Prevention Plan of Action 2.0 2022-2024

The Department's renewed strategic approach to prevent self-directed harm and prohibited abuse or harm

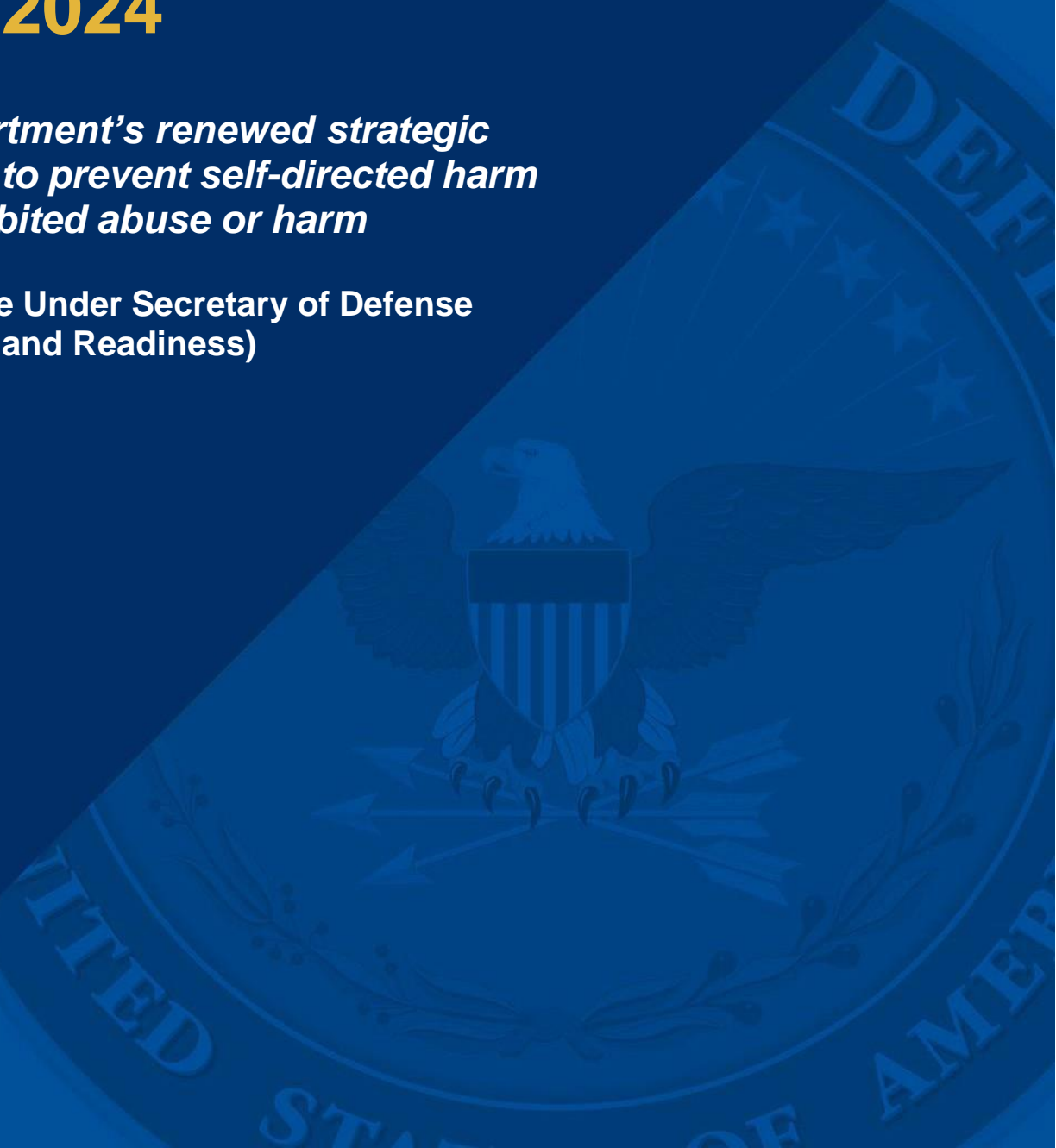**Office of the Under Secretary of Defense (Personnel and Readiness)**

May 2022

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Executive Summary

Self-directed harm and prohibited abuse or harm refers to sexual assault, harassment, retaliation, suicide, domestic abuse, and child abuse. These behaviors impact force readiness, disrupt mission effectiveness, tax scarce resources, and take a human toll. Reduction of these behaviors demands additional steps to solidify the conditions that will sustain lasting progress, align efforts to proven approaches, and drive the changes required to achieve the Department's vision of a military free from abuse and harm.

This document highlights the Department's new emphasis on integrated primary prevention. Integrated prevention will require finding shared solutions to the problems of sexual assault, harassment, retaliation, domestic abuse, suicide, and child abuse. While this range of harmful behaviors has diverse and unique prevention needs, these harmful behaviors also share many risk and protective factors. The Department will synergize existing prevention activities by strengthening efforts that address these shared factors. This approach will align competing priorities, increase program effectiveness, ensure efficient use of resources, and help leaders cultivate safe and healthy climates across the military community.

This revised Prevention Plan of Action (PPoA 2.0) establishes a framework to guide the development, implementation, and evaluation of integrated primary prevention. Importantly, PPoA 2.0 builds on past work by reinforcing the tenets outlined in the 2019-2023 Department of Defense Sexual Assault Prevention Plan of Action (PPoA 1.0). The updated PPoA 2.0 incorporates multiple advancements that have occurred since 2019. Specifically, PPoA 2.0 reflects improvements made during the implementation of PPoA 1.0, incorporates the requirements and aligns language with DoDI 6400.09, "DoD Policy on Integrated Primary Prevention of Self-Directed Harm and Prohibited Abuse or Harm," issued September 11, 2020, and addresses the approved prevention-related recommendations of the Independent Review Commission on Sexual Assault in the Military report released on July 2, 2021. In short, this update expands the scope of the initial PPoA from sexual assault to the integrated prevention of multiple harmful behaviors, removes completed 2019-2023 PPoA objectives, and aligns remaining objectives with the IRC recommendations as approved by the Secretary of Defense, and Congressional requirements.

PPoA 2.0 reflects the Department's urgent need for integrated primary prevention. However, many of the harmful behaviors addressed in this document have unique prevention requirements. Subsequent versions of the PPoA will include these unique requirements and ensure that the military remains on the cutting edge of prevention science.

Part 1: Primary Prevention Framework

BLUF: The PPoA is a *strategy* document intended to orient DoD components to DoD's integrated prevention approach and priorities. Senior leaders should use this document as a guiding framework to ensure their prevention efforts remained aligned with DoD.

Introduction

The Department remains dedicated to stopping incidents of self-directed harm and prohibited abuse and harm before they occur.[1] Since the release of the first Prevention Plan of Action (PPoA 1.0) in 2019, important developments both within and outside of the military highlight the Department's need to evolve and strengthen its prevention strategy over time. In 2020, the Department published its first integrated primary prevention policy, DoD Instruction (DoDI) 6400.09 "DoD Policy on Integrated Primary Prevention of Self-Directed Harm and Prohibited Abuse or Harm", spanning the prevention of sexual assault, suicide, harassment,[2,3] domestic abuse, and child abuse (hereafter referred to as "harmful behaviors"). In 2021, Secretary of Defense Lloyd J. Austin III called for an Independent Review Commission (IRC) on Sexual Assault. The IRC made key recommendations to promote healthy climates and prevent multiple forms of harmful behavior. Recommendation 2.8 of the IRC Report requires the Department to revise PPoA 1.0 to align with the IRC's vision for integrated primary prevention in the military.[4]

This document reflects the Department's updated and revised Prevention Plan of Action (PPoA 2.0). The PPoA 2.0 incorporates all relevant guidance, addresses the approved IRC integrated primary prevention recommendations, new Congressional requirements, and the various forms of harmful behavior encompassed within DoDI 6400.09. This integrated primary prevention strategy will accelerate the Department's prevention efforts while enabling leaders to bolster shared protective factors and reduce risk factors for the entire military community.

DoD Primary Prevention Framework

Overview

Prevention science has evolved considerably over the past thirty years. Researchers have discovered new and effective ways to reduce harmful behaviors within communities and organizations.[5,6] While primary prevention is complex, the steps required to diminish prevalence of harmful behaviors and sustain progress are relatively similar to common planning and

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[1] The terms "self-directed harm and prohibited abuse or harm" and "harmful behaviors" are used throughout this document and align with DoDI 6400.09.

[2] As defined in DoDI 1020.03.

[3] As defined in DoDI 1020.04.

[4] As defined in DoDI 6400.09.

[5] Basile, K.C., DeGue, S., Jones, K., Freire, K., Dills, J., Smith, S.G., Raiford, J.L. (2016). *STOP SV: A Technical Package to Prevent Sexual Violence*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf

[6] National Center for Injury Prevention and Control (U.S.). Division of Violence Prevention. (2017). Preventing Suicide: A Technical Package of Policy, Programs, and Practices. 62. https://www.cdc.gov/violenceprevention/pdf/suicidetechnicalpackage.pdf

coordination processes used routinely throughout the U.S. Armed Forces.[7] First, primary prevention requires a holistic, comprehensive approach driven with unity of effort toward the desired end state. Building this approach requires understanding the current environment, determining the scope of the local problem, and assessing the organizational factors that enable prevention. Second, a comprehensive approach is comprised of integrated, research-based prevention activities,[8] which achieve unity of effort only when implemented as designed in a conducive, supportive environment. Third, prevention activities require the systematic use of data-driven tactics to achieve the desired outcomes. Finally, preventing harmful behaviors requires evaluating change indicators over time, assessing organizational factors to inform adjustments to the prevention approach, and measuring the effectiveness of specific activities.[9]

Prevention System Elements

Reducing harmful behaviors across the military community involves enacting the prevention process in an optimized prevention *system* (see Figure 1). Organizational factors that constitute the prevention system include **human resources, such as equipped and empowered leadership, prevention workforce, and the military community; infrastructure, such as prevention-specific policy, resources, and data systems; and, collaborative relationships within and across organizations.[10]** In an optimized prevention system, human resources attain and sustain prevention-specific knowledge and skills, collaborative relationships form and become more productive, and infrastructure facilitates effective planning, implementation, evaluation, and quality improvement. Too often, prevention activities fail to have an impact because they are implemented without sufficient development of these system elements. The policy requirements for implementing the Prevention System are found in DoDI 6400.09 Section 3.1.

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[7] DoD, Joint Chiefs of Staff, Joint Planning, Joint Publication 5-0 (Washington, DC, 2020). https://www.jcs.mil/Portals/36/Documents/Doctrine/pubs/jp5_0.pdf?ver=ztDG06paGvpQRrLxThNZUw%3d%3d

[8] Research-based policies, programs, and practices are defined as prevention activities selected based on research evidence that they have shown promise in evaluations to decrease the behavior of interest for a specific population or that the activity affected one or more contributing factors to the behavior of interest in settings similar to those being considered for the activity and that positive effects were sustained over time.

[9] Basile, K.C., DeGue, S., Jones, K., Freire, K., Dills, J., Smith, S.G., Raiford, J.L. (2016). *STOP SV: A Technical Package to Prevent Sexual Violence*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf

[10] Pan American Health Organization. (2014*). Plan of Action for the Prevention and Control of Noncommunicable Diseases in the Americas, 2013-2019.* Washington, D.C.: World Health Organization. https://iris.paho.org/handle/10665.2/35009
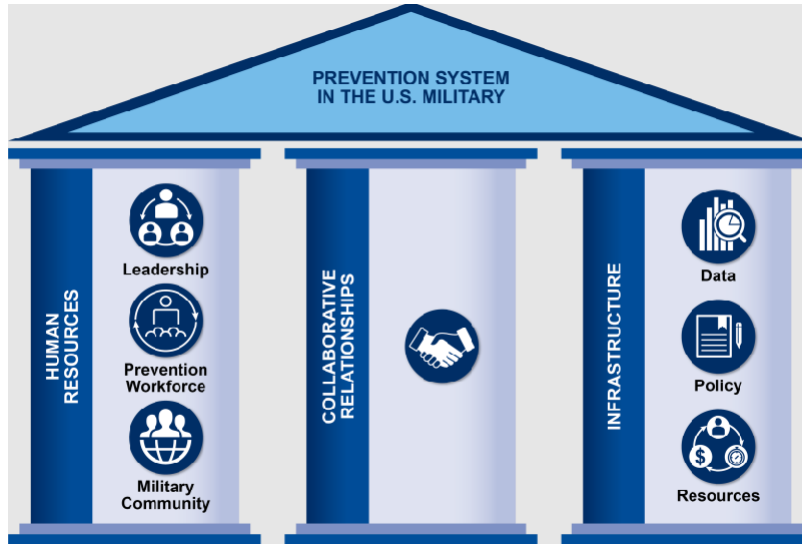
Figure 1. Primary Prevention System

The prevention system is the backdrop against which prevention planning, implementation, and evaluation all take place. A gap or deficiency in any element of the prevention system (e.g., an unskilled or underqualified prevention workforce) will degrade the quality of prevention activities.

Prevention Process Elements

The prevention process is a data-driven effort involving four main steps: **understanding the problem, developing a comprehensive approach, quality implementation, and continuous evaluation**. Requirements for the prevention process are outlined in DoDI 6400.09 Section 3.2 and are referred to as "data-driven actions" in the policy. The first step in the primary prevention process involves understanding the nature and magnitude of a problem within an organization. This is typically achieved through public health surveillance methods that systematically track and periodically assess the prevalence (number of people impacted) and incidence (frequency of occurrence) of a problem over time.
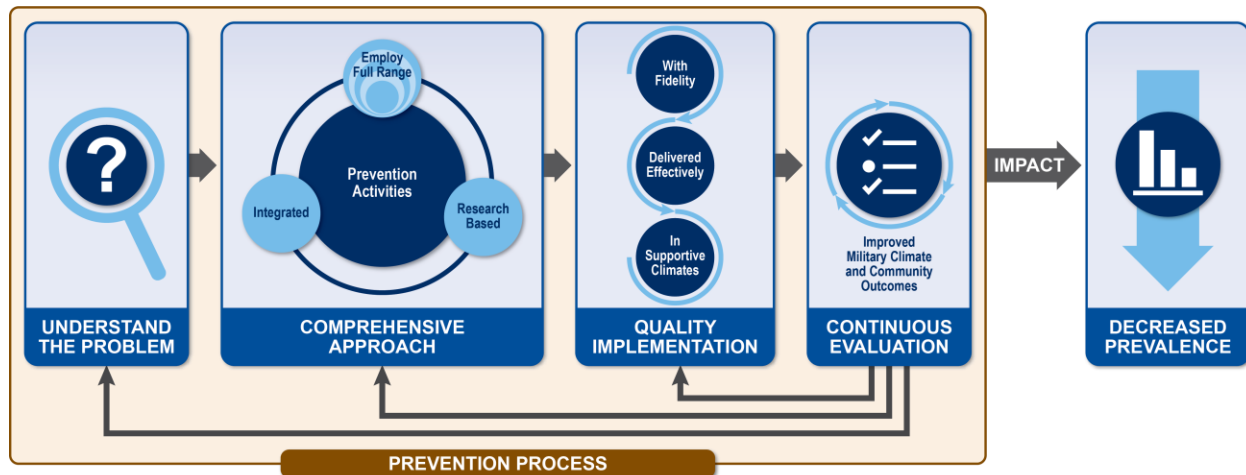

Figure 2. Primary Prevention Process

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The Department has several information collection efforts that assess sexual assault, harassment, suicide incidents, and related behaviors (e.g., the Workplace Gender Relation Surveys, DoD Suicide Event Report system). DoDEA Administrative Instruction (AI) 1356.01, issued in 2018, has helped advance the tracking of child abuse in DoD schools.[11] However, in the National Guard and Reserves, certain information collection efforts are challenging due to the part-time nature of the Force and other varied restrictions caused when NG members are not in a federal status. Furthermore, the Department does not currently have methods to fully assess the prevalence of domestic abuse and child abuse outside of DoD schools, although current efforts are underway to generate more information on these harmful behaviors.

After defining the magnitude of the problem, researchers should identify **factors known to contribute to harmful behaviors and their prevention**. Generally speaking, contributing factors are either risk or protective factors. Risk factors increase the likelihood that harm or abuse will occur. Examples of individual risk factors include previous trauma, substance misuse, and/or other risky or harmful behaviors (e.g., aggressive interpersonal behavior). Examples of community-level risk factors include hazing, bullying, retaliation, or other forms of harassment in the workplace, high drug and alcohol availability, high levels of poverty, and easy access to lethal means. As such, in a military environment, the Department's approach to the prevention of these behaviors is done through a risk-management framework. Protective factors decrease the likelihood that harmful behaviors will occur. Protective factors also buffer someone with risk factors from being affected by harmful behaviors. Examples of individual protective factors include effective communication skills, high levels of social support, and healthy methods of coping with stress. Examples of community-level protective factors include an inclusive culture and climate, high cohesion and social connectedness, and social norms that encourage help-seeking.[12]

Risk and protective factors vary substantially depending on the local context, and further vary at the individual, interpersonal, and community levels. Given the variability of these factors across the spectrum of harmful behaviors, each organization must conduct needs assessments to determine which contributing factors should be prioritized for prevention. Combined, the analysis and dissemination of prevalence survey results, climate assessments, research on contributing factors, and local needs assessments will provide leaders with the information needed to guide prevention decision making.

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[11] AI 1356.01 requires all reports of suspected or alleged incidents of child abuse and neglect to be documented and reported in a Child Abuse Report (CAR) and reported by phone to the local Family Advocacy Program and Child Welfare Services within 24 hours.

[12] For additional examples of risk and protective factors, see page 14 of the IRC Prevention Appendix.

Next, after understanding the problem, effective prevention involves developing a **comprehensive approach** or plan by applying multiple, reinforcing prevention activities (Figure 3) in a coordinated way to address individual, interpersonal, and organizational factors that contribute to harmful behaviors. The comprehensive approach should foster healthy environments and peer norms in addition to building critical personal and interpersonal skills.

For example, alcohol misuse is a risk factor for sexual assault, suicide, child abuse, and domestic abuse. However, implementing policies designed to prevent overconsumption of alcohol *in isolation* will not be sufficient to reduce these harmful behaviors. Instead, pairing alcohol reduction policies with prevention education and skill building programs will reinforce both prevention activities and may lead to fewer incidents of harm.[13] In short, the public health approach examines the *environment* and the *culture* in which individuals live and seeks to fundamentally change the local community in ways that stop harmful behavior before it begins.

Figure 3. Types of Prevention Activities

- **Policy:** A course or principle of action of a government or other institution that may be reflected in regulation, procedure, administrative action, incentive, or voluntary practice

- **Program:** Curriculum or manualized set of activities and information intended for learning and skill development

- **Practice:** Discrete behavior or action contributing to prevention

Comprehensive approaches ideally combine universal and targeted prevention activities. Universal prevention activities are activities that engage <u>all</u> Service members, such as building positive peer environments and promoting shared protective factors. Targeted activities address the unique needs of high-risk subpopulations. Within large organizations, specific subpopulations are at higher risk of different forms of abuse and harm. For example, current data show that young white men are most at risk of dying by suicide in the military, while women, racial/ethnic minorities, and sexual minority individuals are most at risk of sexual harassment, and sexual assault.[14, 15] Pairing targeted prevention activities (i.e., those that target high-risk groups) with universal prevention activities creates a more robust and efficient comprehensive approach.

Integrating prevention activities into a cohesive, cross-functional, and cross-organizational approach yields other advantages, such as promoting unity of effort, avoiding duplication, and lessening training fatigue. Given the associations among harmful behaviors, a comprehensive approach for prevention requires the inclusion of activities that effectively boost the cross-cutting protective factors and mitigate risk factors across the various forms of abuse and harm.

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[13] Basile, K.C., DeGue, S., Jones, K., Freire, K., Dills, J., Smith, S.G., & Raiford, J.L. (2016). *STOP SV: A Technical Package to Prevent Sexual Violence*. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf

[14] DoD CY 2020 Annual Suicide Report. Defense Suicide Prevention Office (2021). 2020https://www.dspo.mil/Portals/113/Documents/CY20%20Suicide%20Report/CY%202020%20Annual%20Suicide%20Report.pdf?ver=0OwlvDd-PJuA-igow5fBFA%3d%3d

[15] Trump-Steele, R., Daniel, S, DeMarco, T., Sampath, S., Severance, L., Klahr, A. (2021). Experiences of sexual minority active duty service members with sexual harassment and sexual assault: Analysis of the 2016 and 2018 WGRA. (Report No. 2021-23). Alexandria, VA: Office of People Analytics.
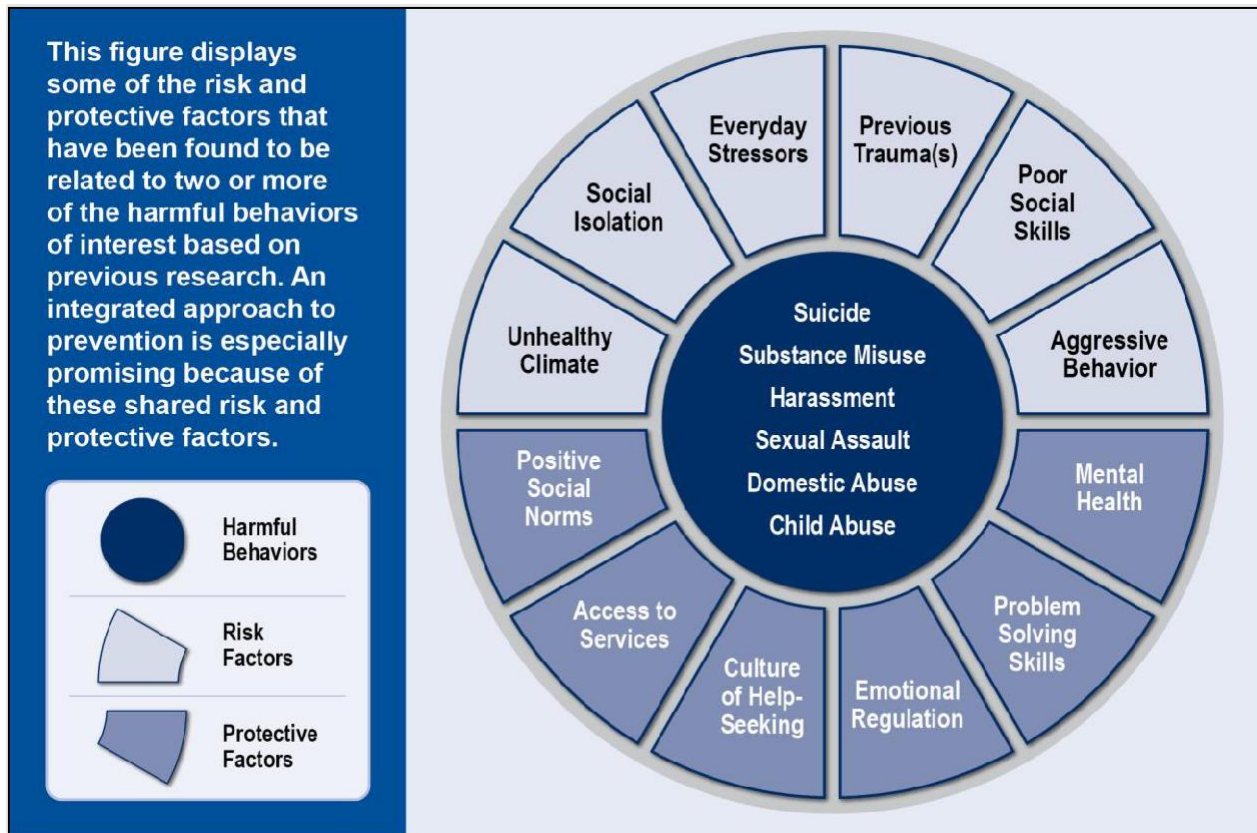
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This figure displays some of the risk and protective factors that have been found to be related to two or more of the harmful behaviors of interest based on previous research. An integrated approach to prevention is especially promising because of these shared risk and protective factors.

- Harmful Behaviors
- Risk Factors
- Protective Factors

Harmful Behaviors: Suicide, Substance Misuse, Harassment, Sexual Assault, Domestic Abuse, Child Abuse

Risk Factors: Everyday Stressors, Previous Trauma(s), Poor Social Skills, Aggressive Behavior, Social Isolation, Unhealthy Climate

Protective Factors: Positive Social Norms, Access to Services, Culture of Help-Seeking, Emotional Regulation, Problem Solving Skills, Mental Health

Figure 4. Shared Risk and Protective Factors for Harmful Behaviors

The specific prevention activities that address individual, interpersonal, and organizational risk and protective factors must be complementary, such that messaging, or skills are mutually reinforcing rather than eroding. Selecting multiple activities that employ a similar approach— such as building skills for bystanders to intervene in high risk situations—are not sufficient to ensure compatibility, since different bystander intervention programs may have conflicting branding and messaging. Instead, various domains of the community must be targeted simultaneously. For example, building crucial skills and abilities for young adults such as financial decision-making and effective communication habits can help protect young adults from domestic abuse and suicide. Increasing connectivity and developing strong support networks for individuals at risk of isolation can decrease the likelihood of sexual assault victimization, sexual harassment, and suicide. Maintaining clean, safe housing and providing affordable, accessible childcare can reduce the risk of child abuse.

Prevention policies, programs, and practices in a comprehensive approach must be selected because of their evidence base and likelihood to impact harmful behaviors or change the factors contributing to harmful behaviors. Research-based prevention activities are efforts that have been rigorously evaluated and shown to decrease specific forms of abuse and harm for a specific population. Ultimately, implementation of research-based prevention provides the greatest confidence that prevention activities will decrease harmful behaviors.

Although implementation of a research-based prevention activity is a significant undertaking and critical step to decrease prevalence, the **quality of implementation** is equally important.[16] The manner and context in which prevention activities take place have a direct effect on the potential success of a comprehensive approach. Leaders and prevention personnel must implement prevention activities **with fidelity in supportive climates**. Fidelity refers to the degree to which an activity is implemented competently and as designed. While adaptation of activities is sometimes necessary to appeal to different participants, the key effective ingredients of the activity must be retained. For example, shortening a prevention program from its original, validated duration or delivering it with unprepared facilitators can alter its efficacy. A supportive climate includes leadership buy-in, organizational motivation to implement an activity, and/or staff with specific skills to implement the activity. Attempting to implement prevention activities in an unsupportive climate decreases their potential impact.

Once a comprehensive approach is implemented in a supportive climate, it must be **continuously evaluated** to determine if its component activities are changing the factors they were designed to address. This includes evaluation of activities and program outputs (e.g., number of leaders trained, number of meetings held with external stakeholders) as well as evaluation of program outcomes, such as lower rates of harassment. Outcome evaluation identifies if and to what extent an activity actually decreased negative behaviors and increased healthy behaviors. Ongoing evaluation is critical for continuous quality improvement. Documenting challenges and success is also important as the Department continues to build a repository of best practices. Prevention personnel will learn which prevention activities work with different populations over time, adjusting implementation when necessary to increase effectiveness.

Before the prevention process can be fully successful (Figure 2), each of the prevention system elements (Figure 1) must be in place. For example, implementing a prevention activity requires personnel time and training. In the absence of a prevention workforce, other personnel may be dual-hatted to implement the prevention activity, which can overtax a military organization leading to decreases in leader buy-in. Lack of buy-in related to overtaxing the organization may be perceived by subordinate leaders as lack of buy-in to the activity. Even if the prevention activity had the potential to reduce harm, not attending to the human resources necessary to implement the activity will decrease effectiveness. Therefore, there is a symbiotic association between the system elements and prevention process. Both must be developed and promoted.

To summarize, effective primary prevention involves tackling every step of the prevention process (Figure 2) within a complete and well-organized prevention system (Figure 1). The prevention system enables the planning and coordination of prevention and includes: Human Resources (Leadership, Prevention Workforce, Military Community), Collaborative Relationships, and Infrastructure (Data, Resources, and Policy). Specific steps in the prevention process include understanding the problem and contributing factors, developing a comprehensive approach that targets contributing factors and engages Service members in solutions, implementing the comprehensive approach with fidelity in supportive climates, and

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[16] Wandersman, A., Alia, K., Cook, B.S., Hsu, L.L., and Ramaswamy, R. (2016). *Evidence-based Interventions are Necessary but Not Sufficient for Achieving Outcomes in Each Setting in a Complex World: Empowerment Evaluation, Getting to Outcomes, and Demonstrating Accountability*. American Journal of Evaluation 37, no. 4: 544-561. https://journals.sagepub.com/doi/full/10.1177/1098214016660613

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evaluating the comprehensive approach. The combination of <u>all</u> of these elements is necessary to decrease the occurrence of harmful behaviors and sustain reductions over time.

Prevention Oversight

The integration and coordination of prevention activities across sectors[17] and settings is essential for sustaining the impact of primary prevention efforts.[18] Oversight, or efforts to monitor the degree to which the prevention system and the prevention process are functioning efficiently and as intended, is the last element of a complete prevention strategy. Oversight will involve monitoring and evaluation of each element of the prevention system (see Figure 1): including setting knowledge standards for the prevention workforce, military community, and military leaders, ensuring collaborative relationship are sustained over time, and tracking prevention data, resources, and policies. For prevention programs, policies, and practices, oversight will involve establishing and tracking measures of performance and measures of effectiveness associated with each step of the prevention process (i.e., identifying the problem, developing a comprehensive approach, implementation, and evaluation). In large organizations, oversight becomes critical to ultimately achieving long-term prevention goals. Successful oversight will prioritize outcomes, guide diverse stakeholders, avoid duplication, ensure consistent messaging, and hold organizations and offices accountable for their progress.

Part 2. Integrated Primary Prevention

History of Integrated Primary Prevention within DoD

The Department's approach to primary prevention has evolved over time. As depicted in Figure 5, the Department adopted a public health approach to prevention because methods used to stop and reduce diseases can be adapted and used to prevent harmful behavior. The offices leading this work initially focused much of their effort implementing prevention activities proven to reduce harm in the civilian sector and evaluating ongoing activities that did not yet have an evidence base of effectiveness. Through this phase of prevention, the importance of quality implementation became clear, such that an effective prevention activity that was not implemented as intended did not have the intended impact. As such, the Department's approach evolved to address both what was implemented (evidence-based practice) and how it was implemented (with quality).

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[17] Several important sectors span civilian-military lines and collaboration across sectors—in accordance with law and DoD regulations—is helpful when implementing large scale prevention strategies. Such sectors include education, government (local, state, and federal), social services, health services, business/labor, justice, housing, media, and organizations that comprise the civil society sector such as crisis centers, local health coalitions, faith-based organizations, youth-serving organizations, foundations, and other non-governmental organizations. Collectively, these sectors can make a difference in preventing abuse and harm by impacting the various contexts and underlying risks that contribute to harmful behaviors. See page 33 in Basile, K.C., DeGue, S., Jones, K., Freire, K., Dills, J., Smith, S.G., & Raiford, J.L. (2016). *STOP SV: A Technical Package to Prevent Sexual Violence.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf

[18] Stone, D., Holland, K., Bartholow, B., Crosby, A., Davis, S., & Wilkins, N. (2017). *Preventing Suicide: A Technical Package of Policy, Programs, and Practices.* Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Preventing Suicide: A Technical Package of Policy, Programs, and Practices.

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Figure 5. Evolution of Primary Prevention

Public Health Approach: Consistently enforce and promote policy, healthy climates, individual and interpersonal skills, and supportive services

Phase I: Abuse and Harm as Public Health Issues

Public health principles for infectious disease and cancer prevention are applied to prevent self-directed harm and prohibited abuse and harm

Phase II: Evidence-Based Prevention Practice

Use of proven, effective prevention activities are prioritized

Phase III: Quality Implementation

Supportive leadership and engaged individuals are essential for prevention activities to be effective

Phase IV: Integrated Prevention

Factors such as alcohol use and unhealthy command climate increase risk for multiple forms of harmful behaviors

Targeting shared factors through integrated approaches enhances prevention effectiveness and efficiency

As prevention policies and practices evolved, the Department's data began to show that climate factors such as toxic leadership, harassment (including hazing and bullying), discrimination, and lack of social support increased the risk for multiple harmful behaviors. At the same time, data began to accumulate suggesting Service members and DoD civilian personnel found training and education across harmful behaviors to be duplicative: often addressing the same risk or protective factors.[19] As a result, leadership across DoD sought to identify opportunities to synchronize prevention activities by leveraging shared risk and protective factors that contribute to multiple harmful behaviors.

Rather than simply combining or sequencing prevention activities to reduce redundancy, **integrated primary prevention** involves taking action to decrease harmful behaviors and reduce their impact on readiness and retention in a way that:

- Incorporates values of inclusivity, connectedness, dignity and respect (access, equity, rights, and participation)—including the elevation of Service member and family member voice—to inform plans, processes, and trainings;

- Recognizes and adjusts plans, processes, and trainings to consider and be responsive to climate issues and populations that have been disproportionately impacted by harmful acts;

2018 Workplace and Gender Relations Survey of Active Duty Members: Overview Report. Report No. 2019-027. Alexandria, VA: Office of People Analytics, 67-68. https://apps.dtic.mil/sti/citations/AD1072334

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- Intentionally seeks to align and find common operating principles across prevention efforts and offices (e.g., equal opportunity, drug reduction response, suicide prevention, sexual assault prevention); and,
- Incorporates multiple lines of effort across individual, interpersonal, and community/organizational levels.[20]

Integrated primary prevention addresses shared risk and protective factors across harmful behaviors through integrated solutions, while maintaining prevention activities that may be unique to a specific harmful behavior.

In addition to the factors outlined in Figure 4, pre-military experiences and conditions must be considered when implementing integrated primary prevention activities. The social determinants of health are the circumstances in which people are born, grow, work, live, age, and the wider set of forces and systems shaping the conditions of daily life. The fact that certain groups and communities are disproportionately impacted by abuse and harm is not a coincidence. In some cases, the increased risk for exposure to harmful behaviors and associated negative health outcomes is a result of longstanding, systemically unjust economic and social policies. For example, policies still exist today that maintain neighborhoods of concentrated poverty and limit access to 1) quality schools, 2) health services, and 3) social support—all factors that protect against harmful behaviors and other adverse health conditions. Exposure to negative conditions in early childhood[21] is associated with increased risk of poor health and further adverse experiences at every subsequent life stage, placing some individuals and groups at greater risk for harmful behaviors during military service.

People join the military with different backgrounds and experiences. Each individual's background and experiences affect who they are, the decisions they make, and how they interact with others. Some individuals bear the burden of past or current hardships based on race, sexual orientation, religion, or ethnicity and those experiences impact their day-to-day lives. The DoD has enacted policies—such as housing, childcare subsidies, and equal pay for equal work—to create equal opportunities; however, equal opportunity is not necessarily enough to ensure equity due to past hardships based on racism, sexism, homophobia, and other types of discrimination and oppression. The IRC directed DoD to ensure prevention activities take these pre-military conditions and experiences into account to provide enhanced skill development and resources for those at greatest need early in their military careers.

To support an integrated primary prevention approach across policy offices, then Acting Under Secretary of Defense for Personnel and Readiness Matthew P. Donovan established the Prevention Collaboration Forum (PCF) Executive Council, which includes leadership from offices engaged in preventing self-harm and prohibited abuse and harm. DoDI 6400.09, published by USD(P&R) in September 2020, was a collaborative effort among DoD

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[20] Integrated primary prevention should incorporate prevention activities at various levels of a social ecological model (see https://www.cdc.gov/violenceprevention/about/social-ecologicalmodel.html). However, different prevention efforts may adjust their social ecological models to account for their populations and/or the local context. For example, a federal program may highlight the individual, organizational, and societal levels in their prevention strategy, while a local women's shelter may highlight the individual, family, and community levels for their stakeholders. Social ecological models can be adapted and adjusted to fit specific prevention strategies.

[21] For more information, visit https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf

stakeholders that set forth the responsibilities and steps the Department must take to stop harmful behaviors before they occur.

Building on the momentum of DoDI 6400.09, the Department leveraged the work of the IRC on Sexual Assault in the Military by framing sexual assault prevention recommendations in the context of integrated primary prevention in order to achieve benefits across the spectrum of harmful behaviors.

To accomplish measurable and sustained reductions in harmful behaviors throughout the military, alignment of prevention activities at all levels within an integrated primary prevention framework is necessary. DoDI 6400.09 provides an essential first step towards integrated primary prevention, outlining the minimum policy requirements needed across the Services to prevent sexual assault, harassment, retaliation, suicide, domestic abuse, and child abuse. As a critical next step, PPoA 2.0 applies current prevention science to the military environment, clearly outlining a holistic prevention strategy that will guide prevention efforts in the years to come.

Primary Prevention Framework applied to Integrated Primary Prevention

2.1. Prevention System - Human Resources: Leadership

Military leaders at all levels are responsible for creating and fostering a climate grounded in mutual respect, trust, and an environment free from abuse and harm. Leaders need to leverage their knowledge, experience, authority, and influence to set the tone for their command climates. Leaders must have a full understanding of the prevention system and process, and the ability to inspire support for the development, implementation, and assessment of a comprehensive approach.

Military leaders must work closely with their prevention workforce to align their experience with that of primary prevention science. To ensure success, leaders' authority and operational experience are paramount when implementing research-based prevention activities in a military environment. Leaders must go beyond "checking the box" for primary prevention activities to succeed. Leaders must cultivate a supportive climate by actively creating buy-in from their subordinates, stressing that prevention is a command priority, and explaining why prevention activities are needed in their unit. Second, leaders must proactively communicate their support for using effective, research-based practices. The lack of visible leadership support undermines the efficacy of proven approaches and enables the status quo.[22] Finally, the oversight capability across the Department must hold all military leaders and the prevention workforce appropriately accountable for adhering to the prevention process and ensuring each of the prevention system elements is sustained over time. In effect, leader-driven prevention is crucial to generating measurable and sustained decreases in harmful behaviors.

2.2. Prevention System - Human Resources: Prevention Workforce

Creating an organization that implements effective primary prevention requires a trained, equipped, and resourced prevention workforce, including dedicated professional staff and

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[22] Gottfredson, D. C., Cook, T. D., Gardner, F. E., Gorman-Smith, D., Howe, G. W., Sandler, I. N., & Zafft, K. M. (2015). Standards of Evidence for Efficacy, Effectiveness, and Scale-up Research in Prevention Science: Next Generation. *Prevention Science: The Official Journal of the Society for Prevention Research*, *16*(7), 893-926. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4579256/

prevention enablers. The prevention workforce should also have expertise in prevention science commensurate with their role, function, echelon, and organization. For example, individuals in strategic and policy roles must be able to synthesize data and research and translate the findings into policy and guidance. Individuals in organizations supporting or overseeing individuals who implement prevention activities must be able to apply the strategic guidance to their sphere of influence. They must also provide tools and technical assistance to prevention professionals at the tactical level to facilitate the execution of the strategic guidance. Individuals at the tactical level who implement prevention activities require collaboration and facilitation skills as well as the ability to apply the strategic guidance, tools, and technical assistance to their unique organization. In addition to these specific skills, the prevention workforce at each level must request feedback from and provide feedback to the other levels to assess programmatic and professional effectiveness. Ongoing, bidirectional feedback ensures that tools, training, and technical assistance are tailored to evolving needs of diverse organizations and their prevention workforce.

The successful implementation of effective prevention activities relies on understanding and applying prevention research and integrating that research with leadership experience. To ensure that implementation activities at all levels include effective, comprehensive approaches, the Department must define and build the competencies of its workforce to use sound research and contextualize the research with leaders' expertise. Training curricula for the prevention workforce must build relevant skills to identify and tailor prevention approaches to sub-populations, such as young Service members, within the military, as applicable.[23]

2.3. Prevention System - Human Resources: Military Community

The entire military community, including all Service members, military dependents, and DoD civilian personnel, must collectively strive to create and support environments free from abuse and harm. Members of the military community should promote DoD, military, and Service core values through their individual actions to shape and support the norms of dignity, respect, inclusion, and connectedness that actively deter harmful behaviors. This can include individuals' efforts to seek and sustain healthy and safe relationships at work and at home, dedication to respectful and non-derogatory communication[24] with peers and significant others, and an enduring commitment to reducing stigma and increasing support for help-seeking. Everyone should understand how to intervene and support individuals undergoing severe stress and/or negative life events. While individuals enter the military community with a diverse array of backgrounds and prior experiences, attributes such as empathy need to be prioritized and learned in order to identify individuals facing adversity and encourage them to seek help before abuse and harm occur.

Everyone in the military community can contribute to producing the supportive climates crucial to the success of prevention activities. Individual engagement is needed for leaders and prevention personnel to understand the practicality and reception of different prevention policies, programs, and practices. For example, if a program is poorly delivered, members of the military community need to share that information with the prevention personnel evaluating

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[23] The term "proven prevention activity" refers to activities that have evidence of targeted behavior change or change to one or more contributing factors, for a given population, resulting from that activity.

[24] IRC recommendation 3.3b highlights the need for Service members to engage in respectful and non-derogatory communication in virtual and cyber spaces (e.g., Tinder), as well as in person.

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the program. Proactive feedback and engagement about the military community's needs enables continuous evaluation, which is critical to the prevention process.

2.4. Prevention System – Collaborative Relationships

Although harmful behaviors have some unique contributing factors, they share several risk factors (e.g., substance misuse, history of violent victimization, lack of nonviolent problem-solving skills). These shared contributing factors can serve as the basis for collaborative relationships. Collaborative relationships between the integrated prevention workforce and stakeholders from other similarly invested organizations allows for greater integration of efforts. Integrated primary prevention activities reinforce shared solutions and create opportunities for common prevention messaging and skill development, while increasing access to those in need via multiple sources of support. Creating complementary programming and initiatives, while maintaining the distinct elements unique to each issue, can support an overall reduction in harmful behaviors. Collaborative relationships require stakeholder buy-in on collective goals, a willingness to share mutually beneficial and effective approaches, and potentially sharing resources. Thus, each issue-specific training is reinforcing the training provided for other topic areas and not redundant

2.5. Prevention System - Infrastructure: Data

Actionable data are critical when making prevention decisions and ensuring institutional accountability. However, sometimes connections between a prevention activity and its long-term outcome (e.g., lower prevalence) is unclear or too slow to observe. In such cases, leaders and prevention personnel must leverage the substantial research that connects prevention activities with short and intermediate outcomes (e.g., measurable success reducing a risk factor or enhancing a protective factor). An integrated comprehensive approach focuses on doing the greatest good for the greatest number of people; therefore, the data that are used to drive and evaluate prevention activities must be representative of the behaviors, attitudes, and climate of the <u>entire organization or population</u>, rather than specific to those who experienced harmful behaviors or those seeking support services.

Regular assessments of the local environment are necessary so that leaders and stakeholders can better understand "why" and "how" the prevalence of harmful incidents changes over time. In addition, local needs assessments help each organization understand which contributing factors leaders should prioritize for prevention. Regular assessments also demonstrate the effectiveness of specific prevention activities in achieving their short and intermediate outcomes. The Department must develop a dedicated and sustainable program of research to better understand factors that contribute to harmful behaviors, methods to identify prevention activities that mitigate those factors, and prevention metrics. Specifically, measures of effectiveness and measures of performance for prevention planning and execution in the military environment are needed. Moreover, data must be systematically captured, analyzed, interpreted, and shared, so that it provides timely and accurate information to inform decisions and drive continuous improvement at all levels

2.6. Prevention System - Infrastructure: Resources

The Department must advance and align budgets related to primary prevention to reflect the Department's stance toward increased prevention efforts. Depending on the unique needs and requirements of each Service, resourcing may be required to conduct research on the factors that contribute to harmful behaviors in unique communities, to adapt and evaluate prevention activities prior to widespread implementation, to equip leaders with

tools to oversee comprehensive prevention, to develop and train a prevention workforce, and to fund implementation of local prevention activities. Resource prevention activities must be undertaken in a way that does not diminish or degrade response capabilities.

2.7. Prevention System - Infrastructure: Policy

Establishing and strengthening prevention-related policy supports the development, implementation, and evaluation of a comprehensive approach. Prevention policies not only represent a portion of the prevention infrastructure and define roles, requirements, and responsibilities; but policies are also prevention tools to achieve environmental change. Both types of prevention policies are described here.

Prior to DoDI 6400.09, DoD policies on self-directed harm and prohibited abuse and harm focused primarily on the response system, leaving prevention roles and requirements unarticulated in Department policy. An effective prevention policy development identifies the roles and responsibilities of a prevention workforce and leadership, and standards for employing proven prevention activities as part of a comprehensive approach. Nevertheless, policies by design are often broad and wide sweeping in their requirements. Coupling policies with prevention expertise and leaders' operational experience at the ground level ensures that policies are operationalized successfully. For example, training requirements outlined in policy may need additional specificity in terms of frequency, audience, delivery, and content. Research-based practices and expertise of prevention experts may be leveraged by leaders to help ensure that adaptations will not have an unintended negative impact on the program's effectiveness.

Prevention policies are also powerful tools to establish environments where abuse and harm are less likely. Local policies can be altered at the installation or unit level. Policies that mitigate situational risk factors for harmful behaviors have the potential for widespread impact within an organization, without necessarily adding time in training.

2.8. Prevention Process - Comprehensive Approach

Consulting with subject matter experts across prevention programs will assist with identifying prevention activities among multiple disciplines and organizations and assist with integration of research-based activities, as appropriate. Development of a comprehensive approach begins with the identification of key contributing individual, interpersonal, and organizational factors. Key contributing factors then guide selection of prevention activities that are shown to mitigate the factors in similar settings. Cohesive alignment of selected activities allows messaging and skills from one approach to reinforce and mutually support those of other approaches. Clearinghouses, reviews, and meta-analyses inform sound decision-making, and provide examples of comprehensive approaches and activities used in other communities that can serve as models for developing a comprehensive approach in military settings.

2.9. Prevention Process - Quality Implementation

Quality implementation means effectively delivering a comprehensive approach with fidelity in a supportive climate. Fidelity refers to delivering the approach competently as it was originally designed. While prevention activities may be tailored or adapted to fit the needs of a particular population, fidelity assures that the key effective ingredients of the activity are preserved. Effective delivery means engaging the audience and key stakeholders in a way that inspires behavior change and skill development. Process evaluation

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and research-informed strategic guidance, tools, and technical assistance facilitate quality implementation. These functions performed by a prevention workforce at various places in an organization ultimately support implementation of a comprehensive prevention approach in each military setting.

Implementation of a comprehensive prevention approach must occur within a supportive climate. In a supportive climate, leaders prioritize and value integrated prevention by ensuring prevention activities are implemented in ways that do not produce resentment within their subordinates or the larger military community. Prevention personnel also help produce a supportive climate by using their specific knowledge and skills to build collaborative relationships, guide leadership, and expertly implement prevention approaches. Service members help sustain supportive climates by remaining open minded and willing to learn new skills and habits when engaging in prevention activities.[25] An understanding of the degree to which a climate supports the implementation of a comprehensive prevention approach also enables leaders to anticipate and address barriers to success in advance of implementation.

One major factor influencing climates is the presence of negative perceptions towards integrated primary prevention resulting from a high saturation of prevention messages and activities in many military communities. Negative perceptions include training fatigue, low perceived value of awareness events and related activities, and failed messaging. Implementation of comprehensive approaches must take into account and reverse negative impressions of primary prevention. Identification of what drives negative program associations will allow the Department to reduce barriers that would impede positive engagement in new proven prevention approaches. In some cases, it may be prudent to pause or stop longstanding activities—even those that appear to be working—to address negative perceptions.

2.10. Prevention Process – Continuous Evaluation

Evaluation is an essential skill related to prevention planning and coordination. Leadership and prevention stakeholders rely on evaluation to determine how and whether prevention resources – money, time, and manpower – are achieving the intended outcomes. Before a prevention activity is widely disseminated, evaluation is necessary to ensure that the prevention approach decreases harmful behaviors or associated risk factors *and* is feasible for the military environment. Prioritization of prevention activities will inform what will have the greatest impact: activities that produce the greatest positive change should be selected over activities that have minimal or short-lived effects. This involves engaging key stakeholders, describing a prevention activity, defining the expected outcomes, gathering data to evaluate progress on outcomes, using data for improvement, and disseminating lessons learned.

Continuous evaluation of a comprehensive approach is a long-term endeavor. In highly mobile environments, continuity of effective prevention activities is important even as personnel transition to and from units. Although some indicators of change can be realized within months of implementing an effective and potent prevention program, detecting such change requires systematic, valid measurement to capture subtle change over time. Evaluation that includes assessment of multiple outcomes is necessary because comprehensive primary prevention often includes activities that address other problem behaviors, such as harassment and alcohol

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[25] Scaccia, J.P., Cook, B.S., Lamont, A., Wandersman, A., Castellow, J., Katz, J., & Beidas, R.S. (2015). A practical implementation science heuristic for organizational readiness: R = MC2. *Journal of Community Psychology, 43*(4): 484-501. https://pubmed.ncbi.nlm.nih.gov/26668443/

misuse. In addition, implementing prevention approaches might first result in increases in help-seeking behaviors and help-seeking prior to crisis. As such, regular, valid assessment of multiple outcomes provides a clearer picture of intermediate impact.

Embedding evaluation at every level is a cornerstone of prevention. Importantly, one challenge of the military environment is the high turnover of personnel. Leaders who embark on a mission to support and sustain prevention activities may not witness the results or outcomes of their programs. Prevention personnel must manage expectations of individuals or institutions desiring rapid results. For example, it can take over ten years to fully evaluate the effects of a prevention program. Nonetheless, slow, steady progress should not dishearten leaders or halt evaluation efforts. Instilling evaluation as a normal part of the prevention process requires an assessment of the current state of evaluation and the prevention system elements necessary for evaluation. The Department must take systematic steps to evolve toward more rigorous evaluation for untested prevention activities. This process likely entails prioritizing activities that are ready for evaluation as well as evaluating activities that are already widely disseminated but not yet tested.

DoD Integrated Primary Prevention Goals

Establishing an optimized organization that supports and sustains the development, implementation, and evaluation of a comprehensive primary prevention approach is a long-term endeavor. Between 2019 and 2022, the Department took some steps towards this goal by completing six of twenty-two objectives from the PPoA 1.0. The original PPoA pushed the Department and the Services to take key steps towards building a robust prevention system and engaging in prevention activities using a public health approach. Key milestones achieved to meet PPoA objectives include: 1) development of metrics and thorough self-assessment across DoD to identify prevention strengths and gaps, 2) developing and fielding of a public health curriculum designed for prevention professionals in the military, and 3) the release of a research agenda that summarizes the DoD's highest priority research topics and methods.

On September 22, 2021, the Secretary of Defense approved the implementation of the recommendations laid forth in the IRC Report, wherever possible. An "Implementation Roadmap" that outlines key milestones and timelines was developed by the Department to guide implementation efforts of the recommendations as approved by the Secretary of Defense. Deadlines for implementation are nested into four tiers: Tier 1 must be completed by FY27, Tier 2 and Tier 3 must be completed by FY28, and Tier 4 must be completed by FY30.[26]

The Department is implementing the following approved recommendations in the context of integrated primary prevention. Implementation will be tracked through a single reporting process.

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[26] Tier 1 implements the approved recommendations that build the Department's basic foundation and infrastructure for sexual assault accountability, prevention, and response programs with estimated completion FY 2027. Tier 2 implementation is dependent on the execution of a Tier 1 actions and builds directly on that Tier 1 infrastructure to apply strategies (e.g., training, education) with estimated completion in FY 2028. Tier 3 recommendations are either chronologically or practically dependent on the execution of a Tier 2 action, and would expand programs and practices within the DoD, or would endure throughout the implementation process. Lastly, Tier 4 actions are either chronologically or practically dependent on the execution of a Tier 3 action or would expand programs and practices outside of the DoD purview with estimated completion in FY 2030. DoD Actions and Implementation to Address Sexual Assault and Sexual Harassment in the Military (defense.gov)

IRC Recommendation 2.1 a: USD(P&R) should define the competencies leaders must have to oversee prevention. (Tier 1, Estimated completion: FY 2027)

IRC Recommendation 2.1 b: The Services and the National Guard Bureau (NGB) should develop and hold leaders appropriately accountable for prevention. (Tier 3, Estimated completion: FY 2028)

IRC Recommendation 2.1 c: The Services and the NGB should equip all leaders to develop and deliver informed prevention messages in formal and informal settings. (Tier 2, Estimated completion: FY 2028)

IRC Recommendation 2.2 a: USD(P&R) should develop a model for a dedicated and capable prevention workforce. (Tier 1, Estimated completion: FY 2027)

IRC Recommendation 2.2 b: USD(P&R) should develop a professional credential for the prevention workforce. (Tier 1, Estimated completion: FY 2027)

IRC Recommendation 2.2 c: The Services should determine the optimum full-time prevention workforce, and equip all echelons of active duty, reserve, and guard organizations. (Tier 1, Estimated completion: FY 2027)

IRC Recommendation 2.3 a: The Services and the NGB should resource and implement prevention strategies at organizational and community levels. (Tier 3, Estimated completion: FY 2028)

IRC Recommendation 2.4:   Modernize prevention education and skill-building to reflect today's generation of Service members. (Tier 2, Estimated completion: FY 2028)

IRC Recommendation 2.5 a: The Services and the NGB should institute a pilot program to link Service members with resources and support. (Tier 1, Estimated completion: FY 2027)

IRC Recommendation 2.5 b: The Services and the NGB should employ virtual-platforms to provide support to all Service members. (Tier 1, Estimated completion: FY 2027)

IRC Recommendation 2.6 b: USD(P&R), the Services, and the NGB should continually review and update all policies that unnecessarily restrict data collection on important populations of Service members. (Tier 1, Estimated completion: FY 2027)

IRC Recommendation 2.7b: USD(P&R) should submit a legislative proposal providing authorization and funding for the NGB to conduct recurring National Guard unit inspections and staff assistance visits for prevention oversight and assistance. (Tier 1, Estimated completion: FY 2027)

IRC Recommendation 2.8:   USD(P&R) should update the Department's prevention strategy, including the DoD Prevention Plan of Action, to incorporate approved IRC recommendations. (Tier 4, Estimated completion: FY 2030)

IRC Recommendation 3.2:   USD(P&R) should direct the Services to educate the force about sexual harassment and sexual assault within the context of the Services' core values.[27] (Tier 2, Estimated completion: FY 2028)

IRC Recommendation 3.7 a: USD(P&R) should develop a standardized "pulse survey" tool that would enable unit-level commanders to collect real-time climate data on sexual harassment and sexual assault from Service members in their units between required administrations of the Defense Organizational Climate Survey (DEOCS). (Tier 1, Estimated completion: FY 2027)

IRC Recommendation 3.7 b: The Secretary of Defense should direct the Services to develop a formal system to share climate survey data at the unit level and initiate and evaluate corrective action plans. (Tier 1, Estimated completion: FY 2027)

IRC Recommendation 3.7 c: USD(P&R) should accelerate efforts to develop a validated "Climate Benchmark" to measure healthy and unhealthy climate at the unit level. (Tier 1, Estimated completion: FY 2027)

IRC Recommendation 3.6:   Building a climate for the reduction of sexual harassment and sexual assault as a fundamental leader development requirement.[28] (Tier 2, Estimated completion: FY 2028)

PPOA Objective 4.9.4:   Address evaluation gaps and develop, implement, and institutionalize an evaluation process by which prevention programs and activities are evaluated and results are disseminated to support continuous quality improvement. (Estimated completion: FY 2028).

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[27] For the purposes of this PPoA, Recommendation 3.2 will be applied across harmful behaviors.

[28] For the purposes of this PPoA, Recommendation 3.6 will be applied across harmful behaviors.

Sec 549A FY22 NDAA: Beginning on October 1, 2022, and annually on the first day of each fiscal year thereafter, the Secretary of Defense shall publish a Department of Defense research agenda for that fiscal year, focused on the primary prevention of interpersonal and self-directed violence, including sexual assault, sexual harassment, domestic violence, child abuse and maltreatment, problematic juvenile sexual behavior, suicide, workplace violence, and substance misuse.[29]

In many cases, the Department's implementation guidance regarding the approved IRC recommendations[30] will require coordination. Table 1 provides an overview of the interplay of the approved recommendations and the elements identified to ensure successful implementation.

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[29] United States National Defense Authorization Act for Fiscal Year 2022: Report of the Committee on Armed Services, House of Representatives. Washington: U.S. Government Publishing Office. Section 549A.

[30] Under Secretary of Defense Personnel and Readiness Memorandum, "Guidance for implementing Tier 1 Recommendations of the Independent Review Commission on Sexual Assault in the Military," October 13, 2021.

Under Secretary of Defense Personnel and Readiness Memorandum, "Guidance for implementing Tier 2 Recommendations of the Independent Review Commission on Sexual Assault in the Military," November 12, 2021.

Under Secretary of Defense Personnel and Readiness Memorandum, "Guidance for implementing Tier 3 and 4 Measures Related to Recommendations of the Independent Review Commission on Sexual Assault in the Military," December 15, 2021.

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Table 1. Map of PPoA 2.0 Elements and IRC Recommendations

Rec	PREVENTION SYSTEM						PREVENTION PROCESS		
	Leadership	Prevention Workforce	Collaborative Relationships	Data	Resources	Policy	Comprehensive Approach	Implementation	Evaluation
2.1a	X					X			
2.1b	X					X			X
2.1c	X						X	X	
2.2a		X							X
2.2b		X				X			
2.2c		X			X				
2.3a	X	X	X	X		X	X	X	X
2.4						X	X	X	X
2.5a			X				X	X	X
2.5b							X		
2.6d				X			X	X	X
2.7b	X	X	X		X				X
2.8			X			X		X	X
3.2	X						X	X	X
3.6	X						X		X
3.7a	X		X	X	X		X	X	X
3.7b	X	X		X		X	X	X	X
3.7c	X			X	X		X	X	X
4.9.4									X
549A				X					

Prevention Oversight

The oversight of the integrated primary prevention-related IRC recommendations will be conducted by the Office of the Secretary of Defense for Personnel and Readiness. The Prevention Collaboration Forum and the Violence Prevention Cell may provide technical assistance to the Military Departments, Services, and National Guard Bureau to monitor and ensure standardization, where appropriate, of implementation.

Appendix A

Glossary

Child Abuse: Defined in DoDI 6400.01.

Collaboration: Exchanging information, altering activities, sharing resources, and enhancing each other's capacity for mutual benefit and a common purpose in accordance with law and DoD regulations.

Credential: A process for verifying preparation, additional training, and/or prior work experiences of prevention human resources by the awarding of either a certificate or certification.

Continuous Evaluation: Routinely analyzing information and data to determine if prevention activities are changing the factors they were designed to address. This includes evaluation of activities and program outputs as well as evaluation of program outcomes.

Data-driven Actions: Defined in DoDI 6400.09.

Discriminatory Harassment: Defined in DoDI 1020.03.

Domestic Abuse: Defined in DoDI 6400.06.

Evaluation: The use of systematic methods to collect, analyze and use information to inform implementation of a policy, program, practice, or processes.

Evidence-Based: Effective policies, programs, practices, or processes that are evidence-based are found to be effective based on research evidence, reflecting significant expertise and investment.

Fidelity: Refers to delivering the approach competently and as it was originally designed.

Harassment (Service Member): Defined in DoDI 1020.03.

Harassment (Civilian): Defined in DoDI 1020.04.

Harmful Behaviors: Self-directed harm and prohibited abuse and harm, including sexual assault, harassment, retaliation, suicide, domestic abuse, and child abuse.

High Risk Groups or Subpopulations: Defined in DoDI 6400.09.

Integrated Primary Prevention: Defined in DoDI 6400.09.

Military Community: Defined in DoDI 6400.09.

Military Leaders: Defined in DoDI 6400.09.

Outcome Evaluation: A systematic process for collecting information to determine the degree to which, if at all, a policy, program, or practice is affecting the intended target population(s) and whether or not program improvements are needed to achieve intended outcomes.

Practice: Discrete behavior or action contributing to prevention.

Prevalence: Defined in DoDI 6400.09.

Prevention Activities: Defined in DoDI 6400.09.

Prevention Workforce: A subset of prevention personnel whose official duties (to include collateral and additional duties) involve prevention of self-directed harm and prohibited abusive or harmful acts and who attain and sustain prevention-specific knowledge and skills (e.g., chaplains, suicide prevention program managers, command climate specialists).

Primary Prevention: Defined in DoDI 6400.09.

Prevention Process: Empirically validated procedures that promote effective planning, implementation, and evaluation of prevention activities (Figure 4).

Program: Curriculum or manualized set of activities and information intended for cognitive learning and skill development.

Protective Factors: Defined in DoDI 6400.09.

Public Health Surveillance Methods: The ongoing, systematic collection, analysis, and interpretation of health-related data essential to planning, implementation, and evaluation of public health practice.

Research-based Prevention Activities: Defined in DoDI 6400.09.

Risk Factors: Defined in DoDI 6400.09.

Sexual Assault: Defined in DoDI 6495.02, Volume 1.

Self-directed harm: Defined in DoDI 6400.09.

Selected Primary Prevention: Takes place BEFORE violence initially occurs. It involves programs and strategies designed to reduce the factors that put people at risk for experiencing violence. Or, they encourage the factors that protect or buffer people from violence. Prevention efforts focused on those individuals or groups that show one or more risk factors for violence.

Sexual Harassment: Defined in DoDI 1020.03.

Sexual Minority: A group whose sexual identity, orientation or practices differ from the majority of the surrounding society. Primarily used to refer to lesbian, gay, bisexual, or non-heterosexual individuals.

Social Determinants of Health: Conditions in the environments in which people are born, live, learn, work, play, and worship that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social Ecological Model: The social ecological model understands health and well-being to be affected by the interaction between the individual, interpersonal, and organizational factors.

Stalking: Defined in DoDI 1020.03.

Suicide: Defined in DoDI 6490.16.

Toxic leadership: An individual's perception that their leader has a disregard for subordinate input, defiance of logic or predictability, and self-promoting tendencies. "Toxic Leadership" behavior includes demeaning/marginalizing, degrading, coercion, deception, and angry/acts of aggression.

Universal Primary Prevention: Primary prevention activities are directed at the general population and attempt to stop maltreatment before it occurs. All members of the community have access to and may benefit from these services. Primary prevention activities with a

universal focus seek to raise the awareness of the general public, service providers, and decision-makers about the scope and problems.