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Strategic Inter-agency Capacity Building for Primary Prevention of Harmful Behaviors in the Military: Current and Future Directions

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Abstract

The Department of Defense (DoD) remains committed to mitigating harmful behaviors that harm personnel and hinder military readiness. DoD's Sexual Assault Prevention and Response Office (SAPRO) and the Division of Violence Prevention (DVP) within the Centers for Disease Control and Prevention (CDC) established a partnership to build capacity for primary prevention though a wide-ranging training and technical assistance (TTA) system, The Integrated Prevention Technical Assistance Center (IPTAC). The system serves as a support system within the Interactive Systems Framework (ISF). The goal for IPTAC's TTA support is to build capacity for integrated primary prevention and build sustainability for prevention in complex military environments. To assess the effectiveness of IPTAC, the system is evaluated on what TTA is delivered, the skills and knowledge increase in TTA participants, participant satisfaction with TTA received, and participant application or intent for application of skills. Early results are positive; however, these results could be improved partly through ensuring a larger focus on tailoring to military contexts within all TTA activities. This article describes the creation of IPTAC, the role of the ISF in the implementation of TTA, and the evaluation of IPTAC. Implications for TTA delivery in the military and civilian sectors are discussed.

Keywords

technical assistance; military; evaluation; primary prevention; violence prevention; technical assistance system

Introduction

The Department of Defense (DoD) remains committed to addressing the challenging issues that harm personnel and hinder military readiness by mitigating harmful behaviors,

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including sexual assault, harassment, retaliation, suicide, domestic abuse, and child abuse. To prevent these harmful behaviors, DoD's Sexual Assault Prevention and Response Office (SAPRO) and the Division of Violence Prevention (DVP) within the Centers for Disease Control and Prevention (CDC) established a partnership to build capacity for primary prevention. This effort was accomplished through the provision of wide-ranging training and technical assistance (TTA) and by supporting an integrated primary prevention system grounded in a public health approach. The interactive systems framework (ISF) (Wandersman et al., 2008) serves as an evidence-based framework supporting the systematic organization and provision of TTA across DoD through this partnership. The goal for TTA support is to build capacity for integrated primary prevention by engaging key collaborators, conducting needs assessments, setting prevention goals, planning for workforce development, selecting prevention activities, implementing and adapting activities, and planning outcome evaluations. Building capacity, in this article, refers to building the knowledge, skills, and ability of the DoD prevention workforce to plan, implement, and evaluate integrated prevention activities that can lead to the reduction of harmful behaviors in the military. The purpose of this article is to describe the creation of a prevention support system for DoD, the role of the ISF in the implementation of TTA, and the evaluation of the prevention assistance as it pertains to satisfaction with the TTA provided and changes in the knowledge, skills, and abilities of DoD prevention personnel. Although these changes are expected to ultimately lead to a decrease in the prevalence of harmful behaviors in the military, empirically verifying this link is outside the scope of this article. This article has implications for not only future TTA delivery in the military but also in the civilian sector. Many of the lessons learned discussed in this article are applicable to other complex environments (meaning, multi-level, hierarchical, or environments led by shared policy) in which technical assistance centers operate or are funded, such as hospital systems, school systems, and other government agencies.

Background on Military Organization

A brief overview of the DoD organizational structure is necessary for understanding the implementation of the TTA delivery system within a military context. The TTA discussed in this article is delivered across three Military Departments, each with its own active and reserve component force and hierarchical levels of command within those force components. Tailoring TTA support to meet the unique needs for each Military Department, component, and level of command is critical to meet the desired outcomes for prevention. The complex organizational relationships within DoD are described elsewhere (DoD, 2020a). To illustrate the relevance for TTA, Figure 1 shows the organizational relationships between the Miliary Departments and Military Services, including their active and reserve components. Each U.S. state has a National Guard force that operates under the Military Departments when activated to a federalized status. Otherwise the National Guard force operate as a non-federal force in support of the states under the authority of each governor, with policy guidance from National Guard Bureau (a joint activity of the DoD, which falls outside of the Military Departments). Each Military Department also has a Military Service Academy with unique TTA needs that differ from the operational military due to the environment integrating the academic demands found in civilian universities with military training and

structure. The Coast Guard resides within the Department of Homeland Security with unique authorities to operate under the Department of Navy in time of war or national emergency, and therefore they also receive the TTA support discussed in this article. Within the DoD, the term "echelon" refers to different levels of command within a Military Department and also within each military services' active and reserve components. Personnel at the different echelons have responsibilities coinciding with their role and level of influence. From the highest echelon (commonly referred to as headquarters [HQ]) to the lowest, roles and responsibilities range from strategic, operational, and tactical. Strategic-level personnel focused on prevention are responsible for determining the overall objectives of an organization or program to reach a certain designated goal, versus operational-level personnel, who integrate strategic objectives and tactical activities, and tactical-level personnel who implement specific prevention activities (DoD, 2022c).

History of DoD-CDC Partnership

The partnership between CDC's DVP and DoD for TTA purposes began in 2016, when Department of Air Force asked DVP to provide public health-focused sexual assault prevention training to newly hired violence prevention personnel, and a formal Inter-Agency Agreement (IAA) was created to support this activity. DVP was a prime partner for DoD in this effort due to the shared mission of DVP and DoD's violence prevention efforts, subject matter expertise of DVP staff, and existing research and resources housed in DVP upon which DoD could build. By partnering with DVP, DoD ensured the appropriate experts were involved to support building prevention efforts in the DoD. In 2019, a revised IAA between DVP and SAPRO was established to expand holistic TTA support to all DoD Military Departments, including the service-level active and reserve components, and the Coast Guard. As DoD evolved its prevention approach beyond the singular focus on prevention of sexual assault to integrated primary prevention of a multitude of harmful behaviors (formally described in DoD instruction [DoDI] 6400.09; DoD, 2020b), the IAA and tasks of the TTA providers also evolved. In DoDI 6400.09 and the new IAA, harmful behaviors included sexual assault, harassment, retaliation (e.g. illegal or hostile actions taken as a result of incident reporting), suicide, domestic abuse, and child abuse. Hereinafter, "harmful behaviors" will refer to these forms of violence. Integrated primary prevention is defined in formal DoD policy as prevention activities that simultaneously address multiple harmful behaviors and create a cohesive, comprehensive prevention approach that reduces redundancy and streamlines prevention efforts (DoD, 2020b). Thus, the DVP and SAPRO IAA provided the foundation for DoD to be poised to build the capacity for primary prevention and a workforce focused on integrated prevention in addition to other core areas for prevention (e.g., suicide prevention).

Establishing a DoD Prevention Workforce

A dedicated and growing prevention workforce that ultimately will include over 2,000 full-time skilled primary prevention professionals (projected hiring up until 2027) are the primary beneficiaries of TTA through the IAA (secondary users include personnel who support primary prevention on a less than full-time basis and not as their primary duties). In 2022, DoD established additional prevention policy (DoDI 6400.11; DoD, 2022a)

that codified the establishment and responsibilities of the integrated primary prevention workforce (IPPW) whose primary full-time duties focus on integrated prevention. The rapid, simultaneous hiring to build a large IPPW resulted in a workforce that varied greatly in their prevention experience and familiarity with the DoD, which created a unique need to build professional capacity for prevention, implementation, and evaluation, both for general prevention skills (i.e., applicable to any organization) and prevention skills specific to military settings (e.g., adapting prevention activities to unique military environments). The IAA, and the TTA generated from it, continues to expand and evolve to meet the needs of DoD to build this prevention capacity. As mentioned previously, prevention capacity, in this case, refers to building the knowledge, skills, and ability of the IPPW to plan, implement, and evaluate prevention activities aimed at reducing the prevalence of harmful behaviors in the military. As part of their effort to coordinate these efforts and provide seamless TTA through the IAA, DVP created an Integrated Prevention Technical Assistance Center (IPTAC) to provide DoD with comprehensive primary prevention training, proactive and on-demand technical assistance, subject matter expertise in research-to-practice translation, and a basic grounding in research and evaluation to create prevention efforts that are both data-informed and continuously and rigorously evaluated. Figure 2 shows the scope of work for the current IAA and further details the main activities under each category of work. Several strategic guidance documents are pivotal in guiding this work as they outline strategies and guidance for integrated primary prevention, while also delineating the roles and responsibilities of the prevention workforce at each echelon for implementing prevention activities. The Prevention Plan of Action (DoD, 2022b) and DoDI 6400.09 are the framework that is used to guide the development, implementation, and evaluation of integrated primary prevention. The Prevention Workforce Model (DoD, 2022a) and DoDI 6400.11 outline roles, responsibilities, desirable elements, and considerations for implementation of a successful prevention workforce. These documents played a critical role in the planning and provision of the TTA that will be described in the sections that follow.

Leveraging an ISF Approach

As past research has documented (Katz & Wandersman, 2016), TTA is often delivered in a haphazard fashion without a systematic means to guide efforts, and the sustainability of TTA outcomes is often not often assessed over time (Scott et al., 2022). The ISF, which aims to bridge the research-to-practice gap, serves as a framework for DoD's organization of the prevention workforce across the DoD and for its provision of TTA. The ISF consists of three structures that are needed to support prevention efforts and bridge the research-to-practice gap: a prevention delivery system for implementing prevention activities, a prevention support system for supporting the work through tools, trainings, and technical assistance, and a prevention synthesis and translation system for distilling the information (e.g., translating scientific information/knowledge into understandable and actionable information and activities for the military), (Wandersman et al., 2008). Along with these three interacting systems, the ISF recognizes the impact of contextual factors such as funding, climate, policy, and existing research & theory.

The ISF also serves as a framework through which DoD organizes the TTA provided to the prevention workforce. For example, in the provision of TTA for DoD, IPTAC provides

support in the prevention synthesis and translation system, in the prevention support system (e.g., building capacity of prevention personnel to implement prevention activities), and in the prevention delivery system (e.g., prevention personnel implementing prevention activities in military environments). Figure 3 shows the main ways that IPTAC provides support in each of the systems, mapped onto the ISF framework. Similar to the systems of the ISF interacting bi-directionally, the different military echelons typically interact in a bi-directional manner. The tools and technical assistance provided by the strategic and operational levels shape the implementation efforts driven by personnel at the tactical level. Further, feedback and evolving needs travel up from the tactical level. For the contextual factors shown in Figure 3, new organizational policies (DoD, 2020b; DoD, 2022a; DoD 2022b) provided guidance for prevention. The newly dedicated funding for integrated primary prevention personnel contributed resources for dedicated staff to lead prevention efforts. This increased funding and policy guidance provides a foundation for progress in the dissemination and implementation of effective TTA. For the contextual factor of climate, DoD leadership shepherds the integrated primary prevention system and supports TTA specifically by speaking at group learning events, which are intended to enhance positive attitudes regarding prevention. The contextual factor of current research & practice has a weak influence on prevention efforts at the delivery level, because effectiveness research is sparse for integrated prevention activities that are delivered specifically within military settings. This can create hesitancy among prevention personnel to implement a new integrated prevention activity without data on effectiveness.

TTA is an important aspect of DoD's prevention system and process because it is intended to build capacity for the prevention workforce and support the translation of research into practice. The type of TTA provided and the system of the ISF addressed often depends on the question posed; however, as noted by Scott et al. (2022), the field needs to better understand what components of TTA serve as the "active ingredients" leading to change and the nuances (e.g., when, how, and for whom) that increase the effectiveness of TTA components. TTA delivery is expected to provide the prevention workforce with a baseline knowledge of integrated primary prevention (e.g., shared risk or protective factors across multiple harmful behaviors), increased prevention skills and abilities (e.g., select and implement research-informed prevention activities, communicate about prevention, conduct needs assessments), and enhanced confidence to put what they learned into action. Some of the anticipated change is currently untested (such as confidence) because the current evaluation was specifically focused on increases in knowledge, self-reported skills, and *intent* to apply the information to their prevention roles.

Wandersman et al. (2012) introduced the evidence-based system for innovation support (EBSIS) to illustrate how the ISF's support system can interact with the delivery system through a cycle of tools, training, technical assistance, and quality assurance/quality improvement. These four components are additive, building off each other to achieve desired outcomes. The logic model for EBSIS states that to achieve desired outcomes, the EBSIS cycle must be added to the current levels of capacity, which will lead to actual outcomes achieved. The outer circle represents the human relationships that are vital throughout the four components. IPTAC relies heavily on EBSIS for the implementation of its delivery system using needs assessment data to determine TTA needs and developing and

using tools, training, and technical assistance to increase capacity. Quality improvement is built into the cycle through various mechanisms, such as monthly reports (an example is provided and discussed in the evaluation section), ongoing provider and recipient feedback forms (also discussed later), and the continuous building of collaborative relationships. Relationship building to enhance collaboration is critically important to the success of TTA, and IPTAC continues to identify ways to further improve this component of the framework, most recently by assigning dedicated technical assistance specialists at the service-level for each Military Department. The TTA providers skillfully navigate conversations with recipients, using a technique that involves volleying between probing, exploring, and listening to identify recipients' level of understanding on integrated primary prevention and render relevant recommendations. Additionally, some TTA providers are visible across multiple TTA areas (e.g., SPARX Knowledge courses, webinars, and one-on-one technical assistance that builds upon and reinforces baseline concepts of integrated primary prevention, such as shared risk/protective factors, using needs assessment data to inform prevention implementation, and adapting a prevention activity with fidelity), which reinforces familiarity with and reliance on the providers. Figure 4 shows the EBSIS cycle, with an example of how the work of IPTAC maps onto the cycle. In the example, CDC's online prevention tool VetoViolence is taught in the aforementioned SPARX Knowledge Prevention of Harmful Behaviors in the Military training (DoD's mandatory 60-hour prevention curriculum designed to develop the baseline information for the IPPW that is mandated by DoD as on on-boarding requirement for new IPPW staff [DoDI 6400.11]). SPARX Knowledge concepts are then reinforced through various TTA activities to help prevention personnel apply the knowledge and skills they develop in the training. The SPARX Knowledge feedback form is used as a quality improvement/quality assurance mechanism, as the form is filled out by course participants daily, and the feedback is considered both for the rest of that training session and for future SPARX Knowledge deliveries (data from the SPARX knowledge feedback forms are being used for a rigorous quasi-experimental design evaluation that is not yet completed, and therefore this data is not available for this article). Those four components are reflected within the circle in Figure 4, and the circle itself represents the relationships built between IPTAC TTA providers and recipients that are an essential aspect of each component. The goal of broader TTA support, including the TTA relationships and four components collectively, is to increase the prevention workforce's capacity to plan, implement, adapt, and evaluate prevention activities, which when combined with the current level of workforce capacity is expected to lead to achievement of the actual outcomes and impact of reducing harmful behaviors in the military. The current evaluation of TTA delivery focuses on the efficacy of IPTAC at increasing workforce's capacity (knowledge, skills, abilities). However, the connection to actual outcomes of reducing harmful behaviors is currently conceptual and presumed, but not yet fully tested.

Training & Technical Assistance Overview

The TTA provided by IPTAC to DoD aligns with each system detailed in the ISF. For example, IPTAC distilled the literature on primary prevention strategies at the outer levels of the social ecology (i.e., community level) to aid the DoD IPPW in identifying, selecting,

and implementing evidence-based strategies that impact risk and protective factors beyond the individual level (CDC Division of Violence Prevention, 2023). In the military, the outer community level of the social ecology refers to all DoD individuals (e.g., military, civilian, dependents) who live and work in the same geographical area and the organizational and social characteristics specific to that military community. Examples include a DoD installation, garrison, or ship, as well as organizational influences (e.g., policy, procedures) impacting those locations and surrounding neighborhoods and towns where DoD individuals reside. Community level prevention strategies would include promoting positive social norms (e.g., strengthen media and leadership messaging), creating protective environments (e.g., increase and promote connectedness with a strong focus on social cohesion), and making system-level changes to increase access to supports and services (e.g., increase access and quality of early childhood services). IPTAC also led webinars that support the translation of scientific literature on a variety of topics for military environments, including addressing risk and protective factors for sexual assault, the social-ecological model, and integrated primary prevention, among other topics. Additionally, IPTAC assisted DoD in developing a sexual assault prevention research agenda (Department of Defense, n.d., a) and an integrated primary prevention research agenda (DoD, 2023), which required reviews and summaries of the literature to provide directions for future research (e.g., multi-level, integrated approaches in military communities and bystander intervention tools for virtual environments).

In alignment with the ISF support system, IPTAC provided support to DoD for understanding the elements of the prevention system during a service-level, self-assessment of their prevention capability. This process introduced many DoD personnel to new concepts, including the public health approach to prevention, that are outlined in DoD prevention guidance (e.g., Prevention Plan of Action 2.0, DoDIs). Several webinars, summit presentations (presentations to all prevention workers within a Service at their mandatory annual prevention summit), and individual TTA events also focused on building the capacity (i.e., knowledge, skills, abilities) of the prevention workforce, with topics including collaboration, logic model development, needs assessments, and process and outcome evaluation. As mentioned, IPTAC also regularly delivers SPARX Knowledge Prevention of Harmful Behaviors in the Military. IPTAC developed tools and resources to support the planning and evaluation of prevention activities. Some examples include a sample outline and template for creation of a comprehensive prevention plan, a step-by-step guide for conducting analyses of sexual assault/sexual harassment data using Excel, the creation of a presentation called “Evaluation 101,” and prevention plan guidelines for toolkits used by commanders in the military.

Delivery System

The ISF prevention delivery system focuses on implementing prevention activities. Given the shift to the public health approach for primary prevention that began DoD-wide in 2019 with the launch of the Prevention Plan of Action 2019-2023, the TTA provided in this facet of the prevention delivery system is limited. IPTAC provided support to ensure the prevention workforce at the tactical level understood the importance of delivering prevention activities with quality and fidelity and to use trained facilitators where appropriate. One

example of TTA provided for this part of the ISF delivery system includes a train-the-trainer session that was conducted for approximately 200 Navy prevention professionals within a larger event titled "*Achieving a Culture of Excellence in the Navy: The Power of Prevention*." The information focused on the prevention process and roles of different stakeholders. The event aimed to equip prevention personnel with the knowledge to identify risk factors and tools that narrow the gaps in Navy policies and prevention activities.

IPTAC delivered TTA in group and individual formats, inperson, and virtually via Microsoft Teams, Zoom, phone, and e-mail. Events included one-time consultations (e.g., meeting facilitation) and expanded consultations occurring over the course of months or more than a year (e.g., coaching). TTA focused on specific topics that appeal to a broad audience, as is the case with webinars, and topics tailored to distinct audiences in response to specific questions, such as how to adapt material to a specific military environment or setting. IPTAC developed TTA plans based on needs assessments conducted for each Military Department, and further evaluated TTA efforts over time that included utilization rates, TTA topics, and intention to apply the skill and/or knowledge enhanced through TTA support. Modeling intentions to apply skills is an emerging area of assessment for our analytic approach, and our available results thus far are discussed in the results section.

Another key element in addition to what TTA is being delivered, are the skills, experience, and background of those delivering it. It is important that TTA providers can build trusting relationships with recipients (Wandersman et al., 2012). The IPTAC team members who deliver TTA are diverse in terms of race, ethnicity, educational backgrounds, and military experience. Experts come from an array of backgrounds and disciplines (e.g., policy, program management, psychology, and public health) to share findings or discuss practical application of prevention activities in the military. About a third of the TTA experts are of racial or ethnic minority backgrounds and several experts have previously served in the military. This diversity is important due to the racially diverse nature of the military. For the over 2 million service members in the total DoD miliary force, 26.8% identify with racial minority groups, 17.3% are Hispanic or Latino, and 19.1% are female (DoD, n.d., b) Considering the three Military Departments are diverse in their Service structure and missions (DoD, 2020a), this breadth and depth of experience and military background of the TTA experts enhances the TTA that is delivered and reinforces the important relationship between TTA provider and recipient. TA specialists who have a military background and a strong understanding of different military communities and cultures (e.g., officer vs enlisted, military spouses, racial diversity, religious diversity) more easily understand community needs, communicate, and arrive at military-relevant TA solutions. IPTAC does not collect data specifically on the demographics and experience of the TTA provider related to TTA outcomes such as satisfaction with the provider. Demographics of the TTA provider is also not covered in the literature; however, the literature does emphasize the importance of ensuring TTA is culturally appropriate, with culture or cultural competency being a component of various TTA system frameworks such as the Strategic Prevention Framework and $R = MC^2$ (Florin et al., 2012; Kenworthy et al., 2022; Scaccia et al., 2015). Although outcomes are only slightly more successful when activities are culturally appropriate, there is evidence that uptake and retention for a prevention activity, especially by minority communities, is substantially improved when cultural adaptations are made (Kumpfer et

al., 2002). The personal experience and cultural background of the TTA provider helps to positively influence the shaping of the TTA to be culturally relevant, although again, this remains untested in our current evaluation.

TTA System Processes

To receive support from IPTAC, prevention personnel within DoD submit TTA requests to a single-entry point located within DoD SAPRO. Requests are then assessed and triaged according to the type of TTA needed and Military Department initiating the request. Service-level prevention personnel functioning at the strategic (HQ) level are included in communications (e.g., emails, meetings, etc.) throughout the lifecycle of TTA support. They provide unique insight relative to their Service-level prevention goals, Service traditions and core values, and other nuanced information that further enhances the TTA support process. Other subject matter experts may be included in discussions to assist in managing and informing the provision of TTA support dependent upon the specific TTA focus (e.g., comprehensive integrated primary prevention plan development, continuing education). Continual assessment of military needs and IPPW capacity is required to adequately define prevention planning and implementation and to ensure the appropriate level and dosage of TTA support is provided for the IPPW. Currently, IPTAC has the resources, time, and personnel to address all TTA requested. Therefore, the level and dosage of TTA support delivered are based on the type of request and the requester. Efforts are underway to build a proactive model of TTA delivery, which is discussed in the future work section of this paper. If the new proactive model results in increased TTA requests, IPTAC will reassess the methods used to distribute TTA to maximize efficiency and alignment with TTA needs. More research is required to fill the gap in the current knowledge and understanding in the field around the most efficient dosage of TTA for a particular audience. As this gap is addressed, it will help inform our efforts.

Evaluation Methods

There are four evaluation questions that assess IPTAC and the TTA provided: (1) What TTA was provided; (2) Were recipients satisfied with the TTA received; (3) Did recipient knowledge and skills increase; and (4) How did recipients apply or intend to apply what they learned to their current position. Qualitative and quantitative data is collected via the following data sources: a TTA tracker, a web-based system for capturing TTA requests, responses, and delivery; a post-event/post-training form; and an annual TTA provider focus group. The data is analyzed using descriptive statistics to assess TTA for breadth and reach, and the findings are used to inform continuous quality improvement. The feedback forms are analyzed immediately after the delivery of the training or webinar to improve the planning and facilitation of the next training or webinar. The feedback form includes a question on future training needs to inform upcoming training topic development. The SPARX Knowledge Prevention of Harmful Behaviors training has daily required participant feedback forms, in addition to the post-event form administered at the end of the training. Information gleaned from these forms is used by the trainers to immediately institute course corrections during the two-week fielding. Immediate changes based on daily feedback include the length of time given for activities, further explanations of confusing topics,

and presentation style of the instructor. The TTA tracker is used to compile monthly reports on TTA, which informs DoD stakeholders on the status of all active TTA requests, frequency of TTA utilization at the service-level, and TTA trends by topics. The monthly reports help to ensure TTA requests move forward at a sufficient pace, and the information shared across the Military Departments encourages further engagement and leveraging of TTA support. Data from monthly reports are shared with DoD leadership and strategic (HQ) Service-level prevention personnel during various reoccurring meetings. Figure 5 illustrates typical content shared at a prevention update and planning meeting. The information shared helps each Military Department track their utilization rate, discuss TTA status (i.e., new, ongoing, or closed requests), and plan future TTA support. Sharing TTA usage information with strategic (HQ) Service-level prevention personnel encourages further discussion about emerging needs for knowledge and skill building and areas where TTA support can assist. Additionally, a needs assessment focus group is completed annually, and the feedback is examined to improve TTA planning, monitoring, and delivery for the following fiscal year.

All webinars and training events are evaluated via a post-event assessment. These assessments were deemed exempt from IRB approval, as all participants of the webinars and training events are federal employees who are providing feedback for training improvement purposes. During some years, individuals who requested other forms of TTA (such as individual TTA) were invited to complete a survey and to participate in a focus group. DVP also conducts yearly focus groups to discuss TTA provided, including how recipients applied the TTA they received and any new processes that needed to be implemented to support TTA provision. Table 1 describes the feedback collection instruments used to gather data from 2019-2023.

Results

Due to the phased hiring approach for the dedicated integrated primary prevention workforce, most prevention personnel occupied higher echelon (HQ level) positions in the initial years of the IAA between DVP and SAPRO. Therefore, TTA services were primarily used by prevention personnel at the strategic level. Between September 2019 and the latter portion of February 2023, IPTAC delivered TTA services to nine distinct DoD audiences (e.g., different Services and Academies) that most frequently covered the following topics: primary prevention planning, evaluation, collaboration, and prevention capability self-assessments. IPTAC provided TTA 327 times through 70 trainings, 141 phone calls, 55 emails, and 61 TTA resource or publication creations. Table 2 provides examples of TTA provided.

Satisfaction with TTA

Data from the post-event feedback form and the TTA provider focus group showed that most recipients were very satisfied with the TTA they received. The post-event webinar feedback form asked participants to rate their agreement with the following statements about the training related to satisfaction: (1) The facilitators presented concepts in a way that was easy for me to understand; (2) The information presented during this webinar is relevant to my role; (3) The tools and resources presented during this webinar are relevant

to my role; and (4) I intend to participate in a future DoD SAPRO webinar. The form used a five-point Likert scale ranging from (1) 'strongly disagree' to (5) 'strongly agree.' Across eight webinars, there was an average response rate of 52%. It is important to note that participants that respond to the webinar feedback form are eligible to receive continuing education credits for attending that webinar. This could potentially skew the results if participants filling out the form for credit differ in a significant way from the general webinar attendees. Almost all respondents (97%) agreed or strongly agreed that the content was presented in a way that was easy to understand ($\overline{X}$ = 4.57, SD = 0.57). Most respondents (92%) indicated the content provided was relevant for their role, ($\overline{X}$ = 4.44, SD = 0.66), and the majority of respondents (90%) agreed or strongly agreed that tools and resources presented were relevant to their role, ($\overline{X}$ = 4.41, SD = 0.74). Webinars on more niche topics (e.g., Cyber Harassment) scored below average on questions regarding relevance to the respondent's roles (i.e., questions 2-3). Qualitative data suggest this seems to be due to respondents being unsure what the connection was between the topic and their specific role and responsibilities in the prevention workforce. Nearly all respondents (98%) indicated they planned to attend a future webinar ($\overline{X}$ = 4.73, SD = 0.52). Generally, qualitative feedback on satisfaction with webinars was very positive. Several respondents commented on the presenters' knowledge and enthusiasm, whereas others commented that content relevance would be increased if presentations included additional examples for implementing prevention activities in a military context. Satisfaction was similarly high for the SPARX Knowledge Prevention of Harmful Behaviors in the Military courses. In the daily SPARX Knowledge feedback forms, satisfaction with trainers was very positive. Respondent feedback on statements around whether the presenter was knowledgeable, well prepared, communicated clearly, used time effectively, had an interesting presentation, checked for understanding, encouraged engagement, answered questions thoughtfully, and ran activities well averaged between 97% to 98% agreement for all questions. On the post-event feedback form for SPARX Knowledge, 92% of respondents across eight trainings that took place between 2022-2023 reported that the training met or exceeded their expectations and goals for the training when asked, "What were your goals/objectives for the training and were these met?" One respondent stated, "This is one of the best trainings I have been in during the last 19+ years. Each of you is invested in the field and in US… an intense and highly rewarding week!" Among respondents who stated the training partially met or did not meet their goals (8%), the primary concerns were the course material was a review of existing knowledge or more practical "real life" tools were needed for application in military settings.

Increase in Knowledge and Skills After TTA

In the post-event feedback form for the webinar series, participants were asked their level of agreement with the statement, "My understanding of the subject improved as a result of this webinar" With a five-point Likert scale ranging from (1) '*strongly disagree*' to (5) '*strongly agree*'. Across six webinars, most respondents (93%) agreed or strongly agreed ($\overline{X}$ = 4.38, SD = 0.72) that their understanding of the subject improved because of the webinar. Qualitative feedback showed that respondents found the webinars informative, beneficial to their roles, and to have expanded their knowledge. However, feedback also showed that when respondents' knowledge or skills did not increase, it was due in part to the information

not being centered on the military context. For example, one respondent stated, “How do we as prevention integrators take this information and put it in the military context?” This sentiment was repeated by another respondent who said, “Webinars could benefit from more examples of implementation in a military context.” These comments appeared when webinar presenters were not a part of the military community. Moreover, these comments support other reported findings that emphasize the importance of ensuring fit between the TTA delivered and the setting that the TTA is being delivered in, and in considering the TTA recipients’ specific goals and challenges (Wandersman et al., 2012). All 10 participants in the TTA provider focus group reported that recipients developed a new understanding of key prevention principles and strengthened their existing knowledge as a result of IPTAC’s TTA, based on the provider’s observations and interactions with the recipients. Three TTA providers further described this growth as follows: (a) improved understanding of integrated prevention, (b) deeper understanding of the importance of strategic practices to achieve outcomes through collaboration and less siloed decision making, (c) deeper understanding of the importance of using data and evidence to test assumptions, (d) increased skills in using and interpreting logic models, (e) increased skills in communicating the importance of primary prevention to leadership, (f) greater understanding that prevention involves changing modifiable risk and protective factors; and (g) improved skills to estimate and communicate timeframes for accomplishing longer-term outcomes to reduce harmful behaviors. The TTA provider focus group included providers of tools, trainings, and direct technical assistance, and their answers were not specific to one type of TTA provided but are reflective of all three types of TTA delivered.

Application of TTA

On the webinar post-event feedback form, participants were asked to indicate their level of agreement with the question, “I intend to apply what I learned in the webinar to my current role,” with response format on a five-point Likert scale ranging from (1) ‘*strongly disagree*‘ to (5) ‘*strongly agree*.‘ Most respondents (89% across eight webinars, $\overline{X} = 4.36$, SD = 0.74) agreed or strongly agreed that they intended to apply what they learned to their current role. However, qualitative feedback on the form outlined challenges with application. This sentiment was apparent in one webinar on Measuring Performance and Effectiveness of Prevention Activities. One respondent noted that there was too much time spent on definitions and not enough on “real world application.” Another said, “many webinars address general concepts and theory without addressing ‘how to’.” This individual went on to say that webinars should address operational challenges. These comments highlight the need for trainers to ensure the content of their webinars/presentations is actionable and addresses common barriers faced by prevention personnel in the military setting. Of note, the quantitative feedback for this webinar on intent to apply the information was consistent with other webinars with 89% of respondents reinforcing the desire for future application ($\overline{X} = 4.34$, SD = 0.77).

On the SPARX Knowledge feedback forms, participants were asked how they planned to apply what they learned in the course. Figure 6, identifies the top five responses across eight SPARX Knowledge trainings included strategic planning, using TTA tools, communication, collaboration, and information sharing. The “strategic planning” category included intent to

apply the information they learned to improve their prevention planning process, such as creating logic models, updating their prevention plans of action, or identifying appropriate prevention approaches. “Using TTA Tools” included when respondents mentioned using specific tools or resources introduced in the training for their job, such as when one respondent stated they plan to “apply assessment tools to [their] already established programs.” “Communication” referred to respondent plans to improve the way they communicate with others around prevention, such as in briefings to leadership or other DoD partners who may not have a background in prevention. “Collaboration” included when respondents mentioned collaborating with their fellow participants, identifying partners, or deepening their relationship with prevention partners. Lastly, the “information sharing” category included when respondents discussed taking knowledge or tools back to share with their teams and communities. One respondent mentioned, “I plan on sharing what I have learned with others in my workplace. In doing so I hope to instill a prevention mentality and arm them to better participate in prevention activities.”

Qualitative data from TTA providers during the TTA provider focus group described ways that TTA was applied by recipients. For example, recipients used tools and resources to engage in required actions (e.g., a template for a required comprehensive primary prevention plan). TTA providers described how recipients commonly diffused the information and resources they gained through TTA with colleagues and supervisors (e.g., sharing it at a team meeting). Several challenges to applying TTA knowledge were also identified, with one provider describing how personnel changes and staff turnover hindered their engagement with TTA. One provider also noted that the TTA dosage was an important part of determining if capacity was built within the TTA recipients. Recipients who engaged in more frequent and consistent communication with IPTAC were better able to benefit from the TTA. As a result, these recipients were also able to build professional development skills that allow them to strengthen prevention processes and systems. Information regarding the application of TTA (vs. intent to apply) has not been collected from the recipients themselves. Attempts to collect this information via a TTA recipient focus group did not receive a response from TTA recipients for unknown reasons.

Discussion

DoD’s public health approach to primary prevention continues to evolve, with some Military Departments and Service-level components having implemented primary prevention efforts longer than others and some having dedicated IPPW staff members in place longer than others. As DoD continues to expand its primary prevention capabilities and increase its capacity for prevention with dedicated IPPW personnel, the need for TTA is anticipated to increase in frequency and complexity. With this expansion, DoD will need to continually monitor and evaluate the TTA provided to ensure resources for TTA are utilized appropriately (Katz & Wandersman, 2016; Scott et al., 2022). The Prevention Workforce Model (2022c) which forms the foundation of DoD’s enterprise-wide prevention workforce leverages the ISF approach, highlighting the importance of the various systems (i.e., prevention synthesis and translation; prevention support; and prevention delivery) and the unique workforce roles and responsibilities of each in addressing the research to practice gap.

Based on the abovementioned findings, IPTAC provided TTA that met or exceeded expectations, with high levels of participant satisfaction across TTA events. Competent TTA providers who are skilled in distilling and presenting information have contributed largely to this satisfaction. Important to note is that only about half of webinar participants filled out the post-event feedback form, which could have resulted in data that is not representative of all participants. TTA recipients noted increases in self-reported knowledge and self-reported intentions to apply the information shared/learned. TTA providers also reported observed increases in TTA recipient knowledge and application of knowledge and skills developed. No formal systematic assessment of TTA application as reported by recipients has occurred to date. This is a limitation in our data collection, as we cannot assess capacity changes in the workforce absent this information. Moving forward, this effort to tally capacity changes will be a priority and is further discussed in the upcoming "Future Work" section. This information will help with understanding some of the nuances associated with TTA, including what works and for whom and the elements of TTA that seem to be driving observed changes in knowledge and application of information. Moreover, increasing the knowledge and understanding of IPPW members on the various prevention topics is a critical component of TTA delivery. It leads to increased comprehension and prioritization and belief in the effectiveness of integrated primary prevention, and therefore, increased shared organizational resolve in applying that knowledge (Scaccia et al., 2015). Qualitative feedback from the webinar post-event form also revealed that when TTA providers were familiar with the military environment and used military specific examples/scenarios in TTA delivery, satisfaction and reports of knowledge gain increased. This finding is relevant to the civilian sector and suggests that TTA may improve when TTA providers take time to develop relationships and get to know the population that receives their services.

Primary prevention and its potential benefit to military readiness are concepts that remain relatively unknown outside DoD's primary prevention community. IPTAC is working on identifying ways to assist the IPPW in further enhancing leadership support for integrated prevention. This entails prevention activities that simultaneously address multiple harmful behaviors and create a cohesive, comprehensive prevention approach that reduces redundancy and streamlines prevention efforts. It also involves helping leaders effectively prioritize prevention efforts among completing operational demands. Creating language, evidence-informed messaging, and resources that highlight for leadership the importance of supporting integrated primary prevention for military readiness is one approach IPTAC is taking to promote wider understanding and adoption of integrated prevention activities.

Taken together, the results presented herein suggest that the TTA services provided by IPTAC have thus far met the needs of the prevention workforce. During the growth and expansion of the DoD prevention workforce, TTA services should be evaluated as rigorously as possible to ascertain details that will allow for interpretation of when and how TTA works, what types of TTA work best, and the best match between TTA question and TTA type. This information will be critical to maximize TTA benefits to support the reduction of harmful behaviors through primary prevention and contribute towards DoD's aim of sustaining and enhancing retention, resilience and well-being, and force readiness.

Future Work and Implications

Future Work

As of 2023, TTA delivery through IPTAC is expanding in several ways to improve its delivery and respond to feedback. In the new structure, each Military Department Service-level component has a specific TTA provider assigned to them. The assigned TTA provider meets with the designated HQ (strategic-level) prevention representative(s) on a regular basis (monthly or bi-monthly) to learn more about the TTA needs experienced at all echelons and suggest ways that IPTAC can address those needs. This is intended to promote proactive TTA through collaborative interaction and relationship building, enhance the support provided, and remove the barrier of needing to reach out to IPTAC to receive TTA. The literature also supports this move to proactive TTA, as studies show the advantage of TTA providers anticipating recipient needs and beginning the TTA process, rather than waiting on requests to arrive (Wandersman et al., 2012; Lamont et al., 2024 (this issue)). Providers are then able to confirm and respond to those needs efficiently and strategically while building on their recipient's strengths.

The evaluation of IPTAC is currently expanding. The evaluation plan was recently updated to increase the amount and quality of data being collected for both the individual TTA delivered and application of TTA. As mentioned, a past attempt to collect data regarding TTA application from individual TTA recipients was unsuccessful. Moving forward, individual TTA will be assessed through two feedback forms – an immediate survey and a 30-day follow-up survey of those receiving individual TTA support. The immediate survey will assess satisfaction with TTA, intent to use the information or tools, topical knowledge gained, and any immediate capacity change. The 30-day follow-up will assess application of knowledge or tools and increased capacity for prevention. These forms will be sent by the assigned TTA provider who provided the support. We anticipate an increase in survey responses to IPTAC TTA because the TTA provider will have built a relationship through recurring engagements during the TTA support, which will be important as past attempts to solicit survey responses on TTA support have been unsuccessful. Although this may introduce hesitation on the recipients' part to give honest feedback to their TTA provider, clear language will be included that their feedback is critical for the improvement of TTA delivery in the future on a system wide level. Due to providers' ongoing relationship and familiarity with direct TTA recipients, it would be difficult to ensure anonymity in responses. Additionally, the post-event feedback form was updated for upcoming group TTA events, with a new focus on assessing increased knowledge/skills and intent to apply information/skills to prevention roles. For example, new questions are included that address the respondent's understanding of learning objectives (replacing a general question addressing whether they increased their knowledge on the subject matter), the respondent's confidence in completing prevention-related tasks after attending the webinar relative to before (which was previously not assessed), and the respondent's likelihood to apply the information in various ways (replacing a general question asking if they intended to apply the information in their professional capacity). These additions to our data collection are critical for addressing previous limitations in IPTAC's ability to assess skills development and capacity change of the prevention workforce.

In addition to expanding the evaluation of IPTAC as discussed above, future work is needed to evaluate IPTAC's impact on distal outcomes like prevalence of harmful behaviors. Further assessment is needed to connect prevention capacity changes in the workforce with increases in the successful execution of research-informed prevention activities and methodologically appropriate evaluations. The change in prevention capacity and the subsequent execution of activities and evaluations are expected to have the intended distal impact of decreasing the prevalence of harmful behaviors. Because IPTAC is in its infancy, past evaluations have not assessed this connection. From the EBSIS Cycle (Figure 4), we expect that the training, tools and direct technical assistance that IPTAC provides the workforce will lead to increased capacity. The results discussed above show an increase in knowledge and skills and an intention to apply the information and skills to their prevention work aimed at preventing harmful behaviors. Following the above plan to assess actual capacity increases, DVP will examine if associations exist between increases in prevention capacity, implementation, and evaluation of research-based strategies and existing data on harmful behaviors (e.g., from DoD annual reports, such as the DoD Annual Report on Sexual Assault in the Military, Fiscal Year 2023; Annual Report on Suicide in the Military, Calendar Year 2022; 2023 On-Site Installation Evaluation Summary; available on SAPR.mil, DSPO.mil, or Prevention.mil, respectively).

Implications for the Military

The future of TTA provision to meet the intricate needs of the expanding DoD prevention workforce is anticipated to be multifaceted and responsive to a wide variety of circumstances due to the complexities of military logistics and operating environments. TTA providers must have a healthy understanding and working knowledge of the military community and the complex working environments within which prevention personnel operate. The current IAA built in continuous monitoring and evaluation of the IPTAC services that are critical to assessing the expanding needs of DoD and ensuring that the TTA provided is building effective prevention capacity in military environments. As the TTA work expands, the evaluation of TTA will need to ensure it is continuing to integrate the ISF framework to assess the TTA provided and its impact over time for those who both receive and provide TTA support. Although the skill levels and the knowledge of prevention professionals will vary in breadth and depth, a certain level of capacity will be necessary (as defined in DoDI 6400.11) to execute prevention activities. TTA efforts that adequately train prevention practitioners will increase the likelihood of making data-driven decisions using the correct and vetted data sources, promoting the health and readiness of the military community, and sustaining collaborative, crosscutting efforts to prevent, reduce, and eradicate harmful behaviors. This type of research-to-practice implementation process is imperative to achieving a ready and resilient force.

Implications for the Civilian Sector

Although IPTAC works within the military environment, the current system and ongoing planned improvements to the delivery and evaluation of the TTA provided can provide many key takeaways for TTA delivery in the civilian sector for funders, providers, and systems. These takeaways, described in the following sections, may be particularly relevant to the delivery of TTA in other large, multi-level organizations.

TTA System Funder Considerations

Based on the finding that TTA delivery, particularly training, was more successful when TTA providers had either a background in the military or strong knowledge of opportunities and challenges specific to the military environment, funders of TTA systems may want to consider the previous experience of TTA providers with the specific population with whom they are working. It may also be helpful to consider prioritizing TTA providers with demographics similar to the population served. This would ensure experts on the challenges and culture of the priority population are present in addition to experts in TTA delivery. At minimum, it would be helpful for providers to demonstrate a plan for how they will adapt the TTA they deliver according to the specific challenges that the population faces while maintaining fidelity.

Funders may also consider using a systematic framework, such as the EBSIS, to inform the system's TTA delivery. The use of a systematic framework helps to ensure providers are delivering technical assistance with a clear purpose and objectives, and that the TTA delivered is rigorously evaluated for the appropriate outcomes. The ISF and EBSIS were a key factor in planning for the improvement of IPTAC's data collection, moving the evaluation focus beyond measures of satisfaction to actual capacity change, and assessing whether IPTAC is meeting its overall objective of improving the implementation and delivery of prevention activities to decrease harmful behaviors. A systematic implementation framework may also help ensure that TTA delivery is complementary, with TTA trainings, tools, and direct TA building off each other to build knowledge and capacity in key areas. However, the switch to using a framework may face pushback from stakeholders, as it may require an overhaul of how TTA is currently delivered and evaluated, requiring more time and resources on the front end. Additionally, evaluating TTA for capacity changes and implementation outcomes requires more creative and time-consuming methods and measures than the evaluation of what TTA was delivered and participant satisfaction rates.

The TTA system's delivery may be more effective if organizations who invest in and benefit from the TTA system have a contributing role in the activities being delivered, including those high up in the hierarchy of the organization (in the military, higher-level leaders shape the delivery processes for TTA). Within a multi-level system such as the military, a plan for how TTA delivery reaches different levels can be put in place, as well as an over-arching TTA plan for the organization. This ensures TTA is cohesive and available to those at higher levels, while still allowing for specific TTA to be accessible to members throughout the organization who may be working in different environments and with different populations, and therefore require more granular TTA delivery.

TTA Provider Considerations

TTA providers may want to consider how they will adapt their TTA delivery to the population with which they are working, and ensure it is applicable to the recipients' environment and specific needs. If TTA providers do not share similar backgrounds or experiences with the population being served, they can prioritize becoming very familiar with the specific strengths, needs, and challenges that population faces. For example, it is important for IPTAC's TTA providers to have a solid understanding of how the military

functions. This is also true for providers outside of the military – credibility and trust decrease when providers are not able to understand and account for recipients' experiences while delivering TTA.

IPTAC evaluation survey responses showed that participants found it challenging to independently apply prevention knowledge without specific direction on application. This was true for two specific scenarios: examples given by TTA providers, which were not previously implemented in a military context and too much time spent on theory and not enough on real-world application. This is important to address for both DoD and for the civilian sector. TTA providers can ensure they are both providing examples that are relevant to the audience and providing support to recipients in applying this information to their individual settings and communities. This approach is consistent with literature on the importance of individualized TTA delivery that is tailored to the situation and recipient of the TTA (Olson et al., 2020) to help the recipient translate the knowledge and skills from the TTA into action.

IPTAC evaluation data show that frequent and consistent communication is a significant factor in increasing knowledge and improving prevention implementation. This is an important finding for the civilian sector, as it shows the impact of strong relationships on TTA effectiveness. In the post-event feedback form for SPARX Knowledge trainings, positive feedback commonly cited how they felt the trainers really cared about the training participants and formed a relationship with them throughout the two-week training session. IPTAC aims to improve the frequency of communication between technical assistance providers and recipients outside of the training environment through the new, proactive TTA delivery system discussed above in "Future Work," where each Service-level component has a dedicated TTA provider that they meet with on a consistent basis. TTA providers in the civilian sector may consider ways to develop and improve relationships with TTA recipients regularly and consistently. This recommendation is consistent with research on the importance of building trusting relationships between TTA providers and recipients through frequent and consistent interaction (Fixsen et al., 2009). TTA providers can also build collaborative relationships with other stakeholders, as a collaborative approach leads to increased communication, empathy, and the building of partnership between the provider and recipient (Stormont & Reinke, 2012).

TTA System Considerations

A future enhancement of IPTAC is to identify ways to reduce decay in knowledge and skill by detecting the essential components of TTA that lead to sustainment and intentions to apply the knowledge and skills acquired. This need is reflected in the literature for TTA in the civilian sector. The EBSIS helps to fill this gap: connecting the creation of tools, delivery of training and technical assistance, and quality improvement leads to desired outcomes. However, the specific features of TTA that lead to its success are still needed. From IPTAC's evaluation, we conclude that some critical features include building trusting and consistent relationships between TTA providers and recipients and the prioritization of applicability of knowledge and skills to recipients' working environments.

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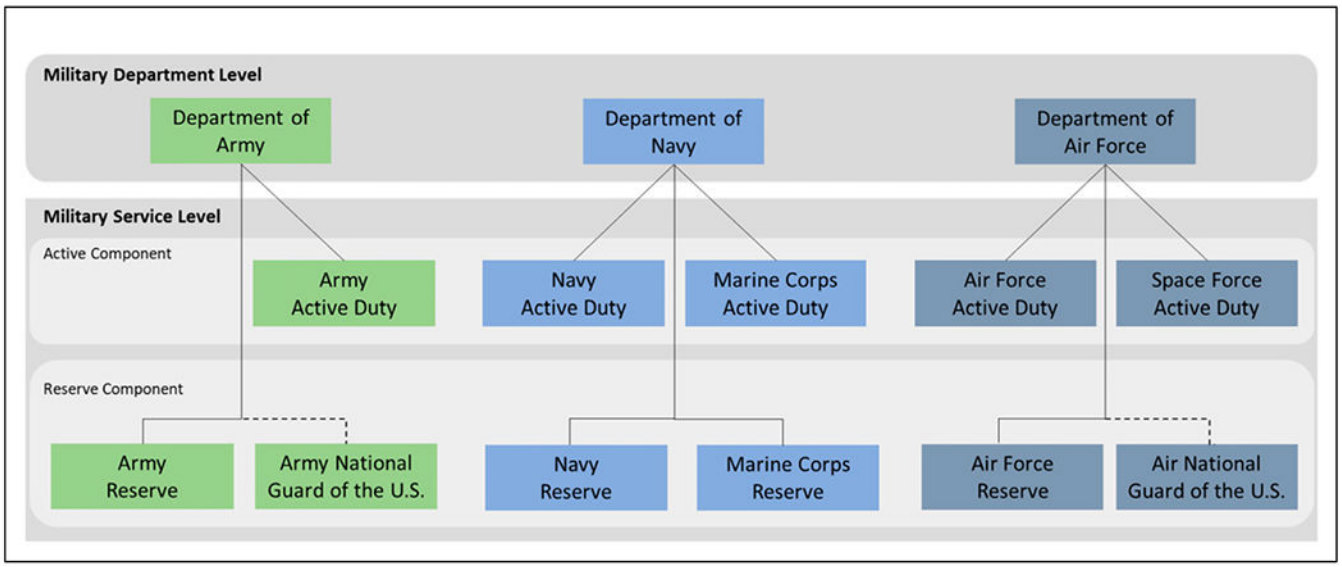

Figure 1.
Military Department Organizational Structure

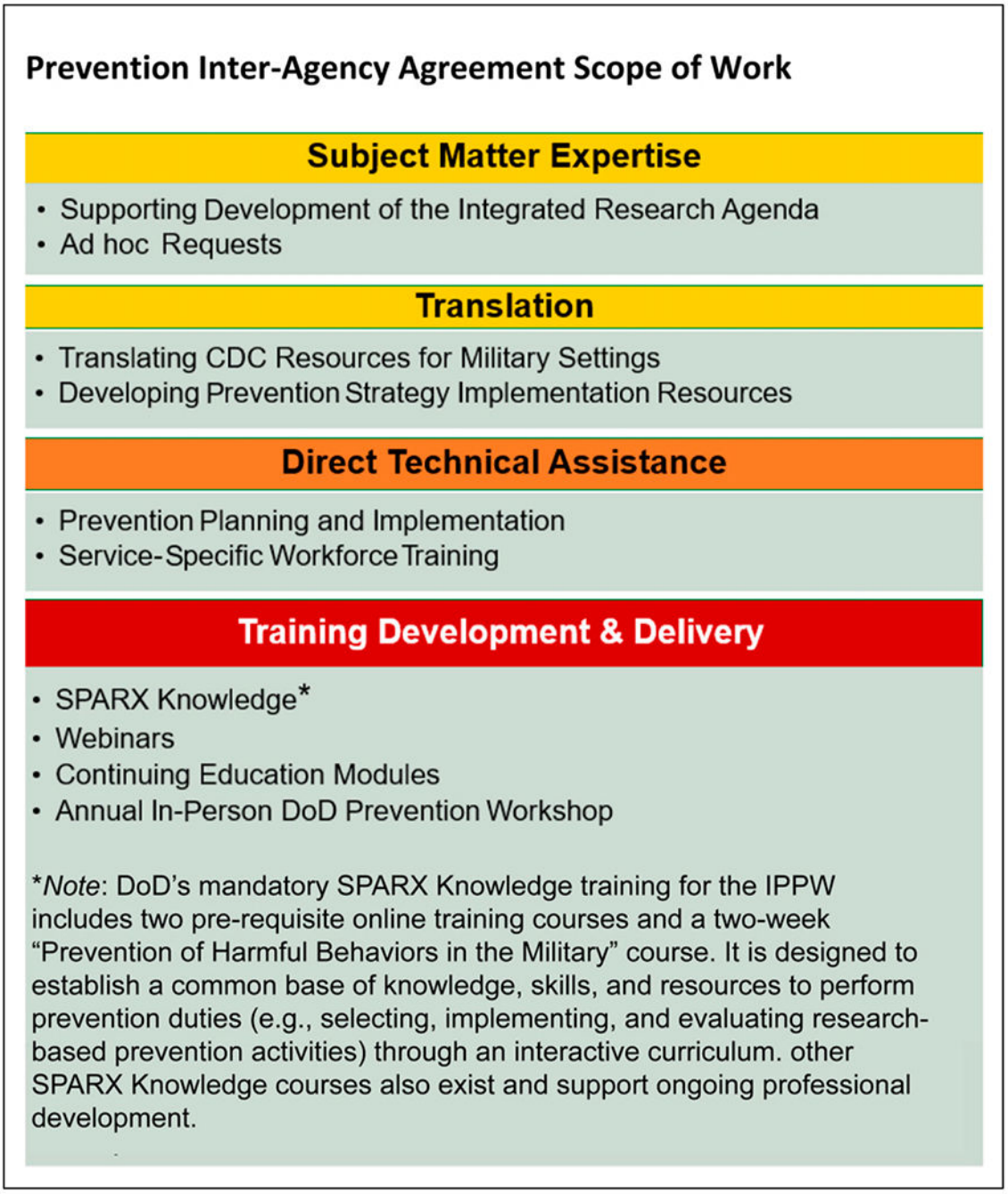

Figure 2.
Department of Defense – Centers for Disease Control and Prevention's Divison of Violence Prevention Inter-Agency Agreement Scope of Work

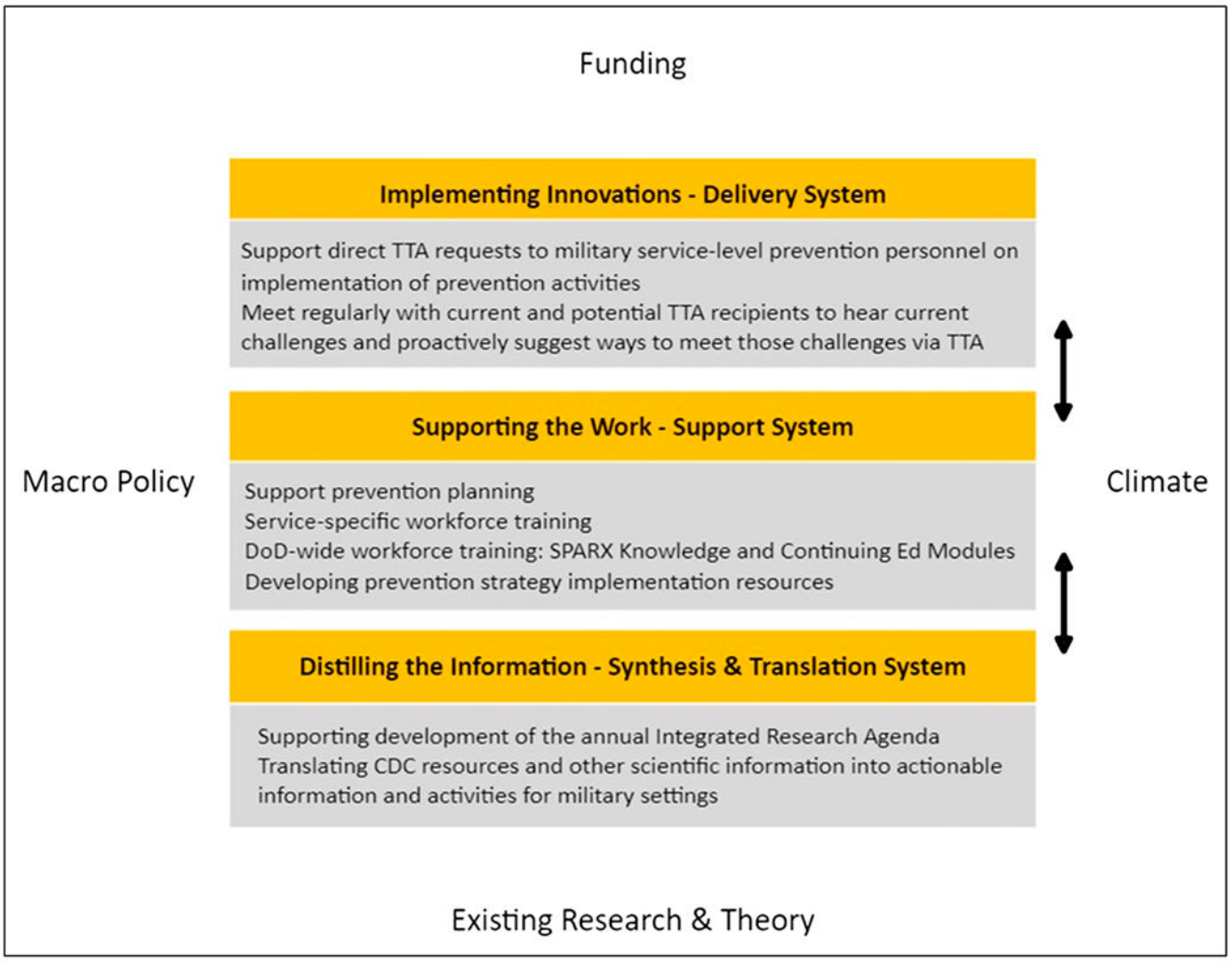

Figure 3.
TTA Alignment With ISF Systems
Note: Figure 3 Adapted From Wandersman et al., 2008

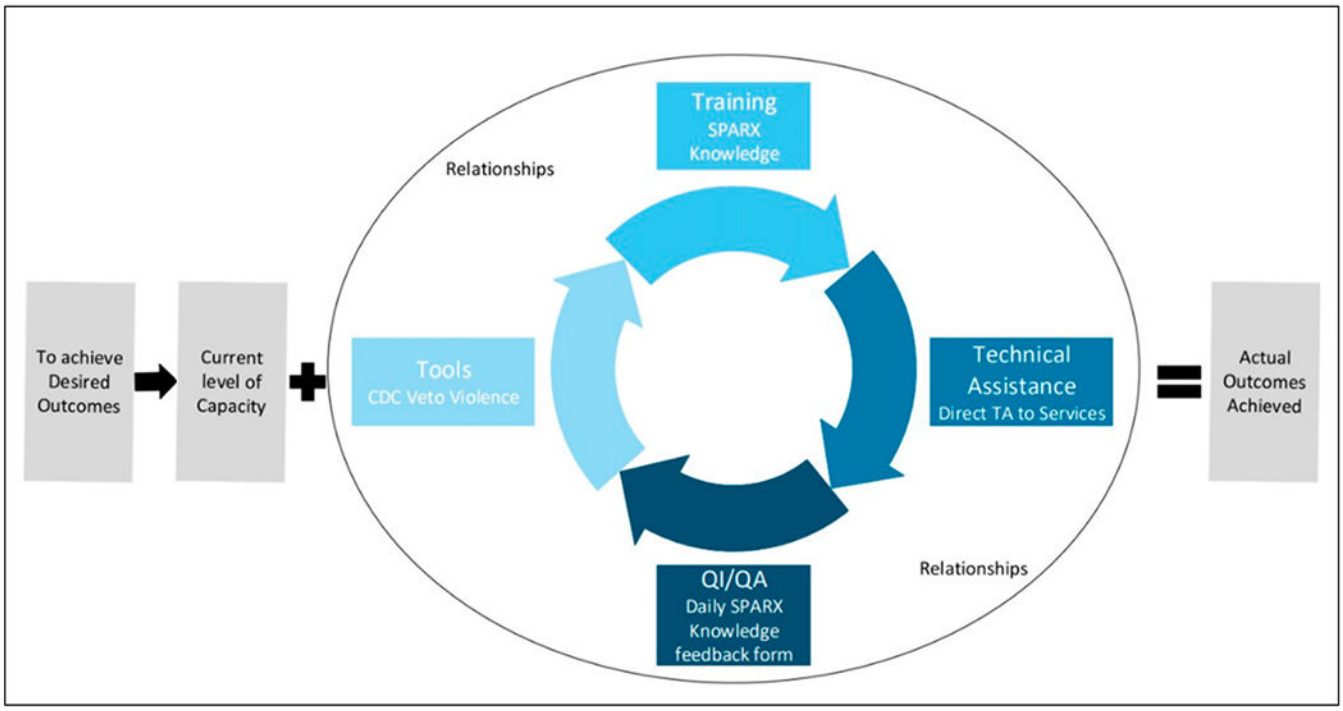

Figure 4.
TTA Aligned With the EBSIS Cycle
Note. Figure 4 adapted From Wandersman et al., 2012

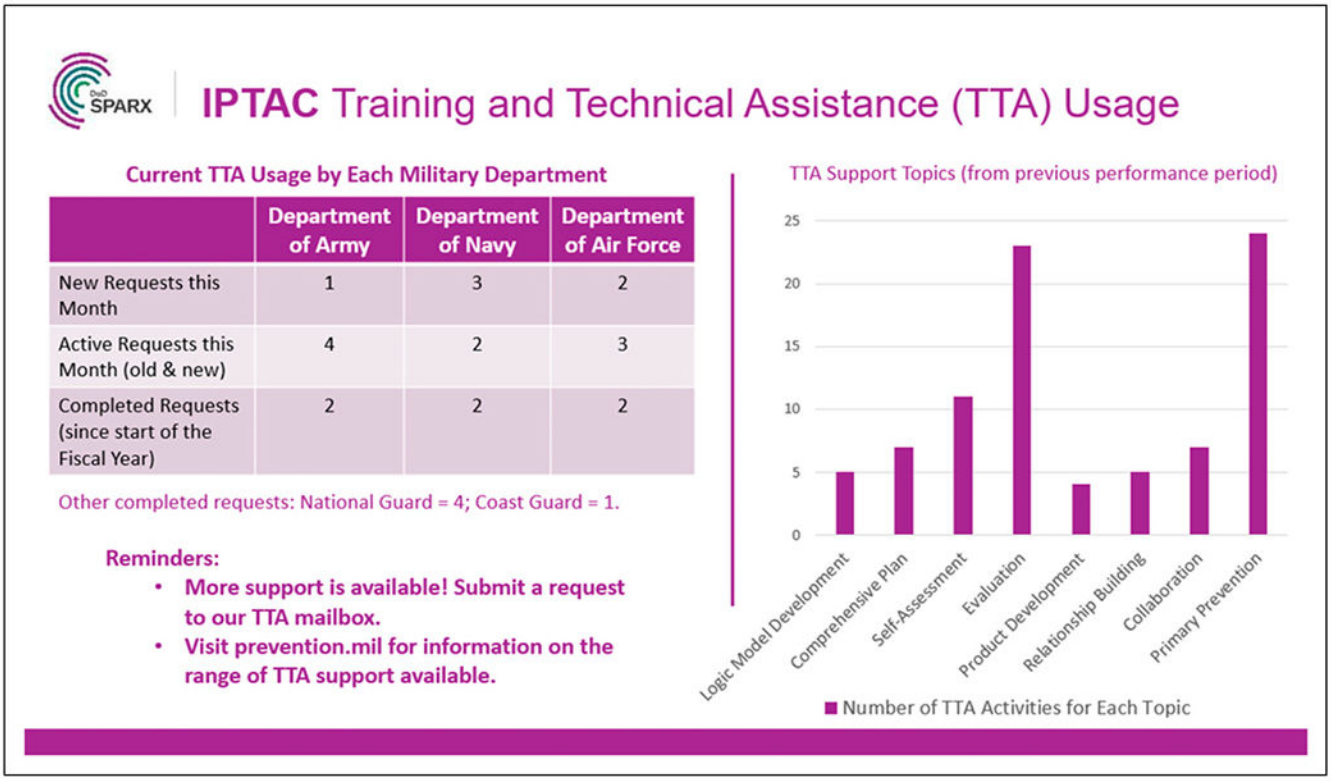

Figure 5.
Monthly Report Information Used to Encourage Further TTA Engagement

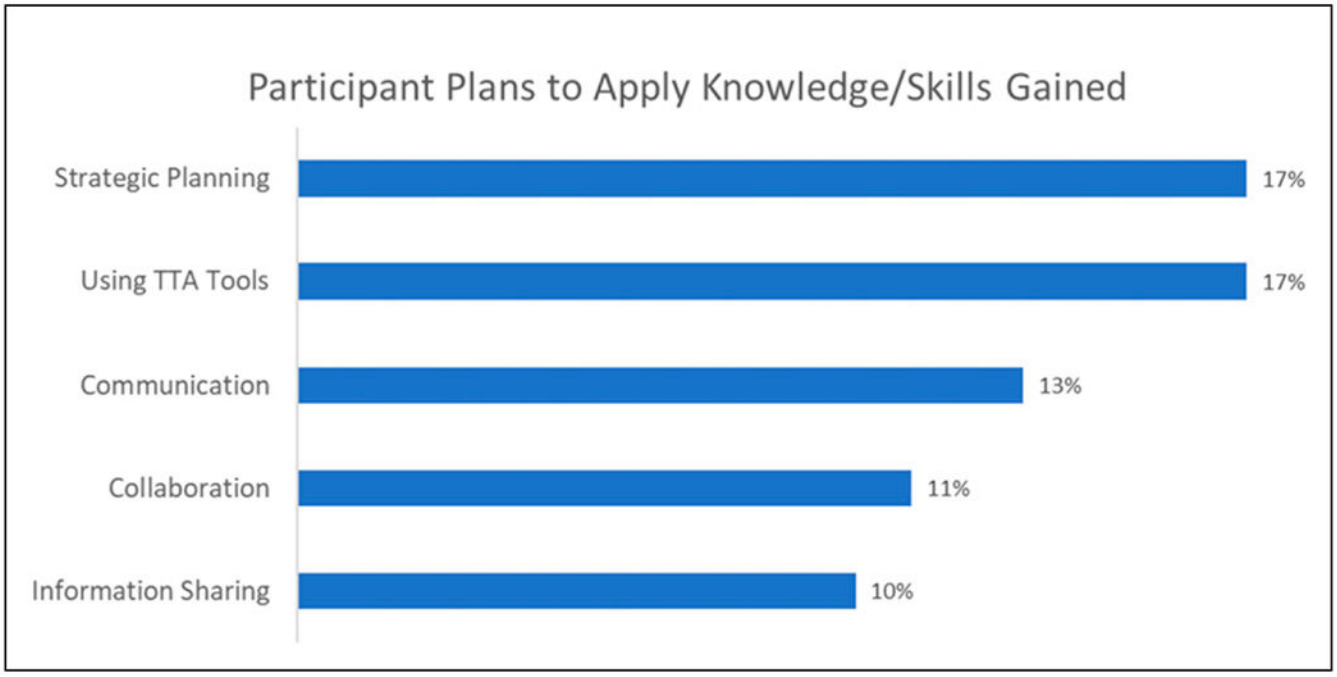

Figure 6.

Intentions to Apply Information From SPARX Knowledge Prevention of Harmful Behaviors in the Military Training

Note. The Horizontal Bars Indicate the Percent of Respondents that Indicated They Intended to Apply the Knowledge/Skills They Gained From SPARX Knowledge in that Bucket. Category descriptions: Strategic planning – Plans to Use Knowledge/Skills to Improve Their Prevention Planning. Using TTA Tools – Plans to Use Tools or Resources From Training in Their Prevention Role. Communication – Plans to Improve Communication About Prevention. Collaboration – Plans to Identify New or Deepen Existing Partnerships. Information Sharing – Plans to Share Knowledge, Tools, Resources With Their Teams or Communities

Table 1.

TTA Feedback Collection Instruments

Feedback instruments	Purpose	Method	Respondents	Timing
Post Event Feedback Form	Satisfaction; Intent to Apply information; Knowledge/Skills gained	Survey sent through link by TA provider; Optional and anonymous	Webinar or group event participants	Immediately after event
Participant Feedback Forms for SPARX Knowledge Trainings	Satisfaction; Intent to apply information; CQI; Knowledge/skills gained; Connection with other participants; other TA needs	Survey link posted at the end of each day of training, and an end-of-training form sent out at the end of the two weeks	SPARX Knowledge training participants	Immediately after each day of training, and a separate one for the last day of training
TTA Recipient Focus Group	Satisfaction; Intent to apply information; Application of information	Individual TTA recipients invited to participate via email	Point of contact for each Department that requested individual TTA	Annually at end of contract year
TTA Provider Focus Group	TTA provider perceptions of individualized TTA provided (participant satisfaction, knowledge/ skills gained, application or intent to apply, future needs)	TTA providers invited to participate via email	TTA providers	Annually at end of contract year

Table 2.

Example TTA by Mode of Delivery and Topic

Mode of delivery	Topic(s)	Description
Virtual training	Evaluation	IPTAC hosted a webinar on *Measuring Performance and Effectiveness of Prevention Activities.* Presenters from the military community and the RAND Corporation discussed measures of performance (MOPs) and measures of effectiveness (MOEs), provided examples of use in the military, and discussed their applicability to prevention workforce members.
Phone call	Comprehensive plan	IPTAC provided guidance on the development of a comprehensive prevention plan.
TTA resource/ publication, Email	Comprehensive plan	IPTAC created a sample outline and template for use in creating a comprehensive prevention plan.
Email	Self-assessment	IPTAC reviewed a Prevention Inventory/Survey and provided feedback on ways to improve it (e.g., suggestions regarding how to reword portions of the survey and length of the survey).
TTA resource/ publication, Email	Evaluation	IPTAC assessed and summarized findings from a survey that assessed knowledge and attitudes related to Sexual Assault/Sexual Harassment and made recommendations to improve the survey. This survey tool will evaluate changes in knowledge and attitudes over time. IPTAC also provided written instructions for all analyses completed in Excel to help build capacity for data analysis.
Virtual training	Evaluation	IPTAC delivered a presentation about outcome evaluation during an annual training hosted for personnel whose mission area focuses on resilience, prevention, and sexual assault.
TTA resource/ publication	Primary prevention	IPTAC created the publication "*Community and Organizational Level Prevention of Harmful Behaviors in the Military*", which describes four evidence-based strategies for integrated primary prevention of harmful behaviors. It provides 3-4 approaches within each strategy, the evidence for them, implementation considerations, and examples of that approach in a military setting.