeeper trainings typically have limited opportunities to actively practice skills in real-life. VReal reduces this barrier by including four real-life situations and simulating SMs, and/or veterans. It is not designed as an additional training, but an alternative to traditional military suicide prevention trainings.

Click here to watch a video about VReal: https://vimeo.com/647020810.

Is the program effective?

In the NE ANG, evaluation of VReal focused on gatekeeper self-efficacy. Across the 331 Airmen who completed the training, significant improvements were seen on all metrics, such as participants' ability to:

- *Communicate* with an individual in distress
- *Recognize* signs of suicide and depression
- *Connect* an individual in distress to resources
- *Be familiar* with relevant resources and suicide knowledge



Moth + Flame also administered an evaluation, which produced positive findings.

90% of the participants achieved the goal of getting the Airman to safety during the virtual role-play.

97% of participants reported they would recommend the training to a peer.

95% of participants thought VReal was more effective than traditional suicide prevention trainings.

Future evaluations should use a comparative approach to compare change in outcomes across similar gatekeeper trainings. To assess if participants retain knowledge of the training content and employ gatekeeper behaviors over time, future evaluations should include follow-up surveys.

How does the program work?

1) *Purchase:* Contact Moth + Flame to discuss plan and pricing options and get approval through your contracting office.
2) *Schedule:* Schedule a time period (i.e., a week, drill weekend) when SMs are present for Moth + Flame staff to visit the base and conduct one-on-one trainings.
3) *Market:* Spread awareness of the training to leadership and SMs to gain interest and participants.
4) *Train:* Have interested service members complete the training, administered by Moth + Flame staff in forty-five minutes or less.

Contact: Cathleen Pearson, Sexual Assault Prevention and Response Program Manager, NE NG, cathleen.a.pearson.civ@army.mil

Click here for VReal Supplemental Information and Materials

Behavioral Health Primary Prevention and Retention (BHPPR)

Proactive Support to New Recruits

Status: National **Implementing Office**: NGB/WRF **Demonstrated Success:** High

What is BHPPR and why is it needed?

Proactively identifies new recruits with SDOH needs and supports those at risk. A fifteen- to twenty-minute questionnaire completed during recruit sustainment program (RSP) or student flight 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 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 of implementation in the NM ARNG (2019–2020), 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 four-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 in NM 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 intermediate outcomes, including BH symptoms and resource utilization, as well as effects on retention and rates of BH issues over a longer period of time. Data collection and analysis recently resumed in South Dakota and evaluation results are not yet available.

How does the program work?

The NM ARNG developed an 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 personnel resources.

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: COL Amber Heinert, Director of Psychological Health and Resiliency Programs, SD ARNG, amber.r.heinert.mil@army.mil

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

SASSI-4

Streamlined Screening for Substance Use Disorders

Status: Operating **State and Service**: OK ARNG **Demonstrated Success:** Moderate

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

Identifies and refers individuals that require treatment for substance use disorders (SUD). SASSI-4 is an online assessment provided to SMs who test positive on urinalyses, have alcohol incidents, or who self-report substance use concerns. Based on the results, SMs receive psychoeducation and referral to appropriate resources (e.g., ASAP training or community-based treatment).

SMs who have positive urinalyses or alcohol incidents are required to complete SUD screening, but this is costly and inconvenient to obtain in the community (i.e., outside the NG). To improve timeliness of SUD treatment and prevent worsening substance use, 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)

Did you know?

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

This cost 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.

Future evaluations should evaluate the program's effects on resource engagement (e.g., preventative trainings) and substance misuse recidivism 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 clinician (e.g., LPC, LCSW) must first complete a seven-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

Crisis Response Plan (CRP)

Mitigating Risk during Suicidal Crises

Status: Concluded **State and Service**: TX ARNG **Demonstrated Success:** High

What is CRP and why is it needed?

Trains BHOs and Chaplains on crisis response and lethal means safety counseling. CRP is a client-centered approach to reduce immediate suicide risk among SMs. Chaplains and BHOs learn 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.

Clinical trials *Evidence-based practice*

among active-duty Soldiers with acute BH risks found that CRP reduced suicide attempts by 76%.

Source: Craig J. Bryan, Jim Mintz, Tracy A. Clemans, Bruce Leeson, T. Scott Burch, Sean R. Williams, Emily Maney, and M. David Rudd, "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.

Is the program effective?

Effective Skill-building

Thirty-seven Chaplains and BHOs from the Texas NG completed the training. They said it improved their knowledge of the core components of a CRP. It also improved their confidence to:

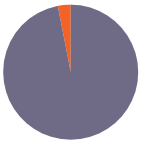
- *Work* with SMs experiencing heightened suicide risk
- *Conduct* suicide risk assessments
- *Provide counseling* to SMs experiencing emotional crises or suicide risk

Need for Follow-up and Outreach

Four months after training, few participants had used CRP with their clients. Most participants gave two reasons for this:

- **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

Future efforts could 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 exercises to help them build competence within a community of peers.

Future evaluations should use *longer-term follow-up surveys* to assess retention of CRP skills among Chaplains and BHOs. Given limited opportunities to use CRP with SMs, trainees may benefit from periodic refresher trainings to maintain their skills; follow-up surveys could be administered just before these refreshers.

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, eight-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 thirty minutes to complete.

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

SafeUTNG
Crisis Intervention Mobile App

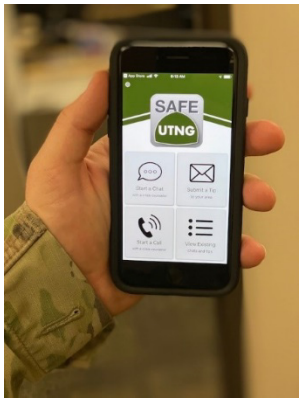
Status: Operating **State and Service**: UT ANG/ARNG **Demonstrated Success:** Moderate

What is SafeUTNG and why is it needed?

Reduces barriers to care 24/7/365 through a confidential crisis intervention 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



Images source: University of Utah Health, *SafeUT National Guard* (2024), https://safeut.org/national-guard.

Is the program effective?

In the UT 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.

Between 2019 and 2022, the app was been **downloaded over 3,600 times.**

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

Future evaluations should employ a pre-post survey design to assess the effectiveness of outreach and marketing efforts. By comparing SMs' perceptions and reported use of the app *before and after* these efforts and comparing across different types of users (e.g., by gender, rank) program managers can continue to calibrate their outreach.

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 UT. 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.

Contact: MAJ David Wood, Group Psychologist, UT ARNG, david.s.wood41.mil@army.mil

Click here for SafeUTNG Crisis Intervention App Supplemental Information and Materials

CALM & Collect

Lethal Means Counselling Training and Firearm Depository

Status: Operating **State and Service**: GU ANG/ARNG **Demonstrated Success:** Limited

What is CALM and Collect and why is it needed?

Establishes a safe place to deposit firearms and teaches SIOs to counsel SMs on storage of lethal means. Intends to reduce suicides and firearm violence by training SIOs to identify and counsel service members at-risk and providing a place for SMs to store their firearms when their suicide is elevated.

SIOs learn to:

- Identify service members that could benefit from lethal means counselling
- Advise service members in storing and reducing access to lethal means
- Explain how reducing access to lethal means can prevent suicide.

Did you know?

An individual's risk of dying by suicide increases from four to six times if there a loaded firearm stored in the home.[vi]

Source: Defense Suicide Prevention Office, "Lethal Means Safety Guide for Military Service Members and Their Families," https://www.dspo.mil/Portals/113/DSPO%20Lethal%20Means%20Safety%20Guide%20for%20Military%20Service%20Members%20and%20Their%20Families_v34_FINAL.pdf.

Is the program effective?

Establishing Need

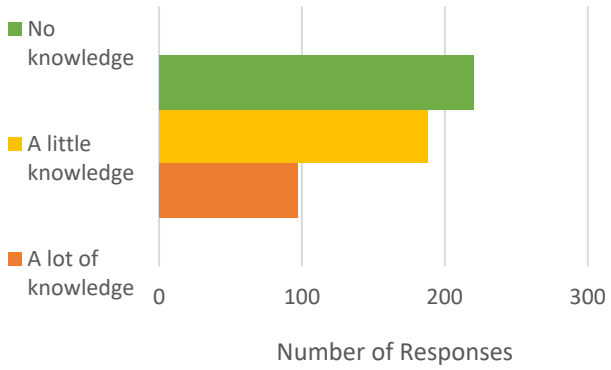
GU conducted a Needs Assessment to inform current and future lethal means safety efforts. Over 500 SMs responded. Among those guardsmen, **35%** indicated being a firearm owner. Overall, respondents reported:

- Low *knowledge* of lethal means counseling and access to safe storage options
- Moderate *knowledge* of safety plans and safe storage practices for medication.

Evaluation Plans

As of September 2023, 30 SIOs completed the CALM training that assessed awareness, knowledge, and intentions related to suicide and lethal means counselling. Analysis will be conducted as the program progresses.

Knowledge of Lethal Means Safety Counseling for Guardsmen



How does the program work?

Increasing Access to Lethal Means Counselling

1) *Conduct the CALM training*. Select a time and date where all SIOs are available, such as before or after mandatory trainings. The course is freely available online, so no licenses need to be purchased.
2) *Offer counseling to Guardsmen*. Trained SIOs identify Guardsmen at risk of suicide and provide lethal means counseling.
3) *Connect Guardsmen to safe storage locations*. When counseling and assisting in developing safety plans, SIOs refer Guardsmen to the safe storage locations on base.

Reducing Access to Firearms

1) *Establish the required policies, SOPs, and Memoranda of Understanding (MOUs)* to purchase and install sun safes through coordination with appropiate leadership and personnel.
2) *Improve awareness of and attitudes about* safe storage locations by marketing them on-base to Guardsmen, SIOs, and other mental health and BH personnel through de-stigmmatizing messages.
3) *Monitor use* of safe storage locations.

Contact: Tawnee Eustaquio, GU ARNG, tawnee.u.eustaquio.civ@army.mil

Click here for CALM & Collect Supplemental Information and Materials

EADS Suicide Awareness and Firearm Education (SAFE)

Hunter Safety Course

Status: Operating **State and Service**: NY ANG **Demonstrated Success**: Limited

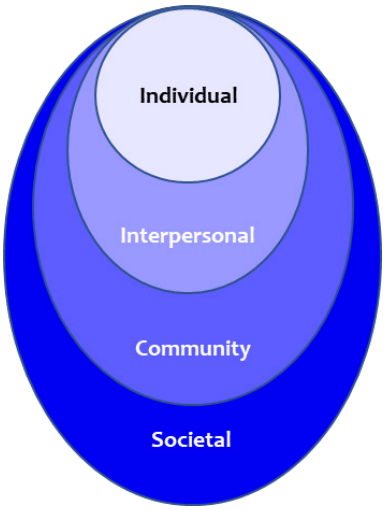
What is EADS SAFE and why is it needed?

Teaches suicide awareness from a hunter safety lens and builds supportive community. EADS SAFE integrates suicide awareness content into existing Hunter Safety curriculum. Outside of the classroom, the program holds outreach events to encourage mental health awareness and safe storage practices to the community.

EADS SAFE consists of:

- An in-person, four-hour course for Airmen
- Community outreach events for Airmen and their families.

The program operates at the individual, interpersonal, and community levels of the socioecological model to address influences on firearm safety in a culturally competent way.



Is the program effective?

Reach

As of August 2023, 3 courses had taken place with 23 SMs. Preliminary findings are promising. From pre- to post-survey, participants increased their consideration of various factors when deciding how to store their firearms…

19% *more participants* reported considering risk factors for suicide.

31% *more participants* reported considering recent or current substance use/misuse by themselves or others.

38% *more participants* considered the emotional state of themselves and others in their household.

39% *more participants* considered the history of suicidal crisis in their household.

The course also received positive feedback from veterans that received the course in the community.

Despite these promising preliminary findings, EADS SAFE experienced its fair share of challenges.

Challenges & Lessons Learned

- *Low response rate to surveys* → Make surveys brief and administer surveys immediately before and after the course when the participants are still in the classroom
- *Low recruitment* → Anticipate no-shows by allowing more individuals to sign up for the training
- *Instructor challenges* → Met with the instructor and the contract office and had instructor complete System for Awards Management criteria.
- *Policy restrictions* → Work with state leaders to confirm compliance with policy

How does the program work?

1) *Contract an instructor:* EADS SAFE should be delivered by an individual your SMs trust and are willing to learn to from (i.e., former or current military, pistol permit instructor). Work with local communities to identify an individual who has these characteristics and is already trained in firearm or hunter safety.
2) *Adapt suicide awareness module:* Adapt NY's content on suicide awareness for your target population to supplement the Hunter Safety curriculum. The course will address individual and interpersonal factors. The course should be conducted in-person and take approximately four-hours.
3) *Conduct community outreach:* Tailor NY's materials to your community and/or develop new materials for Airmen families to handout at community events. Address community factors by creating a culture that supports firearm safety and suicide awareness.

Contact: Karen Silcott, Director of Psychological Health, NY ANG, karen.silcott@us.af.mil

Click here for EADS SAFE Supplemental Information and Materials

Work for Warriors Georgia (WFWGA)

Connecting SMs with Support Services and Job Opportunities

Status: Operating **State and Service**: GA ARNG **Demonstrated Success**: High

What is Work for Warriors and why is it needed?

Streamlines referrals to resources, service providers, and employment support. The program requires SMs to complete a Wellness Poll during Soldier Readiness Processing (SRP), 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, BH, legal needs, Veterans Affairs and health care benefits, education, and more. Centralization of 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 2019, WFWGA has polled over 66,000 SMs to identify resource needs. This has facilitated over 40,000 service referrals, including:

- **9,127** *referrals* to employment assistance
- **2,630** *referrals* to financial assistance
- **1,671** *referrals* to BH services
- **33,418** *referrals* for other services (e.g., TRICARE, legal resources, education benefits)

Secured Employment

As of 2023, WFWGA had helped thousands of individuals gain employment, with a median salary of $60,000 to $70,000.

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)"**

Future evaluations should assess the effectiveness of replicating WFWGA's approach in different NG state contexts. Over the long-term, states could consider examining the *cost effectiveness* of their employment support models by comparing the program's costs to its benefits (e.g., effects on SM retention and earnings).

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 SRP, 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.

WWW.W4WGA.ORG

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Click here for Work for Warriors Supplemental Information and Materials

Appendix A. Prevention Levels and Approaches

Prevention level Public health frameworks outline three levels of prevention: primary, secondary, and tertiary.[22]

- *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[23] and Violence Prevention websites.[24]
- *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: Warrior Resilience and Fitness (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.[25]

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

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

[24] Centers for Disease Control and Prevention, "Violence Prevention Fundamentals."

[25] Eliezer, Williams, Cotting, Reutter, and Dubin, *National Guard Suicide Prevention and Resilience Innovation Framework.*

Appendix B. Supplemental Information and Materials

YogaShield

Enhance Life Skills and Connectedness

Status: Operating

Location: Iowa (IA) ANG/ARNG

Years of NGB support: FY2021

Demonstrated success: Limited (achieved proof of concept; demonstrated partial feasibility and partial outcome effectiveness)

Description: Six-week mental and physical resiliency and stress management program aimed to bring yoga philosophy and somatic and cognitive exercises (e.g., breathing techniques, mindfulness) to a military population. The primary focus area included integrated approaches to destructive behaviors and readiness for physical fitness using yoga culturally appropriate to the NG. The program includes a T4T model to train yoga facilitators.

For more information about Yoga for First Responders, visit https://www.yogaforfirstresponders.org/.

Justification: While many military trainings aim to prevent destructive behaviors by building coping skills and resilience, YogaShield aims to do so by focusing on the neurological foundation of the stress response (i.e., train the body to handle stress better).

Evaluation plan: Pre-post survey design that collected metrics on physical and psychological feelings of stress, resiliency, connectedness, and substance misuse over the six-week yoga curriculum. The survey also tracked satisfaction with the training and utilization of skills over the course of the program. Program managers tracked fidelity to curriculum. Metrics collected on the surveys include: perceived stress, psychological distress, resiliency, alcohol misuse, life purpose, sleep quality, work problems, connectedness, skill use, and satisfaction.

Evidence of effectiveness: *Demonstrated evidence of process effectiveness; Insufficient data to demonstrate outcome effectiveness***.**

As of April 2022, approximately 40 participants completed the course. Due to low participant numbers, a full statistical analysis was not completed. The participants, however, indicated satisfaction with the breathwork and yoga classes. ARNG participants reported that the messaging used in the yoga curriculum was culturally appropriate for the NG (i.e., curriculum and yoga classes were designed a military audience).

Feasibility: YogaShield is primarily an in-person course. It requires trainers to reach a high level of yoga certification before being able to implement, making the start-up slow and time consuming. Recruitment of participants for the entire six-week course was challenging due to lack of pay and allowance funds. The program offered flexibility of in-person and on-line training during initial implementation during the COVID-19 pandemic.

Achievements: Program managers developed a robust pre/post evaluation plan, as well as creating a thorough curriculum that targeted different areas of physical and mental resiliency for SMs.

Challenges: YogaShield's main hurdle was obtaining leadership buy-in. After implementation began, quarterly reports suggested that SMs and leadership held negative perceptions of yoga. Specifically, they did not understand the role yoga, and more specifically YogaShield, could play in preventing harmful behavior (e.g., suicide). The program team was unable to effectively combat these perceptions. Additionally, the program expanded activities into new states before addressing issues of buy-in and having an appropriate number of trainers in place to meet the heightened demand.

Lessons learned: The program managers understood the importance of program evaluation and setting up a feasible and robust pre/post program evaluation from the start of YogaShield. Leadership buy-in is one of the more important

aspects of growing a program, and evaluation results can help secure leadership buy-in; evaluation plans and/or findings should be incorporated into communications about a program. Furthermore, scale-up needs to be carefully planned in the evolution of a program. Specifically, time is often necessary to assess initial effectiveness and to ensure that necessary elements (including leadership support and adequate staff resources) are in place beforehand.

Operational Stress Management (OSM) Resiliency and Self-Care Training

Status: Concluded

Location: Illinois (IL) ARNG

Years of NGB support: FY2022

Demonstrated success: Moderate (achieved proof of concept; demonstrated partial feasibility and partial outcome effectiveness)

Description: Ten-day training for domestic response units with a high mobilization rate to improve operational stress management, resilience, and BH. The course is split into two, five-day blocks, with the first five days teaching the participants skills for their own resilience and stress management, followed by the remaining five days during which the participants receive a T3 version to bring these skills back to their units. The training is implemented by NATAL, an Israeli contractor, and was developed specifically for first responders.

To learn more about Operational Stress Management, visit https://natalglobal.org/our-trainings/osm/.

Justification: During FY2020 and FY2021, IL NG experienced increased domestic operation missions, totaling approximately 400,000 man-days. Throughout this time, many of the same units were called to deploy multiple times, and BH issues increased across the state. To combat this increase in negative behaviors, adapt to the changing conditions in the NG, and prepare Guardsmen to handle high-stress environments and trauma, IL offered this first responder program in highly deployable units. Since the training follows a T3 design, the program has the potential to affect outcomes among a broader group of SMs than its initial participants.

Evaluation plan: Participants completed pre- and post-training surveys onsite immediately before and after the program, respectively. A follow-up survey was administered online 60-days after the course's end. Evaluation metrics include: self-care behavior, confidence in their knowledge of self-care practices and teaching content to their units, confidence in their ability to perform self-care practices and teach content to their units, intentions to use tools and techniques covered in the training, and satisfaction.

Evidence of effectiveness: *Demonstrated preliminary process and outcome effectiveness.*

The course was conducted once in December 2022 with 30 participants. The surveys were developed and administered by NATAL staff, and IDA performed paired *t*-tests, Wilcoxon tests, and McNemar's tests, as relevant, to assess significance of changes in outcomes after the training, compared to before training. IDA also calculated Cohen's *d* to examine effect sizes. Participants reported significant improvements in:

- **Knowledge** of all topics, including stress, resilience ($p < 0.001$, $d = 1.35$)
- **Self-efficacy** of all actions, including recognizing warning signs and managing stress for themselves ($p<0.001$, $d=1.43$) and when supporting and teaching others ($p < .0001$, $d > 1.70$).
- **Awareness** of the Veteran's' Crisis Line, Military OneSource, Deployment Assistance services, and Chaplain services ($p </= .05$, $d > 0.5$).

Participants also reported meaningful changes in their **awareness** of the Military Crisis Line, Military and Family Life Counseling Program, Star Behavioral Health, Transition Assistance, and Employment Assistance ($p > 0.05$, $d = .27$).

The contractor compared data collected immediately after the program to data collected sixty days later and reported that participants maintained improvements in knowledge and self-efficacy. After the training, participants indicated:

- High **intention** to use taught techniques (average of 4.72 out of 5)
- High **satisfaction** (average of 4.91 out of 5).

Feasibility: The program is time-intensive, requiring ten-days of full-time training. Since the program is designed for units that are planning to deploy, the state reported that it would not be feasible to offer regularly during a busy, high-stress time of preparation. Additionally, the training is carried out by an external contractor, NATAL, based out of Israel, and entails a cost and contracting processes. Prior to implementation in Illinois, NATAL had implemented the program both in the Israeli military and in the NJ NG. Due to COVID-19 concerns during 2021, Illinois implemented this program virtually and held a remote coordination meeting with the Israeli team. NATAL also offers in-person or hybrid implementation.

Achievements: Information unavailable.

Challenges: Information unavailable.

Lessons learned: Although subjective questions are effective to measure specific outcomes, it is important to also include objective measures in evaluation surveys. To assess knowledge, for example, a subjective question may ask participants how confident they are in knowledge of Topic A. An objective question would instead resemble a question on an exam and may ask participants to select the correct answer out of a list. Use of objective questions are especially important to assess actual knowledge, behaviors, and use of taught skills after the training. Additionally, it also helpful to include validated scales in evaluation to facilitate comparisons across similar programs.

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Couples Online Relationship Education (ePREP)

Status: Operating

Location: Michigan (MI) ARNG/ANG

Years of NGB support: FY2020–FY2023

Demonstrated success: Moderate (achieved proof of concept; demonstrated limited feasibility and partial outcome effectiveness)

Description: ePREP is a self-paced, online program that aims to teach communication and problem-solving skills in marital relationships. It is based on the in-person curriculum, PREP, which has strong evidence of effectiveness for improving marital quality, strengthening communication skills, and preventing divorce.

For more information about ePREP curricula, visit https://prepinc.com/products/eprep-c.

Justification: Currently available programs, such as Strong Bonds, for building couples' relationship skills require in-person participation on a specified schedule, typically over multiple days. This places a substantial burden on SMs and their partners (e.g., having to take time off of work, travel to a training location, find child care). ePREP seeks to improve accessibility among members of the NG by allowing them to take the course at home on their own schedule.

Evaluation plan: The initial effectiveness trial utilized a convergent mixed methods (both qualitative and quantitative) design for evaluation. The qualitative component involved conducting semistructured open-ended focus groups about topics related to the feasibility, acceptability, and need for online couples relationship education. Evaluation surveys measured pre- and post-training differences in relationship stability, confidence, and knowledge, as well as symptoms of depression, post-traumatic stress, and suicidal ideation.

Evidence of effectiveness: *Demonstrated preliminary evidence of process and outcome effectiveness.*

As of March 2022, twenty-eight couples had enrolled in the program. Preliminary results showed that 36% indicated lower levels of stress after the program, compared to their stress levels before the program. Further information about outcomes is available in a final report.[26]

Feasibility: ePREP uses an established curriculum that is available for purchase and takes approximately 6 months to complete. It requires trained coaches to engage with couples through virtual sessions.

Achievements: Information unavailable.

Challenges: In the MI ARNG, the program initially had significant challenges securing participants. Participant numbers increased following advertisement at Strong Bonds events. However, several couples who enrolled in the program failed to complete it due to the time commitment required.

Recommendations: Initial evaluation of ePREP in the MI ARNG showed promising results. To confirm findings, conduct further evaluation among a larger number of participants. States interested in ePREP should also compare results of this online-only program to results from other versions (e.g., the in-person version of PREP and the experiential version, PREPx).

[26] Paul Andrew Lepley, "A Multi-Method Initial Effectiveness Trial of an Online Relationship Education Program for Reserve Component Couples," Order No. 30522523, Michigan State University, 2023, https://www.proquest.com/dissertations-theses/multi-method-initial-effectiveness-trial-online/docview/2829634059/se-2.

Connectedness and Relationship Education (CARE)

Status: Operating at the state level, with national implementation in progress

Location: Original state-level evaluation conducted in the Ohio (OH) ARNG

Years of NGB support: FY2020–present

Demonstrated success: High (achieved proof of concept; demonstrated strong feasibility and consistent outcome effectiveness)

Description: Relational Leadership Course is a four-hour course designed for NCOs ranking E4 and above and officers O1-O3. It seeks to improve FLLs skills for communicating and building relationships with subordinates. The program ultimately aims to improve SMs' trust in Command, promote unit cohesion, increase help-seeking and proactive discussion of personal problems, and reduce behavioral health profiles and suicide attempts.

Justification: FLLs have limited training in communication and relationship-building skills; improved communication and trusting relationships with subordinates enables FLLs to identify and help address risk factors related to workplace and personal issues among their subordinates.

Evaluation plan: The evaluation used a pre-post design. Participants completed short evaluation surveys immediately before and after the training, with questions measuring satisfaction, knowledge, attitudes, and confidence to apply the training content.

Evidence of effectiveness: *Evidence of process and outcome effectiveness.*

Since 2020, over 2,100 FLLs in the Ohio ARNG completed pre- and post-surveys for the CARE training. Participants indicated high satisfaction with the program: 95% felt the training information was useful, 83% 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 attitudes, knowledge, and confidence measures from pre- to post-training. IDA used a linear regression model (examining effects across Battalions) and McNemar's tests[27] to assess significance of training effects and calculated Cohen's *f* to assess global effect size ($f = 1.17$). From pre- to post-test, participants showed improved:

- **Attitudes** about the importance of leaders building relationships with their subordinates ($p < .001$, average change on 5-point Likert scale = 0.6)
- **Knowledge** of effective communication approaches (e.g., from 65% correct on knowledge of behavioral health resources prior to the training, to 91% correct after the training).
- **Confidence** in their ability to apply skills related to interpersonal communication ($p < 0.001$, average change on 5-point Likert scale = 0.58)
- **Confidence** in their ability to identify risk factors and communicate with subordinates about them ($p < 0.04$, average change on 5-point Likert scale = 0.39)

Feasibility: Implementation of the program utilizes existing staff resources. The curriculum was developed by the program team and requires minimal resources to conduct (e.g., printing materials, training space).

Achievements: Wide-scale implementation was achieved in the OH ARNG as a result of a state policy requiring all FLLs to complete the training. In FY2023, the ID ARNG adopted the training. Ohio and Idaho program teams are collaborating to offer quarterly T4T events throughout FY2024 to facilitate expansion to additional interested states.

[27] McNemar's tests used when outcome data was dichotomous.

Challenges: Even when implemented across Ohio, 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 which will facilitate follow-up data collection to measure whether participants retain and apply the counseling skills.

Recommendations: CARE has demonstrated effectiveness in improving short-term outcomes among unit leaders. To assess the long-term outcomes of the program, and particularly distal effects on subordinates and units (e.g., rates of harmful behavior and/or service utilization), consider implementing a more advanced evaluation design incorporating trends analysis of administrative data and command climate assessments over time. Also consider establishing comparison groups (i.e., units whose leaders did not receive the training), which would substantially improve the strength of any findings that historical trends changed as a result of the program.

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Purple Resolve

Status: Operating

Location: Nevada (NV) ARNG/ANG

Years of NGB support: FY2021–present

Demonstrated success: Moderate (achieved proof of concept; demonstrated feasibility and partial outcome effectiveness)

Description: Purple Resolve is an annual organizational-level training that aims to drive culture change by enhancing connectedness and collective resiliency. The sixteen-hour training is delivered by Guardsmen from diverse military backgrounds certified through a three-day train-the-trainer course.

Justification: Unit climate can be an important protective factor against harmful behaviors. Oftentimes, interventions aim to address individual knowledge, attitudes, and behaviors. Purple Resolve works at the unit level to address collective attitudes and beliefs and promote wider culture change in support of SM well-being.

Evaluation plan: The evaluation plan employed a single group pre-post design with a follow-up survey. Surveys were administered to training participants immediately before and after a selection of trainings, using an online platform. Metrics measured on the pre-post surveys included: connectedness, help-seeking intentions, perceived unit cohesion, general self-efficacy, and life purpose.

Evidence of effectiveness: *Demonstrated evidence of process effectiveness; Insufficient data to demonstrate outcome effectiveness.*

Purple Resolve demonstrated initial process effectiveness, with high participant satisfaction, strong support from state leadership to offer the training, and widespread SM interest in attending the training. The program team did not provide data on the quality of training delivery.

Assessment of outcome effectiveness was limited to a selection of training sessions. For these, the program team conducted paired-sample *t*-tests and found significant improvement on all key program metrics. The following results are summarized from Purple Resolve's final report, authored by the program team:

- Increase in **perceived unit cohesion**, from an average score of 21.35 pre-training to 22.06 post-training ($p < 0.01$, $d = 0.25$). Note, however, that perceptions were measured immediately before and after the two-day training and so do not reflect changes in actual unit cohesion.
- Increase in **participant connectedness**, from an average of 21.44 pre-training to 21.94 post-training; however, the effect size of this change was negligible ($p < 0.05$, $d = 0.12$)
- Increase in **participant intentions to seek help** for a stressful situation, from an average of 16.37 pre-training to 17.00 post-training ($p < 0.01$, $d = 0.22$). Note that more information is needed to understand the scoring and interpretation of the four items included in this measure (likelihood to respond to stressful situation in each of the following ways: Ignore the situation; Ask someone in the NG to help you try and fix it; Seek out services provided by the NG; Ask someone outside the NG to help you try and fix it; Deal with the situation on your own or try to fix it)
- Increase in **life purpose**, from an average of 20.86 pre-training to 22.20 post-training ($p < 0.01$, $d = 0.40$)
- Increase in **general self-efficacy**, from an average of 21.19 pre-training to 21.79 post-training; however, the effect size for this change was negligible ($p < 0.01$, $d = 0.19$)

Full results of Purple Resolve's evaluation are detailed in a final report authored by the program team.

Feasibility: The training is conducted in-person over two-days (sixteen hours), and may thus require scheduling outside of drill weekend. While NG service members can be certified as instructors, the program notes that leading the course requires advanced facilitation skills, given the format and nature of the training content. Certification requires attendance

at a separate three-day course. Finally, the training curriculum is owned by a private company, Blue Courage LLC, and may entail purchasing costs.

Achievements: Information unavailable.

Challenges: Purple Resolve's curriculum was adapted from an existing training developed for policy officers by an external contractor. Program design focused on adapting this curriculum to the NG and planning large scale implementation, without equal attention to evaluation. This posed challenges for the evaluation design, which took place after implementation had already started. Key learning objectives were unclear, which made it difficult to design a survey closely aligned to the training content. Many SMs received the training before evaluation surveys were in place, which means that evaluation data provide only a partial picture of results. Further, large-scale implementation plans precluded use of early evaluation data to refine both the curriculum and the evaluation surveys.

Recommendations: Key learning objectives should be defined for each component of the Purple Resolve curriculum. Evaluation tools can then be adjusted or developed as needed to ensure alignment with the curriculum. Because the training is delivered by SMs certified through a T4T process, assessing fidelity to the curriculum and any differences across trainers is highly important. To do so, the program should consider using a fidelity checklist, with which trainers track the extent to which they covered each component of the curriculum, and pre-post survey data analyses. Finally, command climate assessments can be used to assess the effects of the training on its longer-term goals of improving unit climate and culture.

Ready and Resilient Warrior Workshop

Status: Concluded

Location: Hawaii (HI) ARNG

Years of NGB support: FY2021

Demonstrated success: Limited (did not achieve proof of concept)

Description: Ready and Resilient Warrior Workshop was a seven-session course that intended to boost self-esteem, develop a sense of purpose and belonging, and build resiliency among SMs. The sessions were adapted from the Achieving Success Everyday group counseling model, originally developed for high school students, to fit the NG context. Topics addressed included engagement, communication, lifestyle choices, relationships, finances, and coping. The program targeted high-risk Soldiers and Airmen and post-deployment units.

Justification: NG lacks sufficient post-deployment counseling and support for SMs. The workshop spanned numerous topics to build coping skills and prevent issues from developing after exposure to stress and trauma.

Evaluation plan: Participants completed a pre- and post-survey on the first and last day of the training, respectively. The surveys were available online through Google Forms. Evaluation metrics included: coping behavior, resilience, life purpose, exercise-related self-efficacy, health-related quality of life, identification with the NG, help-seeking self-efficacy, help-seeking intentions, and connectedness. Hawaii also collected qualitative data on training satisfaction.

Evidence of effectiveness: *Insufficient data to demonstrate process and outcome effectiveness.*

As of September 2022, forty-five participants completed the workshop. IDA performed paired *t*-tests, Wilcoxon tests, and McNemar's tests, as relevant, to assess significance of changes in outcomes after the training, compared to before training. IDA also calculated Cohen's *d* to examine effect sizes (i.e., the magnitude of the change from pre- to post-training). Although participants reported moderate to large changes across most metrics, none of these findings were statistically significant:

- Actively **seeking to improve** stressful situations ($d = 0.53$)
- Their **likelihood of asking for help** from NG members when they encounter stressful situations ($d = 0.67$)
- **Believing** their life has a purpose ($d = 0.51$)
- Their **confidence in exercising** even when they are experiencing problems ($d = 0.50$)

Qualitative data demonstrated that participants also indicated high satisfaction with the training.

Feasibility: Ready and Resilient consisted of seven sessions held across seven days. NG staff developed and conducted the workshop. The workshop was primarily held virtually due to COVID-19 measures in Hawaii at the time of the workshop but was intended for in-person delivery. Participation was voluntary and the program took place outside of drill weekends.

Challenges: Hawaii experienced challenges related to staffing and resource constraints. The program manager was unable to dedicate sufficient time to fully develop the curriculum and effectively implement the course. Since the curriculum was not fully developed, HI NG struggled to develop a robust evaluation to assess the workshop's key outcomes of interest. Ready and Resilient also experienced recruitment challenges. Awareness of and participation in the program was low, at least partially due to the sessions being held virtually.

Lessons learned: Providing appropriate staffing to states to be successful is important to running a proper program and evaluation. Programs that rely on internally developed or internally adapted curricula may need additional time and access to subject matter experts to ensure they ultimately use a research-informed curriculum appropriate to their target population.

MyPrime

Status: Operating at the national level

Location: Original state-level evaluation conducted in North Dakota (ND) ARNG

Years of NGB support: FY2021-present

Demonstrated success: High (achieved proof of concept; demonstrated strong feasibility and consistent outcome effectiveness)

Description: MyPrime is an online, self-paced version of Prevention Research Institute's in-person PFL curriculum, which has a strong evidence-base.[28] The program delivers a motivational intervention and self-assessment designed to help participants change their drinking and substance use behaviors. It contains three modules: exploring perceptions of personal risk, reflecting on individual addiction status, and protecting against addiction through personal change.

For more information about MyPrime, visit https://www.primeforlife.org/programs/myprime.

Justification: Prior to MyPrime, NG lacked an evidence-based behavior-change intervention for addressing risky substance use before it progresses to an SUD. While PFL was in use in the U.S. Army, the in-person format of this curriculum posed a barrier to access among dispersed or overseas populations; to fill this gap, the U.S. Army collaborated with the Prevention Research Institute to develop MyPrime. MyPrime makes an evidence-based curriculum easily accessible to NG members in rural states or who live far from their base.

Evaluation plan: The evaluation plan followed a single-group pre-post study design. Survey metrics include: knowledge, beliefs about alcohol and substance use, perceived harm for others and themselves, risk perception, future intentions of alcohol and substance use, readiness for change, and satisfaction.

Evidence of effectiveness: *Demonstrated evidence of process and outcome effectiveness.*

As of October 2023, the program collected pre- and post-training survey data from sixty-six MyPrime participants in the ND ARNG. Participants expressed high satisfaction with the program.

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 showed statistically significant improvements in:

- **Perceived harm** for others and themselves when engaging in occasional or regular substance use behaviors ($p < 0.05$ for 12 out of 14 survey items, $d = 0.20$–0.40).
- **Risk perception** about alcohol tolerance and an individual's ability to make sound decisions after consuming alcohol ($p = 0.01$, $d = 0.36$).
- **Alcohol use intentions** specifically, the number of drinks they intend to consume when drinking, in the next 90 days ($p = 0.008$, $d = 0.18$).
- **Knowledge** of the number of drinks that may constitute impaired driving ($p = 0.02$, $d = 0.19$) and the number of ounces of table wine and 80-proof liquor in a standard drink ($p = 0.002$, and $p < 0.001$, respectively).

Participants' self-reported **readiness to change their substance use behaviors** for alcohol, marijuana, and other drugs also improved after completing the training. Although these results were not statistically significant, they had small to medium effect sizes. From pre- to post-training, participants demonstrated increased readiness

[28] David B. Rosengren, Michele A. Crisafulli, Mark Nason, and Blair Beadnell, *A Review of the Empirical Support for PRIME For Life* (Technical Report 4.1). Lexington, KY: Prevention Research Institute, Inc. 2013. https://primeforlife.org/sites/default/files/2020-09/Empirical%20Support%20for%20PFL%20Report%204.1%20FINAL02.07.13.pdf.

to change behaviors related to:

- Alcohol-use (*d* = 0.29)
- Marijuana-use (*d* = 0.48)
- Use of drugs other than marijuana (*d* = 0.64).

Feasibility: SMs are referred to the program for substance use concerns and must be provided an access code. The training is entirely virtual and self-paced; SMs can access MyPrime at a time convenient to them and from any location. The training does entail licensing costs; interested states can contact NGB's Risk Reduction Program to learn more about the process to purchase licenses.

Achievements: MyPrime has been established as a program of record within the Drug Reduction Program at the NGB-level.

Challenges: Initial evaluation results did not show significant improvement in readiness to change, a key objective of the program, despite observing this finding among other populations who completed PFL. In the ND ARNG, the program team suggested that this difference may have resulted from the process of referring SMs to the training. SMs received a reprimand and initial counseling *before* taking the training and were required to do so to fulfill ARNG requirements; this may have influenced their self-reported readiness to change on the pre-survey.

Recommendations: Future evaluation efforts should use administrative data to determine whether MyPrime participants show reduced rates of substance use recidivism compared to SMs enrolled in the ASAP program prior to the introduction of MyPrime. This will help the NG understand whether MyPrime results in behavior change.

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Risk Reduction Psychoeducation Group

Status: Operating

Location: Connecticut (CT) ARNG

Years of NGB support: FY2020–FY2023

Demonstrated success: Limited (achieved proof of concept; demonstrated feasibility and partial outcome effectiveness)

Description: The Risk Reduction Psychoeducation Group is a two-day (sixteen-hour) session that aims to reduce risky alcohol use and improve coping skills among at-risk SMs. It targets SMs who are referred to ASAP and/or who self-refer. The Connecticut ARNG BH and Resilience, Risk Reduction and Suicide Prevention (R3SP) teams developed the curriculum based on feedback from prior ASAP participants and NG leadership, with the aim of creating a course better tailored to their needs. The course includes education, discussion, and skill-building in areas related to substance abuse, coping skills, finances, employment, education, and insurance. Presentations by various NG and community resources provide participants an opportunity to learn more about available services or schedule appointments for follow-up.

Justification: NG service members enrolled in the ASAP program may lack access to the resources and services they need to address the upstream stressors that contribute to high-risk alcohol use. By developing a course that incorporates these resources directly into the classroom components, the program may reduce logistic and personal barriers to resource utilization and thus lead to longer-term behavior change. Further, the NG lacks a preventive training for SMs with substance use concerns who are not yet enrolled in the ASAP program. By offering this course to self-referrals, the program may prevent negative BH incidents.

Evaluation plan: The program uses a single-group pre-post evaluation design, with short surveys administered to participants immediately before and after the course through Survey Monkey. The survey includes measures of: help-seeking intentions, stigma related to help-seeking, self-efficacy to seek social support, awareness of NG resources and services, reasons for drinking, alcohol-related attitudes, knowledge of alcohol-related behavior changes, connectedness, unit belonging, and retention intentions.

Evidence of effectiveness: *Demonstrated evidence of process effectiveness; Insufficient data to demonstrate outcome effectiveness.*

The program held four courses in 2022, with thirty-seven participants in total, which met the program's target of one course per quarter. The program did not provide data on the quality of curriculum delivery. However, participants indicated high satisfaction. They commonly said they like the engagement and open, informal group interaction and dialogue during the course. Suggestions for improvement were more engagement, shorter classes, and more breaks.

Early trends indicate improved attitudes about drinking and willingness to seek help, but many outcomes did not reach statistical significance or did not result in the intended effects. For example, data collected from 28 participants across four sessions showed significant improvements in participants':

- Alcohol- and behavior-change related **knowledge**, including the ounces of beer in a standard drink ($p < 0.02$) and the definition of "SMART Goals" ($p < 0.05$); however, knowledge measured on six other items did not show improvement.
- Self-reported **awareness** of eight (out of nine total) NG resources/programs ($p < 0.03$ on all items)
- **Belief** that there is someone they can turn to in a time of need ($p < 0.01$, $d = 0.74$)

There were no significant changes in other measured outcomes:

- Self-reported **intentions** to seek help from 1) someone in the NG or 2) someone outside the NG when in a

stressful situation

- **Self-efficacy** to seek social support
- **Readiness to change** substance use behavior

Two important limitations may have influenced these outcomes. First, the program had low overall participant numbers and thus may not have had the sample size necessary to detect significance on some measures. Second, the program curriculum and participant characteristics may have changed from session to session; outcomes appear to contradict each other when comparing separate sessions.

Data are not available on longer-term outcomes, such as resource utilization or recidivism.

Feasibility: While the program team intended the Psychoeducation Group to target ASAP- and command-initiated referrals as well as self-referrals, the program was mainly comprised of ASAP referrals; of 37 participants in 2022, 23 were referred by ASAP and 6 self-referred (another 8 attended on behalf of their units to learn about resources). Since the group is voluntary, this information indicates that continued coordination with the ASAP program and unit leadership is necessary to the feasibility of this program. Involvement of multiple stakeholders (BH Team, R3SP, NG leadership) from program outset may have contributed to the feasibility demonstrated.

The course utilizes an internally developed curriculum and incorporates presentations by NG and community resources; as such, it involves no costs related to licensing and only a small amount of funding to cover the purchase of group facilitation materials. The course does require the investment of personnel time, to include the group facilitator, presenters, and participants; however, given that the course is held on a quarterly basis, this does not impose an ongoing burden on program administrators.

Achievements: The Risk Reduction Psychoeducation Group has become an established program within the Connecticut ARNG, with groups offered nearly every quarter since the start of the program. It continues with state funding.

Challenges: While the program team developed a new curriculum to support relevance of its content to the NG and long-term sustainability, doing so necessitated adjusting the curriculum from session to session during the "pilot" phase of the project. These changes make it difficult to interpret results of the evaluation, as variations in the program's content or delivery may result in different outcomes. Similarly, variations in the motivations for participants to attend the group (i.e., ASAP referrals, self-referrals, attendance on behalf of one's unit) suggest that participants may have had different risk factors prior to their attendance, again likely influencing observed outcomes. Ideally, an evaluation would examine outcomes for each type of participants separately; however, this was not possible because the evaluation surveys were anonymous and did not collect information on reasons for attendance.

Recommendations: Multiple efforts are needed to strengthen the evaluation design of the Risk Reduction Psychoeducation Group. First, revisions to the pre- and post-surveys are necessary to ensure that the measures included in these tools align with the content of the psychoeducation curriculum and the objectives of the program. Second, the program team should avoid making substantial changes to the curriculum in the future, to facilitate comparability of outcomes across sessions. Third, the program team could consider narrowing the target population for each session and/or tracking reasons for participation on pre-post surveys (e.g., ASAP-referrals vs. self-referrals) so as to improve the interpretability of results.

Buddy Aid

Status: Operating at the national level

Location: Original state-level evaluation conducted in the South Dakota (SD) and Wyoming (WY) ARNGs

Years of NGB support: FY2019–present

Demonstrated success: High (achieved proof of concept; demonstrated strong feasibility and consistent outcome effectiveness)

Description: Buddy Aid is a sexual assault prevention and response training that aims to prepare all SMs to treat the threat of sexual assault as equally destructive as other common military threats. Specifically, it informs participants how to identify the signs that a buddy has been victimized by sexual assault or is in psychological distress, provides them a list of what to say and what not to say when a buddy discloses victimization, and emphasizes the importance of help-seeking (e.g., referral to a Victim Advocate (VA)). The 1.5-hour training is in-person, interactive, and delivered at the unit level. The program has developed a sustainable T3 process to prepare new Buddy Aid facilitators, who are typically Sexual Assault Response Coordinators (SARCs) or VAs. Buddy Aid "master trainers" travel to states to run the week-long T3s, which qualify for Continuing Education Units. After becoming certified, new trainers schedule the 1.5-hour Buddy Aid training with units throughout their state, as their state training schedules allow.

For more information about Buddy Aid, visit https://www.dvidshub.net/video/877645/ep-44-understanding-buddy-aid-with-maj-flannery.

Justification: Existing sexual assault prevention and response trainings are focused primarily on awareness and bystander intervention, and they do not include comprehensive training on first line response to sexual assault disclosures. Appropriate first line response can help increase use of support services and lessen secondary impacts of sexual assault on the workplace environment.

Evaluation plan: Participants completed pre- and post-tests immediately before and after each training to measure satisfaction, knowledge, attitudes, and likelihood to apply the training content. Short surveys were administered immediately before and after training, in-person, to all participants. Surveys are voluntary, short (five minutes to complete, with no extraneous questions), and completed on the participant's phone.

Evidence of effectiveness: *Demonstrated evidence of process and outcome effectiveness.*

Over 1,852 SMs had received Buddy Aid training as of 20 July 2022. 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 demonstrated improved preparedness in responding to sexual assault. IDA conducted paired *t*-tests, Wilcoxon tests,[29] and McNemar's tests[30] 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).[31] Significant improvements were seen on several metrics:

- **Beliefs and attitudes** towards sexual assault, specifically in their:
  - 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 ($p < 0.01$, $d = 0.45$)
  - Belief that members of unit would disclose sexual assault victimization to a buddy ($p < 0.01$, $d = 0.30$)
- **Self-efficacy** to support a peer that experienced sexual assault, specifically in their:

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

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

31 Effect sizes were not calculated when data was dichotomous.

- 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 ($p < 0.01$, $d = 0.50$)

Following expansion to new states, analyses showed that while 75% of sessions were facilitated by newly credentialed trainers, they continued to demonstrate outcome effectiveness, similar to the results summarized above. 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 T3 process are just as effective at delivering Buddy Aid training as the program manager/developer).

Feasibility: The Buddy Aid curriculum was developed by NG personnel and is available at no cost. It requires minimal resources (i.e., a classroom with an overhead projector) and 1.5 hour of time during drill weekend to deliver. T3 courses are time intensive, including one week of classroom time plus time to review read-aheads in advance. States must fund their own personnel's training attendance.

Achievements: Buddy Aid was established as a permanent offering at the NG PEC, making it available to a broad audience. Through its mobile training teams, Buddy Aid has certified over 60 SARCs and VAs to lead the training. A Teams page houses resources to support high-quality implementation across participating states.

Challenges: Given its decentralized implementation structure across participating NG states/territories, Buddy Aid has had difficulty tracking process metrics, such as number of sessions trained, participant numbers, which units the training has reached, and fidelity to curriculum.

Recommendations: To strengthen monitoring of program implementation and evaluation of process effectiveness at the state level, explore avenues to enforce reporting on process metrics, such as through a memorandum of agreement, leadership directives, or addition of an administrative support role at the national program management level. To strengthen evaluation of outcome effectiveness, the program team should also consider administering a follow-up survey to select units approximately three months after the training; this will provide information about retention and application of Buddy Aid skills over time.

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Mental Health First Aid (MHFA)

Status: Operating

Location: Rhode Island (RI) ARNG

Years of NGB support: FY2021–present

Demonstrated success: Moderate (achieved proof of concept; has not yet demonstrated feasibility)

Description: MHFA is a one-day gatekeeper training program, developed by the National Council for Mental Wellbeing, that aims to enhance prevention and intervention skills for a range of BH issues. It teaches participants to recognize the signs of distress and intervene by referring to support resources. The RI NG offers the course to NG members and their families as well as NG civilians and contractors. Since beginning implementation in 2021, the program team has offered different versions of the course tailored to specific audiences and (e.g., an adult module, a Veterans module). These versions have shown strong evidence of effectiveness in their intended populations.[32]

For more information about Mental Health First Aid, visit https://www.mentalhealthfirstaid.org/.

Justification: Gatekeeper trainings typically focus on suicide risk. However, MHFA's focus of peer intervention on upstream risk factors for suicide (e.g., substance misuse or psychological distress), may facilitate prevention at lower levels of risk. MHFA provides an evidence-based course, with evidence of outcome effectiveness published in academic journals, that can be adapted to the NG context.

Evaluation plan: The program team used a single-group pre-post evaluation design, with surveys administered immediately before and after the training. Survey metrics include: gatekeeper knowledge, self-efficacy, and behavior; and help-seeking intentions. The program team plans to administer a follow-up survey to enable measurement of longer-term outcomes, such as skill/knowledge retention and intervention behavior.

Evidence of effectiveness: *Demonstrated evidence of process and outcome effectiveness.*

As of November 2023, 110 individuals in the RI ANG have completed MHFA. Overall, participants have indicated high satisfaction. 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 four-point scale) in all measures related to gatekeeper self-efficacy and intentions. These include:

- **Belief** in their own ability to recognize signs of suicide ($p < 0.001$, d=0.82), mental health challenges ($p < 0.001$, $d = 0.77$), and substance use challenges ($p < 0.001$, $d = 0.77$)
- **Preparedness** to talk to someone showing signs of suicide risk and mental and substance use challenges ($p < 0.001$, $d = 0.27$–0.30)
- **Confidence** in their own ability to actively and compassionately listen to someone in distress ($p < 0.001$, $d = 0.27$) and how and where to get help ($p < 0.001$, d=0.77)

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

- Refrain from ignoring and avoiding the situation ($p < 0.001$, $d = 0.43$)
- Likelihood to contact NG resources for support ($p < 0.001$, $d = 0.49$)

[32] Betty A. Kitchener, and Anthony F. Jorm, "Mental Health First Aid Training for the Public: Evaluation of Effects on Knowledge, Attitudes and Helping Behavior," *BMC Psychiatry 2,* no. 1 (2002): 1–6, https://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-2-10.

Feasibility: Delivery of MHFA training requires certification and the purchase of training materials from the National Council for Mental Wellbeing. Certification requires participation in a three-day interactive training, attended either virtually or in-person, two hours of pre-course work, and one hour of post-course work. The cost of certification is approximately $2,000 per instructor.

While MHFA is an eight-hour course, it may be divided into smaller sections for delivery over multiple days. The Council offers the option to have their staff deliver the training, or to train NG staff to deliver the training. The course's content, modules, and format are adjustable. MHFA offers modules for specific target audiences and is self-paced, allowing participants to compete the course at their own speed. Each module's explanation of mental health's relevance, risk and protective factors, selected scenarios, and mental health resources are tailored to its intended population.

Achievements: As of early FY2024, Rhode Island is helping develop guidance for other states interested in adopting the MHFA training.

Challenges: Securing participants and training time have been the primary challenges in Rhode Island. Initially, the program planned to target M-Day NG members; however, due to a lack of 2060 funding to put personnel on orders and a lack of reserved training time during drill weekends, the program offered the training to full-time personnel instead. Some of these challenges were also tracked to have occurred as a result of communication issues, as program information was not being delivered to Soldiers. As leadership support for the program increased over time, the program team was ultimately able to train more audiences, to include M-Day NG members. Additionally, the program has brought on an additional staff member to address administrative concerns (e.g., attendance).

Recommendations: Future evaluation should assess retention of the training content and application of gatekeeper training skills through the administration of a follow-up survey. If the program team offers different versions of the MHFA curriculum, results of the evaluations should be compared to understand differences in effectiveness and acceptability to participants.

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Start

Status: Operating at the national level

Location: Original state-level evaluation conducted in the South Carolina (SC) ARNG

Years of NGB support: FY2019–present

Demonstrated success: High (achieved proof of concept; demonstrated strong feasibility and consistent outcome effectiveness)

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

For more information about Start, visit https://livingworks.net/training/livingworks-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.

Evaluation plan: The evaluation used a single-group pre-post design. LivingWorks built pre- and post-surveys directly into the training interface and required participants to complete them. The surveys use a modified version of the Gatekeeper Behavior Scale to measure confidence, attitudes, and likelihood to apply the training content, and included additional questions on participant knowledge and satisfaction.

Evidence of effectiveness: *Demonstrated 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 ($p < .001$; *M (pre)* = 3.33; *M (post)* = 3.66, $d = 0.55$)
- Help someone who may be considering suicide ($p < .001$; *M (pre)* = 3.43, *M (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.

Achievements: While the program originated in the SC ARNG, uptake among other NG states soon followed, driven by demand for online trainings during the COVID-19 pandemic. Since its early success, NGB selected Start to become a national program available across the 54 states and territories.

Challenges: LivingWorks attempted to collect follow-up data from participants to measure retention and application of the training content. However, these surveys did not receive a response rate sufficient to allow for statistical analyses.

Recommendations: Measure longer-term outcomes (i.e., retention and application of gatekeeper skills) through follow-up surveys to understand the effectiveness of Start and the potential need for repeated training over time (e.g., annually). Future efforts to administer follow-up surveys may have greater success by focusing on a narrower target audience, such as several specific units, and enlisting the support of unit leaders to encourage participation.

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Together Strong

Status: Concluded

Location: North Dakota (ND) ARNG

Years of NGB support: FY2022

Demonstrated success: High (achieved proof of concept; demonstrated strong feasibility and consistent outcome effectiveness)

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 ND ARNG. Members of the ND 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/.

As of August 2023, the Kognito brand has been sunset, and the Together Strong training is no longer offered.

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.

Evaluation plan: The evaluation used a pre-post design. Participants completed evaluation surveys immediately before and after the training, with questions measuring satisfaction, knowledge, confidence, attitudes, and likelihood to apply the training content. The surveys use a modified version of the Gatekeeper Behavior Scale. Participants are required to complete short surveys built into the online training immediately before and after the training. Extraneous questions are optional.

Evidence of effectiveness: *Demonstrated evidence of process and outcome effectiveness.*

In one year of implementation, 1,550 ND 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.[33]

[33] Daniel Coleman, Natasha Black, Jeffrey Ng, and Emily Blumenthal, "Kognito's Avatar-Based Suicide Prevention Training for College Students."

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 ND ARNG developed a policy requiring the training and provided time during drill weekends for SMs to complete it.

Achievements: The ND ARNG secured over 1,500 participants in less than one year of program implementation, demonstrating efficient processes for recruitment, distributing licenses, and overseeing completion of the training.

Challenges: Participants 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.

Lessons learned: Online programs can be delivered at a large scale in a short amount of time, given appropriate leadership and technical support. This may be appropriate for programs with an existing evidence base, but evaluation is still important to assess whether the same outcomes are observed in a new population. Embedding the evaluation surveys directly into the training ensures data collection among all participants, without imposing a substantial burden on the program team or participants.

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VReal

Status: Concluded

Location: Nebraska (NE) ANG

Years of NGB support: FY2022

Demonstrated success: High (achieved proof of concept; demonstrated strong feasibility and consistent outcome effectiveness)

Description: Forty-five-minute interactive suicide prevention gatekeeper training delivered through virtual reality headsets. The training allows SMs to practice taught skills in four life-like scenarios. These scenarios are tailored to the target population, to include first sergeants, front line supervisors, family members, as well as all Airmen. The training was developed by Moth + Flame, in collaboration with the Air Force, to meet Air Force suicide prevention training requirements.

For more information about VReal, visit https://www.mothandflamevr.com/learning-libraries/sp.

Justification: Suicide prevention gatekeeper trainings are typically offered to individuals online or in in-person group settings, with limited opportunities to actively practice skills in real-life. Providing training in virtual reality intends to improve participants' engagement, comfort with live role-playing, and ultimately their ability and confidence to intervene with at-risk service members.

Evaluation plan: The evaluation used a single group pre-post design. Participants completed hard-copy evaluation surveys immediately before and after the training. The surveys were brief, measuring gatekeeper self-efficacy in fewer than ten questions. In addition to the surveys, the virtual reality platform also tracked participants' responses in each training scenario to assess improvements over the course of the training, collected demographics, and asked about training satisfaction.

Evidence of effectiveness: *Demonstrated evidence of process and outcome effectiveness*.

As of July 2023, 331 Airmen 155th Air Refueling Wing completed the training. For the brief, paper surveys, IDA performed paired *t*-tests, Wilcoxon tests, and McNemar's tests, as relevant, to assess significance of changes in outcomes after the training, compared to before training. IDA also calculated Cohen's *d* to examine effect sizes (i.e., the magnitude of the change from pre- to post-training). Significant improvements were seen across gatekeeper self-efficacy, specifically in one's ability to:

- **Communicate** with an individual in distress ($p < 0.001$, $d = 0.92$)
- **Recognize signs** of suicide and depression ($p < 0.001$, $d = 0.95$)
- **Connect** an individual in distress to resources ($p < 0.001$, $d = 0.77$)
- **Be familiar** with relevant resources and suicide knowledge ($p < 0.001$, $d = 0.89$)

The evaluation administered by the contractor also produced positive findings. The summary statistics showed:

- 90% of the participants achieved the goal of getting the Airman to safety
- 62% increase in feeling very prepared to have a conversation with a distressed Airman
- High satisfaction, with 97% of participants reporting they would recommend the training to a peer, and 95% viewing it as more effective than previous trainings.

Feasibility: The in-person training is brief, requiring less than an hour to complete. This may be a reasonable time commitment during drill weekend, especially if this were to replace the existing suicide prevention training. The burden on coordinating staff, however, will be larger. NE ANG had the headsets for seven days, and thus, were training Airmen over all seven days. Although the contractor sends personnel to facilitate the training, there may be more scheduling challenges for NG staff. Additionally, the training is carried out by a contractor, so extra preparation and effort would be needed to complete the contracting process and receive approval.

Achievements: Information unavailable.

Challenges: The contractor's pricing changed from the time NE ANG submitted the proposal, to the time they were granted funds and awarded the contract. NE ANG was able to work with the contractor and NGB to fund the program. There was also personnel turnover during the planning phase of the program, which caused significant delays in the program implementation timeline.

Lessons learned: Further evaluation should utilize a comparative approach to assess effectiveness across similar gatekeeper trainings. Follow-up surveys to assess retention of the training content and longitudinal effects on gatekeeper behaviors, including identification and intervention among individuals in need and participants' own help-seeking behaviors, are also recommended. Lastly, based on the findings from the contractor's evaluation, future programs should focus more heavily on addressing a distressed Airman's safe storage of lethal means and awareness of relevant resources.

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Behavioral Health Primary Prevention and Retention (BHPPR)

Status: Operating

Location: New Mexico (NM) and South Dakota (SD) ARNG/ANG

Years of NGB support: FY2019–present

Demonstrated success: High (achieved proof of concept; demonstrated feasibility and outcome effectiveness)

Description: By screening new recruits during RSP for SDOH-related needs (housing, finances, food security, interpersonal violence), the program proactively identifies soldiers at risk for deployment- and retention-limiting conditions. BHPPR mitigates these risks by providing proactive case management, which consists of follow-up contact, 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 BH 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.

Evaluation plan: The evaluation used screening data collected during RSP and at six-month follow-up case management sessions, as well as routine administrative data collected during RSP/initial training and by service providers**.** The screening assessed SDOH-related needs, Adverse Childhood Experiences, mental health symptoms, and personality (Big-5 Personality Inventory). Responses to these measures were scored to create an overall measure of risk. The evaluation compared incidence of BH challenges in the cohort receiving proactive case management to historical averages.

Evidence of effectiveness: *Demonstrated evidence of process and outcome effectiveness*.

Since the inception of the program, NM and SD have screened over 800 service members in total. These screenings identified about 60% of service members as at-risk in NM and about 25% of service members as at-risk in SD. The analyses presented below are limited to NM as data collection and analysis has only recently resumed in SD.

In the first year of implementation in NM, evaluations 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 behavioral 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).

Analyses suggested that risk scores, assigned based on screening results, predicted some SMs' BH outcomes during RSP. This suggests that the screening may facilitate early intervention to prevent adverse outcomes.

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.

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 BHO to administer assessments during RSP and case managers to conduct

ongoing proactive case management. The burden on staff time led to issues with feasibility over time in both NM and SD. SD recently addressed these staffing challenges and is currently implementing the program in full.

States with insufficient staffing resources 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.

Achievements: 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.[34]

Challenges: In its first years of implementation, BHPPR encountered issues securing leadership support for the program; indeed, leaders considered discontinuing the program. The BHPPR program team leveraged early evaluation findings showing preliminary effectiveness of the program to advocate for its continuation. This strategy was successful, and afterwards, the program expanded to another state.

Recommendations: BHPPR's initial screening included various measures used to assess SMs' level of risk. Ultimately, findings from exploratory analyses of the predictive validity of the screening measures suggest that these measures could be narrowed down to those most predictive of risk; in particular, states could remove the BIG-5 Personality Inventory from the screening, though they may wish to keep it to inform their case management and psychoeducation approach. Further, states should consider administering a brief questionnaire during six-month follow-up questions to measure intermediate outcomes, to include incidence of BH symptoms in the past few months and use of resources/services. These measures can provide a fuller picture of the effects of the program, which had previously focused on long-term outcomes.

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[34] 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: IRC, 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.

SASSI-4

Status: Operating

Location: Oklahoma (OK) ARNG

Years of NGB support: state-funded program; implementation FY2019–present

Demonstrated success: Moderate (achieved proof of concept; demonstrated partial feasibility and partial outcome effectiveness)

Description: An online version of the SASSI-4 (developed by the SASSI Institute) identifies SMs who require treatment for SUDs in accordance with AR 600-85. SMs may be referred to the program by a Drug Testing Coordinator, unit leader, or as a self-referral. Once an SM completes the screening, the tool analyzes the responses to produce a score indicating high or low probability that the SM has an SUD, as well as levels of defensiveness and readiness to acknowledge SUD-related issues. The state's BHO or BH Specialist, who must become certified as a SASSI counselor, then reviews results over the phone with the SM and refers those with high probably of an SUD to required counseling services in accordance with Army policy. 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 screening process for SUDs. SMs who test positive on urinalyses or who have alcohol incidents are required to complete such screenings, but doing so in the community (i.e., outside the NG) can be costly and inconvenient (e.g., due to distance from a provider or availability only during normal business hours). SASSI-4 reduces barriers to care by keeping the assessment process internal to the NG and providing referrals to community-based treatment as needed. By facilitating access to care, the process may reduce suicide risk related to legal/administrative, financial, workplace, and relationship issues arising from substance misuse.

Evaluation plan: The program team used a single-group pre-post evaluation design that employed multiple types of data. Administrative records, maintained by the OK ARNG Risk Reduction Coordinator, track alcohol incidents, urinalyses results, and other sources of referral to the SASSI-4, as well as participants' completion of the screening, receipt of the screening results, and follow-up referral to services. The program team also planned to use these records to track recidivism. A pre-post survey was used to assess the acceptability of the screening process (to include completing the screening and reviewing results with the SASSI counselor) and its effects on participants' help-seeking intentions and readiness to change substance use behaviors. The counselor delivered this survey over the phone before giving the participant access to the SASSI-4 and again immediately after counseling the participant on the screening results.

Evidence of effectiveness: *Demonstrated moderate evidence of process effectiveness*; *Insufficient data to demonstrate outcome 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 ($p = 0.02$) following completion of the SASSI-4 and receipt of counseling on the results of the assessment. The program planned to examine effects of the program on substance misuse recidivism rates, but data on this key outcome was not provided.

Feasibility: Implementation of the program utilized state G-1 medical branch funding for purchase of a SASSI-4 package and existing staff. The RRC distributes SASSI-4 licenses directly to the SM following referral. 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. Staff must possess a clinical license or complete an online, seven-hour training (offered live or on-demand through the SASSI Institute for $120) to administer the SASSI-4 and subsequent counseling. [35]

Achievements: Operating with internal state NG funding.

Challenges: In the OK ARNG, the program 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.

Recommendations: Evaluate the program's effects on resource engagement (e.g., preventative trainings) and substance misuse recidivism over time. Ultimately, the OK ARNG intended for SASSI-4 to streamline the process of referring SMs with substance use concerns to appropriate resources and to reduce recidivism. Analyses of administrative data may be a feasible approach to measuring these outcomes. The ARNG maintains records of whether SMs have accessed required services (i.e., to fulfill ASAP requirements) but may have limited information on voluntary use of other resources. Offering SASSI-4's screening and referral approach in combination with other internally-offered programs (e.g., ND's online MyPrime training) may enable ARNG states to track use of voluntary resources. With these data, the program would be better-placed to assess the effects of screening and referral on substance use recidivism over time

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[35] "SASSI Training: United States," SASSI-Institute, Accessed on May 21, 2024, https://sassi.com/sassi-training-us/.

Military Support Embedded Clinician Program

Status: Operating

Location: Connecticut (CT) ARNG/ANG

Years of NGB support: FY2019–FY2020

Demonstrated success: Limited (achieved proof of concept; demonstrated limited feasibility)

Description: Since approximately 2012, the CT NG has partnered with the Connecticut Department of Mental Health and Addiction Services (DMHAS) to embed licensed mental health providers, contracted through a private company, in NG units during drill weekends. These providers deliver confidential initial support services and referrals to resources, in coordination with the full-time NG BH team. With WRF support beginning in FY19, the CT NG developed a manual and delivered three trainings intended to improve military cultural competency among these providers. The program also conducted outreach to unit leaders to increase awareness and utilization of the embedded clinicians among drilling SMs.

For more information about the Military Support Embedded Clinician Program, visit https://portal.ct.gov/dmhas/programs-and-services/veterans-services/military-support-program.

Justification: Community providers can expand access to mental health and BH services among NG members by delivering services "on-the-spot" (i.e., at the same time and location as required monthly drills) as well as by providing warm hand-offs to other internal NG resources. However, these providers often lack awareness of military protocols and NG-specific resources. Information delivered via training and print materials may improve the acceptability and effectiveness of these providers' services. A partnership with the state of Connecticut promotes sustainability of the program.

Evaluation plan: The CT NG was primarily interested in assessing and improving *process effectiveness* of the program. The evaluation consisted of collecting 1) quarterly reports on service delivery and referral counts from the contracted embedded clinician company, 2) surveys measuring embedded clinicians' satisfaction with NG-developed trainings, and 3) surveys measuring unit leaders' and SMs' awareness of and satisfaction with embedded clinician services. The program team collected cross-sectional survey data (i.e., only once during receipt of IDA technical assistance); however, these surveys could be readministered in the future to measure changes over time.

Evidence of effectiveness: *Insufficient data to demonstrate process and outcome effectiveness.*

Findings related to process effectiveness are available as of August 2020, reflecting approximately one year of Connecticut's management of the Embedded Clinician Program.

- The partner began delivering service delivery reports partway through FY2020. The August 2020 report indicates that embedded clinicians provided 161 **individual consultations** with service members and facilitated 67 **service referrals** during the preceding quarter. During this time, approximately twenty to thirty providers were active in the program.
- The program provided three trainings to the embedded clinicians and received positive feedback. Specific results from the satisfaction surveys were not provided.
- Survey data collected from unit leaders and service members indicated low **awareness** and **utilization** of embedded providers. E.g., of 274 responding service members, 61% knew of the Embedded Clinician Program and only 3% had used these services in the past 12 months. Based on these results, the program team conducted briefings and other outreach efforts to increase awareness; additional data collection is needed to assess effectiveness of these efforts.

Feasibility: The duration of the Embedded Clinician Program—extending over nearly a decade—demonstrates the program's sustainability within the state of Connecticut. Lessons-learned from Connecticut's partnership with

DMHAS and the community service provider can inform feasibility considerations in states with similar partnerships. The program team credits the feasibility of the program to the investments of the DMHAS and private agency, which contribute financial and human resources. However, the program team noted significant management issues with regard to the community provider, specifically related to reporting on service provision; increased NG involvement in oversight activities helped to resolve these issues.

Findings of low awareness and utilization of the services additionally indicate that the program is unlikely to be successful without NG investment in outreach and marketing. Support from unit leaders and the program team's efforts to leverage established events (e.g., Periodic Health Assessments) to provide information and collect data showed promise for improving reach of the program and should be incorporated into program plans.

Achievements: The program team developed an Embedded Clinician Manual and delivered three trainings to improve clinicians' knowledge of military culture and NG resources. It has operated with support from DMHAS since 2012.

Challenges: The Connecticut program team experienced challenges related to management of the Embedded Clinician Program. Because the DMHAS, rather than the NG, manages the contract, the CT NG team perceived a lack of accountability on the part of the community partner, specifically related to reporting on service provision. They believe these issues necessitated increased oversight, but had limited control over this given that the contract was owned by DMHAS. They experienced difficulty acquiring accurate, timely data on the community partner's service provision activities. The team requested annual reports from the partner and, informed by IDA's review of the reports, identified data quality issues that impeded accountability and improvement of the program with regard to its reach. The team documented these issues and presented them to the DMHAS and community partner to establish requirements for improved reporting. In these conversations, it was noted that the providers' concern for SM confidentiality and lack of knowledge of the roles of NG personnel (unit commanders, the BH Team, and SMs) contributed to management and reporting issues. Trainings and monthly meetings were established to help address these issues.

Recommendations: Collect longer-term data to assess the effectiveness of changes in program management over time, to include changes in reach and awareness. Given that other similar programs operate in the CT NG (i.e., Star Behavioral Health Providers, Mobile Vet Centers), the state should also consider comparing the costs and benefits of each of these service provision models, including their resource requirements, reach, and acceptability to SMs.

Crisis Response Plan (CRP)

Status: Concluded

Location: Texas (TX) ARNG

Years of NGB support: FY2021–FY2022

Demonstrated success: High (achieved proof of concept; demonstrated feasibility and outcome effectiveness)

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

To learn more about the CRP training, visit https://strongstartraining.org/upcoming-events/crp-workshop/.

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

Evaluation plan: The program used a single group pre-post evaluation design. The program vendor administered surveys, via SurveyMonkey, to participants immediately before and after the training. A follow-up survey was administered again after four months. These surveys measured participant satisfaction with the training as well as key outcomes, including knowledge of CRP concepts, confidence engaging with at-risk SMs, and confidence in the participant's ability to conduct a suicide risk assessment. The follow-up survey additionally measured use of CRP and/or lethal means counseling among SMs showing signs of suicide risk, as well as barriers to these activities.

Evidence of effectiveness: *Demonstrated evidence of process and outcome effectiveness.*

CRP training was delivered to 37 service providers, including Chaplains and BHOs, in the TX ARNG and ANG. Participants indicated high satisfaction with the training program. The program shows evidence of effectiveness for improving knowledge of CRP for suicide prevention and confidence in counseling practices. IDA used McNemar's tests to assess changes in knowledge of CRP 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. However, **actual use** of CRP was low. Participants reports:

- 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 SMs at four-month follow-up.

Feasibility: The program was implemented virtually through a contract with the 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.

Achievements: The program team successfully executed a contract for the training and conducted it for the target audience within one fiscal year. The training improved knowledge and confidence among a diverse group of professionals, including clinical and non-clinical personnel (i.e., BHOs, BH Specialists, Chaplains, and Texas Military Department Counselors).

Challenges: 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.

Lessons learned: While follow-up surveys did not show a significant decline in participants' ability to work with SMs at risk for suicide or to conduct a suicide risk assessment, these results were self-reported. Include knowledge items on these surveys and/or conduct a follow-up skills assessment to assess retention of the training over time. Given that the majority of participants had not used CRP at the four-month follow-up, such an assessment could inform whether a refresher training or additional consultation session is necessary to promote skill retention; follow-up surveys can be administered just before the refreshers. Additionally, future efforts to train providers in CRP should assess whether there is a concurrent need to conduct targeted marketing and outreach to increase SMs' help-seeking behaviors.

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SafeUTNG Crisis Intervention App

Status: Operating

Location: Utah (UT) ANG/ARNG

Years of NGB support: state-funded program; implemented FY2019–present

Demonstrated success: Moderate (achieved proof of concept; demonstrated feasibility but has not yet demonstrated outcome effectiveness)

Description: SafeUTNG is a mobile app that connects 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. While similar services are available through other means, e.g., the Veterans Crisis Line, SafeUTNG is unique in its close coordination with the NG and other state resources.

Evaluation plan: SafeUTNG's evaluation used back-end data from the mobile application to measure engagement with the app over time, to include the number of app downloads and the number and duration of crisis chats. Additionally, the UT NG conducted a cross-sectional survey to measure awareness of, intention to use, and satisfaction with the app in 2021.

Evidence of effectiveness: *Demonstrated moderate evidence of process effectiveness*; *insufficient data to demonstrate outcome 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. In 2021, survey results showed low awareness and intention to use the app among males, enlisted SMs, and those with lower levels of social support. These findings 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.

Achievements: Developed plan for expansion to other states in Utah's region.

Challenges: The SafeUTNG app originally included a crisis alert function, in which a user could notify the NG of an SM who may be experiencing a mental health or other personal crisis. While this was intended to facilitate crisis intervention, the program team determined that it may make SMs mistrustful of the app and reluctant to use it for their own crises. As such, SafeUTNG removed this functionality.

Recommendations: Re-administer the survey the state used in 2021 to measure the effectiveness of marketing outreach efforts, which appear to be important to encouraging the use of the SafeUTNG app. By comparing SMs' perceptions and reported use of the app before and after these marketing efforts and comparing across different

types of users (e.g., by gender, rank) program managers can continue to calibrate their outreach. Rather than fielding a stand-alone survey, states may find it more feasible to incorporate items about the app into existing surveys, such as their Command Climate Assessments.

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CALM & Collect

Status: Operating

Location: Guam (GU) ANG/ARNG

Years of NGB support: FY2022–present

Demonstrated success: Limited (achieved proof of concept; has not yet demonstrated effectiveness and feasibility)

Description: Reduces access to lethal means among high-risk soldiers through teaching SIOs to counsel on storage of lethal means and offering SMs a place to temporarily deposit firearms. The program uses an online training, Counseling on Access to Lethal Means (CALM), to train SIOs, as a group, at Guam's Annual Suicide Prevention Summit, an event that all SIOs in Guam attend. CALM is an evidence-based, two-hour course that teaches providers to identify and counsel SMs at a heightened risk of suicide. To supplement the counselling that occurs after the summit, the program also establishes an on-base depository for SMs' personal firearms. SMs that receive counselling, as well as those without counselling, are encouraged to store their firearms in the depository until their risk of suicide decreases.

For more information about CALM, visit https://www.calmamerica.org/.

Justification: Lethal means management interventions often teach why safe storage is important and how to safely store lethal means. While many of these interventions in the military provide gun or cable locks at no cost to the SMs, these interventions place the responsibility on the individual to employ and/or purchase safe storage options on their own. Under these approaches, the firearms still remain accessible within the SM's household. GUNG lacks a program or resource that allows SMs to remove lethal means from their household and training for providers on lethal means counseling. More commonly SMs are trained instead of health providers to identify suicidal ideation in their peers, recognize signs of ideation in themselves, and be aware of helpful resources available to SMs.

Evaluation plan: Participating SIOs complete a pre- and post-survey immediately before and after the CALM training, respectively. Sixty days after the training, participants complete a follow-up survey. The surveys measure awareness of lethal means safe storage, attitudes about suicide, readiness to help individuals at risk, beliefs and attitudes of firearms and lethal means safety, counseling intentions, knowledge, and satisfaction. The surveys are brief, requiring no more than 10 minutes to complete, and are available online through Google Forms.

Using administrative data, Gu NG tracks SMs' utilization of the Safe Storage locations, with and without referrals from CALM-trained SIOs, and lethal means counselling.

Evidence of effectiveness: *Insufficient data to demonstrate process and outcome effectiveness.*

Approximately 30 participants have received CALM, with 15 completing the pre/post surveys, as of September 2023. Although, the preliminary data has not yet been analyzed due to the small sample, participants reported high satisfaction the training. As of the time of this report, GU NG has not provided data from their follow-up survey.

Feasibility: Although CALM is an online course, participants complete the course in-person in a group setting at the Annual Suicide Prevention Summit, when the majority of GU NG mental health providers and SIOs are present and in the same place. The CALM course takes approximately two hours to complete and is freely available online. The online format also allows for flexibility in delivery format, offering states the option for their providers to take the course virtually outside of the summit.

The contracting of Safe Storage Locations requires coordination and planning, as states may require policies and MOUs to procced with their purchase and installation.

Achievements: Guam succeeded in purchasing and installing the Safe Storage Locations. To do so, they coordinated with the active-duty side of the NG, wrote a GUNG Installation Firearms Policy that was approved by their TAG, and developed an SOP. Prior to the first offering of CALM, Guam expanded the program to include ANG. Lastly, Guam developed and implemented a needs assessment to better understand their soldiers' educational needs related to lethal means safety and suicide. As of October 2023, there were 504 responses.

Challenges: The majority of the challenges experienced by the GU NG team were delays and disruptions outside of their control. For example, the typhoon in May 2023 disrupted ongoing efforts to secure safes and the CALM kick-off was partially delayed because of the time it took for the SOP to be approved and conflicting events. The CALM kick-off was further delayed by a lack of a firearms policy. To address the latter, the program team placed three individuals on orders to support research and writing for the required policy. The team is also experiencing limited responses to pre- and post-surveys at kick-off of the training. They are currently assessing other methods to improve response rates. One last challenge GU NG encountered was early program expansion. Developed as a program for the ARNG, leadership requested the program be expanded to the ANG, before the program began implementation and after the team updates the GUNG Protection Branch's Installation Firearms Policy to include the program. Although there are not current negative consequences from this, program expansion during the early phases of a program, especially to a state or service it was not designed for, can lead to unforeseen challenges if deliberate steps are not taken to account for additional resource requirements and the particular needs of the new context.

Recommendations: In current and future evaluations, Guam should collect sufficient information on participants' and storage locations' service to compare differences in process and outcome measures across ARNG and ANG.

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EADS Suicide Awareness and Firearm Education (SAFE)

Status: Operating

Location: New York (NY) ANG

Years of NGB support: FY2022–present

Demonstrated success: Limited (achieved proof of concept; has not yet demonstrated effectiveness and feasibility)

Description: In-person, one-day course that integrates suicide awareness content into existing Hunter Safety curriculum to teach Airmen and their families suicide awareness and firearm risk prevention. The course, taught by a local, veteran hunter safety or pistol permit instructor, is supplemented by community outreach events to reach firearm owners and non-owners, including children and family members, to create a culture supportive of firearm safety and mental health awareness.

Justification: NG lacks a lethal means safety and suicide awareness course that targets the specific needs of rural populations with high firearm ownership and low use of safe firearm storage practices. Additionally, the NG is also missing a program that engages with military families and communities to change culture, identify signs of crises, and prevent suicide by firearm.

Evaluation plan: Participants complete pre- and post-course surveys in the classroom immediately before and after the course. They receive the follow-up survey via email sixty days after the course. All surveys are created and delivered through SurveyMonkey. Evaluation metrics include: help-seeking intentions, use of safe storage practices, willingness to use safe storage practices, reasons behind use of safe storage practices, knowledge, and satisfaction.

Evidence of effectiveness: *Insufficient evidence to demonstrate process and outcome effectiveness.*

As of August 2023, three courses have taken place with twenty-three participants. The courses received positive feedback from participants. The sample size is too small to indicate outcome effectiveness. Preliminary data taken across the first year of the program show favorable trends but did not yet reach statistical significance. Improvements were seen in:

- **Familiarity** with specific storage options
- **Willingness to use** safe storage options during periods of personal stress
- **Willingness to discuss** firearm safety with a friend showing signs of suicidal crisis
- **Actual consideration** of risk factors when storing firearms

Feasibility: The course is delivered in-person over four hours by a contracted local hunter safety instructor. To identify an instructor, New York picked an individual from the local community from whom the SMs would be receptive to learning about such sensitive topics as personal firearm safety and suicidal awareness. To incentivize participation, EADS SAFE was designed to supplement other classes that are required for a pistol permit. In development, New York ensured that the course met the state's classroom requirements to receive a pistol permit. Although NY utilized resources and time to add content on suicide awareness to the existing gun safety curriculum, this will be finalized into a module that can be shared to interested states.

Achievements: Presented at WRF Working Group 2023 on their program and their lessons learned.

Challenges: New York experienced challenges working with their initial instructor. After meeting with the instructor and the contract office to address these issues, New York requested that the instructor complete System for Award Management[36] criteria, which enables vendors to receive federal contracting funds. Another

[36] U.S. Federal Contractor Registration, "System for Award Management (SAM)," https://usfcr.com/registrations/about-sam/#about.

challenge New York encountered was state government changes in requirements for pistol permit courses during the course of implementation. These changes did not affect the curriculum; they may, however, negatively impact recruitment. Although the course initially received high interest and recruitment, only half of the anticipated participants attended the first course. New York addressed this by allowing more individuals to sign up for the course, anticipating drop off.

Due to miscommunication and time restraints, the post-survey for the first survey was sent to participants two weeks after the course, as opposed to immediately after the course, as is recommended. New York used this delay as a learning opportunity to improve their processes and planning going forward. To ensure higher response to the post-survey, New York began administering the surveys in the classroom and checked for completion before dismissal. Lastly, to further reduce the survey burden on participants, the program team modified their survey in December of 2023 to reduce the content and make the surveys completable in ten minutes or less.

Recommendations: None at this time.

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Firearm Risk Mitigation

Status: Operating

State(s): Illinois (IL) ARNG/ANG

Years of NGB support: FY2022

Demonstrated success: Limited (achieved proof of concept; has not yet demonstrated effectiveness and feasibility)

Description: In-person, structured psychoeducational brief, developed locally and delivered by a BHO during drill weekend. The brief includes content on reducing an individual's risk of firearm violence and suicide. Participants additionally receive presenter support through a shared decision-making process to develop a personalized firearm safety plan.

Justification: Managing lethal means access is an important part of a comprehensive approach to suicide prevention. Suicide prevention efforts in the NG often include information on the risks of firearms and may provide gun locks. However, firearm storage interventions do not often include tailored, culturally appropriate interventions to motivate individual-level behavior change.

Evaluation plan: Participants complete a survey immediately after the training. Illinois also used a comparison group for their evaluation. They administered the same survey to SMs who completed the standard Annual Suicide Prevention training but not the Firearm Risk Mitigation course. All surveys were completed online through SurveyMonkey. Survey metrics include: firearm owner status and firearm access, use of firearm safe storage practices, desire for better firearm storage practices, intention to change and/or use storage practices, and satisfaction.

Evidence of effectiveness: *Insufficient data to demonstrate process and outcome effectiveness*.

As of November 2023, seventy-nine participants received the training, and sixty-eight SMs completed Annual Suicide Prevention training as a comparison group. IDA calculated Pearson's Chi-squared test of association, one-way ANOVA, and ANCOVA tests to assess the differences in outcomes and other key variables across the two groups. Analysis showed statistically significant improvements in:

- **Firearm handoff intentions**, i.e., intentions to have supportive discussions about handing off a firearm to a loved one or peer ($p = 0.005$)
- Likelihood to develop a **firearm safety plan** ($p = 0.02$) for handoff if safety concerns arise.
- **Help seeking intentions,** specifically, being supportive of talking with a loved one or peer about a plan to hold firearms ($p = 0.04$), and being willing to talk to a non-professional ($p = 0.03$).
- Satisfaction with the Firearm Risk Mitigation training was high ($M = 4.04$ out of 5), and similar to the comparison group's satisfaction with the standard Annual Suicide Prevention Training ($M = 3.96$ out of 5).

Feasibility: The training is conducted in-person on drill weekend within approximately one hour. It is facilitated by a BHO, which is recommended due to the content covered and skills used (i.e., motivating behavior change, shared decision making) throughout the brief.

Achievements: Information unavailable.

Challenges: Training participants skipped many of the evaluation survey questions. Nonresponse was higher in the comparison group (which received Annual Suicide Prevention training only). This limited the ability to compare measures across the two groups.

Recommendations: Future evaluation should assess change in knowledge, attitudes, and intentions by administering a pre-survey in addition to a post-survey, among both Firearm Risk Mitigation participants and the

comparison group. Using a pre-survey to capture the SMs' baseline metrics will strengthen the findings from the analysis. Additionally, a follow-up survey is an important tool to measure retention of the training content and longitudinal effects on firearm storage behavior. Further, evaluation surveys should be closely aligned with the program's content, short-term goals, and long-term goals. Removing measures that the training is not intended to impact (e.g., symptoms of mental health disorders) will assist with this. Minimizing the survey length will also reduce survey fatigue, which could improve the nonresponse rate.

Work for Warriors Georgia (WFWGA)

Status: Operating

State(s): Georgia (GA) ARNG/ANG

Years of NGB support: operating in Georgia 2017–present; supported with WRF funding FY2019–present

Demonstrated success: High (achieved proof of concept; demonstrated strong feasibility and consistent outcome effectiveness)

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. WFWGA is available to all members of the GA NG, Active Duty SMs, Veterans, and family members.

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.

Evaluation plan: The evaluation uses administrative data collected through the Wellness Poll and as a routine part of program operations. WFWGA also sends a customer satisfaction survey to all clients. A short, voluntary customer satisfaction survey is emailed to participants after receiving WFWGA employment support services.

Evidence of effectiveness: *Demonstrated evidence of process and outcome effectiveness.*

Since August 2019, the program has polled over 66,000 SMs to identify resource needs. This has facilitated over 40,000 service referrals, including:

- 1,671 referrals for BH assistance
- 9,127 referrals for employment assistance
- 2,630 referrals for financial assistance
- 33,418 referrals for other types of assistance (e.g., legal resources, education resources, Veterans benefits, TRICARE)

WFWGA's employment assistance has facilitated over 2,000 new full-time hires with a median annual salary of $60–70k.

Feasibility: A customer satisfaction survey completed by some WFWGA service recipients found that awareness of the program was low (below 50%) before the respondents started working with WFWGA. This finding 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.

Achievements: NGB recognized the effectiveness of WFWGA's model and is facilitating its adoption in other states. A white paper detailing WFWGA's efforts is available from the program point of contact.

Challenges: WFWGA's data-driven approach relies on the use of a software platform. Since beginning implementation, GA moved from the original platform (Zoho), to a new platform (Salesforce). Use of these platforms entailed a contract process as well as hiring skilled staff to oversee design and management.

Recommendations: Assess the effectiveness of replicating WFWGA's approach in different NG state contexts and examine the longer-term cost effectiveness of their employment support models. Cost effectiveness evaluation

can compare the program's costs to its benefits (e.g., effects on SM retention and earnings). WFWGA's model collects data relevant to this, to include salaries of program beneficiaries and projected income tax revenue. States need to track detailed information about the costs of implementing the program to facilitate analyses of cost-effectiveness.

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Appendix C. State Program Milestone Criteria

Instructions: Assess each state program using the criteria below. State programs should have "Yes" responses for all the criteria before being considered for scale-up, while giving consideration to their fit with current WRF priorities.

Milestone 1: Robust evaluation plan. The program has developed a comprehensive, detailed evaluation plan consisting of:

A. Relevant process and outcome evaluation metrics
B. Pre-post or a similarly robust evaluation design
C. Strategy for data collection, including data collection tools (e.g., questionnaires) and/or access to relevant administrative data

☐ **Yes**

The evaluation plan contains <u>all</u> key components, and they are of sufficient quality to address relevant evaluation questions.

☐ **Partial**

The evaluation plan contains <u>some but not all</u> of the key components, and/or one or more components are of insufficient quality to address relevant evaluation questions.

☐ **No**

The evaluation plan does not contain any of the three key components, or contains no components that are of sufficient quality address relevant evaluation questions.

☐ **Need more information**

Milestone 2: Initial launch. Since receipt of WRF funding/support, the program has completed steps necessary to establish initial implementation. Initial launch requirements should be tailored to each program; examples include:

A. Secured contracts for services
B. Hired required personnel
C. Finalized materials (e.g., protocol/SOP, curriculum, marketing materials)
D. Scheduled activities

☐ **Yes**

The initiative has completed <u>all</u> steps necessary to initial launch.

☐ **Partial**

The initiative has completed <u>some</u> of the necessary steps to initial launch, and others are in progress.

☐ **No**

The initiative has not made progress toward any steps necessary to initial launch.

☐ **Need more information**

Milestone 3: Evidence of <u>process</u> effectiveness. The program demonstrated evidence of effectiveness on *key* process metrics. The progress the program makes on these metrics suggests its feasibility in the short and long term. Targets for *key p*rocess metrics should be tailored to each program; examples include

A. Reached 100% of target number of participants
B. Held 100% of target number of sessions
C. Participant satisfaction is high (e.g., above mid-point of a rating scale)
D. Demonstrated fidelity to protocol (e.g., results similar across trainers)

☐ **Yes**

The program met all of the process metric targets.

☐ **Partial**

The program met two or less of the process metric targets, and others are in progress (e.g., 50% of target participants reached) or still being assessed (e.g., monitoring fidelity to protocol).

☐ **No**

The program has not made progress toward any of the process metric targets and/or has not yet begun implementation.

☐ **Need more information**

Milestone 4: Evidence of outcome effectiveness. The program demonstrated evidence of effectiveness on *key* outcome metrics, typically defined as showing statistically significant effects (e.g., positive change from pre to post, $p < 0.05$) with meaningful effect sizes ($d > 0.2$). Key outcome metrics should be designated for each program.

☐ **Yes**

The program showed statistically significant outcomes with meaningful effect sizes on the majority of *key* outcome metrics.

☐ **Partial**

The program showed either statistically significant outcomes or meaningful effect sizes on *key* outcome metrics, but not both.

☐ **No**

The program did not demonstrate statistically significant and meaningful effects on *key* outcome metrics.

☐ **Need more information**

Milestone 5: Leadership buy-in: Local NG leadership has supported the program, as demonstrated by:

A. Receiving at least partial funding from the state/territory (e.g., funding for contracts or resources, dedicated personnel to support the program on a full- or part-time basis)
B. Receiving direct expression of leadership support (e.g., communication with WRF/NGB leaders, letter of support)

☐ **Yes**

The program meets criteria A and B.

☐ **Partial**

The program meets either criterion A or B, but not both.

☐ **No**

The program did not meet either criterion and has not received other forms of leadership buy-in.

☐ **Need more information**

Milestone 6: Dissemination of results. The program has produced, released, and/or presented results demonstrating its implementation and effectiveness to broad audiences (e.g., during monthly Community Calls, TAG forums).

☐ **Yes**

The program has completed at least one dissemination activity (e.g., presentation to broad audience, featured in newsletter).

☐ **Partial**

The program has compiled its results and/or has concrete plans for at least one upcoming dissemination activity.

☐ **No**

The program has not participated in any dissemination activities.

- ☐ **Need more information**

Milestone 7: Expansion plan. The program has developed resources to facilitate expansion into partner locations, including:

A. Implementation guidance and/or an SOP
B. Evaluation guidance and tailored data collection strategy for partner locations
C. A cooperative management plan for coordinating implementation and evaluation with partner locations

- ☐ **Yes**

  The program has completed all of the criteria, and they are of sufficient quality to facilitate expansion.

- ☐ **Partial**

  The program has completed two or fewer of the criteria, and/or is making progress on developing resources that are of sufficient quality to facilitate expansion.

- ☐ **No**

  The program has not met the expansion plan criteria, and/or has not developed resources of sufficient quality to facilitate expansion.

- ☐ **Need more information**

Milestone 8: Interest from partner locations. The program has demonstrated relevance and interest for implementation in new partner locations (i.e., additional states, territories, DC)

- ☐ **Yes**

  The program has confirmed plans to expand to at least one partner location.

- ☐ **Partial**

  The program received interest from at least one partner location (e.g., held discussions with another location about potential expansion, received submissions to join the initiative from another location during the WRF submissions process).

- ☐ **No**

  The program has not received interest from any additional locations.

- ☐ **Need more information**

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Appendix E. 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
CDC	Centers for Disease Control and Prevention
DEOCS	Defense Organizational Climate Survey
DMHAS	Department of Mental Health and Addiction Services
DoD	Department of Defense
FLL	First Line Leader
FY	Fiscal Year
IDA	Institute for Defense Analyses
IPW	Integrated Prevention Workforce
MHFA	Mental Health First Aid
MOU	Memorandum of Understanding
NG	National Guard
NGB	National Guard Bureau
OPTEMPO	Operating Tempo
OSM	Operational Stress Management
PEC	Professional Education Center
PFL	Prime for Life
PFT	Physical Fitness Test
R3SP	Resilience, Risk Reduction and Suicide Prevention
RRC	Risk Reduction Coordinator
RSP	Recruit Sustainment Program
SASSI-4	Substance Abuse Subtle Screening Inventory-4
SARC	Sexual Assault Response Coordinator
SDoH	Social determinants of health
SIO	Suicide Intervention Officer
SM	Service Member
SMART-IE	Specific, Measurable, Achievable, Relevant, Time-bound, Inclusive, and Equitable
SOP	Standard Operating Procedure
SRP	Soldier Readiness Processing
SUD	Substance use disorder
T3	Train-the-trainer
T4T	Training for trainers

TAG	The Adjutant General
UTHSCSA	University of Texas Health Science Center San
WGRS	Workplace and Gender Relations Survey of Military Members
WFWGA	Work for Warriors Georgia
WRF	Warrior Resilience and Fitness

Appendix F. Illustrations

Tables

Figures

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13. SUPPLEMENTARY NOTES

14. ABSTRACT

This report summarizes the challenges and successes of state programs supported between fiscal years 2019 and 2023 to inform future program implementation across the National Guard states and territories. It also details the results of specific successful, promising, and unsuccessful programs, with recommendations for improvements.

15. SUBJECT TERMS

Program evaluation; Program implementation; Resilience; Harmful behaviors; Prevention; Suicide; Command climate

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