Promoting the Resilience of Military Children through Effective Programs
Highlights of CNA’s Second Conference on Military Children and Families

How science can help us develop programs and policies that work

Why we convened

On November 29 and 30, 2012, CNA honored National Military Family Appreciation Month by holding a conference in Washington, D.C. titled “Promoting the Resilience of Military Children through Effective Programs.” The conference provided a two-day forum for leaders from the scientific and service communities to advance the goal of helping military children and their families cope with the psychological effects of deployment.

In the last few years, President Barack Obama, First Lady Michelle Obama, Second Lady Jill Biden, and the United States Congress have called attention to this goal through public campaigns and legislation, yet the CNA Center for Research on Military Children and Families has found a fragmented state of knowledge and practice. The scientific investigation of child development has largely ignored the special case of military-connected children, and discussions of military children’s health and well-being have reflected this omission. Nevertheless, we believe that what we know about children generally can inform programs specifically aimed at military children.

Developing and implementing programs that meet the varied circumstances and developmental needs of military children is resource intensive and, increasingly, government agencies and private funders will want to see evidence that programs work. The science of program evaluation can provide this evidence of program effectiveness as well as help develop research-based programs, implement them as intended, and adapt them for specific populations. There may be less funding available in the future and more stringent standards for obtaining it, but sound evaluation can help build programs that use resources more efficiently and that enhance resilience more effectively.

To facilitate the use of science-based program evaluation in developing and improving programming for military children, the CNA conference brought together program funders, developers, evaluators, and users. This brief describes the robust discussions during the conference and highlights key messages about how to promote resilience in military children through effective programs and policies.

Setting the wheels in motion

CNA’s 2011 “Workshop for the Scientific Study of Military Children” took an important first step toward bridging the worlds of knowledge creation and service provision. The workshop taught us that anxiety and stress take a special toll on military children and that resilience is key to meeting those challenges effectively. During the workshop, we produced a roadmap for the integration of basic research, public policy, program development, and program evaluation. In 2012, that roadmap led us to the November 2012 conference, bringing together academic and clinical researchers, leaders of federal funding agencies, and not-for-profit program developers and evaluators. The conference focused on the developmental na-
ture of resilience and how it can nurtured through well-informed and well-designed programs for military-connected children and their families.

Appreciating the military family context

During the last 10 years, the men and women of the United States military have fought two wars. This has been the longest sustained military engagement in our nation’s history, and an all-volunteer force has led it. One war has ended and the other is drawing down, but for the troops who served and for their families, “there is no peace dividend” (Kathryn Roth-Douquet, Blue Star Families). Their lives are marked by the distinction and the particular, private burdens of their service.

Today’s service members are older, more often married, and more often parents than in the recent past. They are also more likely to deploy multiple times, and to return to civilian communities, instead of military bases. The families of today’s armed forces are also unique. When service members deploy for foreign conflicts, spouses and children experience a unique form of separation. Although technology enables some degree of communication, children of all ages face attachment challenges with their military parents. These challenges may persist and even intensify when parents return, when they return injured, and when they do not return. Military children face unique hardships and developmental opportunities before, during, and after deployments, geographical moves, and other experiences related to their parents’ active duty.

This decade has witnessed the proliferation of programs aimed at helping families cope with the stresses of military life. Some of these programs reach children directly, while others reach them through their families, schools, or communities. Some have been developed specifically for military children and others have been adapted from programs for civilian children. Importantly, not all programs that support the mental health and well-being of military children are specifically designed to promote resilience. The CNA conference in November 2012 highlighted several different types of programs for military children and focused on what these types of programs can teach us about developing and evaluating new programs that promote resilience. One key lesson learned from the conference was the importance of gaining a substantial understanding of the characteristics of program participants when designing effective programs for them.

Who are military children?

There are four million children currently connected with the United States military. Half of them have one or more parents on active duty and the rest have parents who are veterans of the last decade’s wars. Most military-connected children are very young; only one in five is a teenager. There are military children living in nearly every zip code in the country, and these children usually attend public schools in civilian communities. Military connected children move around a lot. Their sense of belonging to the military community varies widely; a second-grader whose parent is in the Army, or who has always attended a school on or near a military installation, may feel a greater sense of belonging to the military community than a high school junior with a Reservist parent living in a community with no visible military presence. Military children may not know they have the ability to connect with other people their age who have similar life experiences, and their parents may not understand the importance of developing these connections.
Parents are not the only primary caregivers in many military children’s lives. Military children today are more likely than in the past to have a mother or both parents in the service. They often live with grandparents during periods of parental deployment and rely on older siblings and other extended family for care. The structure of caregiving roles influences how attachments form and are sustained between parents and children. As Sarah Friedman (CNA Center for Research on Military Children and Families) pointed out, most programs for military children reach them through their families, thus, child development researchers and program evaluators must account for the array of caregiving scenarios that define the home lives of military children—whether temporarily, intermittently, or all the time.

Military children start life with some advantages. They are more likely than their civilian counterparts to have parents with at least a high school education, a job, comprehensive healthcare, and access to high-quality childcare (Cathy Flynn and Yuko Whitestone, Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy). Nevertheless, as military children grow up, they are also more likely to have higher rates of stress, lower academic achievement, and problems in social functioning (Barbara Thompson, Office of the Secretary of Defense—Family Policy, Children and Youth). Findings from the Providence and Boston Cohorts of the National Collaborative Perinatal Project paint a similar picture. Recent analyses of children born between 1959 and 1973 show that by the time the children of military families reached mid-adulthood, they were less likely than their non-military counterparts to have graduated from high school, less likely to be married, and more likely to suffer from anxiety or depression (Stephen Buka, Brown University).

What is resilience?

An evolving concept

While many people feel they can identify resilience when they see it (Douglas Coatsworth, Pennsylvania State University), scientists have developed conceptual models of resilience and conducted research to test their hypotheses about resilience and its manifestations. Over the last 30 years, scientific concepts of resilience have evolved. Scientists have moved away from understanding resilience as a personal quality—something an individual “is”—toward defining it as a complex set of skills and dispositions that help or hinder an individual’s ability to tap personal and community resources. There are several conceptual models of resilience. The compensatory model posits that a person’s resources and resourcefulness (her “cumulative assets”) can offset the threats to her adaptation and development (“cumulative risks”). The protection model asserts that adverse experiences can trigger or enhance an individual’s adaptive ability. The challenge model argues that up to a point, experiencing adversity can help people become more competent, but beyond that apex, adversity exerts a negative pull. Each of these theories allows that resilience may increase or decrease over time and may take different forms in different areas of a person’s life. The theories share a focus on identifying positive and developmentally appropriate outcomes and developing consistent measures to evaluate resilience. In the meantime, however, researchers are already developing programs they hope will both build and illuminate resilience.

Child, family, and community correlates that are associated with resilience

Coatsworth and his contemporaries have found resilience to be linked to characteristics of the child and her environment, including her family, school, and community. Children’s sociability, cognitive and problem-solving skills, self-esteem, hopefulness, and good humor are
associated with more successful functioning even under conditions that are not favorable to optimal child development. At the same time, children who live in safe, strong, cohesive communities with good schools, jobs, and public health tend to exhibit greater resilience during times of adversity. Resilience is also associated with a supportive home environment characterized by close, positive, clear, collaborative, and harmonious relationships; flexible, connected, and resourceful organizational patterns; and belief systems that make meaning of adversity.

From a statistical standpoint, these personal, family, and community characteristics are linked to resilience, but they do not serve as proxies for it; they may affect children’s ability to navigate challenges, but they cannot predict an individual child’s resilience. Accurate prediction demands a greater level of specificity than we currently have: it requires isolating different areas of functioning and modeling their interactions with specific social, environmental, and community conditions. Further, resilience does not manifest itself evenly across circumstances. For example, a child may perform well in school during a parent’s deployment, but at the same time exhibit signs of suppressed social functioning. Furthermore, timing matters. An instance of effective adaptation may be specific to a certain time period in a child’s life. Resilience may be evidenced during a month, or a year, or a decade, and may depend on a child’s age, the type of adversity she encounters, and other conditions. The intensity of adaptive processes is also likely to ebb and flow over time. As such, while we know in general terms about the child, family, and community characteristics associated with resilience, there is much to learn about the conditions that promote the resilience of specific individuals in specific conditions of adversity.

An ordinary phenomenon

The children we admire for their resilience are not “superkids” (Tuppett Yates, University of California at Riverside). They are ordinary children who, when faced with extraordinary circumstances, have the personal and environmental resources to do well. To promote resilience in military children, we need to cultivate their well-being from birth onwards through programs that support them directly as well as indirectly through their families and communities. We must look for the keys to healthy human development that enable children—and all people—to meet the challenges and avoid the pitfalls of ordinary and extraordinary experience.

What kinds of programs serve military children?

Resilience can be promoted through programs that serve military connected children directly or through their families, schools, or other community institutions. A host of existing national, state, and local programs aim at supporting military children by promoting resilience or meeting other related needs. The November 2012 conference provided a general description of the types of programs that are currently available to military children, as well as some specific examples of these programs.

Department of Defense programs

Because 37 percent of military children are under the age of 6, many Department of Defense (DoD) programs promoting early childhood health and well-being target the parents of young children (Flynn and Whitestone, Office of Deputy Assistant Secretary of Defense for Military Community and Family Policy). These programs focus on providing high-quality childcare (Department of Defense Development System) and preventing child abuse and ne-
glect (New Parent Support Program). Programs for the 35 percent of military children who are ages 6 to 12 largely reach children who live on or near military installations through instructional, sports, and recreational programs. The DoD also partners with the Boys & Girls Clubs of America, the U.S. Department of Justice’s youth mentoring program, and 4-H Clubs to provide youth development opportunities for military children that are widely available—and easily transported—across the country.

Some DoD programs, such as Child and Youth Behavioral Military Family Life Counselor, provide face-to-face counseling to military children and families at schools within and outside the continental United States. While this program prepares families for the challenges and risks of a military lifestyle, another program, Military OneSource, provides more generalized support services to all military-connected individuals in person, by phone, and online. These support services include information and resources, non-medical counseling referrals, health and wellness coaching, and translation services. This multi-platform service reflects a trend toward leveraging technology to connect military children and families to support resources. Military Youth on the Move and Military Kids Connect are two websites aimed at creating social support networks for military children that are not limited by geography.

School-based peer mentoring

Having served 18,000 young people, the Military Children Education Coalition’s Student 2 Student program is one well-established program that addresses integration into the school community, a key condition of resilience. The Student 2 Student and Junior Student 2 Student programs support high school and middle school students, respectively, as they transition into new schools (Mary Keller, Military Child Education Coalition). These programs train student volunteers to work with relocated students of military families during the first two weeks after their arrival at a new school. Students’ experiences during these initial weeks—which often do not coincide with the beginning of the school year—can greatly influence their social and academic performance going forward.

As described by two student volunteers in a panel session during the November 2012 conference, the Student 2 Student peer network helps incoming students find their way in the school’s academic, extracurricular, and social communities. One volunteer described connecting a military student with a member of the cheerleading squad. Although the new student had missed tryouts, the volunteer arranged a special audition for her, and she was able to join the squad. The Student 2 Student program engages faculty as well. As mentors for the student volunteers, teachers and guidance counselors help build a school culture of student leadership, peer assistance, and universal acceptance.

Family-based peer mentoring

Nearly half of military families have dependent children, many of whom are not yet school age. Focusing on family-based support is consistent with research on resilience-promoting interventions, and supporting children in a family context may be appropriate for military children of all ages. The Tragedy Assistance Program for Survivors (TAPS) exemplifies this family-based approach to support. Like Student 2 Student, TAPS connects military children and families who have lost loved ones with a peer support network. In the TAPS program, these peers are other surviving military spouses and children, as well as surviving extended family, significant others, and friends. Once it has been two years since their own loss, survivors are invited to become mentors. They are connected with individuals who have expe-
rienced a similar loss. For example, a father who lost a son to suicide would support a newly bereaved father who also lost a son to suicide. The program makes extensive use of electronic communication to train mentors and connect well-matched survivors, regardless of geography.

Promoting program participation and overcoming barriers

According to Paula Rauch (Massachusetts General Hospital), programs like TAPS and Staying Strong do a good job of addressing the complexity of military children’s experiences and the diversity of these children’s needs. Staying Strong, a part of the Red Sox Foundation and Massachusetts General Hospital Home Base Program, provides educational resources for parents in military-connected families to help these parents assess whether they need to seek help for their service member, children, or themselves. Conditions like post-traumatic stress disorder (PTSD) in returning service members may be especially difficult for adults to recognize and for children to understand.

These “invisible injuries” may complicate family dynamics and impede reintegration, even when the veteran is receiving clinical care. Too often, however, mental health conditions go untreated. Sometimes this is due to the conditions’ delayed onset, but more commonly, people suffering from treatable mental health conditions do not seek help. One in five returning service members suffers from moderate to severe anxiety or depression and 80 percent of them know they have a serious problem and want help. Yet most people who want help for psychological distress do not seek it because they believe doing so will make them appear weak and damage their career (Charles Engel, Defense Centers of Excellence). The stigma associated with mental health conditions is not unique to the military context, but is particularly prevalent in the Armed Forces, which is 85 percent male and places a large emphasis on individuals’ physical and mental strength.

To support the families of service members suffering from anxiety, depression, and PTSD, programs serving them need to recognize the “cognitive distortion” that trauma can engender, which exacerbates feelings of isolation and leads sufferers to turn away from opportunities for care. Fortunately, however, some simple strategies have been found to be effective in combating these challenges: follow-up calls can build a critical continuity of care, as can the “genuineness” of the care being offered.

How do we know what works?

In an ideal world, we would be able to apply standard metrics to any program or service to determine whether, for whom, and how it works. And in fact, we know quite a bit about the principles of scientific evaluation. We know, for example, that it is best to compare outcomes among people who participate in a program or receive a service with people who do not, but who are otherwise comparable to the participating individuals. If people participating in a program are, for example, more educated, more geographically concentrated, or more motivated than the comparison group, these characteristics could make the program seem more effective than it really is. As such, in evaluating program effectiveness, it is vital to focus on equivalent comparison groups. One way to achieve this is through randomization.

Isolating the intervention – random assignment

Random assignment to comparison groups is one way to eliminate the possibility that outcomes result from pre-existing differences between the two groups rather than from the
program or service (or, intervention) being evaluated. Studies that randomly assign people who are eligible for a program or service to an intervention (“treatment”) or comparison (“control”) group are called randomized controlled trials (RCTs) and are considered by organizations as diverse as the Institute of Education Sciences, the National Academy of Sciences, the Congressional Budget Office, the U.S. Preventive Services Task Force, and the Food and Drug Administration to embody the “gold standard” of evaluation methodology (Jon Baron, Coalition for Evidence-Based Policy). RCTs allow us to establish unbiased, experimental conditions for testing a program’s effectiveness. As such, they are suitable for use in cost-benefit analysis, and can be employed prospectively to inform policy (Peter Schochet, Mathematica Policy Research).

Generalizing results – random selection

Although they generally yield highly valid data, RCTs are not always feasible, timely, or appropriate for all program evaluations. They are often costly and may take years to complete. In the case of entitlement programs or programs with too few participants, limiting participation for the sake of research can be unethical. Furthermore, even when we use RCTs to evaluate programs, they cannot tell us everything we want and need to know. For example, an RCT cannot tell us whether an intervention will work in a population different from the study population—whether results are “generalizable”—unless the study participants are representative of the larger population. The only way to guarantee representativeness is to randomly select study participants from the larger population of interest; however, this is often not feasible. Consequently, results from experiments with random selection offer limited insight to policymakers who want evidence that a program will work in their own state, or to program developers wondering whether success with early adolescents can be replicated among older adolescents.

Rebecca Maynard (University of Pennsylvania) and other conference participants urged researchers to promote the use of RCTs by making them less expensive and more relevant through a phased rollout and pragmatic discussions with stakeholders. For example, a school district might pilot a new science curriculum by first implementing it in a few schools, and subsequently randomly assigning the curriculum to more schools in stages. Schools assigned to the control condition would continue to work with the existing approved science curriculum; thus, if the district finds that the new curriculum does not compare favorably with the existing curriculum, the district will have conserved resources by not implementing the new curriculum in all schools before studying its effectiveness.

Other ways of assessing what works

Experimental evaluation methods such as RCTs offer the most valid information possible regarding a program’s impact. Because even the most effective programs typically have only relatively small effects, we need a clear and sensitive lens to detect these effects and that lens is the RCT method. Nevertheless, when randomization is not possible or desirable, a range of non-random, “quasi-experimental” evaluation designs can provide some useful information. When choosing a quasi-experimental design, it is important to consider the strengths and weaknesses of that design. Quasi-experimental designs are more prone than experimental designs to misinterpret the reasons for an observed change and often lack the statistical strength to detect true change (Schochet). There are a number of quasi-experimental designs available, including interrupted time-series design, matched comparison groups, instrumental variables, and regression discontinuity.
Other questions evaluation can address

Even the most rigorous experimental and quasi-experimental designs can’t tell us why a program works, so if we want to know how to make effective programs more efficient, we need to turn to other evaluation methods (Peg Burchinal, University of North Carolina at Chapel Hill). Evaluation that unfolds in continuous cycles alongside program development and implementation—known as “formative” evaluation—can test a program’s logic model and provide critical insight into implementation issues. This type of evaluation can also avoid some of the common stumbling blocks of subsequent evaluation efforts, such as unrealistic assumptions about enrollment and participation. Early glimpses into program mechanisms can help us build more promising programs and learn more from later-stage evaluations such as comparative effectiveness research and meta-analysis.

In the health field, comparative effectiveness research (CER) attempts to collect and synthesize all available information pertaining to the benefits, risks, and harms of healthcare practices in order to provide timely and reliable information regarding health outcomes (Ann Doucette, The George Washington University). The audience for this kind of information includes patients, physicians, and policymakers, and the evidence reviewed includes clinical trials and published studies. Unlike most other approaches to evaluation, CER studies advocate for new studies to fill identified evidence gaps and actively assists stakeholders in interpreting and applying its findings.

Meta-analysis, which is used in CER, education, (Cay Bradley, Mathematica Policy Research), and other fields, capitalizes on statistical methods for evaluating evidence and seeks to learn more about what works, for whom, and why (Sandra Jo Wilson, Vanderbilt University). Pooling statistical parameters from multiple studies of a given intervention can help us understand the strength of the evidence pertaining to the intervention. Pooling and analyzing evidence from multiple programs that share features or program components can provide information about those components that are effective and those that are less so. Looking across studies that evaluate an intervention in different settings or populations can also provide clues about its generalizability. For example, if three RCTs show a program to be effective among middle- and high school-age students in the Midwest and three others show it to be ineffective among middle school-age students in the South, we might infer that some yet-to-be-determined characteristics that operate in the South are responsible for the failure of the program in that region.

Learning from programs that work

Developing an intervention model for broad adaptability

In developing programs for military children, we can learn much from existing civilian programs that use knowledge about how children thrive to counter environmental risks to their development. Legacy for Children™ is a program that aims to improve the lives of children born into poverty by teaching positive parenting strategies to their mothers. In keeping with the public health model of program development, developers sought to counteract the risk of poverty to young children’s academic, social, and behavioral development by boosting the protective factor of an effective parent-child relationship (Ruth Perou, Centers for Disease Control and Prevention). The program, which brought small groups of mothers together for weekly parenting education and community building, was implemented and tested among 600 mothers in Los Angeles and Miami during the first three-to-five years of their children’s
lives. At age two, children whose mothers were receiving the intervention showed improved social, emotional, and behavioral health compared to children in the control group; these effects diminished over time but persisted at least through age five. Children whose mothers were in the program also showed improved cognitive ability.

Because Legacy for Children™ was designed as a public health model that can be adapted to different populations while maintaining its core principles, developers are now working with Head Start and other parenting programs to adapt the model to suit their unique program infrastructure and populations, such as Spanish-speaking communities, Tribal communities, and military communities. In its second phase of investigation, the Legacy for Children™ study, through a contract to CNA (Sarah L. Friedman, Principal Investigator), is tracing the program’s effects when the study children are in third grade.

Adapting prevention principles for programs targeting military children

Preventive health services for children need to capitalize on opportunities presented by the dynamic, interactive nature of family problem solving. Children’s problem-solving abilities evolve over time, as do the way military families make sense of deployments (William Beardslee, Boston Children’s Hospital, Harvard Medical School). While programs for all children would do well to recognize that families carry unique cultural and developmental perspectives, programs for military children need to be particularly sensitive to how cultural perspectives may vary among different branches of the military and during different stages of children’s deployment.

Helping younger children post-deployment

Deployment is a stressor for all military families. When a parent is deployed, many children experience behavioral problems, sleep difficulties, anxiety, and depression. Children of deployed parents are also twice as likely to suffer neglect (Ruth Paris, Boston University). National Guard and Reserve troops returning from deployment show higher levels of PTSD, drug use, and other combat-related adjustment problems than other active duty personnel (Abigail Gewirtz, University of Minnesota). Several programs have shown promising results for military families with babies, toddlers, and elementary school-age children. Strong Families Strong Forces and After Deployment: Adaptive Parenting Tools (ADAPT) are two programs that cater to families in the National Guard and Reserves, while “Talk, Listen, Connect”: Sesame Workshop Kits for Military Families with Young Children serves families in any branch of the military.

Strong Families Strong Forces and ADAPT help service members from the National Guard and Reserves manage their post-deployment stress by supporting their successful reintegration into their family units. Strong Families Strong Forces is a home-based reintegration program for families with children from infancy through age five (Paris). It promotes successful family functioning through eight modules on parenting, co-parenting, and the parent-child relationship. Preliminary findings from an impact evaluation among 116 families point to improvements in parent mental health, parenting stress, and parenting attitudes. The program evaluation relies on a community-based, participatory research model, which maximizes the program’s relevance, feasibility, and long-term sustainability.

The ADAPT program builds on a specific model of positive parenting that has been shown to be effective in moderating the effects of family stress on children’s adjustment. The 14-week, web-enhanced, group-based program attends to military values and addresses com-
mon barriers to participation among families of returning National Guard and Reserves troops who have children ages 5 to 10. Its emphasis is on creating a united parenting front. Early results of an evaluation study indicate that ADAPT has improved parents’ marital adjustment, disciplinary practices with their children, and confidence in their parenting skills.

“Talk, Listen, Connect” is a set of four video-based workshop kits featuring Sesame Street characters for military families with children ages two through eight. Each kit is customized for families who are experiencing different stages and consequences of deployment, including multiple deployments, physical and psychological injuries, and bereavement (Shelly MacDermid Wadsworth, Purdue University). Four separate evaluation studies, one for each kit, measured caregiver and child assessments of the materials and parents’ perceptions of their impact. Unlike the control kits, the test kits explicitly incorporate the four parental “building blocks of children’s resilience”: (1) acknowledging children’s needs for comfort, protection, and exploration; (2) conveying a sense of security and confidence; (3) combining love and support with clear standards and firm control; and (4) modeling effective coping. Prior to and after viewing the “wounds and injuries” kit, caregivers reported on their own feelings of social isolation, depression, responsiveness to their children, and ability to help their children cope with the experience of having an injured military parent, as well as their perceptions of their children’s feelings of emotional security, social competence, aggression, and anxiety. The evaluation revealed that families who were exposed to the test and control kits found them very appealing and used them extensively. Caregivers reported that both test and control kits helped alleviate their feelings of social isolation and depression, but only the Sesame Street Workshop kit improved their children’s social competence, reduced aggressive behaviors, and helped children cope with their family member’s injury.

Helping younger and older children across the deployment cycle

Perhaps one of the most widely used programs to promote the resilience of military children and families is the Families Overcoming Under Stress (Project FOCUS) program. It provides resilience training for families with preschool-age to teenage children before, during, and after deployment. Primarily serving the Navy and Marines, and more recently targeting Army and Air Force families, Project FOCUS provides a suite of services modeled on the Institute of Medicine’s public health continuum of health prevention strategies. Through web-based and in-person components at 22 military installations, the program offers community group briefings, workshops, consultations, skill building groups, and family consultations, as well as multi-session family resiliency training. Children participating in the intervention reported increased use of positive coping strategies, such as problem solving and emotional regulation, and participating parents said their children had fewer behavior problems, more pro-social behaviors, and less anxiety and depression. Parents also reported experiencing fewer symptoms of anxiety and depression themselves, and reported that, as a family, they felt the program helped them improve their problem solving, communication, and behavior (Patricia Lester, University of California at Los Angeles). The program is set to undergo rigorous evaluation (Kirstin Woodward, BUMED).

Bringing knowledge and policy together to build programs that work

The November 2012 conference taught us much about resilience, how to promote it through well-designed programs for military and civilian children and families, and how to use rigorous methods to evaluate the effectiveness of such programs. However, understanding how to evaluate the effectiveness of programs is only half the battle and such program evalu-
tions must be adequately funded. As our nation transitions out of a decade of war, and the next decade promises a billion dollar reduction in defense funding, our work has just begun (Robert Gordon III, APX Labs). Scientists, program developers, policymakers, and parents need to rise to the challenge of doing more program evaluation with fewer resources. Our first order of business is recognizing existing resources and using them in the best way possible for the benefit of military children and families.

In addition, not only must studies be conducted, their results must be put to effective use (Stephen Buka, Brown University). Applying what we’ve learned from program evaluations to public policy involves not only addressing the question of whether a certain program worked, but also an evaluation of the program’s potential importance and immediate relevance for stakeholders (Woodie Kessel, Dartmouth College and Medical School; Valerie Maholmes, The Eunice Kennedy Shriver National Institute of Child Health and Human Development). Importantly, for many military families, a “75 percent solution today” may mean more than a “100 percent solution three years from now” (Roth-Douquet). Scientific evidence can help policymakers and program designers use resources wisely to build programs that reach a broad range of military children and families and effectively promote resilience. Nevertheless, “until the evidence base is built,” we need to serve people now based on the existing scientific information that has accumulated over several decades (Friedman). This can be accomplished through the mobilization of policymakers, funding agencies, and individual scientists and practitioners who pursue the common cause of building children’s resilience in military and civilian communities.