Building Blocks of Integrated Prevention: How Data Informs Efforts
Transcript: Army Resilience Directorate September Webinar

September 28, 2022

Presenters: Ms. Renee Johnson and Ms. Latoya Johnson, Integrated Prevention Advisory Group

Lytaria Walker 00:00

Welcome to the Army Resilience Directorate Outreach Webinar for September. At this time, all participants are in listen-only mode. However, you may ask questions at any time by placing them in the chat box. There will be several opportunities for questions throughout the webinar, and we should have some time at the very end as well. Today's webinar has been approved for one hour of live continuing education units (CEU). Please note the views of ARD's outreach webinar presenters are their own and are not endorsed by the Department of the Army or the Department of Defense.

Lytaria Walker 00:43

This month our guests are Ms. Renee Johnson and Ms. Latoya Johnson. Ms. Renee Johnson currently serves as the G1 Army Resilience Directorate, Integrated Prevention Division Deputy Director. Ms. Johnson's priorities are to ensure public health approaches to harmful behaviors are available for senior and unit commanders to enhance the readiness of Soldiers, civilians, and their Families. Ms. Johnson earned a Bachelor of Arts in English from the University of Georgia System, West Georgia. She has completed multiple public health certificate programs and a number of strategic courses with the United States Army. Ms. Johnson has nearly three decades of professional public health experience. She's an Army wife and has one daughter.

Lytaria Walker 1:42

Ms. Latoya Johnson currently serves as the Prevention Evaluation Specialist within the headquarters department of the Army G1 Army Resilience Directorate, Integrated Prevention Division. In this role Ms. Johnson assists in building the Department of Defense's Integrated Prevention Advisory Group, also known as I- PAG, by assessing integrated prevention capabilities for the Active Army Guard United States Army Reserve components, civilian employees, Family members, and contract personnel worldwide. Ms. Johnson holds a Master of Public Health with a concentration in community Health and prevention from Drexel University and a Bachelor of Science in Biology from Virginia Commonwealth University. Ms. Johnson is also credentialed as a master certified Health Education Specialist by the National Commission

for Health Education. Ms. Johnson has over a decade of professional public health experience. Ms. Renee Johnson and Ms. Latoya Johnson, thank you for joining us this morning. Please take it away.

Latoya Johnson 03:06

Thank you for that introduction, Ms. Walker. I'm Latoya, and this is Renee, and we are excited to be here to do this webinar today. I do want to provide this disclaimer upfront. I have a qualitative background, which means, I strongly believe in elevating the voice of the Soldier, so I will be sharing some focus group quotes during this presentation to really try to convey what we've heard in the field. The purpose of today's webinar is to describe some of the lessons that we've learned over the past decade related to harmful behaviors and to also provide an overview of the Army's new prevention workforce which is called the Integrated Prevention Advisory Group, or I-PAG for short. Renee and I hope that by the end of this presentation we all have a better understanding of how data will be used to inform prevention activities and also how the I-PAG is going to integrate with existing prevention assets across the enterprise.

Latoya Johnson 04:44

I want to open the discussion with the Secretary of the Army's priority. You can see here she has laid out six objectives that we are to prioritize. I will not read all six of them, but I do want to highlight that three of the six are directly related to data and prevention. With this second objective, the Secretary of the Army wants us to become more data-centric and data informed in order to embrace emerging technologies and to also defend against cyber threats. This concept is also going to be applied to prevention efforts as it relates to using data to inform prevention activities. Those activities could be policies, programs, or practices. Objectives four and five are about building positive command climates and reducing harmful behaviors. These objectives go hand in hand with prevention, as we are striving to stop sexual assault, sexual harassment, retaliation, suicide, domestic abuse, child abuse, and discrimination from ever occurring in our Army. Under the Secretary of the Army's guidance, we are poised to shift from being a response-based organization to being more prevention focused.

Latoya Johnson 06:22

How many people have heard of behavioral health epidemiological consultations or "EPICONs" for short? We have a few people, great. For those that are part of them and are familiar with them, this will be a refresher, and for those that are not familiar with EPICONs, this will be a very high-level overview of an EPICON. The Army Public Health Center—it should say the DHA public health center—has a division called the Behavior on Social Health Outcomes Practice, and this division conducts EPICONs. EPICONs are essentially a holistic public health assessment, and so EPICONs are resources for commanders to use if

they perceive there to be an increase in preventable deaths, like suicides, or an increase in adverse behavioral or social health outcomes. These are a resource for commanders to use, and the primary purpose of an EPICON is to identify those risk factors, things that are thought to be contributing to whatever adverse outcome is happening. We want to identify the risk factors and examine the rates and trends associated with these outcomes.

Latoya Johnson 08:20

BSHOP Chas done this. This group is done this work for over 10 years now, and during that time period they conducted over 30 EPICONs. All of that data was summarized into this report that came out in April of last year. Shameless plug here. If you haven't had a chance to read the report, a decade of behavioral health epic content lessons learned, there's a link to it on the slides. There's also a link posted in the chat that will take you to our milSuite page, where you can find a copy of the report. But overall, the data that went into creating this report included focus groups and interviews with over 5,000 leaders, service members, medical providers, chaplains, etc. There were over 44,000 surveys analyzed, and over 250 index cases reviewed. Again, all of that data went into creating this report. In the end we found that for the suicide related EPICON, the findings fell into three areas: social health, behavioral health, and the organizational environment. Again, I'll say that these were suicide-related at the EPICONs, but suicide isn't the only catalyst or an EPICON. They can be done for homicide, mass casualty events, sexual assault, sexual harassment, quality of life, issues, etc. These are these findings are going to focus on the suicide related EPICONs.

Latoya Johnson 10:06

We will start with social health. Social health really can be defined as a person's ability to form healthy and meaningful relationships with others. We do know from the literature that multiple things can impact a person's social health, like communication, your living conditions, sleeping habits, etc. As we summarized the data from these 30-plus EPICONs, we saw the same things that the literature says in relation to social health. The first thing was communication. We saw a lack of engaged communication up and down the chain of command directly affected mission readiness and work-life balance. This has been a persistent problem across all echelons. We found that the breakdown in communication is most prevalent at the lower echelons. The second thing we saw was that service members frequently endorsed poor sleep quality, limited access to affordable and nutritious food options, and limited access to exercise facilities. Additionally, we saw that in some locations, recreational resources, such as childcare and other community activities were severely limited in some of these locations. When it comes to social health resources, they generally reported positive experiences with resources like the chaplains or the MFLCs,

the military Family and life consultants. Soldiers really enjoyed engaging with these resources and had positive experiences. However, these resources were often underutilized, due to the lack of knowledge or lack of awareness that these resources existed. We have to continue to promote these resources.

Latoya Johnson 12:11

The next thing we saw was related to the living conditions. We probably have all heard this over the years, but there are a lot of frustrations with the aging infrastructure as it relates to the barracks, the aging infrastructure, building maintenance, vandalism, overcrowding, and mold issues. These things continue to be sources of frustration, and another thing I'll mention that's not on here is relationship problems. We know that relationship problems are one of the most common stressors reported by service members. When you take into consideration the lack of quality time with family, poor work-life, balance, and physical separation from support systems, these things further contribute to relationship problems. And so, as I said earlier, I do believe in elevating the voice of Soldiers and I want to share some focus group quotes as it relates to social health. This first one is regarding the barracks from a senior NCO. And it reads: "My barracks are not in good condition. One third of my personnel that live in the barracks don't have hot water. The washer and dryer are not so good. We put a work order in on it, and the work order does not come in until three or four months out."

Latoya Johnson 13:45

This next quote is from a junior NCO, and it is related to the sponsorship program. It reads: "I spent months trying to get in contact with my sponsor, and it kind of made coming here so much worse because I had no help, no insight, no phone number. I had absolutely nothing." And then this last quote is from a senior and CEO. It relates to communication, and it reads: "Technology gives the illusion that you can shift everything on the fly, but what's happening is everything comes crumbling down and nothing gets done to the standard it's supposed to get done." These things are all some examples of how your social health can be impacted. And again, if anyone has experienced some of the same things, or have heard some of the same concerns, or has recommendations for how to handle these situations, please go free to share them in the chat.

Latoya Johnson 14:50

When it comes to the behavioral health findings, there were four major topics highlighted in the data. The first is a good news story, and that is that behavioral health stigma appears to have decreased over the last decade. However, service members do continue to report fears associated with seeking care. So, stigma is still here. It's still around and we definitely still hear "I'm not going to behavioral health. It's going to ruin my career." "I don't want to look weak," etc., etc. But on the flip side of that we've also seen

how leaders who have sought care share their experiences with their Soldiers, this seems to empower Soldiers to go and seek help for themselves. So anytime there's an opportunity for a leader to share their experience, and for a Soldier to see that if a leader went and sought behavioral health care that didn't have negative impacts on their career, those things are always helpful in reducing the stigma. The second thing we saw relates to sleep. Sleep issues have been a problem: both the quality and the amount of sleep that service members get. The important thing here was that nearly half of the service members who died by suicide had documented sleep problems in their medical records. Sleep hygiene is very important.

Latoya Johnson 16:33

The next thing we saw was alcohol issues this—and this should come as no surprise to anyone—it continues to be a problem across the Army. It's ingrained in Army culture. Lastly, we saw that the behavioral health resources continue to be understaffed, and overworked, which ultimately impact access and availability. I just want to share a few focus group quotes. This first one is from a junior NCO as it relates to trust, and it reads: "If my First Sergeant doesn't physically see people struggling, then he doesn't believe it. It's frustrating because he doesn't trust his junior leaders' judgments."

This next quote relates to leadership support and burnout from a senior NCO. It reads: "I try to come in and lead by example and be that face of motivation, but over time I come in, and I'm just like forget it. I'm beat down from the day before." The next quote is from a junior enlisted Soldier, which reads: "Since I came here, I drink a lot more than I used to that's how bad it is here, I think our battalion leads the division in DUI's, drugs, and STDs." So those are just some of the examples of some things that Soldiers have reported and have affected their behavioral health.

Latoya Johnson 18:15

Lastly, the organizational environment. These findings tend to fall into three buckets. The first one being ops tempo, specifically training in ops tempo. But we saw that it's the same high ops tempo inevitably took a toll on the overall behavior on social health of service members. When you add in things like unpredictable schedule, poor time management, and limited manpower, all of this impacts mission readiness. With engaged leadership, I can't stress this enough. Soldiers really, really value engaged leadership. They feel like engaged leaders and engaged leadership leads to effective mentorship and that effective mentorship occurred when leaders expressed an interest in both their professional and personal lives. I know leaders for sure, all of us are limited on time. But if you have 5 minutes to ask your Soldier, "How are you doing? How is your day? How is your weekend?" Something really not related to work. Soldiers really value that.

Latoya Johnson 19:45

Lastly with the cohesion and morale, we saw that service members who report greater unit cohesion prior to the deployment are less likely to report suicidal ideation 3- and 9-months post deployment. overall. We know that a variety of factors influence service members' perceptions of unit cohesion and morale, but in general, across the board, Soldiers reported that once that cohesion morale is diminished, it's really challenging to rebuild.

Latoya Johnson 20:17

Again, I will read some quotes from both group participants that relate to organizational stressors. All of these are going to come from Junior NCOs. This first one reads: "Last week the shortest workday I had was 13-and-a-half hours. The longest was 16-and-a-half hours. I will never catch up."

The next one is related to planning, and it reads. "Certain things that have happened could have easily been avoided had someone had the foresight to either plan for it, or at least sit down and think about it long enough, (like 3 seconds) because a lot of stuff that happens for us is reactionary."

This last quote reads: "People come here to retire, and they just stop caring, and if that's happening at the highest levels, then obviously at the lowest levels, people don't feel cared about." So again, these are just some of the things we've heard over the years and some things that we all may have experience in our own respective work environment.

Latoya Johnson 21:37

Switching gears a little bit, we're going to talk about the social-ecological model (SEM) for a few minutes. The social-ecological model is a CDC prevention framework that is used to stop violence, prevent violence, and in our case, harmful behaviors before they occur. Now, I speak about the SEM in general terms, and then in a military context. The SEM generally consists of four different levels. We have the individual level with the Soldier, and then we have the relationship level (the yellow ring), then we have the community level, and the society level. The overlay of the circles is meant to show how factors at one level influence factors at another level, and this in turn supports the notion that effective prevention really requires simultaneous action across multiple levels in order to sustain the prevention efforts over time and achieve the population-level impact that we are looking for. This slide is meant to depict the social-ecological model in a military context. I'm going to walk through each level and describe that in in the military contact, so we can start with the individual or the Soldier level right there at the bottom. At the individual level, you have the Soldier. You have their genetic makeup, their biological factors, their personal history, and their lived experiences that they carry with them. So, all of these factors, they can either increase or decrease your likelihood of becoming a victim or a perpetrator of violence. Some of

those individual-level factors include your age, your income, your education, level, etc. And so prevention strategies at this individual Soldier level should promote attitudes, beliefs, and practices that prevent harmful behaviors and specific strategies may include trainings related to things like conflict resolution, life skills, healthy relationships, or emotional intelligence.

Latoya Johnson 25:31

Now, at the next level, the relationship level, and we're looking at those proximal relationships that the Soldier has, that may or may not increase the likelihood of then becoming a victim or perpetrator of violence. So, at this level it would include people like your family, your friends, your peers, anyone that really has day-to-day routine, consistent, bi-directional interactions with the Soldier. An important thing to note here is that at this level, the relationship level, there is the most influence on behavior because of those routine day-to-day interactions with the Soldier. Prevention strategies at this level may include parenting or family focus prevention programs or mentoring programs or activities that can promote positive peer norms. Now, since we're talking about the model in a military context, the next ring is what we would consider an extension of the relationship level, and we'll call it the unit level. So, at this level it would include your unit, the leaders, and then the climate that they either create or operate in. So, the unit level is extremely important because it has an indirect influence on the Soldier and the other people in the relationship level, like the family and the friends. For example, if a Soldier has a bad day at work and gets into it with their immediate supervisor or a direct leader at work, the Soldier may bring residual, emotional, or physical effects home.

Latoya Johnson 27:39

Now, at the next level, the community level, the scope is broadened even more by including the settings in which the social relationships occur, as well as community organizations. So, examples would include the school, the workplace, but also programs like SHARP, suicide prevention, ASAP, community assets, Garrison community, or healthcare, etc. The thought here is to identify any characteristics of these settings or programs that may or may not be contributing to harmful behaviors and also community organizations. They influence the levels below them. So, at the community level they're influencing the unit level. The relationship level, and the individual Soldier through the resources that are offered at the community level. Prevention strategies at this level should focus on improving the physical and social environment in these settings, and then addressing other conditions that could be associated with harmful behaviors, such as financial readiness, discrimination, or substance misuse.

Latoya Johnson 29:15

Lastly, at the societal level—and this is the broadest level—we're looking at those broad societal factors that can either encourage or inhibit violence. So, we're looking at your societal norms and values. We're looking at the media, your norms, the societal norms and values, economy, Congress, media etc. We look at those larger global factors. Prevention efforts at this level can include initiatives to strengthen educational opportunities or employment opportunities. And we definitely want to promote social norms that protect against harmful behaviors And so overall, all of these things are indirectly connected and influence the levels below them. As I said earlier, because of these interconnections within the social-ecological model for primary prevention to work, you really want to have a comprehensive approach that includes prevention activities at each of these levels simultaneously.

Latoya Johnson 30:55

Now we're going to try to tie this all together. So, if we think back to some of the data that we talked about earlier, some of the focus group data, the social health and behavioral health organizational environment, we can see how one issue can impact multiple levels of this of this model. And so, if we want to look at a practical example, we could look at family housing for example. We can start with the individual Soldier at the individual level who, remember, has come into the Army with their biological genetic makeup and their lived experiences to date, and they get married. And now that we have a family, we're at the relationship level. They have a family, and now they live in dilapidated family housing. So now the housing situation is impacting the individual Soldier; it's impacting the family at the relationship level. If we look at our extended relationship level to include the unit level, now the Soldier is going to work, and it may impact work. If I get up and I have mold all in my bathroom, and I'm already upset about that. My heater doesn't work. It's cold, and now I have to go to work with an attitude, and I get into it with my coworkers etc. So, we're in influencing our impact at the unit level as well. So, if we consider the community level again, we're talking about housing. So, at the community level, we want to identify any housing characteristics or a program for this, maybe DPW. Any characteristics about that that may be contributing to or preventing harmful behaviors. And then, if we zoom out even further at the societal level, we may want to look at the economy or congressional policies related to housing. So again, just wanted to use a practical example to show how an issue can impact all layers of this social-ecological model.

Latoya Johnson 33:23

Now, to bring it all the way back to the beginning to the SEC Army's priorities and the need for data to inform prevention initiatives in an effort to reduce harmful behaviors to the data that we've talked about. It is just one form of specifically qualitative data that will be used to build out the prevention activities

implemented by the I-PAG. So other types of qualitative data may include interviews, observation notes, open ended survey responses, photos, etc. But that's not the only type of data that we're going to be incorporating. We're going to be looking at quantitative data, surveys, administrative data, medical claims, crime data, prevention research. All of these things will be incorporated when advising leaders on which prevention activities to implement And so, at this time I will turn it over to Renee to describe the I-PAG's purpose, responsibilities, current state, and the way forward.

Renee Johnson 34:29

Thank you so much, Latoya. That was fantastic and a great layout of how we can better leverage known data in the context of our Army body of work and translate some science to practice. I'm here with Latoya in the Taylor building in Crystal City. We're sending you a virtual warm welcome from the national capital region. So how do we get to here? I just want to give you a quick rundown of the background IRC recommendation. 2.1A directs that the Department of Defense will define the competencies that leaders must have to oversee prevention. 2.1B directs the services and the National Guard Bureau to develop and hold leaders appropriately accountable for prevention. 2.1C directs the services of the National Guard Bureau to equip all leaders to develop and deliver informed prevention messages, in formal and informal settings, 2.2B directs the DOD to establish a professional credential for this prevention workforce and 2.2C directs the services to determine the optimum full-time prevention workforce and equip all echelons of active duty, Reserve, and guard organizations. So, just also bear with me one more minute and I'll run down a couple of very big decision points that got us here, specifically to 2.2C.

Renee Johnson 36:12

On 6 June of this year the Under Secretary of the Army approved the prevention workforce model based on the foundational work of Dr. Aaron Watkins, Dr. Macintyre, myself, and many other teammates at Forces Command, Training and Doctrine Command, and Pacific Command. We took into account the OSD guidance and fielded a total Army survey of integrated prevention in the April timeframe and received over 5,000 survey responses. Major James Lunders on the SHARP team provided some significant contributions to the analyses of that data along with Dr. Watkins, Dr. McIntyre, and many others. On 27 June the Under Secretary of the Army directed the work that we put together, using this body of work, and directed rapid execution of workforce hiring actions and removal of the "pilot" verbiage naming convention, and that decision was based on May 22 funding from OSD, provided here to the Army for phase one of the workforce. So, in all of the OSD products you will see the naming convention of "Prevention Workforce."

Renee Johnson 37:47

However, on 7 July the Secretary of the Army provided us with her approval decision point, but she let us know that she does not like the naming convention of Prevention Workforce, and so she wanted us to develop an alternative naming convention. On 22 July the Under Secretary of the Army and the HQDAG1 approved standardized position descriptions and workforce recruitment actions, as well as publication of execution guidance. That guidance can be found in HPDA 269–22 titled "Implementations of the FY22 IRC Hiring Actions." A quick summary of that EXORD is that commands will prioritize hiring actions. We will do enduring manning analysis, which is a full manpower study across the space, across all commands and components and phase one selected locations for execution. Our Forces Command, Training and Doctrine Command, and Pacific Command. The HQDA will lead resource management. OSD is funding, and they have transferred the funding down to the resource manager here in G1 Army Resilience Directorate, and we are doing year of execution transfers to the commands. All the way up to the OSD level, using the abanda system, which is the reason we have those standardized position descriptions with special parentheticals that support this kind of accountability.

Renee Johnson 39:31

On 29 July, the Under Secretary of the Army directed technical oversight for this workforce and directed the naming convention of the Integrated Prevention Advisory Group, I-PAG and coordination with our commands at the ACOM ASDC entry level for near-term execution. Additionally, how does all this information relate? I want to do a quick summary of DoDI 6400.09 which directs the services to establish and integrate policies and responsibilities that mitigate self-directed harm, prohibit abusive and harmful acts using a career cycle perspective, and promote enduring force readiness. We've been directed to leverage existing capabilities to establish a prevention system that facilitates data-informed actions to integrate primary or upstream prevention activities that prevent self-directed harm and prohibited abusive or harmful acts.

Renee Johnson 40:41

This focuses our prevention efforts on research-based programs, policies, and practices, and that's what my teammate Latoya has just spent the last 30 minutes sharing with you here today. The bottom line is that this is a visualization of what the Integrated Prevention Advisory Group will do. These activities are taken from the DOD Prevention Plan of Action 2.0, 2022–2024, and that can be found on page six of the PPOA. If you haven't had a chance to take a look at that, we encourage you to do so, and it's also located on our milSuite page that Dr. Sean C. placed in the chat. The bottom line is that the I-PAG positions are being fielded currently at Fort Hood, Fort Riley, in FORSCOM, Fort Sill, in TRADOC, Camp Humphreys, and Schofield Barracks in the Pacific Theater and Korea. The positions include investigative analysts,

supervisory prevention specialists, prevention specialists, and prevention implementation specialists. Their purpose is to provide a dedicated full-time workforce to support the senior commander and commanders at echelon. As the community of practice works together to develop tailored and targeted activities, organizational approaches, and trainings based on the data. Our in-state is to partner with everyone who can hear our voices today to increase protective factors and decrease these harmful behaviors.

Renee Johnson 42:45

Another visualization of where phase one of four phases for the I-PAG will be going to. DOD directed the Army and all of the other services to utilize the DEOX data to create a hierarchical listing of risk. We did that, but we also took the data, together with the data that I mentioned previously, which included the 5,000 survey responses which assessed the Army's organizational readiness to hire and receptiveness to integrated upstream prevention capabilities. In our phase one fielding of the I-PAG we will be testing two scenarios. The scenario is that they're all embedded with the commanders, but one scenario is focused more on the senior commander level, and the other scenario is embedded at the brigade level. Our assessment evaluation is beginning now, starting 1 October. And if you are at these locations, you will likely receive a request to participate in a survey and/or a sensing session led by the Army Analytics Group Research Facilitation Lab in support of this assessment of our phase one effort.

Renee Johnson 44:22

This is another representation of what is in the primary prevention plan of action (PPOA 2.0), and this is the prevention system recognizing that at the local level the Secretary of the Army has directed us to maximize the forum of the commanding generals Ready and Resilient Council process, which is a strategic process that meets quarterly. That process should be fed by working groups that are meeting monthly or around that time frame where those working groups are focused on overlaying multiple sets of data, like my teammate Latoya just talked about. These come from across all of the harmful behaviors as well as the community or installation if you're in Compo 1; or if you're in Compo 2, State or Territory data; or if you're in Compo 3, organizational data that is driving the SEM for your Soldiers, Family members, and civilians. We also touched on the prevention activities. The data should be driving those tailored and targeted activities at the unit level and focused toward the first term Soldier and their Family members. This is a visualization here of our POAM. Dr. Watkins began this work back in the October time frame of last year, and this is a one slider. I know it's busy, but it represents a Herculean and a huge body of work that I just cannot tell you enough how much planning, analysis, and effort has gone into this to get us here today. This program is why we have those decision points given to us by the Under Secretary of the

Army and the Secretary of the Army to switch from planning a pilot to now rapidly executing phase one of the I-PAG.

Renee Johnson 46:39

We promised to dedicate some time to taking your questions today. I'm here with my teammate Latoya, and we're happy to take any questions from the chat.

Lytaria Walker 47:10

Thank you very much for the presentation. We do have three questions currently in the chat. The first question is, "How does this model integrate or address adverse childhood experiences, and will future integration integrate a trauma-informed approach?"

Renee Johnson 48:00

Thanks, Ms. Walker, that is a fantastic question. If you were with us at the Program Improvement Forum, this question also came up in that context. I'm going to start this off, and then Ms. Latoya is going to jump in with something. I know she'll come up with something really brilliant. We did have some good dialogue with our teammate, Dr. Melinda Key Roberts, at the PIF about the need to balance science and research, informing and driving this translation. What our first term Soldiers, come into the Army, and how those adverse childhood experiences may continue to impact them throughout their entire service and their career in the Army. The integrated prevention had not focused on one-on-one counseling services for Soldiers. They're not necessarily focused on any treatment, any type of clinical or non-clinical treatment. So, some individuals that experience adverse childhood experiences may need enduring, peer support, peer-to-peer support, counseling, and/or one-on-one therapy through the medical treatment facility. We recognize that, but what the I-PAG is really focused on doing is creating a culture and a climate inside the unit, in the organizational level where help-seeking behaviors are emphasized, normalized, applauded, and fully supported by engaged leaders. I hope that is helpful context. So, they're really focused on macro approaches in in this public health approach versus micro one-on-one approaches. I will pause right here and ask my teammate Latoya if she wants to weigh in or add on to anything I just shared.

Latoya Johnson 50:40

I think that was a great response. I agree with you. The I-PAG is not going to focus on providing clinical treatment or any of that, but more so providing educational opportunities, awareness, and trainings since the Soldier would be coming in already with those experiences. We are providing those universal prevention strategies that could hopefully either address that or ignite something if someone does have those experiences and they will take it a step further and seek additional, clinical treatment if they need that.

Renee Johnson 51:30

Thank you, Latoya. Okay, Ms. Walker, we're going to send the net back to you for another question.

Lytaria Walker 51:23

"Since data is a downstream effect, how do we plan to use it to get the upstream cause of the issues we are addressing?"

Renee Johnson 52:12

I will start it off and then I'll pass it to Miss Latoya, based on her experience with working with data, and we have several teammates on from the Integrated Prevention Division, specifically Dr. Katherine Schaughency, who is our data subject matter expert. We will use data in accordance with the Secretary of the Army's guidance and create evidence of delivery of using data to drive decisions. However, when we started this webinar off today, what Ms. Latoya Johnson took us through is a decade worth of data and what we are seeing is some variability shifts over time. For example, the average rank for Army suicides 10 years ago is not the same today as it was 10 years ago. We do see some shifts in the data. However, in this very robust Army body of work of public health, surveillance, and other data available to us, we want to look at prevalence, and short-term ups and downs in raw numbers of data. And so, I want to send it over to my battle buddy and teammate here, Latoya to finish off what I what I've just said.

Latoya Jonson 54:00

I disagree with the statement that data is downstream. I don't necessarily think that's true. With the data what we've seen, at least with this data, over the last 10 years is that the risk factors haven't really changed, and we haven't really been using the data to inform our prevention efforts. Now we're finally doing that, and so we should see different outcomes now that these initiatives will be informed from the data.

Renee Johnson 54:54

That was fantastic, and to that end we will be working with the I-PAGs so that they utilize data to drive their organizational needs and assessments which is a deliverable which will all be collated together to produce the community needs assessment, which will also be a deliverable for the Integrated Prevention Advisory Group workforce. That's something that we must show evidence of delivery all the way up to OSD on, and we have some language about that in our in our working draft of our implementation guide. There's also some good language about using data to put together those community needs assessments in the IEP guide, which is also on our milSuite page.

Lytaria Walker 55:50

Okay, looks like we have time for maybe one more question: How will this model support the Army Reserve component?

Renee Johnson 56:04

That is tough. I think I've set it at the PIF, and I'll say it again here today. We recognize that for integrated prevention, one size does not fit all. What we see as a feasible and realistic for Compo1, where we have the luxury of a garrison, and most times a military treatment facility to plug into and robust installation services, we find that for our teammates in the Guard and Compo 2, and in the Reserve, they don't necessarily have the same option to plug into helping agencies, programs, and services. By the way, it gets even trickier when your drill days are weekends, and after hours, and many of our Reserve leaders, cadre, and Soldiers are doing this out of the goodness of their heart and love for the Army in addition to another full-time job. It's complex, and so bottom line, we recognize there must be some adaptability, scalability, and variability for the Reserve. However, initially, we're working with two leaders to design phase one of the implementation for the Reserve. One is at the OCAR level; the other is at USARC headquarters. Also we recognize that USARC is a direct report to FORSCOM headquarters. We will provide flexibility in the evidence of delivery deliverables for our Reserve I-PAG teammates and build in some adaptability. The Reserve is initiating about 10 hiring actions here in the next 30 days to begin to provide a capability, even if it's regionally aligned at the beginning to be scaled accordingly at the Reserve posts, camps, and stations. My spouse happens to be a commander with the Reserve, and he has many units that are spread across the great State of North Carolina. One of those units is lucky enough to be at Fort Bragg, so they can plug into some things at Fort Bragg. It's great for them to get medical care taking care of and your yearly PHA. However, another one of his units happens to be in the mountains of North Carolina, and that's a two-and-a-half-hour drive away from Fort Bragg, so they can't necessarily tap into something that's available from 8 in the morning until 5 o'clock at night because they're drilling after hours, or they're drilling on weekends when those helping agencies, programs, and services may not be open. We recognize it's even more complex for our Compo 2 and 3 teammates, and we're fully committed to working collaboratively with you all to establish implementation guidance and feasible scalable models.

Willie Williams 59:05

Ma'am, this is Willie Williams, the Director of Service and Support at USARC that is in charge of prevention and workforce. We will finish our hiring in the next couple of weeks of our 10 individuals, and we're getting that scaling down, for the Reserve. The Reserve population will be represented well, and we will have a prevention workforce that is not only an effective but very efficient for our force.

Renee Johnson 59:32

Thanks, Mr. Williams. I'm so glad you were on today and able to chime in on that we're looking forward to this phase one of your positions. We absolutely look forward to working with you on expanding this in the future. Thanks again.

Willie Williams 59:48

I got 7 of the 10 EODs right now.

Renee Johnson 59:53

That's the best news we've heard all morning. Thank you.

Lytaria Walker 59:59

Thank you. Unfortunately, we've run out of time, and we will need to conclude this morning's webinar. I want to extend a gracious thank you to Miss Renee Johnson Miss Latoya Johnson and the entire I-PAG team for taking the time today to provide this great presentation for us. Thank you, participants for joining today's webinar as well. If you've like to receive invitations for ARD's webinars and receive the latest news and information from the Army Resilience Directorate, please go to ARD's website at armyresilience.army.mil and sign up for notifications. Thank you for joining us. Thanks again to our presenters and the entire I-PAG team. Have a wonderful rest of your day.