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Marie M. Osborn
Tiffany E. Ho
Jessica A. Baweja
Amina A. Neville
Adam D. Cooper
Bradley D. Latendresse
Northrop Grumman Defense Systems

Olga G. Shechter
Defense Personnel and Security Research Center
Office of People Analytics

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Defense Personnel and Security Research Center, Office of People Analytics

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Defense Personnel and Security Research Center
Office of People Analytics
400 Gigling Road, Seaside, CA 93955

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ABSTRACT: Despite the prevalence of DoD and Service branch resources to support Service members who are dealing with stressful situations, approximately half of all military personnel who need mental health support, particularly for suicide risk, do not access it. In FY19, the Defense Personnel and Security Research Center, a division of the Office of People Analytics, developed an upstream suicide risk intervention entitled Resources Exist, Asking Can Help (REACH), in coordination with Military Community and Family Policy, Defense Suicide Prevention Office, and the military Service branches. REACH is an intervention designed to normalize help seeking among Service members by reducing barriers to care, increasing comfort with seeking help, and increasing knowledge of resources. REACH includes an interactive icebreaker; a short video modeling stressors and problems that all Service members face; a small group discussion about barriers, solutions, and resources; and a practice call to Military OneSource. The current study is a field test to evaluate the effectiveness of REACH using a formative approach. Participants in the field test came from the Navy, Air Force, and Army Service branches. Researchers trained facilitators who then led REACH sessions with groups of 6 to 20 Service members. Results from three of the four sites demonstrate that REACH sessions lowered perceptions of barriers, increased Service members' comfort with seeking help, and increased their knowledge of resources. Data from the fourth site were analyzed separately and models were underpowered to detect the effect of the REACH session on the outcomes of interest. Recommendations are discussed for how to bring REACH up to scale across the total military force.

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PREFACE

Since FY16, the Defense Personnel and Security Research Center, a division of the Office of People Analytics, has been engaged in the study of barriers to help seeking among military personnel. This research culminated in the development of Resources Exist, Asking Can Help (REACH), an upstream suicide risk intervention that addresses the root causes of why Service members are reluctant to use mental health resources available to them. REACH encourages Service members to reach out for help early, addresses common barriers to care, and promotes a connection to resources. These efforts to support Service member mental health and well-being contribute to the overall Defense Human Resources Activity mission to ensure that Service members and their families receive the care that they need.

Eric L. Lang
Director, PERSEREC

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The authors would like to thank Ms. Lee Kelley and Ms. Erika Slaton from Military Community and Family Policy, Dr. Adam Walsh and Dr. Laura Neely from Defense Suicide Prevention Office, and the Suicide Prevention Program Managers from the military Service branches for their invaluable contributions to the development and field testing of Resources Exist, Asking Can Help (REACH). The authors would also like to thank Suicide Prevention Program Managers, Violence Prevention Integrators, chaplains, and command leadership from USS Bunker Hill, Ellsworth Air Force Base, Joint Base Pearl Harbor-Hickam, Schofield Barracks, Fort Polk, and Fort Drum for their support in bringing REACH to their installations. Finally, this field test would not have been possible without the Service members who participated in REACH sessions and those who volunteered to become REACH facilitators and lead REACH sessions with Sailors, Airmen, and Soldiers.

EXECUTIVE SUMMARY

INTRODUCTION

In FY19 the Defense Personnel and Security Research Center (PERSEREC), a division of Office of People Analytics, developed an upstream suicide risk intervention entitled Resources Exist, Asking Can Help (REACH). Upstream suicide prevention approaches focus on addressing modifiable risk factors prior to the onset of symptoms. REACH seeks to normalize and encourage help seeking among Service members to address the persistent finding that approximately half of all military personnel who need mental health support do not use resources available to them (Office of People Analytics, 2019). Over the course of a 60- to 90-minute session, REACH uses a small group discussion format to reduce Service members' barriers to care and increase their knowledge of resources. The session also includes a skill-building exercise to increase comfort with accessing resources. REACH consists of an icebreaker; a short video modeling stressors and problems that all Service members face; a group discussion about barriers, solutions, and resources; and a practice call to Military OneSource. In the current FY20 study, PERSEREC researchers field-tested REACH at four sites using a formative approach to evaluate its effectiveness and to incorporate lessons learned into the final version of REACH materials. This effort was sponsored by Military Community and Family Policy and conducted in coordination with Defense Suicide Prevention Office and the military Service branches.

METHOD

Navy, Air Force, and Army Service members from USS Bunker Hill, Ellsworth Air Force Base, Joint Base Pearl Harbor-Hickam, Schofield Barracks, Fort Polk, and Fort Drum participated in the REACH field test. Facilitators were identified at these installations who were noncommissioned officers, chaplains, or respected leaders in their units (n = 80). They all had an interest in mental health and suicide prevention. Researchers trained facilitators, after which a smaller subset (n = 33) led REACH sessions with participants (n = 528). Before and after the REACH sessions, participants completed questionnaires evaluating their perceived barriers to help seeking, comfort with reaching out for help for mental health and financial concerns, and knowledge of resources. In addition, participants reported how useful and relevant the information in the REACH session was for them and for other Service members. Facilitators answered questions about their impressions of the facilitator training and their experience with leading a REACH session.

The researchers used descriptive statistics and analyses of covariance to evaluate the effectiveness of REACH. They also used qualitative feedback from participants, facilitators, and stakeholders as well as observations from facilitator training and REACH sessions to inform revisions to REACH materials. Notably, due to DoD travel restrictions in Spring 2020, data collection at Fort Polk and Fort Drum (Site 4) was

delayed and conducted remotely. Thus, the field test findings from Fort Polk and Fort Drum were analyzed separately and are described in Appendix A.

FINDINGS

A total of 361 Service members from Sites 1 through 3 (USS Bunker Hill, Ellsworth Air Force Base, Joint Base Pearl Harbor-Hickam, and Schofield Barracks) and 167 Service members from Site 4 (Fort Polk and Fort Drum) attended a facilitator-led REACH session. Most participants from Sites 1 through 3 were from the Air Force (66.2%), were Active Duty members (89.2%), either had a rank ranging from E-1 to E-4 (59.3%) or E-5 to E-9 (36.3%), and were male (72.9%). Most participants did not have previous experience with professional mental health support (74.2%). Similarly, the majority of Site 4 participants had a rank ranging from E-1 to E-4 (73.1%) or E-5 to E-9 (21.6%), were male (83.8%), and did not have experience seeking mental health support (70.7%).

Results from Sites 1 through 3 indicated that REACH significantly lowered participants' perceived barriers to seeking mental health care. Those barriers were their concerns about privacy and confidentiality, fears of being seen as broken, worries about negative career impact, and perception that existing mental health and financial resources are ineffective. Most importantly, REACH significantly increased participants' comfort with reaching out for help in the future and their knowledge of resources. REACH did not significantly boost participants' confidence that their leadership would be supportive if they reached out for help with a mental health problem. Models using Site 4 data were not adequately powered and did not find statistically significant differences in pre- and post-REACH perceptions of barriers to care, comfort with help seeking, and knowledge of resources. Across all sites, more positive perceptions of the facilitator were associated with improved field test outcomes, pointing to the criticality of this role for promoting a culture of help seeking in the military.

CONCLUSION

REACH was developed to address the finding that many Service members who experience mental health distress do not use available resources because of concerns about barriers to care. By design, REACH encourages a proactive mindset that focuses on the individual and their own need to engage in self-care to be mission ready. Field test results indicate that REACH lowers Service members' barriers to care, increases their comfort with future help seeking, and expands their knowledge of available resources. These short-term measures of effectiveness were evaluated in the current field test. However, researchers also hope to see a difference downstream in the long-term effects of REACH. Specifically, if REACH is implemented across the total military force, the percentage of Service members who proactively reach out for help and use available resources should increase, and the rates of suicidal ideation and completion should decrease over time. Further research is needed to evaluate these hypotheses.

RECOMMENDATIONS

Several recommendations are provided by PERSEREC researchers and Military Community and Family Policy in support of implementing REACH across the Service branches:

- Determine the best use of REACH by identifying the appropriate target audience, determining what training requirement it fulfills (e.g., suicide prevention, resiliency), and preparing implementation guidance and procedures.
- Set the tone for a top-down culture change around mental health and help seeking that inspires more Service members to reach out for help.
- Develop and disseminate a web-based REACH facilitator training.
- Prepare for an increase in call volume to Military OneSource call center based on the scale of REACH rollout.
- Carefully select and certify engaging REACH facilitators.
- Conduct future research that explores the long-term effectiveness of REACH.

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INTRODUCTION

DoD and the Service branches offer a variety of resources to support Service members who are dealing with stressful situations in their lives. Despite the prevalence of these resources, approximately half of all military personnel who need mental health support, particularly for suicide risk, do not access it (Office of People Analytics [OPA], 2019). A shift in the mindset around help seeking for mental health concerns is needed to encourage more Service members to use resources proactively. Relationship problems, legal and administrative problems, ineffective coping skills, and reluctance to seek help are often associated with risk for suicide (Defense Suicide Prevention Office [DSPO], 2019). Addressing these issues before they escalate could offer a way to reduce suicide risk in military personnel. This shift in mindset can be achieved by directly addressing Service members' barriers to care and embracing a more holistic approach to mission readiness that balances accomplishing the mission with taking care of people.

In FY19, the Defense Personnel and Security Research Center (PERSEREC), a division of OPA, developed an upstream suicide risk intervention entitled Resources Exist, Asking Can Help (REACH) in coordination with Military Community and Family Policy (MC&FP), DSPO, and the military Service branches. Upstream suicide prevention approaches focus on addressing modifiable risk factors before they manifest as troubling symptoms or problems. REACH employs motivational interviewing techniques[1] that encourage meaningful conversations with peers, leadership, and suicide prevention gatekeepers. Specifically, REACH's small group discussions with a trusted facilitator highlight the importance of mental health, address perceived barriers to care, encourage self-referrals, and increase awareness of resources. The current FY20 REACH field test was sponsored by MC&FP to evaluate whether REACH reduces Service members' barriers to care and increases their comfort with future help seeking. A secondary goal of the field test was to refine and improve the REACH instructional materials.

BACKGROUND

REACH embodies the public health approach to suicide prevention by focusing on the universal population of all Service members (DSPO, 2019). The primary goal of REACH is to increase Service members' motivation and comfort with seeking help and support from others, particularly for mental health concerns. REACH has three components: a barrier reduction discussion, education concerning available resources, and a skill-building exercise. These components are implemented through the use of an interactive

[1] Motivational interviewing is a counseling approach that aims to enhance an individual's motivation to make a positive behavior change. It involves the use of such strategies as reflective listening, avoiding arguments, and supporting the individual's self-efficacy (Miller & Rollnick, 1991).

icebreaker; a short video originally developed by the Defense Media Activity that models stressors and problems that all Service members face but few openly talk about; small group discussion about barriers, solutions, and resources; and a practice call to Military OneSource made jointly by the facilitator and a session participant.[2]

REACH adapts elements of the Crisis Line Facilitation (CLF) approach for Veterans at risk for suicide (Ilgen et al., 2020). CLF elements include motivational interviewing techniques to address barriers to help seeking, a one-on-one discussion of practical strategies for obtaining support, and a practice call to the Military/Veterans Crisis Line to increase confidence in future use of this resource. In contrast to CLF, REACH targets Service members, is delivered in a small group setting, is facilitated by a trusted figure associated with the unit (e.g., an enlisted leader, officer leader or chaplain), and takes around 75 minutes. For the skill-building component, REACH incorporates listening to an audio recording of a call to Military OneSource[3] and making a group practice call to this resource. Military OneSource was chosen for the demonstration call because it offers effective support for a wide range of military life problems for active duty, National Guard, and Reserve populations.

Barrier Reduction Discussion

Barrier reduction, which is based in part on the Expectancy Value Theory, constitutes the core component of REACH. The Expectancy Value Theory postulates that motivation for a given behavior depends on how likely an outcome is achieved by that behavior (i.e., *expectancy*) and how much the desired outcome is valued (Eccles et al., 1983; Eccles & Wigfield, 2002). An individual's assessment of the *value* of a behavior depends on a few factors, including how well the behavior relates to current and future goals (i.e., *utility*) and whether there are negative aspects of engaging in the behavior (i.e., *cost;* Eccles & Wigfield, 2002). In the case of REACH, the behavior being addressed is seeking help and support from others and the outcome is life satisfaction and mission readiness. REACH seeks to increase Service members' motivation to engage in help-seeking behavior. It stresses how help seeking supports achievement of goals in five domains (physical, emotional, spiritual, social, and financial) and addresses the perceived negative outcomes of help seeking. In other words, the barrier reduction component of REACH aims to increase the *utility value* of help seeking and lower its perceived *cost*.

The perceived negative outcomes of help seeking that REACH addresses are loss of privacy or confidentiality, the fear of being perceived as broken, and negative career impact. These outcomes have been identified as some of the most commonly endorsed barriers to help seeking in the *Status of Forces Survey for Active Duty Service Members* ([SOFS-A]; OPA, 2019). In addition to these negative outcomes, other commonly endorsed barriers to help seeking that REACH addresses are preference for self-

[2] These components reflect the final version of REACH. The qualitative results section explains the changes that were made to REACH throughout the course of the field test.
[3] The audio recording was removed from the final version of REACH because Service members felt it was redundant with the live practice call to Military OneSource.

reliance and a lack of awareness and confidence in available resources. In earlier versions, REACH also addressed lack of trust in leadership, but this barrier was removed from the final version because there was no data point for it on the 2018 SOFS-A. The following subsections provide an overview of these most commonly cited barriers and describe how REACH addresses each of them.

Preference for Self-Reliance

One of the central tenets of the military is its inner strength and resiliency. Service members are taught to handle issues at the lowest level possible as opposed to immediately seeking help from superiors. It therefore comes as no surprise that Service members report a very strong preference for self-reliance, or the preference to cope with a problem oneself (OPA, 2019). Although self-reliance can be beneficial for work-related issues, this internalization strategy often comes up short when it comes to mental health concerns. Past research has found that higher ratings of self-reliance are associated with a more negative view toward help seeking (Adler et al., 2015; Jennings et al., 2015). This association is especially troubling for Service members in light of the greater risk they face of developing mental health conditions such as post-traumatic stress that require external support for symptom reduction.

REACH addresses Service members' preference for self-reliance by acknowledging that coping skills such as using self-help literature and mobile apps may help them with "simple and straightforward" problems, but that some problems require shared care (e.g., non-medical counseling) or medical care (e.g., medication management with a psychiatrist). The key message is that being truly self-reliant means that you are open and honest with yourself and can recognize when it is time to ask for help.

Loss of Privacy or Confidentiality

Another barrier to help seeking is Service members' fears that others will find out that they sought help or that the information they share in a trusted setting will be shared with others. Many Service members may not understand the difference between privacy, confidentiality, and duty to warn, which creates confusion around what can and cannot be reported to others, including to their leadership. Typically, voluntary appointments with a behavioral health care provider are not reported to leadership as long as no safety concerns arise from the session (Hernandez et al., 2016; Rowan & Campise, 2006). This should alleviate fears of career repercussions for seeking help because confidentiality in this case is guaranteed and the impact on one's career is minimal to nonexistent, depending on the circumstances. There are some circumstances, however, in which military behavioral health providers are required to report or notify command of a Service member's use of medical or mental health care. If Service members voluntarily seek medical and mental health care, providers are legally mandated to report if a patient or client reveals imminent harm to self or others (e.g., domestic violence, child abuse, or elder abuse), reveals harm to the mission, has been admitted for in-patient mental health care, has an acute medical condition that interferes with duty, is in a substance abuse treatment program, is in a special

position such as the Personnel Reliability Program, or is in another special circumstance determined on a case-by-case basis (DoD Instruction 6490.08). If the appointment is a result of a Command-Directed Evaluation, the provider will provide updates to leadership.

REACH encourages participants to ask providers about their limits of privacy and confidentiality when determining what resource is appropriate for their needs. In addition, REACH points out that military mental health providers do not report information to the Service member's leadership (except in the case of duty to warn concerns) if there is a self-referral. In contrast, if there is a Command-Directed Evaluation, the military mental health provider reports information on the Service member's fitness for duty to the command. REACH includes a discussion of what information is shared when a Service member seeks help voluntarily compared to when command directed to underscore that taking the initiative to seek help may ensure that greater confidentiality is maintained.

Fear of Being Perceived as Broken

Although the stigma associated with asking for help is not a uniquely military issue (Ahmedani, 2011; Shim & Rust, 2013), it is greatly exacerbated by a military culture that emphasizes self-reliance and the endurance of hardships (Hernandez et al., 2016). The fear of being labeled "weak" and "broken" by peers, leadership, and oneself (i.e., self-stigma) manifests as a significant barrier to care for Service members (Greene-Shortridge et al., 2007; Kessler et al., 2001; OPA, 2019; Wade et al., 2015; Warner et al., 2011). Stigma as a barrier to care is a hurdle that, when overcome, can enable Service members to reach out for help when the stress in their life becomes too overwhelming.

Military leaders and supervisors can play a pivotal role in combating mental-health-related stigma through their speech and actions. Leaders can encourage help seeking by adopting a holistic view of mission readiness that emphasizes the Service member's mental health and well-being. They can also demonstrate their support of mental health help seeking by endorsing the effectiveness of resources and respecting the privacy of those who seek these resources (Acosta et al., 2014). Leaders and fellow Service members need to view one another as allies in combating the issues they all face. Dispelling the myth that Service members should handle everything on their own can also help reduce the stigma associated with help seeking (Acosta et al., 2014).

REACH addresses these sources of stigma in small group discussions that emphasize how recognizing mental health concerns and seeking help equates to inner strength and fortitude of character. REACH promotes the message that, instead of being seen as weak, Service members who take a proactive approach to mental health care should be acknowledged by their leadership and peers for their wisdom and courage. The use of trusted leaders from participants' own units as REACH facilitators further reinforces this message. Facilitators are encouraged to share their personal experiences with help seeking during the REACH session, thus establishing their credibility as a facilitator

and as a leader who endorses mental health help seeking. Facilitators also use motivational interviewing techniques to encourage meaningful conversation and sharing of personal experiences with barriers to care and help seeking. REACH's small group discussion format encourages Service members to view their peers as allies.

Negative Career Impact

Career progression is another major factor in deciding whether or not to reach out for behavioral health care (Kim et al., 2010; Kim et al., 2011). The perceived repercussions for seeking help include the loss of a security clearance and career stagnation or demotion (Hernandez et al., 2016). These two factors are not mutually exclusive. Service members often believe that receiving mental health care will result in security clearance revocation or access suspension, thereby making positions that require access to sensitive or classified information no longer viable. Furthermore, help seeking is thought to result in negative comments and marks equivalent to "unsatisfactory" on branch-specific performance appraisal evaluations (e.g., Fitness Reports, Noncommissioned Officer [NCO] Evaluation Reports). The competition for promotion is fierce, and perfection on yearly evaluations is often necessary to attain desired positions. Therefore, any potential for low grades is avoided by Service members at all costs.

REACH underscores that, although these fears are common, research has shown that fewer than 1% of security clearances are denied or revoked for mental health issues alone (PERSEREC, 2020). Furthermore, as of 2016, the only mental health diagnoses that must be reported on the Standard Form 86, *Questionnaire for National Security Positions,* are schizophrenia, bipolar mood disorder, psychotic disorder, schizoaffective disorder, delusional disorder, borderline personality disorder, antisocial personality disorder, and any other condition that substantially affects judgment, reliability, or trustworthiness (Shedler & Lang, 2015). The more common mental health issues that Service members face, such as depression, anxiety, and post-traumatic stress, do not need to be reported. In addition to addressing concerns about security clearances, REACH underscores that those who seek mental health help on their own initiative are less likely to have the provider contact their command and are more likely to have positive career outcomes.

Lack of Awareness and Confidence in Resources

Once a mental or behavioral health issue has been identified, the next step is to seek the help and care that is needed. The problem, however, is that many Service members who require help do not know what resources exist or which resources are most beneficial (OPA, 2019). Although unfamiliarity of resources is easily remedied through education, the issue of efficaciousness requires a more nuanced explanation. Many resources exist, and each comes with its own benefits and limitations in regard to the type of help (e.g., therapy, counseling, self-help guidance) and the level of confidentiality (e.g., total, partial) they can offer. Increased awareness of this

information makes it simpler to reach out for the care that suits the Service member's specific need (Ramchand et al., 2011).

REACH addresses issues of resource utilization by presenting the most common types of military mental health resources along with their corresponding levels of confidentiality and means by which to access them. In addition, the discussion of differences between counseling and therapy helps participants decide which avenue is the best to pursue given a specific mental health concern. The practice call to Military OneSource and subsequent group discussion also increase Service members' awareness of resources and understanding of how the resources can help.

Education Concerning Resources

Another key component of REACH is the education concerning available resources. REACH highlights the variety of resources available to Service members, such as chaplains, financial consultants, counselors, therapists, and peer mentors. REACH provides examples of how these resources can help and reiterates several times that there is an increased likelihood for positive outcomes if a Service member engages these resources early. REACH also emphasizes the importance of asking about the provider's limits of confidentiality, so that the Service member can make an informed choice about utilizing that resource. Finally, REACH encourages facilitators to invite resources (e.g., chaplains and counselors) directly to the sessions, so that Service members can interact with them and ask questions.

Skill-Building Exercise

The third and final core component of REACH is the practice call to Military OneSource. The practice call is intended to demonstrate how easy it is to call Military OneSource for help with any military life problem and to build confidence in using Military OneSource in the future. Military OneSource was selected for the demonstration because it provides a wide variety of services. In addition, the call center is available 24 hours a day, 7 days a week, which allows for REACH sessions to be facilitated in any time zone. The participants in the REACH session choose the topic for the call (e.g., relationship troubles, disagreements with a supervisor, difficulties paying bills on time), and the facilitator and a volunteer place the call together in front of the group, which takes approximately 5 minutes. The original REACH materials also included an audio recording of a scripted call to Military OneSource that was played immediately before the live demonstration call. Two versions of the audio-recorded call were developed, one for a relationship issue and one for a financial issue, and they highlighted the different resources available. The audio recording was removed from the final version of the REACH materials because Service members felt it was not sufficiently immersive and was redundant with the live practice call to Military OneSource.

CURRENT STUDY

This study assessed the effectiveness of REACH in reducing Service members' perceived barriers to care, increasing their comfort with reaching out for help, and improving their understanding of available mental health resources. A secondary goal of the field test was to refine and improve the REACH instructional materials. The research questions addressed were as follows:

1. Does participation in a REACH session reduce Service members' perceived barriers to seeking help?
2. Does participation in a REACH session increase Service members' comfort with seeking help? And immediately following the REACH session, do participants' perceptions of the facilitator relate to their comfort with help seeking?
3. Does participation in a REACH session increase Service members' knowledge of the resources available to them?
4. Do participants find their REACH session useful?
5. Do the facilitator training procedures effectively support the facilitators in ensuring that REACH is delivered with maximum integrity and effectiveness?
6. How can the REACH instructional materials (i.e., REACH slides and Facilitator's Manual) be improved to be maximally engaging and useful to Service members?

METHOD

Researchers used a formative evaluation approach where qualitative data and stakeholder feedback collected at each site informed process improvements at subsequent sites. REACH was field tested with Army, Navy, and Air Force Service members at four sites where the facilitator training occurred:

- Site 1 - USS Bunker Hill,
- Site 2 - Ellsworth Air Force Base,
- Site 3 - Joint Base Pearl Harbor-Hickam and Schofield Barracks, and
- Site 4 - Fort Polk and Fort Drum.

Site 3 included both Joint Base Pearl Harbor-Hickam and Schofield Barracks because of their physical proximity. Site 4 included both Fort Polk and Fort Drum because one of the Fort Polk facilitators supported Soldiers at both of these installations. This section describes the methodology used to carry out the REACH field test and the data collection and analysis process. Note that DoD travel restrictions in Spring 2020 led to scheduling constraints that delayed data collection at Site 4 (Fort Polk and Fort Drum). Thus, the following sections describe the process used at Sites 1 through 3 (USS Bunker Hill, Ellsworth Air Force Base, and Joint Base Pearl Harbor-Hickam with Schofield Barracks) only. The method and results for Fort Polk and Fort Drum are described in Appendix A.

FACILITATORS AND PARTICIPANTS

The REACH target audience consists of all Service members; however, for the purposes of the field test, participant recruitment focused on junior enlisted Service members and NCOs. The researchers prioritized enlisted ranks because they are at a substantially higher risk for suicide compared to officers (DSPO, 2019). After receiving approval from the command, a convenience sample of participants was recruited at each installation.

Researchers worked with installation points of contact, usually Suicide Prevention Program Managers (SPPMs) and Violence Prevention Integrators (VPIs), to identify REACH facilitators at each site. Facilitators were typically NCOs or well-respected leaders in their units who had an interest in mental health and suicide prevention. The majority of REACH sessions with participants were led by a single facilitator. Some sessions, however, were led by a team of two or three facilitators, and some facilitators conducted more than one REACH session. A critical requirement of the field test was to lead a REACH session during the week of the facilitator training while researchers were still on site. Therefore, 66 facilitators participated in the facilitator training, however, only 31 facilitators led REACH sessions with a total of 361 participants. Table 1 shows the number of facilitators who led REACH sessions and participants for each field test site.

Table 1
Number of Facilitators and Participants per Site

	Facilitators		Participants	
Site Number and Name	***n***	**%**	***N***	**%**
1. USS Bunker Hill (Navy)	4	13.3	76	21.1
2. Ellsworth Air Force Base (Air Force)	6	16.7	119	33.0
3. Joint Base Pearl Harbor-Hickam (Air Force, Navy) with Schofield Barracks (Army)	21	70.0	166	46.0
Total	31		361	

Note: Percentages may not sum to 100% due to rounding.

DATA COLLECTION

Researchers developed a protocol for how to train facilitators at each field test site with maximum consistency and effectiveness. Once trained as a group, facilitators led REACH sessions with participants. Researchers administered questionnaires to facilitators to gather feedback on the facilitator training and their experience with leading a REACH session. Researchers used participant questionnaires to evaluate changes in attitudes toward barriers to help seeking, comfort with reaching out for help before and after the REACH session, and suggestions for refinement of REACH materials. This section describes these procedures in more detail.[4]

Questionnaires

Researchers developed four questionnaires to assess the effectiveness of the REACH session and the facilitator training procedures (see Appendix B). Question development focused on determining the goals of the questionnaires, identifying the information needed to evaluate the research questions, writing the questions, and refining the questions. Figure 1 displays the questionnaire administration timeline for each field test site. Facilitators completed two questionnaires: one following the facilitator training and another following the REACH session they led. Participants also completed two questionnaires: one before the REACH session and one following the REACH session. No personally identifiable information was collected on the questionnaires. Researchers assigned a unique study identification number to each facilitator and participant and linked facilitators and participants using a unique REACH session number. Researchers emphasized to facilitators and participants that their responses were confidential and that the data were solely used to inform edits to REACH materials. The following subsections describe the open-ended and close-ended questions that facilitators and participants answered. Responses to most close-ended questions used a five-point Likert scale with responses ranging from 1 (“Strongly disagree”) to 5 (“Strongly agree”), and some questions were reverse-worded.

[4] The Defense Human Resources Activity Exempt Determination Official determined that the REACH field test did not meet the definition of research with human subjects under 32 Code of Federal Regulations 219.

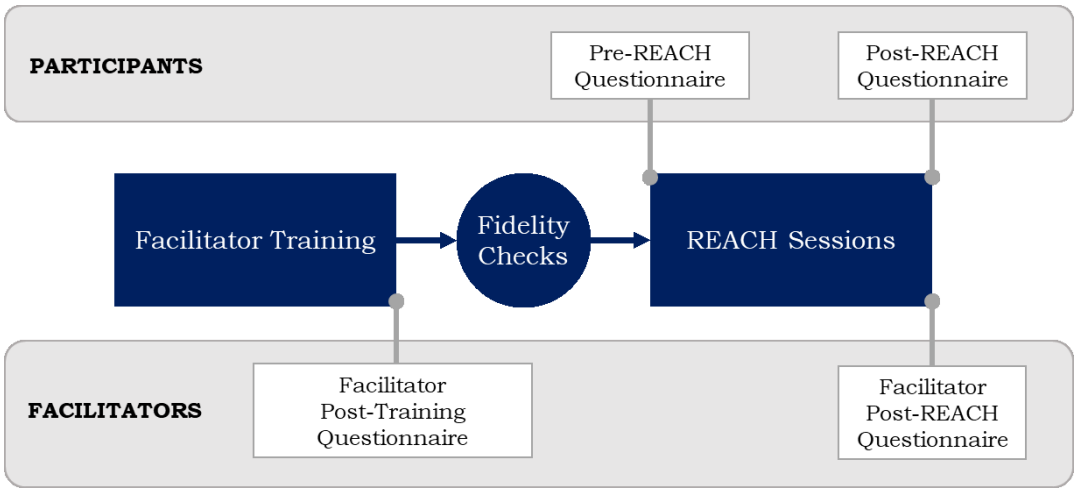

Figure 1 Field Test Questionnaire Administration Timeline

Facilitator Post-Training Questionnaire

Facilitators completed a four-item questionnaire following the facilitator training. Facilitators were asked the degree to which they felt confident about leading a REACH session, thought the facilitator training prepared them to lead a REACH session, and thought the REACH session would have a positive impact on other Service members. Facilitators were also asked one open-ended question on how they thought the facilitator training could be improved. Responses to this questionnaire were not linked to participants' responses.

Facilitator Post-REACH Questionnaire

The post-REACH session questionnaire was designed to evaluate the facilitators' experience with delivering REACH. This 14-item questionnaire asked facilitators to rate the utility of the Facilitator's Manual and talking points, how confident they felt leading the REACH session, how comfortable they were making a "live" practice call to Military OneSource in front of the group, and how engaged their participants were in the session. Facilitators were also asked three open-ended questions concerning the amount of time they spent practicing outside of the facilitator training, suggestions to improve REACH, and suggestions to avoid technical difficulties that may have occurred during a REACH session. Responses to this questionnaire were linked to participants' responses from the same REACH session.

Participant Pre- and Post-REACH Questionnaires

Researchers asked participants to complete a questionnaire before and after their REACH session that used identical questions to evaluate pre- and post-session barriers to care, knowledge of resources, and comfort with future help seeking and accessing resources such as Military OneSource. The 24-item pre-REACH questionnaire asked participants to report their demographics such as Service branch, military component, rank, job code, gender, and highest level of education. The 26-item post-REACH

questionnaire asked participants to rate how useful the information in the REACH session was for their life, the level of their facilitator's engagement and enthusiasm, the value of making a practice call to Military OneSource together as a group, and the value of listening to a recording of a call to Military OneSource. One open-ended question asked participants to provide suggestions for how to improve REACH. Note that a team of facilitators led some REACH sessions; thus, ratings of the level of the facilitator's engagement and enthusiasm could be based on a single facilitator or on multiple facilitators.

Facilitator Training

At each field test site, a team of three researchers trained facilitators as a group. All prospective facilitators received a copy of the REACH PowerPoint slides and accompanying Facilitator's Manual ahead of the training with a request to review these materials thoroughly. Researchers followed a training protocol with key talking points to ensure that each training session contained the same information. The facilitator training lasted approximately 6 to 7 hours over the course of a day. At the start of the training, the researchers discussed ground rules (e.g., facilitators should maintain the confidentiality of the information shared by fellow facilitators during the training). Researchers provided a review of the Facilitator's Manual, a demonstration of the REACH session, and a primer on motivational interviewing techniques. Facilitators then made a practice call to Military OneSource in small groups and practiced presenting one or two slides to the group during a teach-back segment. At the end of the training, facilitators completed a questionnaire regarding their impressions of the training session. Researchers took notes during the training session on whether there were any difficulties with learning the material or grasping the learning objectives.

Facilitators from the first two field test sites (i.e., USS Bunker Hill and Ellsworth Air Force Base) reported that they wished they had had more time to practice presenting REACH before leading a REACH session with Service members. Because of this, facilitator training at Joint Base Pearl Harbor-Hickam and Schofield Barracks included a "fidelity check" in which facilitators were required to demonstrate their preparedness to lead a REACH session. Fidelity checks occurred 1 to 2 days after the facilitator training and before the facilitator led a REACH session. Fidelity checks lasted 30 to 60 minutes. Facilitators presented the introductory slide and one to two other slides that they felt least confident about presenting. After the presentation, researchers provided feedback on whether the facilitator covered all of the key points on the slide(s) and made recommendations for how to improve delivery of the material.

Facilitator-led REACH Sessions

Each facilitator-led REACH session included 6 to 20 Service members. All facilitator-led REACH sessions were 1 to 1.5 hours long and were conducted in person at a location convenient to participants. All facilitators used the REACH PowerPoint and Facilitator's Manual while presenting, and some occasionally had a co-facilitator. Researchers

observed the facilitator-led REACH sessions, provided support as needed, and took notes to inform changes to the REACH materials and facilitator training.

DATA ANALYSIS

In the data analysis phase, researchers used close-ended items to evaluate the impact of REACH on barriers to care, knowledge of resources, and comfort with future help seeking. The researchers used open-ended items, feedback from stakeholders, and observational data to inform revisions to REACH to increase its effectiveness. Researchers developed a data analysis plan to address the research questions identified in the Introduction section of this report:

1. Does participation in a REACH session reduce Service members' perceived barriers to seeking help?
2. Does participation in a REACH session increase Service members' comfort with seeking help? And immediately following the REACH session, do participants' perceptions of the facilitator relate to their comfort with help seeking?
3. Does participation in a REACH session increase Service members' knowledge of the resources available to them?
4. Do participants find their REACH session useful?
5. Do the facilitator training procedures (i.e., training slides and manual) effectively support the facilitator in ensuring that REACH is delivered with maximum integrity and effectiveness?
6. How can the REACH instructional materials (i.e., REACH slides and Facilitator's Manual) be improved to be maximally engaging and useful to Service members?

Quantitative Data Analysis

Researchers used data from closed-ended questions on the Pre- and Post-REACH Questionnaires to answer research questions 1 through 5. All analyses were conducted in R (R Core Team, 2013). Prior to data collection, researchers conducted a power analysis and determined that the number of participants (n = 361) was sufficient to test the effect of the REACH session on key dependent outcomes (see Appendix C for more detail). This section provides details concerning the measurement testing and analyses conducted for research questions 1 through 5.

Measurement Testing

Researchers conducted a confirmatory factor analysis (CFA) to determine whether individual items could reasonably be combined into scales reflecting perceptions of barriers to care, comfort with help seeking, knowledge of resources, REACH session utility, and perceptions of the facilitator. Inter-item correlations were also calculated to assess item-level behavior at each site. Appendix C provides details regarding the factor structure and Cronbach's alpha reliability coefficients for all measures.

Research Question 1 – Change in Perception of Barriers to Care

The first research question focused on whether the REACH session significantly reduced participants' perceived barriers to care (i.e., "preference for self-reliance," "loss of privacy or confidentiality," "fear of being perceived as broken," "negative career impact," "lack of awareness of available resources," and "lack of confidence in available resources"). Participants were asked to respond to an identical set of questions evaluating these barriers before and after the REACH session. Based on the scale of the dependent variables (i.e., interval scale) and the independent variable (i.e., categorical variable, within-subjects), researchers conducted a series of one-way within-subjects analyses of covariance (ANCOVAs) to assess the effect of the REACH session on each barrier. The covariates for this test were participants' perceptions of the facilitator, years in Service, and gender.

Research Question 2 – Change in Comfort With Help Seeking

The second research question focused on whether the REACH session increased participants' comfort with help seeking. The primary independent variable of interest was the effect of the REACH session, and the primary dependent variable was comfort with help seeking. Based on the scale of the dependent variable (i.e., interval scale) and the independent variable (i.e., categorical variable, within-subjects), researchers conducted a one-way within-subjects ANCOVA to assess the effect of the REACH session on participants' comfort with help seeking. The covariates for this test were participants' perceptions of the facilitator, years in Service, and gender.

To further investigate if positive perceptions of the facilitator were associated with greater comfort with reaching out for help and using Military OneSource, researchers conducted two regression analyses to examine these associations. These two models were run using only post-REACH questionnaire data from participants.

Research Question 3 – Change in Knowledge of Resources

Research question 3 focused on whether the REACH session increased participants' knowledge of resources. The primary independent variable for this research question was the REACH session, and the dependent variable was the participants' knowledge of resources available to them.

Based on the scale of the dependent variable (i.e., interval scale) and the independent variable (i.e., categorical variable, within-subjects), researchers conducted a one-way within-subjects ANCOVA to assess the effect of the REACH session on participants' knowledge of resources. The covariates for this test were participants' perceptions of the facilitator, years in Service, and gender.

Research Question 4 – Participants' Perceptions of REACH Session Utility

The analyses for research question 4 were primarily descriptive. This question focused on participants' perceptions of the REACH session, specifically their perceptions of the utility of the Military OneSource audio recording, live practice call, and the overall

REACH session (e.g., whether the REACH information was relevant, whether they learned new information, whether REACH would be beneficial for others). The means and standard deviations for these items were calculated to assess how useful participants found the Military OneSource call recording, the practice call to Military OneSource, and the REACH session.

Research Question 5 – Facilitator Training Procedures and REACH Delivery

The analyses for research question 5 were primarily descriptive. Facilitators were asked to respond to a series of questions after the facilitator training and after leading a REACH session.

Researchers calculated the means and standard deviations for these items to assess whether facilitators felt prepared to deliver REACH following the training. Descriptive statistics were also calculated to assess whether facilitators found the Facilitator's Manual useful and whether they felt confident leading their participants through various components of the REACH session.

Qualitative Data Analysis

Research question 6 used observational data, responses to open-ended questions, and stakeholder feedback to inform changes to the facilitator training procedures and REACH materials. Researchers collected observational data during the facilitator training and during facilitator-led REACH sessions. Researchers also took notes regarding questions that facilitators asked, points of confusion, and where additional emphasis was needed. During the facilitator-led REACH sessions, researchers took notes on how facilitators engaged with participants and whether they experienced any difficulties in delivering the content. Two researchers independently reviewed the notes and identified changes to be made to the facilitator training and REACH materials.

Researchers also reviewed all facilitator and participant responses to the open-ended questions that asked for feedback on how to improve the facilitator training procedures and REACH sessions. At least two researchers reviewed the data and synthesized all feedback into a tracker. Subsequently, the team discussed all proposed edits and determined as a group which ones to implement.

Additionally, researchers obtained feedback from DoD and Service-branch stakeholders (e.g., MC&FP, DSPO, VPIs, SPPMs, and chaplains) at several points throughout the field test. Stakeholders from MC&FP and DSPO observed the facilitator training and one REACH session at Ellsworth Air Force Base. These stakeholders were introduced to the participants at the outset of the facilitator training and told that they were there to observe REACH in action and learn. Subsequently, MC&FP and DSPO stakeholders provided feedback to researchers based on their observations and their review of the Facilitator's Manual and REACH slides. Local installation VPI and SPPM stakeholders were also able to observe facilitator trainings and REACH sessions in person at all sites and provided feedback to researchers based on their observations and experience with

the Facilitator's Manual and REACH slides. Other stakeholders provided feedback based solely on their review of the Facilitator's Manual and REACH slides.

RESULTS

Researchers used results of the quantitative analyses to evaluate the effectiveness of REACH and results of the qualitative analyses to inform revisions to the facilitator training and REACH materials. This section describes results of these analyses.

DEMOGRAPHIC CHARACTERISTICS

Sixty-six facilitators took part in facilitator training, and 31 facilitators subsequently led REACH sessions with Service member participants. Table 2 shows the characteristics of the 31 facilitators who received the facilitator training and led REACH sessions. A majority of the facilitators were from the Air Force (67.7%), almost half had a rank of E-5 or E-6 (41.9%), and more than half had extensive experience presenting trainings and briefings (54.8%).

Table 2
Facilitator Characteristics

Variable	*n*	%
Service		
Air Force	21	67.7
Army	3	9.7
Navy	7	22.6
Rank		
E-5/E-6	13	41.9
E-7/E-8	9	29.0
O-2/O-4	2	6.5
Government civilian	2	6.5
Experience as a presenter		
1-5 times	4	12.9
11-15 times	2	6.5
16-20 times	4	12.9
21+ times	17	54.8

Note: Percentages may not sum to 100% due to missing data.

Table 3 shows the characteristics of the 361 participants who took part in a facilitator-led REACH session. Most participants were from the Air Force (66.2%), were active duty members (89.2%), had a rank ranging from E-1 to E-4 (59.3%) or E-5 to E-9 (36.3%), and were male (72.9%). Most participants did not have previous experience with receiving professional mental health support (74.2%).

Table 3
Participant Characteristics

Variable	*n*	%
Service		
Air Force	239	66.2
Army	28	7.8
Navy	94	26.0
Component		
Active Duty	322	89.2
Reserve	1	0.3
National Guard	34	9.4
Rank		
E-1/E-4	214	59.3
E-5/E-9	131	36.3
O-1/O-3	7	1.9
O-4 +	5	1.4
Years of Service, *M* (Standard Deviation [*SD*])	6.02 (6.42)	
Gender		
Female	89	24.7
Male	263	72.9
Other/Prefer not to say	4	1.1
Education		
High school diploma/GED or equivalent	108	29.9
Some college (no degree)	102	28.3
Trade or technical certificate	5	1.4
Associate's degree	71	19.7
Bachelor's degree	51	14.1
Master's degree	12	3.3
Doctoral degree	1	0.3
Previously sought mental health support		
No	268	74.2
Yes	89	24.7

Note. Percentages may not sum to 100% due to missing data.

QUANTITATIVE DATA ANALYSIS

This section presents results of the quantitative data analysis for research questions 1 through 5. Researchers used ANCOVAs to evaluate the first three questions and descriptive statistics to evaluate the remaining two questions as described in the Method section. Prior to examining the impact of the REACH session on perceptions of barriers to care, comfort with help seeking, and knowledge of resources, researchers evaluated ANCOVA assumptions and computed descriptive statistics. Because the

amount of missing data was minimal, researchers used listwise deletion for the modeling.

Each model controls for participants' years in Service, gender, and perceptions of the facilitator (i.e., these variables are included as covariates). This section presents the results of the full models, including the *F* statistic and significance test for the covariates. However, as mentioned, the focus of the analyses was on the impact of the REACH session on the key dependent variables (perceptions of barriers to care, comfort with help seeking, and knowledge of resources). In addition, three models included an interaction term between the perceptions of the facilitator and the impact of the REACH session (i.e., the independent variable). One assumption of ANCOVA is that there is no interaction between the covariate(s) and the independent variable. For these three models, plots revealed a potential interaction between the impact of REACH and perceptions of the facilitator. One approach to address the violation of this assumption is to include the interaction term in the model. Thus, researchers included the interaction term (REACH session by perceptions of the facilitator) in the models. Further information on the interpretation of the covariates and interaction term is provided in Appendix C.

Table 4 shows the descriptive statistics for the scales and items of interest for research questions 1 through 3. Researchers administered all scales and items before and after the REACH session with the exception of "perceptions of REACH session utility" and "perceptions of the facilitator," which were only measured after the session. There was a decrease in participants' barriers to care following the REACH session, namely for fear of being perceived as "broken," concern that one's mental health problems might not stay private if they reach out for help, concern that one's career may be negatively impacted by reaching out for mental health help, and the belief that available mental health and financial resources are not effective. Perceived lack of leadership support remained relatively stable before and after the REACH session. Comfort with help seeking and knowledge of resources also increased after attending a REACH session. Analyses described below assess whether these mean differences were statistically significant. Last, participants' ratings of their facilitator at the end of the session were overwhelmingly positive (M = 4.44, SD = 0.54 on a scale of 1-5).

Table 4
Descriptive Statistics for Barriers to Care, Comfort With Help Seeking, Knowledge of Resources, and Facilitator Perceptions

	Pre-REACH (*n* = 317)					Post-REACH (*n* = 330)					
Variable	***M***	***SD***	**Median**	**Min**	**Max**	***M***	***SD***	**Median**	**Min**	**Max**	**Cohen's *d***
Barrier: Lack of Leadership Support	2.36	0.97	2.00	1.00	5.00	2.32	0.96	2.00	1.00	5.00	0.08
Barrier: Fear of Being Perceived as Broken	2.73	1.13	3.00	1.00	5.00	2.43	1.09	2.00	1.00	5.00	0.28
Barrier: Loss of Privacy	2.55	1.07	2.00	1.00	5.00	2.40	1.08	2.00	1.00	5.00	0.16
Barrier: Negative Career Impact	2.97	1.16	3.00	1.00	5.00	2.43	1.07	2.00	1.00	5.00	0.48
Barrier: Mental Health Resources Ineffective	2.03	0.75	2.00	1.00	5.00	1.72	0.61	2.00	1.00	4.00	0.47
Barrier: Financial Resources Ineffective	2.04	0.69	2.00	1.00	4.00	1.78	0.64	2.00	1.00	5.00	0.43
Comfort With Help Seeking	3.59	0.79	3.75	1.00	5.00	3.94	0.67	4.00	2.00	5.00	0.47
Knowledge of Resources	4.13	0.61	4.00	2.00	5.00	4.26	0.51	4.00	2.67	5.00	0.24
Perceptions of the Facilitator						4.44	0.54	4.50	1.75	5.00	

Research Question 1 – Change in Perception of Barriers to Care

Table 5 shows that the REACH session did not have a significant main effect on participants' confidence that if they reached out for help with a mental health problem their leadership would be supportive. The REACH session also did not have a significant main effect on participants' willingness to turn to leadership for help. As such, perceptions of this barrier did not change over the course of the REACH session.

Table 5
Change in Perception of "Lack of Leadership Support"

Predictor	*F*	*df*	*p*
REACH Session	0.42	1	0.515
Perceptions of the Facilitator	17.39	1	<.001
Gender	5.20	2	0.005
Years of Service	9.37	1	0.002
Error		640	

Table 6 shows that the REACH session had a significant main effect on participants' fear that they will be perceived as broken if they reach out for help with a mental health problem. Perceptions of this barrier decreased after the REACH session (see Table 4 for descriptive statistics), and the effect size indicates that REACH had a small impact on this barrier (Cohen's $d = 0.28$).[5]

Table 6
Change in Perception of "Fear of Being Perceived as Broken"

Predictor	*F*	*df*	*p*
REACH Session	11.70	1	<.001
Perceptions of the Facilitator	21.59	1	<.001
Gender	1.81	2	0.165
Years of Service	0.12	1	0.733
Error		640	

Table 7 shows that the REACH session had a significant main effect on participants' concern that their mental health problems might not stay private if they reach out for help. Perceptions of this barrier decreased after the REACH session (see Table 4 for descriptive statistics), and the effect size indicates that REACH had a small impact on this barrier (Cohen's $d = 0.16$).

[5] A Cohen's *d* of 0.2, 0.5, and 0.8 is considered a small, medium, and large effect size, respectively (Chen et al., 2010).

Table 7
Change in Perception of "Loss of Privacy"

Predictor	*F*	*df*	*p*
REACH Session	3.45	1	<.001
Perceptions of the Facilitator	28.44	1	0.064
Gender	3.95	2	0.020
Years of Service	0.47	1	0.494
Interaction: Facilitator*REACH Session	3.91	1	0.049
Error		639	

Table 8 shows that the REACH session had a significant main effect on participants' concern that their career may be negatively impacted if they reach out for help with a mental health problem. Perceptions of this barrier decreased after the REACH session (see Table 4 for descriptive statistics), and the effect size indicates that REACH had a small impact on this barrier (Cohen's $d = 0.48$).

Table 8
Change in Perception of "Negative Career Impact"

Predictor	*F*	*df*	*p*
REACH Session	38.08	1	<.001
Perceptions of the Facilitator	13.12	1	<.001
Gender	1.17	2	0.313
Years of Service	2.74	1	0.098
Interaction: Facilitator*REACH Session	2.30	1	0.130
Error		639	

Table 9 shows that the REACH session had a significant main effect on participants' belief that there are effective resources out there for dealing with a mental health problem. Perceptions of this barrier decreased after the REACH session (see Table 4 for descriptive statistics), and the effect size indicates that REACH had a small impact on this barrier (Cohen's $d = 0.47$).

Table 9
Change in Perception of "Mental Health Resources Are Ineffective"

Predictor	*F*	*df*	*p*
REACH Session	39.55	1	<.001
Perceptions of the Facilitator	93.87	1	<.001
Gender	0.93	2	0.394
Years of Service	3.89	1	0.049
Error		640	

Table 10 shows that the REACH session had a significant main effect on participants' belief that there are effective resources out there for dealing with a financial problem. Perceptions of this barrier decreased after the REACH session (see Table 4 for descriptive statistics), and the effect size indicates that REACH had a small impact on this barrier (Cohen's $d = 0.43$).

Table 10
Change in Perception of "Financial Resources Are Ineffective"

Predictor	*F*	*df*	*p*
REACH Session	29.89	1	<.001
Perceptions of the Facilitator	89.57	1	<.001
Gender	2.16	2	0.116
Years of Service	0.11	1	0.736
Error		640	

Research Question 2 – Change in Comfort With Help Seeking

Four items comprised the "comfort with help seeking" scale:

- I would feel comfortable reaching out for help with a mental health problem.
- I would not feel comfortable reaching out for help with a financial problem (reversed).
- If my financial situation was causing me stress, I would reach out for help.
- I would feel comfortable reaching out to Military OneSource for help with a problem.

Table 11 shows that the REACH session had a significant main effect on participants' comfort with help seeking. Participants reported feeling more comfortable with reaching out for help at the end of the REACH session (see Table 4 for descriptive statistics). Effect sizes for each item indicate that REACH had a medium impact on comfort with reaching out to Military OneSource (Cohen's $d = 0.61$), small impact on comfort with reaching out for help with mental health (Cohen's $d = 0.40$) and financial problems (Cohen's $d = 0.37$), and small impact on reaching out for help with a stressful financial situation (Cohen's $d = 0.16$).

Table 11
Change in "Comfort With Help Seeking"

Predictor	*F*	*df*	*p*
REACH Session	41.15	1	<.001
Perceptions of the Facilitator	62.95	1	<.001
Gender	3.21	2	0.041
Years of Service	9.27	1	0.002
Interaction: Facilitator*REACH Session	3.58	1	0.058
Error		639	

Table 12 shows the results of the regression analysis evaluating whether more positive perceptions of the facilitator (i.e., encouraged participation, was enthusiastic, and was passionate about the importance of reaching out for help) were associated with greater comfort with help seeking while controlling for participants' years of Service and gender. More positive perceptions of the facilitator's overall performance were significantly associated with an increase in participants' comfort with help seeking.

Table 12
Regression Predicting "Comfort With Help Seeking"

Predictor	Coefficient	Standard Error (*SE*)	*t*	*p*	*df*
Perceptions of the Facilitator	0.49	0.06	7.71	<.001	325
Years of Service	0.01	0.01	1.46	0.147	
Gender (Male)	-0.01	0.08	-0.07	0.945	
Gender (Other)	-0.55	0.32	-1.73	0.084	

Table 13 shows the results of the regression analysis evaluating whether more positive perceptions of the facilitator's overall performance were associated with greater comfort with reaching out to Military OneSource, while controlling for participants' years of Service and gender. More positive perceptions of the facilitator were not significantly associated with greater comfort with contacting Military OneSource.

Table 13
Regression Predicting "Comfort With Reaching Out to Military OneSource" (Single Item)

Predictor	Coefficient	*SE*	*t*	*p*	*df*
Perceptions of the Facilitator	-0.09	0.08	-1.03	0.307	310
Years of Service	0.01	0.01	1.37	0.172	
Gender (Male)	0.18	0.10	1.73	0.077	
Gender (Other)	-0.32	0.41	-0.78	0.433	

Research Question 3 – Change in Knowledge of Resources

Three items comprised the "knowledge of resources" scale:

- I know what resources exist to help me with a financial problem.
- I don't know who to turn to when I need help (reversed).
- I know what resources exist to help me with a mental health problem.

Table 14 shows that the REACH session had a significant main effect on participants' knowledge of resources. Participants reported being more knowledgeable about financial and mental health resources at the end of the REACH session (see Table 4 for descriptive statistics). The effect size indicates that the REACH session had a small impact on increasing the knowledge of resources (Cohen's d = 0.24).

Table 14
Change in "Knowledge of Resources"

Predictor	*F*	*df*	*p*
REACH Session	11.60	1	0.001
Perceptions of the Facilitator	146.63	1	<.001
Gender	8.10	2	<.001
Years of Service	5.18	1	0.023
Error		640	

Research Question 4 – Utility Value of the REACH Session

Table 15 shows the descriptive statistics for participants' reactions to the audio recording and practice call to Military OneSource as well as their overall assessment of the REACH session's utility value. Participants agreed that making the practice call to Military OneSource was helpful and that, after hearing the call, they felt comfortable making a call to Military OneSource on their own. Participants tended to only slightly agree that listening to the audio recording of the Military OneSource call was useful. In terms of utility of the overall REACH session, participants tended to strongly agree that the REACH session would be beneficial for other Service members. Participants also agreed that the information in the REACH session was relevant to their lives and that the information was novel and useful.

Table 15
Participant Perceptions of the Audio Recording, Practice Call to Military OneSource, and Utility Value of the REACH Session

Item	*n*	Mean	*SD*	Median	Min	Max
It was helpful to make a practice call to Military OneSource together as a group.	342	3.97	1.02	4	1	5
After hearing the practice call, I feel more comfortable making a call to Military OneSource myself.	343	3.94	0.86	4	1	5
I did not find it useful to listen to the audio recording of someone else calling Military OneSource.	341	2.36	1.16	2	1	5
The REACH training would be beneficial for other Service members.	346	4.34	0.68	4	1	5
The information in the REACH training was relevant to my life.	345	3.96	0.84	4	1	5
The REACH training discussed information I had not encountered in other trainings.	346	3.69	0.99	4	1	5
I learned a lot of useful information.	345	4.06	0.77	4	1	5

Research Question 5 – Facilitator Training Procedures

The facilitator plays the most critical role in establishing a supportive environment during a REACH session and generating discussion among group members. The Facilitator's Manual and facilitator training were designed to thoroughly prepare facilitators to lead engaging and impactful REACH sessions. Table 16 presents the descriptive statistics for facilitator perceptions of the REACH facilitator training. Sixty-six facilitators participated in the REACH facilitator training and subsequently completed a questionnaire evaluating their impressions of the training. Overall, the facilitator training received favorable feedback, and facilitators tended to agree that they felt confident about delivering REACH to others following the training. Facilitators also agreed that the training adequately prepared them to lead REACH sessions. Last, facilitators appeared to "buy into" REACH and tended to agree that they could positively impact other Service members through REACH.

Table 16
Facilitator Perceptions of the REACH Facilitator Training

Item	*n*	Mean	*SD*	Median	Min	Max
I feel confident about delivering REACH to others.	66	4.14	0.76	4	1	5
Today's training session adequately prepared me to facilitate REACH to others.	66	4.24	0.77	4	1	5
I will be able to positively impact other Service members by delivering REACH.	66	4.53	0.81	5	1	5

Table 17 presents the descriptive statistics for facilitator perceptions of REACH after leading a session. Thirty-one facilitators who led a REACH session reported that, on average, they spent 3 hours outside of the facilitator training practicing and preparing to deliver REACH. Facilitators tended to strongly agree that the Facilitator's Manual was useful and well-organized. Facilitators also tended to use their own words rather than the talking points provided in the Facilitator's Manual, as they were encouraged to do during the facilitator training. Facilitators also reported again that they felt confident delivering REACH and they felt comfortable making the "live" call to Military OneSource during the session. Facilitators also agreed that participants in their sessions were engaged and actively participated in discussion. Finally, facilitators strongly agreed that they would like to deliver REACH again in the future.

Table 17
Facilitator Perceptions of REACH After Leading a REACH Session

Item	*n*	Mean	*SD*	Median	Min	Max
Number of hours spent practicing.	29	3.05	3.79	2	0	20
The Facilitator's Manual was useful for preparing me to lead REACH.	31	4.52	0.57	5	3	5
The Facilitator's Manual was well organized and easy to follow.	31	4.48	0.51	4	4	5
I used a lot of my own words rather than the talking points when delivering REACH.	31	3.87	0.81	4	2	5
I did not feel confident delivering the REACH training.	31	2.39	1.02	2	1	5
I felt comfortable making the "live" call to Military OneSource in front of the group.	31	4.52	0.63	5	3	5
I would like to deliver REACH training again.	31	4.58	0.50	5	4	5
The audience was engaged and actively participated in the training.	29	4.00	0.76	4	3	5

QUALITATIVE RESULTS

The qualitative results described in this section address research question 6 and focus on how to make REACH maximally engaging and useful to Service members. The findings are grouped by field test site and primarily focus on areas of improvement and changes that researchers made to the REACH facilitator training procedures after Sites 1 and 2. Changes to the REACH PowerPoint slides and Facilitator's Manual were made only after Site 3 to ensure standardization across sites.

Research Question 6 – Feedback on REACH Facilitator Training Procedures and REACH Materials

At the outset of the field test, in line with a formative evaluation process, researchers made a conscious decision to incorporate all qualitative feedback on a rolling basis

after each field test site rather than implement it at the end. Therefore, researchers analyzed observational data, facilitator and participant responses to open-ended questions, and stakeholder feedback throughout the course of the field test and used it to inform revisions to the facilitator training and REACH materials.

Field Test Site 1 – USS Bunker Hill

During REACH sessions at USS Bunker Hill, researchers paid close attention to how facilitators implemented small-group engagement methods that were covered during the facilitator training. Some facilitators rarely used motivational interviewing techniques to generate discussion, and, as a result, their participants appeared less engaged. Researchers also observed that facilitators who shared personal stories of help seeking connected with their participants in an authentic manner; the facilitators who did not personalize their session had less participant engagement.

After observing REACH session practice calls to Military OneSource it became apparent that the calls were taking longer than the anticipated 5 minutes. The calls were taking longer because facilitators spent excessive time providing demographic information to triage consultants per Military OneSource protocol rather than discussing the issue at hand. Researchers also observed that the physical layout of the room in which the REACH session took place (e.g., a mess room on a ship) made it difficult for participants to see the screen with the slides and hear the facilitator. Even with these unanticipated difficulties, there were many positive comments from participants on the questionnaires, indicating that they enjoyed their REACH sessions.

Representative Quotes From REACH Session Participants

- "Thought it was a great training, the practice phone call was a great touch and shows you how easy it is to make the call!"
- "Would've been better in smaller groups. On top of that. Not reading it word for word would be better. Talk about ways to not bring your chain of command into it."
- "Make it more emotional so people can relate/or feel sympathetic. To want to get help or help and step in for other people."
- "The training was very good. I feel that if I was having any problems or a friend had any problems I would know exactly where to go. Thank you for your help."

Subsequent Improvements Made to REACH Facilitator Training and Materials

1. In the facilitator training, researchers increased the emphasis on using motivational interviewing strategies, building participant engagement, and personalizing REACH to meet the needs of the audience. Facilitators were strongly encouraged to start the REACH session with a powerful personal story that touched on help seeking. They were also asked to make their session feel like a small group discussion rather than a briefing or a formal training. Researchers also offered a lot of positive feedback and encouragement to facilitators during teach-backs to boost their confidence.

2. Researchers provided clear guidance to facilitators on how to steer the Military OneSource practice call to increase its demonstration value for participants. Specifically, facilitators were asked to skip the demographic portion of the call and go straight to the discussion of the call topic and resources. Researchers also communicated with the Military OneSource Call Center ahead of time to confirm that it was acceptable to deviate from the standard call protocol.
3. Researchers began proactively discussing the importance of the room setup with installation points-of-contact ahead of time while planning logistics (e.g., a room with moveable chairs and tables that can be arranged into a U-shape or a circle; all participants must be able to see the screen).

Field Test Site 2 – Ellsworth Air Force Base

Feedback from facilitators at Ellsworth Air Force Base indicated that there was some confusion about what "type of training" REACH was. Some facilitators expected it to be a classic bystander intervention training that followed a Question, Persuade, and Refer model, which is used extensively throughout the Air Force. Facilitators also expressed that they would have appreciated more time for preparation and practice between the facilitator training and their first REACH session. Participant feedback suggested that the discussion of the barrier "lack of leadership support" was less effective in changing attitudes, partially due to frontline supervisors often leading REACH sessions or being in attendance. As such, not everyone felt comfortable discussing this barrier in front of their leadership. Additionally, researchers observed that REACH sessions with less confident facilitators benefited from having a co-facilitator.

Several facilitators distributed promotional items to their participants to increase engagement, which turned out to be a helpful strategy. Researchers also observed that facilitators who understood their audience's characteristics (e.g., rank or career field) and personalized the discussion and content to their audience's priorities had better participant engagement overall. Researchers also noted that the REACH sessions took, on average, longer than 1 hour due to completion of pre- and post-REACH questionnaires.

Ellsworth Air Force Base participants commented that a REACH session should be even more interactive and use a small group discussion format and should not feel like a briefing or a presentation. Some participants also reported that they found the audio recording redundant with the live call to Military OneSource, the latter of which they found to be more beneficial. Many participants reported enjoying interactions with a chaplain who introduced himself and described how he could help during the last 5 to 15 minutes of each REACH session. Some participants expressed a desire to have even more resource representatives attend the REACH session. There were many positive comments from participants about the REACH sessions indicating that they found them meaningful and engaging.

Feedback from senior NCOs who attended REACH sessions indicated that they felt that a majority of the information presented in REACH is already covered in other trainings

they have taken over the last 15 years (e.g., First Term Airmen Course). They suggested that REACH would be most appropriate for their subordinates and first-term Airmen. Notably, the sessions these senior NCOs attended included many junior enlisted Airmen, which may have contributed to slightly uncomfortable sharing dynamics.

Representative Quotes From REACH Session Participants

- "This REACH training was very good. It showed me all the tools I or others could use. I will be using the resources I was informed on today!"
- "Great training. The instructors were very enthusiastic and it was clear that they genuinely care about getting the information out. I do believe this should be training every Airman should get."
- "No audio + practice call. Condense information, it is retained better that way."
- "Having the opportunities to speak with different individuals such as the Chaplain, counselor, etc., during the training I think would be beneficial: Firsthand account of services, [puts a] face to a resource, and how they work together with other resources."
- "Felt like it's more useful for members who are under 2 yrs of service. Twenty year [Air Force] AF get the same info just in a different form of training."

Subsequent Improvements Made to REACH Facilitator Training and Materials

1. At the outset of facilitator trainings, researchers began explaining to facilitators how REACH differs from Question, Persuade, and Refer trainings and how it complements them. Specifically, researchers underscored that REACH shifts the focus from bystander intervention to a Service member's individual responsibility to reach out for help and address issues proactively. Researchers used the metaphor of "putting your own oxygen mask on first before helping others," which seemed to resonate with Service members.

2. Researchers changed the structure of the facilitator training to add a day for fidelity checks to allow more time for facilitators to prepare for their first REACH session and to receive individualized feedback. Researchers developed a form for use during the 30- to 45-minute fidelity checks to assist in providing constructive feedback to facilitators on their performance. Researchers also emphasized the advantage of having a co-facilitator, especially for their first few sessions, to ensure that all major points were discussed during the REACH session.

3. Researchers emphasized to facilitators that they need to understand their audience and tailor the discussion and content of REACH to its needs (e.g., career field, rank, situational context). For example, if the audience consists of a group of senior NCOs who are very aware of their resource options, the facilitator should focus discussion more on overcoming barriers (e.g., concerns about the impact of mental health help seeking on their career, concerns about privacy and confidentiality, preference for self-reliance) and less on the available resources.

4. Researchers explained to facilitators that REACH should feel like an engaging small group discussion rather than a formal training, program, class, or resource briefing. During the facilitator training, researchers pointed to "training fatigue" and used SOFS-A data to further substantiate this point by explaining that Service members' preferred format for suicide prevention trainings are small group discussions. Researchers added more examples of how to use motivational interviewing techniques to engage participants in the conversation. In addition, researchers recommended handing out military program swag and promotional products as another strategy for engaging participants.

5. Based on feedback, researchers began recommending that facilitators invite resource representatives or program support personnel (such as chaplains, behavioral health personnel, Military and Family Life Consultants, VPIs, or SPPMs) to attend REACH sessions. These personnel should introduce themselves during the last 10 minutes of the session to establish rapport with participants and highlight the services they can offer.

Field Test Site 3 – Joint Base Pearl Harbor-Hickam and Schofield Barracks

Analysis of stakeholder feedback, participant feedback, and research team observations from Joint Base Pearl Harbor-Hickam and Schofield Barracks indicated that REACH could benefit from more substantial changes as part of the formative evaluation process. One theme that was discussed during the facilitator training is that Service members already take many trainings and often experience "training fatigue," thus REACH should avoid presenting itself as another training.

Feedback from facilitator responses to the open-ended questions focused on their desire for more preparation time. Facilitators expressed that they needed more practice time (e.g., more than 1 to 2 days) before leading a REACH session and that they wanted longer fidelity checks (i.e., one-on-one coaching sessions with the REACH team and/or their SPPM or VPI) to receive feedback and support. Facilitators conveyed that they felt comfortable making the practice call to Military OneSource.

Other themes from participants' feedback included a desire for more small group discussions on important topics such as mental health and wellness, grouping REACH session participants by rank, reducing slide text, asking more open-ended questions, augmenting discussions around financial and clearance concerns, and developing more interactive activities. Participants also suggested that facilitators and participants wear civilian clothes to REACH sessions to feel more at ease.

Feedback also indicated that the recording of a scripted call to Military OneSource was not effective in engaging participants because it did not sound as authentic and it felt redundant with the live practice call to Military OneSource. Participants found more value in making a live call to Military OneSource together as a group.

General comments about the resources highlighted in REACH focused on suggestions to provide additional information (e.g., about financial resources, mobile resilience

tools, and Give-an-Hour) and ways to increase awareness of Military OneSource (e.g., review it at squadron all-calls and develop a web tutorial about it). Participant feedback regarding the barrier of "lack of leadership support" suggested that it was a less effective portion of the session. A few participants felt that the REACH session length should be no longer than 1 hour. Many participants commented positively about the REACH sessions, stating that they enjoyed the small group discussion format and that they learned about new resources.

Representative Quotes From REACH Session Participants

- "I thought the training conducted was very helpful. It was to-the-point & practical. Definitely a different approach used with the practice call. I've personally used the Military OneSource line. It is an excellent resource."
- "Take out the scripted phone call, just stick to group call; small sessions mandated, a large group would definitely take away from any conversation; and more resources than mil-one source."
- "I love that there is an avenue that assists members with learning to take care and seek care for themselves. I'm definitely going to advocate for this program. Thanks!"
- "The training should be broken down into specific ranks E1-E5/E6/E7-E9. This training needs to emphasize from the beginning that this is about you. Since day one we are told we are leaders, we forget we need to take time for ourselves."

Subsequent Improvements Made to REACH Facilitator Training and Materials

1. To help address widespread "training fatigue," researchers eliminated any mention of the word "training" from the REACH materials. Furthermore, they began conceptualizing REACH as a mindset that aims to change the culture of help seeking in the military using small group discussions with a trusted facilitator.

2. To provide more support to facilitators, researchers extended fidelity checks from 30 minutes to 1 hour. SPPMs and VPIs can play a central role in providing feedback on delivery during these practice rounds. Also, when considering the use of REACH beyond the field test, it would be advisable to break up facilitator training into multiple days and allow for more practice time between the training and the facilitator's first REACH session.

3. Researchers made minor edits to the facilitator training and REACH materials to make the sessions more engaging and informative. Specifically, they added an icebreaker at the outset of the REACH session, recommended that SPPMs and VPIs group REACH session participants by rank, reduced slide text, and added information and resources to address financial and clearance concerns.

4. Based on feedback from several field test sites, researchers eliminated listening to an audio recording of a call to Military OneSource to focus this portion of the session exclusively on the live practice call. They also revised the practice phone call protocol to make it more interactive. Specifically, researchers asked facilitators

to recruit a volunteer from the audience to make the call together in front of the group.

5. Based on observational data and participant feedback from multiple field test sites, researchers eliminated the "lack of leadership support" barrier from the REACH materials. In its place, researchers incorporated another critical barrier from SOFS-A, preference for self-reliance, endorsed by 77% of Service members (OPA, 2019). Researchers developed a slide that depicts a self-care continuum and distinguishes between pure self-care, shared care, and medical care. The main takeaway from the slide is that Service members are in control of choosing the optimal resource for their situation, regardless of where the issue falls on the continuum. However, avoiding the problem does not equate to being self-reliant.

DISCUSSION

REACH was developed with a single goal in mind: to reduce the number of Service members who do not reach out to available resources, primarily due to concerns about barriers to care. Taken together, the field test results indicate that REACH accomplished its goal of lowering participants' perceptions of all but one of the most significant barriers to help seeking. Following REACH sessions, participants were less likely to be concerned about the loss of privacy and confidentiality, being perceived as broken, and experiencing negative career impact. To relate these results to the Expectancy Value Theory, REACH was successful at reducing the perceived cost of reaching out for help with a mental health problem. In addition, REACH reduced participants' thinking that existing mental health and financial resources are ineffective. If REACH is implemented on a large scale across the total military force, over time we would expect to see lower rates of barriers to care reported on SOFS-A and *Status of Forces Survey of Reserve Component Members* (SOFS-R).

The only barrier to care that REACH did not appear to affect was Service members' confidence that if they reached out for help with a mental health problem their leadership would be supportive. This may be due to a number of factors. For example, facilitators who led REACH sessions were often participants' frontline supervisors, which made it more difficult to engage in a candid conversation about this barrier. Also, some sessions included both junior enlisted personnel and senior NCOs from the same unit, which similarly stifled the discussion. The most direct way to change perceptions of this barrier is to help military leaders at all levels recognize that REACH is also for them and that all military personnel need to be a part of this culture change. Under optimal circumstances, dedicated REACH sessions should be offered to leaders, so that they can have small group discussions regarding their own mental health and help seeking needs with their peers. We also need to help leaders adopt a more holistic view of mission readiness that more evenly balances mission accomplishment with the mental and physical wellness of their people.

Consistent with findings from the CLF (Ilgen et al., 2020), REACH also increased participants' comfort with seeking help and increased their knowledge of resources. A close examination of the effect sizes indicated that REACH had a moderate impact on comfort with reaching out to Military OneSource, a small impact on comfort with reaching out for help with mental health and financial problems, and a small impact on reaching out for help with a stressful financial situation. This pattern of findings is encouraging given that one of the main goals of REACH was to increase utilization of Military OneSource. Of course, increased comfort with help seeking does not equate to actual behavior, which is why further research is needed to understand the long-term effects of REACH on resource utilization among Service members. SOFS-A and SOFS-R assess awareness and utilization of DoD and Service branch resources and can be used as tracking metrics after REACH is implemented on a large scale.

Passionate and engaging facilitators are key to successful REACH implementation. It was therefore not surprising that more positive perceptions of the facilitator were

associated with an increase in participants' comfort with help seeking. Facilitators showed creativity and ingenuity in tailoring their REACH sessions to their audience. For example, a Navy senior enlisted leader facilitating REACH to young sailors who were about to deploy effectively used humor in discussing social connectedness. He said "Connectedness—that's one that will become tough because you are about to deploy and will be away, but you will be near your brothers and sisters, and sometimes, what feels like your mom and dad on the ship, and they are all there for you." Similarly, an Air Force NCO exercised initiative in tailoring the REACH session to her Airmen. Recognizing that clearance concerns are a salient barrier to care for the Airmen in her intelligence squadron, she brought a copy of the revised Question 21 on the *Standard Form 86 Questionnaire for National Security Positions* to highlight "in real time" what needs to be reported. And the researchers got the idea of having the facilitator make a practice call to Military OneSource with a volunteer from the audience after observing two Army NCOs employ this approach successfully in their REACH sessions. These examples illustrate that REACH is a flexible tool that can be used to start changing the culture around help seeking in the military.

Not only did REACH have an effect on the three main outcomes of interest (barriers to help seeking, comfort with help seeking, and knowledge of resources), overall facilitators and participants had positive impressions of their experience with REACH. Participants indicated that REACH had utility value for their lives—the information presented was relevant, new, and useful. Both facilitators and participants found REACH to be beneficial for Service members in general. Although some facilitators wanted more time to prepare for their field test REACH session, they found the REACH facilitator training and materials useful and effective in preparing them for their role.

In conclusion, this study finds that REACH is an effective and engaging approach to increasing comfort with help seeking among Service members. Military installations that participated in this field test have continued to use REACH and adapt it to their needs. For example, USS Bunker Hill stakeholders plan to use REACH for indoctrination training with junior enlisted Sailors. At Ellsworth Air Force Base, REACH has been added to the initial integrated prevention training for Airmen arriving from tech school for their first duty assignment (e.g., those in the E-1 to E-4 and O-1 to O-2 pay grades). And the SPPM from Schofield Barracks has now held several facilitator trainings to build an internal cadre of trainers who can lead REACH sessions with Soldiers.

LIMITATIONS

As with any study that relies on participant responses to questionnaires, data collected during the REACH field test may be subject to response bias. For example, because facilitators and participants were often from the same unit, participants may have responded more positively to the questionnaires. In addition, there is some evidence that participants may have engaged in flat responding—providing the same answer to each question—and random responding from the larger standard deviations for

reverse-worded items. Despite the evidence, researchers were still able to detect a significant effect of REACH sessions on the dependent outcomes of interest (barriers to care, comfort with help seeking, and knowledge of resources), indicating that most participants completed the questionnaires thoughtfully.

An additional limitation of this study was the revision process between field test sites that introduced variations to the content of facilitator training and REACH materials. This was an artifact of the formative evaluation approach used by the researchers. Data collected at each site, therefore, are based on the version of REACH that was used at that field test site. The changes made throughout the field test may have had an impact on participants' experiences and key dependent measures. To evaluate this possibility, researchers examined effect sizes for key outcomes of interest and they appeared to be consistent across all field test sites.

Finally, the REACH field test did not assess direct measures of behavior. The closest proxy to help seeking behavior was participants' self-reported comfort with help seeking for mental health concerns and financial issues and contacting Military OneSource. In addition, the field test may not have assessed all factors driving help seeking, for example practical concerns such as having the time to attend appointments or engage with helping resources. In the future, if REACH is implemented on a large scale, it will be imperative to track whether it is influencing behavior change in participants. Some useful metrics to consider tracking include the rate of Military OneSource utilization, the number of self-referrals to military installation behavioral and mental health resources, and perceptions of all barriers to care reported on SOFS-A and SOFS-R.

RECOMMENDATIONS

The following recommendations were developed by PERSEREC/OPA researchers and MC&FP for consideration by stakeholders when designing a strategy for how to implement REACH with maximum effectiveness and efficiency:

1. Top-down Implementation Guidance

   The military Services should provide commands top-down guidance that gives them authority to implement REACH and assigns responsibilities for its implementation (Shechter, et al., 2020). The guidance should address whether REACH will replace or complement existing suicide prevention training, whether it can be used for Resilience Tactical Pauses,[6] and whether it can be incorporated into professional military education for enlisted personnel and officers. Throughout the REACH field test, participating installations frequently spoke with researchers about these topics to determine how they could use REACH beyond the field test.

   The guidance should also specify the target audience for REACH. Under optimal circumstances, REACH should be offered to all Service members. If that is not feasible, installations could use a phased rollout approach by first offering it to units whose Service members are more vulnerable to suicide risk based on available surveillance data and then offering it to medium- and low-risk groups.

2. Top-down Culture Change Around Mental Health Help Seeking

   Military leadership needs to set the tone for a culture change around mental health and help seeking. When considering readiness, there is a natural tension between mission accomplishment and Service member mental health and well-being. Leadership needs to adopt a more holistic approach to readiness that takes into account their Service members' physical and mental health. If leadership can succeed at this, they will encourage more personnel to seek help proactively.

3. Web-based REACH Facilitator Training

   A critical requirement for scaling up REACH is the ability to quickly and effectively train new facilitators. In support of this requirement, MC&FP has funded PERSEREC to develop a web-based REACH facilitator training in FY21. The final product will be hosted on MilLife Learning, which is a part of Military OneSource's network of programs and resources that provides self-directed online courses for Service members and their families. The web-based REACH facilitator training will use a combination of videos, slides with voiceover, and knowledge checks to train prospective facilitators. After completing the training, facilitators will conduct a practice run with their SPPM or VPI to receive individualized feedback on their delivery. The objective of the training is to help military installations develop an internal cadre of REACH facilitators.

[6] A Resilience Tactical Pause allows Service members to connect in small groups to talk about mental health, barriers to care, and suicide prevention. It is a forum for everyone to share personal experiences and to highlight ways Service members can get help.

In the interim, while the web-based training is being developed, PERSEREC has a limited capability to provide REACH facilitator training remotely to interested installations via Microsoft Teams. The training takes 6.5 hours and can be spread over 2 or 3 days, depending on the installation's preference.

4. Increase in Call Volume to Military OneSource Call Center

   MC&FP should work closely with the military Services to prepare for an increase in call volume to the Military OneSource call center based on the scale of REACH rollout. If REACH is implemented on a large scale, the volume of phone calls will increase significantly due to practice calls placed during REACH sessions and calls made after exposure to REACH. The following strategies are proposed to effectively manage this increase:

   - Stagger rollout of REACH across the Services and phase implementation in by installation.
   - Inform MC&FP as soon as possible and no later than 1 week in advance when REACH facilitators plan to make practice calls.
   - Recommend specific days and target hours for practice calls.
   - Place no more than five practice calls per hour.
   - Limit the duration of each practice call to 5 to 7 minutes.
   - After rollout, MC&FP should conduct a 30-day assessment with the call center team to determine impact and make needed adjustments.

5. REACH Facilitator Selection and Certification

   The military Services should carefully select facilitators who are well liked, knowledgeable, and have a connection to the participants. Ideally, individuals selected for this role should have prior experience facilitating suicide prevention and resilience trainings and should display passion, conscientiousness, and a desire to make a positive impact. Facilitators should have support from their leadership and availability to regularly lead REACH sessions with Service members. The Services should work with their local installation points of contact (e.g., SPPMs and VPIs) to devise a way to certify REACH facilitators and ensure that only certified facilitators lead REACH sessions.

6. Future Research Directions

   After REACH is implemented more widely within the Services, future research should examine its long-term effectiveness. One approach is to conduct a follow-up study using a randomized control trial comparing the help-seeking behavior of Service members who participated in a REACH session with those who attended a traditional suicide prevention training. Specifically, researchers could follow up with participants 2 months after attending a REACH session to examine whether they have utilized resources since the session. Another approach is to add a question to SOFS-A and SOFS-R asking Service members whether they have

participated in a REACH session. This would allow researchers to evaluate any differences in barriers to care, suicidal ideation, and mental health help seeking as a function of REACH.

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ACRONYMS USED IN THIS REPORT

ANCOVA	Analyses of Covariance
CFA	Confirmatory Factor Analysis
CFI	Confirmatory Factor Index
CLF	Crisis Line Facilitation
DSPO	Defense Suicide Prevention Office
MC&FP	Military Community and Family Policy
NCO	Noncommissioned Officer
OPA	Office of People Analytics
PERSEREC	Defense Personnel and Security Research Center
REACH	Resources Exist, Asking Can Help
RMSEA	Root Mean Square Error of Approximation
SD	Standard Deviation
SE	Standard Error
SOFS-A	Status of Forces Survey for Active Duty Service Members
SOFS-R	Status of Forces Survey of Reserve Component Members
SPPM	Suicide Prevention Program Manager
VPI	Violence Prevention Integrator

APPENDIX A: FIELD TEST SITE 4 — FORT POLK AND FORT DRUM

The field test at Fort Polk and Fort Drum (Site 4)[7] took place in June 2020. Researchers conducted the field test remotely due to travel restrictions and physical distancing requirements resulting from the Coronavirus pandemic. Points of contact at Fort Polk had a short period of time to schedule and plan the field test and to recruit facilitators and participants. As a result, most facilitators who participated in the facilitator training were unable to lead REACH sessions because of prior commitments that were scheduled to occur while the field test was taking place. In addition, REACH sessions were constrained by physical distancing requirements that limited the size of group gatherings.

There were two key differences between the REACH field test at Fort Polk and Fort Drum and the previous field test sites. The majority of Fort Polk facilitators were chaplains. The REACH team collaborated with the Army Office of the Chief of Chaplains to intentionally recruit this population. Chaplains play a key role in Army's suicide prevention efforts, often being the first individuals to have contact with at-risk Soldiers. It was therefore of interest to explore whether REACH could be a useful tool for them. Second, at previous sites the REACH facilitator training was conducted in person; at Fort Polk, it took place virtually. Subsequently, facilitators led socially distanced small group REACH sessions with Fort Polk Soldiers in person and virtual REACH sessions with Fort Drum Soldiers via a video conferencing platform.

METHOD

The REACH team adapted all protocols, materials, and questionnaires to the online format of delivery. The facilitator training contained the same information as the in-person training, which is described in the Facilitator Training section of the main report. The REACH materials used at Fort Polk and Fort Drum reflected all edits and changes described in the Qualitative Results section of the main report. Researchers conducted the facilitator training using the Microsoft Teams video conferencing platform. The REACH sessions at Fort Polk were conducted in person and those at Fort Drum were conducted virtually by one of the Fort Polk facilitators. Because of the in-person and virtual nature of the facilitator training and REACH sessions, questionnaires at Site 4 were administered using one of three formats: paper-based forms, electronic fillable Adobe PDFs, and online Google Forms questionnaires. As with the first three field test sites, researchers analyzed the data from facilitators and participants to evaluate the effectiveness of REACH and to inform the final changes to the REACH materials. This section describes the method used to carry out the field test and data collection at Fort Polk and Fort Drum.

[7] Field test sites were clusters of military installations where researchers trained facilitators who led REACH sessions in the same week for the purposes of the field test.

Facilitators and Participants

Researchers worked with installation points of contact to identify REACH facilitators at Fort Polk. Facilitators attending the facilitator training were chaplains, religious educators, and an SPPM. Fifteen facilitators participated in the facilitator training. Due to scheduling conflicts and Coronavirus physical distancing constraints, most facilitators were not able to conduct a session in person in the immediate week after the field test. Only two trained facilitators led REACH sessions with Soldiers afterwards.

As with Sites 1 through 3, participant recruitment at Site 4 focused on junior enlisted Service members and NCOs. One facilitator, located at Fort Polk and who worked with Soldiers in person at Fort Polk and virtually with Soldiers at Fort Drum, recruited participants at each installation. The other facilitator recruited participants for one REACH session at Fort Polk. In total, there were twelve REACH sessions comprised of 100 participants from Fort Polk and 85 participants from Fort Drum.

Data Collection

As with Sites 1 through 3, facilitators responded to one questionnaire after the facilitator training and one questionnaire after leading a REACH session. REACH session participants completed two questionnaires, one before the REACH session (Pre-REACH Questionnaire) and one after the REACH session (Post-REACH Questionnaire). Researchers added one question to the pre- and post-REACH questionnaires to assess participants' intention to seek help in the future if they felt trapped or stuck in a stressful situation. Researchers also eliminated the question about whether it was useful to listen to the audio recording of the call to Military OneSource because the recording was removed from the REACH session following feedback from Sites 1 through 3.

Facilitator Training

Researchers used Microsoft Teams to conduct the virtual facilitator training. The training took place in two 3-hour blocks over 2 consecutive days. Table 18 provides an overview of the 2-day facilitator training agenda. On Day 1, researchers discussed ground rules (e.g., facilitators should maintain the confidentiality of the information shared by fellow facilitators during the training) and described the importance of the REACH mindset. Researchers then reviewed the Facilitator's Manual and demonstrated what a REACH session should look like. Day 1 homework included making a practice call to Military OneSource and practicing presenting two assigned slides in preparation for a teach-back activity on the second day of training. Those facilitators who did not plan to attend Day 2 were asked to complete a questionnaire evaluating the first day of the training.

Six facilitators returned for the second day of training; the rest were not able to attend due to scheduling conflicts. Day 2 began with a discussion of the facilitators' experience completing the practice call to Military OneSource, followed by a primer on

motivational interviewing techniques. Then, during a teach-back segment, each facilitator presented two slides to the group and received constructive feedback from researchers and fellow facilitators. At the end of Day 2, all six facilitators completed the questionnaire evaluating the facilitator training.

Researchers took notes during the two facilitator training days, focusing on whether there were any difficulties with learning the material, grasping the learning objectives, or using the virtual platform. Only two facilitators were able to lead REACH sessions during the field test period, and only one completed a fidelity check the following day.

Table 18
Fort Polk Facilitator Training Agenda

	Day 1	Day 2
Curriculum	• Ground rules • The REACH mindset and its importance • Facilitator's Manual review • REACH session demonstration	• Military OneSource practice call discussion • Motivational interviewing techniques • Teach-back activity
Homework	• Homework: Make practice call to Military OneSource and practice assigned slides (2) for teach-back activity	• Self-led practice and study to prepare for fidelity check
Facilitator Questionnaire	• Day 1 attendees not returning for Day 2 complete facilitator training questionnaire	• Facilitator training questionnaire for attendees from both days

Facilitator-led REACH Sessions

Compared to Sites 1 through 3 where some facilitators co-led sessions, each REACH session at Site 4 was led by a single facilitator. The two facilitators had many years of experience delivering briefings and trainings to military personnel. One of the two facilitators led one in-person REACH session at Fort Polk. The other facilitator led seven in-person REACH sessions at Fort Polk and four virtual sessions at Fort Drum using the BlueJeans video conferencing platform. The in-person Fort Polk REACH sessions proceeded as described in the main body of the report with participants completing paper-based pre- and post-REACH questionnaires. Fort Drum participants joined the virtual REACH sessions on BlueJeans via computer or mobile phone. Technological issues with the virtual sessions resulted in the use of two data collection formats for the questionnaires: Adobe PDF and Google Forms. In the first virtual session, participants were sent a fillable Adobe PDF of the pre-REACH and post-REACH questionnaires and asked to email their completed questionnaires to the research team. However, those participants who joined the REACH session using their mobile phones could not complete the PDF questionnaire because the form had not been optimized for use on a mobile phone. For subsequent Fort Drum virtual sessions, researchers converted the pre- and post-REACH questionnaires into a single instrument using a Google Forms survey to collect participants' pre- and post-REACH

questionnaire responses. Researchers provided a link to the questionnaire at the beginning of the REACH session and asked participants to click on the link and complete the pre-REACH questionnaire. Afterwards, participants were asked to resume the REACH session on their phone or computer and, at the very end, to complete the post-REACH questionnaire and submit their responses.

Researchers assisted the facilitator during the four virtual sessions by presenting and managing the progression of the REACH slides, posting the "Dear Leadership" video link, posting the link for the online pre- and post-REACH questionnaires, and generally monitoring the chat feature. In addition to providing the previously mentioned facilitation assistance, researchers also observed the REACH session and took notes on what went well and what could be improved.

RESULTS

This section describes the demographic characteristics of participants and the results of quantitative and qualitative analyses. Analyses are organized by research question.

Demographic Characteristics

REACH sessions were conducted with 185 participants, 100 from Fort Polk and 85 from Fort Drum. However, because of issues with administering the pre-REACH questionnaire in the first virtual REACH session and participants arriving late to the virtual REACH session, demographic characteristics data were missing for 18 participants. Table 19 provides the demographics of the 167 Army Soldiers who participated in the REACH sessions and completed the pre-REACH questionnaire. All but one participant were from the active duty component. The majority of participants had a rank ranging from E-1 to E-4 (73.1%) or E-5 to E-9 (21.6%); were male (83.8%); had a high school diploma, GED, or equivalent (58.1%) or some college with no degree (24.6%); and did not have experience previously seeking mental health support (70.7%).

Table 19
Participant Characteristics

Service	Count	%
Component		
Active Duty	164	98.2
Reserve	1	0.6
Rank		
E-1/E-4	122	73.1
E-5/E-9	36	21.6
O-1/O-3	5	1.8
O-4 +	1	0.6
Years of Service, *M* (*SD*)	4.33 (4.96)	
Gender		
Female	23	13.8
Male	140	83.8
Other/Prefer not to say	2	1.2
Education		
High school diploma/GED or equivalent	97	58.1
Some college (no degree)	41	24.6
Trade or technical certificate	3	1.8
Associate's degree	5	3.0
Bachelor's degree	8	4.8
Master's degree	4	2.4
Previously sought mental health support		
No	118	70.7
Yes	47	28.1

Note. Percentages may not sum to 100% due to missing data.

QUANTITATIVE DATA ANALYSIS

The power analysis conducted before the initiation of data collection indicated that 356 participants were needed to evaluate the effectiveness of the REACH session. Given that only 185 Soldiers participated at Site 4 and only 167 responded to both the pre- and post-REACH questionnaires, the planned statistical tests (i.e., one-way within-subjects ANCOVAs) were underpowered to detect the effect of the REACH session on the outcomes of interest (i.e., barriers to care, knowledge of resources, and comfort with help seeking). However, for consistency with the other sites, researchers conducted the same analyses for each research question that were carried out for Sites 1 through 3.

Table 20 shows the descriptive statistics for the scales and items relevant to research questions 1 through 3. Examination of the descriptive statistics indicates that there was a decrease in participants' perceived barriers to care following the REACH session,

namely for perceived lack of leadership support, fear of being perceived as "broken," concern that their career may be negatively impacted by reaching out for mental health help, and the belief that available mental health and financial resources are not effective. Participants' concern that their mental health problems might not stay private if they reach out for help remained relatively stable. Participants' comfort with help seeking, intentions to seek help in the future, and knowledge of resources also increased after attending a REACH session. Researchers analyzed the statistical significance of these mean differences as described in the following subsections. At the end of their session participants rated their facilitator positively (M = 4.30, SD = 0.71 on a scale of 1-5).

Table 20
Descriptive Statistics for Barriers to Care, Comfort With Help Seeking, Knowledge of Resources, and Facilitator Perceptions

	Pre-REACH					Post-REACH					
Variable	***N***	***M* (*SD*)**	**Median**	**Min**	**Max**	***N***	***M* (*SD*)**	**Median**	**Min**	**Max**	***d***
Barrier: Lack of Leadership Support	164	2.41 (1.02)	4.00	2.00	5.00	162	2.15 (1.01)	2.00	1.00	4.00	0.25
Barrier: Fear of Being Perceived as "Broken"	164	2.72 (1.21)	3.00	1.00	5.00	163	2.45 (1.17)	2.00	1.00	5.00	0.22
Barrier: Loss of Privacy	164	2.48 (1.19)	3.00	1.00	5.00	163	2.50 (1.23)	2.00	1.00	5.00	0.02
Barrier: Negative Career Impact	164	2.74 (1.20)	3.00	1.00	5.00	162	2.57 (1.23)	2.00	1.00	5.00	0.13
Barrier: Mental Health Resources Ineffective	165	2.07 (0.90)	2.00	1.00	5.00	161	1.82 (0.78)	2.00	1.00	5.00	0.29
Barrier: Financial Resources Ineffective	165	2.01 (0.78)	2.00	1.00	3.00	162	1.81 (0.80)	2.00	1.00	5.00	0.25
Comfort With Help Seeking	165	3.67 (0.81)	3.50	1.00	5.00	161	3.92 (0.77)	4.00	1.50	5.00	0.32
Intention to Seek Help	165	3.75 (1.00)	4.00	1.00	5.00	162	3.91 (0.99)	4.00	1.00	5.00	0.16
Knowledge of Resources	164	3.95 (0.72)	4.00	2.00	5.00	162	4.10 (0.70)	4.00	2.33	5.00	0.21
Perceptions of the Facilitator						160	4.30 (0.71)	4.50	2.00	5.00	--

The following subsections describe the results of the one-way within-subjects ANCOVA and regression analyses organized by research question. As in the body of the report, the focus is on the interpretation of the main effect of interest for each model. Each model controls for participants' years in Service, gender, and perceptions of the facilitator. Of note, all models, except one, found a significant association between the covariate of "perception of the facilitator" and the outcome of interest. The interpretation for any significant associations between perceptions of the facilitator and the outcomes is that more positive perceptions of the facilitator were associated with lower perceptions of barriers to care, greater comfort with help seeking, and improved knowledge of resources.

Research Question 1 – Change in Perception of Barriers to Care

Research Question 1 evaluated whether REACH reduced participants' perceptions of barriers to seeking help. All barriers to care items were examined individually with the exception of perception of "lack of leadership support." This scale included the following two items:

- If I needed help with a mental health problem, I am confident that my chain of command would be supportive (reversed).
- If I faced a problem or a difficult challenge, I would be open to turning to my leadership for help (reversed).

Cronbach's alpha for this scale was .85 and .94 on the pre- and post-REACH questionnaires, respectively, suggesting that the overall scale was fairly reliable.

Table 21 shows that the REACH session did not have a significant main effect on ratings of any of the barriers to care assessed. In particular, there was no change in participants' confidence that if they reached out for help with a mental health problem their leadership would be supportive, participants' willingness to turn to leadership for help, participants' fear that they will be perceived as broken if they reach out for help with a mental health problem, participants' concern that their mental health problems might not stay private if they reach out for help, participants' concern that their career may be negatively impacted if they reach out for help with a mental health problem, participants' belief that there are effective resources out there for dealing with a mental health problem, or participants' belief that there are effective resources out there for dealing with a financial problem.

Table 21
ANCOVA Results for Barriers to Care as a Function of REACH Session

Predictor	*F*	*df*	*p*
Change in Perception of "Lack of Leadership Support"			
REACH Session	<.01	1	0.97
Perceptions of the Facilitator	30.56	1	<.001
Gender	0.41	1	0.525
Years of Service	0.11	1	0.740
Error		148	
Change in Perception of "Fear of Being Perceived as Broken"			
REACH Session	0.02	1	0.877
Perceptions of the Facilitator	10.73	1	<.001
Gender	0.10	1	0.748
Years of Service	0.01	1	0.982
Error		148	
Change in Perception of "Loss of Privacy"			
REACH Session	1.35	1	0.248
Perceptions of the Facilitator	12.01	1	<.001
Gender	1.12	1	0.291
Years of Service	0.03	1	0.855
Error		148	
Change in Perception of "Negative Career Impact"			
REACH Session	1.62	1	0.205
Perceptions of the Facilitator	10.01	1	<.001
Gender	1.59	1	0.209
Years of Service	0.18	1	0.672
Error		148	
Change in Perception of "Mental Health Resources Are Ineffective"			
REACH Session	1.84	1	0.177
Perceptions of the Facilitator	80.93	1	<.001
Gender	4.85	1	.029
Years of Service	0.74	1	0.390
Error		148	
Change in Perception of "Financial Resources Are Ineffective"			
REACH Session	2.12	1	0.147
Perceptions of the Facilitator	109.56	1	<.001
Gender	2.05	1	0.155
Years of Service	0.06	1	0.812
Error		148	

Research Question 2 – Change in Comfort With Help Seeking

Research Question 2 examined whether REACH increased participants' comfort with reaching out for help. Four items constituted the "Comfort With Help Seeking" scale:

- I would feel comfortable reaching out for help with a mental health problem.
- I would not feel comfortable reaching out for help with a financial problem (reversed).
- If my financial situation was causing me stress, I would reach out for help.
- I would feel comfortable reaching out to Military OneSource for help with a problem.

Cronbach's alpha for this scale was .77 and .80 for pre- and post-REACH ratings, respectively, suggesting that the overall scale was fairly reliable. Table 22 shows that the REACH session did not have a significant main effect on participants' comfort with help seeking. Effect sizes for each item indicate that REACH had a small impact across the various help-seeking outcomes, namely comfort with reaching out for help with a mental health problem (Cohen's d = 0.35), reaching out for help with a stressful financial situation (Cohen's d = 0.33), and comfort with reaching out to Military OneSource (Cohen's d = 0.31).

Table 22
Change in "Comfort With Help Seeking"

Predictor	*F*	*df*	*p*
REACH Session	0.32	1	0.573
Perceptions of the Facilitator	57.64	1	<.001
Gender	3.24	1	0.074
Years of Service	0.32	1	0.572
Error		148	

An additional item examined whether REACH positively affected participants' intention to seek help if they felt trapped or stuck in a stressful situation:

- If I feel trapped or stuck in a stressful situation, I will reach out to someone for help.

Table 23 shows that the REACH session did not have a significant main effect on participants' intention to seek help in the future if faced with a stressful situation.

Table 23
Change in "Intention to Seek Help"

Predictor	*F*	*df*	*p*
REACH Session	0.02	1	0.897
Perceptions of the Facilitator	42.90	1	<.001
Gender	<.01	1	0.967
Years of Service	0.16	1	0.688
Error		148	

Table 24 shows the results of the regression analysis evaluating whether more positive perceptions of the facilitator (i.e., encouraged participation, was enthusiastic, and was passionate about the importance of reaching out for help) were associated with greater comfort with help seeking while controlling for participants' years of Service and gender. More positive perceptions of the facilitator's overall performance were significantly associated with an increase in participants' comfort with help seeking.

Table 24
Regression Predicting "Comfort With Help Seeking"

Predictor	Coefficient	*SE*	*t*	*p*	*df*
Perceptions of the Facilitator	0.58	0.07	5.03	<.001	148
Years of Service	-0.01	0.01	-0.62	0.538	
Gender (Male)	-0.32	0.15	-2.22	0.028	

Table 25 shows the results of the regression analysis evaluating whether more positive perceptions of the facilitator's overall performance were associated with greater comfort with reaching out to Military OneSource while controlling for participants' years of Service and gender. More positive perceptions of the facilitator were not significantly associated with greater comfort with contacting Military OneSource.

Table 25
Regression Predicting "Comfort with Reaching out to Military OneSource" (Single Item)

Predictor	Coefficient	*SE*	*t*	*p*	*df*
Perceptions of the Facilitator	0.61	0.38	7.83	<.001	148
Years of Service	-0.01	0.08	-0.501	0.617	
Gender (Male)	-0.29	0.16	-1.796	0.075	

Research Question 3 – Change in Knowledge of Resources

Research Question 3 examined whether REACH increased participants' knowledge of resources. Three items constituted the "Knowledge of Resources" scale:

- I know what resources exist to help me with a financial problem.
- I don't know who to turn to when I need help (reversed).
- I know what resources exist to help me with a mental health problem.

Cronbach's alpha for this scale was .67 and .66 for the pre- and post-REACH ratings, respectively, suggesting that the internal consistency of the overall scale was acceptable. Table 26 shows that the REACH session did not have a significant main effect on participants' knowledge of resources.

Table 26
Change in "Knowledge of Resources"

Predictor	*F*	*df*	*p*
REACH Session	2.11	1	0.148
Perceptions of the Facilitator	152.84	1	<.001
Gender	1.50	1	0.223
Years of Service	8.67	1	<.001
Error		148	

Research Question 4 – Utility Value of the REACH Session

Research Question 3 examined whether participants found the REACH session useful. Table 27 shows the descriptive statistics for participants' reactions to the practice call to Military OneSource as well as their overall assessment of the REACH session's utility value. Participants strongly agreed that making the practice call to Military OneSource was helpful and agreed that, after hearing the call, they felt comfortable making a call to Military OneSource on their own. In terms of utility of the overall REACH session, participants tended to strongly agree that the REACH session would be beneficial for other Service members and agree that the information in the REACH session was relevant to their lives and was novel. Participants strongly agreed that they learned a lot of useful information.

Table 27
Combined Descriptive Statistics of Participant REACH Utility Value Reactions

Item	*n*	Mean	*SD*	Median	Min	Max
It was helpful to make a practice call to Military OneSource together as a group.	161	4.22	0.82	4.00	1.00	5.00
After hearing the practice call, I feel more comfortable making a call to Military OneSource myself.	161	4.11	0.81	4.00	1.00	5.00
The REACH training would be beneficial for other Service members.	161	4.21	0.89	4.00	1.00	5.00
The information in the REACH training was relevant to my life.	161	3.99	0.84	4.00	1.00	5.00
The REACH training discussed information I had not encountered in other trainings.	161	3.86	0.91	4.00	1.00	5.00
I learned a lot of useful information.	161	4.20	0.80	4.00	1.00	5.00

Research Question 5 – Facilitator Training Procedures

Research Question 5 examined whether the facilitator training procedures effectively supported facilitators in fulfilling their roles. Table 28 presents the descriptive

statistics for perceptions of the REACH facilitator training from nine facilitators who responded to the questionnaire. Of the nine, three attended the first day of training only and six participated in both days of training. Overall, the facilitator training received favorable feedback, and facilitators tended to agree that they felt confident about delivering REACH to others following the training. Facilitators also agreed that the training adequately prepared them to lead REACH sessions. Facilitators moderately agreed that that they would be able to positively impact other Service members through REACH.

Table 28
Facilitator Perceptions of the REACH Facilitator Training

Item	*n*	Mean	*SD*	Median	Min	Max
I feel confident about delivering REACH to others.	9	4.11	0.78	4.00	3.00	5.00
Today's training session adequately prepared me to facilitate REACH to others.	9	3.89	0.78	4.00	3.00	5.00
I will be able to positively impact other Service members by delivering REACH.	9	3.67	1.12	4.00	1.00	5.00

Table 29 presents the descriptive statistics for facilitator perceptions of REACH after leading a session. The two facilitators who led REACH sessions reported that, on average, they spent 1.25 hours outside of the facilitator training practicing and preparing for their REACH session. Facilitators tended to strongly agree that the Facilitator's Manual was useful and well organized. The two facilitators tended to use their own words rather than the talking points provided in the Facilitator's Manual, as they were encouraged to do in the training. Facilitators also reported again that they felt confident delivering REACH and they felt comfortable making the "live" call to Military OneSource during the session. Facilitators also agreed that participants in their sessions were engaged and actively participated in discussion. Finally, facilitators strongly agreed that they would like to deliver REACH in the future.

Table 29
Facilitator Perceptions of REACH After Leading a REACH Session

Item	*n*	Mean
Number of hours spent practicing	2	1.25
The Facilitator's Manual was useful for preparing me to lead REACH.	2	5.00
The Facilitator's Manual was well organized and easy to follow.	2	5.00
I used a lot of my own words rather than the talking points when delivering REACH.	2	3.50
I did <u>not</u> feel confident delivering the REACH training.	2	1.50
I felt comfortable making the "live" call to Military OneSource in front of the group.	2	4.50
I would like to deliver REACH training again.	2	5.00
The audience was engaged and actively participated in the training.	2	4.50

QUALITATIVE RESULTS

As described in the main body of the report, researchers relied on qualitative feedback to inform changes to the REACH facilitator training procedures and REACH materials in response to research question 6. Site 4 qualitative feedback included observational data from the virtual REACH facilitator training at Fort Polk and virtual REACH sessions with Fort Drum Soldiers as well as facilitator and participant responses to open-ended questions. Although researchers were not able to observe the Fort Polk REACH sessions in person, they maintained frequent communication with the two facilitators to review how their sessions were going and answer any questions. After the data collection was complete, researchers reviewed the qualitative data, sorted the data into themes, and identified a list of final changes to make to the REACH slides and Facilitator's Manual.

Research Question 6 – Feedback on REACH Facilitator Training Procedures and REACH Materials

Research Question 6 focused on identifying improvements to the REACH facilitator training procedures and REACH materials. Most Fort Polk facilitators reported that they enjoyed the training and found it to be of value. However, those who attended both days of the training also commented that the overall training length could have been shorter, given both the virtual format and the fact that chaplains already possess some of skills that were taught on Day 2 (e.g., motivational interviewing). Also, although fidelity checks at previous field test sites proved to be very useful for facilitators without a mental health background, facilitators from Fort Polk did not see the same need for them. Moreover, many of them likely did not sign up for a fidelity check because they were unable to lead a REACH session during the field test period. The purpose of the field test fidelity check is to give facilitators a chance to practice presenting REACH right before their first session.

Soldier who attended an in-person or virtual REACH session provided generally positive feedback. They found the REACH sessions engaging and useful, even when they were conducted using the virtual format, as was the case for Fort Drum participants. Some participants wanted more visual aids and more examples of people reaching out for help. They also suggested that the session could have been longer than an hour to allow more time for discussion.

Researchers' observations of virtual REACH sessions with Fort Drum Soldiers also indicated that sessions were engaging and meaningful for participants. However, it is important to note that the facilitator who led the virtual sessions was very experienced and comfortable with delivering virtual suicide prevention and resilience trainings and already had an excellent preexisting rapport with his participants. Some helpful strategies he used to enhance participant engagement included calling on specific individuals by name and asking them to verbally share their thoughts, asking participants to type their thoughts into the chat box if they were hesitant to speak up, and reading responses from the chat box and reflecting on them in "real time." Above

all, the facilitator was able to model inclusiveness and kindness and demonstrate how much he cared about the topic. Researchers incorporated many of these strategies into the REACH Facilitator Manual's dedicated appendix on how to lead a virtual REACH session.

Representative Quotes From REACH Session Participants

- "Great training! Recommend every soldier attend the brief (REACH)."
- "REACH could be improved by actually getting someone who works with one of the programs to come and speak."
- "I feel like this program is a step in the right direction from the [Ask Care Escort] ACE program, but I also feet it needs to be hit harder for senior leaders."
- "It was very helpful, I wouldn't change anything."

DISCUSSION

REACH was developed to empower Service members to reach out for help without worrying about perceived or real barriers to care. Although the mean differences between the Soldiers' ratings of barriers to care, comfort with help seeking, and knowledge of resources before and after the REACH session were not statistically significant, the trends were in the expected direction. Perceptions of several barriers decreased after the REACH sessions. Specifically, the concern about lack of leadership support for help seeking, fear of being perceived as "broken," concerns about negative career impact, and the belief that mental health and financial resources are ineffective. Only the concern about the loss of privacy when seeking help remained relatively stable. Although the observed mean differences were not statistically significant, the descriptive statistics indicate that the REACH sessions were having the desired effect on Soldiers' perceptions of these barriers to care. Comfort with help seeking and knowledge of resources also appeared to increase following a REACH session, but again, the differences were not statistically significant. Given a larger sample size, the observed differences may have become significant, which would be consistent with the results from Sites 1 through 3.

Overall, facilitators and participants had positive impressions of their experience with REACH. Participants indicated that the information presented in REACH was novel, relevant, and had utility value for their lives. Both facilitators and participants found REACH to be beneficial for themselves and other Service members. One facilitator noted that REACH emphasizes an upstream approach to suicide prevention by focusing on a "collection of issues that can be minimized and managed before a Soldier gets in trouble or faces suicidal ideation" and "self-referral before the boom goes off." Some participants even suggested that the session be longer to allow for more discussion. In line with one of the goals of REACH, one facilitator noted that the discussions that occurred were "candid." This facilitator also shared in an after-action report to the Army Office of the Chief of Chaplains that two Soldiers sought help from

him after the REACH session and another six were escorted to behavioral health and shown the process for how to start seeing a counselor or a therapist.

As with the other field test sites, passionate and engaging facilitators were instrumental to the success of REACH. Positive perceptions of the facilitator were associated with lower ratings of barriers to care, greater comfort with help seeking and reaching out to Military OneSource, and improved knowledge of resources. Perceptions of the facilitator reflected the extent to which the facilitator encouraged participation, was enthusiastic in their delivery of REACH, showed passion for the importance of reaching out for help, and clearly explained information on the slides. Notably, the REACH facilitator training underscored the importance of these factors in the facilitator's delivery of REACH, and the results confirm that they were very important to Soldiers. The facilitator who led the majority of the REACH sessions also credited his supportive battalion leadership by clarifying that "good leaders at the company level made for a successful implementation." Indeed, it is critical that facilitators have this sort of support from their leadership as well as availability in their schedule to lead REACH sessions.

The REACH sessions with Fort Drum Soldiers gave researchers a first-hand opportunity to observe what REACH looks and feels like when conducted virtually. These sessions served as the proof of concept that successful virtual REACH sessions are achievable when led by an experienced facilitator who is comfortable with delivering virtual trainings. In addition, having a co-facilitator can be very helpful to ensure that a virtual session runs smoothly. One advantage of video conferencing platforms is that facilitators can easily record their session and review it later to improve their facilitation skills. (Note that participants must be informed ahead of time if a session is going to be recorded.)

Researchers learned through follow-up communication with one of the Fort Polk facilitators that he continues to use REACH with his Soldiers. He was recently asked by battalion leadership to conduct additional REACH sessions with companies that had incidents of problematic behavior. This facilitator also received leadership support to create a video recording of a REACH session to help future facilitators better prepare to fulfill their roles. This recording will be incorporated into the web-based facilitator training described in the main body of this report, which will be ready for dissemination by the end of FY21.

APPENDIX B: QUESTIONNAIRES

PRE-REACH QUESTIONNIARE FOR PARTICIPANTS

REACH
Resources Exist, Asking Can Help

Pre-REACH Questionnaire

PARTICIPANT ID#

Instructions

A) Please respond to each of the questions below and ensure your response is clearly identifiable. Refer to these examples:

CORRECT

INCORRECT

B) Please do not include any identifying information on this questionnaire.

1. What is your military Service branch?

- ☐ ARMY
- ☐ NAVY
- ☐ AIR FORCE
- ☐ MARINE CORPS

2. What is your military component?

- ☐ ACTIVE DUTY
- ☐ RESERVE
- ☐ NATIONAL GUARD

3. What is your current paygrade/rank?

- ☐ E-1
- ☐ E-2
- ☐ E-3
- ☐ E-4
- ☐ E-5
- ☐ E-6
- ☐ E-7
- ☐ E-8
- ☐ E-9
- ☐ W-1
- ☐ W-2
- ☐ W-3
- ☐ W-4
- ☐ W-5
- ☐ O-1/O-1E
- ☐ O-2/O-2E
- ☐ O-3/O-3E
- ☐ O-4
- ☐ O-5
- ☐ O-6 OR ABOVE

4. What is the code for your current MOS/AFSC/NEC? [Example: 1 1 B]

WRITE IN YOUR RESPONSE

5. How many years have you served in the military? [Example: 5]

WRITE IN YOUR RESPONSE

6. What is your gender?

- ☐ MALE
- ☐ FEMALE
- ☐ OTHER/PREFER NOT TO SAY

7. What is the highest degree or level of education you have completed?

- ☐ LESS THAN HIGH SCHOOL
- ☐ HIGH SCHOOL DIPLOMA/GED OR EQUIVALENT
- ☐ TRADE OR TECHNICAL CERTIFICATE
- ☐ SOME COLLEGE (NO DEGREE)
- ☐ ASSOCIATE'S DEGREE
- ☐ BACHELOR'S DEGREE
- ☐ MASTER'S DEGREE
- ☐ DOCTORAL DEGREE

PLEASE CONTINUE ONTO THE NEXT PAGE. →

Pre-REACH Questionnaire

PARTICIPANT ID#

8. I have sought help from a trained mental health professional for my problems in the past. ☐ YES ☐ NO

9. If you answered yes to Question 8, please rate your level of satisfaction with the support you received.

VERY DISSATISFIED	DISSATISFIED	NEITHER SATISFIED NOR DISSATISFIED	SATISFIED	VERY SATISFIED
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
10. I know what resources exist to help me with a financial problem.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
11. I worry that my mental health problems might not stay private if I seek help.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
12. I would feel comfortable reaching out for help with a mental health problem.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
13. I don't know who to turn to when I need help.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
14. I know what resources exist to help me with a mental health problem.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
15. I would not feel comfortable reaching out for help with a financial problem.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
16. If I needed help with a mental health problem, I am confident that my chain of command would be supportive.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

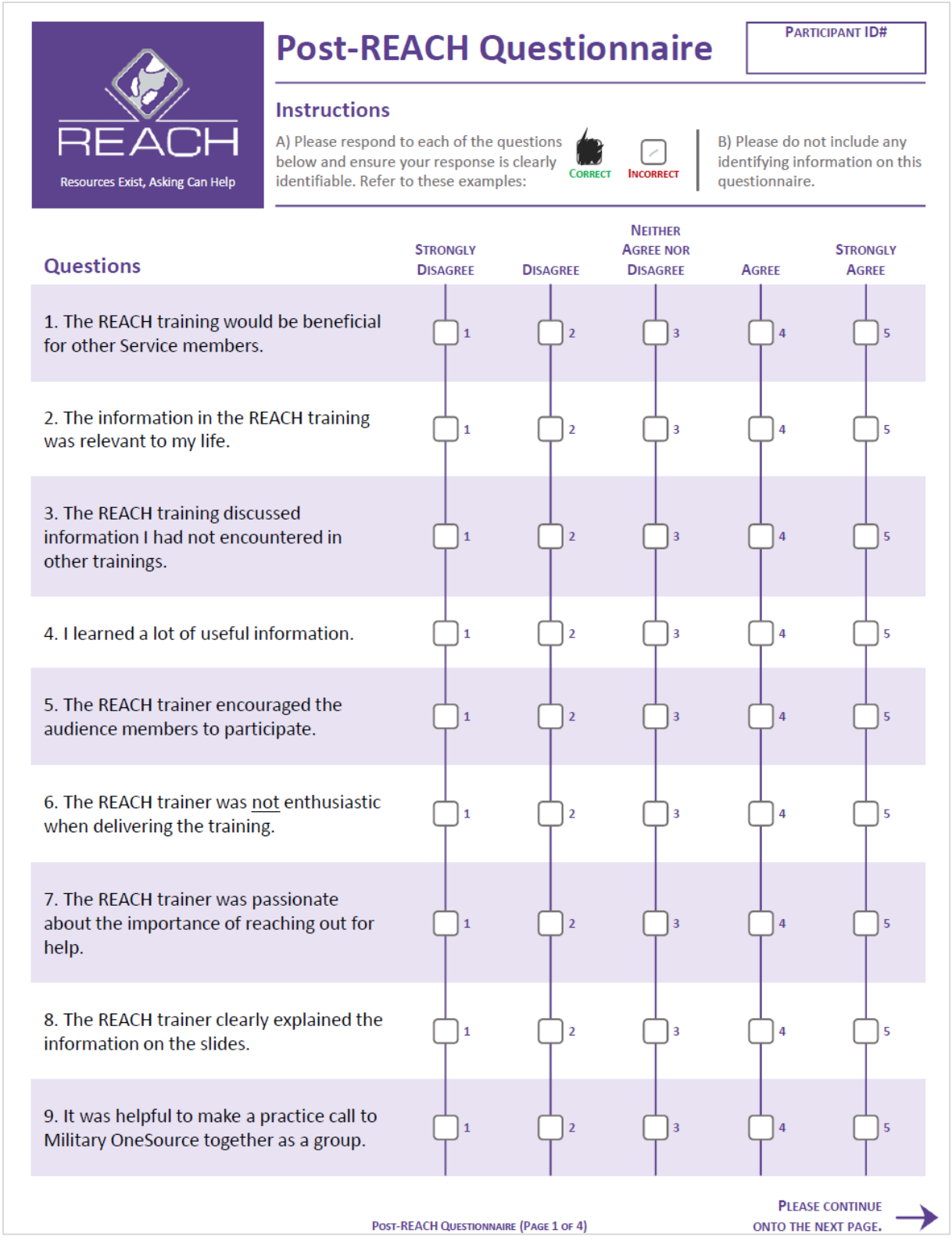
PLEASE CONTINUE ONTO THE NEXT PAGE. →

Pre-REACH Questionnaire

PARTICIPANT ID#

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
17. There are effective resources out there that can help me with a mental health problem.	1	2	3	4	5
18. If my financial situation was causing me stress, I would reach out for help.	1	2	3	4	5
19. I worry that if I seek help for a mental health problem, it might have a negative impact on my career.	1	2	3	4	5
20. There are effective resources that can help me with a financial problem.	1	2	3	4	5
21. I worry that if I seek help for a mental health problem, others might see me as broken.	1	2	3	4	5
22. If I faced a problem or a difficult challenge, I would be open to turning to my leadership for help.	1	2	3	4	5
23. I would feel comfortable reaching out to Military OneSource for help with a problem.	1	2	3	4	5
24. If I feel trapped or stuck in a stressful situation, I will reach out to someone for help.	1	2	3	4	5

POST-REACH QUESTIONNAIRE FOR PARTICIPANTS



REACH
Resources Exist, Asking Can Help

Post-REACH Questionnaire

PARTICIPANT ID#

Instructions

A) Please respond to each of the questions below and ensure your response is clearly identifiable. Refer to these examples: CORRECT INCORRECT

B) Please do not include any identifying information on this questionnaire.

Questions	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
1. The REACH training would be beneficial for other Service members.	1	2	3	4	5
2. The information in the REACH training was relevant to my life.	1	2	3	4	5
3. The REACH training discussed information I had not encountered in other trainings.	1	2	3	4	5
4. I learned a lot of useful information.	1	2	3	4	5
5. The REACH trainer encouraged the audience members to participate.	1	2	3	4	5
6. The REACH trainer was not enthusiastic when delivering the training.	1	2	3	4	5
7. The REACH trainer was passionate about the importance of reaching out for help.	1	2	3	4	5
8. The REACH trainer clearly explained the information on the slides.	1	2	3	4	5
9. It was helpful to make a practice call to Military OneSource together as a group.	1	2	3	4	5

POST-REACH QUESTIONNAIRE (PAGE 1 OF 4)

PLEASE CONTINUE ONTO THE NEXT PAGE.

Post-REACH Questionnaire

PARTICIPANT ID#

Questions	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
10. After hearing the practice call, I feel more comfortable making a call to Military OneSource myself.	1	2	3	4	5
11. If I feel trapped or stuck in a stressful situation, I will reach out to someone for help.	1	2	3	4	5
12. I know what resources exist to help me with a financial problem.	1	2	3	4	5
13. I worry that if I seek help for a mental health problem, it might have a negative impact on my career.	1	2	3	4	5
14. I don't know who to turn to when I need help.	1	2	3	4	5
15. I know what resources exist to help me with a mental health problem.	1	2	3	4	5
16. I would not feel comfortable reaching out for help with a financial problem.	1	2	3	4	5
17. I worry that my mental health problems might not stay private if I seek help.	1	2	3	4	5
18. I worry that if I seek help for a mental health problem, others might see me as broken.	1	2	3	4	5

PLEASE CONTINUE ONTO THE NEXT PAGE. →

Post-REACH Questionnaire

PARTICIPANT ID#

Questions	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
19. There are effective resources that can help me with a financial problem.	1	2	3	4	5
20. I would feel comfortable reaching out for help with a mental health problem.	1	2	3	4	5
21. If I faced a problem or a difficult challenge, I would be open to turning to my leadership for help.	1	2	3	4	5
22. I would feel comfortable reaching out to Military OneSource for help with a problem.	1	2	3	4	5
23. If I needed help with a mental health problem, I am confident that my chain of command would be supportive.	1	2	3	4	5
24. If my financial situation was causing me stress, I would reach out for help.	1	2	3	4	5
25. There are effective resources out there that can help me with a mental health problem.	1	2	3	4	5

PLEASE CONTINUE ONTO THE NEXT PAGE. →

Post-REACH Questionnaire

PARTICIPANT ID#

26. Please share your thoughts on how we can improve the REACH training.

PLEASE WRITE-IN YOUR RESPONSE

POST-FACILITATOR TRAINING QUESTIONNAIRE

REACH
Resources Exist, Asking Can Help

Post-Facilitator Training Questionnaire for Facilitators

PARTICIPANT ID#

Instructions

A) Please respond to each of the questions below and ensure your response is clearly identifiable. Refer to these examples: CORRECT INCORRECT

B) Please do not include any identifying information on this questionnaire.

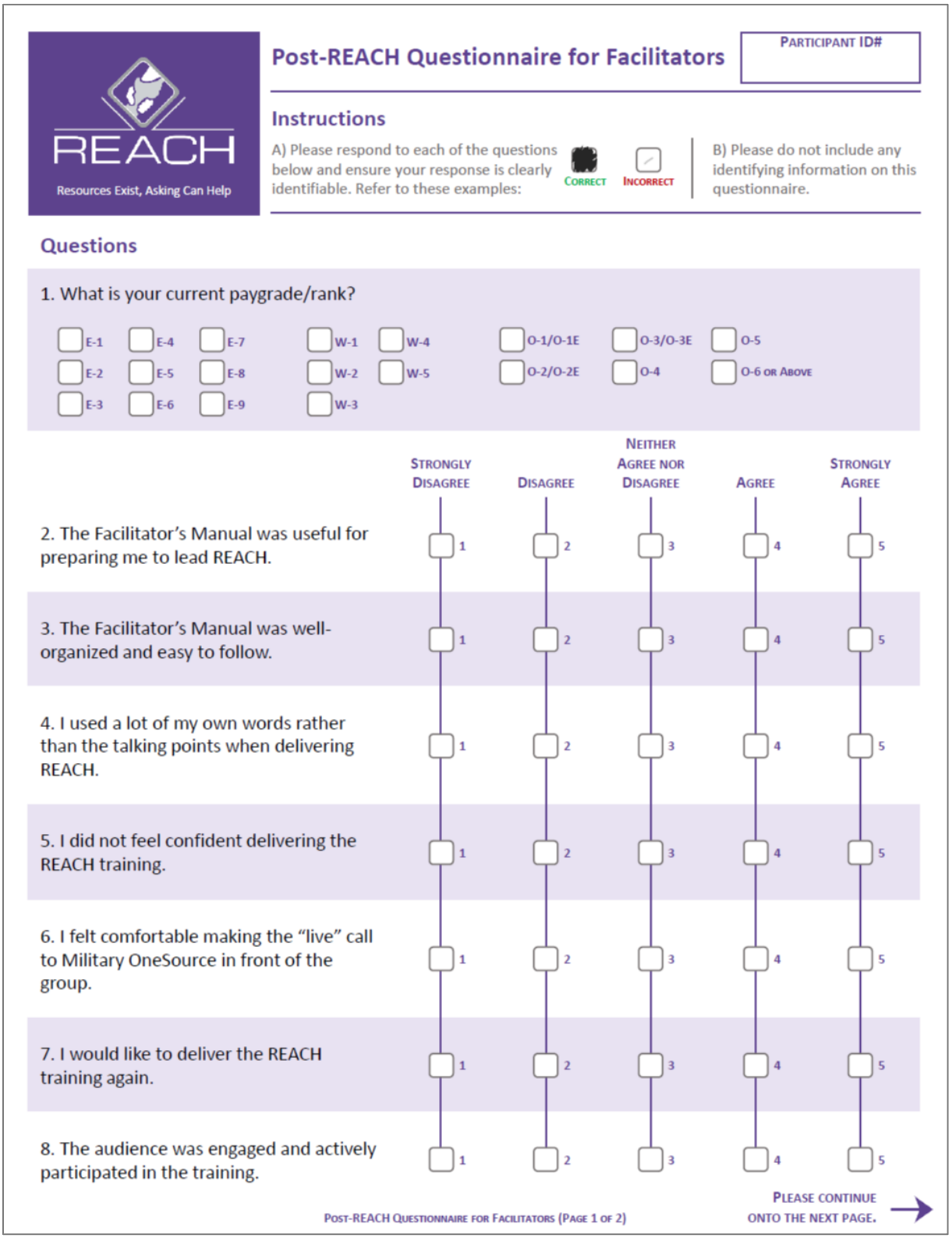
Questions	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
1. I feel confident about delivering REACH to others.	1	2	3	4	5
2. Today's training session adequately prepared me to facilitate REACH to others.	1	2	3	4	5
3. I will be able to positively impact other Service members by delivering REACH.	1	2	3	4	5

4. Please share your thoughts on how we can improve the REACH facilitator training in the future.

PLEASE WRITE-IN YOUR RESPONSE

POST-TTT QUESTIONNAIRE FOR FACILITATORS (PAGE 1 OF 1)

POST-REACH QUESTIONNAIRE FOR FACILITATORS



REACH
Resources Exist, Asking Can Help

Post-REACH Questionnaire for Facilitators

PARTICIPANT ID#

Instructions

A) Please respond to each of the questions below and ensure your response is clearly identifiable. Refer to these examples: ■ CORRECT ☑ INCORRECT

B) Please do not include any identifying information on this questionnaire.

Questions

1. What is your current paygrade/rank?

☐ E-1 ☐ E-2 ☐ E-3 ☐ E-4 ☐ E-5 ☐ E-6 ☐ E-7 ☐ E-8 ☐ E-9 ☐ W-1 ☐ W-2 ☐ W-3 ☐ W-4 ☐ W-5 ☐ O-1/O-1E ☐ O-2/O-2E ☐ O-3/O-3E ☐ O-4 ☐ O-5 ☐ O-6 OR ABOVE

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
2. The Facilitator's Manual was useful for preparing me to lead REACH.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. The Facilitator's Manual was well-organized and easy to follow.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. I used a lot of my own words rather than the talking points when delivering REACH.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. I did not feel confident delivering the REACH training.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. I felt comfortable making the "live" call to Military OneSource in front of the group.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. I would like to deliver the REACH training again.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8. The audience was engaged and actively participated in the training.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

POST-REACH QUESTIONNAIRE FOR FACILITATORS (PAGE 1 OF 2)

PLEASE CONTINUE ONTO THE NEXT PAGE. →

Post-REACH Questionnaire for Facilitators

PARTICIPANT ID#

9. How much time did you spend practicing how to deliver REACH outside of the facilitator training? (for example, 2 hours; 1 hour reviewing the talking points and 1 hour practicing presenting)

PLEASE WRITE-IN YOUR RESPONSE

10. How much experience do you have as a presenter (e.g., giving briefings, presenting trainings, etc.)?

☐ 1-5 TIMES ☐ 6-10 TIMES ☐ 11-15 TIMES ☐ 16-20 TIMES ☐ 21+ TIMES

11. Before the REACH training, what was your level of awareness of Military OneSource?

☐ I HAVE USED IT BEFORE. ☐ I KNEW WHAT IT WAS, BUT I HAVE NOT USED IT. ☐ I HAVE HEARD OF IT, BUT I DID NOT REALLY KNOW WHAT IT WAS. ☐ I HAVE NEVER HEARD OF IT.

12. How can we improve the REACH training for other Service members in the future?

PLEASE WRITE IN YOUR RESPONSE, AND CONTINUE ON THE BACK IF NECESSARY

13. Did you encounter any technical difficulties or other issues while delivering REACH?

☐ YES ☐ No

14. If yes, do you have any suggestions for how these can be avoided in the future?

PLEASE WRITE-IN YOUR RESPONSE

APPENDIX C: RESULTS OF POWER ANALYSIS, MEASUREMENT TESTING, AND INTERPRETATION OF COVARIATES FOR SITES 1-3

POWER ANALYSIS

Prior to initiating data collection, researchers conducted a power analysis to determine the number of participants needed to evaluate the impact of key independent variables. Initial analytic plans focused on three primary independent variables: the effect of the REACH session, the differences among military Services, and the interaction between these two variables. Power analyses[8] revealed that the sample size needed to test these independent variables was n = 356, n = 872, and n = 656 participants, respectively. Thus, researchers strove to recruit 872 participants across all REACH sessions. After completing data collection, the researchers determined that the number of participants (n = 361) was sufficient to test only one independent variable—the effect of the REACH session. They thus revised the analytic plan to include only the REACH session as the primary independent variable and to exclude the Service-level differences and interaction variables.

MEASUREMENT TESTING

Participants in REACH sessions responded to a series of statements designed to assess their perceptions of barriers to care, their comfort with seeking help, and their knowledge of resources available to them. Participants responded to these statements both before and after the REACH sessions. To assess whether the items associated with these constructs can be reasonably combined into a scale, researchers conducted CFAs for *knowledge of resources*, *comfort with help seeking*, and *barriers to care*. This appendix presents the results of those analyses. In addition, participants responded to four statements examining their perceptions of the REACH facilitator and perceptions of the utility of the REACH session. Thus, results of CFAs for eight scales in total are also presented.

Table 30 shows the fit indices for six out of the eight CFAs conducted. For the remaining two CFAs conducted on the knowledge of resources scale, because the scale contains only three items, the raw and standardized factor loadings to assess the associations between the constructs are presented. (Fit indices cannot be calculated as the model is saturated or just-identified.). Each of the scales is described in greater detail in the following sections. As a general reminder, Confirmatory Factor Index (CFI) and Tucker Lewis Index values of above .95 are considered good fit; correspondingly, Root Mean Square Error of Approximation (RMSEA) and Standardized Root Mean Square Residual values should be at or below .06 and .08, respectively.

[8] Details of the power analysis, including the assumptions made regarding effect sizes and correlations, are available upon request.

Table 30
Fit Indices for CFAs (Sites 1-3)

	CFI	TLI*	RMSEA	SRMR**	x^2	*df*	*p*	Cronbach's Alpha
Pre-REACH								
Barriers to Care	0.81	0.71	0.18	0.08	174.83	14	<.001	0.81
Comfort With Help Seeking	0.99	0.96	0.08	0.02	406.02	6	<.001	0.79
Post-REACH								
Barriers to Care	0.76	0.60	0.26	0.11	217.52	9	<.001	0.82
Comfort With Help Seeking	0.99	0.96	0.09	0.02	7.38	2	0.025	0.78
Perceptions of Facilitator	1.00	1.00	0.00	0.02	463.35	6	<.001	0.77
Utility of the REACH Session	0.95	0.84	0.19	0.05	23.91	2	<.001	0.79

* TLI = Tucker Lewis Index.
** SRMR = Standardized Root Mean Square Residual.

Barriers to Care

Participants responded to seven statements intended to assess their perceptions of any perceived barriers to seeking help:

- I worry that my mental health problems might not stay private if I seek help.
- If I needed help with a mental health problem, I am confident that my chain of command would be supportive (reversed).
- If I faced a problem or a difficult challenge, I would be open to turning to my leadership for help (reversed).
- There are effective resources out there that can help me with a mental health problem (reversed).
- I worry that if I seek help for a mental health problem, it might have a negative impact on my career.
- There are effective resources out there that can help me with a financial problem (reversed).
- I worry that if I seek help for a mental health problem, others might see me as broken.

CFA results for the items assessing barriers to care suggest that the model demonstrates relatively poor fit both pre- and post-REACH. All of the fit indices suggest that a one-factor model does not represent the items well. Alternative models (e.g., removing the item or items with the lowest factor loadings) did not substantially improve fit. This suggests that the items should not be combined into a scale and should be examined individually

Comfort With Help Seeking

The participants responded to four statements designed to assess their comfort with seeking help:

- I would feel comfortable reaching out for help with a mental health problem.
- I would not feel comfortable reaching out for help with a financial problem (reversed).
- If my financial situation was causing me stress, I would reach out for help.
- I would feel comfortable reaching out to Military OneSource for help with a problem.

Both pre- and post-REACH fit indices for the comfort with help seeking items show good to excellent fit. The RMSEA for the scale is very slightly above optimal in the post-REACH ratings. However, overall, the fit indices reflect that a single factor of comfort with help seeking represents the items well and that the items can be combined into a single scale score representing the participants' overall comfort with seeking help. Cronbach's alpha for the scale is .79 and .78 for the pre- and post-REACH, respectively, suggesting that the overall scale is fairly reliable.

Knowledge of Resources

Participants responded to three statements intended to gauge their perceptions of their level of knowledge regarding the resources available to them:

- I know what resources exist to help me with a financial problem.
- I don't know who to turn to when I need help (reversed).
- I know what resources exist to help me with a mental health problem.

Table 31 presents the standardized and unstandardized factor loadings, as well as the Cronbach's alpha, for the items that assess participants' knowledge of resources. Again, although researchers cannot calculate fit indices for this model, the degree to which each item is associated with the proposed single underlying construct can be examined. As shown in Table 31, the standardized loadings (which can generally be interpreted in the same way as a correlation coefficient) do seem to be consistently and strongly related to the proposed construct. Although note that the first item in a three-factor CFA is, by default, set to have a factor loading of 1, so it should not be interpreted to reflect the strength of the loading for that particular item.

Table 31
Factor Loadings for "Knowledge of Resources" (Sites 1-3)

	Knowledge of Resources	Unstandardized Loading	Standardized Loading	Cronbach's Alpha
Pre-REACH	I know what resources exist to help me with a financial problem.	1.00	0.65	0.72
	I don't know who to turn to when I need help.	1.13	0.67	
	I know what resources exist to help me with a mental health problem.	1.09	0.74	
Post-REACH	I know what resources exist to help me with a financial problem.	1.00	0.63	0.69
	I don't know who to turn to when I need help.	0.94	0.48	
	I know what resources exist to help me with a mental health problem.	1.35	0.95	

Inter-item correlations both pre- and post-REACH show that items are correlated on average at $r = .47$ and $r = .45$, respectively, suggesting that the items are highly intercorrelated. This is further reflected in the fact that the Cronbach's alpha is acceptable even though there are only three items in the scale. Overall, the results support that the items assessing knowledge of resources can be combined into a single underlying scale to assess participants' overall knowledge of resources, both pre- and post-REACH.

Perceptions of the Facilitator

After completing the REACH session, participants answered four statements assessing their perceptions of the facilitator:

- The REACH facilitator encouraged the audience members to participate.
- The REACH facilitator was not enthusiastic when delivering the training (reversed).
- The REACH facilitator was passionate about the importance of reaching out for help.
- The REACH facilitator clearly explained the information on the slides.

A CFA conducted on these items revealed excellent fit on all indices, suggesting that a single factor of perceptions of the facilitator represents the items well. Cronbach's alpha of .77 furthermore suggests that the scale is reliable.

Utility of the REACH Session

Participants also responded to statements regarding their perceptions of the utility of the session. A review of the fit indices for this four-item model shows that the RMSEA

and the CFI both indicate mediocre to poor fit. A review of factor loadings and correlations for each of the items does not reveal any specific item that might be removed to improve model fit, and this is further confirmed by the fairly high Cronbach's alpha. Thus, if these items were combined into a single scale, the results should be interpreted somewhat cautiously because the score might be invalid or unreliable.

INTERPRETATION OF COVARIATES AND INTERACTION TERMS

Several of the models found significant associations between the covariates and the impact of REACH. Researchers interpret these tests here for clarity. Throughout, statistically significant associations between years of Service and dependent outcomes indicate that an increase in the number of years of Service is associated with a decrease in perception of barriers and an increase in comfort with help seeking or knowledge of resources. That is, individuals with more years of military Service reported lower perceptions of barriers, higher comfort with help seeking, and greater knowledge of resources than individuals with fewer years in Service. The interpretation is similar for any significant associations between perceptions of the facilitator and the outcomes. More positive perceptions of the facilitator were associated with lower perceptions of barriers, greater comfort with help seeking, and greater knowledge of resources.

The models also show some significant associations with gender and dependent outcomes (i.e., perceptions of barriers, comfort with help seeking, and knowledge of resources). Examination of the marginal means for gender reveal that women reported somewhat higher perceptions of barriers than men, but somewhat greater knowledge of resources and greater comfort with help seeking. Note, however, that gender was assessed here using three categories (male, female, and other/prefer not to say); thus, without further post hoc testing, researchers cannot conclude that any of these differences are significant. Because this analysis was not the focus of the results here, post hoc testing was not conducted.

Finally, the model associated with the barrier of "loss of privacy" had a significant interaction between the perceptions of the facilitator and the REACH session ($F(1) = 3.91$, $p = 0.049$). Examining the descriptive statistics, this interaction indicated that participants who had a more positive perception of the facilitator showed a greater decline in their concerns about loss of privacy than participants who had somewhat less positive perceptions of the facilitator. However, note that all participants reported very positive perceptions of the facilitator (with a median score of 4.5 on a 5-point Likert scale). Thus, this interaction should be interpreted cautiously because it could be reasonably interpreted as showing a differential impact of REACH on people who perceive the facilitator as positively as possible compared to people who perceived them only very positively.

Again, because these significant interactions were not the primary focus of the REACH field test, researchers did not interpret them in the Results section. Interpretation, instead, focused only on the impact of the REACH session on key dependent outcomes.