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Dean Cisler
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Michael Hunter
Kirk Kennedy
James Beneda
Fred Katana
Carolyn Taylor
Leanna Attias
Peraton Inc.

Olga Shechter
Defense Personnel and Security Research Center
Defense Personnel Analytics Center

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Peraton Inc.

Olga Shechter
Defense Personnel and Security Research Center, Defense Personnel Analytics Center

Released by – Eric L. Lang

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

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ABSTRACT: Despite the range of resources available to support Service members who encounter life stressors, approximately 50%–80% of military personnel who need mental health support, particularly those at risk for suicide, do not utilize resources. In FY21, the Defense Personnel and Security Research Center, a division of the Defense Personnel Analytics Center, developed a web-based Resources Exist, Asking Can Help (REACH) facilitator training designed to assist with REACH dissemination. REACH is an upstream suicide risk intervention that aims to normalize help-seeking among Service members by reducing barriers to care and increasing knowledge of resources. This field test used a randomized evaluation design to assess the effectiveness of the web-based REACH facilitator training relative to the existing instructor-led facilitator training. We also used a one-group pretest-posttest design to evaluate the effectiveness of REACH for reducing barriers to care, increasing knowledge of resources, and increasing resource utilization among geographically isolated Service members, who have limited access to services. Results indicated that while the web-based and instructor-led training formats resulted in similar levels of facilitator knowledge gain, training satisfaction, and confidence to lead a REACH session, facilitators appeared to rate instructor-led training as more useful and engaging than web-based training. Geographically isolated Service member participants reported decreased perceived barriers to help-seeking and increased knowledge of resources and likelihood of future help-seeking at 3-month follow-up. Participants' rates of resource utilization in response to a significant stressor (27%– 44%) were similar 3 months before and after a REACH session. Report recommendations address how to implement REACH more broadly across the total military force.

14. SUBJECT TERMS: mental health support, suicide, suicide prevention, resources exist asking can help, REACH, upstream suicide risk intervention, help-seeking, geographically isolated Service members, limited access to services, instructor training, web-based training, resource utilization.

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Preface

Prior research by the Defense Personnel and Security Research Center (PERSEREC), a division of the Defense Personnel Analytics Center, has culminated in the development of an innovative, upstream suicide risk intervention entitled Resources Exist, Asking Can Help (REACH). Using a small group discussion format, REACH addresses the root causes of why Service members are reluctant to use mental health resources. An FY20 initial field test found that after attending a REACH session, Service members reported reduced barriers to seeking mental health care, improved knowledge about available resources, and greater comfort with reaching out for help in the future. The current field test extends these findings by evaluating a new web-based REACH facilitator training, assessing barriers to care and help-seeking behavior over time, and targeting geographically isolated Service members who may have limited access to mental health and community resources. These efforts to support Service member mental health and well-being contribute to the overall Defense Human Resources Activity mission to ensure that military personnel and their families receive the care they need.

Eric L. Lang
Director, PERSEREC

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The authors thank Suicide Prevention Program Managers (SPPMs), Violence Prevention Integrators, chaplains, and command leadership from Fort Irwin; Fort Wainwright; Joint Base Elmendorf-Richardson; Kentucky Joint Force Headquarters; Naval Air Station Fallon; Naval Air Weapons Station China Lake; Naval Region Southwest; and Army and Air National Guard units in Alaska, Idaho, Kentucky, Massachusetts, Michigan, Missouri, Nebraska, Nevada, North Dakota, Ohio, Oklahoma, Oregon, Tennessee, and Guam. Their support in bringing REACH to their installations was invaluable. Most importantly, this field test would not have been possible without the Service members who participated in REACH sessions and those who volunteered to become REACH facilitators and lead REACH sessions with Airmen, Sailors, and Soldiers.

Executive Summary

Introduction

Approximately 50%–80% of all military personnel who need mental health support, particularly those at risk for suicide, do not utilize available resources (Ho et al., 2018; Hom et al., 2017; Office of People Analytics [OPA], 2019). In FY20, Defense Personnel and Security Research Center (PERSEREC), a division of the Defense Personnel Analytics Center, conducted an initial field test of Resources Exist, Asking Can Help (REACH), which is an upstream suicide risk intervention designed to normalize help-seeking among Service members. Results indicated that after attending a REACH session, Service members reported reduced barriers to seeking mental health care, improved knowledge about available resources, and greater comfort with reaching out for help in the future (Osborn et al., 2020). In FY21, PERSEREC developed a web-based REACH facilitator training to enable the Services to disseminate REACH. The current field test evaluated the effectiveness of: (a) the web-based REACH facilitator training relative to the existing instructor-led facilitator training (based on facilitator responses) and (b) REACH for reducing barriers to care, increasing knowledge of resources, and increasing resource utilization (based on participant responses) among geographically isolated Service members, who have limited access to services.

Method

Field test facilitators (*n* = 61) were Army, Air Force, and Navy personnel from geographically isolated installations (U.S. Government Accountability Office [GAO], 2021) and National Guard locations.[1] We randomly assigned the 61 facilitators to receive instructor-led or web-based facilitator training. After completing the training, they participated in a 1-hour fidelity check (i.e., one-on-one coaching) meeting with the study team to practice delivering REACH and receive feedback. After the fidelity check, facilitators completed a web-based questionnaire concerning their experience with the REACH facilitator training. A subset of these facilitators (*n* = 36) led REACH sessions with Service member participants (*n* = 440). Before the REACH sessions and 3 months after, facilitators asked participants to complete questionnaires evaluating their perceived barriers to help-seeking, resource utilization, and knowledge of resources. Forty-nine participants (11% of participants) completed both questionnaires.

We used descriptive statistics, analyses of covariance (ANCOVAs), and analyses of variance (ANOVAs) to evaluate the effect of REACH facilitator training format (instructor vs. web-based training) on facilitator outcomes. We also conducted a thematic analysis (Braun & Clarke, 2006) of qualitative feedback from facilitators concerning their reactions to the facilitator training. We conducted a series of bivariate analyses (Student's *t*-tests and χ^2 tests) and calculated Cohen's *d* effect sizes to examine changes in Service member participant outcomes from baseline to 3-month follow-up. We also used descriptive statistics to analyze participants' use of specific helping

[1] Locations included Fort Irwin; Fort Wainwright; Joint Base Elmendorf-Richardson; Kentucky Joint Force Headquarters; Naval Air Station Fallon; Naval Air Weapons Station China Lake; Naval Region Southwest; and Army and Air National Guard units in Alaska, Idaho, Kentucky, Massachusetts, Michigan, Missouri, Nebraska, Nevada, North Dakota, Ohio, Oklahoma, Oregon, Tennessee, and Guam.

resources, helping resources participants considered using but did not, and reasons participants did not consider reaching out for help.

Key Findings

Both REACH facilitator training formats resulted in facilitator knowledge gain and high levels of training satisfaction. After completing the training, a large majority (94%–96%) of facilitators in both training format groups felt the training they received met their expectations. Facilitators in the two training format groups identified similar levels of knowledge gain; satisfaction with the training organization, extent to which training prepared facilitators to lead a REACH session with others, and training length; perceived utility of the fidelity check; and confidence to lead a REACH session with others. Facilitators' perceived utility and engagement appeared to be higher when they attended the instructor-led training group versus the web-based training, but those who completed web-based training also reported high levels of engagement, and facilitators in both training format groups stated they would recommend the REACH facilitator training to others. Facilitators who completed the web-based training commented more frequently than those who completed the instructor-led training about the value of the one-on-one fidelity check. In addition, facilitators who completed web-based training reported experiencing technology issues and work interference that exacerbated their concerns about training length.

Our field test results indicate that REACH accomplished its goal of lowering geographically isolated Service member participants' perceptions of barriers to help-seeking. Following the REACH session, participants were less likely to perceive that seeking help would cause others to see them as broken or negatively impact their career, report that they do not know where to get help or lack confidence in the effectiveness of available resources. REACH also significantly increased participants' perceived knowledge of available resources and the likelihood of using Military OneSource the next time they have a concern, as well as recommending it to a friend. We observed sustained effects of REACH on these outcomes 3 months after the REACH session. The prevalence of help-seeking was similar at baseline and follow-up. Service member participants felt that their facilitators expressed passion and enthusiasm for help-seeking during the REACH session and encouraged them to participate.

Recommendations

Our recommendations call for DoD to consider expanding implementation of REACH and funding a larger scale study to collect behavioral measures that do not rely solely on self-report. DoD should also conduct a user experience study to identify technology challenges and solutions to improve REACH web-based facilitator training. To promote widespread dissemination of REACH, DoD should provide support for provision of fidelity checks to REACH facilitators. For facilitators to be able to complete the REACH facilitator training and fidelity check, commanders and leaders must protect their time from work interference. We also provide recommendations for expanding web-based REACH facilitator training to address implementation concerns we identified. Finally, based on the positive feedback from REACH facilitators, we recommend that DoD consider adapting REACH's training design to improve other prevention training efforts for military personnel.

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Introduction

DoD and the Service branches offer a wide range of resiliency and mental health resources to support Service members who encounter life stressors. However, approximately 50%–80% of all military personnel who need mental health support, particularly those at risk for suicide, do not utilize available resources (Ho et al., 2018; Hom et al., 2017; OPA, 2019). Barriers to care, such as concerns about career impact and lack of knowledge of available resources, influence Service members' perceptions of stigma and help-seeking attitudes, intentions, and behaviors (Adler et al., 2015; Clary et al., 2021; Ho et al., 2018; Hom et al., 2017; Jensen & Bowen, 2022). In addition, Service members in geographically isolated areas have difficulty accessing resources and mental health support and are at an increased risk for suicide attempts (U.S. GAO, 2022).

In FY19, Defense Personnel and Security Research Center (PERSEREC), a division of Defense Personnel Analytics Center, in coordination with the Office of Military Community and Family Policy, the Defense Suicide Prevention Office, and the military Service branches, developed an upstream suicide prevention program entitled REACH. Upstream suicide prevention approaches aim to address modifiable risk factors before they manifest as troubling symptoms or problems. REACH provides a comfortable setting for discussing Service members' barriers to help-seeking, presents information and data to address these barriers, and connects Service members to resources. In FY21, PERSEREC developed the REACH web-based facilitator training to support a future large-scale dissemination of REACH across the total military force. The Defense Suicide Prevention Office sponsored the current FY22 REACH field test to evaluate the effectiveness of (a) the newly developed web-based REACH facilitator training relative to instructor-led REACH facilitator training and (b) the REACH intervention for increasing resource utilization.

Background

Service members stationed at remote installations and installations outside of the contiguous United States (OCONUS) often have limited access to mental health and community resources (GAO, 2021, 2022). An in-depth study of four remote and isolated installations found that at three of them, Service members faced commute times of more than 1-hour to access health care providers within DoD's Tricare network (GAO, 2021). Additional stressors for this population include increased commuting costs, higher costs of consumer goods, longer travel distance and time needed to reach grocery stores, and the high cost of off-base housing. As of October 2021, clinics at remote OCONUS installations had not filled 17 (40%) of 42 authorized positions for behavioral health consultants and behavioral health care facilitators (GAO, 2022). Past research has also found a lower rate of behavioral healthcare utilization in remote locations, with remote Service members making fewer visits to specialty behavioral care providers and fewer psychotherapy visits than their non-remote counterparts (Brown et al., 2014).

In addition to geographic isolation, risk factors for suicide include financial concerns, relationship problems, legal and administrative issues, ineffective coping skills, and reluctance to seek help (Pruitt et al., 2018). REACH empowers Service members to reach out for help and proactively address these problems before they become too overwhelming. It employs motivational

interviewing techniques[2] that encourage meaningful conversations with peers, leadership, and suicide prevention specialists. Specifically, REACH's small group discussions with a trusted facilitator highlight the importance of treating mental health in the same way Service members treat physical health, encourage self-referrals, and increase awareness of available resources. Facilitators are typically noncommissioned officers (NCOs), chaplains and other well-respected leaders in their units who have an interest in mental health and suicide prevention (Osborn et al., 2020). A 90-minute REACH session includes three components: (a) a help-seeking barrier reduction discussion, (b) education about available resources, and (c) a demonstration of help-seeking behavior involving a practice phone call to Military OneSource made jointly by the facilitator and a session participant. The session also includes an interactive icebreaker and a short video developed by the Defense Media Activity depicting everyday life stressors and problems common to Service members (Atchley et al., 2019). In line with the DoD-supported public health approach to suicide prevention, it is important to note that REACH applies to all Service members, as opposed to only those already at risk for suicide (OPA, 2021; Osborn et al., 2020).

In FY20, PERSEREC conducted an initial field test of REACH with 33 facilitators and 528 active duty Service member participants at six installations (Osborn et al., 2020). Service members completed a baseline questionnaire and a post-REACH questionnaire immediately after REACH delivery. Results indicated that after attending a REACH session, Service members reported reduced barriers to seeking mental health care, improved knowledge about available resources, and greater comfort with reaching out for help in the future. Positive perceptions of the REACH facilitator were associated with increased participant comfort with help-seeking. However, the initial field test only assessed attitudes towards help-seeking and did not assess help-seeking behavior. It is also unknown whether REACH will demonstrate similar effects for geographically isolated Service members. Non-medical counseling, offered by telephone and via referrals to in-person non-military providers through Military OneSource, can be especially valuable for Service members without readily available access to military treatment facilities (MTFs), Military and Family Life Counselors (MFLCs), and installation-based Military and Family Support Centers.

> "The training was very good. I feel that if I was having any problems or a friend had any problems, I would know exactly where to go. Thank you for your help."
>
> —FY20 REACH field test participant

REACH relies on trusted and knowledgeable facilitators; therefore, a critical requirement for scaling it up across the Service branches is providing readily available and effective training for new facilitators. In FY21, PERSEREC developed a web-based, asynchronous REACH facilitator training hosted on the Office of Military Community and Family Policy's MilLife Learning platform (https://millifelearning.militaryonesource.mil/course/reachfc)[3] to enable the Services to disseminate REACH effectively and efficiently. PERSEREC modeled the web-based training after the successful instructor-led REACH facilitator training previously field-tested in FY20. The web-based

[2] Motivational interviewing is a counseling approach that aims to enhance an individual's motivation to make a positive behavior change. It involves using strategies such as reflective listening, avoiding arguments, and supporting the individual's self-efficacy (Miller & Rollnick, 2013).

[3] MilLife Learning offers free web-based training resources to assist Service Members, their families, and those who support them.

REACH facilitator training includes videos, slides with voiceover, and knowledge checks completed by trainees. Similar to the instructor-led training, the web-based training includes (a) information about why REACH is important and how it differs from other suicide prevention trainings, (b) an overview of the REACH target audience, (c) an explanation of the REACH facilitator's role, (d) a review of the REACH facilitator's manual, (e) a primer on motivational interviewing, (f) a practice call to Military OneSource, (g) a demonstration of REACH delivery with Service members, and (h) information about preparing to lead in-person and virtual REACH sessions. It is important to note that prior to the current field test, PERSEREC has not previously evaluated the effectiveness of the web-based REACH facilitator training relative to the instructor-led training.

Current Study

The current field test evaluated the effectiveness of (a) the newly developed MilLife Learning web-based REACH facilitator training format, relative to the existing instructor-led REACH facilitator training format and (b) the REACH intervention for reducing barriers to care and increasing resource utilization among geographically isolated Service members. We addressed the following research questions:

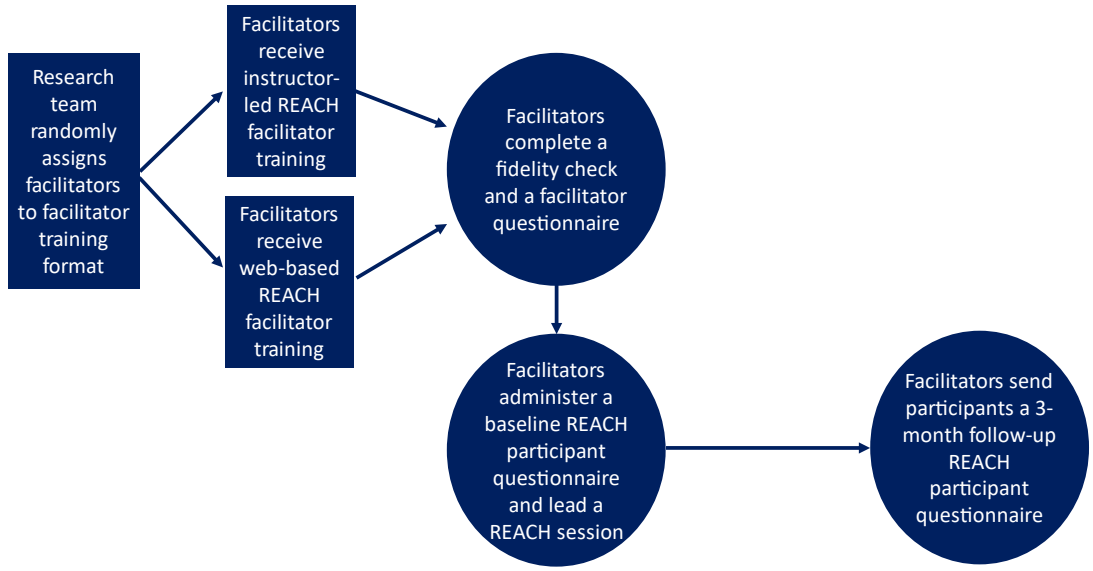
1. Are there differences between instructor-led versus web-based REACH facilitator training formats with respect to facilitators' knowledge gain, perceived utility, and training satisfaction?
2. Do facilitators report comparable levels of confidence about leading a REACH session with others following instructor-led versus web-based REACH facilitator training?
3. Do Service members report favorable perceptions of their REACH facilitator?
4. Do Service members report reduced barriers to care after attending a REACH session?
5. Do Service members report improved knowledge of available resources after attending a REACH session?
6. Do Service members report increased resource utilization after attending a REACH session?
7. Are Service members more likely to report that they recommended Military OneSource to a friend after attending a REACH session?

Method

This section describes the methodology used to carry out the FY22 REACH field test. Figure 1 depicts the study procedure and timeline. We used a randomized evaluation design to assess the effectiveness of instructor-led versus web-based REACH facilitator training. We field tested the web-based REACH facilitator training with 61 facilitators from active duty and reserve components. We then used a one-group pretest-posttest design to evaluate the effectiveness of REACH for reducing barriers to care and increasing resource utilization among geographically isolated Service members. We field tested REACH with 440 active duty and National Guard military personnel representing seven geographically isolated installations and 17 state, plus Guam. The following sections describe the field test participant study samples and data collection procedures.

Figure 1

Study Procedure and Timeline



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REACH Facilitators and Service Member Participants

For the purpose of this field test, recruitment focused on Service members from geographically isolated installations identified in the GAO (2021) report and National Guard locations. We prioritized geographically isolated installations and National Guard units because Service members in these locations have difficulty accessing resources and mental health support and are at increased risk for suicide attempts (GAO, 2022).

Facilitator Recruitment

We worked with installation points of contact, typically Suicide Prevention Program Managers (SPPMs), to identify personnel at each site who were passionate about mental health and help-

seeking and had prior experience with leading suicide prevention and resilience trainings, to receive the REACH facilitator training. Recruited facilitators were frontline supervisors, SPPMs, mental health professionals, chaplains, and/or other staff.

We received a list of personnel who could serve as REACH facilitators from each site point of contact. Using the RAND function in Excel, we randomly assigned personnel from each site to either the instructor-led or web-based REACH facilitator training format. To participate in the randomized evaluation of the facilitator training format, facilitators had to complete facilitator training and a 1-hour fidelity check meeting. The purpose of the fidelity check meeting was to allow facilitators to practice delivering REACH and receive supportive and constructive feedback. A total of 101 individuals completed REACH facilitator training, and 61% (*n* = 62 facilitators) completed a fidelity check meeting with the REACH field test team. Of these, 99% (*n* = 61 facilitators) completed the post-facilitator training questionnaire, comprising the final facilitator sample used for data analysis.[4] Table 1 shows the background characteristics of facilitators who completed the web-based or instructor-led training and completed the questionnaire. We found no statistically significant differences in facilitator background characteristics as a function of training format assignment.

[4] One facilitator did not receive the facilitator questionnaire link due to a host server failure.

Table 1

Background Characteristics of REACH Facilitators Assigned to Instructor-Led or Web-based Training

	Instructor-Led Facilitator Training Group (*n* = 31)		Web-Based Facilitator Training Group (*n* = 30)		Total (*n* = 61)	
Background Characteristic	***n***	**%**	***n***	**%**	***n***	**%**
Gender						
Male	14	45	16	53	30	49
Female	17	55	14	47	31	51
Education						
Less than a college degree	8	26	8	27	16	26
Associate's degree	5	16	6	20	11	18
Bachelor's degree	3	10	7	23	10	16
Master's or doctoral degree	15	48	9	30	24	39
Military Service member	20	64	25	83	45	74
Branch						
Army	13	42	17	57	30	49
Navy	6	19	6	20	12	20
Air Force	1	3	2	7	3	5
Not in the military	11	36	5	17	16	26
Component						
Active Duty	11	36	13	43	24	39
National Guard	7	23	11	37	18	30
Reserve	2	7	1	3	3	5
Not in the military	11	36	5	17	16	26
Pay grade						
E-4 to E-6	8	26	7	23	15	25
E-7 to E-8	4	13	8	27	12	20
O-1 to O-3	2	7	4	13	6	10
O-4 to O-5	2	7	3	11	5	8
Not in the military	11	36	5	17	16	26
Unknown	4	13	3	10	7	12
OCONUS	10	32	6	20	16	26
Role*						
Suicide prevention specialists	8	26	10	33	18	30
Frontline supervisors	5	16	6	20	11	18
Risk reduction personnel	6	19	3	10	9	15
Religious affairs personnel	4	13	1	3	5	8
Mental health professionals	4	13	0	0	4	7

	Instructor-Led Facilitator Training Group (*n* = 31)		Web-Based Facilitator Training Group (*n* = 30)		Total (*n* = 61)	
Victim advocates	0	0	2	1	2	3
Background Characteristic	***n***	**%**	***n***	**%**	***n***	**%**
Other	6	19	11	37	17	28
Presentation experience						
1-5 times	3	10	4	13	7	12
6-20 times	3	10	3	10	6	10
≥ 21 times	25	81	23	77	48	79

Note. Percentages may not total 100% due to rounding.

*Respondents could select more than one role. Other roles include resiliency training staff, Service member and family readiness staff, and substance abuse prevention staff.

Of the 61 facilitators in the final sample, 59% (*n* = 36) conducted REACH sessions with Service member participants.[5] Recruited facilitators dropped out of the study for many reasons, including declining participation after study enrollment, not attending REACH facilitator training and/or the required fidelity check, changing their role, or being unable to lead a REACH session within the study timeline (especially for National Guard facilitators, whose Service Members drilled once a month). Table 2 shows the number of facilitators in the REACH facilitator sample and the number of facilitators who led REACH sessions, by site.

Table 2

Number of REACH Facilitators, by Site

	REACH Facilitator Sample (*n* = 61)		Facilitators Leading a REACH Session(s) (*n* = 36)	
Site	***n***	**%**	***n***	**%**
Fort Irwin	10	16	4	11
Fort Wainwright	4	7	2	6
Joint Base Elmendorf-Richardson	4	7	2	6
Kentucky Joint Force Headquarters	1	<1	1	3
Naval Air Station Fallon	8	13	2	6
Naval Air Weapons Station China Lake	3	5	2	6
Naval Region Southwest	1	<1	1	3
Army and Air National Guard*	31	51	22	61
Total	61	100	36	100

Note. Percentages may not total 100% due to rounding.

*Army National Guard facilitators were located in Alaska, Idaho, Kentucky, Massachusetts, Missouri, Nebraska, Nevada, North Dakota, Ohio, Oklahoma, Oregon, Tennessee, and Guam. Air National Guard facilitators were located in Alaska, Michigan, and Tennessee.

[5] Four of these 36 facilitators conducted more than one REACH session, and six facilitators co-led five REACH sessions in teams of two.

REACH Service Member Participant Recruitment

Power analyses indicated that 199 Service members would need to complete a follow-up questionnaire to yield 0.80 power to detect a small program effect of REACH (Cohen's *d* = 0.20) on selected barriers to care (i.e., perception of being seen by others as broken, negative career impact, and lack of confidence in the effectiveness of available resources). This effect size is comparable or smaller in magnitude to effect sizes identified in PERSEREC's FY20 REACH field test (which are perception of being seen by others as broken [Cohen's *d* = 0.28], negative career impact [Cohen's *d* = 0.48], lack of confidence in the effectiveness of available resources [Cohen's *d* = 0.47 or 0.48]; Osborn et al., 2020).[6] Failure of the analytic sample to meet the minimum sample size identified by the power analysis may have precluded our statistical tests from detecting program effects that actually existed.

The 36 REACH facilitators who conducted REACH sessions recruited a convenience sample of approximately 440 Service member participants.[7] Of these Service member participants, 61% (*n* = 269) completed a baseline questionnaire, and 29% (*n* = 80) completed a follow-up questionnaire.[8] Our study protocol did not allow the research team to contact REACH participants directly. Consequently, we lack information on how many REACH participants received the follow-up questionnaire from their REACH facilitator. The 49 participants (18% of those completing a baseline questionnaire across 14 REACH sessions) who completed both the baseline questionnaire and a 3-month follow-up questionnaire comprise the final participant sample used for analysis of survey data.

Table 3 shows the background characteristics of the Service member REACH participant analytic sample (with baseline and 3-month follow-up data; *n* = 49) compared to Service member REACH participants who only completed the baseline questionnaire (*n* = 220). Compared with the latter group (*n* = 220), the participant analytic sample (*n* = 49) was less likely to be in the Army and more likely to be in the Air Force, was less likely to be an NCO and more likely to be a senior NCO or warrant officer and had more years of Service duty. Importantly, the participant analytic sample and Service member REACH participants completing only a baseline questionnaire reported similar levels of barriers to care, knowledge of resources, and resource utilization at baseline.

[6] Neither the previous PERSEREC study nor this power analysis included an intraclass coefficient when calculating power analysis or program effects. The previous PERSEREC study included participant perceptions of the REACH facilitator as a covariate in models testing program effects.

[7] We asked REACH facilitators to report the number of REACH participants attending each REACH session, but only about half of facilitators did so. We estimated this number of REACH participants by combining the number facilitators reported with the number of additional baseline and/or follow-up questionnaires we received.

[8] Of the 440 REACH participants, 99 could not access the baseline questionnaire because of host server problems, lack of Wi-Fi access in the room, or facilitator failure to share the web questionnaire link; 10 refused to give consent to complete the baseline questionnaire; and 62 did not complete the baseline questionnaire for unknown reasons.

Table 3

Background Characteristics of the Participant Analytic Sample and Service Member REACH Participants Who Completed a Baseline Questionnaire Only

	Participant Analytic Sample (*n* = 49)		REACH Participants Who Completed a Baseline Questionnaire Only (*n* = 220)	
Background Characteristic	***n***	**%**	***n***	**%**
Gender				
Male	34	69	177	80
Female	15	31	43	20
Married*	32	65	106	48
Component				
Active duty	9	18	63	29
National Guard or Reserve	40	82	157	71
Service				
Army**	29	59	174	79
Air Force**	15	31	27	12
Navy	5	10	19	9
OCONUS	15	31	64	29
Pay grade				
Junior enlisted	2	4	31	14
NCO*	21	43	137	62
Senior NCO or Warrant Officer***	17	35	21	10
Officer	9	18	29	13
Unknown	0	0	2	<1
Responsible for child*	31	63	101	46
Years in Service*** (Mean, SD)	14 (8)	8	8 (7)	7
Education (Years; Mean, SD)	14.88 (2.07)	2.07	13.79 (2.23)	2.23

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$.

Table 4 shows the REACH session sites of Service members who completed a baseline questionnaire and the final participant analytic sample. There were no financial incentives or command directives associated with participating in REACH sessions or completing the questionnaires.

Table 4

Number of REACH Participants, by Site

	REACH Participants Completing a Baseline Questionnaire		REACH Participants Completing a Baseline and 3-Month Follow-up Questionnaire	
Site	***N***	**%**	***N***	**%**
Fort Irwin	21	8	3	6
Fort Wainwright	7	3	0	0
Joint Base Elmendorf-Richardson	18	7	0	0
Kentucky Joint Force Headquarters	9	3	6	12
Naval Air Station Fallon	17	6	3	6
Naval Air Weapons Station China Lake	5	2	0	0
Naval Region Southwest	2	1	2	4
Army and Air National Guard*	190	71	35	71
Total	269	100	49	100

Note. Percentages may not total to 100% due to rounding.

*Army National Guard participants were located in Idaho, Kentucky, Massachusetts, Missouri, Nebraska, Nevada, North Dakota, Oklahoma, Oregon, and Guam. Air National Guard participants were located in Alaska, Michigan, and Tennessee.

Procedure

As shown previously, Figure 1 depicts the study procedure and timeline. Ten facilitators completed facilitator training using a different format than assigned. We conducted intent-to-treat analyses of the effectiveness of the assigned training format and analyses of the completed training format and identified few differences. As a result, in our data analyses of facilitator training effectiveness, we used completed REACH facilitator training format for these individuals versus their originally assigned format.

Facilitators participated in a 1-hour fidelity check meeting with research staff and completed a web-based questionnaire concerning their experience with the REACH facilitator training. After completing their fidelity check, facilitators recruited REACH participants, scheduled a REACH session, and administered a web-based baseline questionnaire to their REACH participants at the outset of the session and a follow-up questionnaire 3 months later. The remainder of this section describes facilitator training field test procedures, REACH intervention field test data collection, and study measures.

Facilitator Training Field Test

A team of three researchers conducted four group training events via Zoom for Government with facilitators assigned to the instructor-led training condition. The training team followed a protocol with key talking points to ensure that each group of facilitators received the same information. The instructor-led facilitator training lasted approximately 6.5 hours and included two sessions over 2 consecutive days. It also included opportunities for facilitators to ask questions and receive answers;

in this training format, facilitators taught select REACH content back to the group and received feedback, suggestions for improvement, and support.

The facilitators assigned to the web-based REACH facilitator training format received written instructions for how to log into the MilLife Learning website and access the training. The web-based facilitator training also lasted approximately 6.5 hours, and facilitators could complete the training asynchronously at their own pace and convenience.

After completing facilitator training, all facilitators participated in a 1-hour fidelity check meeting with a research team member trained to assess fidelity and provide coaching on REACH delivery. During this meeting, facilitators practiced delivering REACH content and received feedback on their tone, content mastery, and suggestions for improvement. We administered a confidential web-based questionnaire to facilitators at the end of their fidelity check to assess differences between instructor-led versus web-based REACH facilitator training formats.

REACH Intervention Field Test

Facilitator training included instructions for facilitators to administer the participant baseline questionnaire with maximum consistency and effectiveness, using a questionnaire administration script. We emailed facilitators 3 months after their REACH session instructing them to send the follow-up questionnaire weblink to their REACH participants.

We assigned a unique study identification number to each facilitator and linked facilitators and Service member participants using this identification number. The anonymous REACH participant baseline and follow-up questionnaires included fields for participants to generate a 7-digit participant identification number based on the state or country where they last attended high school, their birth month, mother's first name, and their middle initial. We used this participant identification number to link baseline and follow-up questionnaire responses for individual participants. This reliance on participants to create and enter their study identification number at baseline and follow-up may have contributed to our problems with matching all 80 follow-up questionnaires to associated baseline questionnaires. We did not collect personally identifiable information (PII) from REACH participants or link facilitator PII gathered during recruitment to facilitator questionnaire data.[9]

Measures

We developed three questionnaires to evaluate facilitator and REACH session participant outcomes (see Appendix A). Using a facilitator post-training questionnaire, we measured facilitator training effectiveness with respect to knowledge gain, perceived training utility, and training satisfaction, as well as confidence about leading a REACH session. Using participant baseline and follow-up questionnaires, we measured barriers to care, knowledge about resources, and resource utilization.

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

Facilitator Post-Training Questionnaire. The facilitator post-training questionnaire consisted of 31 items addressing the following topics:

- *Demographic characteristics* (10 items). Facilitators reported their (a) gender, (b) education, (c) years in the Service, (d) component, (e) Service branch, (f) Military Occupational Specialty (MOS) code, (g) pay grade/rank, (h) installation, (i) whether they were currently stationed within the contiguous United States (CONUS) or OCONUS, and (j) their role. Facilitator education was negatively correlated with one study outcome (facilitator knowledge gain, $r = -0.50$, $p < 0.001$), indicating that facilitators with higher levels of education reported lower levels of knowledge gain after the REACH facilitator training than facilitators with lower levels of education. Therefore, we controlled for facilitator education in analyses of knowledge gain.

- *Past presentation experience* (one item). Facilitators selected from five response options the number of times they had previously presented to a group. To address skewness of responses, we coded this measure as dichotomous (*1 to 20 times* or *21 or more times*). Presentation experience was correlated with facilitator knowledge gain ($r = -0.33$, $p < 0.001$) and opinion about training length ($r = -0.27$, $p < 0.05$), indicating that facilitators with more presentation experience reported lower knowledge gain after REACH training and were less likely to agree that the REACH facilitator training was too long compared to facilitators with less presentation experience. Therefore, we controlled for facilitator presentation experience in analyses of these outcomes.

- *Knowledge of REACH facilitator training topics before and after the training* (six items). Facilitators first considered what they *already knew* before the REACH facilitator training and then what they *learned during* the training. Facilitators reported their knowledge in several key REACH facilitator training areas, such as motivational interviewing, Military OneSource resources, and barriers to care, before and after the REACH Facilitator Training. Response options ranged from 0 = *no knowledge* to 3 = *a lot of knowledge*. We subtracted the score before REACH facilitator training from the score after training for each item to calculate knowledge gain for each topic. The six knowledge gain scores exhibited high internal consistency (Cronbach's $\alpha = 0.80$), so we calculated a mean of the six items to measure each facilitator's overall knowledge gain.

- Perceived training utility (13 items):

    - *Perceived utility of training components* (seven items about instructor-led training and five items about web-based training). Facilitators rated each component of the REACH facilitator training (e.g., introduction to REACH and the role of a facilitator, motivational interviewing, and Military OneSource resources and practice call) in terms of its usefulness for leading their own REACH session. Response options ranged from 1 = *not at all useful* to 5 = *extremely useful*. The seven items about instructor-led training did not exhibit an acceptable degree of internal consistency, and the components that facilitators rated for instructor-led training were different from those for web-based training, so we considered the 12 perceived utility scores about individual training components separately in our analyses.

  - *Perceived utility of the fidelity check* (one item). Facilitators rated their agreement with a statement that the fidelity check was useful for preparing them to lead a REACH session. Response options ranged from 1 = *strongly disagree* to 5 = *strongly agree*.

- *Training satisfaction* (eight items). Facilitators rated a series of statements about training organization and engagement, adequacy of the training in preparing facilitators to lead a REACH session, whether they would recommend the REACH facilitator training to others, and the extent to which the training met their expectations. Facilitators also rated a statement about the REACH facilitator training feeling too long. All response options ranged from 1 = *strongly disagree* to 5 = *strongly agree*. Three additional open-ended questions inquired about what facilitators liked the most about the training, what they liked the least, and why they felt the training did or did not meet their expectations.

- *Confidence about leading a REACH session with others* (one item). Facilitators assessed their confidence about leading a REACH session with others. Response options ranged from 1 = *strongly disagree* to 5 = *strongly agree*.

Participant Baseline Questionnaire. REACH Service member participants completed a 46-item baseline questionnaire at the beginning of their REACH session. The questionnaire addressed the following topics:

- *Demographic characteristics* (12 items). REACH participants reported their (a) gender, (b) marital status, (c) education, (d) years in the Service, (e) component, (f) Service branch, (g) installation, (h) MOS code, (i) pay grade/rank, (j) installation, (k) whether they were currently stationed CONUS or OCONUS, and (l) whether they had ever been responsible for care of a child aged 17 or younger.

- *REACH session format* (one item). Participants reported whether they attended an in-person or virtual REACH session.

- *Barriers to care* (five items). To measure barriers to care identified in the Status of Forces Survey of Active Duty Members (OPA, 2019), participants rated each of five factors that might affect their decision to receive mental health counseling or services if they ever have a problem. All response options ranged from 1 = *strongly disagree* to 5 = *strongly agree*.

  - *Being seen by others as broken* (one item). Participants rated how much they agreed that seeking help would cause others to see them as broken.

  - *Loss of privacy* (one item). Participants rated how much they agreed that they worry that their mental health problems might not stay private if they seek help.

  - *Negative career impact* (one item). Participants rated how much they agreed that seeking help would negatively impact their career.

  - *Lack of knowledge about resources* (one item). Participants rated how much they agreed that they do not know where to get help.

- *Lack of confidence in the effectiveness of available resources* (one item). Participants rated how much they agreed that effective resources exist that can help them with a mental health problem. We reverse coded this item.

- *Knowledge about available resources* (11 items). Participants reported their level of knowledge of 11 support services: (a) chaplains and enlisted religious affairs personnel, (b) the Military & Veterans Crisis Line, (c) Military OneSource, (d) MFLCs, (e) mental health clinic/MTF, (f) financial counselors, (g) embedded behavioral health providers, (h) DSTRESS line, (i) Deployed Resiliency Counselors, (j) Family Readiness Program, and (k) emergency room. Response options were 0 = *I have never heard of this service*; 1 = *I have heard of this service, but I do not really know what it is*; 2 = *I have heard of this service, but I only superficially understand it*; and 3 = *I know a lot about this service*. These 11 items exhibited very high internal consistency (Cronbach's α = 0.92), so we created a composite measure by calculating their mean score.

- Resource utilization (five items).
  - *Past Military OneSource utilization* (one item). Participants reported whether they had used Military OneSource during the past 3 months and marked all applicable responses. Response options included *no* and five ways they may have used Military OneSource (visited www.MilitaryOneSource.mil, email, talked to a consultant on the phone, used the chat feature, and used the text feature). We coded this measure as 0 = *no* or 1 = *yes*.
  - *Likelihood of using Military OneSource in the future* (one item). Participants reported how likely it is that they will use Military OneSource the next time they have a concern. Response options ranged from 1 = *very unlikely* to 5 = *highly likely*.
  - *Likelihood of recommending Military OneSource to a friend* (one item). Participants reported how likely it is that they would tell a friend to call Military OneSource for services. Response options ranged from 1 = *very unlikely* to 5 = *highly likely*.
  - Help-seeking (two items). The questionnaire asked whether participants had experienced a problem during the past 3 months that caused them significant stress. Sixteen out of 49 participants (33%) reported experiencing a problem at both baseline and follow-up. The questionnaire asked these participants whether they had sought help for the problem. Response options were *yes, but I considered it* and *no, and I did not consider it*. We coded help-seeking in two ways:
    - *Sought help.* We coded this measure as 1 = *sought help* or 0 = *did not seek help.* The questionnaire asked participants who reported seeking help to identify the sources of help from a list of 14 sources of help. The list included both informal sources (i.e., family member or friend) and formal sources (e.g., MFLC, mental health professional, or someone in their chain of command).
    - *Sought help or considered it.* We coded this measure as 1 = *sought help or considered it* or 0 = *did not seek help or consider it.* The questionnaire asked participants who reported they had not sought help, but had considered it, to identify the sources of help they considered from the list of 14 sources of help.

The questionnaire also asked participants who had not sought help and had not considered it to identify their reasons for not considering asking help from a list of 12 possible reasons (e.g., did not trust mental health professionals, difficulty arranging the time to talk to someone, and concern about cost).

Participant 3-Month Follow-up Questionnaire. Facilitators asked REACH Service member participants to complete a follow-up questionnaire approximately 3 months after their REACH session. In addition to the original questions from the baseline questionnaire described above, the follow-up questionnaire also included questions about participants' impressions of their REACH facilitator:

- *Perceptions of facilitator* (three items). Participants rated three items assessing the extent to which their facilitator (a) encouraged participation, (b) was enthusiastic when delivering REACH, and (c) was passionate about the importance of help-seeking. Response options ranged from 1 = *strongly disagree* to 5 = *strongly agree*. The three items exhibited very high internal consistency (Cronbach's α = 0.97), so we created a composite measure by calculating a mean score of these items.

Results

This section presents the results from our analysis of REACH facilitator and participant questionnaire data grouped by research question. Appendix B provides a description of our research questions and analytic approach.

REACH Facilitator Training Results

This section presents the quantitative and qualitative data analysis results from the facilitator training questionnaire. We first present results corresponding to Research Question 1, evaluating the differences between instructor-led and web-based REACH facilitator training formats with respect to facilitators' knowledge gain, perceived training utility, and training satisfaction. Results include qualitative data analysis findings concerning (a) what facilitators liked the most about REACH facilitator training, (b) what they liked the least, and (c) why REACH facilitator training did or did not meet facilitators' expectations. We then present quantitative results corresponding to Research Question 2, evaluating facilitators' reported confidence about leading a REACH session with others.

We conducted eight statistical tests of differences between instructor-led and web-based facilitator training formats:

1. Knowledge gain,
2. Perceived utility of the fidelity check,
3. Training organization,
4. Adequate preparation to lead a REACH session with others,
5. Training engagement,
6. Willingness to recommend REACH facilitator training to others,
7. Satisfaction with training length, and
8. Confidence about leading a REACH session with others.

We used a Bonferroni-corrected α level of 0.006 to determine statistical significance. This adjustment was made to mitigate the risk of Type I (false positive) errors, and we derived this corrected threshold by dividing the conventional α level of 0.05 by eight.

Research Question 1: Knowledge Gain, Perceived Utility, and Training Satisfaction

Table 5 shows that, after controlling for facilitator education and presentation experience, facilitators in both the instructor-led ($F = 80.76$, $p < 0.001$) and web-based ($F = 61.52$, $p < 0.001$) REACH facilitator training groups reported statistically significant knowledge gain. As shown in Table 6, after controlling for facilitator education and presentation experience, the effect of the training format on knowledge gain was not statistically significant. Facilitators who completed the web-based REACH facilitator training reported a similar level of knowledge gain relative to those who completed the instructor-led training.

Table 5

Knowledge Gain among Facilitators

	Before Training		*After Training*				
	M	***SD***	***M***	***SD***	***F***	***df***	***p***
Facilitators Who Completed Instructor-Led Training (*n* = 29)							
Time (before vs. after training)	2.26	0.47	2.98	2.73	80.76	1	<.001
Education					12.73	1	<.001
Presentation experience					0.83	1	0.37
Error						52	
Facilitators Who Completed Web-based Training (*n* = 32)							
Time (before vs. after training)	2.02	0.56	2.73	0.33	61.52	1	<0.001
Education					11.82	1	0.001
Presentation experience					12.71	1	<0.001
Error						58	

Table 6

Knowledge Gain among Facilitators Who Completed Web-Based vs. Instructor-Led Training

	Knowledge Gain Among Facilitators (*n* = 61)				
Predictor	***M***	***SD***	***F***	***df***	***p***
Training format			0.31	1	0.58
Instructor-led	0.75	0.50			
Web-based	0.73	0.48			
Education			17.02	1	<0.001
Presentation experience			5.39	1	0.02
Error				57	

Tables 7 and 8 depict the ratings of perceived utility of REACH facilitator training for facilitators who completed instructor-led and web-based training, respectively. Mean perceived utility scores appeared to be higher among facilitators who completed instructor-led training (3.67–3.92 on a scale of 1–4) than those who completed web-based training (3.00–3.23). Facilitators who completed the instructor-led training perceived the most utility from the REACH demonstration and teach-backs, whereas facilitators who completed the web-based training perceived the most utility from the module teaching about the REACH mindset. Standard deviations for individual training components appeared to be lower among facilitators who completed the instructor-led versus web-based training, suggesting more consistency in perceptions of utility among facilitators who completed the instructor-led training.

Table 7

Perceived Utility of Instructor-Led REACH Facilitator Training Components

	Facilitators Who Completed Instructor-Led Training (*n* = 29)			
Instructor-Led Facilitator Training Component	***M***	***SD***	***Minimum***	***Maximum***
Introduction to REACH and facilitator's role	3.71	0.45	3	4
Review of facilitator's manual	3.75	0.52	2	4
Facilitator's manual discussion	3.67	0.55	2	4
Demonstration of REACH	3.92	0.28	3	4
REACH session discussion	3.67	0.47	3	4
Motivational interviewing	3.67	0.55	2	4
Teach backs	3.88	0.44	2	4

Table 8

Perceived Utility of Web-Based REACH Facilitator Training Components

	Facilitators Who Completed Web-Based Training (*n* = 32)			
Web-Based Facilitator Training Component	***M***	***SD***	***Minimum***	***Maximum***
REACH mindset	3.23	0.62	2	4
Motivational interviewing	3.10	0.91	1	4
Military OneSource resources and practice call	3.00	0.92	0	4
Session preparation	3.07	0.91	1	4
Session best practices	3.03	1.00	0	4

Although we could not conduct a statistical test of the difference between facilitators' perceived utility of instructor-led versus web-based training, Table 9 shows that the effect of training format on perceived utility of the fidelity check was not statistically significant. Facilitators who completed the web-based and the instructor-led REACH facilitator training perceived similar levels of utility value from the fidelity check.

Table 9

Perceived Utility of the Fidelity Check for Preparing Facilitators to Lead a REACH Session

	Perceived Utility of the Fidelity Check among Facilitators (*n* = 61)				
Predictor	***M***	***SD***	***F***	***df***	***p***
Training format			0.20	59	0.66
Instructor-led	4.69	0.83			
Web-based	4.78	0.74			

As shown in Table 10, both groups of facilitators reported high levels of training satisfaction. The training format did not have a statistically significant effect on perceptions that the training was well-organized and that it adequately prepared facilitators to lead a REACH session with others. Facilitators who completed the web-based training reported comparable levels of satisfaction with respect to these two outcomes relative to facilitators who completed the instructor-led training.

However, facilitators who completed the web-based training reported significantly lower levels of engagement (*M* = 4.13 on a scale of 1–5, *SD* = 1.29) than their counterparts who completed the instructor-led training (*M* = 4.86, *SD* = 0.34; *F* = 8.52, *p* = 0.005). Finally, facilitators who completed the web-based training were somewhat less likely to report that they would recommend it to others (*M* = 4.31, *SD* = 1.24) relative to facilitators who completed the instructor-led training (*M* = 4.86, *SD* = 0.34); however, this difference was not statistically significant at the Bonferroni-corrected *α* value of 0.006 that we used.

Table 10

Training Satisfaction among Facilitators Who Completed Instructor-Led vs. Web-Based Training

	Facilitators Who Completed Instructor-Led Training (*n* = 29)		Facilitators Who Completed Web-Based Training (*n* = 32)				
Satisfaction Measures	***M***	***SD***	***M***	***SD***	***F***	***df***	***p***
Felt REACH facilitator training was well organized	4.62	0.85	4.34	0.85	1.56	59	0.22
Felt the training adequately prepared facilitators to lead a REACH session with others	4.76	0.43	4.59	0.82	0.90	59	0.35
Perceived REACH facilitator training as engaging	4.86	0.34	4.13	1.29	8.56	59	0.005
Would recommend REACH facilitator training to others	4.86	0.34	4.31	1.24	5.18	59	0.03

Table 11 indicates that, after adjusting for presentation experience, the effect of the training format on the perception that the facilitator training was too long was not statistically significant. Facilitators in the web-based training group (*M* = 2.50 on a scale of 1–5, *SD* = 0.75) and their counterparts in the instructor-led group (*M* = 2.17, *SD* = 0.83) generally disagreed that the training felt too long.

Table 11

Satisfaction with Training Length among Facilitators Who Completed Instructor-Led vs. Web-Based Training

	Perception that the REACH Facilitator Training Was Too Long (*n* = 61)				
Predictor	***M***	***SD***	***F***	***df***	***p***
Training format			2.59	1	0.11
Instructor-led	2.17	0.83			
Web-based	2.50	0.75			
Presentation experience			4.81	1	0.03
Error				58	

Most-liked Elements of the REACH Facilitator Training. Table 12 shows the most common themes from facilitator responses to the open-ended question about what they liked the *most* about the

REACH facilitator training they received. Facilitators in the instructor-led training group most commonly reported liking

- **the training information or knowledge they gained:** One facilitator wrote that she liked "learning the 'behind the scenes' of how and why this training was built." Another facilitator mentioned "the amount of knowledge to help Service members get the help they need."
- **the interactivity and level of engagement:** Many facilitators receiving instructor-led training reported liking the ability to ask questions, participate in discussions, and receive feedback in real time. One facilitator wrote, "It was very engaging and interactive, validating students, with a lot of great data and information to counteract myths." Another facilitator noted that the instructor-led REACH facilitator training was "absolutely better than the standard death by PowerPoints we receive regularly."

> "I enjoyed the positive and upbeat style of the training. I also appreciated the time allotted to Q&A so we could focus in on areas where we needed more information."
>
> —Facilitator from the instructor-led training group

- **the instructors:** Facilitators also valued the instructors' education, knowledge, and explanation of details, as well as having access to them during the training. One facilitator stated, "I really liked having an actual facilitator to learn the material from," and another indicated, "The team really did a great job explaining details!"

Table 12

Most Common Themes About What Facilitators Liked Most About Training, by Training Format

Facilitators Who Completed Instructor-Led Training	Facilitators Who Completed Web-Based Training
Training information or knowledge gained	Fidelity check
Interactivity and level of engagement	Training information or knowledge gained
Training instructors	Quality of facilitator training materials

Other facilitators who completed the instructor-led training valued the ability to incorporate their own story and style into the REACH session. A number of facilitator responses also identified specific training components that they liked, including teach-backs, the fidelity check, the content on motivational interviewing, and the live demonstration call to Military OneSource.

Facilitators who completed web-based training most commonly reported liking

- **the fidelity check:** Facilitators liked presenting REACH content to a trained REACH expert in a one-on-one setting, which gave them an opportunity to receive constructive feedback. One facilitator noted, "The fidelity check provided valuable feedback for me about presenting REACH in a group setting," and another facilitator commented, "This was the best formatted and functional online DoD course I have taken. Also, the level of personal interaction with the fidelity check is fantastic, providing a clear and complete avenue for feedback and answering questions before giving the REACH session. Well done!" Our fidelity check staff noted that facilitators with

presentation experience were able to deliver REACH with a high level of quality, while some facilitators without presentation experience struggled with delivering content in a manner that preserved core content and pedagogy components. We addressed facilitation skills, motivational interviewing techniques, and REACH content with facilitators who did not have prior presentation experience.

- **the training information or knowledge they gained:** Several facilitators who completed web-based training specifically referenced the value of the REACH program in their comments, including its emphasis on self-care, prevention, and overcoming barriers to help-seeking. For example, one facilitator wrote, "NEEDED! REACH sessions help bridge the gap between thinking about seeking help and actually taking action to seek help." Another facilitator commented, "I love the idea of REACH and mindset. This is truly prevention training!"

- **the quality of facilitator training materials:** Facilitators really liked the presentation slides and the facilitator's manual with step-by-step information, guidelines, and ideas. One facilitator noted "the run through of each slide with feedback afterwards and the manual that incorporates suggestions of what to say and ask," and another wrote, "I enjoyed having a manual available that is filled with resources to help in giving REACH sessions."

> "I really like that the guide is step by step. It gives ideas and guidelines to use if you don't know what to do or say. Once comfortable, I like that you have the ability to adapt and use your experience to enhance the training."
>
> —Facilitator from the web-based training group

Least-liked Elements of REACH Facilitator Training. Table 13 shows the most common themes from facilitator responses to the open-ended questions concerning what they liked the *least* about the REACH facilitator training they received. Facilitators who completed the instructor-led training reported liking the least

- **nothing:** Among facilitators who completed the instructor-led training, more than half did not identify something they liked the least about the training, and many offered positive comments, such as reiterating excitement to see prevention efforts taking place.

- **the virtual training format:** One facilitator wrote, "I wish we could have done the training in person." Another commented, "While understanding the constraints of time and funding, I believe that the training would be even better if it were able to be done in an in-person setting. Virtual training can be difficult."

Table 13

Most Common Themes About What Facilitators Liked Least About Training, by Training Format

Facilitators Who Completed Instructor-Led Training	Facilitators Who Completed Web-Based Training
Nothing	Web-based training format
Virtual training format	Technology issues
	Training length

Other comments pertained to the length of training and presentation slides. One facilitator noted, "Sometimes it would feel a little long," and another commented, "The slides were not prepared so that they could be printed with the key questions, notes, and cues all at the bottom on one page so that nothing important gets overlooked. Working for the military has made me value the concise." Another facilitator indicated, "I would have liked access to a recorded session or additional web-based features to check my knowledge while reviewing the material."

Facilitators from the web-based training group reported liking the least

- **the web-based training format:** More than one fourth of facilitators in the web-based training group expressed a preference for in-person training in a classroom setting instead of asynchronous web-based training. One facilitator commented, "I feel the REACH facilitator training would have been much more beneficial if it was conducted in person rather than virtually." Several facilitators who completed web-based training noted that their work interfered with their ability to complete the web-based training. One facilitator wrote,

  > I would have preferred to attend this training in person. In-person training is best for me, because I give 100% of my attention to whatever is right in front of me. I struggled with the prioritization of the online training because–despite telling myself I would make this training a priority—I allowed all the distractions and priorities of my job duties to consume every bit of time in my day. I kept pushing the training to the right, choosing to give 100% of my time and energy to the cat herding task that was right in front of me here at work. It's not easy to let go of the wheel when I'm in the driver's seat. Attending this training in-person would've forced me out of the car.

- **technology issues:** Facilitators who completed the web-based training also mentioned encountering some technology issues. Some referenced experiencing limited internet access or bandwidth problems caused by their workplace network and usability problems, such as the slides not working. One facilitator reported experiencing "multiple malfunctions with the web-based software causing delays, restarts, and requiring workarounds to advance presentation materials; the delays added an additional 2 hours of time to my reported length of time that it took to complete the course." Another facilitator reported, "The videos online took a lot of bandwidth and made the training last a little longer due to glitches." Our project staff also experienced problems accessing the web-based training using multiple browsers and nonmilitary servers and equipment.

  > "It was hard to get the training to load up."
  >
  > —Facilitator from the web-based training group

- **the training length:** The technology issues exacerbated facilitator concerns about the length of the training. A civilian facilitator wrote that the web-based training "was not very user friendly and had numerous glitches which made the 6-hour training more of a 12-hour training." Another facilitator remarked, "It was hard to use outside resources in my job. I don't have a cellphone with me. Also, the training was very long. I have probably spent 20 hours or more on the training." Some facilitators who did not mention technology problems did not like the time

commitment to complete the web-based training and thought it could be shortened, although the mean score for satisfaction with training length among facilitators who completed the web-based training was 2.50, halfway between 2 = *disagree* and 3 = *neither agree nor disagree* (see Table 11). However, the quantitative results suggested that facilitators generally disagreed that the training felt too long.

Other comments mentioned workplace interruptions that made the training difficult to complete. One facilitator reported, "The training online was hard to accomplish in my working environment. Lots of people coming in and out behind me." Facilitators mentioned work interference specifically related to fidelity checks. One facilitator noted, "A heavy workload at the time was just making it hard for me to keep a fidelity check appointment. Everyone was great at working with my schedule. Thank you!" Another facilitator wrote that other work commitments made it challenging to complete his fidelity check soon after he completed the web-based training: "Being flexible with my work schedule was invaluable, but retaining specific teaching material weeks later isn't the easiest". Our project staff had to reschedule multiple fidelity checks due to facilitators being diverted to address competing work responsibilities, such as responding to a suicide at their installation or other emergencies. Finally, facilitators made some helpful suggestions about adding the Vet Center call center as a confidential resource for Service members. Additionally, they recommended enhancing the user-friendliness of the web-based training to allow facilitators to easily revisit and review training content after initial completion.

The Extent to Which REACH Facilitator Training Met Facilitators' Expectations. Among facilitators who completed the instructor-led training, 96% indicated that the training met their expectations. Comments most frequently referred to the training information or knowledge gained. One facilitator reported, "I gained a much better understanding of programs and policies available to members and how to create discussion among the recipients of the training."

> "Very informative and did not take long to complete."
>
> —Facilitator from the instructor-led training group

Additional responses addressed the thoroughness, organization, and helpfulness of the instructor-led facilitator training. For example, one facilitator stated that the training was "very organized, focused, thoughtful and relevant with a clear theme throughout. It provides actual takeaways to Service members that could save a life." Another facilitator wrote, "I definitely feel as though I was set up to be successful," while another commented, "I learned so much not only about REACH but also tips I could use throughout my career for unrelated trainings."

Among facilitators who completed the web-based training, 94% indicated that the training met their expectations. The most common responses addressed

- **the training information or knowledge gained:** Facilitators commented that the web-based training was informative and included great material. A facilitator noted, "The level of training exceeded expectations of quality of information," and another one stated, "The REACH training met my expectations as far as setting up a solid framework of the material being presented and additional resources."

- **the REACH focus on help-seeking:** Facilitators provided positive feedback about REACH being an opportunity for Service members to learn about help-seeking and self-care. One facilitator wrote, "Great tool to inform Soldiers on the resources and options to seek help."

Other facilitators in the web-based training group appreciated REACH's focus on overcoming barriers to care and using resources available to Service members. A facilitator reported, "I gained a better understanding of the barriers Soldiers face when seeking help, while another one noted, "The discussion about barriers is real, and REACH can help move barriers to care."

Research Question 2: Confidence About Leading a REACH Session with Others

Table 14 indicates that the effect of training format on feelings of confidence about leading a REACH session with others was not statistically significant. After training, facilitators in both training format groups reported high levels of confidence to lead a REACH session with others (*M* = 4.38 to 4.41 on a scale of 1–5). Facilitators who completed the web-based REACH facilitator training reported similar levels of confidence relative to those who completed the instructor-led training.

> "Working one-on-one with direct honest feedback in the fidelity check was extremely helpful as well as confidence building."
>
> —Facilitator from the web-based training group

Table 14

Feelings of Confidence about Leading a REACH Session with Others Among Facilitators Assigned to Instructor-Led vs. Web-Based Training

	Feelings of Confidence About Leading a REACH Session with Others (*n* = 61)				
Predictor	***M***	***SD***	***F***	***df***	***p***
Training format			0.05	59	0.82
Instructor-led	4.41	0.81			
Web-based	4.38	0.48			

Research Question 3: REACH Session Participants' Perceptions of the Facilitator

Participants generally rated their REACH session facilitator very positively with respect to showing enthusiasm during the session (*M* = 4.51 on a scale of 1–5, *SD* = 0.92), encouraging participation (*M* = 4.57 on a scale of 1–5, *SD* = 0.89), and being passionate about the importance of help-seeking (*M* = 4.59 on a scale of 1–5, *SD* = 0.89). The mean score for participant perceptions of their facilitator was 4.56 on a scale of 1–5, with a standard deviation of 0.88.

REACH Session Participant Results

This section presents the results from quantitative data analyses examining the differences between REACH session participants' responses at baseline and 3-month follow-up about perceived barriers to care, knowledge about available resources, and resource utilization. Because of our small participant analytic sample (*n* = 49), we did not apply a Bonferroni adjustment due to concerns

about limited statistical power. Instead, we provide table notes about results that would be impacted by a Bonferroni-adjusted α level (α = 0.05/11, or 0.0045).

Research Question 4: Barriers to Care

To identify the changes in perceived barriers to care among REACH session participants, the baseline and follow-up questionnaires asked participants to rate factors that might affect their decision to receive mental health counseling or services. Table 15 compares the mean responses to barriers to care questions among the participant analytic sample at baseline and at 3-month follow-up.

Overall, the mean ratings of perceived barriers to care were lower at the 3-month follow-up than at baseline. Responses to the follow-up questionnaire showed a statistically significant reduction in perceived barriers to care, including concerns about being seen by others as broken, negative career impact, lack of knowledge about resources, and lack of confidence in the effectiveness of available resources. These reductions each corresponded to a small to medium effect size (Cohen's *d*) [10] in the desired direction. Participants' reduced perceptions of loss of privacy as a barrier to care were not statistically significant, but corresponded to a small effect size (Cohen's *d* = -0.26).

Table 15

Changes in Perceived Barriers to Care for REACH Participants from Baseline to 3-month Follow-up

	Baseline Participant Analytic Sample (*n* = 49)		Follow-up Participant Analytic Sample (*n* = 49)					
Perceived Barriers to Care	***M***	***SD***	***M***	***SD***	***t***	***df***	***p***	***Cohen's d***
Being seen as broken	2.82	1.09	2.37	1.07	-2.77	47	0.008[a]	-0.40
Loss of privacy	2.85	1.09	2.57	1.12	-1.79	47	0.08	-0.26
Negative career impact	2.47	1.00	2.10	0.92	-2.77	47	0.008[a]	-0.40
Lack of knowledge about resources	2.16	1.01	1.74	0.91	-2.70	47	0.01[a]	-0.39
Lack of confidence in the effectiveness of available resources	2.06	0.70	1.67	0.56	-4.06	47	<0.001	-0.59

[a] This result is no longer statistically significant after application of a Bonferroni adjustment (*α* = 0.005).

Research Question 5: Knowledge About Available Resources

Table 16 shows that 3 months after attending a REACH session, participants reported a significant increase in their knowledge of available resources compared to the baseline. This increase corresponded to a large effect size (Cohen's *d* = 0.84).

[10] Cohen (1988) defined *d* measures of small, medium, and large effect size as 0.2, 0.5, and 0.8, respectively.

Table 16

Participant Change in Knowledge About Available Resources

	Participant Analytic Sample (*n* = 49)					
Predictor	***M***	***SD***	***t***	***df***	***p***	***Cohen's d***
Time			5.75	46	<0.001	0.84
Baseline	2.84	0.72				
Follow-up	3.30	0.55				

Research Question 6: Resource Utilization

Table 17 shows that participants reported similar levels of Military OneSource utilization during the 3-month period following their REACH session compared to the 3-month period before their REACH session. However, our analysis identified a small effect size (Cohen's *d* = 0.22) in the desired direction.

Table 17

Participant Change in Utilization of Military OneSource

	Participant Analytic Sample (*n* = 49)				
Predictor	***n***	***%***	***X^2***	***p***	***Cohen's d***
Time			0.75	0.38	0.22
Baseline	13	27			
Follow-up	18	37			

Table 18 shows that 3 months after attending a REACH session, participants reported a significantly increased likelihood of using Military OneSource in the future, relative to baseline. This increase corresponded to a medium effect size (Cohen's *d* = 0.54).

Table 18

Participant Change in Likelihood of Using Military OneSource in the Future

	Participant Analytic Sample (*n* = 49)					
Predictor	***M***	***SD***	***t***	***df***	***p***	***Cohen's d***
Time			3.77	48	<0.001	0.54
Baseline	3.06	0.97				
Follow-up	3.63	1.05				

Sixteen out of 49 REACH participants in our analytic sample (33%) reported at both baseline and follow-up that they experienced a problem during the past 3 months that caused them significant stress. Table 19 shows the proportion of these participants who sought help, did not seek help but considered it, or did not seek help and did not consider it at baseline and follow-up.

Table 19

Participant Reports of Help-Seeking, Not Seeking Help but Considering It, or Not Considering It

	Participants Who Experienced a Problem Causing Significant Stress at Baseline and 3-Month Follow-Up (*n* = 16)					
	Sought Help		Did Not Seek Help but Considered It		Did Not Seek Help and Did Not Consider It	
Time	***n***	***%***	***n***	***%***	***n***	***%***
Baseline	5	31	5	31	6	38
Follow-Up	7	44	8	50	1	6

Table 20 shows that the prevalence of help-seeking was similar at baseline and follow-up among participants who reported experiencing a problem that caused significant stress during the last 3 months. However, our analysis identified a small effect size (Cohen's *d* = 0.27) in the desired direction. The most sought out sources of help were friends, family members, and significant others.

Table 20

Participant Change in Seeking Help

	Participants Who Experienced a Problem Causing Significant Stress at Baseline and 3-Month Follow-up (*n* = 16)				
Predictor	***n***	***%***	***X^2***	***p***	***Cohen's d***
Time			0.30	0.59	0.27
Baseline	5	31			
Follow-up	7	44			

Table 21 shows that the percentage of participants who sought help or considered it increased among participants who reported experiencing a problem that caused significant stress during the last 3 months. This increase corresponded to a large effect size (Cohen's *d* = 0.82) in the desired direction. The most commonly considered sources of help were family members, significant others, and friends, although approximately 35%–42% of selected helping sources were professionals.

Table 21

Participant Change in Seeking Help or Considering It

	Participants Who Experienced a Problem Causing Significant Stress at Baseline and 3-Month Follow-up (*n* = 16)				
Predictor	***n***	***%***	***X^2***	***p***	***Cohen's d***
Time			4.40	0.04[a]	0.82
Baseline	10	63			
Follow-up	15	94			

[a] This result becomes no longer statistically significant after application of a Bonferroni adjustment ($\alpha = 0.005$).

Participants' most common reasons for not considering seeking help were concerns that doing so would negatively impact their career and not wanting anyone to interfere. Other reasons participants frequently reported included thinking friends and family would have less respect for them if they found out and thinking less of themselves if they could not handle their problem on their own.

Research Question 7: Likelihood of Recommending Military OneSource to a Friend

Table 22 shows that 3 months after attending a REACH session, participants reported a significantly greater likelihood of recommending Military OneSource to a friend, relative to baseline. This increase corresponded to a medium to large effect size (Cohen's *d* = 0.54).

Table 22

Participant Change in Likelihood of Recommending Military OneSource to a Friend

	Participant Analytic Sample (*n* = 49)					
Predictor	***M***	***SD***	***t***	***df***	***p***	***Cohen's d***
Time			4.87	48	<0.001	0.70
Baseline	3.61	0.98				
Follow-up	4.16	0.83				

Discussion

The current field test assessed the effectiveness of the REACH facilitator web-based training format in comparison to the instructor-led training. The evaluation also focused on the effectiveness of REACH in reducing barriers to care, increasing knowledge of available resources, and increasing resource utilization among geographically isolated Service members. This section provides a summary of the main study results, stakeholder recommendations, and methodological limitations.

Facilitator Outcomes

Both REACH facilitator training formats resulted in facilitator knowledge gain. Facilitators in both training format groups reported high levels of training satisfaction. Training satisfaction is important because it is positively correlated with the motivation to learn and apply newly acquired skills (Chung et al., 2022). Following the completion of the training, an overwhelming majority of facilitators in both training format groups felt that the training met their expectations. Additionally, they reported a high level of confidence in leading a REACH session with others.

A comparison of facilitator survey data about the two training formats identified similar levels of knowledge gain; satisfaction with the training organization, extent to which training prepared facilitators to lead a REACH session with others, and training length; perceived utility of the fidelity check; and confidence to lead a REACH session with others. Facilitators' perceived utility and engagement appeared to be higher in the instructor-led training group versus web-based group, but those who completed web-based training also reported high levels of engagement, and facilitators in both training format groups agreed they would recommend the REACH facilitator training to others. Facilitators who completed the instructor-led training perceived the most utility from the REACH demonstration and teach-backs, whereas facilitators who completed the web-based training perceived the most utility from the training module about the REACH mindset.

> "I appreciate this training seems to have care and purpose in its design--versus the typical military training of being talked at, having to read verbose PowerPoints, or listening to robotic computer animations in click-through-as-fast-as-you-can mandatory online training."
>
> —Facilitator from the web-based training group

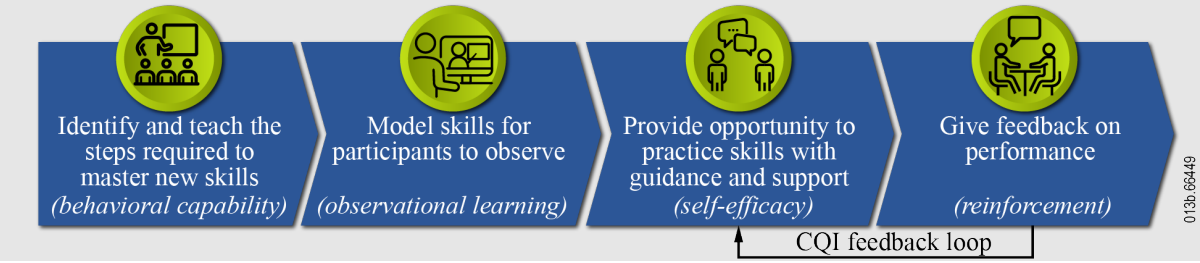
Facilitators' open-ended comments about their training experience helped contextualize these quantitative findings. Facilitators in both training format groups liked most the information and knowledge they gained; they made many other positive comments about the REACH project staff and the quality of the facilitator training materials. Comments from facilitators about what they liked best about the instructor-led training reinforced the importance of opportunities they received for engagement and interaction.

Facilitators who completed the web-based training commented more frequently than those who completed the instructor-led training about the value of the one-on-one fidelity check. For facilitators who completed the web-based training, the fidelity check served as the only (a) source of real-time interaction with a REACH expert and (b) opportunity to receive direct feedback to promote program delivery skills building and foster continuous quality improvement. It provides the last two

steps in a successful approach to skills-based training informed by social cognitive theory (Bandura, 1986; see Figure 2) and common in other evidence-based prevention interventions (e.g., Coventry et al., 2020). Comments from facilitators regarding the web-based training highlighted the fidelity check as an important means of bolstering confidence and self-efficacy.

Figure 2

Skills-Based Training Approach Informed by Social Cognitive Theory (Bandura, 1986)



Note: CQI = Continuous Quality Improvement

Facilitators in both training format groups identified the training format as something they liked least about the training. Both groups frequently commented that they preferred in-person training to the virtual instructor-led or web-based training they received. In addition, facilitators who completed web-based training reported experiencing technology issues and work interference that exacerbated their concerns about training length. Technology issues included interface problems between their installation servers and the MilLife Learning website. Work interference issues included the presence of people in facilitators' work environment that made completing training difficult, as well as heavy workload, suicide(s), or other emergencies at their installation that interfered with completing a fidelity check soon after training completion, which impeded-retention of specific REACH content.

Participant Outcomes

REACH was originally developed to empower Service members to reach out for help without worrying about perceived or real barriers to care. Our field test results indicate that REACH accomplished its goal of lowering geographically isolated Service member participants' perceptions of barriers to help-seeking. REACH also significantly increased participants' perceived knowledge of available resources and likelihood of using Military OneSource the next time they have a concern. It is important to note that we observed these effects sustained over a period of 3 months following the REACH session. Service member participants felt that their facilitators expressed passion and enthusiasm for help-seeking during the REACH session and encouraged them to participate.

Following the REACH session, participants were less likely to perceive that seeking help would cause others to see them as broken or negatively impact their career, report that they do not know where to get help or lack confidence in the effectiveness of available resources. They were marginally less likely to worry that their mental health problems might not stay private if they sought help. These results indicate that the findings from prior research on barriers to care (Adler et al., 2015; Clary et al., 2021; Ho et al., 2018; Hom et al., 2017; Jensen & Bowen, 2022) and the effectiveness of REACH in mitigating these barriers (Osborn et al., 2020) extend to geographically isolated Service members. Consistent with findings from the FY20 field test (Osborn et al., 2020), REACH also increased geographically isolated Service member participants' knowledge of available resources.

One of the main goals of REACH is to increase utilization of resources such as Military OneSource, which can be especially valuable for Service members without readily available access to MTFs, MFLCs, and installation-based Military and Family Support Centers. Previous research involved data collection immediately following the REACH session (Osborn et al., 2020) and did not have the capability to measure resource utilization. Three months after participants' REACH session, we identified small effect sizes in the desired direction for Military OneSource utilization and help-seeking and increases in the likelihood of future Military OneSource utilization and prevalence of seeking help or considering it. Participants most commonly identified family members, significant others, and friends as sources of help they contacted or considered. REACH participants' most common reasons for not considering seeking help were concerns about negative career impact and interference from others. Following their REACH session, participants' inclination to recommend Military OneSource to others also increased.

> "This was a great class, and you did a great job leading the REACH session. Quick story of the impact from your REACH session…My grandmother passed away 6 months ago. My family had been dealing with the stress of her passing, with less income due to retirement at the same time. They were feeling stressed and overwhelmed. I mentioned for them to call Military OneSource and since they reached out, I can say they seem to be doing a lot better lately. I would have never directed them to Military OneSource if it wasn't for your knowledge of Military OneSource while facilitating the REACH session. I am grateful for the time and compassion you devoted to those of us who attended the REACH session. Thank you very much!!"
>
> —REACH participant in an email to his facilitator

Limitations

A primary limitation of this study was the dependence on self-reported data, which may be unreliable. An improved approach to measuring outcomes would involve collecting behavioral measures derived from administrative data sources, such as data call logs from Military OneSource; services provided by MTFs, MFLCs, and installation-based Military and Family Support Centers; Tricare claims data; or suicide attempt or death data. Assessing behavioral outcomes using administrative or self-reported data, including suicidal ideation, would require an extended follow-up period, a more thorough power analysis, and enhanced data collection methods to handle follow-up more effectively for nonresponse. Employing such methods would allow for an objective

evaluation of the actual effectiveness of REACH in increasing help-seeking behavior and reducing suicidal ideation, attempts, and deaths.

Additional limitations of our study included generalizability of findings, small sample size, evaluation design and implementation issues, and lack of control for potential confounding variables. Only 59% of facilitators who completed a questionnaire went on to lead a REACH session, suggesting that our facilitator training outcome findings may not be representative of all REACH facilitators. Our participant analytic sample (*n* = 49) comprised 11% of the total estimated number of REACH session participants in our study and exhibited many differences at baseline from other REACH session participants who provided data on their background characteristics. REACH facilitators recruited a convenience sample of Service members to attend REACH sessions. As a result, REACH participants were not representative of the total military force. For example, very few REACH participants were junior enlisted Service members, and a large percentage were NCOs. The majority (71%) of REACH participants in our field test were from National Guard, who may have fewer barriers to care than active duty personnel. National Guard Service members only drill once a month, and they may use their military email address infrequently because of their regular employment elsewhere, which may have contributed to our low follow-up survey response rate. In addition, we relied on facilitators to send follow-up questionnaire links to participants and communicate with them about data collection. As such, our study team did not communicate with REACH participants about follow-up data collection directly. Although some of our findings are similar to those reported previously (Osborn et al., 2020), it is impossible to generalize our results to other REACH session participants in our study or outside our study. Our participant analytic sample did not meet the sample size requirement suggested by our power analysis, which may have precluded the detection of statistically significant differences related to resource utilization behavior. Nevertheless, we identified many impressive effect sizes in the desired direction, which suggest potential benefits of a larger future study.

Our use of a randomized evaluation design to assess the effectiveness of the web-based REACH facilitator training resulted in 16% of facilitators completing a different training format than we randomly assigned to them. The one-group pretest-posttest design that we used to evaluate participant outcomes did not include a comparison group. Thus, we could not eliminate several potential threats to validity, such as historical changes unrelated to the program, maturation effects, or testing artifacts. Our analyses did not adjust for clustering of facilitators and participants, which may have yielded false positive results (Borhan et al., 2020; Murray et al., 2004). We conducted 11 statistical tests of participant outcomes after attending a REACH session; however, due to concerns about statistical power, we did not adjust for multiple comparisons or potential confounding factors that may be related to both REACH participation and outcomes, such as marital status, responsibility for dependent children, or pay grade.

We also experienced many challenges during the field test implementation, including facilitators not completing training or fidelity checks, lack of communication from facilitators about their REACH session participant attendance counts and sharing the follow-up survey weblink with participants, web survey hosting outages that prevented facilitator and participant data collection, and low participant follow-up response rates. Nevertheless, we received 269 completed participant baseline

questionnaires and 80 completed 3-month follow-up questionnaires[11] despite not providing financial incentives and receiving little command support for study participation.

[11] Of the 80 completed follow-up questionnaires we received, 31 did not match study IDs for completed baseline questionnaires, so we only included the remaining 49 REACH participants who completed both baseline and follow-up questionnaires in our participant analytic sample (*n* = 49).

Recommendations

Based on the results of our analysis, we offer the following stakeholder recommendations for future REACH implementation and enhancement:

1. Strengthen REACH implementation and evaluation

The DoD should consider expanding REACH implementation beyond its current implementation by interested volunteers by funding the development of a comprehensive REACH dissemination plan. The plan might include information about how to select appropriate staff to receive REACH facilitator training, facilitator responsibilities, installation leadership roles and responsibilities, staff time and resources needed, guidance and communication tools for recruitment of Service members, implementation tips, and tools for local evaluation. Development of the plan might include gathering input from the Services about the best way to disseminate the plan itself, anticipated challenges, and brainstormed solutions that could be included in the plan to support installations. For example, the plan should identify and discuss possible solutions to the challenges facilitators experienced in our field test.

> "REACH leads up to proactive and current measures for self-care. I have always felt that suicide prevention training was too reactive and a check-the-block function. REACH provides Service members with guidance on how to put themselves first!"
>
> —Facilitator from the web-based training group

With respect to evaluation, the current study collected behavioral measures using self-report data from a limited sample. DoD should fund a larger scale study to collect behavioral measures using both self-report and administrative data, such as Military OneSource call logs, other service provider utilization, self-referrals, or Tricare data. Such a study should also address program costs, including facilitator training costs and costs associated with organizing and conducting REACH sessions; cost-effectiveness; and cost-benefit. Assessment of these outcomes will require random assignment of Service members to receive REACH or serve as controls and an improved implementation and evaluation design that addresses anticipated technology challenges related to web-based instructor training and data collection.

2. Improve and re-evaluate web-based REACH facilitator training

The DoD should conduct a user experience study to identify specific technology challenges associated with the web-based REACH facilitator training on the MilLife Learning website and develop solutions to address them. Solutions might include providing frequently asked questions and troubleshooting guidance on the MilLife Learning website, including preferred web browser(s), needed bandwidth, operating system requirements, options to complete training on personal devices, instructions for setting up a Wi-Fi hot spot if needed, and/or how to access training content on CDs for personnel with network access issues. Particularly in geographically isolated areas with poor Wi-Fi coverage, Service members may need additional guidance and support to access the web-based REACH facilitator training.

> "The slides were not working."
>
> —Facilitator from the web-based training group

The web-based training demonstrates promise for widespread dissemination, as it yielded comparable facilitator knowledge gains to instructor-led training, and facilitators expressed satisfaction with various aspects of the web-based training. Overall, facilitator survey results suggest that, although facilitators may prefer in-person learning, the web-based REACH facilitator training could provide an effective core learning mechanism for a DoD-wide effort to disseminate REACH. Our randomized evaluation identified positive REACH facilitator training effects, with minimal differences in effectiveness observed between the web-based and instructor-led training formats. DoD and the military Services should address concerns expressed by facilitators about the web-based REACH facilitator training available on MilLife Learning and consider re-evaluating it subsequently. Web-based facilitator training is free and readily accessible. It may be particularly valuable for bringing REACH to geographically isolated installations, where access to mental health and community resources is limited and risk of suicide attempt is elevated (GAO, 2021, 2022).

3. Provide one-on-one fidelity check support to REACH facilitators

The DoD should fund and support provision of fidelity checks for REACH facilitators to promote widespread dissemination of the program. A REACH implementation strategy centered around web-based facilitator training, complemented by one-on-one fidelity checks, will offer a more cost-effective approach compared to relying solely on instructor-led training. Facilitators in both training groups highlighted the value of one-on-one fidelity check support, but those receiving web-based training were more vocal about the need for fidelity checks as a core component of REACH facilitator training. The MilLife Learning web-based REACH facilitator training should provide instructions for how facilitators can easily request a fidelity check from an expert trained in REACH. Because a small number of contractor staff have such expertise and training, DoD should provide funding for some full-time staff who could provide fidelity checks and administer other aspects of the REACH program. This effort could also include development and pilot testing of a training of trainers to expand capability to provide fidelity checks across the Services. It is important to note that even though the web-based training presently highlights the importance of fidelity checks to facilitators, it does not provide a mechanism for requesting one. Furthermore, there is no funded capability for PERSEREC to provide fidelity checks to REACH facilitators outside of the present field test.

4. Protect facilitators' time to complete web-based REACH facilitator training and fidelity checks

Commanders and leaders should safeguard facilitators' time from work interference, allowing them to complete the web-based REACH facilitator training and a 1-hour fidelity check before leading REACH sessions with Service members. Facilitators in our study who completed web-based training noted the tension between wanting to complete the REACH facilitator training and managing their existing job responsibilities, interruptions, and people coming in and out of their work environment. Shortening the web-based facilitator training from 6.5 hours to 4 hours could reduce the time burden for facilitators. Alternatively, DoD could provide funding to support in-person or virtual instructor-led training, which facilitators in our study perceived to be more useful, engaging, and appropriate in length compared to web-based training.

Our fidelity check staff has had to reschedule numerous fidelity checks due to facilitators being diverted to competing work responsibilities. This delay has impacted their ability to practice what they learned soon after acquiring the knowledge. If leadership seeks to transform the existing culture around mental health and help-seeking, they should prioritize safeguarding the staff selected to undergo web-based REACH facilitator training. Facilitators require dedicated time for training and a scheduled fidelity check without interruption. Such commitment will serve as an investment by leadership in a cost-effective staff professional development effort that will benefit other Service members.

5. Expand web-based REACH facilitator training to include a module on self-care

The REACH facilitator training could benefit from a module on facilitator self-care. While our study did not specifically evaluate deficiencies in self-care among facilitators, it's important to note that the foundation of REACH is derived from data on Service members' barriers to self-care (OPA, 2019), as outlined in Osborn et al. (2020). While training and resources are available for first responders to help them deal with stress and trauma, an additional web-based REACH facilitator training module on self-care and secondary trauma would reinforce the importance of REACH facilitators and participants alike receiving needed care. Because the military is a service-oriented organization and community, many Service members, military leaders, and civilians who work with Service members value serving others and selflessly prioritize their mission over self-care. A self-care module for REACH facilitators could also be beneficial for medical corpsmen, chaplains and enlisted religious affairs personnel, paramedics, security forces, Special Operations Command personnel, sexual assault response coordinators, victim advocates, and SPPMs.

> "I honestly believed we shared something mutual in learning that we can ultimately deal with things in our everyday lives. We found understanding in one another, in processes, and in peer support channels. Honestly, one thing that I have learned post-REACH sessions is that no matter what, life has a way of showing you pain, gratitude, understanding, and ultimately HOPE."
>
> —Facilitator from the web-based training group, emailing participants after the REACH session

6. Expand web-based REACH facilitator training to include an optional module on facilitation skills

The REACH facilitator training could benefit from an optional module covering facilitation skills, including adult learning principles and tips for creating engaging and interactive sessions that maximize learning and retention. This module could be beneficial for staff who facilitate other types of training, including resiliency training, sexual assault prevention training, and suicide prevention training. Our analyses noted that REACH facilitator presentation experience was associated with knowledge gain and satisfaction with training length. Our fidelity check staff also noted that facilitators with past presentation experience were able to deliver REACH with a high level of integrity, while other facilitators without presentation experience struggled with delivering content in a manner that preserved core content and critical pedagogy components. A well-designed module could supplement coaching on facilitation skills, which typically occurs during fidelity checks. Alternatively, DoD could support development of criteria for selecting prospective REACH facilitators, which could include group facilitation training, skills, and experience.

> "I do not feel that the virtual training prepares someone to teach. I will be fine because I have education, training, and experience as a facilitator. But I think of an E5 with no prior experience trying to learn to facilitate this via web-based learning, and most will not be sufficiently prepared. Most won't be after the in-person training. The virtual course is sufficient if someone already has experience in the field of suicide prevention or prevention in general and has basic facilitation skills."
>
> —Facilitator in the web-based training group

7. Consider REACH's training design as a framework for other military training

The DoD should examine applying the REACH training model to enhance other military training efforts such as resilience, suicide prevention, and sexual assault training. Facilitators in both REACH training groups often compared REACH's training design, experiential learning approach, practical instrumental support, and upstream prevention focus with the methods used in other military trainings. Creating a DoD adaptation toolkit to assist facilitators could be valuable, aiding them in identifying core components of their training, enhancing its design, incorporating experiential learning based on adult learning principles (Cordiner, 2016; Knowles, 1990), addressing barriers to behavior change, and prioritizing instrumental support needs derived from Service member input and feedback. Similarly, REACH's focus on proactive help-seeking could benefit other training areas beyond suicide prevention, including alcohol and other drug abuse prevention, bullying victimization, intimate partner violence victimization, sexual harassment or assault victimization, or physical health concerns.

> "It's engaging and less of a training/briefing. I'd call it a discussion/information-sharing session."
>
> —Facilitator from the web-based training group

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Acronyms Used in This Report

ANCOVA	Analyses of Covariance
ANOVA	Analyses of Variance
CONUS	Continental United States
GAO	Government Accountability Office
MFLC	Military and Family Life Counselor
MOS	Military Occupational Specialty
MTF	Military Treatment Facility
NCO	Noncommissioned Officer
OCONUS	Outside of the Contiguous United States
OPA	Office of People Analytics
PERSEREC	Defense Personnel and Security Research Center
PII	Personally Identifiable Information
REACH	Resources Existing, Asking Can Help
SPPM	Suicide Prevention Program Manager

Appendix A: Questionnaires

Facilitator Questionnaire

Informed Consent Form for REACH Facilitators

Study Title: REACH Field Test with Geographically Isolated Service Members
Principal Investigator: Olga Shechter, Ph.D.
Office: Defense Personnel Analytics Center
Telephone: (831) 236-9959
Email: olga.g.shechter.civ@mail.mil

PRINCIPAL PURPOSE: We are inviting you to participate in a research study that involves filling out a survey. The survey takes about 10-20 minutes to complete, and we will use the information collected on the survey to evaluate the effectiveness of the REACH Facilitator Training.

Key Information:

- **Study Purpose:** The purpose of the study is: 1) to evaluate the effectiveness of REACH for increasing help-seeking behavior among geographically dispersed Service members located CONUS and OCONUS, and 2) to assess the effectiveness of the virtual REACH facilitator training hosted on MilLife Learning relative to the instructor-led REACH facilitator training.
- **Study Risks:** There is minimal risk from completing this survey. We will take multiple precautionary steps to safeguard the confidentiality of your data and prevent unintended disclosure of any data. No personally identifiable information (PII) will be collected on the study survey, and your name will not be associated with your survey responses.
- **Study Benefits:** While there are no immediate benefits to you from taking part in this study, your responses could potentially help promote help-seeking behavior among Service members who need support. Your responses will also help us better understand how to improve future REACH facilitator training experiences for others who step into this role.
- **Study Alternatives:** This study is for research purposes, and the alternative is not to participate. Your participation is voluntary. This means that you are free to choose not to take part in the survey, or to skip any questions that you do not want to answer, without penalty.

Who will have access to my survey data?
Your name or other PII will not be attached to your survey responses, and only the study staff will have access to your survey responses. Survey responses will only be reported in aggregate in the final study report, which means that responses from all REACH facilitators will be grouped together and reported out as a single set of numbers. Importantly, if you verbally indicate that you intend to harm yourself or others, we will need to refer you to resources for support.

Whom to contact about this study
During the study, if you have questions, concerns, or complaints, please contact the Principal Investigator, Dr. Olga Shechter, at the telephone number or email listed at the top of the page. The Exempt Determination Official (EDO) has determined that the study does not constitute human subjects research in accordance with 45 CFR 46.102.

Thank you for considering participation in the survey. We take your privacy very seriously.

Authorization:

Your response below signifies the following:

· You have read this consent form and received satisfactory answers to any questions you had about this study.
· You voluntarily choose to participate in this study.
· Your consent does not take away any legal rights in the case of negligence or other legal fault of anyone who is involved in this study.
· Nothing in this consent form is intended to preempt any applicable federal, state or local laws regarding informed consent.

Do you consent to participate in this research study?
- ☐ Yes
- ☐ No

Post-Facilitator Training Questionnaire

Please complete this survey after completing the REACH Facilitator Training and your fidelity check. Your feedback will help us improve the REACH Facilitator Training, so please answer all questions to the best of your ability.

(Reminder: Your responses will be kept confidential and will not be linked to your name).

1. Please enter the StudyID number assigned to you (e.g., X999XX).

_____

2. What is your gender?
- ☐ Female
- ☐ Male
- ☐ Other/Non-binary

3. What is the highest degree or level of education you have completed?
- ☐ Less than high school
- ☐ High school diploma/GED or equivalent
- ☐ Trade or technical certificate
- ☐ Some college (no degree)
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Doctoral degree

4. How many years have you served in the military? *(Round up your answer to the next whole number; please enter 00 if not in the military)*

_____

5. What is your military component?
- ☐ Active Duty
- ☐ Reserve
- ☐ National Guard
- ☐ Not in the military

6. What is your military Service branch?
- ☐ Army
- ☐ Navy
- ☐ Air Force
- ☐ Marine Corps
- ☐ Not in the military

7. What is the code for your current MOS? [Example: 11B] *(If not in the military enter 00)*

_____

8. What is your current pay grade/rank?
- ☐ E-1
- ☐ E-2
- ☐ E-3
- ☐ E-4
- ☐ E-5
- ☐ E-6
- ☐ E-7
- ☐ E-8
- ☐ E-9
- ☐ W-1
- ☐ W-2
- ☐ W-3
- ☐ W-4
- ☐ W-5
- ☐ O-1
- ☐ O-2
- ☐ O-3
- ☐ O-4
- ☐ O-5
- ☐ O-6 or above
- ☐ Not in military

9. Which military installation are you currently assigned to?

_____

10. Are you currently stationed OCONUS?

- Yes
- No

11. What is your current role?

- Suicide Prevention Program Manager (SPPM)/Violence Prevention Integrator (VPI)
- Chaplain
- Mental health professional (e.g., psychologist, psychiatrist, clinical social worker, embedded mental health provider, other mental health counselor)
- Sexual Assault Response Coordinator (SARC)
- Frontline supervisor
- Other: Please specify your role:_____

12. How many times have you presented to a group (e.g., giving briefings, presenting trainings, etc.)?

- 1-5 times
- 6-10 times
- 11-15 times
- 16-20 times
- 21+ times

13. Which version of the REACH Facilitator Training did you complete?

- Virtual REACH Facilitator Training for MilLife Learning
- Instructor-led REACH Facilitator Training

14. Approximately how long did it take you to complete the virtual REACH Facilitator Training (excluding rests and breaks)?

- Less than 3 hours
- 3-4 hours
- 4-5 hours
- 6-7 hours
- 8-9 hours
- 10+ hours

15. Please rate each of the following REACH Facilitator Training components in terms of their usefulness for leading your own REACH session.

Module 1: REACH Mindset

- Not at all useful
- Slightly useful

- Moderately useful
- Very useful
- Extremely useful

16. Please rate each of the following REACH Facilitator Training components in terms of their usefulness for leading your own REACH session.

Module 2: Motivational Interviewing

- Not at all useful
- Slightly useful
- Moderately useful
- Very useful
- Extremely useful

17. Please rate each of the following REACH Facilitator Training components in terms of their usefulness for leading your own REACH session.

Module 3: Military OneSource Resources and Practice Call

- Not at all useful
- Slightly useful
- Moderately useful
- Very useful
- Extremely useful

18. Please rate each of the following REACH Facilitator Training components in terms of their usefulness for leading your own REACH session.

Module 4: Session Preparation (i.e., steps facilitators need to complete before leading a REACH sessions)

- Not at all useful
- Slightly useful
- Moderately useful
- Very useful
- Extremely useful

19. Please rate each of the following REACH Facilitator Training components in terms of their usefulness for leading your own REACH session.

Module 5: Session Best Practices (i.e., slide by slide demonstration of an actual REACH session with feedback videos)

- Not at all useful
- Slightly useful
- Moderately useful
- Very useful

□ Extremely useful

20. Please rate each of the following REACH Facilitator Training components in terms of their usefulness for leading your own REACH session.

	Not at all Useful	Slightly Useful	Moderately Useful	Very Useful	Extremely Useful
Introduction to REACH and your role as a facilitator	□	□	□	□	□
Review of Facilitator's Manual	□	□	□	□	□
Facilitator's Manual discussion and Q&A	□	□	□	□	□
Demonstration of REACH	□	□	□	□	□
REACH session discussion and Q&A	□	□	□	□	□
Motivational Interviewing 101	□	□	□	□	□
Teach Backs	□	□	□	□	□

21. Please indicate how much you disagree or agree with the following statement:

I feel confident about leading REACH sessions with others.

□ Strongly disagree
□ Disagree
□ Neither agree nor disagree
□ Agree
□ Strongly agree

22. Please indicate how much you disagree or agree with the following statement:

The REACH Facilitator Training I received adequately prepared me to lead a REACH session.

□ Strongly disagree
□ Disagree
□ Neither agree nor disagree
□ Agree
□ Strongly agree

23. Think about what you already knew and what you learned during this training. Then evaluate your knowledge in each of the following areas related to REACH topics **before** and **after** the REACH Facilitator Training.

BEFORE training	**No knowledge**	**Little knowledge**	**Some knowledge**	**A lot of knowledge**
Motivational Interviewing	□	□	□	□
Confidential and non-confidential resources	□	□	□	□
Military OneSource	□	□	□	□
Barriers to care	□	□	□	□
Ways to overcome barriers to care	□	□	□	□
Benefits of proactive help-seeking	□	□	□	□
AFTER training	**No knowledge**	**Little knowledge**	**Some knowledge**	**A lot of knowledge**
Motivational Interviewing	□	□	□	□
Confidential and non-confidential resources	□	□	□	□
Military OneSource	□	□	□	□
Barriers to care	□	□	□	□
Ways to overcome barriers to care	□	□	□	□
Benefits of proactive help-seeking	□	□	□	□

24. Please indicate how much you disagree or agree with the following statement:

I would recommend the REACH Facilitator Training to others.

□ Strongly disagree
□ Disagree
□ Neither agree nor disagree
□ Agree
□ Strongly agree

25. Please indicate how much you disagree or agree with the following statement:

The REACH Facilitator Training was engaging.

□ Strongly disagree
□ Disagree
□ Neither agree nor disagree
□ Agree
□ Strongly agree

26. Please indicate how much you disagree or agree with the following statement:

The REACH Facilitator Training felt too long.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

27. Please indicate how much you disagree or agree with the following statement:

The REACH Facilitator Training was well-organized.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

28. Please indicate how much you disagree or agree with the following statement:

The fidelity check was useful for preparing me to lead a REACH session.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

29. What did you like the most about the REACH Facilitator Training?

_____
_____
_____

30. What did you like the least about the REACH Facilitator Training?

_____
_____
_____

31. Did the REACH Facilitator Training meet your expectations?

- Yes
- No

Why or why not?

_____

Baseline REACH Participant Questionnaire

Informed Consent Form for REACH Participants

Study Title: REACH Field Test with Geographically Isolated Service Members
Principal Investigator: Olga Shechter, Ph.D.
Office: Defense Personnel Analytics Center
Telephone: (831) 236-9959
Email: olga.g.shechter.civ@mail.mil

PRINCIPAL PURPOSE: We are inviting you to take part in a research study that involves filling out two surveys. You will be completing the first survey today and the second one 3 months from now. Each survey should take about 15-20 minutes to complete. Information collected in the surveys will be used to evaluate the effectiveness of the REACH program for supporting geographically dispersed Service members located CONUS and OCONUS.

Key Information:
• **Study Purpose:** The purpose of the study is to evaluate the effectiveness of the REACH program for supporting geographically dispersed Service members located CONUS and OCONUS.
• **Study Risks:** There is minimal risk from completing this survey. We will take multiple precautionary steps to safeguard the confidentiality of your data and prevent unintended disclosure of any data. No personally identifiable information (PII) will be collected on the survey, and your name will not be associated with your survey responses.
• **Study Benefits:** While there are no immediate benefits to you from taking part in this study, your responses could help us improve REACH delivery for other Service members.
• **Study Alternatives:** This study is for research purposes, and the alternative is not to participate. Your participation is voluntary. This means that you are free to choose not to take part in the survey, or to skip any questions that you do not want to answer, without penalty.

Who will have access to this study and/or contact information?
Your name or other PII will not be attached to your survey responses, and only the study staff will have access to your survey responses. Your survey responses will only be reported in aggregate in the final study report, which means that responses from all respondents will be grouped together. Importantly, if you verbally indicate that you intend to harm yourself or others, your REACH facilitator will need to refer you to resources for support.

Whom to contact about this study
During the study, if you have questions, concerns, or complaints, please contact the Principal Investigator, Dr. Olga Shechter, at the telephone number or email listed at the top of the page. The Exempt Determination Official (EDO) has determined that the study does not constitute human subjects research in accordance with 45 CFR 46.102.

Thank you for considering participation in the surveys. We take your privacy very seriously.

Authorization:
Your response below signifies the following:

· You have read this consent form and received satisfactory answers to any questions you had about this study.
· You voluntarily choose to participate in this study.
· Your consent does not take away any legal rights in the case of negligence or other legal fault of anyone who is involved in this study.
· Nothing in this consent form is intended to preempt any applicable federal, state or local laws regarding informed consent.

Do you consent to participate in this research study?

- ☐ Yes
- ☐ No

Pre-REACH Participant Study ID Generator

In addition to this questionnaire, we will also ask you to complete a second questionnaire approximately 3 months from now. To enable us to link your responses between the two questionnaires anonymously, we ask that you to create a Study ID number by answering the following questions. Please answer these questions as accurately as possible.

1a. What is the two-letter abbreviation of the state where you last attended high school? (Example response if it is New York: NY). If this was outside of the United States, please use the first two letters of the country where you last attended high school.

_____

1b. What day of the month were you born? (Example response if you were born on November 2: 02)

_____

1c. What are the 1st and 2nd letters of your mother's first name? (Example response if your mother's first name is Martha: MA. If you do not know your mother's name please enter "ZZ").

_____

1d. What is your middle initial (Example response if your middle name is Eric: E. If you do not have a middle name, enter X).

_____

Thank you!

Pre-REACH Participant Questionnaire

Please complete this Pre-REACH Session Participant Questionnaire before the REACH session. Your feedback will help us improve the REACH training experience, so please answer all the questions to the best of your ability.

(Reminder: Your responses will be kept confidential and will not be linked to your name).

1. Please enter your REACH Facilitator's StudyID *(provided by your facilitator)*

   _____

2. What is the format of your REACH session?
   - ☐ In-Person
   - ☐ Virtual

3. What is your gender?
   - ☐ Female
   - ☐ Male
   - ☐ Other/Non-Binary

4. What is your marital status?
   - ☐ Never married
   - ☐ Not married, but cohabitating
   - ☐ Currently married
   - ☐ Separated
   - ☐ Divorced
   - ☐ Widowed

5. What is your military component?
   - ☐ Active Duty
   - ☐ Reserve
   - ☐ National Guard

6. What is your military Service branch?
   - ☐ Army
   - ☐ Navy
   - ☐ Air Force
   - ☐ Marine Corps

7. Which military installation are you currently assigned to?

   _____

8. Are you currently stationed OCONUS?
   - ☐ Yes
   - ☐ No

9. How many years have you served in the military? *(Round up your answer to the next whole number).*

_____

10. What is the code for your current MOS? [Example: 11B]

_____

11. What is your current pay grade/rank?

- E-1
- E-2
- E-3
- E-4
- E-5
- E-6
- E-7
- E-8
- E-9
- W-1
- W-2
- W-3
- W-4
- W-5
- O-1
- O-2
- O-3
- O-4
- O-5
- O-6 or above

12. Have you ever been responsible for the care of children aged 17 years old or younger who live with you? "Responsible for their care" means that you are responsible for ensuring they receive doctor appointments and other needed services.

- Yes
- No

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

- Less than high school
- High school diploma/GED or equivalent
- Trade or technical certificate
- Some college (no degree)
- Associate's degree
- Bachelor's degree

- Master's degree
- Doctoral degree

14. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever have a problem:

There is sufficient information available for people to be able to help themselves.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

15. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever have a problem:

I know how to help myself.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

16. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever have a problem:

Strong people can resolve psychological problems by themselves.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

17. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever have a problem:

I would prefer to manage my problems on my own.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

18. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever have a problem:

I would rather get information on how to deal with the problem on my own.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

19. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever have a problem:

Seeking help would negatively impact my career.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

20. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever have a problem:

Seeking help would cause others to see me as broken.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

21. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever have a problem:

I don't know where to get help.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

22. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever have a problem:

Seeking help for a stress, emotional, alcohol, or family problem will make a positive difference.

 Strongly disagree
 Disagree
 Neither agree nor disagree
 Agree
 Strongly agree

23. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever have a problem:

If I felt trapped or stuck in a stressful situation, I would deal with it on my own to try and fix it.
 Strongly disagree
 Disagree
 Neither agree nor disagree
 Agree
 Strongly agree

24. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever have a problem:

I worry that my mental health problems might not stay private if I seek help.
 Strongly disagree
 Disagree
 Neither agree nor disagree
 Agree
 Strongly agree

25. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever have a problem:

There are effective resources out there that can help me with a mental health problem.
 Strongly disagree
 Disagree
 Neither agree nor disagree
 Agree
 Strongly agree

26. What is your level of knowledge of the following support service?

Chaplains and Enlisted Religious Affairs Personnel
 I have never heard of this service
 I have heard of this service, but I do not really know what it is
 I have heard of this service, but I only superficially understand it
 I know a lot about this service

27. What is your level of knowledge of the following support service?

Military & Veterans Crisis Line

- I have never heard of this service
- I have heard of this service, but I do not really know what it is
- I have heard of this service, but I only superficially understand it
- I know a lot about this service

28. What is your level of knowledge of the following support service?

Military OneSource

- I have never heard of this service
- I have heard of this service, but I do not really know what it is
- I have heard of this service, but I only superficially understand it
- I know a lot about this service

29. What is your level of knowledge of the following support service?

Military & Family Life Counselors (MFLCs)

- I have never heard of this service
- I have heard of this service, but I do not really know what it is
- I have heard of this service, but I only superficially understand it
- I know a lot about this service

30. What is your level of knowledge of the following support service?

Mental Health Clinic/Military Treatment Facility

- I have never heard of this service
- I have heard of this service, but I do not really know what it is
- I have heard of this service, but I only superficially understand it
- I know a lot about this service

31. What is your level of knowledge of the following support service?

Financial Counselors

- I have never heard of this service
- I have heard of this service, but I do not really know what it is
- I have heard of this service, but I only superficially understand it
- I know a lot about this service

32. What is your level of knowledge of the following support service?

Embedded Behavioral Health Providers

- I have never heard of this service
- I have heard of this service, but I do not really know what it is
- I have heard of this service, but I only superficially understand it

 I know a lot about this service

33. What is your level of knowledge of the following support service?

DSTRESS Line
 I have never heard of this service
 I have heard of this service, but I do not really know what it is
 I have heard of this service, but I only superficially understand it
 I know a lot about this service

34. What is your level of knowledge of the following support service?

Deployed Resilience Counselors
 I have never heard of this service
 I have heard of this service, but I do not really know what it is
 I have heard of this service, but I only superficially understand it
 I know a lot about this service

35. What is your level of knowledge of the following support service?

Family Readiness Programs
 I have never heard of this service
 I have heard of this service, but I do not really know what it is
 I have heard of this service, but I only superficially understand it
 I know a lot about this service

36. What is your level of knowledge of the following support service?

Emergency Room
 I have never heard of this service
 I have heard of this service, but I do not really know what it is
 I have heard of this service, but I only superficially understand it
 I know a lot about this service

37. In the past 3 months, have you used Military OneSource? [Mark all that apply]
 No
 Yes, visited www.MilitaryOneSource.mil
 Yes, emailed Military OneSource
 Yes, talked to a Military OneSource consultant on the phone
 Yes, contacted Military OneSource using the chat feature
 Yes, contacted Military OneSource using the text feature

38. How likely is it that you will use Military OneSource the next time you have a concern?
 Very unlikely
 Unlikely

 Not sure
 Likely
 Highly unlikely

39. How likely is it that you would tell a friend to call Military OneSource for services?
 Very unlikely
 Unlikely
 Not sure
 Likely
 Highly likely

40. In the last 3 months, have you experienced a problem that has caused you significant stress?
 Yes
 No

41. Did you seek help for this issue?
 Yes
 No, but I considered it
 No, and I did not consider it

42. Who did you seek help from? [Mark all that apply]
 Spouse or significant other
 Parent or sibling
 Friend who is not in the military
 Military friend not in my chain of command
 Someone in my chain of command
 Military & Family Life Counselors (MFLCs)
 Mental health professional in a military facility (e.g., psychologist, psychiatrist, clinical social worker, other mental health counselor)
 Civilian mental health professional (e.g., psychologist, psychiatrist, clinical social worker, other mental health counselor)
 Chaplain, pastor, rabbi, or other spiritual counselor
 Someone at Military and Veterans Crisis Line
 Someone at a civilian-run crisis line (e.g., National Suicide Prevention Lifeline)
 Someone at Military OneSource
 Mental health mobile app(s)
 Some other individual/resource not listed above

If other, please specify _____

43. Who did you consider seeking help from? [Mark all that apply]
 Spouse or significant other
 Parent or sibling
 Friend who is not in the military

- ☐ Military friend not in my chain of command
- ☐ Someone in my chain of command
- ☐ Military & Family Life Counselors (MFLCs)
- ☐ Mental health professional in a military facility (e.g., psychologist, psychiatrist, clinical social worker, other mental health counselor)
- ☐ Civilian mental health professional (e.g., psychologist, psychiatrist, clinical social worker, other mental health counselor)
- ☐ Chaplain, pastor, rabbi, or other spiritual counselor
- ☐ Someone at Military and Veterans Crisis Line
- ☐ Someone at a civilian-run crisis line (e.g., National Suicide Prevention Lifeline)
- ☐ Someone at Military OneSource
- ☐ Mental health mobile app(s)
- ☐ Some other individual/resource not listed above

If other, please specify _____

44. Why did you not consider seeking help? [Mark all that apply]

- ☐ I did not know where to get help
- ☐ I did not trust mental health professionals
- ☐ It was difficult to arrange the time to talk to someone
- ☐ I was concerned it would cost too much money
- ☐ I was embarrassed
- ☐ I was concerned it might impact my security clearance
- ☐ I thought my coworkers and/or superiors would have less confidence in me if they found out
- ☐ I was concerned it would negatively impact my career
- ☐ I thought my friends and family would have less respect for me if they found out
- ☐ I would think less of myself if I could not handle it on my own
- ☐ I received treatment or therapy previously and did not think it was effective
- ☐ I did not want anyone to interfere

45. In the last 3 months, have you recommended any helpful resources to someone who was struggling?

- ☐ Yes
- ☐ No

46. Please identify the types of resources you referred them to. [Mark all that apply]

- ☐ Chaplain and Enlisted Religious Affairs Personnel
- ☐ Military & Veterans Crisis Line
- ☐ Military OneSource
- ☐ Military & Family Life Counselors (MFLCs)
- ☐ Mental Health Clinic/Military Treatment Facility
- ☐ Emergency Room
- ☐ Other

If other, please specify here: _____

Follow-Up REACH Participant Questionnaire

Post-REACH Participant Study ID Generator

The baseline REACH questionnaire you completed 3 months ago requested that you create a unique Study ID to enable us to link your responses to the two questionnaires anonymously. Please answer the following questions by providing the same responses you provided to the first questionnaire.

1a. What is the two-letter abbreviation of the state where you last attended high school? (Example response if it is New York: NY). If this was outside of the United States, please use the first two letters of the country where you last attended high school.

_____

1b. What day of the month were you born? (Example response if you were born on November 2: 02)

_____

1c. What are the 1st and 2nd letters of your mother's first name? (Example response if your mother's first name is Martha: MA. If you do not know your mother's name please enter "ZZ").

_____

1d. What is your middle initial (Example response if your middle name is Eric: E. If you do not have a middle name, enter X).

_____

Thank you!

Post-REACH Participant Questionnaire

The questions on the *Post-REACH Session Participant Questionnaire* pertain to the REACH session you attended approximately 3 months ago. Your feedback will help us improve the REACH training experience, so please answer all the questions to the best of your ability.

(Reminder: Your responses will be kept confidential and will not be linked to your name).

1. What was your military Service branch 3 months ago?
   - ☐ Army
   - ☐ Navy
   - ☐ Air Force
   - ☐ Marine Corps

2. Which military installation were you assigned to 3 months ago?

   _____

3. Think back to your impressions of the facilitator who lead the REACH session and your experiences with accessing resources afterwards. How much do you agree with the following statement:

The REACH Facilitator encouraged the audience members to participate.

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

4. Think back to your impressions of the facilitator who lead the REACH session and your experiences with accessing resources afterwards. How much do you agree with the following statement:

The REACH Facilitator was enthusiastic when delivering the training.

- ☐ Strongly disagree
- ☐ Disagree
- ☐ Neither agree nor disagree
- ☐ Agree
- ☐ Strongly agree

5. Think back to your impressions of the facilitator who lead the REACH session and your experiences with accessing resources afterwards. How much do you agree with the following statement:

The REACH Facilitator was passionate about the importance of reaching out for help.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

6. Think back to your impressions of the facilitator who lead the REACH session and your experiences with accessing resources afterwards. How much do you agree with the following statement:

After hearing the practice call during my past REACH session, I feel more comfortable making a call to Military OneSource myself if needed.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree
- We did not make a practice call to Military OneSource

7. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever had a problem:

There is sufficient information available for people to be able to help themselves.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

8. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever had a problem:

I know how to help myself.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

9. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever had a problem:

Strong people can resolve psychological problems by themselves.

- Strongly disagree

- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

10. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever had a problem:

I would prefer to manage my problems on my own.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

11. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever had a problem:

I would rather get information on how to deal with the problem on my own.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

12. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever had a problem:

Seeking help would negatively impact my career.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

13. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever had a problem:

Seeking help would cause others to see me as broken.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

14. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever had a problem:

I don't know where to get help.
- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

15. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever had a problem:

Seeking help for a stress, emotional, alcohol, or family problem will make a positive difference.
- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

16. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever had a problem:

If I felt trapped or stuck in a stressful situation, I would deal with it on my own to try and fix it.
- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

17. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever had a problem:

I worry that my mental health problems might not stay private if I seek help.
- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

18. Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever had a problem:

There are effective resources out there that can help me with a mental health problem.

- Strongly disagree
- Disagree
- Neither agree nor disagree
- Agree
- Strongly agree

19. What is your level of knowledge of the following support service?

Chaplains and Enlisted Religious Affairs Personnel

- I have never heard of this service
- I have heard of this service, but I do not really know what it is
- I have heard of this service, but I only superficially understand it
- I know a lot about this service

20. What is your level of knowledge of the following support service?

Military & Veterans Crisis Line

- I have never heard of this service
- I have heard of this service, but I do not really know what it is
- I have heard of this service, but I only superficially understand it
- I know a lot about this service

21. What is your level of knowledge of the following support service?

Military OneSource

- I have never heard of this service
- I have heard of this service, but I do not really know what it is
- I have heard of this service, but I only superficially understand it
- I know a lot about this service

22. What is your level of knowledge of the following support service?

Military & Family Life Counselor (MFLC)

- I have never heard of this service
- I have heard of this service, but I do not really know what it is
- I have heard of this service, but I only superficially understand it
- I know a lot about this service

23. What is your level of knowledge of the following support service?

Mental Health Clinic/Military Treatment Facility

- I have never heard of this service
- I have heard of this service, but I do not really know what it is
- I have heard of this service, but I only superficially understand it

 I know a lot about this service

24. What is your level of knowledge of the following support service?

Financial Counselors
 I have never heard of this service
 I have heard of this service, but I do not really know what it is
 I have heard of this service, but I only superficially understand it
 I know a lot about this service

25. What is your level of knowledge of the following support service?

Embedded Behavioral Health Providers
 I have never heard of this service
 I have heard of this service, but I do not really know what it is
 I have heard of this service, but I only superficially understand it
 I know a lot about this service

26. What is your level of knowledge of the following support service?

DSTRESS Line
 I have never heard of this service
 I have heard of this service, but I do not really know what it is
 I have heard of this service, but I only superficially understand it
 I know a lot about this service

27. What is your level of knowledge of the following support service?

Deployed Resilience Counselors
 I have never heard of this service
 I have heard of this service, but I do not really know what it is
 I have heard of this service, but I only superficially understand it
 I know a lot about this service

28. What is your level of knowledge of the following support service?

Family Readiness Programs
 I have never heard of this service
 I have heard of this service, but I do not really know what it is
 I have heard of this service, but I only superficially understand it
 I know a lot about this service

29. What is your level of knowledge of the following support service?

Emergency Room
- I have never heard of this service
- I have heard of this service, but I do not really know what it is
- I have heard of this service, but I only superficially understand it
- I know a lot about this service

30. Since attending the REACH session, have you used Military OneSource? [Mark all that apply]
- No
- Yes, visited www.MilitaryOneSource.mil
- Yes, emailed Military OneSource
- Yes, talked to a Military OneSource consultant on the phone
- Yes, contacted Military OneSource using the chat feature
- Yes, contacted Military OneSource using the text feature

31. How likely is it that you will use Military OneSource the next time you have a concern?
- Very unlikely
- Unlikely
- Not sure
- Likely
- Highly likely

32. How likely is it that you would tell a friend to call Military OneSource for services?
- Very unlikely
- Unlikely
- Not sure
- Likely
- Highly likely

33. Since attending the REACH session, have you experienced a problem that has caused you significant stress?
- Yes
- No

34. Did you seek help for this issue?
- Yes
- No, but I considered it
- No, and I did not consider it

35. Who did you seek help from? [Mark all that apply]
- Spouse or significant other
- Parent or sibling

- ☐ Friend who is not in the military
- ☐ Military friend not in my chain of command
- ☐ Someone in my chain of command
- ☐ Military & Family Life Counselors (MFLCs)
- ☐ Mental health professional in a military facility (e.g., psychologist, psychiatrist, clinical social worker, other mental health counselor)
- ☐ Civilian mental health professional (e.g., psychologist, psychiatrist, clinical social worker, other mental health counselor)
- ☐ Chaplain, pastor, rabbi, or other spiritual counselor
- ☐ Someone at Military and Veterans Crisis Line
- ☐ Someone at a civilian-run crisis line (e.g., National Suicide Prevention Lifeline)
- ☐ Someone at Military OneSource
- ☐ Mental health mobile app(s)
- ☐ Some other individual/resource not listed above

If other, please specify _____

36. Who did you consider seeking help from? [Mark all that apply]

- ☐ Spouse or significant other
- ☐ Parent or sibling
- ☐ Friend who is not in the military
- ☐ Military friend not in my chain of command
- ☐ Someone in my chain of command
- ☐ Military & Family Life Counselors (MFLCs)
- ☐ Mental health professional in a military facility (e.g., psychologist, psychiatrist, clinical social worker, other mental health counselor)
- ☐ Civilian mental health professional (e.g., psychologist, psychiatrist, clinical social worker, other mental health counselor)
- ☐ Chaplain, pastor, rabbi, or other spiritual counselor
- ☐ Someone at Military and Veterans Crisis Line
- ☐ Someone at a civilian-run crisis line (e.g., National Suicide Prevention Life-line)
- ☐ Someone at Military OneSource
- ☐ Mental health mobile app(s)
- ☐ Some other individual/resource not listed above

If other, please specify _____

37. Why did you not consider seeking help? [Mark all that apply]

- ☐ I did not know where to get help
- ☐ I did not trust mental health professionals
- ☐ It was difficult to arrange the time to talk to someone
- ☐ I was concerned it would cost too much money
- ☐ I was embarrassed
- ☐ I was concerned it might impact my security clearance
- ☐ I thought my coworkers and/or superiors would have less confidence in me if they found out

- ☐ I was concerned it would negatively impact my career
- ☐ I thought my friends and family would have less respect for me if they found out
- ☐ I would think less of myself if I could not handle it on my own
- ☐ I received treatment or therapy previously and did not think it was effective
- ☐ I did not want anyone to interfere.

38. Since attending the REACH session, have you recommended any helpful resources to someone who was struggling?

- ☐ Yes
- ☐ No

39. Please identify the types of resources you referred them to. [Mark all the apply]

- ☐ Chaplain and Enlisted Religious Affairs Personnel
- ☐ Military & Veterans Crisis Line
- ☐ Military OneSource
- ☐ Military & Family Life Counselors (MFLCs)
- ☐ Mental Health Clinic/Military Treatment Facility
- ☐ Emergency Room
- ☐ Other

If other, please specify here: _____

Appendix B: Analytic Approach

We conducted quantitative analyses to evaluate (a) the effectiveness of the web-based REACH facilitator training for MilLife Learning relative to the instructor-led training with respect to facilitator knowledge gain, perceived training utility, and training satisfaction; (b) facilitator level of confidence after completing web-based versus instructor-led REACH facilitator training; (c) REACH participants' perceptions of their facilitator; and (d) the effectiveness of REACH for reducing barriers to care and increasing knowledge of available resources and resource utilization among geographically isolated Service members. We used R analytic software (R Core Team, 2014) for all quantitative analyses. We conducted a qualitative content analysis of facilitator responses to open-ended questions concerning what they liked the most and least about the REACH facilitator training and why the training met their expectations. This section describes our analytic approach.

Analysis of Facilitator Survey Data

Across Research Questions 1 and 2, we tested a total of eight outcomes among facilitators, so we used $\alpha = 0.05/8$ or a threshold of 0.006 for the following analyses:

1. Knowledge gain,
2. Perceived utility of the fidelity check,
3. Training engagement,
4. Training organization,
5. Adequacy of the training in preparing facilitators to lead a REACH session,
6. Willingness to recommend REACH facilitator training to others,
7. Training length, and
8. Confidence to lead a REACH session with others.

Research Question 1 focused on potential differences in knowledge gain, perceived training utility, and training satisfaction between facilitators completing instructor-led versus web-based REACH facilitator training. We first assessed knowledge gain by conducting one-way within-subjects repeated measures analyses of covariance (ANCOVAs) to examine the effect of time (before and after REACH facilitator training) on knowledge separately for facilitators completing instructor-led training and facilitators completing web-based training. We then conducted a one-way between-subjects repeated measures ANCOVA to examine the effect of facilitator training format on knowledge gain among all facilitators. All analyses of knowledge gain included education and presentation experience as covariates.

To assess perceived training utility, we computed descriptive statistics (means, standard deviations, and ranges) to evaluate the perceived usefulness of the content among facilitators in each training format group. We then conducted a one-way between-subjects repeated measures analyses of

variance (ANOVA), to examine the effect of facilitator training format on perceived utility of the fidelity check.

To assess training satisfaction, we conducted a series of one-way between-subjects repeated measures ANOVAs, to evaluate the effect of facilitator training format on facilitator ratings of training organization, adequacy of the training in preparing facilitators to lead a REACH session, training engagement, and willingness to recommend REACH facilitator training to others. We conducted a one-way between-subjects ANCOVA to assess the effect of facilitator training format on perceptions of training length, while including presentation experience as a covariate.

We calculated descriptive statistics (counts and percentages) to evaluate whether instructor-led and web-based facilitator training met facilitators' expectations.[12] Finally, we conducted a thematic analysis (Braun & Clarke, 2006) to identify similar and distinct themes mentioned in responses to open-ended questions by facilitators from both groups regarding what they liked the most about the training, what they liked the least, and why they felt the training did or did not meet their expectations. A team of two coders independently coded 50% of responses and then conducted a reliability check. The coding team met frequently throughout the coding process to identify new codes, review each other's work, and resolve areas of disagreement.

Research Question 2 focused on potential differences in confidence to lead a REACH session between facilitators completing instructor-led versus web-based REACH facilitator training. We conducted a one-way between-subjects repeated measures ANOVA to examine the effect of facilitator training format on confidence to lead a REACH session with others.

Analysis of Participant Data

Research Question 3 focused on REACH participants' perceptions of their facilitator. We reported mean participant perception scores and standard deviations separately for facilitators who completed instructor-led or web-based training.

Research Questions 4 through 6 focused on potential changes in REACH participants' barriers to care, knowledge of resources, and resource utilization after attending a REACH session. We addressed these research questions by conducting a series of bivariate analyses (paired Student's *t* tests and χ^2 tests) to examine the effect of time (baseline versus follow-up) on study outcomes. We also calculated Cohen's *d* effect sizes. For analyses of help-seeking or considering seeking help, we subset participants to those who reported experiencing a problem that caused significant stress during the last 3 months (n = 16) at both baseline and follow-up. We also calculated counts and percentages of participants who used specific helping resources, those who considered using each helping resource but did not, and reasons participants did not consider help-seeking.

[12] Due to small cell sizes, we were unable to conduct a χ^2 test.

Research Question 7 focused on potential changes in participants' reported likelihood of recommending Military OneSource to others after attending a REACH session. We addressed this research question by conducting a bivariate analysis using paired Student's *t* test to examine the effect of time (baseline versus follow-up) on this outcome. We also calculated the Cohen's *d* effect size.