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Examining Army prevention programs of record for alignment with the Army SEM and with effective prevention principles

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Abstract

This report uses the Army-specific socio-ecological model (SEM) developed in an earlier phase of this study and principles of effective prevention to examine nine large-scale Army prevention programs. To describe Army prevention programs, we reviewed Army documents and spoke with high-level program subject matter experts (SMEs). We then analyzed the extent to which the main components of each program addressed the shared risk and protective factors, were offered at key career touchpoints, and aligned with the principles of prevention. By reviewing institution-level program materials and engaging with institution-level SMEs, we have identified opportunities to better integrate Army prevention programs and to make them more effective by addressing a broader set of risk and protective factors more comprehensively. Insights from this program review will be used in conjunction with discussions with personnel implementing the programs at multiple installations to develop a system of integrated primary prevention.

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Cover image: Soldiers conduct physical tasks during a competition at Schofield Barracks, Hawaii, Feb. 2, 2022. Photo By: Army Spc. Matthew Mackintosh

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Executive Summary

Background

This study supports Army Resilience Directorate (ARD) initiatives to develop integrated prevention strategies that enhance protective factors and mitigate the risk factors associated with multiple harmful behaviors—including suicide, substance misuse, domestic violence, sexual harassment and assault, discrimination, and extremism—at appropriate touchpoints across Soldiers' careers. This approach aligns with recommendations from the Centers for Disease Control and Prevention and recent efforts within the Department of Defense and the Army to address these issues. The ARD asked CNA to assist the Army in better understanding shared risk and protective factors associated with two or more of the harmful behaviors listed above. Specifically, ARD asked CNA to identify shared risk and protective factors at each level of a socio-ecological model (SEM) that considers influences on behavior at the individual, interpersonal, community, and society levels.

A previous CNA report addressed two key questions: (1) What risk and protective factors are associated with the target harmful behaviors at each level of an Army-specific SEM?, and (2) what approaches and strategies have been shown to help prevent two or more of the target harmful behaviors? This report examines existing Army prevention programs for their alignment with the Army SEM and effective prevention principles. A subsequent report will identify barriers to and opportunities for integration and make recommendations for developing an integrated prevention approach.

To describe Army prevention programs, we reviewed Army regulations, handbooks, material on the ARD website, and other available documents. We then spoke with high-level program subject matter experts (SMEs) to address questions that we could not answer based on information in the available sources. Prevention program SMEs reviewed and revised the program summaries that we generated from this information. We then analyzed the extent to which the main components of each program addressed the shared risk and protective factors, were offered at key career touchpoints, and aligned with the principles of prevention.

Army prevention programs

ARD requested that we analyze the eight Army prevention programs of record and the Army's Military Equal Opportunity (MEO) program to capture the key programs that are likely to help prevent the target behaviors. We briefly summarize each program below:

- The Army Suicide Prevention Program (ASPP) seeks to reduce the risk of suicide for Active Army and Reserve Component Soldiers, Army civilians, and Army family members [1].
- The Army Substance Abuse Program (ASAP) provides alcohol abuse, substance abuse, and gambling disorder prevention and control policies, procedures, and responsibilities for all Army components, Department of the Army (DA) civilians, and other eligible personnel.
- The Family Advocacy Program (FAP) promotes public awareness, prevention, and early identification of child abuse and neglect, domestic abuse, and problematic sexual behavior in children and youth [2].
- The Army's Sexual Harassment/Assault Response and Prevention (SHARP) program is an "integrated, proactive effort to end sexual harassment and sexual assault within [its] ranks." Its intent is to "foster a culture free of sexual harassment and sexual assault through prevention, education and training, response, victim support, reporting procedures, and establishing appropriate accountability" [3].
- The Army's MEO program aims to create a cohesive and combat-ready Army by ensuring that every Soldier is treated with dignity and respect regardless of race, color, gender, religion, age, disability, or national origin.
- The Army's Financial Readiness Program (FRP) provides comprehensive personal financial educational and counseling services to Soldiers and their families.
- The Army's Comprehensive Soldier & Family Fitness (CSF2) program is a resilience-building program that is required of all Soldiers across the career span and encouraged for families and Army civilian personnel. It aims to increase the physical and psychological health, resilience, and performance of participants so that they can thrive and meet a wide range of operational demands.
- The Army's Holistic Health and Fitness (H2F) is a daily program of face-to-face instruction that aims to optimize Soldiers' physical and non-physical (i.e., mental, sleep, nutrition, and spiritual) performance. When the program is fully implemented, Soldiers will receive H2F programming throughout their careers, from initial through

sustainment training, delivered by unit-owned teams of interdisciplinary experts on unit-owned equipment in unit-owned facilities.

- Strong Bonds is a unit-based program intended to develop resiliency in Army families across the Active, Reserve, and National Guard components. Strong Bonds is targeted to four specific groups of Soldiers: those who are single, married, in families, or pre/post-deployment.

Program alignment with Army SEM

Fourteen of the 15 protective factors that we identified in our Army SEM are addressed by at least one program we reviewed. However, commanders have considerable discretion to prioritize these protective factors. Only 10 of the 15 protective factors are addressed (at least by providing Soldiers with awareness factor) by mandatory training, and all programs except for SHARP, FRP, and MEO address some protective factors through non-mandatory training. For example, although CSF2 addresses 10 protective factors, only 2 factors are addressed in the mandatory components. Some programs also allow for variation in implementation at the unit level. Although this flexibility allows for adapting to the schedule, requirements, and composition of the unit, spreading prevention across 9 programs *and* involving so many discretionary components make it difficult for the Army to ensure that all Soldiers receive sufficient coverage of the shared risk and protective factors.

We identified more gaps in the coverage of risk factors in the Army SEM. Ten of the 40 risk factors we identified are not addressed by any program, and another 12 are addressed only by non-mandatory components of programs. Many unaddressed factors are immutable characteristics such as race, gender, and sexual orientation. Army prevention programs address more than 70 percent of the shared risk factors associated with domestic violence, and at least 50 percent for all harmful behaviors. The risk factors addressed by the largest number of programs are alcohol misuse (5), and poor mental health, financial stress, isolation/lack of social support, and close relationship stressors (4 each).

Program alignment with touchpoints across a Soldier's career

Our analysis of the timing of the training in the identified programs revealed that primary prevention education and training is required at numerous touchpoints throughout a Soldier's career. Career and personal touchpoints that already have associated training requirements include, for example, pre-accession, initial training, first duty station, arrival in a new unit, pre-deployment, post-deployment, marriage, birth of a child, and a disabling disease. Although FRP

and CSF2 training occurs at several of these touchpoints, other mandatory training associated with them, such as that provided by SHARP or ASPP, is not primary-prevention focused.[1] Expanding mandatory training to address a broader set of risk factors and protective factors would not necessarily take more time if the Army integrated programs to reduce redundancies and make the most efficient use of touchpoints where training occurs. Such an approach could include targeting Soldiers at the highest risk for specific behaviors with micro-applications pertaining to those behaviors (e.g., family financial and relationship planning in advance of a deployment).

Program alignment with principles of effective prevention

Our analysis of targeted programs' alignment with evidence-based prevention principles revealed that programs focused on developing positive behaviors (CSF2, H2F, FRP, and Strong Bond) align better with effective prevention principles than do programs created to deter specific harmful behaviors. These programs differ in scope, however, in terms of whether they are mandated and in their specific objectives. Among the programs focused on specific harmful behaviors, ASAP is least aligned with prevention principles, which is particularly concerning because alcohol misuse is not only a harmful behavior in its own right but also a risk factor for other harmful behaviors. FAP and MEO are intermediate cases: They address specific harmful behaviors (domestic violence and discrimination) but have been designed with a more comprehensive focus on skill development.

The most consistently represented principle across prevention programs is *appropriately timed* (i.e., mandated training touchpoints exist for many of the programs, such as annual training). There is room to improve the timing, for example tying more relevant training to circumstances or events when Soldiers are at greater risk for particular types of harmful behaviors, such as checking into a new unit or to the unit's deployment cycle. The least represented principle is *systematic evaluation and refinement*. Although some programs collect data for this purpose and have done some effectiveness research, none has a defined feedback process for continuous improvement.

Overall, our analysis indicates that CSF2 and H2F offer particularly promising models for developing an integrated prevention program because of their existing alignment with the principles of effective prevention. That alignment could be improved by integrating the two programs and modifying them to incorporate key shared risk and protective factors, a peer support and mentoring structure to reinforce positive behaviors, full-time program facilitators

[1] We note that ASPP *is* focused largely on primary prevention, but the one-hour mandatory training is not.

and trainers, training support packages that include lesson plans with active teaching methods to help Soldiers practice skills, and a systematic evaluation and refinement process.

Discussion and implications

By reviewing institution-level program materials and engaging with institution-level SMEs, we have identified opportunities to better integrate Army prevention programs and to make them more effective by addressing a broader set of risk and protective factors more comprehensively. However, we do not yet know how these programs are administered at Army installations or how unit commanders integrate the resources available to them. It may be that although the programs are managed separately, Soldiers perceive an integrated and comprehensive prevention system because installation and unit commanders are effectively integrating them. Or it may be that in execution, some of these programs are not as aligned with effective principles and do not address as many risk and protective factors as their governing documents would suggest.

In the next phase, we will engage with program SMEs, providers of training and other services, and (as available) unit commanders and staffs to learn how they are currently integrating prevention programs and what barriers are impeding more efficient and effective integration. Our final report will incorporate these insights to develop complete courses of action to remove barriers and achieve better integrated prevention.

Contents

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Introduction

Multiple risk and protective factors affect the likelihood that people will experience or engage in various harmful behaviors [4]. For example, healthy relationships and a sense of belonging protect against both interpersonal violence and suicidal ideation [5]. The Army Resilience Directorate (ARD) would like to better understand shared risk and protective factors associated with multiple harmful behaviors, including suicide, substance misuse, domestic violence, sexual harassment and assault, discrimination, and extremism. Furthermore, ARD would like to develop integrated primary prevention strategies that enhance protective factors and mitigate risk factors at appropriate touchpoints across Soldiers' careers. Integrated primary prevention activities address shared risk and protective factors known to precede harmful behaviors.

This integrated prevention approach aligns with the recommendation of the Centers for Disease Control and Prevention (CDC) that prevention programs should address shared risk and protective factors associated with multiple forms of violence [6]. The CDC further recommends using a social-ecological model (SEM) that addresses risk and protective factors at multiple levels (i.e., individual, interpersonal, community, and society) [7]. For the Army context, ARD is especially interested in developing a SEM that identifies shared risk and protective factors at the individual, interpersonal, unit, installation/local community, and Army levels.

This approach also aligns with other recent efforts within the Department of Defense (DOD) and the Army. In 2019, the Office of the Undersecretary of Defense for Personnel and Readiness published *Prevention Plan of Action 2019-2023*, which describes a comprehensive approach to sexual assault prevention that involves policies, programs and practices, and continuous evaluation [8]. Elements of the prevention system include equipping leadership with the right tools, training and resourcing a prevention workforce, building collaborative relationships with other stakeholders, collecting and analyzing data, and reviewing and revising policies. A 2020 instruction titled *DOD Policy on Integrated Primary Prevention of Self-Directed Harm and Prohibited Abuse or Harm* calls for an integrated approach to preventing suicide, harassment, sexual assault, domestic abuse (including child abuse), and problematic sexual behavior in children and youth. The policy's purposes include integrating policies and responsibilities to mitigate the targeted harmful behaviors across the career cycle; focusing prevention efforts on research-based programs, policies, and practices; and adapting the CDC's framework for sexual violence prevention to include specific risk and protective factors [9].

In addition, although not described as a prevention strategy, the Army's Holistic Health and Fitness (H2F) program, launched in 2020 to replace the previous physical readiness doctrine, is a brigade-centric, integrated behavioral health approach that develops Soldiers' physical, nutritional, mental, spiritual, and sleep readiness across the career cycle [10]. These Army initiatives will likely fit into the integrated prevention strategies that ARD seeks by, for example, reducing barriers to seeking help. ARD wishes to build on these policies by specifying the risk and protective factors and related prevention approaches associated with the harmful behaviors of interest: suicide, substance misuse, domestic violence, sexual harassment and assault, discrimination, and extremism.

ARD asked CNA to help the Army develop a model for an integrated prevention program that addresses shared risk and protective factors at the optimal points in Soldiers' careers. Several key issues must be addressed in developing this model, including both identifying shared factors and assessing the ability of existing Army prevention programs to address these factors effectively. The following questions guide this effort:

1. What risk and protective factors are associated with two or more of the target harmful behaviors at each level of an Army-specific SEM?
2. What approaches and strategies have been shown to help prevent two or more of the target harmful behaviors?
3. What prevention programs are currently available to Army units? To what extent do the programs address shared risk and protective factors and align with evidence-based prevention approaches? How widely are these programs implemented, who participates in the programs, and at what point in their careers do they participate?
4. What are the barriers to developing and implementing an integrated prevention program?
5. How can the Army build on current prevention programs to prevent the target harmful behaviors more efficiently and effectively through an integrated approach that addresses all levels of the Army SEM?

A previous report addressed the first two questions. That report included an Army-specific SEM that identified risk and protective factors associated with two or more of the target behaviors across five levels: individual, interpersonal, unit, installation/local community, Army, and society. We also identified a set of 11 principles of effective prevention that are applicable to the target behaviors. This report addresses the third question: What prevention programs are available today to Army units? Information from both reports and additional SME discussions to identify barriers will be leveraged to develop recommendations for an integrated primary prevention system that simultaneously addresses risk and protective

factors across the SEM for the primary prevention of multiple harmful behaviors. These recommendations will be included in a third report.

Method

The first step for this phase of the research was to identify key Army prevention programs that are most likely to help prevent the target behaviors. At the recommendation of ARD, we focused on eight Army Programs of Record (PORs) as well as the Military Equal Opportunity (MEO) program. To determine how well those programs align with identified risk and protective factors and principles of effective prevention, and how they are implemented, we began by reviewing available documents. These include Army field manuals, regulations, pamphlets, and handbooks, material on the ARD website, past research provided to us by the sponsor, and other sources referenced by these initial sources. We sorted information obtained from these sources into a template based on the principles of effective prevention (see Background). We also examined the matrix built during the first phase of the study that matches shared risk and protective factors to harmful behaviors, and considered which of these risk and protective factors are addressed by Army PORs and the MEO program.

Next, we engaged subject matter experts (SMEs) who were program managers at the Army Headquarters level, ARD personnel, and a few installation program officials. We asked them to confirm program details and clarify our understanding of the program components beyond what we gleaned from the program and policy documents. We tailored questions for each program SME based on our knowledge of the programs and of the principles of effective prevention.

Following discussions with these SMEs, we generated program summaries based on the document review and SME discussions. Primary program SMEs were given the opportunity to review the summaries and make revisions. These summaries were used as the basis for our analysis, which addressed the following questions:

- What shared risk and protective factors are addressed by the programs we reviewed?
- To what extent do these programs engage with Soldiers at important career and personal touchpoints?
- To what extent do these programs address the principles of effective prevention?

This analysis forms the starting point for phase III of our study, which will offer a model for building on current programs to develop a more integrated approach to prevention that addresses the shared risk and protective factors in the Army SEM.

Organization of report

The background section reviews our findings from the first phase of the study by describing the Army SEM, shared risk and protective factors, and the principles of effective prevention. The next section provides a brief description of the Army prevention programs included in this study (with more detailed program summaries in the Appendix). Following the program descriptions, we present our analysis and findings comparing the programs to the Army SEM and the principles of effective prevention. Finally, we offer a conclusion and recommendations for the next phase of this research.

Background

In the first phase of this effort, we conducted an extensive review of the military, government, and civilian literature on risk and protective factors as well as effective prevention of the harmful behaviors of interest (i.e., suicide, substance abuse, domestic violence, sexual harassment/assault, discrimination and extremism). We also conducted an in-depth examination of research related to three protective factors that are particularly relevant in the prevention literature, and have been shown to protect against multiple harmful behaviors: life skills, resiliency, and connectedness. Based on this review, we developed an Army-specific SEM that identified risk and protective factors across six levels: individual, interpersonal, unit, installation/local community, Army, and society. We also identified a set of 11 principles of effective prevention that are applicable to the target behaviors [11]. An overview of the Army SEM and the prevention principles is provided below.

Army SEM for integrated prevention

Social-ecological models of prevention are based on the concept that individual behavior and experiences are shaped by factors at multiple levels of influence. For example, individuals are influenced by their own experiences, beliefs, and skills. They are also influenced by their close relationships and by the larger groups, communities, and societies to which they belong. Considering influences on individual behavior from a SEM perspective allows researchers and practitioners to consider the "whole picture" and explore interactions between the multiple factors/levels of influences on behavior. Ultimately, designing prevention strategies to reduce harmful behaviors using SEM frameworks increases the likelihood of success of primary prevention efforts by allowing those intervening to target harmful behaviors from all levels, and from multiple vantage points [12].

The Army SEM developed for this project (Table 1) provides a framework for addressing multiple risk and protective factors in a multifaceted and coordinated prevention effort to maximize the potential to reduce multiple harmful behaviors. The Army SEM depicts 40 risk and 15 protective factors associated with two or more of the target harmful behaviors across six Army-specific SEM levels. A more detailed version of the Army SEM, which shows the risk and protective factors associated with each harmful behavior, is provided in Appendix A: Army SEM of Shared Risk and Protective Factors.

Table 1. Risk and protective factors across the SEM

SEM Level	Risk Factors	Protective Factors
Individual: Includes personality traits, skills and abilities, circumstances, and personal history.	Gender: male Poor mental health Marital status: unmarried Age: young adult Low education attainment Financial stress Rank: enlisted Antisocial and aggressive behavior Impulsivity Past exposure to trauma/abuse Alcohol misuse Unhealthy or dysfunctional parenting Deployment Non-heterosexual orientation Gender: female Lower rank: junior enlisted or junior officer Combat exposure Hostile gender attitudes and beliefs Previously committed the harmful behavior Low SES Race/ethnicity: non-Hispanic white Combat arms occupation Sexual identity crisis Poor physical health or recent medical issue Low self-esteem	Life skill: decision-making/problem-solving Life skill: empathy High academic achievement Positive affect Marital status: married Spirituality/religiosity
Interpersonal: Includes factors associated with close relationships (e.g., intimate partners, family members, friends, acquaintances with whom one interacts with frequently).	Association with unhealthy/dysfunctional peer groups Isolation/lack of social support Close-relationship stressors	Social connectedness and support Family cohesion and support Healthy peer relationships

SEM Level	Risk Factors	Protective Factors
Unit: Includes factors within the military unit that influence a person's behavior, such as leadership approaches, unit-level policies, operational tempo, nature of unit occupations, peer interactions and support, and unit cultural norms and expectations	Stigma associated with reporting/seeking help Toxic/permissive unit climate Toxic/ineffective or weak leadership	Unit cohesion and connectedness Positive leadership engagement Unit level policy enforcement
Installation/ local community: Includes factors at the military base and surrounding community that influence individual behavior, including access to resources and characteristics, policies, and practices in the community	Availability of alcohol Access to location or methods Social/community disorganization Low community SES	Community connectedness and support Restrict or limit access to instruments of harmful behavior
Army: Includes factors related to Army culture, policies, and practices as well as practices and values espoused and modeled by senior leaders.	Stigma associated with reporting/seeking help Harmful norms (gender, violence, drinking) Structural barriers to accessing help/resolution	Prevention policies
Society: Includes state and federal policies as well as broader culture, subcultures, and political trends and movements.	Weak policy/law Weak economic conditions	(None Identified)

Source: [11]

Identifying principles of effective prevention

Prevention strategies and programs can be grouped into three categories based on when the programs occur:

1. Primary prevention takes place before the harmful behaviors have occurred to prevent initial victimization and perpetration.
2. Secondary prevention occurs immediately after an incident to address short-term consequences for victims.
3. Tertiary prevention refers to long-term responses after the harmful behavior has occurred to mitigate the lasting effects of problematic behaviors for victims and to

incorporate interventions for perpetrators [13-14]; it could include grief or trauma counseling.

Although the focus for this project is primary prevention, some secondary prevention efforts can be important in the military context because appropriate responses to harmful behaviors establish a culture and climate that help prevent reoccurrence. Therefore, in developing a set of effective prevention principles appropriate for the military audience, we consider secondary prevention principles that we believe to be key to an effective integrated prevention program for the Army. (For this study, tertiary prevention and response programs are not included because the sponsor wants this research to focus on prevention efforts that precede harmful behaviors.)

To identify principles of effective prevention relevant to this study, we reviewed seminal literature on effective approaches to preventing multiple harmful behaviors [15-16], two or three key sources on effective prevention approaches for each of the target harmful behaviors, and the literature on integrated prevention approaches. This review resulted in a set of 11 principles of effective prevention, organized into three categories as shown in Table 2.

Table 2. Principles of effective integrated prevention

Category	Principle
Program Content	**Theory-driven:** Programs are based on well-established and empirically supported theory about the causes of the behavior and related risk and protective factors a program should address to influence the desired outcomes.
	Comprehensive: Programs encompass multiple components from awareness to skill building to resource support, and include universal and targeted interventions at multiple SEM levels (e.g., individual, relationships, work environment, community, society).
	Socioculturally relevant: Programs address the cultural and social norms of the target audience, respecting their values, beliefs, and language while acknowledging grievances, correcting misconceptions, and promoting positive norms that protect against harmful behaviors.
	Fosters positive relationships: Programs foster safe, trusting relationships within the training context and in participants' social and work environment, including promoting social connectedness, bystander strategies, peer organizations, and mentoring.
	Skills-oriented: Programs develop social and emotional skills that protect against harmful behaviors, including communication, self-efficacy and empowerment, self-regulation, healthy relationships, critical thinking, problem-solving, stress management, coping, empathy, risk avoidance, and conflict resolution.
Program Delivery	**Actively engaging:** Programs use varied teaching methods (e.g., small group discussion, role-playing, skill practice) that actively engage participants and allow them to learn and practice new skills.

Category	Principle
	Of sufficient dosage and intensity: Programs are of sufficient depth, length, and frequency (including refreshers) to support sustained changes in attitudes and behavior.
	Appropriately timed: Programs are timed to reach participants as early in life as possible, when they are most receptive to change, at key transition points, or when they are at potentially heightened risk.
	Delivered by well-qualified, trained, and supported staff: Program staff are sufficiently trained and qualified, supported by the administration, and committed to program goals.
Program Policies	**Incorporates systematic evaluation and refinement:** Programs have clear goals and objectives, results are systemically evaluated relative to the goals (including gathering participant feedback), and refinements are made to improve effectiveness.
	Accompanied by victim-centered response efforts: Response efforts ensure support for victims, including ensuring privacy and confidentiality, providing advocacy and counseling, ensuring safety, maintaining zero tolerance for retaliation, and offering amnesty for collateral misconduct.

Source: Wolters et al., 2022 [11].

The principles align well with the Army SEM in that prevention programs should address risk and protective factors that are theoretically or empirically linked (*theory-driven)* to the harmful behaviors across all SEM levels (*comprehensive)*. In addition, several protective factors *foster positive relationships* (e.g., social connectedness and support, healthy peer relationships). Finally, the Army SEM lists several life skills and related attributes as protective factors, which aligns with the *skills-oriented* principle.

Summary

The first phase of this research created an Army-specific SEM of 40 shared risk factors and 15 shared protective factors associated with at least 2 harmful behaviors at six levels: individual, interpersonal, unit, installation/local community, Army, and society. It also identified 11 principles of effective prevention programs based on a targeted literature review of prevention research. The next section of this report briefly describes the 8 Army prevention PORs and the Army's Military Equal Opportunity (MEO) program, followed by an analysis of the extent to which the programs address shared risk and protective factors and incorporate the principles of effective prevention.

Overview of Army Prevention PORs and the MEO Program

In this section, we briefly describe each of eight Army prevention PORs and the MEO program reviewed in Phase 2. ARD asked that we focus on these programs because, of the more than 200 existing efforts, they are the most robust, widely employed, and likely to have been evaluated. They also had the most available information with which to assess their alignment with principles of effective prevention. Some of the programs included in this deep dive are focused on a specific harmful behavior (e.g., suicide), while others are focused on developing protective factors (e.g., Holistic Health and Fitness program). Because no POR is focused on discrimination, a harmful behavior covered in the Phase 1 review, the sponsor requested that we include Army MEO for its focus on discrimination. The program descriptions presented here are ordered such that those focused on specific harmful behaviors are presented first, followed by more general primary prevention programs.

More detailed descriptions of these programs are found in the Appendix. Here, we provide the program name, its primary goals, and a brief overview of its components, including the following information:

- Which components are primary prevention
- Which components are mandatory
- Whether implementing the program is a full-time or collateral duty
- Whether the program includes skill training

It should be noted that the program descriptions are based primarily on policy documents, supplemented with a phone discussion with a SME associated with each program. More information on the extent to which the programs are implemented according to policy will be obtained during Phase 3 of this research.

Army Suicide Prevention Program (ASPP)

The goal of the ASPP is to minimize suicidal behavior by reducing the risk of suicide for Active Army and Reserve Component Soldiers, Army civilians, and Army family members [1]. It includes standing battle rhythm events at the installation, brigade, and battalion levels, handbooks for commanders at multiple levels, and a designated Suicide Prevention Program Manager at each installation [2]. It also includes awareness training for all Soldiers, skill

training for leaders and gatekeepers[2], and web pages on the ARD website with links to numerous skill development and resilience resources.

ASPP policy documents have a focus on primary prevention, but also describe procedures for responding to an attempted or completed suicide. The only mandatory element is the annual one-hour Ask, Care, and Escort (ACE) suicide awareness training for all Soldiers. ACE training is designed to help Soldiers understand risk and protective factors for and warning signs of suicide, the three steps of the ACE suicide prevention method, their role in suicide prevention, and available resources. Administering this training is a collateral duty, but full-time behavioral health officers provide some of the skill training to gatekeepers. While the focus at all levels is more on skill building (how to save a Soldier from suicide or increase your own or another's resilience) than on deterrence, the mandatory one-hour annual training provides little time for skill development (e.g., via practice).

Army Substance Abuse Program (ASAP)

The goal of the ASAP is to increase Soldier and unit readiness by reducing the risk of alcohol or other drug misuse and restoring to duty those substance-impaired Soldiers who have the potential for continued military service. The program includes deterrence through random drug testing. Mandated training is minimal; Army policy requires that newly-assigned Soldiers receive a newcomers' briefing that provides information on ASAP services, community laws and command policies, drug- and alcohol-free activities, and the Limited Use Policy[3]. Corporals and above are to receive information during Professional Military Education on signs and symptoms of substance misuse. In addition, Soldiers who test positive or have an alcohol- or drug-related incident must participate in a mandatory, intensive course that teaches about responsible drinking and addiction. ASAP also mitigates damage through the Substance Use Disorder Clinical Care Program. Other components identified in Army policies are awareness campaigns through various messaging media, a Unit Risk Inventory to identify high-risk units, and optional tailored training. These measures may contribute to primary prevention, but the program is more focused on deterrence and treatment. Only the random testing (and the consequences for those caught) is mandatory. The certification requirements for ASAP trainers are under review. Skill development is not a focus of the program.

[2] Gatekeepers are individuals who, in the performance of their assigned duties and responsibilities, provide specific counseling to Soldiers and Army Civilians in need [17].

[3] Limited Use Policy prohibits the use by the government of protected evidence against a Soldier in actions under the Uniformed Code of Military Justice or on the issue of characterization of service in administrative proceedings. It is intended to urge Soldiers to seek care without fear of negative career consequences [18].

Family Advocacy Program (FAP)

The goal of the FAP is to promote public awareness, prevention, and early identification of child abuse and neglect, domestic abuse, and problematic sexual behavior in children and youth [2]. FAP consists of coordinated efforts designed to prevent and intervene in cases of family distress, and to promote healthy family life [19]. The program includes mandatory trainings for all Soldiers, for commanders, and for gatekeepers. Soldiers going through a divorce who have children are required to take the course "Parenting Through Divorce." Optional training for families includes the courses "Parents as Teachers" and "Thrive." Other optional support for families includes activities such as playdates. Families at elevated risk may self-refer, or be referred by commanders, to the New Parent Support Program (NPSP), through which they receive in-home skill-building visits with professional staff. FAP also includes awareness campaigns through messaging. Finally, victim advocates (VAs) provide intervention after domestic violence has occurred.

The activities and optional trainings for families contribute to primary prevention, but the awareness campaigns and mandatory training also help to identify domestic violence after it has begun to occur so that the Army can intervene. FAP is administered by full-time social workers with clinical licenses, and has an emphasis on skill building.

Sexual Harassment/Assault Response and Prevention (SHARP)

The goal of the Army's SHARP program is to foster a culture free of sexual harassment and sexual assault through prevention, education and training, response, victim support, reporting procedures, and appropriate accountability [3]. Components include sexual harassment reporting processes (informal and formal), sexual assault reporting processes that detail the roles and responsibilities for various personnel, required training for all Soldiers at multiple touchpoints, and separate required training for commanders.

All Soldiers are required to receive at least two hours of SHARP training per year that focuses mostly on response and victim care, with relatively less focus on prevention issues—although some information is provided on prevention and bystander efforts. Topics covered typically include the commander's SHARP policy and plan of action, installation- or unit-level sexual harassment/assault data trends and high-risk areas, reporting options, unit/installation prevention and bystander efforts, the installation/unit's SHARP team, supporting on-post and off-post agencies, and upcoming SHARP events. Although the program goal is to increase the number of full-time professionals focused on prevention training, current prevention training is provided mostly by fellow Soldiers who deliver the training as a collateral duty.

Military Equal Opportunity (MEO)

The goal of the Army's MEO program is to create and sustain effective units by eliminating discriminatory behaviors or practices that undermine the teamwork, mutual respect, loyalty, and shared sacrifice of the men and women of America's Army. The program includes required training at multiple touchpoints and multiple cultural initiatives. They include US Army Project Inclusion, ethnic observances, Army Heritage Month, and special emphasis programs to ensure equal opportunity for specific subpopulations.

The mandatory training encompasses both prevention and response. Topics include indicators of EO problems, appropriate behaviors for unit cohesion and teamwork, interpersonal communication to promote a healthy climate, overview and results of the unit climate assessment, the impact of individual and institutional discrimination, the EO complaint system, individual responsibilities regarding EO, and legal and administrative consequences for perpetrating discrimination or harassment [20]. Each brigade has at least one full-time MEO professional.

Financial Readiness Program (FRP)

The goal of the Army's FRP is to provide service members with information, consultation, and skill-building opportunities to help them achieve and maintain financial readiness. It includes mandatory financial training at key professional and personal touchpoints, and voluntary educational and personal financial counseling. Soldiers may seek the counseling after an event such as repossession or foreclosure, or in advance of making a decision, such as asking FRP staff to review a contract before they sign it.

The DoD mandates that certain skills be covered at the specified touchpoints, such as knowing the difference between a "need" and a "want," creating and managing a spending plan, analyzing the implications and identifying strategies for buying a car or financing a home, and knowing strategies for managing debt (problem-solving). The training is meant to be primary prevention, although SMEs observe that its preventive value could be improved by shifting the timing (e.g., training about child-related expenses before Soldiers have children rather than after the child has been born). Full-time professional staff provide financial counseling and some training. In addition, military personnel who are not certified financial advisors provide financial readiness training in some military settings, but they must adhere to the curriculum provided. Training is focused on skill building.

Comprehensive Soldier and Family Fitness (CSF2)

The goal of the CSF2 program is to increase resilience and performance enhancement skills by building on the physical, emotional, social, spiritual, and family dimensions of strength, so that Soldiers can thrive and meet a wide range of operational demands. Policy specifies mandatory initial and annual completion of a self-assessment tool (formerly the Global Assessment Tool, now called an Azimuth Check), results of which link the user to online self-development tools. Policy also indicates that resilience training should be provided in the unit at least monthly by master resilience trainers (MRTs), who are provided with modules to teach each of 14 resilience skills that help to develop six competencies: self-awareness, self-regulation, optimism, mental agility, strength of character, and connection. Institutional resilience training (IRT) is embedded into professional military education (PME) programs through modules that develop resilience skills (e.g., thinking skills, active constructive responding, effective communication, goal setting, and energy management). Performance Enhancement training—which is available to individual Soldiers, leaders, and units upon request—enhances skills taught in the other training components, such as mental skills foundations, attention control, goal-setting, and energy management.

Although the unit-based MRT skills training is mandatory, implementation depends on commander discretion, so implementation varies. The focus is on primary prevention and skill development rather than targeting specific harmful behaviors. Unit MRTs fulfill that role as a collateral duty, but MRTs who provide performance enhancement training at installation-based Ready & Resilient (R2) Centers are full-time professionals.

Holistic Health and Fitness (H2F)

The Holistic Health and Fitness program, like CSF2, focuses on developing skills that promote fitness and help prevent harmful behaviors. However, whereas CSF2 focuses on the social-emotional aspects of resilience, H2F emphasizes physical fitness through a sports medicine approach. The goal is to enhance readiness and lethality by optimizing physical and non-physical performance, reducing injury rates, and improving rehabilitation times. It is a face-to-face daily program of instruction that includes cognitive enhancement, nutrition, injury control, physical training, and spiritual aspects. Personnel include strength coaches, who develop individualized strength and conditioning programs for Soldiers; occupational therapists and cognitive performance specialists, who teach skills such as tactical breathing and visualization to address mental barriers to physical performance; physical therapists, who use progressive and sequential training methods to help Soldiers improve their strength and

flexibility; and chaplains, who help Soldiers develop spiritual skills to cope with stress, hardship, or tragedy.

When the program is fully implemented, Soldiers will receive H2F programming throughout their careers, from initial through sustainment training, delivered by unit-based teams of interdisciplinary experts who work out of unit-level Soldier Performance Readiness Centers. Although it is mandatory, focused on skill building and primary prevention, and delivered by full-time professionals, it is in the process of being implemented and has not yet reached most brigades.

Strong Bonds/Building Strong and Ready Teams

The goal of the Army's Strong Bonds program, which is undergoing a name change to Building Strong and Ready Teams, is to increase the resiliency of Soldiers by developing a resilient Army family. It is a unit-based program administered by Unit Ministry Teams (who are full-time). The program is typically delivered in a retreat format and led by Army chaplains. It is focused on skill building and primary prevention by teaching communication and relationship building skills through selected course curriculum. Although most of the courses are directed toward communication and relationships, other curricula focus on understanding how to find a long-term partner, decision-making, conflict resolution, love, and being a better partner. The program is entirely voluntary.

Analysis of Army Prevention PORs and the MEO Program

Using the program summaries in the Appendix, we analyzed the extent to which the 8 Army PORs and the MEO program: 1) address shared risk and protective factors, 2) are delivered at career and personal touchpoints across a Soldier's career, and 3) align with the principles of effective prevention. In this section, we summarize the results of those analyses.

The Army prevention PORs and the MEO program are all multi-faceted, in that many of them have prevention and response components, mandatory and non-mandatory components, and training, outreach, and awareness components. The program experts we spoke with indicated that there is variability in how the programs are implemented at the installation and unit level, but our research is focused on policy and guidance, and does not provide that level of granularity at this time. Further, we did not have full programs of instruction for all components of all prevention programs. Thus, our analysis represents a high-level crosswalk between known program elements and shared risk and protective factors and principles of effective prevention. These crosswalks may not represent a complete mapping because of differences in implementation at each installation and in each unit. However, by reviewing policy and program materials and engaging with program SMEs, we have identified initial opportunities to better integrate Army prevention programs and make them more effective, addressing a broader set of risk and protective factors more comprehensively.

Alignment of Army prevention programs and shared risk and protective factors

The following crosswalk identifies shared risk and protective factors that are addressed in some manner by the reviewed programs. However, the crosswalk does not identify the depth of coverage for each of the risk and protective factors. For example, the ASPP ACE training provides little more than awareness of the risk factors for suicide. In contrast, the NPSP component of the FAP program involves multiple in-home visits to build skills that protect against harmful behaviors. The goal of the current section is to depict where connections exist and highlight gaps in shared risk or protective factor coverage. The section on program alignment with effective prevention principles will consider the depth of coverage, to the extent we have sufficient detail.

Army prevention programs that address shared risk and protective factors

Risk and protective factors identified in the Army SEM are depicted in Table 3 and Table 4, alongside the prevention programs that address those factors. High-leverage factors, meaning those associated with four or more of the target harmful behaviors, are listed in bold font. Light blue cells indicate that the associated risk and protective factors are addressed as part of mandatory program components; light yellow indicates the factors are addressed in a non-mandatory program component.

Table 3. Programs of record linked to the SEM and risk factors

SEM Level	Risk Factor	ASAP	ASPP[a]	CSF2	FAP	FRP	H2F[b]	MEO	SHARP[c]	Strong Bonds
Individual	**Low education attainment**									
	Gender: male									
	Gender: female									
	Poor mental health									
	Age: young adult									
	Antisocial and aggressive behavior									
	Marital Status: unmarried									
	Impulsivity									
	Financial stress									
	Past exposure to trauma/abuse									
	Alcohol misuse									
	Unhealthy or dysfunctional parenting									
	Low SES									
	Deployment									
	Non-heterosexual orientation									
	Lower rank: junior enlisted or junior officer									
	Combat exposure									
	Hostile gender attitudes and beliefs									

SEM Level	Risk Factor	ASAP	ASPP[a]	CSF2	FAP	FRP	H2F[b]	MEO	SHARP[c]	Strong Bonds
	Previously committed the harmful behavior									
	Rank: enlisted									
	Race/ethnicity: non-Hispanic white									
	Combat arms occupation									
	Sexual identity crisis									
	Poor physical health or recent medical issue									
	Low self-esteem									
Interpersonal	**Association with unhealthy/dysfunctional peer groups**									
	Isolation/lack of social support									
	Close-relationship stressors									
Unit	**Stigma associated with reporting/seeking help**									
	Toxic/permissive unit climate									
	Toxic/ineffective or weak leadership									
Installation/ local community	Availability of alcohol									
	Access to high-risk location or methods for harmful behaviors									
	Social/community disorganization									
	Low community SES									
Army	**Stigma associated with reporting/seeking help**									

SEM Level	Risk Factor	ASAP	ASPP[a]	CSF2	FAP	FRP	H2F[b]	MEO	SHARP[c]	Strong Bonds
	Harmful norms (gender, violence, drinking)									
	Structural barriers to accessing help/resolution									
Society	**Weak policy/law**									
	Weak economic conditions									

Source: CNA.
[a] The primary prevention component of mandatory ASPP training is largely limited to listing risk factors for Soldiers to be aware of.
[b] H2F training will be mandatory once fully implemented.
[c] SHARP is primarily focused on awareness and response, but it has some limited primary prevention activities.
Note: Light blue shading indicates mandatory prevention efforts, while light yellow shading indicates voluntary prevention efforts.

As shown in Table 3, the majority of risk factors are addressed in some manner by one or more of the reviewed programs. Among these factors, 15 are addressed by 3 or more programs, with at least 1 of those programs addressing the risk factor in a mandatory component. Moreover, all of the high-leverage risk factors under the Army's control (excluding immutable Soldier characteristics such as gender, as well as Society-level factors) are addressed by at least one mandatory component. For example, poor mental health (an individual-level risk factor for all 6 harmful behaviors in this study) is addressed in 2 mandatory and 2 non-mandatory prevention programs. Across the SEM, Army prevention programs address 18 of 25 risk factors at the individual level, all risk factors at the interpersonal and unit level, 3 of 4 risk factors at the installation/local community level, all risk factors at the Army level, and neither of the risk factors at the society level. However, several of these risk factors are immutable characteristics, such as gender, race, and sexual orientation, military characteristics such as rank and combat arms occupations, or conditions outside the Army's control (e.g., economic conditions). In total, approximately half (21 of 40) of the identified risk factors are not addressed in the prevention programs we reviewed or are addressed only in non-mandatory program components that are not required for all Soldiers.

Table 4. Programs of record linked to the SEM and protective factors

SEM Level	Protective Factor	ASAP	ASPP[a]	CSF2	FAP	FRP	H2F[b]	MEO	SHARP[c]	Strong Bonds
Individual	**Life skill: decision-making/problem-solving**			■		■	■		■	
	Life skill: empathy				■				■	
	High academic achievement									
	Positive affect			■			■			
	Marital status: married									
	Spirituality/religiosity									
Interpersonal	**Social connectedness and support**						■		■	
	Family cohesion and support				■					
	Healthy peer relationships									
Unit	**Unit cohesion and connectedness**				■			■	■	
	Positive leadership engagement									
	Unit level policy enforcement									
Installation/ local community	Community connectedness and support									
	Restrict or limit access to instruments of harmful behavior				■					
Army	**Prevention policies**	■								
Society	(None identified)									

Source: CNA.
[a] The primary prevention component of mandatory ASPP training is largely limited to listing risk factors for Soldiers to be aware of.

[b] H2F training will be mandatory once fully implemented.
[c] SHARP is primarily focused on awareness and response, but it has some limited primary prevention activities.
Note: Light blue shading indicates mandatory prevention efforts, while light yellow shading indicates voluntary prevention efforts.

All except one protective factor (high academic achievement) is addressed in at least one prevention program. While this factor can be improved upon while in service, it is largely a characteristic that service members come to the Army already possessing. Ten of the protective factors are addressed by a mandatory prevention program component, and all of the high-leverage protective factors are addressed by at least one mandatory program component. Although many of the protective factors are addressed in mandatory program elements, some programs allow flexibility in whether and how the factors are addressed, and other programs address the factors in non-mandatory program elements alone. For example, Strong Bonds is entirely voluntary, and the FAP training curriculum is not standardized across the Army. Although CSF2 addresses 10 of the 15 protective factors, the specific skills taught during the mandatory training address only 2 of the shared protective factors.

Army prevention programs that address shared risk and protective factors associated with each harmful behavior

The preceding section identified risk and protective factors in the Army SEM that are addressed in each of the nine programs reviewed—regardless of whether those factors are central to the program's focus. For example, the ASPP program focuses on preventing suicide, but in so doing, addresses the risk factor of alcohol misuse. Additionally, we were interested in the extent to which prevention programs aimed at a specific behavior address the factors associated with that behavior, and also whether the programs aimed at developing positive behaviors address specific risk and protective factors in the Army SEM. These associations are depicted in Table 6, which are color coded to convey the number of programs that address each factor, as follows:

- Blue color gradient: Cells coded blue indicate that the risk or protective factor is associated with the specific harmful behavior listed at the top of the column. Programs that address the factor are shown in the cell; progressively darker shading indicates that a larger number of programs address the factor associated with each harmful behavior.
- Hatched-marked cells: The literature does not indicate that the factor is associated with that harmful behavior [11] and, as expected, no program aimed at that behavior addressed the factor.

- Salmon-colored cells: Although the literature indicates that the risk or protective factor *is* associated with the harmful behavior, none of the reviewed programs explicitly addressed the factor.

Four Army programs aim to develop skills and dispositions that can protect against harmful behaviors generally, but do not target specific harmful behaviors: CSF2, Strong Bonds, H2F, and FRP. Where these programs address a risk or protective factor, we show that program for *all* harmful behaviors in which the literature indicates the risk (or protective) factor applies.

Table 5. Prevention program coverage of shared risk factors

SEM Level	Risk Factors	Suicide	Sub. Misuse	Domestic Violence	Sexual Harass./ Assault	Discrim.	Extrem.
Individual	**Low education attainment**						
	Gender: male						
	Gender: female					**MEO**	
	Poor mental health	**ASPP**, H2F	H2F	FAP, H2F	H2F, **SHARP**	H2F	H2F
	Age: young adult	**FRP**	**FRP**	FAP, **FRP**	**FRP**, SHARP	**FRP**	
	Antisocial and aggressive behavior			FAP, **CSF2**	SHARP, **CSF2**	**CSF2, MEO**[a,]	
	Marital Status: unmarried	SB[b]	SB	SB	SB	SB	
	Impulsivity	**CSF2**, SB	**CSF2**, SB	**CSF2**, SB	**CSF2**, SB		**CSF2**, SB[a]
	Financial stress	**ASPP**, **FRP**, SB	**FRP**, SB	**FAP**, **FRP**, SB		**FRP**, SB	**FRP**, SB
	Past exposure to trauma/abuse	**ASPP**		**FAP**	**SHARP**		
	Alcohol misuse	ASAP, **ASPP**, SB	ASAP, **ASPP**, SB, SHARP	ASAP, FAP, SB	ASAP, SB, **SHARP**		
	Unhealthy or dysfunctional parenting			FAP			
	Low SES			FAP			
	Deployment		ASAP, SB	FAP, SB	SB		
	Non-heterosexual orientation						
	Lower rank: junior enlisted or junior officer			FAP[a]			
	Combat exposure	SB	SB		SB		
	Hostile gender attitudes and beliefs			FAP		**MEO**	
	Previously committed the harmful behavior	**ASPP**	ASAP		**SHARP**		
	Rank: enlisted						
	Race/ethnicity: non-Hispanic white						
	Combat arms occupation						

SEM Level	Risk Factors	Suicide	Sub. Misuse	Domestic Violence	Sexual Harass./ Assault	Discrim.	Extrem.
	Sexual identity crisis						
	Poor physical health or recent medical issue	ASPP, **H2F**	**H2F**				
	Low self-esteem			SB		SB	
Interpersonal	**Association with unhealthy/dysfunctional peer groups**				**SHARP**		
	Isolation/lack of social support	SB, ASPP		**FAP**, SB	SB, **SHARP**		SB
	Close-relationship stressors	**ASPP**, H2F, SB	H2F, SB	FAP, H2F, SB	H2F, SB		
Unit	**Stigma associated with reporting/seeking help**	**H2F**	ASAP, **H2F**	**FAP**, **H2F**	**H2F**		
	Toxic/permissive unit climate		ASAP			**MEO**	
	Toxic/ineffective or weak leadership			FAP[a]	**SHARP**	**MEO**	
Installation/Local Community	Availability of alcohol		ASAP	FAP			
	Access to high-risk locations or methods for harmful behavior	ASPP	ASAP				
	Social/community disorganization						
	Low community SES			FAP			
Army	**Stigma associated with reporting/seeking help**	**H2F**	ASAP, **H2F**	**FAP**			
	Harmful norms (gender, violence, drinking)		ASAP		**SHARP**	**MEO**[a]	
	Structural barriers to accessing help/resolution	**H2F**	ASAP[a]	FAP[a]	**H2F**	**H2F**	
Society	**Weak policy/law**						
	Weak economic conditions						

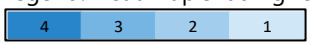
Source: CNA.

[a] These are risk factors that are addressed by a prevention program for a harmful behavior but were *not* identified in the literature as related to that harmful behavior. Additional analysis is ongoing to determine if SEM changes are necessary.

[b] SB is an abbreviation for Strong Bonds.

[c] Bolded items in the shaded cells address the risk factor in a mandatory prevention program component.

Legend: Heat map shading represents the number of PORs associated with a harmful behavior and risk factor:



Note: Salmon-colored shading indicates risk factors that are associated with harmful behaviors, but were not present in the analysis of PORs. Grey-hatched shading indicates risk factors not associated with a specific harmful behavior.

Notably, although none of the programs we reviewed is designed to prevent extremism, four programs aimed at developing positive behaviors more generally (CSF2, H2F, Strong Bonds,

and FRP) address risk factors associated with extremism: poor mental health, financial stress, impulsivity, and isolation/lack of social support.

For all the harmful behaviors except extremism, at least 50 percent of the shared risk factors are addressed by at least one Army prevention program. Notably, more than 70 percent of the risk factors for domestic violence are addressed by Army prevention programs.[4] The high-leverage risk factors *poor mental health, financial stress*, *alcohol misuse,* and *close relationship stressors* are addressed in more programs than are other risk factors. Although this analysis may seem to indicate that the Army is addressing a majority of the risk factors, it is important to note that the analysis is based primarily on review of program documents and materials. In reality, a particular factor may be simply referenced in training but not as the basis for skill development. The next phase of our research will provide additional insight into depth of coverage and suggest ways in which coverage of high-leverage factors might be enhanced through an integrated prevention approach.

Compared to the coverage of risk factors, the Army prevention programs more extensively address protective factors (Table 6). All but one protective factor (high academic achievement) is addressed by at least one prevention program. Level of academic achievement is a characteristic Soldiers generally bring to the service with them, and which can be enhanced through PME and career opportunities.

While coverage of protective factors is more comprehensive than risk factors, it is important to note that most of these prevention program components are non-mandatory or unstandardized in implementation across the force (SHARP, MEO, and FRP are notable exceptions). Specifically, Strong Bonds, CSF2, and H2F are comprehensive programs that address many protective factors in the Army SEM; however, Strong Bonds is an optional program, and H2F is not fully implemented, nor are the mental and spiritual readiness aspects mandatory for all Soldiers. The mandatory components of CSF2, if implemented as intended, could help develop many factors that protect against the harmful target behaviors. However, SMEs indicate uneven implementation across units. The Army could increase coverage of Army SEM protective factors by standardizing the delivery of program components. The next phase of this research may help reveal depth of coverage and how this could be enhanced through integration.

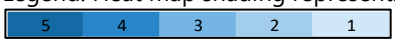
[4] This calculation was done by considering *only* the risk factors in which the literature supports a connection. Hatched-marked cells are excluded from these percentage calculations.

Table 6. Prominence of protective factors related to programs of record across the harmful behaviors

SEM Level	Protective Factors	Suicide	Sub. Misuse	Domestic Violence	Sexual Harass./ Assault	Discrim.	Extrem.
Individual	**Life skill: decision-making/problem-solving**	**CSF2**, **FRP**, **H2F**, SB	**CSF2**, **FRP**, **H2F**, SB	**CSF2**, FAP, **FRP**, **H2F**, SB	**CSF2**, **FRP**, **H2F**, SB, **SHARP**		
	Life skill: empathy			CSF2, **FAP**, H2F, SB	CSF2, H2F, SB , **SHARP**	CSF2, H2F, SB	CSF2, H2F, SB
	High academic achievement						
	Positive affect	**CSF2**, **H2F**, SB	**CSF2**, **H2F**, SB				
	Marital status: Married	SB	SB				
	Spirituality/religiosity	ASPP, CSF2, H2F	CSF2, H2F				
Interpersonal	**Social connectedness and support**	CSF2, **H2F**, SB	CSF2, **H2F**, SB	CSF2, **H2F**, SB, FAP	CSF2, **H2F**, SB, **SHARP**		CSF2, **H2F**, SB
	Family cohesion and support	CSF2, SB	CSF2, SB	CSF2, **FAP**, SB	CSF2, SB, **SHARP**		
	Healthy peer relationships		CSF2, SB	FAP[a]	CSF2, SB, **SHARP**		CSF2, SB
Unit	**Unit cohesion and connectedness**	CSF2, H2F	ASAP, CSF2, H2F	**FAP**[a]	CSF2, H2F, **SHARP**	CSF2, H2F, **MEO**	
	Positive leadership engagement	CSF2	CSF2		CSF2, **SHARP**	**MEO**[a]	
	Unit level policy enforcement		ASAP			MEO	
Installation/Local Community	Community connectedness and support	ASPP, CSF2		CSF2, **FAP**			CSF2
	Restrict or limit access to instruments of harmful behavior	ASPP	ASAP	FAP[a]			
Army	**Prevention policies**		**ASAP**	FAP[a]			
Society	(None Identified)						

Source: CNA.

[a] These are risk factors that are addressed by a prevention program for a harmful behavior but were *not* identified in the literature as related to that harmful behavior. Additional analysis is ongoing to determine if SEM changes are necessary.
[b] Bolded items address the protective factor in a mandatory prevention program component.
Legend: Heat map shading represents the number of POR associated with a harmful behavior and risk factor:



Note: Salmon-colored shading indicates risk factors that are associated with harmful behaviors, but were not present in the analysis of PORs. Grey-hatched shading indicates risk factors not associated with a specific harmful behavior.

Implications for developing an integrated prevention program

The analyses presented in this section indicate that the majority of shared risk and protective factors in the Army SEM are addressed in existing Army programs, and that many factors are addressed by multiple programs. This coverage overlap may indicate opportunities for coordinating and integrating prevention efforts. For example, decision-making and problem-solving skills are taught by MRTs in the CSF2 program, FRP, H2F, Strong Bonds, FAP, and SHARP. An integrated prevention program might incorporate decision-making and problem-solving skills that are taught by MRTs in the CSF2 program, reinforced in FRP training as part of financial planning and debt management, and revisited again during ASAP training to develop responsible drinking strategies prior to a holiday break. Analyses in the next two sections of this report provide additional information about training touchpoints and effective practices that might be incorporated into an integrated prevention program.

Alignment of prevention programs with career and personal touchpoints

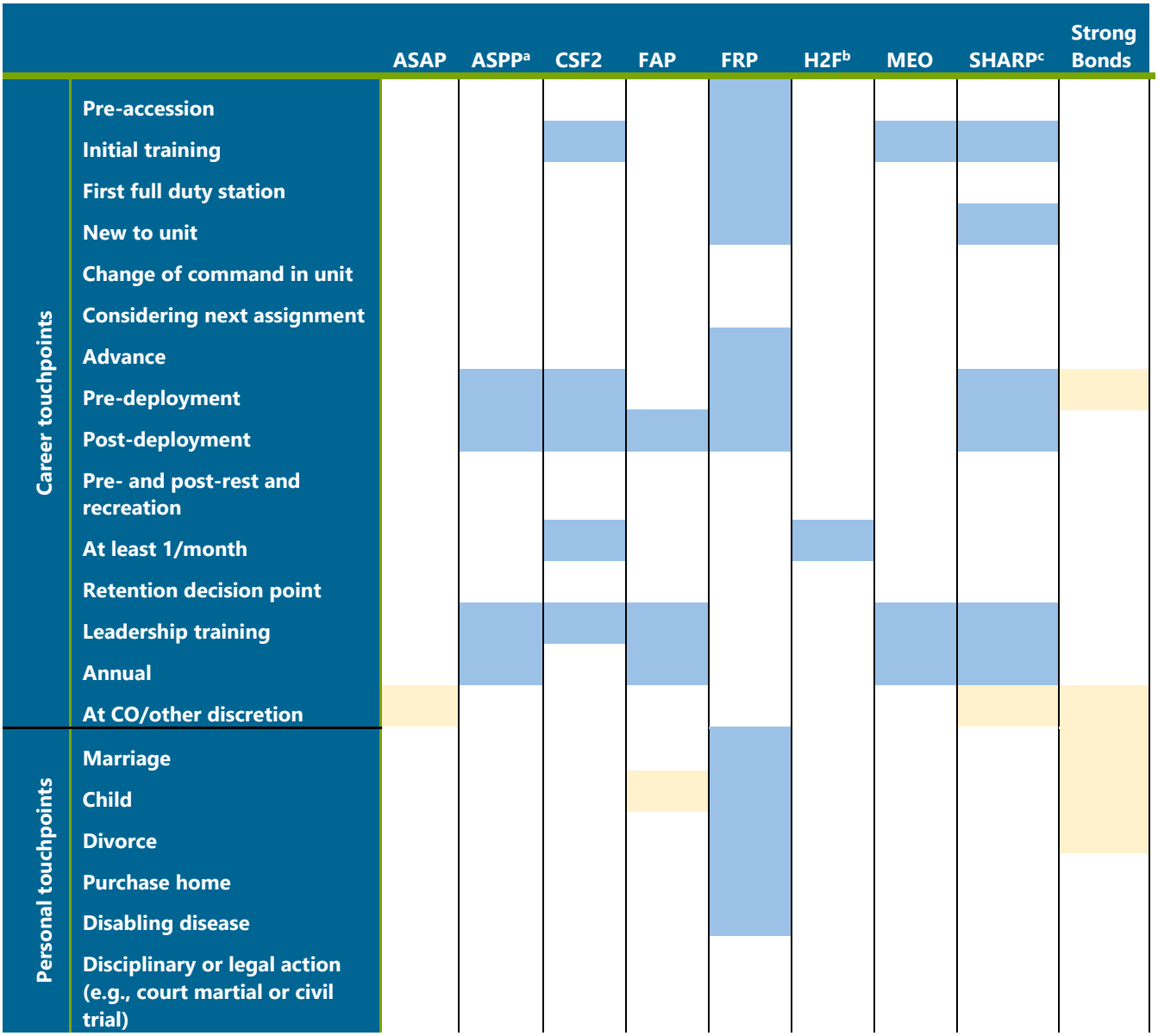
ARD asked CNA to identify touchpoints in a Soldier's career and personal life that should be the focus of prevention efforts. To identify these touchpoints, we built on a recent Navy project that identified multiple touchpoints for developing and reinforcing life skills (also called social and emotional skills or 21st century skills—several of which are listed as protective factors in the Army SEM) [21]. The Navy project—which leveraged literature review and discussion with Navy SMEs—determined that the life skills training should be provided as early as possible (even before accession when possible) and enhanced and reinforced throughout the career. Navy SMEs indicated that existing training touchpoints and transition periods (e.g., before/after deployment, change of duty station, change of command) are appropriate opportunities for enhanced and refreshed training [21].

Using these touchpoints as a starting place, we also identified additional touchpoints where the prevention programs we examined provide primary prevention activities. In Table 7, we list the program touchpoints, and differentiate the activities by whether they are mandatory

(shaded blue) or voluntary (shaded yellow) The touchpoints are organized to indicate whether they are career touchpoints that are experienced by most or all Soldiers or personal touchpoints that will not necessarily be experienced by all Soldiers and not at intervals dictated by the Army.

Each entry, unless noted otherwise in a footnote, indicates that some type of primary prevention activity is conducted at that touchpoint, such as teaching or enhancing life skills, reducing financial or family stressors, and so on.

Table 7. Touchpoints associated with the prevention programs



	ASAP	ASPP[a]	CSF2	FAP	FRP	H2F[b]	MEO	SHARP[c]	Strong Bonds
Health problems (e.g., on limited or light duty)									
Adverse event (e.g., foreclosure, death of loved one)									

Source: CNA.
[a] The primary prevention component of mandatory ASPP training is largely limited to listing risk factors for Soldiers to be aware of.
[b] H2F training will be mandatory once fully implemented.
[c] SHARP is primarily focused on awareness and response, but it has some limited primary prevention activities.
Note: Light blue shading indicates mandatory prevention efforts, while light yellow shading indicates voluntary prevention efforts.

The table highlights that primary prevention education and training is required at numerous touchpoints throughout Soldiers' careers. CSF2 and the congressionally mandated FRP training account for many of these requirements. The CSF2 touchpoints and those identified by Congress for mandatory financial readiness training are consistent with the prior CNA Navy project, which indicated that training and education should occur early in the servicemember's career and be refreshed and reinforced at key assignment or career transition points (e.g., deployment, advancement). It is important to reiterate that we do not have information regarding training content at each touchpoint; we simply indicate that program materials show that some type of primary prevention activity should occur at that touchpoint as part of that particular program. For instance, although SHARP program documents identify multiple training touchpoints across a Soldiers career, this training focuses more strongly on awareness and response information rather than primary prevention training. And, as noted previously, the content and duration of training can vary across units within each of the programs. Here we simply indicate that some form of primary prevention activity should occur at that touchpoint for that program.

The table also shows that there are several important touchpoints for which none of the programs we reviewed has mandatory or voluntary training opportunities. For instance, Soldiers selecting their next duty station could benefit from prevention activities as this transition point can be stressful, especially for those with families who must consider the effect of a move by weighing the costs and benefits of what could be the best career move, but a suboptimal move for their children or spouse. Close relationship stressors (like those that could be associated with a PCS move) are risk factors for suicide, substance misuse, and the perpetration of domestic violence and SA/SH. Making a decision whether to remain in the Army has similar stressors, but none of the PORs offer training at these touchpoints. Training

gaps also exist at change of command in the unit, pre- and post-recreation,[5] facing disciplinary or legal action, or going on limited or light duty because of an injury or other medical condition.

Applications of this analysis to integrated prevention

One approach to integrated prevention strategies is to provide training in life skills or shared protective factors that are the most relevant at each touchpoint and include appropriate *micro-applications*[6] to emphasize how that skill can be applied at that touchpoint. In other words, integration requires identifying touchpoints that are associated with greater risks for multiple harmful behaviors, and then incorporating protective factors associated with those behaviors into the training provided at those touchpoints.

As an example, our current research indicates that deployment is associated with an increased risk for substance misuse, domestic violence, and SA/SH. Simultaneously, the life skill of problem-solving and decision-making is a protective factor for these same behaviors. An integrated prevention program, then, might make Soldiers aware of the harmful behaviors associated with deployment and provide a pre-deployment refresher training on problem-solving and decision-making skills, with applications that are relevant to these harmful behaviors.

For instance, in our recent Navy study, we identified the following component skills associated with problem-solving and decision-making: the ability to identify a problem and its possible causes; to assess information; to create relevant options for addressing the problem and achieving desired outcomes; and to evaluate the outcome of a solution [21]. We then provided specific micro-applications of these component skills that could be applied for the prevention of specific harmful behaviors or the promotion of positive behaviors. Similarly, for the Army, integrated training at these touchpoints could involve incorporating problem-solving and decision-making skill practice into the required training and ensuring that activities involve micro-applications for each of the harmful behaviors that are at higher risk of occurring during or after deployment and combat.

Although there may be concerns that additional training time will detract from other mission-essential activities, it is not clear that more time would be required. Integrating the training that is already occurring at these touchpoints, eliminating redundancies, and tailoring micro-applicants to the most relevant behaviors could reduce total training time and improve training effectiveness.

[5] Soldiers do receive safety counseling prior to leave, but this is not part of any of the programs we reviewed.
[6] Micro-applications are contexts in which life skills are applied.

Alignment with effective prevention principles

In addition to identifying the extent to which the programs address risk and protective factors in the Army SEM across a Soldier's career, we analyzed the degree to which the programs align with the principles of effective prevention described in our previous report and summarized in the background of this paper. This section details our analysis methods and findings, beginning with an overview of the degree of alignment for each of the programs. We then discuss the programs that are most and least aligned with the principles, as well as the principles that are most and least consistently demonstrated in the prevention programs. We conclude by discussing implications of the analysis for developing an integrated prevention program, including the most promising models among the current prevention programs, and what would be needed to bring these programs (or an integrated version of the most promising models) into stronger alignment with the principles.

Methodology

The first step in determining the degree of alignment of prevention programs with effective prevention principles was for team members responsible for researching each prevention program to review program documents and talk with SMEs about the programs. Information gathered from these activities was entered into a spreadsheet that was organized according to the 11 principles.

Next, three researchers independently analyzed the information on the spreadsheet and determined the extent to which each program aligned with each of the 11 principles. The degree of alignment was judged primarily on the requirements specified in DOD and Army regulations and policy documents and confirmed by SMEs. In cases where SMEs indicated that regulatory requirements that align with a specific principle are inconsistently implemented, we relied on the regulation to determine degree of alignment. The alignment category was assigned based on the degree to which the program's regulatory requirements aligned with the definition of the principle holistically, or with its substantive components when applicable.

For example, our definition of *Comprehensive* includes three main components: The program (1) encompasses multiple components from awareness to skill building to resource support and (2) includes universal and targeted interventions (3) at multiple SEM levels (e.g., individual, relationships, work environment, community, and society). We rated a program as "aligned" with this principle if it aligned with all three components of the definition, "partially" if it aligned with one or two components, and "not aligned" if it aligned with none of the components.

Alignment categories depicted in Table 8 were defined by the three-member team as the following:

- Aligned (green): The program aligns with the principle holistically and with all relevant components (when applicable).
- Partially aligned (orange): The program addresses some relevant components of the principle.
- Not aligned (red): The program does not meet the intent of the principle.
- Not applicable (white): The principle does not apply to the program (e.g., victim-centered is not applicable to some of the prevention programs).
- Unclear (blue): Insufficient information is available to make a determination.

Once individual alignment judgments were made, the three-member research team convened to review the independent analyses and reach consensus on the degree of alignment. Then members of the larger research team reviewed the alignment judgments for their respective programs and provided feedback. The alignment chart was revised based on this feedback, and then used by the three-member team to identify key findings and implications for developing an integrated prevention program. We hope to explore implementation fidelity in greater depth in the next phase of the project, which may result in refinement to the alignment chart shown in Table 8.

Overview of alignment

Our judgment regarding the degree to which each of the programs aligns with the principles of effective prevention is displayed in Table 8.

Table 8. Program alignment with effective prevention principles

	Principle	ASAP	ASPP	CSF2	FAP	FRP	H2F	MEO	SHARP	Strong Bonds
Content	Socioculturally relevant	Unclear	Aligned	Aligned	Aligned	Partially Aligned	Partially Aligned	Aligned	Not Aligned	Aligned
	Theory-driven	Unclear	Aligned	Aligned	Aligned	Aligned	Aligned	Partially Aligned	Partially Aligned	Aligned
	Comprehensive	Not Aligned	Partially Aligned	Aligned	Aligned	Aligned	Aligned	Partially Aligned	Not Aligned	Aligned
	Skills-oriented	Not Aligned	Partially Aligned	Aligned	Aligned	Aligned	Aligned	Aligned	Partially Aligned	Aligned
	Fosters positive relationships	Not Aligned	Partially Aligned	Partially Aligned	Aligned	Partially Aligned	Aligned	Partially Aligned	Partially Aligned	Aligned
Delivery	Delivered by qualified, committed, supported staff	Unclear	Partially Aligned	Partially Aligned	Aligned	Aligned	Aligned	Aligned	Aligned	Aligned

	Principle	ASAP	ASPP	CSF2	FAP	FRP	H2F	MEO	SHARP	Strong Bonds
	Appropriately timed	Not Aligned	Aligned	Aligned	Aligned	Aligned	Aligned	Aligned	Aligned	Aligned
	Sufficient dosage and intensity	Not Aligned	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	Partially Aligned
	Actively engaging	Unclear	Aligned	Aligned	Partially Aligned	Aligned	Aligned	Aligned	Not Aligned	Aligned
Policy	Incorporates systematic evaluation and refinement	Partially Aligned	Not Aligned	Partially Aligned	Partially Aligned	Partially Aligned	Partially Aligned	Partially Aligned	Not Aligned	Partially Aligned
Policy	Accompanied by victim-centered response efforts	N/A	Partially Aligned	N/A	Aligned	N/A	N/A	Aligned	Aligned	N/A

Source: CNA.

Alignment by program

In reviewing the alignment down the columns for each program, we observe that programs focused explicitly on developing positive behaviors (CSF2, H2F, FRP, and Strong Bonds) have more alignment with the principles of effective prevention than do programs designed to address specific harmful behaviors (in particular, ASAP and SHARP). This finding is unsurprising, given that programs created to develop positive attributes and behaviors will, almost by definition, better align with a theory of prevention. In contrast, a program that addresses undesired outcomes must spend time defining the behaviors, conveying their inappropriateness, and indicating consequences for engaging in the behavior. Although these programs *can and should* leverage theories of root causes and build skills and positive relationships that will reduce the risk of the harmful behaviors, time constraints may result in de-prioritizing these primary prevention topics.

Importantly, programs that focus on positive behaviors differ in their scope. CSF2 and H2F are universal programs for all Soldiers that focus on the central Army objective of unit readiness. FRP is also a universal training but with a narrower objective: helping Soldiers achieve and maintain financial readiness. Strong Bonds is a voluntary (rather than universal) program designed to help Soldiers and their families improve their relationships and their communication skills.

The poor alignment of programs that target specific harmful behaviors is concerning, particularly with respect to ASAP. Alcohol misuse is not only a harmful behavior in its own right but also a risk factor associated with the other harmful behaviors. Although some straightforward fixes would bring the program into stronger alignment (e.g., mandating the

training for all units), a deeper, unresolved problem is the complicated role of alcohol in the military culture. Although the Army wants to reduce the consequences of irresponsible drinking, excessive drinking is more common in the military than it is in other occupations, and is often not only tolerated but perceived as expected or encouraged [22-24]. The fact that ASAP is the only program among the prevention programs that is not mandated for all Soldiers at appropriate times throughout their careers is emblematic of this complicated relationship.

Alignment by principle

In reviewing the alignment across the rows for each prevention principle, the principle that is most consistently represented in the prevention programs is *appropriately timed*. For many of the programs, Army regulations mandate training at key transitional touchpoints in a Soldier's career, including initial entry, annual refreshers, and as part of leader courses.

At the other extreme, no POR aligns well with the principle of systematic evaluation and refinement. Some programs collect data intended for this purpose, and some have had independent assessments that provide some evidence of program effectiveness. These evaluations, however, do not appear to be implemented consistently and systematically in any program, nor are we aware of processes to use the feedback for continuous program improvement.

Because our program information to date comes from policy documents and institution-level SMEs, we know little about the dosage and intensity that Soldiers receive in their units. Alignment with the principle of sufficient dosage and intensity will become clearer when we speak with installation- and unit-level stakeholders in the next phase of the study.

For several other principles of prevention, the current Army approach is partially aligned but has room for improvement.

- **Sociocultural relevance.** Multiple prevention programs clearly address the context of Army life and the Army's mission and core values. Less clear, however, is the extent to which they address elements of Army culture that allow harmful behaviors to continue, such as tolerance of heavy drinking and harmful norms and attitudes (e.g., homophobia, unhealthy ideas of masculinity, hostile gender attitudes).
- **Theory driven.** As noted in the previous section, programs focused on developing positive behaviors address many of the shared protective factors identified in the Army SEM. Programs with the goal of reducing specific harmful behaviors, however, appear to be more focused on deterrence, intervention, and response than on addressing root causes, risk factors, and protective factors.
- **Comprehensive.** With the exception of FAP, only programs focused explicitly on developing positive behaviors (HSF2, H2F, FRP, and Strong Bonds) are considered fully

comprehensive. Those focused on reducing harmful behaviors do not consistently address the multiple levels of knowledge and/or target the needs of different populations. As examples, ASPP addresses three SEM levels and all four knowledge levels but does so mostly through leveraging other programs and involves only one hour of mandatory training; ASAP is designed around random drug testing and mandates training only for those who fail these drug tests.

- **Skills-oriented.** This principle, which is related to the knowledge levels component of the comprehensive principle, is a major focus of CSF2, H2F, FRP, FAP, and Strong Bonds. Although all prevention programs except for ASAP involve at least some skill development, the universal training in ASPP and SHARP is primarily at the awareness level.
- **Foster positive relationships.** Several prevention programs address building interpersonal skills but do not explicitly emphasize developing positive, trusting relationships between instructors and participants, or include a formal support structure (e.g., mentoring, peer support groups) to reinforce skills between training events. The exceptions are H2F, FAP, and Strong Bonds: H2F employs full-time professionals within the unit to train and mentor Soldiers; FAP uses community activities to build an extended family; and Strong Bonds is conducted at an off-site retreat to ensure a positive, trusting environment.
- **Well-trained, qualified, committed, and supported staff.** Although most programs provide adequate training and certification to the trainers, instructors and trainers for two programs (CSF2 and ASPP) have another full-time job and administer the programs as an additional duty. The certification requirement for ASAP trainers is under review.

Implications for developing an integrated prevention program

Army programs aimed at developing positive behaviors are generally well aligned with the principles of effective prevention and could serve as models, both in content and delivery, for an integrated prevention program. CSF2 and H2F are particularly promising candidates around which to build an integrated prevention program. CSF2 has the advantages that it is already universal and that it leverages the R2 performance centers at Army installations across the country and around the world. H2F has the advantages of full-time professional staff and of bringing this professional support from the installation level to the unit level, but it is new and has not yet been introduced to all brigades. Transitioning either of these to a fully integrated program might be accomplished by addressing the following issues related to content, delivery, and policy:

- **Content.** A single integrated program would ensure coverage of the key shared risk and protective factors in the Army SEM. These include military cultural factors that contribute to harmful behaviors, such as alcohol misuse. It may include additional opportunities to build conflict resolution and problem-solving skills that are currently covered in other PORs such as MEO and Strong Bonds. The program might also include a peer support and mentoring structure to reinforce positive behaviors and avoid negative ones between training sessions.
- **Delivery.** An integrated program should ensure that program facilitators are unit-based and full-time. Examples in existing Army programs include surgeons, chaplains, embedded behavioral health experts, occupational therapists (OTs), physical therapists (PTs), athletic trainers, MEO professionals, FAP professionals, VAs, and the H2F program manager. It might also include training support packages (TSPs) with lessons and materials to promote engaging instruction and skill development, such as the MEO Harmful Behavior Prevention Tool and the Strong Bonds workshop materials. Integrated prevention training should occur at key touchpoints, such as when a Soldier reports to a new unit and as part of the deployment cycle. In addition, rather than simply repeating the content at each subsequent touchpoint, the training should be cumulative so that the Soldier advances from awareness to understanding to skill development.
- **Policy.** An integrated program should have not only clearly defined and measurable goals but also a feedback process for assessment and continual refinement. Because none of the PORs is consistently implementing a systematic evaluation process, successfully addressing this prevention principle would be a significant win for the Army. An integrated program may also include victim-centered responses to certain harmful behaviors.

As the Army considers these or other enhancements to develop an integrated prevention approach, several approaches are possible, including the two outlined below:

- **Single, unit-based program:** The Army could adopt a program that covers the prevention goals of all existing PORs. Although such a program would be focused on skill development for primary prevention, it would also need to include training modules for intervention pertaining to specific harmful behaviors. For example, it might include awareness training to recognize and respond to elevated risk of suicide, sexual assault, and domestic violence, as well as procedures for the unit to respond to victims of these behaviors. These modules would incorporate refreshers at key touchpoints on the factors that protect against these behaviors.
- **Unit-based and installation-based companion approach:** Alternatively, there could be a unit-based holistic program for primary prevention (focused on skill building and

resilience) and a companion installation-based program for prevention, intervention, and victim-centered response to specific harmful behaviors. Installation SMEs dedicated to suicide, sexual assault and harassment, domestic violence, substance misuse, discrimination, and extremism would share an office and coordinate awareness campaigns, as well as their assistance to units responding to harmful behaviors. This installation-level structure would mirror the structure at the Department of the Army level of an integrated prevention program office (which would likely exist in either approach).

Areas for exploration

As noted above, our analyses relied heavily on Army regulations and policy guidance, supplemented by information from program-level SMEs. Although many programs mandate training and have standardized training curriculum, we do not know how consistently the curricula are implemented, how many Soldiers receive it, and at what levels of instruction. For programs without a standardized curriculum, we know little about the training Soldiers receive without speaking with providers who administer the programs across different installations. In addition, the Army does not dictate the integration of prevention programs but instead provides unit leaders with information about resources available to their units through different programs. In phase 3 of this research, we hope to learn about how these programs are implemented and integrated at the installation and unit level.

Conclusions

In this report, we used two key outputs from the first phase of this research to evaluate the Army's 8 prevention PORs and the MEO program: 1) the Army SEM depicting shared risk and protective factors for 6 harmful behaviors: suicide, substance abuse, domestic violence, sexual harassment/assault, discrimination, and extremism, and 2) the principles of effective prevention of harmful behaviors [11]. We conducted document reviews and discussions with HQ-level program proponents to develop summaries of the primary components of these programs. We then analyzed the extent to which those programs address shared risk and protective factors, are provided at key career touchpoints, and align with principles of effective prevention. This analysis can be used to identify opportunities to better integrate Army prevention programs and to make them more effective, addressing a broader set of risk and protective factors more comprehensively. Opportunities for integration can focus on shared risk and protective factors, career and personal touchpoints, increasing prevention aspects of primarily response-based programs, and building on existing programs that already address primary prevention and skill building.

First, almost all the shared protective factors are addressed to some extent by at least one prevention program, and many are addressed by multiple programs. However, several shared risk factors are not addressed by any of the prevention programs we reviewed. ARD should explore ways to incorporate these shared risk factors explicitly in ongoing or new prevention efforts.

Second, our crosswalk of prevention programs across important career and personal touchpoints indicated that mandatory prevention programs exist across many primary touchpoints (e.g., entry into the unit, deployment, marriage). Indeed, most of the prevention programs contain mandatory components; however, these are primarily short-duration annual (or situation-dependent) training. These mandatory components generally do not include comprehensive skill building or a focus on primary prevention.

Third, Army prevention programs focused on harmful behaviors were originally conceptualized primarily as response-based programs. Although they are evolving to include more prevention principles, they are not as well aligned to these principles as those programs that were built to focus on positive behaviors.

Fourth, the Army has four PORs that are focused primarily on primary prevention and building skills to reinforce positive behaviors: CSF2, FRP, H2F, and Strong Bonds. Although each of these includes mandatory components (except Strong Bonds), implementation varies across commands. Nevertheless, these programs are generally comprehensive and could provide a basis for integration among prevention efforts for multiple harmful behaviors.

In general, the Army prevention programs have a great deal of potential for building an integrated prevention system. In total, they cover most of the shared risk factors and almost all the protective factors the literature identifies as related to the harmful behaviors of interest. For many of the risk and protective factors, more than one prevention program addresses them. What is unclear is *to what extent* these factors are being addressed (e.g., to what extent factors are covered in sufficient dosage and intensity). The current analysis does not have detailed enough information to make definitive conclusions about the dosage and intensity of the prevention efforts.[7] However, our discussions with program officials made it clear that there is considerable discretion in the extent to which the unit commanders implement mandatory programs and make use of voluntary programs and services offered by the prevention experts. Headquarters-level program experts indicated that there is also variability in how the installations engage with the unit commanders and provide installation-wide services. Given the centrality of the installations and unit commanders in executing prevention programs, we highly recommend engaging installation-level points of contact and battalion/brigade commanders to determine the extent to which the available prevention programs are implemented as intended and integrated with one another, and to identify any barriers to use.

The next phase of this research will explore barriers to and opportunities for integration of prevention programs at the installation and unit level. This exploration will be the basis for analysis to develop recommendations for an integrated prevention system for the Army that will align with the principles of effective prevention and include as many shared risk and protective factors across as many touchpoints as possible.

[7] A Program of Instruction review was beyond the scope of the tasking for this study. However, such a review would allow for a more definitive determination about the dosage and intensity of the PORs.

Appendix A: Army SEM of Shared Risk and Protective Factors

Table 9. Risk factors associated with two or more harmful behaviors

SEM Level	Risk Factor Label	Suicide	Substance Misuse	Domestic Violence	Sexual Harassment/ Assault	Discrim.	Extremism	Total
Individual	Gender: male	X	X	P	P	P	X	6
	Poor mental health	X	X	VP	VP	V	X	6
	Marital status: unmarried	X	X	V	V	V	X	6
	Age: young adult	X	X	VP	V	P		5
	Low education attainment	X	X	VP	V	P		5
	Financial stress	X	X	VP		V	X	5
	Rank: enlisted	X	X	VP	VP	P		5
	Antisocial and aggressive behavior	X	X	P	P			4
	Impulsivity	X	X	P	P			4
	Past exposure to trauma/abuse	X	X	VP	VP			4
	Alcohol misuse	X	X	VP	VP			4
	Unhealthy or dysfunctional parenting		X	P	VP			3
	Deployment		X	VP	V			3
	Non-heterosexual orientation	X			V	V		3
	Gender: female			V	V	V		3
	Lower rank: junior enlisted or junior officer	X	X		V			3
	Combat exposure	X	X		V			3

	Hostile gender attitudes and beliefs			P	P	P		3
	Previously committed the harmful behavior	X	X		P			3
	Low SES			VP	V			2
	Race/ethnicity: Non-Hispanic white	X	X					2
	Combat arms occupation	X	X					2
	Sexual identity crisis	X				V		2
	Poor physical health or recent medical issue	X	X					2
	Low self-esteem			P		V		2
Interpersonal	Association with unhealthy/dysfunctional peer groups		X	VP	P	P	X	5
	Isolation/lack of social support	X		VP	VP		X	4
	Close-relationship stressors	X	X	P	P			4
Unit	Stigma associated with reporting/seeking help	X	X	VP	VP			4
	Toxic/permissive unit climate	X	X		VP	VP		4
	Toxic/ineffective or weak leadership				VP	VP		2
Installation/ local community	Availability of alcohol		X	VP	VP			3
	Access to location or methods	X	X		VP			3
	Social/community disorganization			VP	VP			2
	Low community SES			VP		VP		2

Army	Stigma associated with reporting/seeking help	X	X	VP	VP			4
	Harmful norms (gender, violence, drinking)		X	VP	VP	VP		4
	Structural barriers to accessing help/resolution	X			VP	VP		3
Society	Weak policy/law	X	X	VP		VP	X	5
	Weak economic conditions	X	X	VP		VP		4

Source: CNA.
Note: "V" indicates a risk factor for victimization, and "P" indicates a risk factor for perpetration of a harmful behavior. Suicide, substance misuse, and extremism do not have Vs or Ps because those harmful behaviors involve a single actor.

Table 10. Protective factors associated with two or more harmful behaviors

SEM Level	Protective Factor Label	Suicide	Substance Misuse	Domestic Violence	Sexual Harassment/Assault	Discrim.	Extremism	Total
Individual	Life skill: decision-making and problem-solving	X	X	P	P			4
	Life skill: empathy			P	P	P	X	4
	High academic achievement		X	P	P		X	4
	Positive affect	X	X					2
	Marital status: married	X	X					2
	Spirituality/religiosity	X	X					2
Interpersonal	Social connectedness and support	X	X	VP	P		X	5
	Family cohesion and support	X	X	VP	VP			4

	Healthy peer relationships		X	P	V		X	4
Unit	Unit cohesion and connectedness	X	X		VP	VP		4
	Positive leadership engagement	X	X		VP	VP		4
	Unit-level policy enforcement		X		VP	VP		3
Installation/ local community	Restrict or limit access to instruments of harmful behavior	X	X	VP				3
	Community connectedness and support	X		VP				2
Army	Prevention policies		X	VP	VP	VP		4
Society	None identified							0

Source: CNA.
Note: "V" indicates a risk factor for victimization, and "P" indicates a risk factor for perpetration of a harmful behavior. Suicide, substance misuse, and extremism do not have Vs or Ps because those harmful behaviors involve a single actor.

Appendix B: Summary of Army Prevention Programs of Record

In this section, we describe in further detail each of the eight Army PORs and the MEO program. Descriptions include the following information:

- Program goals and sources of information
- Whether the program is prevention- or response-based and coordinates with other programs
- Where integration is strongest
- Training content, delivery, and target audience
- Trainers' training and whether they are collateral duty
- Evidence of program effectiveness

Army Suicide Prevention Program (ASPP)

Overview and background

Summary

The Army Suicide Prevention Program (ASPP) is an Army-wide effort sponsored by the Deputy Chief of Staff, G-1 to provide resources for suicide prevention, intervention, and postvention. In addition to the Program Office at Headquarters Department of Army G-1 ARD, ASPP is overseen by Commands. The ASPP is a commanders' program, with program coordinators assigned to installations/garrisons. Personnel are required to support SP training and education needs, and to administer a Suicide Prevention task force that oversees the ASPP requirements. As with suicide prevention programs in the other services, it is tied to the Defense Suicide Prevention Office [25].

Sources

ASPP is governed by Army Regulation 600-63, *Army Health Promotion*, and by Department of the Army Pamphlet 600-24, *Health Promotion, Risk Reduction, and Suicide Prevention* [1-2]. We reviewed these policies as well as the ASPP resources on the ARD website, including *Reducing Suicide in Army Formations: BDE and BN Commander's Handbook* [26]. Other associated materials we reviewed include the slides and the facilitators handbook for the required annual

suicide training, ACE (Ask, Care, Escort) for Soldiers, and U.S. Army Public Health Center Technical Guide No. 362, *Implementation of the Commander's Ready and Resilience Council*. Finally, we spoke with the ASPP program manager [27].

Program goals

The goal of the ASPP "is to minimize suicidal behavior by reducing the risk of suicide for Active Army and Reserve Component Soldiers, Army civilians, and Army family members" [1].

Program components

Main focus

Prevention, intervention, and postvention

ASPP policy mostly discusses primary prevention but also includes intervention and postvention elements. The Unit Leaders Guide describes four tiers of prevention, all of which are focused on Soldiers who have not yet attempted suicide. Tier 1 is "sustain upstream prevention" and refers to general quality of life programs. Tier 2 is "protect—foundation of universal prevention" and is also focused on prevention for all Soldiers. Tier 3 is "engage—actions to identify and support people at risk." Tier 3 includes ACE training for all Soldiers, additional prevention training for gatekeepers, and the safe storage of weapons, which applies to all except in rare cases in which a commander asks for a Soldier's gun. This tier is still primary prevention. Tier 4 entails "actions to support people known to be at risk" [26]. Tiers 3 and 4 also include intervention.

Postvention includes a Suicide Response Team (SRT) that "convenes at the discretion of the commander as a result of an attempted or completed suicide" [1]. The SRT is led by the command surgeon or director of psychological health. It includes a command psychiatrist or behavioral health officer, chaplain, G-1 representative, provost marshal, and (as needed) representatives of the Staff Judge Advocate, ASAP manager, and Army Community Services (ACS) officer. Army suicide postvention has the following three objectives:

1. Set a foundation for healthy grieving and facilitate healing of individuals and the unit.
2. Prevent other negative effects of exposure to suicide through identification and referral of those most at risk for behavioral health concerns, include suicide behaviors.
3. Safely memorialize the deceased.

Together, the SRT responds to medical, spiritual, administrative, and legal needs of the unit and family of the Soldier who committed or attempted suicide in support of objectives one and two. The Suicide Postvention Unit Commanders' Handbook also facilitates objectives one and two. Army Command Policy (AR 600-20) clarifies objective three: it is the commanders' responsibility to provide a memorial service for all Soldiers who die in the unit, but he or she

may "scale down a memorial event to offer closure to unit members while not glamorizing the manner of death when a Soldier dies by suicide" [3].

Coordination with other programs

ASPP policy references several other Army programs. For example, the unit leader's guide cites the following resources [26]:

1. ASAP and Employee Assistance Program
2. ACS
3. Behavioral health providers/Installation Director of Psychological Health
4. Chaplains
5. Employment Readiness Program
6. Emergency Room
7. Equal Opportunity
8. Exceptional Family Member Program
9. Family Advocacy Program
10. Financial Readiness Program
11. Morale, Welfare, and Recreation (MWR)
12. Performance Experts (PEs) at the Ready and Resilient (R2) Performance Center
13. Relocation Assistance Program/Soldier and Family Assistance Center
14. Survivor Outreach Services
15. Sexual Assault Response Coordinator (SARC)/VAs
16. Military and Family Life Consultants (MFLCs)

However, acknowledgement that other Army programs can contribute to protective factors or mitigate risk factors associated with suicide does not necessarily indicate the extent to which ASPP is coordinated with these programs. Because installations, brigades, and battalions have access to stakeholders from various programs, coordination often occurs at those levels and the degree to which it occurs likely varies across installations and units.

Where integration is strongest

More complete knowledge of where program integration works well will be found at the installations and units where the programs are administered, but the ASPP program manager informed us of one instance of coordination across programs at the Army level. Counseling on Access to Lethal Means Safety training, which was already provided by the Suicide Prevention Resource Center to MFLCs and behavioral health providers, is now also provided to some chaplains who have counseling credentials.

Trainers

Behavioral health officers train the trainer for all suicide prevention trainings within the medical community. Behavioral health officers or chaplains may also provide the suicide prevention training for ACS, Child and Youth Services, and youth activities staffs [2]. The PEs at the R2 Performance Center teach Engage for Suicide Prevention [26].

Ask, Care, Escort-Suicide Intervention (ACE-SI) Tier Two is an additional train-the-trainer course intended for staff sergeants and above selected by the commander [26].

Training

Target audience

Several levels of suicide prevention and intervention training exist. SMEs we spoke with reported that unit commanders determine who receives leadership or gatekeeper suicide training.

Leadership training

ACE-SI is a four-hour leadership training intended for squad and section leaders, platoon sergeants, platoon leaders, first sergeants, company executive officers and commanding officers, and Army civilians assigned at the company level [2]. ASPP does not know how many Soldiers and civilians receive ACE-SI or ACE-SI Tier Two training.

Junior enlisted training

Engage for Suicide Prevention targets junior enlisted Soldiers [26]. It is an optional substitute for ACE and is provided by the Performance Centers.

Mandatory training for all Soldiers

There is a mandatory annual one-hour ACE training for all Soldiers. Although it may be ideal for a graduate of ACE-SI or ACE-SI Tier Two to deliver the one-hour ACE training, the ACE facilitator's handbook is publicly available, and the training is designed to be deliverable by personnel who are not ACE-SI graduates.

Although family members of Soldiers are not required to take ACE, the curriculum is approved for families; commanders "must" ensure that it is available to families and "should" encourage families to take part in it [2].

Gatekeeper training

Policy designates primary and secondary gatekeepers to play special roles in suicide prevention and intervention [2]. Gatekeepers have a one-time suicide training requirement, with a curriculum determined by the Army G-1. The training required may vary by type of gatekeeper. For example, the ASPP Program Manager reports that judge advocates are encouraged to receive ACE-SI training. The following gatekeepers are listed in AR 600-63:

Table 11. Suicide gatekeepers identified in policy

Primary Gatekeepers	Secondary Gatekeepers
Chaplains and Chaplain Assistants	Military Police
ASAP Counselors	Trial Defense and Legal Assistance Attorneys
Family Advocacy Program Workers	Inspectors General
Army Emergency Relief Counselors	DOD School Counselors
Emergency Room Medical Technicians	Red Cross Workers
Medical/Dental Health Professionals	

Source: [2].

Delivery

ACE is intended to be provided in settings with 8 to 30 participants and involves multiple group activities and volunteer demonstrations [28]. Although it is required annually for all Soldiers, there are additional requirements for units deploying for more than 90 days. Behavioral health officers from a combat stress control unit provide the deploying unit with suicide prevention training before, during, and after the deployment [2].

ASPP promotes several formal and informal means to reinforce suicide prevention skills outside of training events. These include a strategic communications plan involving articles and billboards, an equal opportunity advisor to promote a positive and trusting command climate, and a Better Opportunities for Single Soldiers program that promotes connectedness and positive behavior for single Soldiers [1, 26]. Perhaps most importantly, it stresses that frontline supervisors foster the connectedness and trust to enable effective suicide prevention and intervention.

Content

Risk and protective factors and skills addressed

ASPP policy lists the following risk factors, all of which are evidence-based:

- Failed intimate relationship or relationship strain
    - Chaplains provide relationship training through Strong Bonds, and the FAP provides education to strengthen relationships as well. ACS assists with referrals for additional support. MFLCs provide support for relationship issues [1].
- Previous suicide attempts
- Family history of suicide
- Depression, post-traumatic stress disorder (PTSD), or other behavioral health illness

  - Prevention screening assesses for depression and PTSD. Medical treatment facilities provide treatment, MFLCs ensure seamless coverage, and strategic communication campaigns raise awareness of treatment availability [1].
- Death of a loved one
  - MFLCs provide grief support, as do chaplains [1].
- Social isolation
  - Policy recommends joining social support groups, faith-based organizations, and self-help groups, and directs small unit leaders to be familiar with their Soldiers including their personal lives. Army also assigns each Soldier a unit battle buddy.
- Drug or alcohol abuse
  - ASAP combats substance misuse, and the ASAP manager is a member of the suicide prevention task force.
- Access to lethal means
  - Commanders should educate their Soldiers about safe storage of guns and should remove access to lethal means for high-risk Soldiers [26].
- Current or pending disciplinary or legal actions
  - Legal Assistance attorneys help Soldiers and their families address pending legal and administrative actions and may identify and escort Soldiers at risk to behavioral health [1]. Company commanders and first sergeants should monitor medical and legal actions as known risk factors [26].
- Serious medical problems
  - Provision of medical care is integrated into ASPP, including membership of the Director of Health Services, Health Promotion Officer, and Command Surgeon in the Suicide Prevention Task Force at the installation level [1]. At the brigade level, the surgeon is a member of the Ready and Resilient process chaired by the brigade commander [26].
- Work-related problems
  - Behavioral Health Pulse, a voluntary and anonymous survey tool used by behavioral health officers, includes questions about the work environment such as issues of overload and morale [26]. First-line supervisors are best positioned to work with Soldiers to resolve situational issues [1, 26].
- Excessive debt
  - ACS includes financial management assistance [1]. Unit leaders should encourage financial counseling, and the Unit Risk Inventory (an anonymous survey) includes questions about financial difficulties [26].

- Severe or prolonged stress
    - The command surgeon coordinates the use of medical assets in stress management, the command psychiatrist or behavior health officer provides training in stress management, the chaplain assists in stress management, leaders educate Soldiers about stress, various websites provide self-screening for anxiety disorders, ACS FAP provides training to families to relieve stress, and MFLCs provide stress management support [1].

The Unit Leaders Guide to Suicide Prevention lists resources to assist with the following protective factors, all of which are directly supported by empirical evidence or aimed at addressing evidence-based risk factors:

- Resilience
- Financial planning
- Community programs
- Spiritual growth
- Adequate sleep

ASPP uses language familiar to Army culture, such as "be aware of what's in your ruck, don't just suck it up [with photo of Soldier carrying rucksack]" and "battle buddy." Its training to rank-and-file Soldiers directly acknowledges stigma associated with seeking help [28].

Climate and culture focus

ASPP is built on the concept, fundamental to all military units, that the commander has a holistic responsibility for all aspects of the unit's readiness [1-2, 26].

Effectiveness

Published research

We are not aware of published research on the effectiveness of the ASPP.

Program evaluation

The ASPP program manager has the responsibility to "establish and maintain program-level evaluation plans, measures, data collection, analyses, and reporting procedures" [2]. ASPP conducts staff assistance visits to ensure policy compliance and works with the Army Public Health Center to collect and analyze data on suicide incidence, suicide ideation and attempts, and substance abuse incidence and drug testing.

ASPP is in the process of developing methods to assess program effectiveness. To that end, they have produced logic models tying ASPP activities to outputs, short-term outcomes, mid-term

outcomes, and long-term outcomes. These include three distinct logic models to describe the inputs and outputs of command visibility tools, of integrated primary prevention trainings, and of community-based R2 integration for suicide prevention. At present, some of these outputs and outcomes are not observed by ASPP at the Army level and/or are not defined in a manner that is readily measurable.

Army Substance Abuse Program (ASAP)

Overview and background

Summary

The Army Substance Abuse Program (ASAP) is administered by HQDA G-1, Army Resilience Directorate. ASAP provides alcohol abuse, substance abuse, and gambling disorder prevention and control policies, procedures, and responsibilities for all Army components, DA civilians, and other eligible personnel.

Sources

The sources of the information provided in this section include the following:

- SMEs: R2I Prevention, HQDA G-1, Army Resilience Directorate; Chief, Information Systems Branch, Army Resilience Directorate
- Documents: Army Regulation 600-85 [18], DoDI 1322.31 [29], *U.S. Army Suicide Prevention Program Logic Models: Three Functions: Suicide Prevention Implementation, Monitoring, and Evaluation Planning* [30], DoD Inspector General Report [31], Unit Risk Inventories brief [32], Fort Knox News article [33], ADAPT Brief [34]; Army news article [new option to treat] [35]; *Prime for Life Workbook* [36]
- Websites: Army ASAP website [37], Army Fort Knox Risk Reduction Program website [38]

Program goals

According to the ASAP website, ASAP objectives are the following [39]:

- Increase individual fitness and overall unit readiness
- Provide services that are proactive and responsive to the needs of the Army´s workforce and emphasize alcohol and other drug abuse deterrence, prevention, education, and rehabilitation

- Implement alcohol and other drug risk reduction and prevention strategies that respond to potential problems before they jeopardize readiness, productivity, and careers
- Restore to duty those substance-impaired Soldiers who have the potential for continued military service
- Provide effective alcohol and other drug abuse prevention and education at all levels of command and encourage commanders to provide alcohol and drug-free leisure activities
- Ensure that all personnel assigned to ASAP staff are appropriately trained and experienced to accomplish their missions
- Achieve maximum productivity and reduce absenteeism and attrition among civilian corps members by reducing the effects of the abuse of alcohol and other drugs
- Improve readiness by extending services to the Soldiers, civilian corps members, and Family members

Program components

Main focus

Deterrence, prevention, and treatment

ASAP consists of three components regarding alcohol and drug abuse: (1) deterrence, (2) prevention, education, and training, and (3) substance use disorder (SUD) treatment. According to one SME with whom we spoke, the main emphasis of ASAP has been deterrence, but more recently the focus has turned to prevention.

Deterrence

Deterrence consists of random drug testing,[8] identification and detection, and referral. Deterrence aims to prevent individuals from abusing drugs (including illegal drugs, other illicit substances, and prescription medications). Specific policies differ by substance. The military personnel deterrence drug-testing program is mandatory; it depends on an aggressive and thorough urine analysis program requiring the participation of all Soldiers and civilians (in testing-designated positions) selected for testing. It is based on the tenet that the unpredictability of testing is a determining factor deterring Soldiers from using drugs, and that high frequencies of unpredictable random testing contribute to deterrence. Commanders are

[8] Random testing includes Inspection Random Testing (IR), in addition to seven other testing premises: Inspection Unit (UI), Inspection Other (IO), Probable Cause (PO), Command Directed (CO), Soldier Consent, Volunteer (VO), Rehab testing (RO), and Accident/Mishap (AO).

required to test 10 percent of their assigned end strength each month; they may conduct tests of several smaller percentages within a month to achieve the 10 percent total. In addition, Soldiers who are not selected for random testing during the first three quarters of each fiscal year are selected in the fourth quarter of the year. Commanders are also encouraged to conduct periodic unit sweeps. Soldiers who test positive for illicit drugs are evaluated for a SUD, disciplined as appropriate, and processed for separation.

Regarding alcohol, commanders are charged with identifying Soldiers with problematic alcohol abuse and referring them to Behavioral Health for a SUD evaluation. While alcohol testing is not mandatory, commanders may use unannounced tests as part of unit inspection, search or seizure based on probable cause, competence for duty, Soldiers enrolled in a SUD treatment, mishap or safety inspection, voluntary consent, pre-accession physical or initial service, or valid medical purpose.

Prevention, education, and training

Prevention initiatives are targeted at the total force and tailored to diverse groups. They are intended to emphasize cooperation with installations and local communities, and to de-glamorize alcohol. The latter includes prohibition of marketing and promotion of practices that glamorize alcohol. Each installation has a prevention coordinator (PC) responsible for administering the prevention and education functions of ASAP. Some of these duties include marketing ASAP services; ensuring that all personnel are provided prevention training, education, or other services; and designing, developing, and administering target group-oriented alcohol and other drug abuse prevention training and education. One SME we spoke with told us that there are limits to how much ASAP personnel can target these efforts to entities outside of the Army and for functions that are not funded by the Army.

Currently, there are no requirements for mandatory annual prevention training, but the regulation does encourage PCs, to the extent possible, to teach at least one class to each unit per year. One SME estimates that currently fewer than 50 percent of Soldiers receive annual ASAP training or education. The SME speculated that one of the reasons for a reduction in training could be the restrictions imposed by COVID-19.

Another component of prevention is identifying high-risk units by administering the Unit Risk Inventory (URI) and Reintegration URI (R-URI), which are part of the Army's Risk Reduction Program (RRP). Both URI and R-URI are self-reported anonymous surveys that screen for high-risk behaviors and attitudes within units. The URI is administered annually, and within 120 days before an operational deployment, while the R-URI is administered to units between 30 and 90 days after returning from deployment. The inventories ask about alcohol and drug abuse, personal and unit relationships, domestic violence, suicide, crime, perception of the Army environment, and financial problems [32]. Information from these surveys, as well as data collected as part of the RRP, is intended to give Army leadership a better understanding

of a unit's risk of harmful behaviors [33]. The RRP Coordinator (RRPC) receives URI results along with the Commander. The RRPC and PC (PCs do not receive direct access to the URI results), develop an action plan to present to the Commander based on URI results. The RRPC and other installation risk factor SMEs then discuss URI results and action/mitigation strategies with the Commander. The RRP does not mandate actions when a unit is at a high risk of an event (referred to as being "in the red"), but the regulations do dictate actions that Commanders are required to take when Soldiers have high-risk events, such as drug-positive or alcohol incidents. However, while Alcohol and Drug Abuse Prevention Training (ADAPT) and Substance Use Disorder Clinical Care Program (SUDCC) are tracked, ASAP does not require Commanders to send Soldiers to ADAPT or SUDCC, and there are no consequences for non-compliance by a Commander.

Education efforts may include posting prevention messages on installation or unit social media pages, distributing flyers, information campaigns, coordinating messaging with Public Affairs Officers, and giving presentations to installations or depots. Standard education materials do not exist; the level of effort and variety of approaches are largely up to the installation PC in coordination with other ASAP staff and installation commander.

The only mandatory *training* is for individuals who have a positive urinalysis or who have had an incident that involved a substance abuse issue. These Soldiers must attend an ADAPT Prime for Life (PFL) course, which is typically taught by installation PCs, but may also be taught by other personnel who are certified to teach the course at that location. ADAPT-PFL is a 12-hour intervention that focuses on the adverse effects and consequences of problematic substance abuse. ADAPT is delivered primarily to active-duty Soldiers; dependents and retirees may attend based on space availability.

Treatment

In 2016, clinical treatment for SUDS transitioned from ASAP to the SUDCC, which was created under the US Army Medical Command. SUDCC operates exclusively in the capacity of SUD treatment.

Treatment by a SUDCC Behavioral Health provider can be mandatory or voluntary. Soldiers who are required to attend ADAPT-PFL must be assessed by a Behavioral Health provider, and if a SUD is diagnosed, the Soldier is enrolled in mandatory SUD treatment under the following conditions: (1) The SUD is related to illegal drug use, which includes the illegal use of prescription drugs, (2) alcohol abuse is identified through law enforcement investigation and/or apprehension, and/or an alcohol breath or blood test indicates alcohol impairment while on duty, and a diagnostic assessment confirms the presence of a SUD, (3) the Soldier is receiving more extensive treatment than standard outpatient behavioral health care, and (4) the substance abuse affects the Soldier's judgment, reliability, or trustworthiness, or presents a clear risk to safety, security, occupational functioning, or mission.

Coordination with other programs

The SME we spoke with noted that PCs often coordinate with installation chaplains and other resources, such as MWR and ACS, to provide opportunities to disseminate substance abuse awareness and information. The level of coordination varies by installation and by commander.

Trainers

PCs are civilians who, according to AR600-85, must train, sustain, and improve their skills, proficiency, and professionalism through initial training, certification courses, and professional development training programs. According to one SME, PC requirements are currently being reevaluated [18].

Training

Target audience

All members of the military community are to be provided with the information needed to make responsible decisions about personal use of alcohol. Currently the only mandatory component of the program is random drug testing for all Soldiers.

Delivery

No standardized training materials are available; PCs are required to create their own materials, and they may vary by purpose of the training, audience, and so on. According to AR600-85, education and training programs must include information on the effects and consequences of abuse of substances and gambling disorders, including information describing services that are available at the installation and/or community [18].

ADAPT-PFL is a 12-hour educational/motivational intervention that focuses on the adverse effects and consequences of problematic substance abuse.

Content

Risk and protective factors addressed

ASAP addresses the risk of alcohol misuse, which is a risk factor for several harmful behaviors at the individual level of the SEM. At the unit level, by including training that includes deglamorizing alcohol and promoting alcohol-free events, ASAP addresses the permissive unit climate regarding the acceptance of alcohol, as well as the incompatibility of substance abuse more generally with Army values.

At the installation/local community level, ASAP addresses the risk factor of the availability of alcohol, and the protective factor of restricting or limiting access to alcohol by working with the community and installation leadership in limiting the marketing of alcohol and promotion of alcohol-free events. At the Army level, ASAP addresses the harmful norm of alcohol and drug abuse, and, to the extent that some Soldiers can self-refer for help with alcohol abuse, it

addresses the stigma associated with reporting or seeking help. It is not clear how the stigma is reduced for Soldiers who self-refer for help with drug abuse, but whose commanders must be notified. ASAP also addresses the protective factor of prevention policies for SUD with mandatory annual drug testing.

Targeted prevention. Information from URI and R-URI surveys, as well as data collected as part of the RRP, is intended to give Army leadership a better understanding of a unit's risk of harmful behaviors so that they can determine what, if any, intervention efforts are necessary. [33].

Culture and climate focus

As mentioned, at the unit level, by including training that deglamorizes alcohol and promotes alcohol-free events, ASAP addresses the permissive unit climate regarding alcohol acceptance.

Effectiveness

Published research

It is not clear how effective ASAP has been in reducing substance abuse. However, according to a recent DOD IG audit, the services are not administering in a timely manner the mandatory annual Alcohol Use Disorder Identification Test-Consumption to identify personnel who may be at risk for developing alcohol use problems [31]. The audit also revealed that the services did not provide timely intake assessments or treatment for alcohol misuse, and some of the servicemembers involved in alcohol-related incidents were not referred for an intake assessment.

Program evaluation

At the end of each fiscal year, installation ASAP managers are required to use input from the PCs to evaluate all prevention education and training, including a report of all prevention program activities and accomplishments. Their evaluation is then sent to ARD. G-1 is required to establish and maintain program-level evaluation plans, measures, data collections, analyses, and reporting procedures for implementation.

The ADAPT-PFL course was recently evaluated [34]. That analysis found that of the 44,000 Soldiers who attended the course between FY 14 to FY 19, about 10 percent had a relapse, and almost 7 percent had a relapse within one year after completing the course. Soldiers in paygrades E-1 to E-4 accounted for 78 percent of the Soldiers who relapsed within one year of taking the course. However, Soldiers who attended ADAPT had slightly higher promotion rates than non-attendees and were more likely to reenlist than their peers who did not attend. The study also found the program to be highly cost effective; the savings in potential recruiting and training costs avoided are nine times greater than the costs of the course itself. The study also found, however, that the compliance rate decreased from 45 percent in FY 14 to 33 percent in

FY 19. Some of the noncompliance is because 82 percent of E-1 and E-2 Soldiers separated between 90 and 365 days after the substance abuse incident.

Potential opportunities for integration

Commanders could be required to act on factors identified as putting their units at higher risk for harmful behaviors, including alcohol or drug incidents; they could have actions prescribed to them, those actions could be tracked, and the effectiveness of those actions could be evaluated.

PCs could be granted access to the RRP results and provide analysis and recommendations to Commanders. The PC and RRPC should already be working together, and in many cases they are the same individual.

PCs could provide embedded brigade combat teams with the RRP results, as this is where integration between H2F performance teams, CSF2 MRTs, and embedded behavioral health providers will identify those who might otherwise have fallen through the cracks. The brigade currently has direct access to the Commanders Risk Reduction Toolkit, which includes the RRP results.

Family Advocacy Program (FAP)

Overview and background

Summary

The ACS FAP is administered by HQDA DCS, G-9, Soldier and Family Readiness. FAPs consist of coordinated efforts designed to prevent and intervene in cases of family distress, and to promote healthy family life [19].

Program goals

The primary mission of the FAP is to promote public awareness, prevention, and early identification of child abuse and neglect, domestic abuse, and problematic sexual behavior in children and youth [2]. The FAP is designed to address prevention, identification, evaluation, treatment, rehabilitation, follow-up, and reporting of family violence.

Sources

The description and analysis of the FAP in this report come from a SME discussion with the Deputy FAP Program Manager and the following sources:

- 32 CFR Part 61—Family Advocacy Program [19]

- DOD Instructions
  - DoDI 6400.01 and DODM 6400.01 vol 1-4—*Policy and Guidance on the Development of the FAP* [2, 40-43]
  - DoDI 6400.05—*New Parent Support Program* [44]
  - DoDI 6400.06—*DOD Coordinated Community Response to Domestic Abuse Involving DOD Military and Certain Affiliated Personnel* [45]
  - DoDI 1342.24—*Transitional Compensation for Abused Dependents* [46]
  - DoDI 6400.09—*DoD Policy on Integrated Primary Prevention of Self-Directed Harm and Prohibited Abuse or Harm* [9]
- AR – 608-18—Family Advocacy Program (last published in 2011, currently undergoing revision) [47]
- FAP evaluation report completed by Penn State's Clearinghouse for Military Family Readiness [48]
- Two recent General Accountability Office (GAO) Reports (GAO-21-289 and GAO-20-110) [49-50]
- Logic models for each program element (provided by the Deputy FAP Manager) [51]

Program components

The FAP is a multi-faceted program that includes elements of training, awareness, prevention, and intervention regarding domestic and child abuse. The FAP is supported by a logic model that outlines the inputs (policies, proponents, and risk and protective factors) for domestic violence, child abuse, and problematic sexual behavior in children. The logic model then details the FAP activities that address the program goals and risk and protective factors. Finally, the logic model outlines operational and programmatic short-term, intermediate, and long-term outcomes.

Main focus

Prevention

FAP prevention activities are focused primarily on families with young children. FAP does not conduct large-scale prevention activities with other types of family/relationship units (e.g., childless married couples). FAP offers a suite of prevention activities and classes that serve all families with young children. FAP also offers a targeted suite of prevention activities that serves families deemed at risk for child or domestic abuse.

Primary prevention activities for families with small children

There are two primary prevention activities, available to all families, that have evidence-based curriculum: *Parents as Teachers* and *Thrive*. These activities focus on general parenting techniques. In addition, installations offer many other activities that serve as primary prevention for families. One important activity mentioned by the FAP program SME is playgroups for parents and young children to help them connect to other families on an installation (to reduce feelings of isolation). Playgroups provide an opportunity to talk with parents about other prevention services available in the area, including WIC and lactation consultation. Some FAPs also offer stress management classes and parenting classes. The FAP SME noted that the Army requires Soldiers who are going through a divorce to take a "parenting through divorce" class that FAP offers for free. The Army also offers a class tailored to families after deployment called ADAPT. ADAPT, Thrive, and several other parenting classes have skill building and positive relationship components. Each of these classes is facilitated by FAP professionals and other SMEs as needed (e.g., lactation consultants). Some of these classes are PowerPoint-based. However, many involve discussion, activities, and videos.

Primary and secondary prevention activities for "at risk" families with small children

The FAP runs a NPSP for families who are at risk for child or domestic abuse [44]. The NPSP is open to everyone; however, when resources are constrained, they offer the extensive services only to those at high risk. Soldiers and families can self-refer to (or request) the NPSP. Commanders and other community members who might recognize a family in need can also refer someone to NPSP. The NPSP provides in-home visitation from social workers and nurses to support families from prenatal to 3 years old. Social workers and nurses who provide services are FAP employees or contractors who must meet strict education and experience requirements. For example, all NPSP social workers are required to have an unrestricted clinical license to practice social work or marriage and family therapy and at least 2 years of direct experience in the prevention of child or domestic abuse.[9] Further, all NPSP registered nurses are required to have at least a bachelor's degree in nursing, a current unrestricted license, and at least 2 years of direct experience in child or domestic abuse cases, maternal or child health, community health, or mental health.[10] Home visits can include education about developing infants, soothing and safe-sleep techniques, and other new parenting skills. The NPSP offers classes (e.g., lactation, and infant massage), playgroups, and connections to other services (e.g., WIC). The NPSP provides information to support the health of the child and parent, including child development, safe sleep, and relational changes, and may also provide information on important issues such as birth control education. The playgroups provide interaction for the children but also an opportunity to provide new parents with additional information about services and resources available to them.

[9] DODI 6400.05.
[10] DODI 6400.05.

The entire NPSP program was described by SMEs as "filling the gap" left when new parents are geographically separated from extended family and friends. In addition to engaging new mothers, several FAPs have worked to hire male FAP staff to encourage more fathers to participate in the NPSP and FAP prevention education offerings.

Awareness

In addition to the training and prevention efforts, FAP also works to build awareness of domestic and child abuse as well as the services available to Soldiers and families. Awareness campaigns are managed by FAPs at each installation, thus there is variability in how they are executed. Standard awareness campaigns include installation sponsored activities associated with "awareness months" (e.g., domestic violence prevention (October) or child abuse prevention (April) months). Activities might include installation-sponsored runs or Take Back the Night events. Additional awareness campaigns may be developed to meet local needs, such as special events surrounding holidays like Valentine's Day, Easter, or Thanksgiving, and local campaigns around Foster Care Month or Teen Dating Violence Month. The goal of the awareness campaigns is to get information out to Soldiers and Families. These awareness activities serve as reinforcers of information addressed in annual training and through prevention programs by reminding personnel (and their Families) about available services and programs and to support healthy behaviors as the norm and raise awareness of abusive behaviors. Further, the awareness activities are designed to be specific to local culture on an installation. For example, awareness activities in Germany could include local Christmas-Market engagement, while activities in Alaska might focus on indoor family activities (to accommodate the weather).

Intervention

The FAP also provides intervention for instances of domestic or child abuse. The FAP provides victim-centered response by having a victim's advocate (VA) available at every installation 24/7. If the installation is too small to have a live and local responder, the calls are answered through one central location and the non-local VA calls back to the installation to "wake someone" local to respond. FAP clinicians make case assessments and facilitate a coordinated response with the commands, law enforcement, health care providers, child protective services, and other entities as needed. This coordinated response often involves relocating persons involved in the domestic abuse situation. That might mean finding barracks space for a Soldier or finding a hotel or local domestic violence shelter for a family. FAP providers also help secure civilian or military protective orders as appropriate. More permanently, FAP personnel help facilitate expedited transfers (of Soldiers) to other locations and facilitate "safety moves" of families away from the perpetrator, if needed [45, 52].

Coordination with other programs

The FAP is executed by FAP managers (FAPMs) at Army installations. They are the ones who provide the training, coordinate awareness campaigns, manage prevention efforts, and coordinate intervention. The local control of this program naturally leads to variability in the way the program is executed (within the bounds of statute, DOD, and Army policy). Thus, integration between programs providing services to Soldiers and Families at each installation are at the discretion of the FAPMs. Generally speaking, FAP programs coordinate regularly at the installation level with the ASAP, FRP, SHARP and other programs because they have multiple shared risk factors (e.g., substance misuse, financial distress, legal issues, relationship distress, and general lack of life skills and problem-solving).

Trainers

All trainers are FAP personnel that have been screened and selected to work for the FAP. There are no "collateral duty" trainers. Although the FAP personnel are trained in FAP methods, they are not specifically trained in how to provide training. FAP personnel are required to take a Family Advisory Staff Training Course. Additional training is available that is topic specific (e.g., child abuse, intimate partner, and multi-victim (with children)). Many FAP staff have certifications related to specific prevention education curricula.

Training

Target audience

Training consists of annual mandatory training that all Soldiers receive [45, 47]. Targeted training is required for new unit commanders (Company, Battalion, and Brigade) within 90 days of taking command and covered professionals and installation employees who interact with Soldiers and families and might see signs of domestic abuse (e.g., law enforcement, chaplains, legal, family programs, healthcare, school, or daycare workers) [47].

Delivery

Training content is tailored to the audience (all Soldiers, commanders, and others within the community). Annual FAP training is generally one to two hours and primarily delivered by one presenter. DOD requires that this training describe the dynamics of domestic abuse, including the role that power differences between genders can play. It must also provide DOD- and military-specific domestic abuse policies and procedures, common misconceptions associated with domestic abuse (e.g., beliefs, attitudes, and cultural issues), and military and civilian domestic abuse resources [41, 45, 50]. There is limited discussion or interactive activities.

Commander-specific training is required within 90 days of appointment, during pre-command courses and/or deskside briefings prior to company, battalion, or brigade command [47]. In addition to all elements of annual FAP training, commander FAP training includes specifics about their roles in response and prevention, the importance of collaboration with FAP

regarding safety plans in the aftermath of an incident of abuse—particularly locally specific information about weapons removal, barracks space, etc.—and additional services FAP can provide commands during awareness months or throughout the year.

Community-specific training is tailored to the role of the community member; for example, personnel working in the child development center are trained to notice signs of abuse, informed of mandated reporting processes, and advised regarding available services.

Content

Skills emphasis

Annual all-Soldier FAP training is not focused on skill building or specifically on developing positive relationships. It is a baseline training in which Soldiers are made aware of what constitutes abuse, risk factors, and how to recognize and respond to incidents (bystander training is included); the resources available to Soldiers and families experiencing a domestic violence crisis (e.g., New Parent Support Program) or before domestic violence or child abuse takes place; and the services available to them regardless of marital status, gender of the abuser or perpetrator, or same- or different-gender relationship.

Commander FAP training was characterized by program SMEs as knowledge development and awareness, as opposed to skill building.

Community-specific training includes FAP training with Chaplains. Such training discusses the Chaplain's privileged roles with Soldiers and Families because of the trusting relationships they can build and their ability to suggest and connect victims and perpetrators to services they might not otherwise seek.

Climate/culture focus

Commander-specific training emphasizes that demonstrating care and concern for Soldiers and their Families is an essential part of leadership which requires recognizing signs, symptoms and risk factors for abuse and connecting Soldiers and Families to available resources. Further, community engagement events and awareness campaigns are tailored to the climate and culture elements in the unit or local community (especially OCONUS locations).

Risk and protective factors

Risk and protective factors addressed through the FAP are outlined in the FAP logic model and summarized below [51]:

Table 12. Shared risk and protective factors addressed by the FAP program

SEM-level	Risk Factor	Protective Factor
Individual	Early marriage, young parental age, low SES and rank, history of abuse and/or adverse child experiences, poor parenting knowledge, behavioral health or substance use disorder, military life stressors (e.g., frequent relocation/ deployment), *antisocial and aggressive behavior, hostile gender attitudes and beliefs*	Stable income, high parenting knowledge, *decision-making/problem-solving, empathy*
Interpersonal	Family conflict Social isolation	Good physical health of family, high marital satisfaction, high social support, connectedness to family and friends, *healthy peer relationships*
Unit	Low support from peers, friends and Army leaders, *stigma associated with reporting/seeking help*	Connectedness to peers, friends and command
Installation	Income inequality, high alcohol outlet density, remote or isolated locations	Coordinated network of policies, programs and resources that help support families, access to behavioral health and substance use disorder services, *restricted or limited access to instruments of harmful behavior*
Army	Military life stressors (OPTEMPO, frequent relocation, deployment, unaccompanied tours, rotational assignments, *stigma associated with reporting/seeking help*)	Coordinated network of policies, programs and resources that help support families
Society	None	None

Source: FAP logic Model and SME discussions; note that italicized factors are those in which the SME indicated the program addresses them; however, the logic models do not specifically list those factors [51].

Effectiveness

The FAP is required to regularly report instances of child or domestic abuse. While evaluation of this metric over time could indicate trends in prevalence, these trends will not be easily tied to specific FAP training, awareness, prevention, or intervention efforts.

Published research

CNA is aware of three recent evaluations of FAP by outside organizations. In 2020, the GAO published a report to Congress describing their recommendations regarding DOD's tracking and response to child abuse [49]. This study encompassed child abuse (including child-on-child) occurring on military installations or with military dependents. The GAO made 23 recommendations, with three recommendations specifically for the Army, regarding incident reporting procedures and procedures to inform victims and families about the process and resources available, composition of the Incident Determination Committees (IDCs) (to include medical personnel) and ensuring timely access to certified pediatric examiners overseas.

In 2021, the GAO published a report to Congress describing their recommendations for domestic abuse prevention, response, and oversight for all of DOD [50]. Although their recommendations focused primarily on DOD in general, the GAO report noted undesirable variability in the content of required domestic abuse training across a sample of Army installations. The GAO organized the DOD mandated content into five categories and examined the extent to which information from these categories was included in the training at five Army installations[11]. GAO found no installation that was addressing all five areas. Additionally, three installations were addressing four requirements, one installation addressed three requirements, and the final installation only addressed one requirement. The variability in training coverage across installations provides an impetus for Army FAP to provide standardized curriculum Army-wide. The GAO report also made recommendations, across the Services, regarding the Incident Determination Committees (IDC) composition and actions. In July 2021, the Army published a directive describing the IDC's purpose, composition, authorities, procedures, and decisions [53]. It is too soon to evaluate the effects of this policy change.

In 2020, Penn State published a report detailing its findings and recommendations for improving the effectiveness of the FAP. Their recommendations are organized into five categories and summarized below [48]:

- **FAP infrastructure**—explore the impact of merging ACS FAP prevention activities with the MEDCOM FAP treatment activities into one unified FAP

[11] This was also done for the Navy, which does not currently have a standardized curriculum. Both the Marine Corps and the Air Force have standardized service-level curricula.

- **FAP content**—increase the use of evidence-based (or evidence-informed) strategies and components; provide a limited menu of available programs focusing on those that are evidence-informed; offer programs online; target populations based on their level of risk; offer programs that address multiple content areas and risk factors (as appropriate); and promote universal-prevention programs to foster coping skills and resilience
- **FAP implementation**—use a standardized pre-assessment screening tool Army wide to assess risk for families and individuals; create an online FAP guide that provides standardized access to training resources; consider hiring a headquarters-level FAP training coordinator
- **FAP reach**—reduce barriers to participation through evidence-informed stigma reduction strategies; rebrand the program to "promote healthy families"; focus on universal programs and engage in wider marketing; consider increasing provided childcare at events to encourage more parents to participate
- **FAP data collection and evaluation**—implement screeners for continual assessment of risk and to link families to tailored programs; develop an integrated information infrastructure that would link multiple datasets that would enable the reporting and monitoring of all services received by all families; conduct ongoing evaluations evidence-based (or evidence-informed) programs across multiple installations

FAP response to published research

The FAP is currently revamping the training offered to provide a standardized curriculum for all required training. This will reduce installation-level variability, increase compliance with DOD and Army Directives, and allow for more systematic comparison across the Army. However, FAP SMEs emphasized the continued importance of unit-level discretion in determining how to best design awareness campaigns and prevention program implementation to meet the needs of the local communities and commands. FAP envisions creating a suite of available materials, tools, and ideas that installation-level FAPMs can use and tailor to the needs of the community they serve. FAP hopes that standardized training and institutional-specified awareness and prevention activities will be optimally balanced to meet the policy requirements and local needs.

Sexual Harassment and Assault Response Program (SHARP)

Overview and background

Summary

The Army describes its Sexual Harassment/Assault Response and Prevention (SHARP) Program as an "integrated, proactive effort to end sexual harassment and sexual assault within [their] ranks." The SHARP program's intent is to "foster a culture free of sexual harassment and sexual assault" through

- Prevention
- Education and training
- Response capability
- Victim support
- Reporting procedures
- Establishing appropriate accountability [3]

Sources

This summary of SHARP is compiled from the following sources:

- Army Regulation (AR) 600-20, Chapter 7, Sexual Harassment/Assault Response and Prevention Program [3]
- U.S. Army, *SHARP Guidebook* [54]
- Center for Army Analysis (2019), *Sexual Harassment/Assault Response and Prevention (SHARP) Program Review* [55]
- GAO (2017), *Sexual Violence: Actions Needed to Improve DOD's Efforts to Address the Continuum of Unwanted Sexual Behaviors*, GAO 18-33 [56]
- GAO (2015), *Sexual Assault: Actions Needed to Improve DOD's Prevention Strategy and to Help Ensure It Is Effectively Implemented*, GAO 16-61 [57]
- Andrew (2013), *Leading Change: Sexual Harassment/Assault Response and Prevention (SHARP)*, US Army War College Strategy Research Project [58]
- Britzky (2021), "A Small Tweak to How the Army Trains New Soldiers Is Dramatically Reducing Sexual Assault Reports," *Task & Purpose* [59]

- SME discussions with SHARP Prevention Staff, SHARP Academy staff, and a SARC

Program goals

Program goals include (SHARP Program Review, SHARP Guidebook):

- Preventing and addressing sexual harassment (SH) and sexual assault (SA) in the Army
- Promoting an Army culture and command climate that ensures that team members are treated with dignity and respect
- Providing education and annual training that will enable commanders to prevent and appropriately respond to SH/SA
- Providing unity of effort for SH/SA prevention efforts across the Army

The rationale for a unity of effort for SH and SA originates from research that has established a "continuum of harm" in which SH and SA are often found to be interrelated, and in which acts of SH, if unchecked, may lead to acts of SA [54]. Because of this link between SH and SA, the previously existing Prevention of Sexual Harassment (POSH), the Equal Opportunity (EO) response to sexual harassment, and the Sexual Assault Prevention and Response programs were integrated to form SHARP.

A SHARP Program Review found a need for clearer program guidance to help SHARP professionals make sense of the proliferation of instructions, regulations, and memos that make it difficult to discern accurate doctrine and policy interpretations. According to the Review, revised policy should focus on unit size, mission, and location to adequately address requirements of small and/or geographically dispersed organizations, brigade-sized elements, and very small (company-sized) battalions which struggle to meet current SHARP regulatory requirements.

Program components

Main focus

Response with some prevention

While the intent of SHARP is to encompass both prevention and response, according to SME discussions SHARP is currently victim- and response-focused, with a limited amount of prevention activities. SHARP professionals reported that their activities tend to focus on responding to reports of SH and SA and providing case management and victim advocacy and services to those who have suffered SH or SA. Prevention activities and training for SHARP professionals appear to be (currently) limited, and few SHARP professionals specialize in prevention activities.

This section summarizes SH and SA response and prevention components.

Sexual harassment response

SHARP establishes detailed informal and formal SH reporting processes (SHARP Guidebook). Informal SH complaints are not filed in writing and are typically resolved by the complainant with victim services provided by the SARC and VA, upon request. Formal SH complaints are filed in writing, sworn to accuracy, and required to be investigated. SH complainants are to be provided information and resources, including counseling on a plan for protection from reprisal and retaliation as well as feedback on the investigation on a strict timeline. Anonymous complaints can be made by any means from an unidentified complainant and are referred to the subject's commander for evaluation and, potentially, investigation.

Sexual assault response

SHARP establishes detailed SA reporting processes and specifies roles and responsibilities for SARCs and VAs (SHARP Guidebook), as described in the "Trainers" subsection. SHARP also specifies roles and responsibilities for other personnel, including healthcare personnel, chaplains, the victim's and subject's commanders, legal professionals, and witnesses [54].

Sexual harassment and assault prevention

A SHARP Program Review concluded that SHARP should "conduct research and analysis to develop an evidentiary-based prevention program" (p. 55) [55]. A GAO report on DOD-wide SH policy found a lack of attention to risk and protective factors, "risk domains," and the SEM levels (individual, relationship, community, society) at which risk and protective factors interact [56].

SMEs raised that SHARP prevention training focuses on preventing SH and SA as they are occurring. They stressed a potential need to refocus prevention training "to the left," meaning to address issues that arise earlier in the social processes that lead to SH or SA, before an act is about occur, such as (for example) identification of risk factors or attention to victim "grooming" by perpetrators.

Although the focus of SHARP is mainly on response, program documentation does mention prevention initiatives, although these initiatives seem not to be well developed at the current time. For example, the Intervene, Act, and Motivate (I. A.M.) STRONG campaign is intended to combat sexual assaults in the Army by engaging all Soldiers in preventing SAs before they occur. In addition, there are ongoing initiatives to increase SHARP's focus on prevention. These include efforts to build a SHARP prevention workforce, DoD's Prevention Plan of Action (PPoA), and the development of a Commander's Toolbox [8].

SMEs reported that SHARP currently has only a handful of staff that are solely focused on primary prevention, which makes it difficult for the Army to establish a robust prevention program. Current SHARP professionals (SARCs and VAs) are focused on response and victim support and will (for the most part) not be able to also take on primary prevention roles.

SHARP prevention staff are working to gain authorizations to build a prevention workforce of up to 250 personnel, but these authorizations do not yet exist.

DOD's PPoA guides SA prevention efforts throughout DoD by providing guidelines for the establishment of comprehensive prevention processes and systems and identifying services actions to take to realize effective prevention.

Coordination with other programs

PPoA is driving integration of SH/SA policy with those of other destructive behaviors. SMEs report that the Army's PPoA initiatives are currently being expanded to address not only SHARP, but also substance abuse, suicide prevention, and family advocacy as well.

Trainers

There are full-time and collateral-duty SARCs and full-time VAs who take on SA/SH response functions as part of their duties. Their roles are as follows:

- **SARCs**. SARCs oversee SA awareness, prevention, and response training; coordinate medical treatment, including emergency care, for victims of sexual assault; and track the services provided to a victim of SA from the initial report through final disposition and resolution. SARCs are responsible for ensuring that victims of SA receive appropriate and responsive care.
- **VAs**. Upon notification of a SA and after receiving consent from the victim, the SARC will assign a VA to assist the victim. The VA provides non-clinical crisis intervention, referral, and ongoing non-clinical support to victims. Support includes providing information on available options and resources to victims. The VA, on behalf of the SA victim, provides liaison assistance with other organizations and agencies on victim care matters and reports directly to the SARC when performing victim advocacy duties.

SHARP staff training

SHARP professionals receive specialized training in SH/SA response and prevention. The SHARP Program Review recommended more training in coaching and master facilitation for SHARP professionals and in cultural diversity for PMs.

As part of DOD's PPoA to expand its prevention workforce, position descriptions for SHARP PMs, SARCs, and VAs have been revised to set expectations for these roles to include awareness and familiarity with primary prevention (but will not change the response focus of these staff).

SHARP staff, including SARCs, VAs, and PMs, receive some prevention training as part of their overall training program. These include parts of the SARC/VA Career course and the SPARX course provided by DOD, as follows.

***SARC/VA Career Course*.** The SHARP Career course is a 6-week course focused on preparing individuals to effectively respond to SH complaints and victims of SA [55]. SMEs report that this course does provide some exposure to prevention concepts as well. For example, part of the Career course is a 4½-day, "24-hour training" session focused on prevention concepts. The session covers topics including providing Army Soldiers and civilians with knowledge and skills needed to engage in prevention-related behaviors, establishing clear behavior norms, and engaging large cross sections of unit personnel in prevention activities. Only full-time SARCs and VAs receive this training; collateral-duty SARCs, VAs, and PMs do not.

***SPARX*.** SPARX is a DOD-sponsored 2-week virtual training course with a focus on primary prevention. The course is intended to provide SHARP professionals (especially program managers (PMs), but also SARCs and VAs) with an understanding of primary prevention based on a public health model and a set of primary prevention tools they can take back to their units, including bystander intervention strategies and techniques to alter the climate of a unit to identify and counteract harmful behaviors. Course lessons include understanding and using data, conducting needs assessments, evidence-based prevention approaches, and delivering prevention activities in a supportive climate with fidelity. The course is provided by DOD, and SMEs report that the Army has trained about 120 people to date. Each service receives about 18 seats per month in the course, and there is a waiting list.

Staffing issues

The SHARP Program Review reported that SHARP may be somewhat understaffed due to high military personnel turnover rates and vacancies in civilian billets. Pay and job satisfaction were reported as potential causes of personnel losses, as well as high lead times for onboarding new SARCs and VAs.

Collateral Duty issues

The Army's extensive use of collateral-duty SARCs (a practice not followed by other services) is an issue raised in the SHARP Program Review. Collateral-duty SARCs are limited in their ability to fulfill the role of a full-time SARC because they receive less training (the same 80-hour foundational course as full-time SARCs, but without the 7-week Career course), do not have access to the same datasets as full-time SARCs (so cannot enter data into databases), and cannot manage cases without coordinating with a SARC who has database access.

Training

Delivery

According to SMEs, most SHARP training uses passive rather than active delivery techniques, such as PowerPoint presentations or videos. Other sources have reported the use of actively engaging delivery techniques such as videos tailored to different groups or interactive skits

and scenarios focusing on topics such as bystander intervention in SHARP 360 training [58-59].

Other actively engaging techniques come from the Basic Officer Leadership Course (BOLC), TSPs, and leadership training. BOLC includes active learning components such as facilitated discussions and simulated scenarios. In addition, commands can offer Soldiers TSPs. TSP topics include intervention skills training, a bystander intervention support package, and a SHARP "escape room" exercise in which Soldiers must answer questions about SA/SH policy to solve the room. SMEs reported that TSPs provide some exposure to prevention and intervention topics. TSPs are provided at command discretion; there is no information about how many Soldiers receive this training. Under DoD's PPoA, new training content is currently being developed and/or delivered for multiple leader courses. This includes the SHARP Academy's development of a virtual Commander's Prevention Toolkit, a video training tool on implementing unit prevention strategies.

Overall, SMEs reported that the amount of SA/SH training received by the typical Soldier varies by unit (as some units receive more, or more focused, training than others), but E-4s and below typically receive approximately 4 hours per year: a 2-hour mandatory annual training session, a 30 minute to 1-hour newcomer's session, plus other non-training events designed to expose Soldiers to SH/SA issues (for example, blood drives or athletic events such as runs or walks).

Target audience

SHARP program procedures and processes apply to the following groups (SHARP Guidebook):

- Active-duty Soldiers, including those who were victims of SA prior to enlistment or commissioning
- Army National Guard and Army Reserve Component Soldiers who are victims of SH/SA when performing active service and inactive duty training
- Military dependents 18 years of age and older who are eligible for treatment in the military healthcare system, at installations in the continental United States (CONUS), and OCONUS, and who were victims of SA perpetrated by someone other than a spouse or intimate partner[12]
- Civilians and contractors are eligible for SHARP services as well. Civilians are eligible for SARC and SHARP VA services and can make Unrestricted Reports. Contractors can make Unrestricted Reports and can access the services of a SARC and VA while undergoing emergency medical treatment when they are in a deployed environment

[12] The definition of Intimate Partner has changed so that, if a victim is sexually assaulted by someone they are dating, the victim can still receive SHARP services.

Army personnel are exposed to SH/SA training at several points in their careers, including basic training, as part of a unit, and when assuming leadership responsibilities, as follows.

Basic training. According to Britzky (2021) and SMEs, Army recruits now receive some exposure to SH/SA issues in basic training [59]. Before the change, new recruits did not have SH/SA training until roughly two weeks into training, despite the early days of training being when most cases of inappropriate contact were reported (Britzky 2021) [59]. The change likely occurred to address this (SHARP Program Review) [55].

Unit-level training. ***Newcomer's briefs and annual refreshers*****.** Soldiers receive a mandatory newcomer's brief upon arrival to a new unit, and all solders receive mandatory annual SH/SA refresher training. SMEs reported that the newcomer's brief is usually facilitated by full-time SARCs or VAs or collateral-duty SHARP professionals.

Unit-level training. ***Deploying or returning from deployment.*** Soldiers about to deploy or returning from deployment receive required SA/SH training. Neither of these trainings replace annual refresher training; they are supplemental only.

Leadership training. SHARP offers leadership training in the form of a Basic Leadership Course (BLC) and BOLC. It is mandatory insofar as it is integrated into the courses that all new sergeants and officers must take. The BLC covers topics in SA/SH response and prevention for enlisted who reach the rank of sergeant (E-7). The BOLC is a similar course for officers.

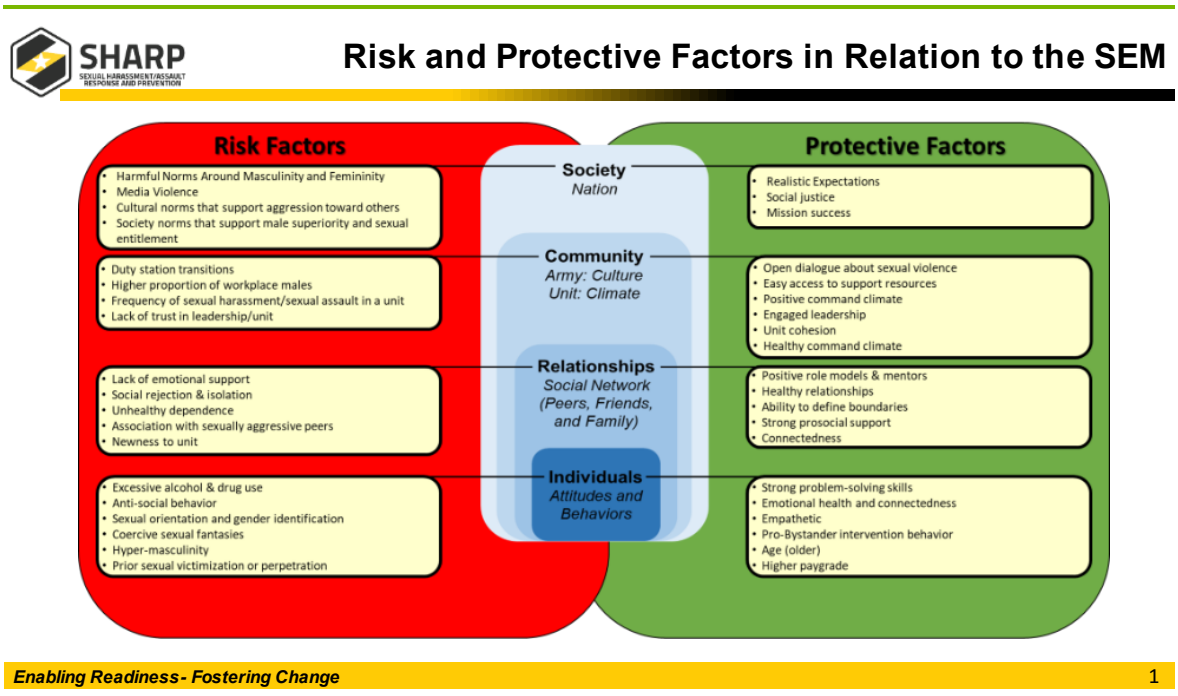
Content

Risk and protective factors

Unit-level training. Newcomer's briefs and annual refreshers**.** SMEs reported that this training sometimes touches on prevention-related issues, including making Soldiers aware of risk and protective factors, prevention basics, healthy relationships and consent issues, and bystander intervention.

Leadership training. The course explains SHARP program fundamentals, defines Army SH and SA policies, and covers appropriate response techniques, risk and protective factors, and prevention strategies. Figure 1 lists the risk and protective factors related to SH and SA on the Army SEM, as included in a slide deck from the BLC and BOLC leadership courses.

Figure 1. Risk and protective factors in relation to the SEM



Source: BLC and BOLC leadership training slides.

Figure 1 shows risk factors that we also identified as predictive of SH/SA and at least one other harmful behavior (HB):

- **Individual:** Poor mental health, young adult, past exposure to trauma/abuse, alcohol misuse, antisocial behavior, and previously committed the harmful behavior
- **Interpersonal:** Isolation/lack of social support, association with unhealthy/dysfunctional peer groups
- **Community (unit and installation/local community):** lack of trust in leadership/unit
- **Army:** harmful norms around masculinity/femininity

Protective factors that we identified as predictive of SH/SA and at least one other HB are:

- **Individual:** Life skills: decision-making/problem-solving, empathy
- **Interpersonal:** Social connectedness and support, family cohesion and support, healthy peer relationships
- **Unit:** Unit cohesion and connectedness, positive leadership engagement

Skill building

***Unit-level training. Newcomer's briefs and annual refreshers*.** Although there are some skill-building activities, most of the focus is not on prevention, according to SMEs with whom we spoke. However, the goal of the Intervene, Act, and Motivate (I.A.M.) STRONG SA prevention campaign is for Soldiers to engage in peer-to-peer communication and active intervention strategies to create a climate that does not tolerate attitudes and behaviors that facilitate SH/SA.

Unit-level training. Deploying or returning from deployment. According to SMEs, the content of pre- and post-deployment training does not include prevention, but rather focuses on issues such as the culture of the place to which the Soldier is being deployed with respect to SH/SA issues. Soldiers are provided information about SHARP procedures and how SARC resources can be accessed during deployment. Post-deployment training focuses on helping the Soldier orient to the availability and location of SHARP resources at the new duty location.

Leadership training. In BLC and BOLC, SMEs report that the prevention content is elementary, providing a baseline understanding of the differences between prevention, response, and care for victims.

Command climate and inclusion focus

Commanders are responsible for SH/SA prevention in their units, especially through cultivating climates that encourage individuals to intervene to correct behavior that could lead to SH/SA [3, 54]. That includes some exposure to bystander training during annual trainings (GAO 2017 and SME discussions) [56].

Beyond training initiatives, there are additional (limited) initiatives to address command climate. For example, the 4-week pre-command course for incoming battalion and brigade commanders includes a lesson provided by ARD that discusses issues such as the importance of command culture on building a positive prevention focus for a unit. The unit provides some suggestions on implementation, including suggestions for newcomers' briefs, use of command climate surveys, and conducting "sensing sessions" with Soldiers. According to SMEs, the discussion takes place at a high level and is not a "deep dive" into the topic. Implementation is at the discretion of the commander in any case, and it is not clear to what extent any of the ideas are put in place, or how effective they are.

A few issues have been raised with respect to SHARP training offerings. Some SMEs suggested that training could be more inclusive in terms of encompassing a wider variety of potential scenarios. Currently, the focus is on male perpetrators and female victims, as these represent a large majority of Army SAs, but more attention might also be paid to other types of SH/SA incidents, including those involving male victims or homosexual perpetrators and victims.

Effectiveness

Published research and program evaluation

Although there is little systematic evaluation of SHARP program activities, there have been several evaluations or reviews of SHARP that have identified issues to be addressed. That includes two GAO reports and a survey- and interview-based SHARP Program Review. Those issues have been included throughout this section.

SME awareness of research

SMEs report that there is a need for more evaluation of SH/SA training programs to assess effectiveness. The lack of systematic program evaluation means that ineffective initiatives may be continued, and that potentially effective programs may be terminated without any attempt to assess whether they are having an impact. Additionally, SMEs stress that an evidence base, including quantitative data, increases the credibility of the program in the eyes of participants. However, to date, the Army has reported several accomplishments with respect to its PPoA efforts, which we interspersed throughout this section [60].

Military Equal Opportunity (MEO) Program

Overview and background

Summary

The Army's Military Equal Opportunity (MEO) program aims to create a cohesive and combat ready Army by ensuring every Soldier is treated with dignity and respect regardless of race, color, national origin, religion, sex (including pregnancy), gender identity, or sexual orientation. The program is administered by the Assistant Secretary of Army, Manpower & Reserve Affairs and provides support to Soldiers and their family members both on and off post.

Sources

This MEO program summary is based on information from the following sources:

- MEO SMEs who administer and oversee the MEO program
- DOD and Army regulations and program documents (DODI 1020.03, DODI 1350.02; *Army Command Policy* Regulation 600.20, 2020; *Commanders' Equal Opportunity Handbook* TC 26-6, 2008) [20, 61-63]

- Websites (TRADOC—Harmful Behaviors Prevention Tool, Command Diversity Office; Army Equity and Inclusion Agency; Commands' Equal Opportunity pages—Forts Knox, Gordon, and Huachuca) [64]
- News articles (Lacdan 2019) [65]

History

The Army's equal opportunity (EO) program was established in 1970 in response to growing violence at posts and installations in the United States and overseas that was thought to echo race riots across the US in the late 1960s. The Army's research found that discrimination, low morale, and the resulting lack of communication and camaraderie across racial lines undermined mission effectiveness and combat readiness. Since then, the Army has made a deliberate effort to eliminate systematic discrimination and other forms of unequal treatment.

Program goals

The MEO program is designed to "create and sustain effective units by eliminating discriminatory behaviors or practices that undermine teamwork, mutual respect, loyalty, and shared sacrifice of the men and women of America's Army" [20]. Program goals are as follows:

- Build and maintain a cohesive, combat-ready Army that is focused and determined to accomplish its mission.
- Provide support to military personnel and their family members, both on and off post, and within the limits of the laws of localities, states and host nation.
- Ensure MEO exists for all Soldiers.
- Ensure every Soldier is treated with dignity and respect.
- Supports commanders and equal opportunity (EO) professionals who are responsible for the execution of MEO policies in their units, organizations, and agencies.

Program components

Main focus

Prevention with some response

Most MEO program components are geared toward prevention of discriminatory behaviors. In addition, a response process serves victims through formal, informal, and anonymous complaint processes, assurances of confidentiality, and consequences for any retaliation.

Coordination with other programs

The MEO program works closely with the Army's Sexual Harassment/Assault Response and Prevention (SHARP) program. The SHARP program handles all sexual assault and sexual

harassment training and response, whereas the MEO program addresses non-sexual harassment. The two programs work together to identify harassment (e.g., bullying, discrimination) that may escalate into sexual harassment or assault and move from one program's purview to another.

Training

Targeted audience

MEO prevention and response education is required of all Soldiers at entry, annually, and as part of PME programs. In addition, the Army provides an EO representative's course.

Content

The Army MEO program offers TSPs to be used at the different points in a Soldier's career. TSPs identify mandatory requirements and offer sample lesson plans, resources, and other training aids. The general content of MEO education at each career level is summarized below, followed by an overview of competencies, skills, and risk and protective factors addressed across MEO training.

MEO education content by career level

MEO education is offered at entry level, annually, at four levels of leadership training, and to EO professionals, as follows:

- *Entry Level*: A two-hour TSP provides each new Soldier with basic EO knowledge encompassing policy, ethnic and gender awareness, behaviors that violate Army policy, the EO complaint system, appeals, prevention of sexual harassment, and techniques for dealing with discrimination.
- *Annual Common Military Training (CMT)*: All Soldiers receive 2-4 hours of EO CMT overseen by the commander and delivered by the MEO professional. CMT must cover the topics of leadership roles and responsibilities for MEO programs; complaints processing; reprisal and reprisal prevention and detection; and climate assessment methodologies. DOD-provided terminal learning objectives for the CMT include coverage of EO policies and programs, harassment and retaliation, sexual violence, command climate assessment (CCA), dissident and protest activity, and the CDC guiding principles of sexual violence.
- *Leadership training:* Leadership courses are progressive, enabling Soldiers in every supervisory position to recognize the importance of effective leadership and resolve discriminatory and harassment practices. DOD requires that PME and leadership development training include an overview of the MEO program and the leader's role, information on retaliation, and a training module on fostering a climate that does not

tolerate discrimination. In addition, MEO TSPs encompass the content summarized below:

- Basic Officer Leadership Course (BOLC) TSP provides newly commissioned officers with the basic knowledge of the EO program and also discusses the future leader's responsibilities within the scope of EO and sexual harassment prevention.
- New Leader Training TSP is designed for Warrior Leader Course (WLC), Warrant Officer Basic Course (WOBC), and Basic Officer Leadership Course (BOLC II). Training focuses on policy, behavior and actions that violate and support the EO program, appropriate responses and strategies to sexual harassment, prevention of reprisals, and new leaders' responsibilities in resolving complaints.
- Intermediate Leader Training TSP is for mid-grade leaders (SSG-CPT) and focuses on policies, concepts, leader roles and responsibilities, identification and resolution of EO problems, complaints, sexual harassment, problem-solving, and creating and maintaining a healthy EO climate.
- Senior Leader Training TSP for senior leaders (1SG-COL) emphasizes the senior leader role, actions, and responsibilities for implementing EO programs, monitoring and assessing command climates, and EO action plans.

- *Equal Opportunity Professionals*: The EO Representative's Course prepares Soldiers to serve as the principal advisor and trainer on matters of discrimination and bias. The six-day, 23-lesson training package includes viewgraphs, student guides, student handouts, and practical exercises.

Competencies and skills

The Commanders' EO Handbook dictates that EO training must cover basic knowledge of the Army EO program objectives, EO command policy, EO Action Plan, and POSH. It also must cover social emotional skills and interpersonal communication that promotes unit cohesion and a healthy climate. Soldiers must be able to recognize and respond to indicators of EO problems and understand the impact of individual and institutional discrimination.

Risk and protective factors addressed

MEO policy guidance, combined with information provided by SMEs, indicates that MEO training and education addresses the individual-level risk factors of *antisocial and aggressive behavior*, *gender: female*, and *hostile gender attitudes and beliefs*, as well as the Army-level risk factor of *harmful norms* through TSP content that addresses harassment and ethnic and gender awareness. In addition, MEO program policies address the unit-level risk factors of *toxic/permissive unit climate* and *toxic/ineffective or weak leadership* in stating that Army

leaders in a supervisory or command position will not condone or ignore discrimination, harassment, disparaging terms, or hostile work environments. Correspondingly, the regulation addresses the protective factors of *unit cohesion and connectedness*, *positive leadership engagement*, and *unit-level policy enforcement* through emphasis on commanders' responsibility to maintain a positive unit climate free from discrimination and harassment.

Delivery

Commanders must ensure that mandatory MEO CMT is conducted annually. MEO professionals facilitate the trainings, although commanders and unit leaders are expected to attend and be involved. The trainings must incorporate mandatory EO topics but can include additional topics according to the organization's command climate and needs. Small group, discussion-based training is the preferred teaching method. Other methods such as lectures, seminars, roleplay and scenarios, and print may be used when appropriate or necessary.

The Harmful Behavior Prevention Tool (HBPT) and accompanying handbook may be used for CMT or additional education tailored to unit needs. The HBPT provides MEO scenarios to promote discussion-based learning in groups of 10 or less. The scenarios model discriminatory behavior towards race, ethnicity, and sexual orientation in military settings.

Trainers

MEO professionals are responsible for the annual MEO training using the MEO TSP package, but commanders are highly encouraged to be active participants. The position of an MEO professional is not a collateral duty. MEO professionals serve as their commanders' principal advisors on matters of unintentional or intentional discrimination or biases. Each brigade must have at least one full time MEO professional. Small installations (fewer than 10k Soldiers) must have at least two MEO professionals and large installations (more than 10K) must have at least four. The qualifications of officers or NCOs and Army civilians to be chosen as MEO professionals are shown in Table 13.

Table 13. MEO professional qualifications

Officer and NCO	Department of Army Civilians
• Record of outstanding duty performance • Favorable behavioral health screening • Commander interview and recommendation • Minimum of 3 years of service remaining • Various other qualifications (i.e., personal readiness, meet APFT standards, qualified for promotion, no evidence of prior criminal or other offenses)	• Grade GS-11 or above • Occupy or scheduled to occupy assigned position in MEO program • Considered suitable for MEO duties based on interview by commander

Source: [3].

MEO professionals receive certification upon completion of an 11-week Advisor Course from Defense Equal Opportunity Management Institute (DEOMI). The course is split into general MEO training and service-specific training. Prior to the COVID-19 pandemic, the in-person course consisted of eight weeks of common core training followed by three weeks of service-specific training. Since the pandemic began, the course has been an initial eight-week virtual course followed by three weeks of in-person training. The in-person training is split between common core and service specific training. The students have multiple opportunities to practice facilitating training topics from conflict resolution to scenarios.

In 2019, Army leadership expressed interest in re-establishing their annual two-day in-person EO training, called the MEO Policy and Training Symposium. The two-day conference provides MEO professionals with updates to EO policy and best practices positively impacting readiness, climate and morale issues. The symposium aims to build cohesion and assert leadership's emphasis on removing harmful behaviors and discrimination from the ranks.

Other initiatives

In addition to the required training described above, the Army offers other events and programs to promote diversity and inclusion, as summarized below.

US Army Project Inclusion

The US Army Project Inclusion is a holistic effort to improve diversity, equity, and inclusion. The program is part of a five-year strategic diversity plan begun in 2020. The project instituted measures that include suspending photos from promotion boards; redacting race, ethnicity, and gender data from Officer and Enlisted record briefs; and assessing military justice cases

for racial disparity. In addition, "Your Voice Matters" listening sessions for Soldiers, Army civilians, and family members are conducted by teams of 8 to 10 professionals including EO advisors, EEO professionals, and a chaplain or military psychologist. The sessions provide an opportunity for participants to voice concerns and questions on topics such as dignity, respect, and diversity. Issues identified in the listening sessions are be used to update diversity and inclusion training across all ranks and Senior Executive Servicemembers.

Special and ethnic observances

As part of the Army's EO education process, commanders must ensure special and ethnic observances are held annually. These activities promote awareness of different cultures and understanding of contributions of all Army members. Special and ethnic observances include, but are not limited to, Martin Luther King, Jr. Day, Women's History Month, African American/Black History Month, and Native American Indian Heritage Month.

Army Heritage month

Commanders are required to celebrate Army Heritage during the month of June. Army Heritage month promotes Army values, fosters a culture of equity and inclusion, recognizes diversity as a strength and force multiplier, promotes unit cohesion, and recognizes the Army's birthday. For both cultural and ethnic observances and Army Heritage Month, commanders can delegate planning and execution to other military members as long as the whole community is invited to participate.

Special Emphasis Programs

Although no EO training is targeted to a specific demographic, the Training and Doctrine Command (TRADOC) website describes Special Emphasis Programs that aim to ensure minorities, women, and those with disabilities are provided equal employment and advancement. Targeted groups include the Federal Women's Program, Hispanic Employment Program, Asian American Employment Program, American Indian and Alaska Native Employment Program, Persons with Disabilities Employment Program, and Disabled Veteran's Affirmative Action Program

Effectiveness

TRADOC is responsible for evaluating the effectiveness of the MEO and Harassment Prevention and Response education and training in TRADOC Service schools and training courses, as well as the DEOMI MEO Advisors Course at DEOMI. The Advisors Course is evaluated through student after-action reports. MEO professionals are then responsible for evaluating the effectiveness of MEO training and making sure the program is compliant with Army regulations. Although MEO professionals complete an after-action report on the EO training, program experts were not aware of a more formal evaluation system.

Although not identified as an evaluation tool, CCAs use the Defense Organizational Climate Survey, interviews, focus groups, records reviews, observations, and staff assistance visits as such. The MEO is then tasked with managing and maintaining command data, preparing a quarterly data pull, and analyzing trend data to identify problem areas. The results of the analysis should be reported to leadership on a quarterly basis and used to inform future EO efforts.

Financial Readiness Program (FRP)

Overview and background

Summary

The Army's Financial Readiness Program (FRP) is administered by HQDA DCS, G-9 Soldier and Family Readiness. It provides comprehensive personal financial educational and counseling services to Soldiers and their families.

Sources of information

The sources of the information provided in this section include the following:

- Lead Financial Education Program Manager, Soldier & Family Readiness Division, Deputy Chief of Staff, G-9
- Documents: Army Regulation 608-1; *National Defense Authorization Act*; *Inventory of Financial Knowledge and Skills for Servicemembers and Families*, 2016; Headquarters, Department of the Army Executive Order 140-21; Military Compensation and Retirement Modernization Commission; *Congressional Research Service Report [R46983]* [66-71]
- Websites: Securing the Financial Frontline, Army Family and MWR [72-73]

Program goal

The goal of FRP is to provide servicemembers with information, consultation, and skill-building opportunities to help them achieve and maintain financial readiness.

Program components

Main focus

One of the two main functions of the FRP is providing voluntary educational and counseling programs in personal financial readiness. These programs provide Soldiers the opportunity to

meet with Personal Financial Counselors (PFCs) for financial planning, advocacy, money management, insurance, and other financial matters.

The second function is providing financial literacy training at certain touchpoints, as mandated by the 2016 National Defense Authorization Act [71].

Prevention and intervention

According to our SME, the focus of the mandatory training is primary prevention, but this is not always the case in practice. For instance, while one of the mandatory touchpoints for financial literacy training is the birth of a child, the optimal timing of that training would be before the Soldier and partner were expecting a child, so that they could determine whether they were financially prepared for the cost of a child and could begin to make financial preparations. However, in most cases, this training happens after the birth of a child. As a consequence, the mandatory training is not always focused on primary prevention.

The voluntary component of FRP is focused on both prevention and intervention. Counselors often see Soldiers who are facing foreclosure or repossession, or their security clearance may be in jeopardy because of an adverse financial event. In these cases, counselors are performing duties to help mitigate the negative consequences of the financial issues, but the assistance is not in time to prevent the problems in the first place. They also help Soldiers or family members who are victims of domestic violence in need of developing spending plans, or those seeking emergency food assistance or bus fare.

Other efforts are targeted at prevention, such as informing Soldiers of predatory actions on the part of landlords who often increase rent when Basic Allowance for Housing rates are increased. FRP personnel tell Soldiers to bring contracts (for rent, cars, mortgages) in to the Program Manager or to the Judge Advocate General to ensure that the contracts are in their best interest. A number of Soldiers take advantage of this opportunity, but most do not want to wait for that review.

On a voluntary basis, Soldiers can request that FRP counselors review their credit scores, but there is no mechanism by which counselors are notified when adverse financial events happen, such as when Soldiers' credit scores go down, their car is repossessed, or they become enrolled in Supplemental Nutritional Assistance Program or other social welfare programs. This inability to be informed when Soldiers are facing financial hardships limits FRP's ability to prevent more financial hardships, or to assist in mitigating those that have already happened.

Coordination with other entities

The FRP has a collaborative effort with Army Public Health to integrate some PFCs into centers and to integrate some financial education into their classes. For instance, FRP has incorporated a financial education piece into Army Wellness Centers' Meals in Minutes in class, which teaches how to provide nutritious meals that require little time and are also affordable.

The FRP also works with Child Care Aware to provide subsidies for childcare.

Training

Content

Risk and protective factors addressed

Financial stress is one of the shared risk factors we identified in our literature review; it is associated with every harmful behavior except SH/SA. The SME we spoke with indicated that financial health should be considered on a par with the other facets of health—physical, mental, and spiritual—that are widely recognized as important for overall well-being and for preventing harmful behaviors. For instance, financial stressors are a significant contributing factor in suicide.

The mandatory training is targeted at a number of shared life skills that we identified as protective against several harmful behaviors, most of which are targeted at the individual SEM level. While the curriculum can be expanded by the Services, DoD mandates that certain skills be covered at specific touchpoints. For instance, some of the learning objectives specified in the Inventory of Financial Literacy Knowledge and Skills for Service Members and Families includes knowing the difference between a "need" and a "want" (self-regulation), understanding the fundamentals of creating and managing a spending plan (planning and organizing), analyzing the implications and identifying strategies for buying a car or financing a home (decision-making), and knowing strategies for managing debt (problem-solving) [70]. The SME we spoke with indicated that most of the risk and protective factors we have identified are covered in one or more of the courses they offer, but we are not able to identify specific factors other than those required by DOD.

The stigma associated with Soldiers and their families seeking help when they have financial difficulties is one of the shared risk factors that we identified at the unit level. It is not clear how stigma is mitigated, however. For instance, we learned that victims of domestic violence and Soldiers in financial distress do seek financial help from FRP. However, we also learned that at some installations, some of the social welfare program offices that are located in an ACS building require Soldiers and/or family members to wait in a hallway to be served. Such a public acknowledgement of need is a deterrent for a lot of families, according to the SME with whom we spoke.

Target audience

Mandatory financial literacy training milestones include the following [74]:

- During initial entry training

- Upon arrival at first duty station and every subsequent duty station (for members in enlisted pay grades of E-4 or below and officers in the pay grades of O-4 and WO2 or below)
- On the date of promotion of the member (for members in enlisted pay grades of E-5 or below and officers in the pay grade of O-4 or below)
- When the member vests in the Thrift Savings Plan
- When member becomes entitled to receive continuation pay
- At each major life event during the member's service, such as marriage, divorce, birth of a first child, or disabling sickness or condition
- During leadership training
- During pre-deployment and post-deployment training
- At transition points from a regular component to a reserve component and when separating or retiring from service

The Army has also added mandatory financial literacy training to pre-accession for enlisted Soldiers and to pre-commissioning (e.g., before going to ROTC or West Point) for officer candidates. It has also incorporated financial education at all enlisted professional military education (e.g., basic, advanced, senior, master and nominate leader) and in the company commanders/first sergeant pre-command course.

Mandatory training based on promotions and change of duty station are the only modules that are the same across all paygrades, but the training encourages them to look introspectively at changes since their last promotion and consider how the material is relevant to their current situation. According to the SME, the Army is also trying to adopt more "trigger-based training" instead of annual training because people learn best when they are going through the event.

Because the Army's Executive Order set a deadline of September 2021 for the establishment of the required training, the FRP mandatory training that we reviewed and discussed with SMEs is relatively new.

Family members are able to make use of the voluntary services offered, as well as all of the mandatory training except for accession financial literacy.

Delivery

Because some of the life events are private, such as divorce or a disabling sickness or condition, the Army developed different delivery methods to allow Soldiers to take the training when and where they can best learn from it. That means that available time, privacy, or learning style are factors Soldiers can consider in determining which method they will use for each mandatory milestone. The different options also help to vary the repeated training of the same training for

certain milestones to some degree. The three methods include: (1) distributed learning, (2) one-on-one financial counseling, and (3) group training. Family members are encouraged to take all trainings.

The Army is not able to determine what percentage of training is taken via each of the methods; they keep track only of which Soldiers have completed the mandatory training via any method. The one exception to this is that all pre-accession enlisted training is conducted via distributed learning. We also learned that group training is best suited to pre- and post-deployment training.

Regardless of the delivery method, all the Terminal Learning Objectives specified in the *Inventory* are met, but the materials are not all the same, and all materials are approved by G-9 [70]. The pre- and post-deployment training is standardized and controlled to ensure accuracy across the Total Force. Unlike other services, however, the Army does not post these materials online to prevent it from being used by entities outside of the Army.

Trainers

There are several groups of individuals who are authorized to provide one-on-one or group training. One group is the government credentialed financial readiness staff at ACS. Another group is OSD-contracted PFCs, and a third is National Guard Soldier and Family Readiness Support Specialists. Trainers in the latter group do not have to be credentialed, but they can teach only the mandatory training, without alterations, and may not do any counseling. An additional group of trainers are those who train in institutional settings, such as basic training. Those trainers may be Sergeants First Class, and they too are restricted to teaching the materials as provided and are prohibited from doing any financial counseling.

Effectiveness

Program evaluation

The FRP, through the Army Public Health Center, recently conducted an evaluation of the Basic Leader Course, but the results are not publicly available as of this writing. The annual Status of Forces Survey has questions tailored to financial education, which provide another source of data for analysis.

There is also an ongoing pilot through H2F at Fort Drum in which PFCs are embedded in the unit. A financial wellbeing assessment through the Consumer Financial Protection Bureau is being used to determine whether Soldiers' wellbeing scores will increase with the presence of PFCs.

SME awareness of research

The SME we spoke with was not aware of any published research using Status of Forces Survey data.

Published research

The current mandatory training is too new to have been evaluated in terms of its impact on Soldiers' financial readiness. However, the Military Compensation and Retirement Modernization Commission (MCRMC) study conducted between 2013 and 2015 found that the financial literacy programs that existed at that time did not adequately educate servicemembers and their families [69]. The MCRMC cited academic research that showed a correlation between financial readiness training and improved financial readiness among servicemembers [69]. Their recommendations were enacted by Congress and incorporated into the 2016 NDAA, including the recommendations for mandatory financial literacy training at key touchpoints in servicemembers' careers.

A recent Congressional Research Service report noted that the more frequent training as mandated by the 2016 NDAA could be beneficial because it will expose servicemembers to financial literacy several times in their first decade of service [68]. They note, however, that the effectiveness of that training depends on its implementation.

Comprehensive Soldier & Family Fitness (CSF2)

Overview and background

Summary

The Army's Comprehensive Soldier & Family Fitness (CSF2) program, administered by the ARD, is a resilience-building program that is required of all Soldiers across the career span, and encouraged for families and Army civilian personnel. It aims to increase the physical and psychological health, resilience, and performance of participants so that they can thrive and meet a wide range of operational demands.

Sources

This CSF2 program summary is based on information from the following sources:

- ARD SMEs who administer, oversee, and implement the CSF2 program

- Army regulations and program documents (AR 350-53, 2014 [75]; *MRT Skills Overview*, 2014 [76]; *MRT Participant Guide*, 2014 [77]; *R2C Information Paper*, 2014 [78], *R2 Performance Center Fact Sheets* [79-83])
- Websites (ARD, 2020 [84]; US Army—Army Values [85], ArmyFit [86]; Penn Positive Psychology Center [87])
- Army Research Facilitation Team evaluation reports (Lester et al 2011 [88-89]; Harms et al., 2013 [90])
- Articles in peer-reviewed journals (Cornum et al., 2011 [91]; Eidelson & Soldz, 2012 [92])
- Theses from military studies students at Army institutions of higher education (Dunning, 2013 [93]; Ignazzitto, 2013 [94]; Johnson, 2019 [95]; Knorr, 2012 [96]; Lorusso, 2018 [97]; Roy 2013 [98]; Timmons, 2013 [99]; Wang, 2014 [100])

History

The Comprehensive Soldier Fitness (CSF) program was established in 2009 by then-Army Chief of Staff General George Casey in response to increased rates of PTSD, suicide, and other mental health issues among Soldiers who experienced multiple deployments as part of the wars in Iraq and Afghanistan. The program was expanded to include families in 2010, renamed Comprehensive Soldier and Family Fitness (CSF2) in 2012, and currently operates under Army Regulation (AR) 350-53, promulgated in 2014. In addition, in 2014, CSF2 became part of the umbrella Ready and Resilient Campaign (R2), which has the goal of synchronizing and integrating key Army programs focusing on building resilience and preventing a variety of harmful behaviors.

Drawing on positive psychology approaches, CSF2 takes a proactive approach, providing Soldiers with the skills they need to be more resilient in the face of adversity. The program is modeled on the Penn Resilience Program, developed by the Positive Psychology Center at the University of Pennsylvania (UPenn). Although the UPenn resilience program developed curriculum and training materials for CSF2 and still owns the copyright, the program has evolved to include military-specific trainings such as Engage (bystander intervention/prosocial behavior training), Deployment Cycle Resilience Training, and the Squad Leader Development Course. Training materials and AR 350-53 are currently being updated.

Goals

The goal of CSF2 is to increase resilience and performance enhancement skills by building on five dimensions of strength:

- **Physical dimension:** Performing and excelling in physical activities that require aerobic fitness, endurance, strength, healthy body composition, and flexibility derived through exercise, nutrition, and training.
- **Emotional dimension:** Approaching life's challenges in a positive, optimistic way by demonstrating self-control, stamina, and good character.
- **Social dimension:** Developing and maintaining trusted, valued relationships and friendships that are personally fulfilling and foster good communication, including a comfortable exchange of ideas, views, and experiences. This dimension encompasses adherence to the Army Values and other beliefs embodied in the Army profession.
- **Spiritual dimension:** Identifying one's purpose, core values, beliefs, identity, and life vision.
- **Family dimension:** A nurturing family unit is one that is safe, supportive, loving, and provides the resources needed for all members to live in a healthy and secure environment.

Program components

CSF2 is not meant to replace existing efforts to diagnose and treat mental health problems but is instead considered a proactive program to help Soldiers become more resilient when faced with adversity. Although not articulated as "primary prevention," many of the resilience skills the program seeks to enhance can protect against numerous harmful behaviors. For example, early program evaluations examined associations between resilience training and occurrences of suicidal behaviors and substance misuse. CSF2 encompasses three components, which are listed below and described in greater detail in the sections that follow:

- Online assessment and self-development, including mandatory completion of a self-assessment tool upon entry in the Army and annually thereafter.
- Resilience training, which regulation requires to be incorporated into basic training at initial entry and in leadership courses, and offered at least monthly at the unit level.
- Metrics and evaluation, which includes technical reports and monthly unit status reporting.

Main focus

Online assessment and self-development

Upon entry into the Army and annually thereafter, Soldiers respond to the web-based *Global Assessment Tool (GAT*), which was recently updated and renamed the *Azimuth Check*. This 10-minute survey assesses a Soldier's level of overall fitness across the five dimensions of

readiness. Several versions of the survey were created, including GAT-Trainee for new accessions, GAT-S for all Soldiers, GAT-Department of Army Civilian (GAT-DAC), and the GAT-Family (GAT-F) for Army spouses.

After taking the Azimuth Check, Soldiers receive confidential, individualized feedback for each of the five dimensions, including a graph comparing their overall and dimension scores relative to their job function and the force as a whole. They also receive personalized self-development training materials linked to their individual dimension scores, including videos and articles, infographics, health news, unique program applications, geo-specific uniform resource locator-linked reference material, and regular emails (upon user opt-in) containing personalized fitness tips. The Azimuth Check is supposed to be completed annually, but program experts indicated that compliance is poor and that they are not allowed to mandate tracking of participation.

Coordination with other programs

CSF2 and the Army's H2F program have similar areas of focus, but H2F focuses primarily on physical fitness, whereas CSF2 emphasizes mental fitness. CSF2 also works with Army Wellness Centers and some PE training modules emphasize skills that help prevent harmful behaviors, including self-awareness, self-regulation, and critical thinking.

Trainers

Master Resilience Trainers (MRTs)

Competency and skills training and development for all Soldiers is delivered through unit-level MRTs, who receive intensive train-the-trainer preparation and return to their units to teach these competencies and skills to Soldiers in their units. Level 1 MRTs assume responsibility for resilience training as a collateral duty, with one MRT assigned per each 250-member unit. MRTs are E6-E8, O1-O4, or W1-W4, and receive 10 days of intensive training that includes developing an individualized implementation plan for their unit. They may take additional training (5-10 days at each level) to become Level 2-4 MRTs, which enables them to become training staff for the MRT Level 1 course.

MRT-Performance Enhancers (MRT-PEs)

In addition, the MRT Performance Expert (MRT-PE), who delivers optional performance enhancement training, must have a master's or doctoral degree in psychology, counseling, or kinesiology with a specialized emphasis in sport and/or performance psychology; and must complete a rigorous two-week certification program in addition to completing, at a minimum, the MRT Level 2 course. Performance enhancement training is provided by MRT-PEs associated with 32 R2 Performance Centers located at major installations both within and outside the continental United States.

Institutional Resilience Trainers

ARD also has program of instruction time in all Initial Entry Training and some Professional Military Education courses. Trainers are from the schoolhouses' cadre; however, a certain percentage of these trainers must be MRT-qualified.

Training

CSF2 seeks to develop specific competencies and resilience skills in Soldiers across their careers. Toward that goal, the program provides training through three mechanisms: MRTs, who provide training and development at the unit level; IRT that is embedded in established military education and training across the Soldier's career; and optional performance enhancement (PE) training available to individuals or units. Each of these training components is described below.

Content

Competencies and skills

MRT

Unit-level MRTs focus their efforts on developing six competencies through the teaching and reinforcement of 14 skills, as shown in Table 14.

Table 14. MRT competencies and skills

MRT Competencies	MRT Skills
Self-awareness Self-regulation Optimism Mental Agility Strengths of Character Connection	Goal Setting Hunt the Good Stuff ATC (**A**ctivating event, **T**houghts, and **C**onsequences) Energy Management Avoid Thinking Traps Detect Icebergs Problem-Solving Put it in Perspective Mental Games Real-time Resilience Identify Character Strengths in Self and Others Character Strengths: Challenges and Leadership Assertive Communication Effective Praise and Active Constructive Responding

Source: [76-77].

Specific strategies are offered to help Soldiers practice and cultivate each MRT skill. For example, *Goal Setting* involves seven steps: (1) define your goal, (2) know where you are right

now, (3) decide what you need to develop, (4) make a plan for steady improvement, (5) pursue regular action, (6) commit yourself completely, and (7) continually monitor your progress [76].

Institutional Resilience Training

IRT includes a series of modules that include resilience skills (seven thinking skills, character strengths, active constructive responding, effective communication, and optimism), and two performance skills (goal setting and energy management). These courses are sequential and progressive, and aim to help enlisted leaders and officers understand how to foster a positive climate that promotes resilience.

Performance Enhancement

Performance Enhancement training is available to individual Soldiers, leaders, and units upon request. PE training emphasizes six performance enhancement skills (which overlap to some extent with the MRT skills):

- *Mental Skills Foundations.* Identifying issues that affect performance and understanding what can be controlled to maximize training and ensure optimal performance regardless of the situation.
- *Building Confidence.* Setting the conditions for confident, optimal, and consistent performance by developing effective thinking patterns.
- *Attention Control.* Maintaining present awareness to ensure consistent, optimal performance by identifying strategies for shifting one's attention to what is most relevant.
- *Energy Management.* Maintaining composure under pressure and ensuring effective, efficient, and consistent performance by developing personalized strategies to regulate mental and physical activation.
- *Goal Setting.* Building self-motivation and empowering pursuit of excellence by developing strategies to deliberately energize, direct, and sustain behavior toward personally relevant and meaningful objectives.
- *Integrating Imagery.* Accelerating physical training, preparation, recovery, or healing, and ensuring maximum consistent performance through the use of anticipation and mental rehearsal techniques.

Examples of available programs include Great Teams Workshop for Culture Development, Leader Development Course, and Counseling Enhancement Workshop for leaders. Typically, unit-level training is tailored to the needs of the unit. Following participation in a seminar or unit training, an individual may schedule one-one-one sessions with a Performance Expert to focus on a specific performance and set goals with the help of a trainer. CSF2 program experts

report that a codified list of performance skills has been created to help Soldiers in specific military occupational specialties (MOS), which may be incorporated into IRT or into a training package tailored to a specific unit request.

Risk and protective factors addressed

The competencies and skills that the CSF2 program seeks to develop align with several protective factors in the Army SEM developed for this project, and incorporate additional factors not on the Army SEM but that may protect against specific harmful behaviors, as shown below:

- **Individual level:**
    - Three MRT skills align with protective life skills identified in the Army SEM: *decision-making/problem-solving*, *empathy*, and *positive affect.*
    - The spirituality dimension of CSF2 aligns with the Army SEM protective factor of *spirituality/religiosity*.
    - CSF2 also aims to develop the life skills of *self-regulation* and *self-awareness.* Although these skills are not on the Army SEM of shared protective factors, *self-regulation* has been shown to be protective against substance misuse (Institute of Medicine, 2013) [101].
- **Interpersonal level:**
    - The CSF2 program addresses three protective factors identified in the Army SEM: *social connectedness and support, family cohesion and support*, and *healthy peer relationships*.
    - In addition, CSF2 addresses the interpersonal protective factor of *communication,* which is not on the Army SEM but protects against substance misuse (Guerra et al., 2014) [102].
- **Unit-level:** CSF2 addresses the Army SEM protective factors of *unit cohesion and connectedness* and *positive leadership engagement.*
- **Installation/local community level:** According to CSF2 program experts, CSF2 addresses the protective factor of *community connectedness and support.*

Addressing culture and climate

MRT

CSF2 addresses unit climate and culture by working through unit-level MRTs to develop unit cohesion and connectedness, which includes supportive relationships with and among unit members. Specific skills that help nurture a positive climate include *Identify Character*

Strengths in Self and Others; using *character strengths* to overcome challenges, increase team effectiveness, and strengthen your leadership; *Assertive Communication*; and *Effective Praise and Active Constructive Responding*. CSF2 program experts report that the MRT training also emphasizes the importance of "psychological safety" within the unit, that is, building a safety net for unit members to speak out when something is wrong. In addition, they noted that the IRT and performance enhancement components of CSF2 (see next two sections) is aimed at fostering a positive climate that promotes resilience.

Performance enhancement

They also noted that the performance enhancement training supports development of a positive culture and climate. For example, a training module called Engage emphasizes bystander intervention and prosocial behavior, and another module entitled Gaining Resilience in Training (GRIT) includes a focus on team communication.

Targeted audience

Resilience training should be offered to all Soldiers at the unit level about once per month, with a goal of training on least 12 of the 14 MRT skills over the course of a year. The specific modules covered vary by unit and may not all be taught in any given year. MRT skills training is also offered during installation/unit in-processing for each CONUS and OCONUS assigned Soldier. Families and Army civilians are encouraged to participate in MRT-provided resilience training, which they may access upon request to the R2 performance centers or through training activities organized by command-level Family Readiness Groups.

In addition to receiving unit-level resilience training from MRTs, resilience training should be offered as part of institutional training at several touchpoints along a Soldier's career, including Initial Military Training (IMT) and various enlisted leader and officer courses. Performance enhancement training is available upon request for Army leaders at any level. This training is offered to DACs and Army Families based on availability of training seats.

Delivery

Program experts report that MRTs are expected to provide training on one or two skills each month in a classroom-like setting and include the use of visual displays and practical exercises such as worksheets or group activities to practice the skills.

IRT is often taught in 1- to 2-hour modules, although the Basic Officer Leader Course-B and the Basic Leader Course each have 6 hours of resilience training and the Warrant Officer Candidate School has 4 hours.

The MRT-PEs provide training at no cost on topics and to teams identified by the Army leader. Methods used are tailored to the unit by typically including activities that engage participants, such as interactive games or team-building activities. MRT-PEs also use a coaching approach to assist leaders, MRTs, and individual Soldiers to improve performance.

Effectiveness

Program evaluation

AR 350-53 states that the CSF2 constantly monitors its effectiveness and outcomes through research and command monitoring and with the support of various internal and external organizations, including establishing an evidence base for the value of resilience training [75]. According to the regulation, metrics and evaluation include *technical reports and research* conducted by the Army Research Facilitation Team; monthly *unit status reporting*; *R2 Portfolio Capabilities Assessment* to determine which programs can provide evidence of impact on key R2 measures of effectiveness; *metrics* to provide senior Army leadership with key gauges of CSF2 program fielding, execution, and results; and ongoing program evaluation of CSF2 resilience training by Walter Reed Army Institute of Research to determine whether instructors are training the material to standard.

Published research

The Army's Research Facilitation Team published a series of evaluation reports in 2011 and 2013. The first two reports used GAT results (Soldiers' self-reports) to establish that Soldiers who reported higher levels of resilience and psychological health were less likely to engage in multiple harmful behaviors and were more likely to be promoted or selected for command positions [88-90]. Evaluation reports in 2013 again used the GAT, this time to examine the efficacy of the MRT in influencing Soldier resilience and psychological health across time. These evaluations reported that Soldiers in units with MRTs exhibited significantly higher resilience and psychological health scores—particularly for adaptability, character, coping, friendship, and optimism—than those in units without MRTs [88, 90]. These studies were criticized in academic circles for a number of issues, including reliance on GAT results rather than on actual outcomes measures [92, 98-99, 103-104].

SME awareness of research

CSF2 program SMEs noted that the MRT skills are evidence-based, but acknowledged that there have been no recent evaluations, and noted the lack of resources to conduct rigorous evaluation (including control groups) in the Army setting.

Holistic Health and Fitness (H2F)

Overview and background

Summary

The US Army's H2F System, led by the TRADOC Center for Initial Military Training (CIMT), is designed to optimize Soldier physical and non-physical (mental, sleep, nutrition, and spiritual) readiness. Active Component brigades are resourced with a team of H2F interdisciplinary performance experts, equipment, and future facilities.

Sources

This H2F System summary is based on information from the following sources:

- TRADOC SMEs who administer and oversee the H2F program
- Army regulations and program documents (*US Army H2F Operating Concept* [105], *ATP 7-22.01 H2F Testing* [106], ATP 7.22.02 *H2F Drills and Exercises* [107], and FM 7-22 *Holistic Health and Fitness* [10], derived from DODD 1308.1 and DODI 1308.3 [108-109])

Program goals

The goals of H2F are to:

- Optimize physical and non-physical performance
- Reduce (particularly musculoskeletal over-use) injury rates
- Improve rehabilitation and reconditioning times after injury
- Improve overall Soldier and unit morale and effectiveness
- Enhance Soldier readiness and lethality

The H2F System represents a cultural shift in the way the Army trains, develops, and cares for its Soldiers. The system is designed to encompass five domains of human performance—physical, sleep, nutritional, spiritual, and mental readiness.

History

The H2F System was established in 2020 to improve deployable rates by improving health and fitness-related knowledge, attitudes, and behaviors [105]. As of April 2020, the equivalent of 13 Brigade Combat Teams worth of personnel from across the Army were non-deployable, with musculoskeletal injuries a significant contributor and obesity and poor lifestyle choices also playing a role [105]. In 2021, H2F performance teams were fielded to 28 brigades across five installations. In 2022, 10 more brigades were fielded with military personnel only. The

deployment of the H2F System will continue at a rate of 10 brigades per year until there are 110 resource brigades across the Army. In 2021, CIMT developed an H2F Integration Team (HIT) to ensure standards are systematically and deliberately applied across the Army to optimize the H2F System. In 2022, this team of human performance SMEs is conducting a week-long training workshop at each H2F-resourced brigade to standardize program implementation, establish best practices, and lessons learned. In addition, the HIT engages with brigade, division, and installation leadership to ensure common H2F understanding across the enterprise.

H2F equipment is expected to arrive for in-unit use in 2022. The H2F Academy, which is to be the Army's premier teaching facility for performance readiness, is planned but not yet complete as of 2022. Once complete and located at Fort Eustis, Virginia, it will be the center of excellence for the H2F System.

Program components

Main focus

H2F shifts physical readiness training from response- to prevention-based, from installation- to unit-based (with embedded personnel, equipment, and facilities), and from stove-piped to integrated (coordinated) care.

From response to prevention

Drawing on the VA's shift from a "find-it, fix-it" approach to a holistic health approach, H2F moves Army health and fitness from a response model to a prevention model [10]. The SME with whom we spoke considered H2F programming to be primary prevention in that it builds cognitive, interpersonal, and intrapersonal skills that are intended to prevent harmful behaviors. This connection between program goals, activities, and desired outcomes (a logic model) is described in the H2F Operating Concept. In short, it says, when people start exercising, eating better, sleeping better, and thinking more clearly, they make better choices, which not only improves readiness, but also reduces their risk of harmful behaviors.

From installation- to unit-based

H2F doctrine moves Army health and fitness from outsourcing medical needs outside the brigade to addressing those needs from within (the Army's 2021 rewrite of FM 7-22). This embedded approach draws from evidence-based practices in professional sports and the US Army Special Operations Command Tactical Human Optimization, Rapid Rehabilitation, and Reconditioning (THOR3) Program. Because they are embedded, H2F experts move with their commands, providing far-forward medical care and performance expertise.

From stove-piped to integrated care within H2F

Brigade H2F performance teams are SMEs who advise commanders and deliver interdisciplinary programming, as follows:

- A cognitive enhancement program delivered by OTs (to address mental and sleep fitness)
- A nutrition program delivered by registered dietitians
- A spiritual program delivered by unit ministry teams of a chaplain and religious affairs specialist
- Injury control delivered by a certified athletic trainer and PTs
- Physical training delivered by certified strength and conditioning specialists

H2F does not necessarily target Soldiers at risk for harmful behaviors, but its experts do identify needs and provide referrals to Soldiers who could use care from another H2F domain. Because some H2F experts are neither servicemembers nor in the Soldier's chain of command, daily training sessions become a safe space for the Soldier to discuss their personal or work challenges. For example, a strength coach conducting one-on-one training with a Soldier may identify a need and provide a warm handoff to the OT in their brigade. This integrated, or coordinated, care approach draws from best practices in healthcare research—it "deliberately organizes patient care activities and shares information among all participants concerned with a patient's care to achieve safer and more effective care" [110].

Not yet coordinated with other programs

The H2F System is designed for its H2F experts to coordinate with CSF2 MRT instructors, ACFT graders, and medical unit and installation personnel. This linkage is intended, but does not yet exist; currently, H2F and CSF2 are stove-piped. Although H2F and CSF2 have similar domains and graduate-level sports medicine professionals, anecdotally, the embedded H2F experts provide a better return on investment (ROI) than the CSF2 experts, who require a drive across base to be seen.

Training

Content

Risk and protective factors addressed

H2F SMEs confirmed that H2F was designed to address risk and protective factors at the individual, interpersonal, and unit SEM levels (see Table 15).

Table 15. Risk and protective factors that H2F programming addresses

SEM level	Risk factors	Protective factors
Individual	Poor mental health, poor physical health, recent medical issue	Spirituality/religiosity, life skills: problem-solving, decision-making, positive affect
Interpersonal	Close-relationship stressors	Social connectedness/support, life skills: empathy
Unit	Stigma associated with help-seeking, structural barriers to help-seeking	Unit cohesion/connectedness

Source: CNA.

Skill emphasis

H2F addresses risk and protective factors by building from skill awareness in initial training to skill understanding and application in unit training.

The cognitive enhancement program promotes *mental health*, the life skills of *decision-making, problem-solving*, and *empathy*, *positive affect*, *social connectedness and support*, and *unit cohesion and connectedness* by building cognitive, interpersonal, and intrapersonal skills. Cognitive skills include cognitive capability and problem-solving. Intrapersonal skills include emotional regulation, normalizing physiological responses to stress, anger and stress management, and self-awareness. Interpersonal skills include communication, conflict resolution, and team building. OTs and cognitive performance specialists provide this training and education (e.g., tactical breathing and visualization) to operationalize resilience competencies, address mental barriers to physical performance, and optimize individual and unit cohesion and performance.

The physical training program promotes *physical health* by teaching Soldiers how to execute their individualized strength and conditioning program to prevent injuries and achieve their unit mission and individual tasks. Strength coaches tailor individual training programs based on training objectives and needs assessments and address individual weaknesses in real time.

The injury control program protects against *medical issues* by teaching Soldiers progressive and sequential training methods to improve their strength and flexibility. PTs provide injury diagnosis and treatment near where Soldiers train. Athletic Trainers diagnose and treat acute musculoskeletal conditions before, during, and after physical training.

The nutrition program promotes *physical health* and *mental health* by building the knowledge and habits to use nutrition for physical performance and recovery. Registered Dietitians

coordinate nutrition education and training programs and provide individual and group counseling to enhance combat performance.

The spirituality program promotes *spirituality/religiosity*. Chaplains help Soldiers develop these skills, often needed in times of stress, hardship, or tragedy.

The immersive nature of the H2F program protects against the *stigma associated with help-seeking* and the *structural barriers to accessing or seeking help*. Structurally, the architecture in the unit—the fixed facility and framework of training concepts—supports access to care. Access to care does not depend upon appointments away from the unit or online, nor on self-management training systems. It does not pull Soldiers away from their work environment nor push them to complete training elsewhere. Stigma-wise, H2F removes the penalties to seeking care (e.g., pilots are no longer pulled off the flight line and promotions are no longer affected) and makes daily care-seeking rather than hiding injuries part of the organizational fabric of the unit (e.g., so that, just like professional athletes, they can "get back in the game" more quickly).

Culture/climate focus

H2F programming addresses military cultural norms such as binge drinking that affect Soldier health. H2F fosters positive relationships and team cohesion by teaching interpersonal skills, self-awareness, communication, anger/stress management, and problem-solving. A SME with whom we spoke described how the holistic training, care, and accommodation that H2F experts provide translates to "they really care about me," a message that can benefit life at work and at home.

Targeted audience

H2F programming is designed to target Soldiers throughout their careers, from initial training through sustainment training, at each unit in their career. The rollout is not yet complete; as of 2022, H2F is in its second year of a sustainment training rollout and beginning its initial training rollout. Initial and sustainment training cover all five domains. Soldiers receive a daily H2F program of instruction at the individual or unit level. For example, improved ruck marching performance might be taught at the unit level, whereas ACL recovery is individual treatment. H2F unit training is mandatory, but H2F individual training is voluntary.

Being victim-centered is not a primary role of H2F. Military OTs are trained in victim-centered support, but it is not their primary purpose.

Delivery

H2F is a comprehensive program in that it is optimized, immersive, in real time, and reinforced outside of training. It is optimized in all five domains to provide progressive and sequential training and education. It is immersive because of its daily dose of face-to-face programming

from embedded personnel on unit-owned equipment and facilities. It is in real time in that H2F occupational and PTs provide diagnosis and treatment near where Soldiers train, including combat training center rotations to eliminate medical evacuations from field training exercises. Whereas there is no written requirement for H2F programming to be reinforced outside of training, SMEs said that because H2F experts are "powerful motivators and role models," they can speak not only to proper form, but also "how to eat so gains are not lost and sleep for brain/muscle recovery."

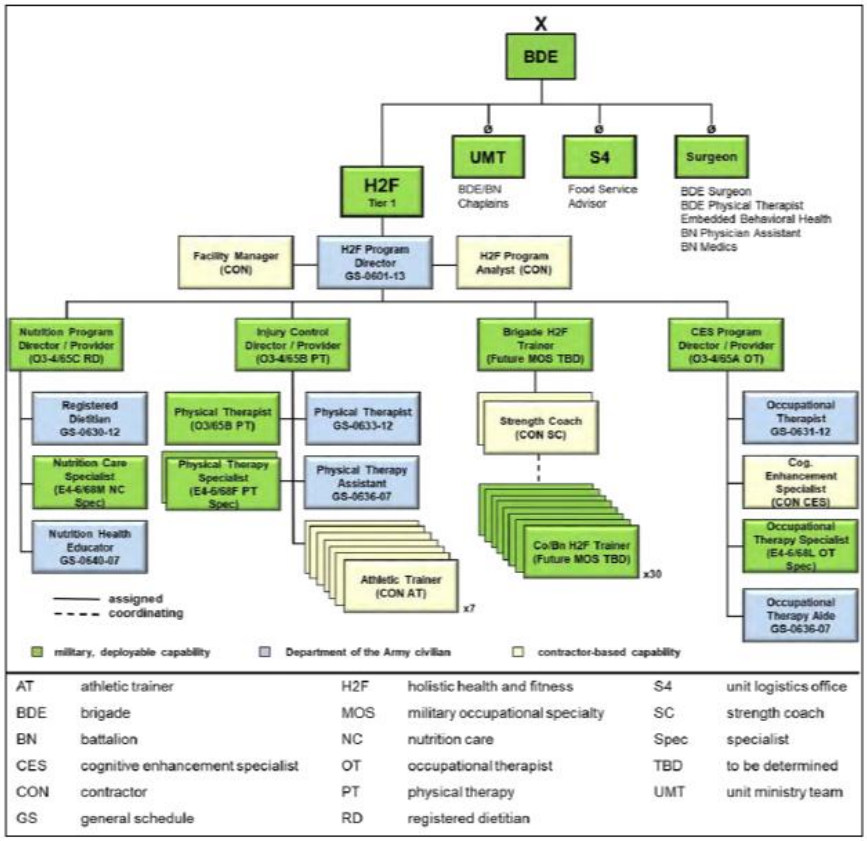
Trainers

H2F performance teams are a mix of military, civilians, and contractors. Contractors and civilians are full-time staff with mostly graduate and some bachelor's degrees. All military personnel are in full-time assignments that use their MOS.

Contractors are graduate-degree-level athletic trainers, strength coaches, and cognitive enhancement specialists. *Civilians* include graduate-degree-level registered dietitians, PTs, and OTs. They also include bachelor-degree and associate-degree-level nutrition health educators, PTs assistants, and occupational therapy aides. *Military positions* include O-3 PTs, E4-E6 physical therapy specialists, E4-E6 occupational therapy specialists, E4-E6 cognitive enhancement specialists, and E4-E6 nutrition care specialists. H2F Trainers do not yet exist, but the H2F planners at TRADOC believe it will eventually become an MOS. Being a Military Fitness Trainer is a *collateral duty* for an E5-E6 in which they plan and organize unit PT. Two Soldiers per company are selected to be MFTs based on interest and ability. They receive 2 weeks of distance learning and 2 weeks of residence learning.

Figure 2 shows the structure of brigade H2F performance teams.

Figure 2. H2F performance team structure for a Tier 1 Brigade



Source: [10].

Effectiveness

Program evaluation

The H2F program has not yet been evaluated but has responded to the Secretary of the Army's request for a robust ROI plan through the development of 16 measures of effectiveness. These MOEs are medical, programmatic, and quality-of-life, pulled from existing DoD data sources, and rolled up into a SPHERE dataset that analysts can use to compare brigades with and without H2F programming.

Strong Bonds

Overview and background

Summary

Strong Bonds began in 1997 as the Building Strong and Ready Families program and is a unit-based program intended to develop resiliency in Army families [111]. The program is typically delivered in a retreat/getaway format and led by Army Chaplains. Strong Bonds is targeted to four specific groups of Soldiers: those who are single, married, in families, or pre-/post-deployment. It is also available to the Active Component, Army National Guard, and Army Reserve Component.

Training for the Strong Bonds program is conducted by Unit Ministry Teams (UMTs), consisting of Army Chaplains and Religious Affairs Specialists.

Sources of info for this summary

SME:

- Chief, Soldier and Family Spiritual Readiness Division
- Documents:
    - *10 U.S. Code § 1789—Chaplain-led programs: authorized support* [112]
    - *Army Regulation 165-1*, 23 July 2015 [113]
    - "Decreasing Divorce in U.S. Army Couples: Results from a Randomized Controlled Trial Using PREP for Strong Bonds," 19 April 2010 [114]
    - *FM 1-05 Religious Support*, October 2012 [115]
    - "PREP for Strong Bonds: A review of outcomes from a randomized clinical trial," 1 September 2015 [116]
    - "USAG Bavaria Religious Support Office Annual Chaplain Historical Summary: January–December 2017" [117]
    - *Strong Bonds Program Management Guide* 2018 [118]
    - "Chaplain Corps—Strong Bonds Impact Assessment," April 2018 [119]
    - DACH-ZA Information Paper, "Reform the Army Strong Bonds (ASB) Program," 22 March 2019 [120]
    - *Army Chaplain Corps Journal CY20* [121]
    - *Army Chaplain Corps Journal CY21* [122]

- Department of the Army: Office of the Chief of Chaplains, DACH-ZA, "Reforming the Army Strong Bonds Program," 10 September 2021 [123]

Program goals

The stated goal of Strong Bonds is to increase the resiliency of Soldiers by developing a resilient Army family. The resiliency of a strong Army family is beneficial to the warfighter, allowing them to focus on their mission as a Soldier without the distractions that can stem from a turbulent homelife and increase their overall readiness as a Soldier. To achieve this goal, Strong Bonds strengthens the communication abilities of Soldiers, establishing and maintaining relationships, and decision-making. The improved communication is beneficial to the Soldier and their family and will spill over into their Army and professional relationships and be useful to the unit and their leaders within the Army.

Program components

Main focus

The primary focus of the Army Strong Bonds program is to develop a resilient Army family, affecting the readiness of the Army. To do this, Strong Bonds focuses on communication and relationship building through selected course curriculum at Strong Bond events. While most of the courses are directed toward communication and relationships, some of the curriculum can focus on other aspects, such as understanding how to find a long-term partner, decision-making, conflict resolution, love, and being a better partner.

Prevention, intervention, response

Prevention is the basis of the Strong Bonds program. Through the coursework, those who partake in the program develop and hone skills that strengthen the relationship with spouses and families or learn how to establish a relationship as a single Soldier. Ultimately, through the program, the relationships that the Soldier has/establishes will be able to navigate the challenges that arise both in military life and within a relationship and family. Strong Bonds courses can alleviate or address circumstances that lead to suicide, domestic violence such as spousal abuse and child abuse, and substance misuse. Communication and relationship building are common across all the target groups.

Coordination with other programs

Strong Bonds does not specifically coordinate with other programs. However, it is noted that the composition of Strong Bonds can have an impact like other programs, specifically programs that focus on suicide, spousal and child abuse, and substance misuse. By strengthening the family relationship, the consequential impacts are that Soldiers are less likely to turn to substances or have negative thoughts that may lead to suicide, and are more likely to have better communication and problem-solving skills that can improve relationships and prevent

domestic abuse/domestic violence. While various Army programs may address one or more of the harmful behaviors directly, a strength of the Strong Bonds program is that it may indirectly impact on one or more harmful behaviors.

Training

Content

The Strong Bonds program highlights a retreat-based model that allows Soldiers and families to be in a relaxing, neutral environment to partake in the program curriculum. Currently, there are three formats that the program uses for Strong Bonds training:

Table 16. Strong bonds training format

Format	Training Location	Hours of Instruction	Includes
Alpha	Local	3 hours	• Meal (1) • Curriculum • Childcare
Bravo	Local	6 hours	• Meal (2) • Curriculum • Childcare
Charlie	Off-site	9 hours	• Meal (5) • Curriculum • Childcare • Transportation (as required)

Source: [118].

The specific course curriculum that Strong Bonds programs can utilize has variability, and is dependent on unit needs, UMT capabilities, and commanders' guidance. Development of communication skills and strengthening relationships are the most common objectives of the course curriculum. A sample of the curriculum is below [118]:

Family:

- 5 Love Languages
- Prevention and Relationship Education Program (PREP)
- Couples Communication
- Active Relationships/Families
- 8 Habits of Successful Marriages/7 Habits of Highly Effective Army Families
- LINKS/Our Home Runs

- Survival Skills for Healthy Families/Family Wellness
- Laugh Your Way to a Better Marriage
- Oxygen
- Fighting for Your Marriage

Single:

- PICK
- Got Your Back/PREP
- Active Relationships
- 7 Habits of Successful Soldiers
- 5 Love Languages for Singles

Skills emphasis

Because the mission of Strong Bonds is to establish a strong and resilient Army family, the emphasis of the program is on relationship building and communication skills. Through the coursework, problem-solving and decision-making skills are also developed.

Risk and protective factors

The SEM levels that Strong Bonds addresses are at the individual and interpersonal levels. Numerous risk factors can be addressed through the Strong Bonds program, including unmarried, impulsivity, financial stress, alcohol misuse, deployment, combat exposure, low self-esteem, close relationship stressors, and isolation/lack of social support. Protective factors within the Strong Bonds program include life skills (decision-making, problem-solving, and empathy), positive affect, married, social connectedness and support, family cohesion and support, and healthy peer relationships.

Culture/climate

The Strong Bonds program aims to change the Army climate as result from the communication skills that are developed. Soldiers will be able to better describe what is affecting them, leaders will have improved their communication skills. Overall, the skills developed through the program will begin to impact the unit and the climate surrounding it.

Targeted audience

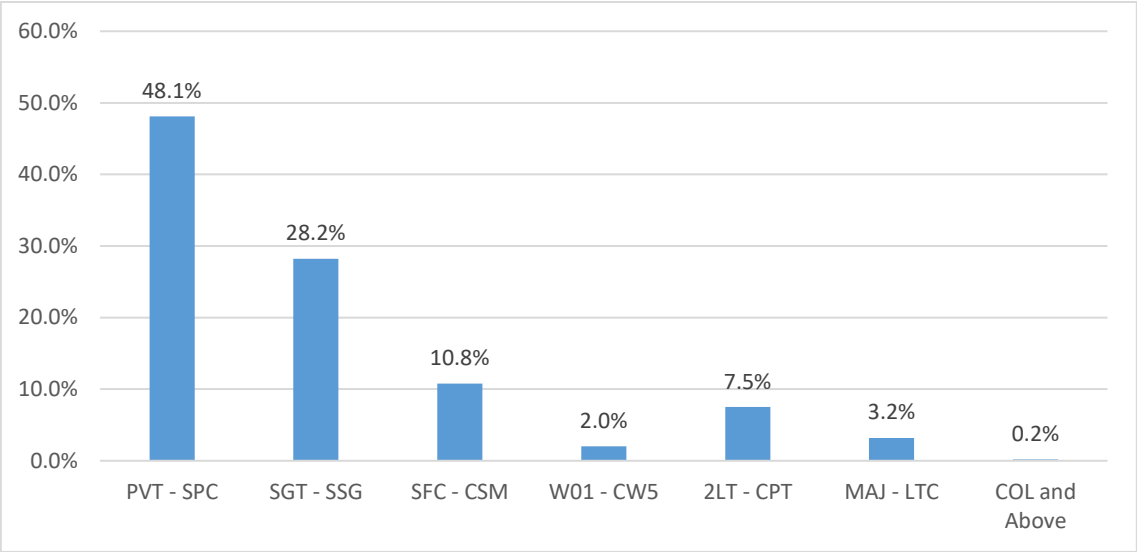
Strong Bonds is geared toward 4 populations [111]:

- Single Soldiers

- Couples
- Families
- Pre- and post-deployment

Strong Bonds is accessible to both enlisted and officer ranks within the Army. Of the participants, the largest representative group is from junior enlisted ranks, and enlisted personnel participate in the program more than warrant and commissioned officers.

Figure 3. Participants by grade



Source: [120].

Events are determined by unit needs and command support. The program is voluntary to attend, and Strong Bond events are organized with the collaboration between UMT and commanders to plan as needed. Strong Bonds events are also advertised by the unit and the tools at their disposal. It was mentioned that some units use social media, word of mouth, and op-orders through unit, and commanders discussing it at formation.

Delivery

The prevalent model for Strong Bonds training is through small group format, typically fewer than 20 people. Depending on the course session, the format can range from a lecture followed by a discussion, interactive discussions and role playing, and workshops. UMTs may provide supplemental material, both of their own development and commercially available products (with approval).

Outside of the training at Strong Bond events, there is not a formal process to provide additional or follow-on courses. Chaplains will follow up with individuals directly if they identify them as needing additional support or training.

Within FY 2021, Strong Bonds program was provided to more than 43,000 participants (Soldiers, spouses, and children) associated with the Active component, National Guard, and Army Reserves.

Table 17. Strong Bonds events and participant attendance, fiscal year 2021

Component	Events	Soldiers	Spouses	Children	TOTAL
AC	1,156	15,119	8,138	10,107	**33,364**
ARNG	245	3,926	2,314	2,613	**8,853**
USAR	77	644	216	279	**1,139**
TOTAL	**1,478**	**19,689**	**10,668**	**12,999**	**43,356**

Source: [124].

Trainers

Strong Bonds training is facilitated by UMTs, including the chaplain and religious affairs specialists. The specific courses for a Strong Bonds event are based on the unit needs and what the chaplain is trained on. Members of the UMT may have training and certifications for specific courses that are commercially available and may lead to limitations on what they are able to provide. Other individuals who are trained in specific courses can be used for the events. Although Strong Bonds is a program that is chaplain-led, it is not a religious program. Training does not have to be religious, spiritual, or faith-based.

Future plans/ongoing efforts

Presently, Strong Bonds program is going through reform. One of the objectives of the reform is to increase the outreach of the program to include more Soldiers and Soldier Families. Implementation of the program will be less reliant on the retreat-based format and instead focus on increasing the number of short-term events. The costs of the program include a lot of overhead due to the retreat format, and reforming the program will reduce the costs. Another part of the program reform objective will allow the program to reach more of the Army population, specifically the high-risk Soldiers. Chaplains and commanders will be able to determine the curriculum to address specific in-unit issues. Evidenced-based implementation is also a component of the program reform, with the objective to establish sustainable effect and efficiency [123].

Effectiveness

Program evaluation

An evaluation of the overall program includes pre- and post-event surveys, and follow-ups that occur six months after a Strong Bonds event. In the quantitative assessment of Strong Bonds impact, the participants all showed an increase in knowledge and behavior categories from their pre- to their post-Strong Bonds event surveys. Categories included in the assessment are communication, conflict resolution, healthy interaction, help-seeking, parenting, relationship commitment, stress management, relationship confidence, and relationship satisfaction. The immediate post-event survey focused on knowledge, and the six-month post event follow up focused on behavior assessments of the participants. In both immediate and six-month follow-ups, each assessment area shows an increase in knowledge and behavior.

Furthermore, the impact assessment identified direct and indirect benefits of the Strong Bonds program. Strong Bonds is intended to build resiliency through having a strong Army family and is a direct benefit from the program. In addition, the program strengthens readiness, has an impact on retention, and develops awareness of Army chaplains.

Published research

Evaluation of the various curriculum has also been published and supports the desired goals of the Strong Bonds program. For example, a study examining the PREP has shown that divorce rates among those that partake in the curriculum are significantly lower than those that do not [116].

Figures

Tables

Abbreviations

ACE	Ask, Care, and Escort
ACE-SI	Ask, Care, Escort-Suicide Intervention
ACS	Army Community Service
ADAPT	Alcohol and Drug Abuse Prevention Training
ADAPT-PFL	Alcohol and Drug Abuse Prevention Training-Prime for Life
ARD	Army Resilience Directorate
ASAP	Army Substance Abuse Program
ASPP	Army Suicide Prevention Program
BLC	Basic Leadership Course
BOLC	Basic Officer Leadership Course
CCA	command climate assessment
CDC	Centers for Disease Control and Prevention
CIMT	Center for Initial Military Training
CMT	Common Military Training
CONUS	continental United States
CSF	Comprehensive Soldier Fitness
CSF2	Comprehensive Soldier & Family Fitness
DA	Department of the Army
DEOMI	Defense Equal Opportunity Management Institute
DOD	Department of Defense
EO	equal opportunity
FAP	Family Advocacy Program
FAPM	Family Advocacy Program managers
FRP	Financial Readiness Program
GAO	General Accountability Office

GAT	Global Assessment Tool
H2F	Holistic Health and Fitness
HBPT	Harmful Behavior Prevention Tool
IMT	Initial Military Training
MCRMC	Military Compensation and Retirement Modernization Commission
MEO	Military Equal Opportunity
MFLC	Military and Family Life Consultants
MOS	military occupational specialty
MRT	master resilience trainer
MRT-PE	MRT Performance Expert
MWR	Morale, Welfare, and Recreation
NPSP	New Parent Support Program
OCONUS	outside continental United States
OT	occupational therapist
PC	prevention coordinator
PFC	personal financial counselor
PFL	Prime for Life
PME	professional military education
POR	program of record
POSH	prevention of sexual harassment
PPoA	Prevention Plan of Action
R2	Ready and Resilient
ROI	return on investment
RRP	Risk Reduction Program
RRPC	RRP Coordinator
R-URI	Unit Risk Inventory and Reintegration
SARC	Sexual Assault Response Coordinator
SB	Strong Bonds

SEM	socio-ecological model
SHARP	Sexual Harassment/Assault Response and Prevention
SME	subject matter expert
SRT	Suicide Response Team
SUD	substance use disorder
SUDCC	Substance Use Disorder Clinical Care Program
TRADOC	Training and Doctrine Command
TSP	training support packages
UMT	unit ministry team
URI	Unit Risk Inventory
VA	victim's advocate

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