GETTING TO OUTCOMES®
RESOURCE GUIDE

FOR U.S. AIR AND SPACE FORCE COMMUNITY ACTION PLANNING

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About This Resource Guide

Getting To Outcomes® (GTO) helps users prioritize among problems, select evidence-based measurable and attainable goals, and then implement them with the highest quality possible while monitoring the process and outcomes. Learning the GTO process is a way to think critically about current efforts, remaining gaps and priorities, and new initiatives that have the potential for positive impact.

GTO can be used to help Community Action Teams (CATs) efficiently and effectively develop a high-quality Community Action Plan (CAP). This **Resource Guide** is a companion document to *Getting To Outcomes Handbook for U.S. Air and Space Force Community Action Planning*. In that **Handbook**, each chapter includes guidance and tools to help an installation develop a high-quality CAP. The tools are worksheets that prompt GTO users to consider a variety of planning and evaluation issues and record the results of their decisions. This supplementary Resource Guide provides links to other information and helpful tips for completing the tools. The Resource Guide is a streamlined version of a GTO guide that was developed for Air and Space Force installation CATs working to develop a CAP.[1] Additionally, a companion **Workbook** presents blank versions of the tools for use by any installation. The Handbook, Workbook, and Resource Guide can be downloaded at www.rand.org/t/TLA1268-1.

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[1] Matthew Chinman, Patricia A. Ebener, Amy L. Shearer, Joie D. Acosta, and Sarah B. Hunter, *Getting to Outcomes® Operations Guide for U.S. Air Force Community Action Teams*, Santa Monica, Calif.: RAND Corporation, TL-311-AF, 2020 (https://www.rand.org/pubs/tools/TL311.html).

Contents

Glossary

(When relevant, the GTO step associated with that term is provided in parentheses.)

Activities are the important parts of an evidence-based program, policy, practice, or process (P^4) that need to be implemented to reach the desired outcomes (GTO Step 6—Planning for P^4 Implementation and Evaluation).

Adaptation is the process of changing an evidence-based P^4 to make it more suitable to a particular population or an organization's capacity without compromising or deleting the activities of the P^4 that make it effective (often called core components) (GTO Step 3—Explore Research-Based and Promising P^4, GTO Steps 4 and 5—Selecting the Best Option).

Capacities are the resources (e.g., staff, skills, facilities, and finances) that an organization has to implement and sustain a P^4 (GTO Step 3—Explore Research-Based and Promising P^4, GTO Steps 4 and 5—Selecting the Best Option).

Continuous quality improvement (CQI) is a systematic assessment using feedback from evaluation information about planning, implementation, and outcomes to improve P^4 (GTO Steps 7–9—Using Evaluation to Improve P^4).

Culture can be thought of as a person's or an organization's values, practices, beliefs, religion, customs, rituals, or language, for example, and there can be subcultures or countercultures within an overarching culture (GTO Step 3—Explore Research-Based and Promising P^4, GTO Steps 4 and 5—Selecting the Best Option).

Desired outcomes are specific changes in behaviors and risk and protective factors that you expect to result from a specific P^4. They make a broad goal—such as reducing suicide rates—more concrete. Well-written desired outcomes are specific, measurable, appropriate, realistic, and time-based (SMART) (GTO Step 2—Setting Goals and Desired Outcomes).

Dosage is a way to show how much of a P^4 a participant receives. Depending on the P^4, the dosage can be the amount of time, the number of sessions or modules completed, or the number of activities in which a participant actually takes part (GTO Step 6—Planning for P^4 Implementation and Evaluation, GTO Steps 7–9—Using Evaluation to Improve P^4).

Fiscal, resource, and technical capacities include adequate funding and other basics needed to implement a P^4 as planned (e.g., transportation, food, printed materials, and evaluation resources). Technical capacities are the expertise factors needed to address all aspects of P^4 planning, implementation, and evaluation; access to special materials needed for implementation; and the technology appropriate to the implementation, such as computers (GTO Step 3—Explore Research-Based and Promising P^4, GTO Steps 4 and 5—Selecting the Best Option).

Fit expresses the overall compatibility between a P^4 and the target population, organization, and stakeholders (GTO Step 3—Explore Research-Based and Promising P^4, GTO Steps 4 and 5—Selecting the Best Option).

The **goal** is the overarching big picture of the impact that a Community Action Plan (CAP) seeks to achieve through its included P^4. Goals reflect the anticipated impact in the future. Each CAP should include goals for addressing the problems that it is targeting (GTO Step 2—Setting Goals and Desired Outcomes).

Logic models illustrate how a goal to address a specific need will be reached. Like a flow chart, a logic model shows needs; goals; and, for each goal, desired outcome(s), P^4 to achieve the desired outcome, and how the quality of the P^4 and its actual outcomes will be assessed (GTO Step 2—Setting Goals and Desired Outcomes).

Measures are individual questions or scales on a survey designed to obtain information about the behavior and/or risk, protective, and resilience factors being examined (GTO Step 6—Planning for P^4 Implementation and Evaluation, GTO Steps 7–9—Using Evaluation to Improve P^4).

A **needs and resources assessment** is a systematic way to identify current problems that suggest the potential need for improvement and to identify related community resources (GTO Step 1—Identifying Priority Problems to Address).

A **P^4** is a program, policy, practice, or process in your CAP.

P^4 capacity refers to the degree to which a team or wing is ready and able to develop and implement a P^4. It is a combination of motivation (commitment), capacity (ability), and other resources (GTO Step 3—Explore Research-Based and Promising P^4, GTO Steps 4 and 5—Selecting the Best Option).

Partnership and collaboration capacities involve connections with other service providers who can help implement and support a P^4 (GTO Step 3—Explore Research-Based and Promising P^4, GTO Steps 4 and 5—Selecting the Best Option).

The **priority population** is the group(s) determined to be most in need of an evidence-based P^4 (GTO Step 1—Identifying Priority Problems to Address, GTO Step 2—Setting Goals and Desired Outcomes, GTO Step 3—Explore Research-Based and Promising P^4, GTO Steps 4 and 5—Selecting the Best Option).

A **program** is a purposeful organized set of activities designed to improve knowledge, awareness, or skills; change attitudes; or change behavior.

Promising P^4 refers to programs, policies, practices, and processes that have documented successful outcomes but do not have enough research evidence to prove that they will be effective across a wide range of settings and service members.

Research-based P^4 are activities that have decreased the behavior of interest for a specific population or improved one or more contributing factors to the behavior of interest in similar settings and whose positive effects were sustained over time.

A **scale** is a grouping of individual survey questions that work together to assess a single attribute or concept. Individual questions are designed to be averaged together and interpreted as a group (GTO Steps 7–9—Using Evaluation to Improve P^4).

Staff and volunteer capacities refer to staff with appropriate credentials, training, experience, and commitment to a P^4—trained and committed volunteers (GTO Steps 4 and 5—Selecting the Best Option).

Stakeholders are the individuals invested in the delivery and results of a P^4. Stakeholders include participants, participants' families, wings, community members and organizations, leadership, volunteers, funders, and Community Action Board (CAB) and Community Action Team (CAT) members (GTO Steps 4 and 5—Selecting the Best Option).

Sustainability refers to the continuation of a P^4 after initial startup has been completed (GTO Step 10—Sustainability).

Tasks encompass all the broader actions needed to prepare for and carry out a P^4. They include such aspects as preparation, training, and debriefings of implementers, among others (GTO Step 6—Planning for P^4 Implementation and Evaluation).

Tools are the worksheets and templates associated with each GTO step that prompt GTO users to make and record decisions (GTO Steps 1–10).

Abbreviations

BASICS	Brief Alcohol Screening and Intervention for College Students
CAB	Community Action Board
CAP	Community Action Plan
CAT	Community Action Team
CBT	cognitive behavioral therapy
CDC	Centers for Disease Control and Prevention
GTO	Getting To Outcomes
NIAA	National Institute on Alcohol Abuse and Alcoholism
P^4	program, policy, practice, or process
PHQ-9	Patient Health Questionnaire-9
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment

Resources for GTO Step 1

Resource List 1-1. Links to Existing Local Data Sources to Help Identify Priority Problems to Address with Your Community Action Plan

1. The **Defense Equal Opportunity Management Institute Organizational Climate Survey (DEOCS)** provides periodic installation surveys and reports on organizational effectiveness, equal opportunity and fair treatment, and sexual assault prevention and response. You can view sample surveys and reports, request new assessments, and get help interpreting reports and creating and executing an action plan at www.deocs.net.
2. The **Airman and Family Readiness Center (A&FRC)** provides quarterly trends data on support services offered to Airmen and their family members (i.e., financial, transition, relocation, etc.). Information about concerns identified through leadership consultations, unit networking, and community partnerships is provided on an as-needed basis.
3. The **Chaplain Corps** provides quarterly data on the top five counseling trends from the Air Force Chaplain Corps Activity Reporting System (AFCCARS); aggregated quarterly data on suicide ideation, sexual harassment and assault, bullying (all types), and domestic violence (all types and financial problems); and additional data upon request.
4. The **Drug Demand Reduction Program (DDRP)** provides raw numbers on active-duty and civilian drug test results by fiscal year and information on illicit drug use trends and concerns on an as-needed basis.
5. **Legal (Judge Advocate [JA])** provides aggregate quarterly data on the number and types of legal assistance visits (such as child custody and domestic relations) and aggregated military justice data, such as the number of Article 15s, court martials, and other relevant installation data and trends.
6. The **Director of Psychological Health or Suicide Prevention Program Manager (SPPM)** can provide quarterly aggregated data on suicides and suicide-related data trends, risk factors, and known warning signs; the number of psychiatric inpatient hospitalizations; and the number of high-interest patients being treated within the Mental Health Flight.
7. The **Sexual Assault Response Coordinator (SARC)** provides quarterly aggregated data on sexual assault trends, demographics, risk factors, and unrestricted and restricted report referrals. Reports on the top five trends are provided semiannually.
8. **Community Action Team and Community Action Board meeting minutes** are another source of information on the issues and experiences of your installation community.
9. **The Chief's Council, First Sergeant's Council, and Junior Enlisted Council,** as well as any other bodies or advisory councils that meet with enlisted or members on a regular basis, often hear from members about ongoing and pressing issues and might be able to provide verbal feedback about the challenges and priority problems that members are facing.
10. **Human Resources Advisors (HRAs)** who deal with diversity and inclusion issues often collect information to self-assess the current state and monitor progress toward aligning their diversity and inclusion plans with unit goals, messaging, and priorities.

STEP 3 Resources for GTO Step 3

Resource List 3-1. Finding Research-Based P^4 That Address Your Priority Problems

Several resources exist to help you find programs, policies, practices, and processes (P^4) that have been evaluated and determined to be effective. The following are resources that aggregate information about research-based practices and programs and are a good starting point to finding P^4 that might be appropriate for the needs you are targeting.

1. The **Clearinghouse for Military Family Readiness at Penn State** is a searchable catalog of P^4 to strengthen military families, including P^4 that enhance resilience. Search for P^4 that address such topics as alcohol and drug use, life stress, suicide, relationships, sexual assault, diet and nutrition, sleep, and fitness, to name a few. P^4 can be filtered from the strongest evidence of effectiveness (*effective randomized control trial*) to *unclear* or *ineffective*. If you have questions or need help, Clearinghouse staff are available via live chat on the website from 0900 to 1700 EST/EDT, over the phone at 1-877-382-9185, or via email (clearinghouse@psu.edu). If you are unsure of where to start looking, we recommend this resource as a first step: https://militaryfamilies.psu.edu/services-we-offer/program-selection/
2. The **Community Guide** is intended to help organizations select interventions that improve health and prevent disease in a variety of community settings. To view the lists of P^4, start with the "Topics" drop-down menu. Topics include excessive alcohol consumption, violence, physical activity, worksite health, mental health, and others. Each topic section lists P^4 evaluated by the Community Preventive Service Task Force of the Centers for Disease Control and Prevention (CDC) and its assessment of the evidence (*recommended*, *insufficient evidence*, or *recommended against*): www.thecommunityguide.org
3. The **Violence Prevention Effectiveness Studies Registry** provides a searchable database of abstracts of published studies that measure the effectiveness of interventions to prevent violence. Filter your search by P^4 that are *recommended* based on their evidence of effectiveness. Additional filters include type of violence, region, year, and keywords. This registry is maintained by a collaboration between the Public Health Institute, the World Health Organization, and the CDC: www.preventviolence.info
4. **Blueprints for Healthy Youth Development** is a catalog of programs for children, youth, and families that are rated based on their evidence of effectiveness. Searchable topics include problem behavior, education, emotional well-being, physical health, and relationships. Other tools, including needs assessments and surveys, are available through the website as well: www.blueprintsprograms.com
5. The **California Evidence-Based Clearinghouse** is a tool for identifying, selecting, and implementing evidence-based child welfare practices that will improve child safety, increase permanency, increase family and community stability, and promote child and family well-being: www.cebc4cw.org
6. The **National Institute of Justice Crime Solutions** is a clearinghouse of programs and practices for reducing crime, rated by effectiveness. Programs and practices address a broad range of criminal justice, juvenile justice, and crime victim service outcomes. Filter by evidence rating, topic, setting, age, and others: www.crimesolutions.gov

Didn't find a program that meets your needs among those included in these resources?

7. The **Center for Community Health and Development at the University of Kansas Community Toolbox** curates an extensive list of databases for evidence-based programs and best practices: https://ctb.ku.edu/en/databases-best-practices
8. If a P^4 in which you are interested is not listed in one of these registries, you could try to apply the criteria used by these registries. The Clearinghouse for Military Family Readiness at Penn State registry has a four-page document at https://militaryfamilies.psu.edu/wp-content/uploads/2017/08/continuum.pdf that could be used to categorize a P^4 you are considering. To do this, you would need to learn about any studies or evaluations that have been done. You might need to gather some of this evidence yourself—for example, by talking with colleagues who have used the P^4 you are considering. All of this can be complicated, so talk to your Community Support Program Manager if you need help. It might be best to start by contacting the Clearinghouse and asking it for assistance: https://militaryfamilies.psu.edu/contact-us/. Pulling together the existing evidence can help you draw conclusions about the effectiveness of P^4 you are considering. **It is recommended that P^4 in your CAP be at least at the "promising" (or second-highest) level.**

Resource List 3-2. Responsible Alcohol Use Interventions

Policy/Program Name and Description	Mode	Target Audience	Summary of Evaluation Findings	References
Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use. SBIRT consists of three major components: 1. Screening—A health care professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any health care setting. 2. Brief intervention—A health care professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice. 3. Referral to treatment—A health care professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services. SBIRT is not a proprietary model; it is a general approach using the three components described above. There are many free resources on how to implement SBIRT: "A Pocket Guide for Alcohol Screening and Brief Intervention" is a detailed flowchart also created by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) for alcohol screening and brief interventions: https://www.integration.samhsa.gov/clinical-practice/sbirt/NIAAA_SBIRT_Pocket_Guide_-2-.pdf There is free online training through Medscape (registration is free): https://www.medscape.org/viewarticle/830331 Providers can download a free app (search for "OHN SBIRT" in the Apple app store) that provides screening tools and specific advice that providers can give. The University of Colorado has extensive training resources: https://bigsbirteducation.webs.com/ The Substance Abuse and Mental Health Services Administration (SAMHSA) also has a long list of resources: https://www.integration.samhsa.gov/clinical-practice/sbirt	Brief one-on-one in person		SBIRT has been positively evaluated in several studies. A recent study (Babor, Del Boca, and Bray, 2017) of more than 1 million people who were screened for drug and alcohol use disorders over a 5-year period evaluated the effectiveness of SBIRT in a variety of medical and community settings. The study, funded by SAMHSA, found SBIRT to be an innovative and effective way to integrate the management of substance use disorders into primary care and general medicine. Substantial numbers of patients received recommendations for intervention or treatment, with greater intervention intensity associated with larger decreases in substance use. Patients receiving SBIRT demonstrated significant reductions in substance use, with some caveats that raise questions about the best ways to implement SBIRT as a public health program. It was also associated with improvements in treatment system equity (the provision of care to patients varying in economic status, race/ethnicity, and setting) and efficiency and was found to be cost-effective.	Babor, Del Boca, and Bray, 2017

Policy/Program Name and Description	Mode	Target Audience	Summary of Evaluation Findings	References
Brief Alcohol Screening and Intervention for College Students (BASICS), a Harm Reduction Approach, is a preventive intervention for college students 18 to 24 years old. It targets students who drink alcohol heavily and have experienced or are at risk for alcohol-related problems, such as poor class attendance, missed assignments, accidents, sexual assault, and violence. BASICS is designed to help students make better alcohol-use decisions based on a clear understanding of the genuine risks associated with problem drinking, enhanced motivation to change, and the development of skills to moderate drinking. The program is conducted over the course of two brief interviews that prompt students to change their drinking patterns. The program's style is empathetic, nonconfrontational, and nonjudgmental, and it aims to (1) reduce alcohol consumption and its adverse consequences, (2) promote healthier choices among young adults, and (3) provide important information and coping skills for risk reduction. Staffing expertise needed: Health professional and coordinator who knows motivational interviewing. Information about this program (costs, etc.) can be found here: https://www.blueprintsprograms.org/programs/brief-alcohol-screening-and-intervention-for-college-students-basics/ There are two separate groups that provide training, and costs could differ between them: George A. Parks, Ph.D., Caring Communication (206) 930-1949; geoaparks@earthlink.net Or: Jason Kilmer, jkilmer@uw.edu http://depts.washington.edu/abrc/basics.htm	Brief one-on-one in person. Assessment can be online.	Individuals or specific groups. Has not been done with military personnel.	The initial study done at the University of Washington (Marlatt et al., 1998; Baer et al., 2001) screened high school students intending to attend the university and selected 348 students-to-be who were predicted to be at high risk for drinking problems in college. After random assignment, the treatment group but not the control group underwent the brief intervention during the freshman year. Assessments at baseline, 6 months, 2 years, and 4 years measured both drinking rates and harmful consequences. A separate group of normal students not at high risk was followed for comparison. Participants who received BASICS demonstrated a significantly greater deceleration of drinking rates and problems over time in comparison with control participants. These results were sustained at the 2- and 4-year follow-ups. Multiple other studies have found similar outcomes (e.g., Borsari and Carey, 2000), although the program appeared to work somewhat better in combination with a parent-based intervention (Turrisi et al., 2009).	Baer et al., 1991; Borsari and Carey, 2000; Marlatt et al., 1998

Policy/Program Name and Description	Mode	Target Audience	Summary of Evaluation Findings	References
Check Your Drinking is a brief web-based program that provides personalized feedback designed to reduce high-risk drinking and normative data regarding drinking and the associated risks. The program is free to the public. For more information: https://screen.evolutionhealth.care/cyd/	Online assessment and feedback	Young adults (ages 18–24) who are problem drinkers. Has not been used in military settings.	This study evaluated the efficacy of an alcohol-related web-based personalized feedback program delivered in the workplace to young adults. Participants (N = 124) were randomly assigned to one of three conditions: web-based feedback (WI), web-based feedback plus a 15-minute motivational interviewing session (MI), or a control group. Results indicated that participants in the intervention group (WI and MI conditions combined) reported significantly lower levels of drinking than those in the control group at a 30-day follow-up. This was particularly true for participants classified as high-risk drinkers at the baseline assessment. Similar results were found when comparing the WI condition with the control group. No differences were found between the WI and MI conditions, indicating that the addition of a 15-minute motivational interviewing session did not increase the efficacy of the web-based feedback program.	Doumas and Hannah, 2008

Policy/Program Name and Description	Mode	Target Audience	Summary of Evaluation Findings	References
CheckUp & Choices (formerly Drinker's Checkup and College Drinker's Checkup) is a confidential, evidence-based digital program created to assist those who want to assess their drinking or substance use through a series of questionnaires and personalized solutions. CheckUp & Choices uses the elements of motivational interviewing to determine the user's stage of change and then create a customized plan that provides detailed feedback and is anonymous. Once a user has engaged in the full assessment phase, the choices modules in CheckUp & Choices ask subscribers to set up customized e-mail and text messages reminding them of the change plan. These can be empowering messages, encouraging change, and positive feedback supporting wise decisions. Subscriptions are offered at three-month increments or one year, with a 100% money-back guarantee. CheckUp & Choices has a significant Facebook presence with daily articles, posts, and shares. For more information: https://checkupandchoices.com/	Online	College students or adults who are problem drinkers; has not been used in military settings	In Experiment 1, 144 students were randomized to either the computer-delivered intervention (CDI) or an assessment-only control group with follow-ups at 1 and 12 months. Participants in both groups significantly reduced their drinking at both follow-ups. Compared with the control group, the CDI group reduced their drinking significantly more at 1 and 12 months on three drinking measures. Using a more conservative criterion yielded one significant difference in a measure of heavier drinking at the 1-month follow-up. The mean between-groups effect sizes were d = 0.34 and 0.36 at 1 and 12 months, respectively. In Experiment 2, 82 students were randomized to either the CDI or a delayed-assessment control group with follow-up at 1 month. Compared with the delayed assessment control group, the CDI group significantly reduced their drinking on all consumption measures. These results support the effectiveness of the CDI with heavy-drinking college students when used in a clinical setting. An earlier study had 61 adult problem drinkers who were randomly assigned to either immediate treatment or a 4-week wait-list control group. Overall, participants reduced the quantity and frequency of drinking by 50% and had similar reductions in alcohol-related problems that were sustained through 12-month follow-up.	Hester, Delaney, and Campbell, 2012; Hester, Squires, and Delaney, 2005

Policy/Program Name and Description	Mode	Target Audience	Summary of Evaluation Findings	References
The eCHECKUP TO GO programs (alcohol, marijuana, sexual violence, and tobacco) are personalized, online behavior interventions that assess the problem and provide concrete feedback and solutions. The alcohol version was developed first and has the most evidence. eCHECKUP TO GO was designed to decrease alcohol use by reducing risk factors associated with drinking (e.g., positive alcohol beliefs and expectancies, high normative perceptions about peer drinking) and to increase protective behavioral strategies (e.g., strategies to limit drinking and risky drinking behavior) to reduce alcohol-related consequences. eCHECKUP TO GO provides personalized normative feedback on peer drinking, positive alcohol beliefs, and positive alcohol expectancies, such as perceptions of peer drinking. The alcohol program costs $1,075 per campus per year (includes all students). There is a practitioner package for those who want to work in person and one-on-one that includes all the programs ($3,500 per year). The assessment takes about 6–7 minutes to complete, is self-guided, and requires no face-to-face contact time with a counselor or administrator. For more information: http://www.echeckuptogo.com/	Online	See Evaluation Findings; was not used in the military	eCHECKUP TO GO has been evaluated in several studies, in several populations. *College freshmen:* Seven studies demonstrate the program's efficacy with the general college freshman population and at the population level (Hustad et al., 2010; Doumas et al., 2011; Doumas and Andersen, 2009; Lane and Schmidt, 2007; Wilson, Henry, and Lange, 2005; Steiner, Woodall, and Yeagley, 2005; Henry, Lange, and Wilson, 2004). Outcomes improved include heavy drinking, general alcohol use, alcohol-related problems, and alcohol-related consequences. Outcomes were generally stronger for those who were heavy drinkers. *Integrated into alcohol education:* Two studies demonstrate reductions in alcohol use and related harms and improvement in retention rates and grade point average when eCHECKUP TO GO is integrated with 3rd Millennium Classroom's knowledge-based curriculum (Lane and Schmidt, 2007; Salafsky, Moll, and Glider, 2007). *Added to alcohol education:* Three studies demonstrate significant improvements in outcomes when eCHECKUP TO GO is added to existing alcohol education programs (Lane and Schmidt, 2007; Wilson, Henry, and Lange, 2005; Henry, Lange, and Wilson, 2004). *As a stand-alone intervention:* Two studies show the efficacy of eCHECKUP TO GO as a stand-alone intervention (Walters, Vader, and Harris, 2007; Steiner, Woodall, and Yeagley, 2005). *Heavy drinkers:* Two studies show the efficacy of eCHECKUP TO GO with heavy drinkers (Walters et al., 2009; Walters, Vader, and Harris, 2007). *Athletes:* One study shows eCHECKUP TO GO's efficacy reducing heavy drinking in first-year intercollegiate athletes (Doumas, Haustveit, and Coll, 2010).	Doumas et al., 2011; Doumas and Andersen, 2009; Henry, Lange, and Wilson, 2004; Hustad et al., 2010; Lane and Schmidt, 2007; Salafsky, Moll, and Glider, 2007; Steiner, Woodall, and Yeagley, 2005; Walters, Vader, and Harris, 2007; Walters et al., 2009; Wilson, Henry, and Lange, 2005

Policy/Program Name and Description	Mode	Target Audience	Summary of Evaluation Findings	References
VetChange is a free app for veterans and service members who are concerned about their drinking and how it relates to posttraumatic stress after deployment, as well as for all people who are interested in developing healthier drinking behaviors. This app provides tools for cutting down or quitting drinking, tools for managing stress symptoms, education about alcohol use and how it relates to posttraumatic stress disorder (PTSD) symptoms, and guidance to find professional treatment. For information, search for "VetChange" in the app store.	Online	Used with veterans	A randomized clinical trial evaluated VetChange's impact on drinks per drinking day, average weekly drinks, percentage of heavy drinking days, and PTSD symptoms. Six hundred participants were randomized to either an initial intervention group (n = 404) or a delayed intervention group (n = 196) that waited 8 weeks for access to VetChange. Initial intervention group participants had greater reductions on each drinking measure and PTSD symptoms between baseline and the end of the intervention than did delayed intervention group participants between baseline and the end of the waiting period. Delayed intervention group participants showed similar improvements to those in the initial intervention group following participation in VetChange. Alcohol problems were also reduced within each group between baseline and 3-month follow-up. Results indicate that VetChange is effective in reducing drinking and PTSD symptoms in Operation Enduring Freedom and Operation Iraqi Freedom veterans.	Brief et al., 2013

Resource List 3-3. Healthy Relationships and Communication Interventions

Policy/Program Name and Description	Mode	Target Audience	Summary of Evaluation Findings	References
Meditation: A recent study (Kohlenberg et al., 2015) experimented with the effect of meditation and meditation with social awareness on mindfulness and social connectedness. There were 3 groups: a control group that watched a nature video; an intrapersonal group that participated in Phase 1, an intrapersonal meditation; and an interpersonal group that experienced Phase 1 and Phase 2, expanding from intrapersonal meditation to begin to consider others in the group. The intervention ran approximately 1 hour total, with 2 additional assessments at 48 hours and 2 weeks post-intervention. The meditation used was particular to this study. This study's meditation was built on 1) contextual behavioral theory of mindfulness (Sisti, Stewart, and Kohlenberg, 2014; Tsai et al., 2009) 2) therapeutic model of social connectedness derived from functional analytic psychotherapy (Kohlenberg and Tsai, 1991). For more information: Contact the developer, Robert Kohlenberg (fap@u.washington.edu).	Brief, in person	Adults; not tested with military personnel	Results found that mindfulness increased for all three groups. Only the intra- and interpersonal meditation saw an increase in social connectedness measures. The Inclusion of the Other in the Self Scale found that social connectedness was greater for both inter- and intrapersonal meditation. Prior studies found similar results.	Kohlenberg et al., 2015; Bowen et al., 2012
The Marriage Checkup: Seeks to assist in outreach for couples who would usually be excluded from marital therapy for an assortment of reasons by reframing the treatment to fall in line with the concept of a medical or dental checkup. Participants received 4 sessions over 2 years, each lasting around 2 hours. Each year, 1 assessment session and 1 feedback session would occur, with 2 weeks between the assessment and feedback sessions. Both the control group and the treatment group received 2-week, 6-month, and 1-year follow-up questionnaires. The Marriage Checkup includes assessment and feedback sessions of about 2 hours, each including social support interactions, problem-solving interactions, and therapeutic interviews. The feedback session was approximately 2 weeks after the assessment session. This intervention requires a clinician to implement. For more information: Information on the program itself can be found in two sources: Córdova, 2009 Córdova, 2014	Brief, in person	Married couples; not tested with military personnel	There were significant effects in the levels of intimacy and acceptance with the couples. Intimacy significantly increased. Acceptance similarly significantly increased, but there was a significant bump following intervention points and a decreasing effect throughout follow-up. For women, the effect was largely sustained over the 2 years, whereas for men the effect began to disappear between 6 and 12 months. Early increases in acceptance led to long-term satisfaction increases.	Hawrilenko, Gray, and Córdova, 2016; Córdova et al., 2014

Policy/Program Name and Description	Mode	Target Audience	Summary of Evaluation Findings	References
Family of Heroes: An internet-based intervention focused on psychoeducation and simulated conversations about postdeployment stress and mental health treatment. A visual meter allows the user to see how their side of the interactive conversation is going, with a focus on deescalation of the conversation. The intervention takes about 1 hour, with surveys at baseline and one 2-month follow-up survey. For more information: https://kognito.com/products/family-of-heroes Organizations can contact Kognito to purchase a license to make the training available to families in their area. Kognito can be reached at 212-675-9234 or info@kognito.com.	Remote	Military veterans	The study looked at 103 veteran significant-other pairs. It found that the veterans' reactivity to criticism significantly decreased. Veterans also reported a decrease in their perceived family member's reactivity.	Interian et al., 2016
ePREP: This intervention focuses on improving relationship functioning by building communication and problem-solving skills, based on cognitive behavioral therapy (CBT) delivered via computer. The intervention consisted of 1-hour computer sessions followed by weekly standardized emails over 8 weeks. An individual license is $34.95, and the purchase is good for six months. The program can be completed in one to three hours depending on the time you want to spend on each concept. You will be able to stop, start, and review the program as often as you need in that six-month period. For more information: https://www.lovetakeslearning.com/ Email: contact@lovetakeslearning.com Phone: (800) 366-0166	Remote	Adults, not tested with military personnel	Initial trials found that ePREP showed promise in improving key outcomes, such as problematic communication, intimate partner violence, depression, and anxiety, and maintained these at the 2-month follow-up. At a 10-month follow-up, participants in the ePREP condition experienced improved mental health (less anxiety) and relationship outcomes (greater reduction in physical assaults, fewer incidences and greater reductions of psychological aggression). These positive impacts were also found to remain even if the relationship ended.	Davies, Morriss, and Glazebrook, 2014; Braithwaite and Fincham, 2009; Braithwaite and Fincham, 2007
Emotional Reappraisal: Couples in both groups were asked to report fact-based summaries of their most significant disagreement with their spouse on 7 different occasions over 24 months. In waves 4–6, the study group participated in a 7-minute writing task in which they reappraised the conflict by writing as a third-person observer to the conflict. For more information, contact the developer, Eli Finkel: https://www.psychology.northwestern.edu/people/faculty/core/profiles/eli-finkel.html	Remote	Couples; not tested with military personnel	The control group saw a decrease in overall marital quality over time, whereas the intervention group did not. The intervention group also saw a significant decrease in conflict-related marital distress.	Finkel et al., 2013

Policy/Program Name and Description	Mode	Target Audience	Summary of Evaluation Findings	References
Acceptance and Commitment Therapy: A web-based intervention based on *Finding Life Beyond Trauma: Using Acceptance and Commitment Therapy to Heal from Post-Traumatic Stress and Trauma-Related Problems* (Follette and Pistorella, 2007). The initial assessment was done in person, but the intervention was 6 hour-long multimedia interventions from acceptance and commitment (ACT) therapy. For more information: https://contextualscience.org/list_of_resources_for_learning_act The site contains free practical audio exercises and videos about learning and applying ACT, as well as additional references.	Remote	Women who have experienced sexual or physical violence; not tested with military personnel	Significant positive correlations were found across all outcome and process measurements. Participants had decreased PTSD, depression, and anxiety scores. Process measures found a significant decrease in psychological inflexibility.	Fiorillo et al., 2017; Ahtinen et al., 2013; Ly et al., 2012
OurRelationship is a web-based counseling program for individuals or couples. Programs take 7–8 hours to complete over the course of 2 months. They include brief videoconference calls with a staff coach to help couples apply what they've learned to their relationship. OurRelationship is an online adaptation of Integrative Behavioral Couple Therapy, a well-validated in-person couple therapy (Christensen et al., 2004; Christensen et al., 2010). For more information: https://www.ourrelationship.com/	Remote	Adults in relationships (enrolled as individuals or couples)	Several well-designed studies have shown positive outcomes: 300 heterosexual couples (600 individuals) participated in a wait-listed randomized control trial (Doss et al., 2016). Compared with the control group, couples participating in the intervention had significant improvements in relationship satisfaction and relationship confidence and a decrease in negative relationship quality. Couples also improved in individual domains, including symptoms of anxiety and depression, perceived health, work functioning, and quality of life. In one study, OurRelationship was even more effective than in-person couple therapy (Georgia, 2017).	Doss et al., 2016; Nowlan, Roddy, and Doss, 2017; Doss et al., 2019; Georgia, 2017

Resource List 3-4. Work-Life Balance Interventions

Policy/Program Name and Description	Mode	Target Audience	Summary of Evaluation Findings	References
Headspace is a mindfulness intervention delivered through a smartphone application, offering 10-minute guided meditations (audio only), occasional animated videos (audio and video), and longer and focused meditations. Meditations use techniques such as body scanning, guided breathing, and focus. The intervention has been used in the following ways: • Daily mindfulness exercises from the Take 10 feature for 10 minutes a day over 10 days; control condition listened to 10 excerpts from the audiobook *The Headspace Guide to Meditation and Mindfulness* (Economides et al., 2018) • Participants used app as desired over four weeks (no minimum use required) (Wen et al., 2017) • 30-day program of daily guided meditations that increase in duration, beginning with 10 minutes a day for the first 10 days, 15 minutes a day for the next 10 days, and 20 minutes a day for the next 10 (Bennike et al., 2017) • One session of self-guided mindfulness meditation per week for 4 weeks (Wylde et al., 2017) • Daily mindfulness exercises from the Take 10 feature for 10 minutes a day over 10 days (Howells et al., 2016) For more information: www.headspace.com	Smartphone app	Adults (see evaluation findings); no reported military use	Numerous studies have shown promising outcomes in increasing mindfulness skills and reducing stress. For example: **Self-selected adults who had not meditated in the last 6 months** (Economides et al., 2019) were randomly assigned to the Take 10 mindfulness Headspace feature or to a Headspace audiobook featuring an introduction to the concepts of mindfulness and meditation. Although both interventions were effective at reducing stress associated with personal vulnerability, only the mindfulness intervention had a significant positive impact on irritability, affect, and stress resulting from external pressure. **Medical residents** (Wen et al., 2017): 30 primarily female (90%) medical residents completed this study, showing significant increase in mindfulness at week four but no significant changes in positive or negative affect (mood). However, both positive affect and mindfulness scores increased with increasing use of the smartphone app (negative affect did not change). **Novice pediatric nurses** (Wylde et al., 2017): Nurses using the Headspace smartphone app showed improvements in certain mindfulness skills (acting with awareness and nonreactivity to inner experience) and marginal improvements in compassion satisfaction and burnout compared with those participating in a traditional mindfulness intervention. The traditional mindfulness group had significantly less of the "acting with awareness skills" than the smartphone group. Other differences between the smartphone and traditional mindfulness intervention groups were not significant. **Self-selected adults** (Howells, Ivtzan, and Eiroa-Orosa, 2016): 121 predominantly female (87%) participants showed significant increases in positive affect with a medium effect size and reduced depressive symptoms with a small effect size, although no statistically significant differences in satisfaction with life, flourishing, or negative affect were found. No statistically significant gains were observed in the control condition.	Economides et al., 2019; Wen et al., 2017; Bennike, Wieghorst, and Kirk, 2017; Wylde et al., 2017; Howells, Ivtzan, and Eiroa-Orosa, 2016

Policy/Program Name and Description	Mode	Target Audience	Summary of Evaluation Findings	References
Mental Health Guru is a brief online training targeted to workplaces. Employees complete two modules that include information, interactive exercises, videos, quizzes, and personalized feedback intended to increase knowledge about depression and anxiety, destigmatize mental health, and encourage help-seeking. For more information: https://mhguru.com.au/info/about	Modular website	Adults; not tested with military personnel	Only one published study is available (randomized controlled trial) with promising results. **Employees of a large multidepartmental government agency** (Griffiths et al., 2016): Mental Health Guru participants showed significantly greater improvements in knowledge about depression and anxiety compared with a control group. Participants also had significantly greater reductions in depression, anxiety, and personal stigma. There was no effect on help-seeking intentions or help-seeking attitudes. However, self-reported help-seeking behavior was significantly greater in the Mental Health Guru group at posttest. Participants also had greater intentions to seek help for depression from the internet at 6-month follow-up.	Griffiths et al., 2016
Learning2Breathe is a mindfulness program originally developed for use in schools with adolescents, but it has been adapted for use with college students and educators. The purpose of the program is to build emotion regulation skills by practicing principles of mindfulness. The program comes with sample outcome measures, teacher narratives, audio files, posters, wallet cards, and customizable workbooks. It can be delivered in 6, 12, or 18 sessions. For more information: https://learning2breathe.org/	Brief, in person	Adolescents, college students, educators	Several studies have shown promising outcomes. Learning2Breathe has been recognized in the 2015 Collaborative for Academic, Social, and Emotional Learning Guide as meeting research criteria for effective social-emotional learning programs. For example: **Female high school seniors** (Broderick and Metz, 2009): Compared with the control group, participants had a significant reduction in negative affect (mood) and a significant increase in feeling calm/relaxed/self-accepting.	Broderick and Metz, 2009; Mahfouz et al., 2018 Many more references available here: https://learning2breathe.org/list-of-l2b-publications/
Stress Free Now is an 8-week mindfulness-based stress management intervention. The intervention is delivered through weekly web page views and 5- to 10-minute video clips of key concepts, audio guided meditations (20–25 minutes) that participants are encouraged to practice five times a week, daily articles about the research and benefits of the week's mindfulness theme, and daily tips on managing stress and incorporating mindfulness. For more information: http://www.clevelandclinicwellness.com/Pages/StressFreeNow.htm Smartphone app: https://my.clevelandclinic.org/mobile-apps/stress-free-now-app	Website and smartphone app	Adults; not tested with military personnel	Preliminary evidence suggests positive outcomes. **Adults age 18 and over recruited at clinics (patients with psychosis excluded)** (Morledge et al., 2013): This 12-week randomized controlled trial found significant positive effects for stress, mindfulness attention, psychological well-being, and other outcomes for participants who remained active in the intervention for 6 to 8 weeks. Change scores were larger for the more active participants compared with all participants.	Morledge et al., 2013; Allexandre et al., 2016

Policy/Program Name and Description	Mode	Target Audience	Summary of Evaluation Findings	References
Moodgym is an online self-help intervention for anxiety and depression management. The intervention consists of 5 online cognitive behavioral training modules (30 minutes weekly) and quizzes and exercises with visual aids and detailed feedback focusing on thoughts, moods, problem-solving, and coping methods. For more information: https://moodgym.com.au/	Modular website	Adults, including employees and under-graduate and graduate students	At least 4 studies using randomized control trial designs have shown improvements in anxiety and depressive symptoms. Examples include: **Employees in transportation, health, and communications sectors** (Phillips, 2014): Randomized control trial showed reduction in depressive symptoms, as measured by the Patient Health Questionnaire-9 (PHQ-9). **Undergraduate university students** (Ellis et al., 2011; Sethi et al., 2010): This randomized control trial found improvements in anxiety and depression compared with the control group and compared with the control intervention. Anxiety and depression were measured using the Depression, Anxiety, and Stress Scale-21.	Phillips, 2014; Ellis et al., 2011; Sethi et al., 2010; Guille et al., 2015; Christensen, Griffiths, and Jorm, 2004; O'Kearney et al., 2006
MoodPrism is a smartphone app that helps participants understand their emotional health through daily tracking and colorful, detailed feedback reports on their wellness, anxiety, and depression symptoms. It provides health information based on daily mood and links to mental health resources. For more information: https://www.moodprismapp.com/	Smartphone app	Universal (ages 13+); not tested with military personnel	**App users age 13 and over** (Bakker et al., 2018): This study compared users of three different apps with a wait-listed control group. Compared with the control group, there was a positive improvement within the group as well as against the control group for a range of mental health indicators. MoodPrism had a significant positive impact on psychological well-being and emotional self-awareness. Compared with the control group, MoodPrism did not show a significant improvement in generalized anxiety scores.	Bakker et al., 2018
MoodMission is a smartphone app designed to help individuals cope with feelings of anxiety and depression. Users input information about their current mood and are provided with a tailored list of five simple, quick, and effective “missions” (activities) that can help improve mood. Users can track what does and does not work for their specific feelings, obtaining more accurate feedback the more they use the app. For more information: https://moodmission.com/	Smartphone app	Universal (ages 13+); not tested with military personnel	**App users age 13 and over** (Bakker et al., 2018): This study compared users of three different apps with a wait-listed control group. Compared with the control group, MoodMission had a significant positive impact on depression symptoms (measured using the PHQ-9), on mental well-being, and on coping self-efficacy, but users did not show a significant improvement in generalized anxiety scores.	Bakker and Rickard, 2018; Bakker et al., 2018

Policy/Program Name and Description	Mode	Target Audience	Summary of Evaluation Findings	References
MoodKit encourages users to engage in mood-enhancing activities, identify and change unhealthy thinking, rate and chart their mood over time, and create journal entries to promote well-being. MoodKit was developed by clinical psychologists and uses principles of CBT. For more information: http://www.thriveport.com/products/moodkit/	Smartphone app	Universal (ages 13+); not tested with military personnel	**App users age 13 and over** (Bakker et al., 2018): The randomized control trial shows that there is a positive improvement within group as well as against the control group for a range of mental health indicators. Relative to the control, MoodKit had a significant positive impact on depression symptoms (measured using the PHQ-9), on mental well-being, and on coping self-efficacy, but users did not show a significant improvement in generalized anxiety scores.	Bakker et al., 2018
myStrength is a smartphone app based on principles of CBT designed to help users with feelings of anxiety and depression as well as insomnia and chronic pain through mood tracking, targeted activities, and a library of wellness resources. For more information: https://mystrength.com/	Web- and mobile-based platform	Adults; not tested with military personnel	Several white papers and case studies on the https://mystrength.com/outcomes website suggest evidence of effectiveness. Peer-reviewed papers show a return on investment (ROI) and reductions in anxiety and depression. **Patients of a rural community health center** (Abhuliman and Hirsch, 2018): Medical claims from a large sample of app users were matched to a control group. The ROI study demonstrated an incremental cost reduction of $382 per user (an ROI between 142% and 695%).	Abhulimen and Hirsch, 2018; Hirsch et al., 2017
SuperBetter is a free website and smartphone app in which users play games and accomplish challenging goals to increase social support, build resilience, and improve mental health. SuperBetter is based on principles of CBT. Recommended game time is five minutes twice a day. For more information: https://www.superbetter.com/	Website and smartphone app	Adults, college students, adolescents; not tested with military personnel	Some studies have shown promising outcomes, including: **Adult iPhone users with significant depression symptoms** (Roepke et al., 2015): SuperBetter users had greater reductions in depression scores than the wait-listed control at posttest and at longer-term follow-up. The sample was self-selected, and there was high attrition.	Roepke et al., 2015; Chou, Bry, and Comer, 2017 Other references available here: https://www.superbetter.com/science

Policy/Program Name and Description	Mode	Target Audience	Summary of Evaluation Findings	References
Team Resilience (web-based) is an online adaptation of an evidence-based intervention. The e-learning module aims to increase the participant's ability to be resilient in the workplace, knowledge about resilience, awareness of helping resources, and willingness to use those resources. The online program consists of video, audio, interactive exercises, and quizzes. The program consists of 55 slides that participants can view on a computer or mobile device at their own pace (viewed over 4 to 6 weeks). Contact: Joel B Bennett, Ph.D. Organizational Wellness & Learning Systems (817) 921-4260 Email: owls@organizationalwellness.com https://organizationalwellness.com/pages/evidence-based-curriculum	Modular website	Adults (not tested with military personnel); previous studies with restaurant workers (Bennett et al., 2010) and employees of an engineering firm (Bennett et al., 2018)	The original in-person Team Resilience training was rated by the National Registry for Evidence-Based Programs and Practices as a *promising practice*. The web-based version was developed later and evaluated by the developers: **Employees of a national engineering firm** (Bennett et al., 2018): In this nonrandomized quasiexperimental study with a convenience sample, participants increased their workplace resilience compared with the control group. There was no difference in stress between participants and control. Participants significantly improved in several areas from pre- to post-: perception of ability to be resilient, knowledge of how to be more resilient, knowledge of where to get help, and willingness to use the resources.	Bennett et al., 2010; Bennett et al., 2018

Policy/Program Name and Description	Mode	Target Audience	Summary of Evaluation Findings	References
Mindfulness-Based Stress Reduction (MBSR) is a mindfulness training program designed to reduce stress and help participants improve coping skills. In-person training is provided by a trained facilitator who completes an 8-week or 9-day fundamentals course (approx. $4,850 to $5,390) conducted by the University of Massachusetts Center for Mindfulness. The implementation approach has varied slightly in published studies and has included • a 30-minute session once a week for 4 weeks (Mackenzie et al., 2006) • a daily exercise for 15 consecutive days, with 15 minutes each day to practice each exercise (Halamová, Kanovský, and Pacúchová, 2018). Contact: The Center for Mindfulness (508) 856-2656 mindfulness@umassmed.edu www.umassmed.edu/cfm/	Typically brief in-person sessions, but has included remote (emailed instructions; Halamová, Kanovský, and Pacúchová, 2018)	Numerous civilian adult populations, including veterans with PTSD	MBSR is designated as a *promising practice* by the Penn State Military Families Clearinghouse. Several studies have shown improvements in physical and psychological symptoms, life satisfaction, and mental health-related quality of life (https://www.continuum.militaryfamilies.psu.edu/program/fact_sheet_680). Evaluation findings include: **Nurses and nurse aides in geriatric teaching hospital in Canada** (Mackenzie et al., 2006): Significant improvements in burnout symptoms, relaxation, and life satisfaction for the intervention group. Size effects were small for emotional exhaustion and life satisfaction and insignificant for depersonalization and relaxation. **Convenience sample of adults** (Halamová, Kanovský, and Pacúchová, 2018): MBSR participants reported significantly decreased self-criticism and self-uncompassionate responses with effects present at 2-month follow-up. There was a short-term increase in self-compassion, but this was not present at the 2-month follow-up. Participants had decreased feelings of inadequacy and self-uncompassionate responses at the posttest survey, but these did not persist to the longer-term follow-up. Participants had decreased self-criticism for both the posttest survey and the follow-up survey.	McIndoo et al., 2016; de Vibe et al., 2013; de Vibe et al., 2015; Mackenzie et al., 2006; Call et al., 2014; Halamová, Kanovský, and Pacúchová, 2018

Tip 4-1. Types of Adaptations

RED-LIGHT ADAPTATIONS

may greatly weaken the P⁴ and generally would not be advised. For example, reducing or eliminating practice components to save time may make the P⁴ less effective.

Examples

- Shortening a program (for example, deleting an activity or whole session)
- Reducing or eliminating activities that allow participants to personalize material
- Reducing or eliminating opportunities for skill practice or certain topics
- Replacing interactive activities with lectures or individual work

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YELLOW-LIGHT ADAPTATIONS

are complex so proceed with caution. They often require expert assistance from the developer or someone experienced with using the P⁴ in the Air Force to avoid weakening the P⁴'s content.

Examples

- Changing the order of lessons or sequence of activities
- Adding or replacing activities to address additional topics or reinforce learning
- Replacing or supplementing videos (with other videos or activities)
- Using other models or tools that teach the same skill
- Implementing the program with a new population (e.g., an ethnic or cultural group)
- Adapting a program to the Air Force that has no prior use in the military

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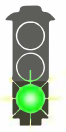
GREEN-LIGHT ADAPTATIONS



are considered safe, minor changes that can help a P⁴ better connect with the audience (i.e., fit a program to the culture and context) without reducing its effectiveness.

Examples

- Updating or customizing statistics and other information included in the curriculum or handouts
- Adjusting the location of the program to one familiar and convenient for participants
- Adding debriefing or processing questions
- Making activities more interactive and appealing to different learning styles

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STEP 6

Resources for GTO Step 6

Tip 6-1. The Difference Between Process and Outcome Evaluation in GTO

PROCESS EVALUATION

tracks **quality** of a P4

- Who participates in a P4? (Did we reach the right target population?)
- How much do participants use the P4? (Did the target population get the right "dose"?)
- How well was the P4 delivered (adhered to curriculum, faithful to P4 model)?
- How satisfied are participants?

OUTCOME EVALUATION

tracks **change** in participants

- How much did P4 participants change on the outcome of interest (actual behaviors or behavioral risk and protective factors)?

Example for Evaluation Planner tools: P4, Moving Forward, aims to reduce stress among Airmen

How much do participants use the P4?

Considerations	Methods and Data Collection	Schedule for Data Collection/ Analysis	Person(s) Responsible
What percentage of Airmen who started the course took all eight modules?	Completion data from Commander's Call surveys	At Commander's Call 1, 3, and 5 months after the intervention is announced	Volunteer evaluator

Did the P4 reduce stress?

Evaluation Design	Scale Name/ Questions	Scale Source/ Questions	Items to Include
Pre-/post- with comparison group	Ten-item measure of perceived stress scale (PSS); frequency of different stress-related feelings from 0 (never) to 4 (very often)	Cohen et al., 1983	All ten PSS items about experiences in the past month

Resource List 6-1. Examples of Process Evaluation Measures

Types of Measures	Description	Source
Characteristics of participants compared with the target population (e.g., compare demographics of actual participants with those of the intended target population).		
Gender	Do you describe yourself as a man or a woman? *Response options: Man, Woman*	N/A
Age	What is your age? *Response options: Number*	N/A
Ethnicity	What is your ethnicity? *Response options: Hispanic or Latino, not Hispanic or Latino*	Office of Management and Budget, 1997
Race	What is your race? Select all that apply. *Response options: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, White*	
Pay grade	What was [is] your highest pay grade? *Response options: E1–E4, E5–E6, E7–E9, O1–O3, O4 and above*	N/A
Brief interventions: Level of delivery the P^4 achieved and whether all planned components were delivered		
Program attendance and dosage	How many sessions a participant attended within a given time period How many minutes a participant received of the program within a given time period	Gamarra et al., 2015 ; Christensen et al., 2006
Training fidelity and quality	Staff observations of whether the trainer covered all the training elements or whether some were skipped or not given adequate time Staff perceptions of how prepared the trainer was—for example, whether they were able to present material without reading verbatim from script or slides; whether they brought all necessary materials with them, such as handouts or props	Farris et al., 2019
Attention and participation	Staff observations of whether trainees appeared attentive (for example, nodding, active posture, looking at trainer or slides) Self-report of whether trainees were able to pay attention—for example, asking how much participants agree with the statement "I was able to pay attention during the training" Staff observations of the number of trainees who actively participated—for example, by asking or responding to questions or making productive contributions to discussions	Farris et al., 2019
Participant-program staff interactions	Number and quality of documented accounts of collaboration between participants and program facilitator or provider	Gamarra et al., 2015
Attrition rate of participants involved in program	The number of participants who were still participating at the end of the program divided by the number who enrolled at the start of the program to determine the percentage of attrition	Shear et al., 2016
Remote interventions: Level of delivery the P^4 achieved and whether all planned components were delivered		
Reach of the intervention	Number of website sessions: A session is a group of interactions that take place on a website within a given time frame (also described as the number of visits made to a website).	Acosta et al., 2020

Types of Measures	Description	Source
Engagement with the intervention	Bounce rate: The percentage of total website sessions that are single-page visits Average session duration: The total duration of all sessions divided by the number of sessions	Acosta et al., 2020
Remote and brief interventions: Participant perceptions		
Likelihood to recommend	How likely participants would be to recommend the program to others—for example, how much participants agree with the statement "I would recommend this program to others"	Tompkins and Witt, 2009 Lee, Lee, and Choi, 2011; Lee et al., 2011
Perceived usefulness of the material	Participant ratings of the usefulness of the material covered in the program	Thomas and Taylor, 2015
Understanding of factors that contribute to participants' use (or lack of use) of the intervention	Open-ended questions on post-program evaluation survey asking: • What factors contributed to your use of the intervention (e.g., the intervention is easy to access throughout the day)? • What factors made it difficult to use the intervention (e.g., the material was hard to navigate, the technology did not work well)? • Did the material help you to think of ways the recommendations could be incorporated into your daily life? Why or why not? • What obstacles did you experience in trying to incorporate the recommendations into your daily life (e.g., it was difficult to fit the recommendations into the demands of my military job; I don't think it is an important issue or concern for me)? • In what ways could the intervention be modified to increase the chances that you will use the recommendations in your daily life?	
Participant satisfaction	The proportion of participants indicating that they were satisfied or very satisfied with • the program content • the exercises or interactive pieces of the program • the user friendliness of the program material. The extent to which participants indicated that they incorporated strategies from the program into their daily life Participant ratings of how knowledgeable the trainer was (for example, was the trainer able to easily answer trainee questions?)	Farris et al., 2019
Satisfaction with an online course	Participant responses to the Telecourse Evaluation Questionnaire to understand important factors for satisfaction in the online environment	Bolliger, 2004
System Usability Scale A 10-item scale to assess the usability of a website or web-based system	For more information: This scale is available for free to use at https://www.usability.gov/how-to-and-tools/methods/system-usability-scale.html This scale uses a 5-point Likert scale to assess agreement from "strongly disagree" to "strongly agree." Items ask about the complexity and consistency of the system, whether users would use the system frequently, and their confidence using the system.	Brooke, 1996

Types of Measures	Description	Source
Mentoring Event Evaluation A 7-point Likert scale with 6 questions to evaluate satisfaction with the event	For more information: "Speed Mentoring: An Innovative Method to Facilitate Mentoring Relationships" https://www.tandfonline.com/doi/pdf/10.3109/01421591003686278 This scale was developed specifically for use with this specific type of mentoring event and is available in the reference listed. Mentors and mentees were asked their level of agreement with items that asked about the extent to which their time was well spent, whether the discussions were stimulating, whether they would recommend the event to a colleague, and whether one-on-one mentoring was better than paired mentoring. Mentees were also asked whether their key questions were answered and whether they would be pursuing a relationship with one of the mentors.	Cook, Bahn, and Menaker, 2010

Resource List 6-2. Examples of Outcome Measures for P[4] That Address Alcohol Use

Sample Measure	Brief Description	Reference(s)
Protective Behavioral Strategies Scale-20 For a listing of the 20 items, see Table 2 in Richards et al., 2018: https://www.sciencedirect.com/science/article/pii/S2352853218300075?via%3Dihub	Protective behavioral strategies are most commonly defined as behaviors that are used while drinking to reduce alcohol use (e.g., stop drinking at a set time) or limit alcohol-related problems (e.g., use a designated driver). The Protective Behavioral Strategies Scale-20 lists 20 such behaviors and asks the degree to which respondents engage in protective behavioral strategies when using alcohol or "partying" on a 6-point response scale ranging from 1 (never) to 6 (always). The Protective Behavioral Strategies Scale has demonstrated internal consistency, convergent validity, and construct validity.	Treloar, Martens, and McCarthy, 2015
NIAAA measure of binge drinking For more information: https://www.niaaa.nih.gov/research/guidelines-and-resources/recommended-alcohol-questions	NIAAA has developed a 3-, 4-, 5-, or 6-item set of questions that assess drinking, including heavy drinking. The 3-item set asks about the frequency of past-12-month drinking, the number of drinks consumed on a typical drinking day in the past 12 months, and the frequency of binge drinking in the past 12 months to capture information about both level of consumption and drinking patterns, as recommended. The 4-item set adds a question about the maximum number of drinks consumed in a 24-hour period in the past 12 months. This question is important because it provides additional information about drinking patterns and because it is highly correlated with alcohol use disorders. It is inserted before the binge drinking question, which then becomes question 4 in the 4-item set. The 5-item set adds a question about maximum drinks in a 24-hour period in the respondent's lifetime as the last question in the set. Finally, the 6-item set adds, as the fourth question immediately following the item about maximum drinks in a 24-hour period in the past 12 months, an item that asks about the frequency of consuming this maximum number of drinks in the past 12 months. The 12-month time frame can be changed depending on the needs of the evaluation.	Caetano et al., 1997; Cherpitel et al., 1995; Greenfield and Rogers, 1999; Midanik et al., 1996; Rehm and Bondy, 1996; Rehm, Greenfield, and Rogers, 2001; Room, Bondy, and Ferris, 1995
Alcohol Use Disorders Identification Test (AUDIT) For more information: https://auditscreen.org/	AUDIT is a 10-item measure that asks about the three key domains of alcohol intake, potential dependence on alcohol, and experience of alcohol-related harm. Its reliability and validity have been established in research conducted in a variety of settings and in many different nations. It is considered to be a highly suitable screening instrument for the whole range of unhealthy alcohol use in primary care and other health care settings. AUDIT has been used in primary care research and in epidemiological studies for the estimation of prevalence in the general population as well as specific institutional groups (e.g., hospital patients, primary care patients).	Hundreds of studies have been conducted assessing AUDIT or using AUDIT with various populations. The link provides access to multiple references organized into the following categories: primary publications, systematic and other reviews, AUDIT derivatives, validation in different populations, and comparison with other instruments: https://auditscreen.org/about-validation/

Sample Measure	Brief Description	Reference(s)
Brief Young Adult Alcohol Consequences Questionnaire (B-YAACQ) For a copy of the actual measure and scoring guidelines: https://arlbuffalo.com/the-young-adult-alcohol-consequences-questionnaire/the-brief-yaacq/ For more information, contact: Christopher Kahler, Ph.D. Center for Alcohol and Addiction Studies, Brown University Box G-BH Providence, RI 02912 christopher_kahler@brown.edu	This scale can help assess alcohol problems among college students, track changes in alcohol problems throughout college, and measure the response to alcohol interventions. It consists of 24 items and was derived from the 48-item Young Adult Alcohol Consequences Questionnaire. The B-YAACQ has items that cover the full range of the alcohol problems continuum from signs of excessive drinking to symptoms consistent with alcohol abuse and alcohol dependence. The tool can be used for a number of purposes: by college students as a self-assessment, by community and educators to monitor alcohol problems on their local college campus, and to identify treatment needs. Its brevity and good resolution across a range of drinking problems support its clinical utility. Raw scores on the brief scale can range from 0 to 24. Validity/reliability: In Kahler et al., 2005, the B-YAACQ showed excellent distributional properties, had items adequately matched to the severity of alcohol problems in the sample, covered a full range of problem severity, and appeared highly efficient in retaining all of the meaningful variance captured by the original 48 items in the Young Adult Alcohol Consequences Questionnaire.	Kahler, Strong, and Read, 2005; Read et al., 2006; Kahler et al., 2008; Devos-Comby and Lange, 2008; Verster et al., 2009
Daily Drinking Questionnaire For more information, contact R. Lorraine Collins, Ph.D., Department of Community Health and Health Behavior, University at Buffalo, the State University of New York lcollins@buffalo.edu	The Daily Drinking Questionnaire assesses weekly alcohol consumption. It is a condensed version of Calahan's Drinking Habits Questionnaire, which assesses the volume, quantity, and frequency of alcohol consumption. On the Daily Drinking Questionnaire, respondents fill in a series of seven boxes indicating their typical pattern of alcohol use on each day of the week in the past month. A modified version of the Daily Drinking Questionnaire that includes a second set of boxes for the typical number of hours spent drinking for each day in a typical week has also been developed.	Collins, Parks, and Marlatt, 1985; Dimeff, 1999
Drinking Norms Rating Form (DNRF) The DNRF is simply an extension of the Daily Drinking Questionnaire. Thus, when using this measure, a reference group would be chosen (e.g., other members of your unit) and the Daily Drinking Questionnaire would be used (e.g., how many drinks do you think other members of your unit drink on a given day?). Actual amounts of drinking can be compared with perceived drinking and used in prevention—e.g., people often overestimate how much others actually drink. For information, contact John Baer, Ph.D., Alcohol & Drug Abuse Institute, University of Washington (206) 616-3397 jsbaer@u.washington.edu	The DNRF is an extension of the Daily Drinking Questionnaire, which obtains subjects' estimates of typical alcoholic drinks on each day of the week. The DNRF asks people to rate themselves and also to consider different groups of people and rate "typical" or "average" drinking for persons in that group (e.g., people in your unit or wing). People are asked to think about the days of the week those individuals usually drink and then estimate the number of standard drinks typical individuals in each group drink on those days. They are instructed to try to average across members in each reference group and to think back over the past 3 months when making their estimates. Studies of the DNRF have found it to be valid, predictive of drinking behavior, and reliable (Broadwater et al., 2006).	Baer, Stacy, and Larimer, 1991; Broadwater et al., 2006; Kypri and Langley, 2003; Larimer et al., 1997; Dimeff, 1999

Resource List 6-3. Examples of Outcome Measures for P[4] That Address Healthy Relationships and Communication

Sample Measure	Brief Description	Reference(s)
Postdeployment Social Support Scale	A subscale of the Deployment Risk and Resilience Inventory, this 15-item subscale uses a 5-point Likert scale to assess perceived availability of social support since returning home from the war zone. This scale has demonstrated good internal consistency (0.87) in prior research with veterans.	King et al., 2006 For more information: This scale is available for free at https://www.ptsd.va.gov/professional/assessment/deployment/postdeployment-support.asp
Perceived Relationship Quality Components Inventory (PRQCI)	Consists of 6 3-item subscales that measure the components of relationship quality: satisfaction, commitment, intimacy, trust, sexual passion, and love. Items such as "How satisfied are you with your relationship?" (satisfaction; α = 0.96), "How committed are you to your relationship?" (commitment; α = 0.90), "How intimate is your relationship?" (intimacy; α = 0.89), "How much do you trust your partner?" (trust; α = 0.93), "How passionate is your relationship?" (sexual passion; α = 0.90), and "How much do you love your partner?" (love; α = 0.87) are scored on a 7-point scale ranging from 1 (not at all) to 7 (extremely). Consider using just one or two relevant subscales (3 questions each) to reduce respondent burden.	Ratelle et al., 2013 For more information: Scale available for free here: http://socialinteractionlab.psych.umn.edu/sites/socialinteractionlab.dl.umn.edu/files/behavioral_scales/Behavioral%20Scales/Perceived%20Relationship%20Quality%20Components%20Inventory%20%28PRQC%29.doc
Perceived Criticism Scale	Participants are asked, "How critical is your spouse of you?" Responses on a 10-point Likert-type scale range from 1 (not at all critical) to 10 (very critical indeed). In addition, participants are asked to rate "How critical are you of your spouse?" on the same scale. Prior studies found test-retest reliability for perceived criticism to be 0.75 over intervals of 2 weeks and approximately 20 weeks, respectively. Perceived criticism is negatively correlated with marital satisfaction.	Chambless and Blake, 2009 For more information: The 2-question scale was developed by Hooley and Teasdale, 1989.
Quality of Marriage Index (QMI)	A six-item Likert-scale to assess a partner's evaluation of the quality of her or his marriage. The first five items in the measure are each ranked on a 7-point scale, ranging from 1 (strongly disagree) to 7 (strongly agree). Examples of these items include "we have a good relationship" and "my relationship with my partner makes me happy." The final question asks participants to rate their overall level of happiness from 1 (not at all happy) to 10 (extremely happy). The sum of the items was used, with a possible range from 6 to 45. The measure has been extensively validated and was found to be reliable in evaluation studies of relationship interventions (Cronbach's 0.97).	Norton, 1983; Cigrang et al., 2016 For more information: QMI developed by Norton, 1983. The brevity of the instrument in comparison with other tools can be a considerable advantage because large populations can be assessed in a short period of time. The six items are available in their entirety here: https://bmcresnotes.biomedcentral.com/articles/10.1186/s13104-019-4438-2/tables/1
Inclusion of the Other in the Self Scale (IOS)	A single-item pictorial measure with Venn diagrams measuring the perceived closeness of the self and another person (X). The item has 7 response options and shows the circles as separate to almost entirely overlapping and asks participants to select the pair of circles that best describes their relationship with X. Prior studies have shown this to be a reliable measure of relationship closeness.	Aron, Aron, and Smollan, 1992; Gächter, Starmer, and Tufano, 2015 For more information: The Venn diagram images are available for free online at http://sparqtools.org/mobility-measure/inclusion-of-other-in-the-self-ios-scale/
Couples Satisfaction Index (CSI-4)	Very brief (4-item) measure of couples' satisfaction with their relationship. Participants rate their happiness in the relationship, warmth, and satisfaction with the relationship. Scores are summed and can range from 0 to 21, with greater scores indicating higher satisfaction. This brief measure was originally 32 items and has been psychometrically optimized.	Funk and Rogge, 2007 Copy of the measure available here: http://couples-research.com/wp-content/uploads/2017/06/CSI-4.docx

Resource List 6-4. Examples of Outcome Measures for P[4] That Address Work-Life Balance

Measure	Brief Description	Reference(s)
Mindfulness*		
* Mindfulness interventions teach participants skills to ultimately improve mood, stress, and other outcomes. The measures in this category just determine whether participants have learned the mindfulness skills. In your outcome evaluation, be sure to use measures in the other sections of the table as well to assess your ultimate desired outcomes (e.g., improved mood, decreased stress, decreased burnout).		
Five Facet Mindfulness Questionnaire (FFMQ)	Measures the five facets of mindfulness (subscales): observing, describing, acting with awareness, nonjudging of inner experience, and nonreactivity to inner experience. The scale is constructed of 39 statements rated on a 5-point scale (1 = never or very rarely true to 5 = very often or always true), with higher scores indicating greater mindfulness. Each of the five subscales has good internal consistency (Cronbach's α ranging from 0.75 to 0.91). To reduce participant burden (i.e., the length of the survey), consider using only one or two subscales at a time. Subscales are listed at the end of the PDF link on the right under "Scoring."	Baer et al., 2006 Copy of the measure available here: https://ogg.osu.edu/media/documents/MB%20Stream/FFMQ.pdf
Mindful Attention to Awareness Scale–State (MAAS)	5-item unidimensional scale of "state" (or current) mindfulness. This measure assumes that respondents are receiving a page or text to rate their immediate experiences. Respondents rate statements such as "I was finding it difficult to stay focused on what was happening" on a 7-point Likert scale from 0 (not at all) to 6 (very much). Scores are calculated as an average across the scale, with higher scores indicating greater dispositional mindfulness. MAAS has demonstrated good internal consistency (α = 0.92).	Brown and Ryan, 2003; Carlson and Brown, 2005 Copy of the measure available here: https://ggsc.berkeley.edu/images/uploads/The_Mindful_Attention_Awareness_Scale_-_State.pdf
Cognitive and Affective Mindfulness Scale–Revised (CAMS-R)	12 items measuring mindfulness. Participants rate statements such as "I can accept things I cannot change" on a 4-point Likert scale from 1 (rarely/not at all) to 4 (almost always). This measure is valid and reliable, and experts recommend it because it is easier to score and easier for participants to understand than some other measures of mindfulness.	Feldman et al., 2007 Copy of the measure available here: https://ggsc.berkeley.edu/images/uploads/The_Cognitive_and_Affective_Mindfulness_Scale_%E2%80%93_Revised.pdf
Mental health and mood		
Kessler-10 (K-10)	The K-10 is a very well-established 10-item measure of psychological distress. Respondents rate on a 5-point Likert scale how often they experienced symptoms of depression and psychological distress in the last 30 days. Scores are summed on a range from 10 to 50, with higher scores indicating greater distress. Cut points have been established that indicate levels of severity.	Kessler et al., 2002 Examples of studies using this measure: Ellis et al., 2011; Day et al., 2013 Copy of the measure available here: https://www.tac.vic.gov.au/files-to-move/media/upload/k10_english.pdf
Stress and coping		
Coping Self-Efficacy Scale (CSES)	This 26-item measure is widely used to measure ability to cope with stress. Respondents rate how confident they are that when things are not going well they can engage in 26 different coping actions (e.g., "Take your mind off unpleasant thoughts") from 0 (cannot do at all) to 10 (certain can do). Items are summed to create a CSES score (α = 0.95; scale mean = 137.4, standard deviation = 45.6).	Chesney et al., 2006 Examples of studies using this measure: Bakker and Rickard, 2018

Measure	Brief Description	Reference(s)
		Copies of the measure available here: https://prevention.ucsf.edu/sites/prevention.ucsf.edu/files/CopingSelf-EfficacyScale.pdf https://prevention.ucsf.edu/research-project/coping-self-efficacy-scale-scoring
Perceived Stress Scale (PSS-10 and PSS-4)	This 4- or 10-item measure is perhaps the most widely used measure of perceived stress. Respondents rate how often in the last month they experienced stress-related feelings or circumstances, such as "In the last month, how often have you found that you could not cope with all the things that you had to do?" on a five-point scale from 0 (never) to 4 (very often). The PSS is scored by reversing responses to the four positively phrased items and then summing across all scale items. An even briefer 4-item scale can be made from items 2, 4, 5, and 10 of the PSS-10.	Cohen, Kamarck, and Mermelstein, 1983; Cohen, 1988 Examples of studies using this measure: Hinkle, 2015; Radhu et al., 2012; Arpin-Cribbie, Irvine, and Ritvo, 2012; Rose et al., 2013; Chiauzzi et al., 2008 Copy of the measure available here: http://www.mindgarden.com/documents/PerceivedStressScale.pdf
Life satisfaction*		
* Brief and remote interventions are not likely to change participants' satisfaction with life, but you might consider measuring this to understand overall life satisfaction within your wing (i.e., for context, with the expectation that it is not likely to change through the intervention listed here).		
Satisfaction with Life Scale; also called Life Satisfaction Scale	A widely used 5-item self-report scale assessing respondents' satisfaction with life (e.g., "I am satisfied with my life"). Respondents rate statements on a 7-point Likert scale (1 = strongly disagree, 7 = strongly agree). Scores are summed, with higher scores indicating greater life satisfaction. It has shown high test–retest reliability (r = 0.82) and high internal consistency (α = 0.87).	Diener, Emmons, Larsen, and Griffin, 1985 Examples of studies using this measure: Howells et al., 2016; Mackenzie et al., 2006; Foster et al., 2018; Roepke et al., 2015 Copy of the measure available here: https://fetzer.org/sites/default/files/images/stories/pdf/selfmeasures/SATISFACTION-SatisfactionWithLife.pdf
Job satisfaction and burnout		
Job Satisfaction Scale	Consists of 9 subscales each with 4 items (34 items total): Pay, Promotion, Supervision, Fringe Benefits, Contingent Rewards (performance-based rewards), Operating Procedures (required rules and procedures), Coworkers, Nature of Work, and Communication. Respondents rate their agreement with statements such as "My supervisor is quite competent in doing his/her job" on a six-point Likert scale. Internal consistency ranges from 0.6 to 0.82 for subscales and was 0.91 overall in a community sample of 2,870 respondents.	Spector, 1985 Examples of studies using this measure: Mackenzie et al., 2006 Copy of the measure available here: http://shell.cas.usf.edu/~pspector/scales/jsspag.html
Maslach Burnout Inventory	One of the most well-established measures of burnout, the Maslach Burnout Inventory consists of 22 items assessing work-related burnout, such as "I doubt the significance of my work." Different survey versions are available depending on the population being assessed (e.g., human services professionals, physicians, etc.). Manuals and survey licenses are available to purchase from the developers.	Maslach and Jackson, 1996 Examples of studies using this measure: Mackenzie et al., 2006 Purchase different forms of the survey from the developers here: https://www.mindgarden.com/117-maslach-burnout-inventory

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