Phase I Findings from the Cabana Suicide Prevention Innovation Pilot

Feasibility, Engagement, and Evidence-Generation Implications

December 2025

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Program Context:

U.S. Department of Veterans Affairs
Suicide Prevention Innovation
Broad Agency Announcement (BAA): 36C10X24R0053

This document distills findings from the Phase I Final Report and independent Phase I Evaluation prepared under VA Suicide Prevention Innovation BAA 36C10X24R0053.

How to Use This Report

This report summarizes key findings and implications from Phase I of the Cabana Suicide Prevention Innovation Pilot, supporting review of what was achieved, what was demonstrated, and which questions are appropriate to examine in subsequent phases. It does not replace the Phase I Final Report or the independent Phase I Evaluation, but distills core operational, engagement, and measurement findings relevant to program readiness, evaluability, and alignment with prevention- and stepped-care–oriented behavioral health strategy.

Key Findings

- **Phase I confirmed that Cabana can operate as a stable, scalable service**—not merely a pilot or prototype—delivering live, professionally moderated peer support consistently in real-world conditions and on an accelerated timeline.
- **Engagement data demonstrated different patterns of use**, supporting feasibility as an ongoing support resource as well as a one-time intervention.
- **Early-engagement support was delivered without increasing clinical workload**, a critical consideration given persistent behavioral health workforce constraints.
- **The model successfully reached military-connected and Veteran users with elevated anxiety and depressive symptoms**, indicating engagement beyond low-risk or "worried well" populations.
- **Validated mental health measures (PHQ-9 and GAD-7) were collected voluntarily within a non-clinical platform**, demonstrating that meaningful measurement can occur without clinical intake, diagnosis, or staffing.
- **Phase I established the feasibility of segmenting users by level of need** using platform and partner data, a prerequisite for evaluating appropriate triage and escalation to clinical services.
- **The pilot generated high-integrity engagement and assessment data** suitable for longitudinal analysis and quasi-experimental comparison in Phase II.
- **Integration with Veteran Service Organizations and external datasets positions the program to examine outcomes and utilization patterns** relative to comparable non-participants.
- **Cabana's group-based, professionally moderated structure presents a materially different cost profile from 1:1 therapy**, establishing a credible foundation for stepped-care and cost-avoidance analysis.
- **Collectively, Phase I findings support a plausible and testable theory of change**: that timely, lower-intensity engagement may reduce reliance on higher-cost clinical services while improving continuity of support.

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1. Purpose and Scope of Phase I

Phase I of the Cabana Suicide Prevention Innovation Pilot was designed to assess the feasibility, operational performance, and evaluability of a virtual, peer-based mental health support model operating alongside existing behavioral health systems.

The phase was not intended to determine clinical efficacy, cost savings, or population-level impact. Rather, its purpose was to establish whether the model could be deployed reliably at scale, engage individuals with policy-relevant mental health needs, generate usable data, and support future analyses relevant to outcomes, value, and cost avoidance.

Accordingly, Phase I focused on questions central to responsible program expansion:

- Can the model operate consistently and safely in real-world conditions?
- Does it engage populations for whom early intervention is policy-relevant?
- Can it produce data suitable for rigorous longitudinal and economic analysis?
- Does the model align with stepped-care and prevention-oriented frameworks increasingly emphasized in federal behavioral health strategy?

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2. The Intervention Model Under Evaluation

Cabana delivers live, professionally moderated peer support groups through a virtual platform, complemented by lightweight self-guided tools such as mood check-ins, guided journaling, and psychoeducation content.

Key features of the model include:

- Open access without diagnosis, referral, or waitlists
- Non-clinical positioning intended to reduce stigma and access barriers
- Professional moderation to ensure safety and fidelity
- Design intent to support individuals whose needs fall below, between, or adjacent to traditional 1:1 clinical care

The model is explicitly structured as a lower-intensity intervention within a broader continuum of mental health support, consistent with stepped-care and prevention paradigms.

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3. What Phase I Demonstrated

3.1 Operational Feasibility and Service Delivery

Phase I demonstrated that Cabana can function as a stable, repeatable service rather than a time-limited pilot artifact. The platform supported ongoing live group sessions, consistent moderation standards, and integration with Veteran Service Organization workflows.

This was achieved without reliance on clinical staffing or diagnostic intake processes, supporting the model's feasibility as a scalable complement to existing behavioral health systems.

3.2 Engagement and Reach

Engagement data indicate utilization across live group sessions and asynchronous tools. Participation patterns, coupled with user satisfaction ratings, suggest the potential for impact across repeat use and low-engagement users, an important threshold for early-engagement interventions.

While Phase I was not designed to maximize reach nor assess impact, observed engagement levels are suggestive of the model's viability as both a persistent support resource and a temporary intervention.

3.3 Reach into Populations with Meaningful Mental Health Need

Analysis of voluntarily completed PHQ-9 and GAD-7 measures indicates that military-connected and Veteran users exhibited higher average symptom scores than the general Cabana user population.

These distributions are directionally consistent with established literature on mental health burden among military-connected populations. Although Phase I was not powered to assess symptom change over time, the findings indicate engagement with individuals experiencing clinically relevant anxiety and depressive symptoms rather than exclusive use by low-risk users.

This distinction is central to the policy relevance of early-engagement and prevention-oriented models.

3.4 Measurement Feasibility Without Clinical Burden

Phase I established that validated mental health measures can be embedded within a non-clinical platform without materially degrading engagement.

Users completed PHQ-9 and GAD-7 instruments without the presence of clinical staff and without reframing the platform as a treatment modality. Data quality and score distributions were consistent with expected patterns.

This capability is critical for future outcome evaluation and cost analysis, as it enables measurement at scale without drawing on constrained clinical resources.

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4. Signals Toward Impact, Value, and Cost Avoidance

Phase I was not designed to estimate cost savings or return on investment. However, several directional signals emerged that inform hypotheses for Phase II.

Segmentation and Appropriateness of Care

Engagement and screening data support segmentation of users by level of mental health need, a necessary condition for evaluating stepped-care models and appropriate triage.

Unit Economics of Support Delivery

The model's group-based structure materially alters the unit economics of support delivery. By design, Cabana provides professionally moderated support at a substantially lower per-participant cost than 1:1 clinical care, particularly for individuals whose needs may not warrant therapy-level intervention.

Pathway to Comparative and Utilization Analysis

Integration with VSO data and external longitudinal datasets creates a credible pathway for quasi-experimental comparisons between Cabana users and non-users with similar profiles. This enables future analyses of utilization patterns, escalation to clinical care, and potential cost avoidance.

Taken together, Phase I supports a plausible and testable theory of change: that timely, lower-intensity engagement may reduce reliance on higher-cost services while improving continuity of support.

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5. What Phase I Did Not Attempt to Answer

It is important to distinguish demonstrated findings from questions intentionally deferred to subsequent phases.

Phase I did not:

- Establish causal clinical outcomes
- Measure reductions in suicide attempts or ideation
- Quantify health care utilization changes
- Produce definitive cost savings estimates
- Evaluate long-term durability of effects

These boundaries reflect appropriate phase-specific design choices rather than limitations in execution.

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6. Implications for Phase II and Program Scale

Phase I findings support progression to a second phase focused on longitudinal outcomes, segmentation, and economic analysis.

Specifically, Phase I demonstrates that:

- The intervention can be delivered reliably at scale
- It engages policy-relevant populations
- Measurement infrastructure is in place
- Data sources can be linked to support more advanced analyses

Phase II is therefore positioned to move from feasibility to decision-relevant evidence aligned with prevention strategy, stepped-care optimization, and cost containment.

Summary

Phase I establishes Cabana as a viable early-engagement mental health intervention capable of operating at scale, engaging individuals with meaningful need, and generating the data required for responsible evaluation of impact and value.

The results do not yet answer whether the model should be scaled broadly. They do demonstrate that it is appropriate — and necessary — to ask that question in Phase II.

Related Documentation

- *Cabana VA Pilot – Phase I Final Report, Anonymous Peer Support Groups for Veterans,* Reporting Period: 1 June 2025 – 1 December 2025. Cabana (Even Health, LLC).
- Richardson, C. B., Cantor, G., & Perkins, D. F. (2025). *Cabana Program Feasibility Study – Phase I evaluation brief.* Clearinghouse for Military Family Readiness at Penn State.