I-PAG: Context, Guidance, and Implementation

Transcript: U.S. Army Resilience Directorate Outreach Webinar

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Presenter:
Sarah Sullivan, M.S.

Lytaria Walker:	00:00:51	Welcome to the Army Resilience Directorate Outreach Webinar for March. At this time, all participants are in listen-only mode. However, you may ask questions at any time by placing them in the Q&A box. There will be several opportunities for questions throughout the webinar, and we should have some time at the very end as well. Please note: the views of ARD Outreach Webinar presenters are their very own and are not endorsed by the Department of the Army or the Department of Defense. This month our guest is Ms. Sarah Sullivan, M.S. Ms. Sarah Sullivan is a Prevention Integrator for the United States Army Resilience Directorate's Integrated Prevention Division, where she focuses on the prevention of sexual violence. She advises on projects aimed at evaluating prevention activities in the military and in building the capacity for prevention of harmful behaviors. Ms. Sullivan is D-SAACP-certified, an applied suicide intervention skills credentialled trainer, a registered mediator, and a Green Dot trainer, and has provided crisis advocacy services to child and adult trauma survivors for 15-plus years.
Lytaria Walker:	00:02:10	Additionally, she is a United States Air Force veteran and proudly served as a Cryptologic Language Analyst from 2010 to 2015. Ms. Sullivan began her career by responding to those directly impacted by intimate partner violence and sexual violence at the Sexual Assault Response Network of Central Ohio, at the Rape Crisis and Sexual Assault Services in Augusta, Georgia, and as the Fort McCoy Sexual Harassment and Assault Response and Prevention Garrison Victim Advocate. The time working in the response field as a Survivor Advocate drove her passion for wanting to get ahead of the issue of sexual violence and focus on ways to prevent the outcome of sexual harassment, sexual assault, and suicide. She has since dedicated her life to preventing sexual violence in the military and the civilian community through her time as a Sexual Assault Response Coordinator, and now as a Prevention Integrator focused on identifying shared risk and protective factors within the United States Army. Ms. Sullivan, thank you for joining us this afternoon. Take it away, ma'am.

Sarah Sullivan,...:	00:03:27	Thank you so much. Good afternoon all, or good morning or good evening because we have folks from all over the place. Good day to you all. I am very excited to be here. As was stated, my name is Sarah Sullivan, and I have the privilege today to talk to you all about the I-PAG, which stands for Integrated Prevention Advisory Group. I'll give you a little bit of context. We're going to talk about some of the guidance that got us to where we are and how the Army is implementing this new workforce.
Sarah Sullivan:	00:04:06	As was stated, anything that I mention today as a non-federal entity shouldn't be interpreted as federal endorsement of that entity or their products, and that the views expressed here are mine and not the official policy of the US Government Department of Defense or the Department of the Army. Some of our objectives today are to take away an understanding of the I-PAG at the installation level, specifically the roles and responsibilities of the I-PAG, expectations for collaborating with the Prevention Program Specialists, how the I-PAG integrates with the CR2C, how the I-PAG supports leaders, and how the I-PAG works together to execute the prevention process and to meet those key milestones.
Sarah Sullivan:	00:05:01	Really, my goal for the session is to help you understand where the I-PAG is coming from, help you understand the guidance that's provided for the I-PAG, and also how the I-PAG fits within the Army and its structure. As I stated before, maybe some folks are just joining, I-PAG stands for Integrated Prevention Advisory Group. Many of you may have read the DoDI 6400.11 and other DoD materials. You might see the acronym "IPPW," which stands for Integrated Primary Prevention Workforce. The Army has adopted the term I-PAG for its workforce. So if you see IPPW, go ahead and equate that in your mind to the Army's I-PAG. Additionally, for a little bit of information upfront, I'd like to start by explaining a little bit how the Army is rolling out the I-PAG.
Sarah Sullivan:	00:06:00	The Army's rolling out the I-PAG in a phased approach, meaning that we are hiring in different phases. So the hiring of our I-PAG actually started this past summer, and there were five locations identified within the first phase. Currently we have I-PAG staff at Fort Sill, Fort Hood, Fort Riley, Schofield Barracks, and Camp Humphreys. We will not reach full operating capacity until FY2027, so this is going to be something that is implemented over the course of several years. Additionally, the Reserve and the National Guard have also begun hiring their I-PAG or IPPW personnel. I wanted to state that upfront just so you have an idea about how this workforce is rolling out. In case you're

wondering, “Well, I’m not seeing I-PAG yet on the ground.” If you’re not located at those locations, you won’t see them quite yet. Our phase two is being looked at, and once it’s approved, then we’ll open up that information for the next phase and where our I-PAG will be located.

Sarah Sullivan: 00:07:17 I’d like to start by discussing the primary prevention framework. I recognize that many of you have been around since all of this has begun rolling out. I want to break it down because these documents that we’re going to be talking about really are essential in understanding the role of the I-PAG. I saw quite a few names on the participant list that I recognized, so hello all. Thank you for all being here. I’d like to start by talking about the PPOA 2.0. This is a guiding document for the I-PAG and is our implementation roadmap.

Sarah Sullivan: 00:07:57 Many of you may remember when it was published last May, May of 2022. It is an important document because it replaces some information in the PPOA 1.0. If you all have been around for a minute, you might remember when the PPOA initially came out, and then this PPOA 2.0 replaced some of those objectives and also updated those objectives with the Independent Review Commission, or the IRC recommendations. As many of you are aware, the IRC was an impartial and independent assessment of sexual assault and sexual harassment in the military that was directed by the president. The recommendations were published in 2021. One of those recommendations was 2.2C, which is what brought about our full-time prevention workforce. And that brings us back to the PPOA 2.0.

Sarah Sullivan: 00:09:02 I want to point out a couple important things specifically about this document. Unlike the PPOA 1.0 that was focused solely on sexual violence, sexual assault, and sexual harassment, the PPOA 2.0 actually broadens that. It doesn’t only include sexual assault or intimate partner violence or suicide behaviors, but instead it’s focused on two or more harmful behaviors. Those are laid out in the document, and I’ve gone ahead and listed those on the screen for you as well. When we say harmful behaviors, what do we mean by that? What we mean is self-directed harm and prohibited abuse and harm, which includes sexual assault, harassment, retaliation, suicide, domestic abuse, and child abuse.

Sarah Sullivan: 00:09:57 The second thing about this document to note is that it’s focused on primary prevention. A lot of times we’ll say “prevention.” When we talk about prevention, there’s a spectrum there. This is specifically talking about primary

prevention. Preventing harm before it ever occurs, a very upstream approach. I want to give a description, along that prevention spectrum as we also talk about things like secondary or tertiary prevention. For my SHARP folks out there, an example of secondary prevention might be, like many of you have taught, bystander intervention or how to be an upstander. You might use a scenario, something along the lines of, you see someone doing some gray zone behaviors. Maybe excessive flirting, and the other person doesn't seem like they're very interested in that. Or you might see some more blatant behaviors, maybe sexual harassment occurring, or potential for stalking.

Sarah Sullivan: 00:11:02 Or maybe you're at a party or a bar and you see someone else feeding someone alcohol, and you might be concerned that that could lead to a sexual assault. We teach bystander intervention and we talk about how there's different ways to intervene in that situation in order to prevent it from escalating further into things like sexual assault. That would be an example of that secondary prevention. When we talk about tertiary prevention, that might look like when a sexual assault has occurred and we want to be there as victim advocates or SARCs in order to assist that person to know their rights or help them seek justice, whether that's through the criminal justice system or however they define justice for them. Also providing them resources and healthy coping mechanisms in order to start that recovery process from that trauma.

Sarah Sullivan: 00:12:05 We do that for several different reasons. Some of those reasons include that we want to help prevent further harm. Instead of maybe turning to various substances in order to deal with that type of trauma or having thoughts of suicide or other types of suicide behaviors, that's tertiary prevention. The PPOA 2.0 is focused on that primary prevention, much farther upstream, and we're going to talk about that more in just a little bit. So when we talk about or we look into the PPOA, we notice that it uses a lot of terms that at first may seem extremely intuitive at first glance, but really have some significant meaning for the I-PAG. I want to break these down over the next few slides, and we're going to start with that top left term.

Sarah Sullivan: 00:13:07 When we talk about "comprehensive" as it's used in the PPOA, this refers to the idea that risk and protective factors can exist at different levels. We can view this using the Social Ecological Model, or the SEM. I know many of you probably have seen either this exact same image or maybe something similar that represents the Social Ecological Model. In this model, as you can see, we have these different layers of risk and protective factors

that can influence if someone engages in a harmful behavior. That can occur at the individual level, the relationship level, and in the Army, we specifically have a couple additional levels added onto that: the unit level or installation level.

Sarah Sullivan: 00:14:03 So what we mean by a comprehensive approach is that we're not just looking at one of those levels. We're looking at all the levels at once in order to build this combined approach. Let me give you a further breakdown of that. For my ASAP folks that are out there, let me give an example of preventing suicide behaviors. What does that look like when we talk about prevention? Well, at that individual Soldier level, we might provide that annual training. That's something that we're already doing. But we can't stop there when we want to talk about this comprehensive approach. We need to add those other layers into it as well. So we might work with Families in order to build those social supports. We might even do things like teach healthy relationship skills or financial skills, or even resiliency skills.

Sarah Sullivan: 00:15:06 In addition to that, at the community level, we might go out into the community in order to find ways to reduce access to lethal means. By taking all of these multiple approaches to get after the harmful behavior, then we are looking at it comprehensively. The next term that I want to talk about is "integrated." I mentioned that earlier, and this is going to be one of those really key terms. When we say "integrated" in regard to the PPOA 2.0, we're talking about addressing two or more harmful behaviors at the same time. So even though we recognize that each of these harmful behaviors is distinct and they have siloed programs for them, we also need to recognize that they share a common set of underlying risk and protective factors. Let me ask you, in the chat box, what are some risk or protective factors for any of the harmful behaviors that we mentioned in the first slide? What are some risk or protective factors that you all can think of?

Sarah Sullivan: 00:16:16 Connectedness, Family support, ACEs (Adverse Childhood Effects). Okay, what else? Unit cohesion, awareness, education. What are some risk and protective factors? Healthy relationships, behavioral health. What else? Okay, someone mentioned acceptance of violence, those social norms or beliefs. So you all are spot on, and when you're naming these risk and protective factors, some of those things may be specific to a certain harmful behavior, but then some may also have these shared factors that could contribute to harmful behavior. We heard many of those that you all mentioned. Maybe some protective ones might be having positive social normal beliefs or

problem-solving skills. Someone mentioned connectedness. Other risk factors could be things like poor social skills or social isolation or aggressive behavior. When we address those factors, they have a wider-reaching effect. Essentially, we're getting more bang for our buck when we're addressing those risk factors for shared harmful behaviors.

Sarah Sullivan: 00:18:13 The next one that I want to talk about is "climate-focused." I know from coming from the SHARP world, we talk a lot about this. We need to be climate-focused. We need to create these healthy environments, and that really has to be fostered by leadership. Because when we talk about the climate, they're breeding grounds, whether that's for healthy behaviors or non-healthy behaviors. I like to think of it in terms of a garden. Let me ask, does anybody like to garden? Do I have any gardeners out there?

Sarah Sullivan: 00:18:53 I was going to say, "I have no gardeners? Oh goodness." We've got quite a few. Well, you all are better than me because I kill just about anything I try to plant. I could probably kill some of those fake plants that people have given me. However, I do love to admire other people's gardens. When I think about climate, I oftentimes think there's some plants that can grow just about anywhere. You could go out, you could spread some seeds around and leave it, and there's something that might grow. But when we start to plant a garden and we want to grow certain things, we want to make sure that the environment for that is right. So we might make sure that the soil is fertile. We might want to make sure that it has the right acidity levels or pH levels, depending on what you're trying to grow.

Sarah Sullivan: 00:19:43 You want to make sure that you're watering it and getting the right amount of water, not too much, not too little, so that whatever you're trying to grow can grow successfully. But you also have to be consistent. If I go out in the beginning of June, and I water my tomato plant, and I say, "Well, I'm good. I don't have to do that anymore. I did it that one time, so I'm good to go." Well, if I'm not making sure that it's getting water consistently, what if we're in the middle of a drought? What's going to happen to those tomatoes? They might grow. I might get these little shriveled up tiny little tomatoes that are not edible. But if I'm taking care and tending that garden, hopefully the outcome of that is going to be some big juicy tomatoes, so I can make my BLT sandwiches, or in my case, pesto, mozzarella, and tomato sandwiches. Sorry if it's lunchtime and I just made you hungry.

Sarah Sullivan: 00:20:41 The same thing is true when we're talking about our climate for prevention. We have to have those healthy climates in order for our prevention work to be effective. Because if we're implementing these prevention activities that we'll talk about, and we don't have a healthy climate, then we shouldn't expect to get the outcomes that we want to get. So that's really key to this. One of the other terms that I want to talk about is being "data-driven." I'll be honest with you, "data" feels a little bit like a buzzword right now. I feel like people will say data and we're like, "Yeah, data. We just need more data. We need all the data."

Sarah Sullivan: 00:21:22 Which is true, we do need data. We need data to make informed decisions, but we also want to make sure that we're applying those public health principles for the data, in order to make those data informed decisions. We want to make sure that we're collecting the right data, and we need to think about what data we do have and what data we need to collect. There are some really great public health examples and lots of examples from other fields where this can be the case. I'm an example person, I like to think in examples. So if that's helpful for you, then hopefully this will be really helpful. There is a really great, it's used in several things, and you may have heard this before, but during World War II, there were these planes that kept going out, and many didn't come back.

Sarah Sullivan: 00:22:23 The ones that did come back, they would look at, and they would look at all the bullet holes in the plane. The first inclination was simply to cover and reinforce where the bullet holes were because that's the data we have. We know where the bullet holes are from the planes that are coming back. And there was a person that said, "Hey, you're looking at this wrong. We need to be thinking about the planes that didn't come back, and reinforcing the places in the plane that don't have bullet holes." Why is that? Why do you think that was? Why do you think you need to look at that instead? What do you all think? Because that's what took the plane down. The ones that didn't make it back. So the holes broke through those planes.

Sarah Sullivan: 00:23:23 The ones that weren't coming back must have hit something critical. The ones that were making it back were the ones that didn't have something critical hit or were able to survive it because of one thing or another. We need to be thinking about the data that we don't have as much as we do about the ones that we do have. Additionally, in order to do that, we also need to be thinking and we need to know how to understand the data and how to use it appropriately and objectively. We need to communicate it accurately and effectively as well. Because if

we have data but we're not effectively or accurately communicating it, then that's not going to do us any good either. So we really do need to be data-driven and making sure we're making these informed decisions.

Sarah Sullivan: 00:24:14 Another term that we need to discuss is "research-based." What we mean by "research-based" is using the most appropriate research available as a strong scientific basis for selecting prevention activities or stopping prevention activities. When we talk about prevention activities, we're talking about programs, policies, and practices. There's a lot of really great research out there that's credible, that's been peer-reviewed, and that can tell us a lot about preventing violence. If you're unfamiliar or haven't seen the CDC technical violence packages, they're a really great place to start. They've consolidated some of those things for us. Those are for single harmful behaviors. They're coming out with some integrated ones as well, I should note, it's just not published yet.

Sarah Sullivan: 00:25:13 We need to be looking at the research that's available and thinking about, "Okay, this happens in the community." We're talking about there are some shared risk and protective factors. How does that apply to the military? Is it the same? Well, we can start with that basis and making sure that we have a strong scientific basis in those prevention activities that we're implementing, that we're putting into place. From that, we might learn that there's additional shared risk or protective factors for the military population specifically. We also need to think about and look at what we're currently doing. Is what we're doing based in science at this moment? If it's not, then we either need to stop doing those activities or we need to evaluate them in order to find out if they are effective, or maybe to figure out why they're not effective in order to make those adjustments.

Sarah Sullivan: 00:26:17 The last term that I want to mention is "evaluative." Now let me ask you a question. Lots of folks hear the word evaluation, and what happens? People get clammy hands and think it's a scary word. Does anybody think "evaluation" is a scary word? Can you send me some emojis? There's a surprised one, or maybe you love evaluations and you want to put a heart emoji. I don't know. How do y'all feel about that word when you hear it? Okay. I do have a couple surprised faces. I got a couple thumbs up. No hearts, interesting. Oh, we're about even right now. Somebody sent me a heart. Someone's got some love for evaluations. Thank you, I love that. Let me ask you this, and thank you for putting some of those things in the chat. What happens if we skip evaluating things? Let me ask you that

question. What happens if we're like, "Oh, we don't need to evaluate"?

Sarah Sullivan: 00:27:16 No checks and balances. It stays the same. You don't know if it's effective. There's no feedback loop. False correlations. Waste of energy. Waste of time. Waste of resources. Waste of all the things. So even though sometimes we hear that word and we're like, "Ugh," It's actually a really important piece of knowing, is this effective? Is what we're doing getting us to the results that we want to have, getting us to the outcomes that we want to have? We have to be able to do that continuously through those continuous assessments, through that evaluation piece. I want to keep in mind, when we're talking about evaluations here, we're not evaluating people in terms of our prevention activities. We're evaluating the programs, practices, and policies. We want to know what we're doing is working. It actually ends up saving us money and time and energy later down the road.

Sarah Sullivan: 00:28:23 Good things come from evaluations too. This I-PAG workforce that we're talking about came from evaluations. Recognizing that there's some gaps, and we need to fill those gaps. I like to say that because we have some folks on our I-PAG team that really like to point out, evaluations can be great. It can actually lead to getting you more resources for the things that are working, which is what we want. I want to keep in mind that evaluation isn't measuring compliance. We want to measure effectiveness. Those are some of our key terms. There is one more thing that I'd like to mention on this slide, in regard to this Social Ecological Model, and I want to talk about how it applies to the I-PAG.

Sarah Sullivan: 00:29:24 Remember how earlier I talked about the IRC recommendations and how 2.2C is what got us to add our full-time prevention workforce? Another recommendation is 2.3A that I want to mention because it specifically talks about prevention at the organizational and community levels. Those are these outside levels up here. You might be asking yourself, why should we focus on implementation and evaluation at these organizational and community levels? Why do you think that is? Why do you think we want to focus on these levels when it comes to primary prevention in the military as well?

Sarah Sullivan: 00:30:16 Why do you think it's important to focus at these outer levels? Okay, greater reach. Because it's shared. Making policies, okay. That can be far reaching. Builds that framework. It's impacting a bigger population of folks. Oh, sorry, if you are still wondering where I'm getting this, some folks have theirs set to only come

to hosts and panelists instead of to everyone. You can do that. That's completely fine. I wanted to make sure that I'm saying that, so you're not thinking I'm just making stuff up over here. Shared risk and protective factors, fantastic. Yes. When we focus at these community and organization levels, we really are getting a larger return on our investment.

Sarah Sullivan: 00:31:11 If we think about the Army and the Army structure, and we think about turnover in the Army, individuals are always shuffling around. Maybe they're PCSing, they're ETSing, they're going on deployments. We're always having folks move around everywhere. But what tends to stay the same? Well, the organization and the community. So if we're focusing on those outer layers, we can have a larger and more enduring impact as well. That can be where the I-PAG comes in also. The I-PAG is an additive capability, and I wanted to make sure I reiterate that. The I-PAG is an additive capability. They're not replacing anyone. They are being added as an additional resource. They're an advisory group. The IRC revealed some gaps when it comes to prevention, especially when it comes to primary prevention and focusing on their shared risk and protective factors. The I-PAG is here to help fill that gap.

Sarah Sullivan: 00:32:17 They're here to connect prevention partners. As you can see here on the left, we've named a few of those. Whether that's leadership, whether that's Soldiers and not just Soldiers, all the folks within our military community to include Family members, dependents, and our Army civilians. Another huge part of our military community as well. We need to add in there our prevention collaborators. Not only the folks that are inside of the gates, but also the folks that are outside of the gates. Our community organizations, our law enforcement, and then of course our program specialists, which are all of our folks from SHARP, FAP, ASAP, et cetera. We know that there are great things going on across the Army. We know that, and we're here to help add to that. The I-PAG are here to strengthen those local programs, practices, and policies.

Sarah Sullivan: 00:33:15 Additionally, they're here to help identify and analyze existing data for shared risk and protective factors and identify evidence-based programs and tailor them for the local community. Something that might work at Fort Hood, for instance, might not work as well at a place like Detroit Arsenal. Tailor that comprehensive plan for the local community. Advise on content, delivery, and dosage of integrated primary prevention activities, review and crosswalk existing policies, and then also identify those risk and protective factors for two-plus harmful behaviors within that community.

Sarah Sullivan: 00:34:02 I just went through what the I-PAG does, and here are some of the documents that provide the foundation, guidance, and additional details for supporting those activities. We already discussed PPOA 2.0, and I'd like to turn our attention to the DoDI 6400.11. Some of you have probably read the DoDIs and the PPOA 2.0, and the DoDI 6400.11 is our newest document that just came out in December. It does several things. It establishes and implements policy. It assigns responsibilities. It prescribes procedures and identifies requirements for addressing primary prevention of harmful behaviors. It establishes roles, requirements, and training and education standards for our I-PAG personnel that are coming on board. It also establishes learning objectives for leaders so that they can oversee and support prevention activities. It provides assessment and evaluation requirements as well for integrated primary prevention. Let me ask, just by a show of emojis, how many folks have read all of these?

Sarah Sullivan: 00:35:27 Okay, so I got a few folks that have read them all. Anybody sleep with them under their pillow, osmosis, bringing them in? No. I don't know, somebody's going to be like, "Yeah, that's me. I do that." If you haven't read them all, or maybe it's been a minute since you've read them all, I encourage you to read them. Especially if you're interested in understanding the direction and the guidance that the I-PAG are receiving and what they're following. Keep in mind that there really is an art to integrated prevention. It's not just throwing a bunch of things together and saying, "Well, we reduced redundancy. Our job is done." It really involves taking action to decrease harmful behaviors in a way that incorporates inclusivity. It's using the voice of the military community.

Sarah Sullivan: 00:36:23 There's this whole idea, that I'm sure a lot of you probably have heard before, which is, "Nothing about us without us." This idea is really needed for when prevention activities are implemented because we want to make sure that they are resonating with our community, that they're appropriate, and that they're meeting the needs of that community. We recognize this hasn't always been the case, especially within the military, but it really is a defining feature of integrated prevention, and it's the I-PAG's approach to it. We also know that in the Army, there are subpopulations that are disproportionately impacted by harmful behaviors. We recognize that anyone can be impacted by violence, but we also recognize that there are certain populations that are disproportionately impacted. Racial and ethnic groups, sexual and gender identity groups.

Sarah Sullivan: 00:37:26 Our approaches need to recognize that and take that into account. Lastly, the I-PAG have to work with our prevention partners and our program specialists. We are here to collaborate and work with them. Again, not take the place of them, by no means. It's an additive capability. We need to be able to find common ground because we want to make sure that we're working across the aisle. We want to make sure that we are collaborating with diverse partners, and we want to be able to find solutions to complex problems. Because I'm sure, as you all know, these are very complex problems that we are trying to solve.

Sarah Sullivan: 00:38:11 This visual is a nice visual sum-up of what the DoDI 6400.11 does. If you've read it, and again, I encourage you to do so, it equips leaders for prevention. It empowers leaders with data. That's a goal of it, to talk a lot about data within it. It also creates or provides clear roles and responsibilities for our I-PAG. I want to highlight here that you'll notice that the I-PAG is here in the middle. We're surrounded by leaders. I wanted to point that out because we're providing support to leaders and doing that through the prevention process, helping them understand the problem through conducting needs assessments. We're helping them plan a comprehensive approach. Think about that SEM model, making sure that all the activities that we're doing are following in line with all those multiple levels on our SEM model. That there is quality implementation, that we don't decide that we're just going to say, "Oh, let's create a new training." Or pick something that is already researched-based and see how it goes. We're going to need to make sure that it is being delivered with fidelity, that there is quality implementation happening. Also that there's continuous evaluation taking place. That evaluation really helps us understand if something is working, especially over time, and being able to show that progress.

Sarah Sullivan: 00:39:53 Let's talk about a day in the life. As we mentioned before, the I-PAG scope includes military community and research-based preventions activities that have the potential to reduce two or more harmful behaviors, and that could be universal or selected. The I-PAG prioritizes environmental and contextual factors and shares information, research, and evaluation findings with our prevention partners. I want to make sure I say that. We had a lot of questions last time about sharing information. We want to make sure that we are sharing information and being transparent, that we can work together. When I say share information, some people get a little edgy. Certainly not asking for PII or PHI of clients, nothing like that. We want to make sure that it is aggregated data, non-

attributional, non-identifying information to help inform our prevention activities.

Sarah Sullivan: 00:40:55 The I-PAG also provides encouragement, research-based advisement, and support to leaders in their efforts when they're developing those healthy climates to create those protective environments. And it also fosters collaboration. With our DoD partners, with our Army partners, with our community partners, remember, those folks outside the gates, in order to maximize prevention resources and services that are available to our military community. You might be asking yourself, "Okay, we have this broad overview of I-PAG, but what are they doing day-to-day? What might that look like?" There's lots of different things. For you folks that have been in different Army programs for a while, I know y'all have been dual- and triple-hatted. We're here to help with some of that, to take some of those things and consolidate them and make them make more sense.

Sarah Sullivan: 00:41:58 For the I-PAG teammates, they might do several different things. Maybe in a day, they attend a community forum with partners in order to review the comprehensive integrated primary prevention plan for their military community and assess what current data they have. They would consider things like what change is happening, what change might be needed? Are there any emerging needs that have become clear? If so, how does the prevention plan need to be adjusted in order to meet those needs? I-PAG teammates might also meet with senior enlisted advisors. In the DoDI 6400.11, there is a piece of that. New leaders to a new installation, a new unit, are required to receive an in-brief from their I-PAG staff. That in-brief might include things like discussing the fundamentals of the prevention approach.

Sarah Sullivan: 00:43:04 It could be things like explaining what prevention activities are currently being implemented and evaluated, and also to gain the leader's perspective and experience in order to open that dialogue on prevention. I-PAG teammates might also meet with the commander to review the findings of a command climate assessment and begin to develop actions to address those findings. Again, we want to look at the risk and protective factors for two or more harmful behaviors when we're looking at those command climate assessments. Additionally, the I-PAG might work with our program specialists in order to identify research-based trainings to implement.

Sarah Sullivan: 00:43:49 For instance, what if there's been a unit that's experiencing uptick in relationship issues? Well, the I-PAG could work with program specialists to help identify research-based trainings

that could be implemented for that unit. Then they would observe the delivery of the training in order to ensure that there's fidelity happening there within it, that quality implementation piece. The I-PAG team members might also attend community partner meetings downtown to look at the zoning of alcohol outlets around an installation. Maybe prior to that, our I-PAG do a literature review and find that when there are more alcohol establishments surrounding a community to include military installations, that there are higher incidents of harmful behaviors occurring. So if an I-PAG team member working with community partners to look at the zoning of those alcohol outlets then, potentially that could decrease access and availability, which could subsequently lead to a decrease of over-consumption.

Sarah Sullivan: 00:45:05 Some other things that I-PAGs might do on a daily basis might be things like engage and educate program specialists, leaders, and prevention partners on what primary prevention is and their role in it. Regularly assess community needs, and those community needs assessments need to happen on a regular basis, so we have an understanding of what is changing over time. Additionally, identifying prevention activities that may positively impact climate. Identify, adapt, implement, and evaluate research-based prevention activities with those responsible for the prevention programming. Advising leadership on community needs and promoting research-based decisions. The I-PAG is not making any decisions on what will be implemented. They're an advisory group. They're providing information to leaders so that they can make those decisions. That really leads us to this next visual that I think can be pretty useful in seeing how the I-PAG falls within the Army.

Sarah Sullivan: 00:46:16 As I mentioned before, the DoDI 6400.11 lays out leader responsibilities when it comes to primary prevention. Leaders have to support prevention. It's more than signing a policy and saying, "I support prevention." There's much more to it. In order for it to be effective, leaders have to do several different things. Analyze the environment in which they operate in order to determine how to prevent harmful behaviors. They need to be promoting and demonstrating positive character and leadership development. They also need to communicate to their military community that prevention is a priority, that it's important to them. Also create those respectful command climates where everyone can voice concerns without fear of retaliation. Again, remember that garden analogy. We need to have those healthy climates so that we can plant our seeds, those prevention activities, so that will grow into what we want it to be.

Sarah Sullivan: 00:47:20 Notice here, if you read through the 6400.11, it talks about program specialists. Specifically, it defines program specialists as those that are involved in a harmful behavior remediation program and who lead secondary and tertiary prevention efforts including response. Our I-PAG will be working with our program specialists alongside them. Our I-PAG, again, are focused on primary prevention, looking at the shared risk and protective factors of two or more harmful behaviors. Our program specialists are focused on that secondary prevention and tertiary piece, that intervention and response piece. In a couple slides, it's going to lay that out a little bit more so you can see the differences there.

Sarah Sullivan: 00:48:17 You may also be wondering where or how does the I-PAG fit in with the CR2C? They're going to leverage the existing CR2C governance structure. This slide is a graphical representation of the CR2C structure. This is the process that the I-PAG will use to present recommendations and prevention plans, and advise senior leadership. As we've discussed, the I-PAG is intended to link arms with all prevention programs and partners to strengthen that prevention system. When the I-PAG attend the CR2C, the information shared should not be a surprise to the other collaborators in the room. It should reinforce the work that's already being done.

Sarah Sullivan: 00:49:07 Lastly, the DoDI 6400.11 also offers some examples of prevention activities in order to help clarify how the I-PAG and program specialists and clinical personnels' roles and responsibilities differ. This visual is helps to break that down with an example. As you can see, in the green is I-PAG, in the purple are clinical personnel, and in the blue are program specialists. To break that up a little bit more into wills and won'ts, the I-PAG will perform primary prevention. They will not perform response activities. Again, they're an advisory group. They're not a program that's offering resources to individuals. That's not what they are. The I-PAG will work together with leaders in order to address shared risk and protective factors at the local level. They do not decide how military leaders should implement prevention activities.

Sarah Sullivan: 00:50:12 They're there to provide information, gather it, and give that to commanders so that they can make informed decisions. The I-PAG will implement prevention activities that address two or more harmful behaviors at the same time. They are not implementing activities or tools that address a single harmful behavior. The I-PAG will act as a resource for leaders and service members. They're not there to add training fatigue to folks. They're being created in order to help reduce that

redundancy. The I-PAG will implement research-based activities in group settings, not perform clinical tasks, not diagnose anyone, not do individual counseling or individual training or couples training. They're there to implement research-based activities in those group settings. The I-PAG will leverage existing personnel and integrate capabilities across a unit or installation. They're not deciding how program experts should engage in other prevention efforts. They're not there to tell program specialists how to run their program. That's not why they're there.

Sarah Sullivan: 00:51:29 They're there to collaborate and work with us so that we can strengthen our efforts and do a service to our military communities. We all want to prevent harmful behaviors from happening. This is a workforce that will provide additional capabilities. I'd like to end with a quote from Major General Allan Pepin. What he said was, "With anything new, we're going to get the clay, and we're going to mold it to the unique requirements." If you think of I-PAG as the clay, we have those guiding documents. We have the PPOA 2.0, we have the DoDI 6400.09, we have the DoDI 6400.11, and we have a mission, but we're working to figure out how we're going to mold the I-PAG to fit into the Army in order to fit its needs. I want to reiterate the reminder that we all have a role to play in prevention. In order to get to those longer term outcomes of decreasing the prevalence of harmful behaviors, we're going to have to work together to address those shared risk and protective factors of Soldiers, our Army Family members, and our Army civilians.

Sarah Sullivan: 00:52:51 This is not something that can be done alone. We're going to need to work with everyone in order to see the outcomes that we want to see. I will stop there, and if you have any questions, I'll be happy to answer those to the best of my ability. I hope you all really like my owl picture that I chose because I could not help myself.

Lytaria Walker: 00:53:20 Thank you, Ms. Sullivan, for the presentation. We will now take a few questions from the audience. If you would like to ask a question, please type your question in the Q&A box, and we will read them aloud. There will be a short delay before the first question is announced. First question, what mechanisms usurp resistance in implementing the PPOA? That is, how are decision maker leaders incentivized to energize and synchronize efforts? Another way to ask this is, how are leaders accountable to integrate I-PAG and the PPOA?

Sarah Sullivan: 00:54:08 Great question. The PPOA is the implementation roadmap. It's that guiding document to look years out and say the things that

need to be implemented. When we talk about leaders, especially when it comes to roles, responsibilities, accountability, if you haven't read the 6400.11, I encourage you to read it. That really adds some concrete things to assist leaders in understanding their roles in primary prevention and their role in making sure that there are comprehensive approaches that are data-driven, and it provides some accountability for that. That's the document that I would point you to in order to look into that and see what's listed. I can even move back to that slide, if that's helpful as well, so that you'll have a memory of that also. Is that helpful?

Lytaria Walker: 00:55:26 Okay. Next question. I-PAG will not be telling prevention agencies what to do in programs but will be helping to evaluate process and outcomes of these agencies. Is this correct?

Sarah Sullivan: 00:55:54 Yes, but let me clarify a little bit. Again, I-PAG is not overseeing or in charge of any of the program specialists or the programs themselves. What I-PAG is there to do is to assist in making sure that the prevention activities that are put into place, those programs, practices, and policies, are effective by looking at shared risk and protective factors. There was something in that statement that I definitely wanted to help clarify.

Lytaria Walker: 00:56:35 Should I read it again?

Sarah Sullivan: 00:56:37 Oh, actually, I see it in the chat box as well. So it says, "but will be helping to evaluate process and outcomes of these agencies." Not the agencies themselves, not the programs themselves. Looking at those prevention activities that are put in place as part of that comprehensive approach. Again, it's not evaluating a person. It's: is what we're doing effective? Is it getting us to the outcomes that we want to get to? Can I ask a quick question? How many folks have taken SPARX training? Because I know that there are some folks that have, so can I get some thumbs up or some hands or whatever the case is? Great. Some people have, and some people haven't. I bring that up because, for the folks that have, they talk about logic models within SPARX training, and I think that that can be a very helpful visual when we're talking about outcomes.

Sarah Sullivan: 00:57:38 For those that have taken SPARX and have seen that, it really helps lay out thinking about prevention activities. What's needed? What are those inputs? What are the activities themselves? What are the outputs that we're looking to gain? Then furthering that, what are the outcomes? Whether those are short term, one to two years, intermediate, three to five years, or long term, longer than that. What are those

outcomes? Is what we're doing working? Is it getting us to the outcomes that we want to see? Which in our case, is a decrease in harmful behaviors. Does that help answer that question?

Lytaria Walker: 00:58:31 I'll watch the chat for a reply.

Sarah Sullivan: 00:58:33 Thank you. Thank you, Ms. Walker.

Lytaria Walker: 00:58:35 Sure. Next question. Where do the RRPC, SPPM, SHARP fit into this since they aren't clinical and are doing primary prevention, training, interpreting, et cetera? They aren't program specialists by definition as remedial or clinical, but are still focused on one area.

Sarah Sullivan: 00:58:59 So as it's listed in the 6400.11, SPPM, SHARP, FAP, those would fall under program specialists. Obviously, each program has their own regulations that they have to work towards and make sure that they fall in line with. So things like annual training that SHARP folks provide, that is not something that I-PAG would do. I-PAG is focused on two or more harmful behaviors. So that's not something that they would align with. We're not taking that from anyone. If you're looking into the 6400.11, the way it's written, that's what they are suggesting. This slide helps with that as well to help lay that out. I'll leave that up if you want to read through it, because I think it really does a good job explaining where each capability fits in place, if that's helpful.

Lytaria Walker: 01:00:11 Thank you.

Sarah Sullivan: 01:00:16 These are just examples by the way. This is not all encompassing. This is simply examples of some prevention activities. This is not all encompassing by any means. It helps you get an idea about how I-PAG fits in at the ground level. I don't want you to think that this is all encompassing. They provided some specific examples so that it creates a nice visual for understanding.

Lytaria Walker: 01:00:48 Thank you for that. Unfortunately, we have run out of time, and we will need to conclude this afternoon's webinar. I want to extend a gracious thank you to Ms. Sullivan for taking the time today to provide this great presentation for us. Thank you, listeners, for joining today's presentation as well. Once the webinar ends, you will be prompted to complete a survey. We appreciate your feedback, as this helps us to improve upon future webinars. If you'd like to receive invitations for ARD 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 there. Please also follow us on ARD's newly launched LinkedIn and Instagram platforms. Thank you for joining us today, and have a wonderful rest of your day. Thank you, Ms. Sullivan.