



OFFICE OF THE UNDER SECRETARY OF DEFENSE
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PERSONNEL AND
READINESS

The Honorable Roger F. Wicker
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

MAY 21 2025

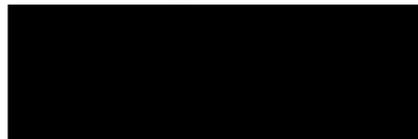
Dear Mr. Chairman:

The Department's response to section 578 of the John S. McCain National Defense Authorization Act for Fiscal Year 2019 (Public Law 115-232), "Pilot Program for Military Families: Prevention of Child Abuse and Training on Safe Childcare Practices," is enclosed. This is the final report as required by section 578(e)(2), and provides a summary of the pilot, findings from the pilot, and recommendations on the future utility of the selected model.

The Defense Health Agency and the Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy collaborated in a pilot to evaluate the effectiveness of the HealthySteps (HS) program implemented in select military medical treatment facilities. While the request for the pilot was to assess the impact of a specific prevention program on the incidence of child abuse and neglect (CAN), this was not feasible due to the small population, low base rate of CAN, and inability to reach statistical significance to determine program impact. Consequently, the Department executed the HS model to evaluate the implementation of prevention strategies within the military. Of the 16 outcomes evaluated, 5 had significant effects. Of those five, effect sizes were modest and may not represent clinically meaningful findings. Therefore, the HS model may not be ideal for implementation within the Department of Defense (DoD) for reducing rates of CAN. The DoD has several existing programs designed to address CAN as well as other prevention and clinical programs that provide support and resources to the target population.

Thank you for your continued strong support for our Service members and their families. I am sending a similar letter to the House Armed Services Committee.

Sincerely,



Jules W. Hurst III
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member



OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
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PERSONNEL AND
READINESS

The Honorable Mike D. Rogers
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

MAY 21 2025

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Sincerely,



Jules W. Hurst III
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

Report to the Committees on Armed Services of the Senate and the House of Representatives



Final Report on the Pilot Program for Military Families: Prevention of Child Abuse and Training on Safe Childcare Practices

May 2025

The estimated cost of this report or study for the Department of Defense is approximately \$2,610 in Fiscal Year 2024. This includes \$0 in expenses and \$2,610 in DoD labor.
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INTRODUCTION

This final report is in response to section 578 of the John S. McCain National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2019 (Public Law 115–232), “Pilot Program for Military Families: Prevention of Child Abuse and Training on Safe Childcare Practices,” which directed the Department of Defense (DoD) to implement a 2-year pilot that aims to “reduce child abuse and fatalities due to abuse or neglect in covered households.” The Secretary of Defense, acting through the Defense Health Agency (DHA), “shall carry out a pilot program to: provide information regarding safe childcare practices to covered households; identify and assess risk factors for child abuse in covered households; and facilitate connections between covered households and community resources.” Section 578 provided guidance on the design of the pilot, the required elements, the target population, and reporting requirements. An initial report,¹ signed August 28, 2019, describes the development and early execution of the pilot. This report is in response to section 578’s requirement to provide a final report at the conclusion of the pilot.

(e) REPORTS—...

(2) FINAL REPORT.—Not later than 180 days after the termination of the pilot program, the Secretary shall submit to the committees specified in paragraph

(1) a final report on the pilot program. The report shall include the following:

(A) A comprehensive description of, and findings of, the assessments under subsection (d).

(B) A comprehensive description and assessment of the pilot.

(C) Such recommendations for legislative or administrative action the Secretary determines appropriate, including whether to—

(i) extend the term of the pilot program;

(ii) expand the pilot program to additional installations; or

(iii) make the pilot program permanent.

PILOT SUMMARY

A pilot assessing the impact of a specific prevention program on the incidence of child abuse and neglect (CAN) was not feasible. As noted in Cuijpers,² determining the effects of a prevention program requires significant statistical power and a large sample population. With the relatively low base rates of reporting of CAN within the military, linking program causality would be extremely difficult. Therefore, DHA and the Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy (ODASD(MC&FP)) collaborated in a pilot using the HealthySteps (HS) model to evaluate the implementation of prevention strategies within the military. Specifically, this pilot assessed how the HS program improved child and parental outcomes, enhanced integration and utilization of existing family services available across disparate military support settings, and increased satisfaction and perceived support among military parents.

¹ <https://www.health.mil/Reference-Center/Congressional-Testimonies/2019/08/28/Prevention-of-Child-Abuse-and-Training-on-Safe-Childcare-Practices>.

² Cuijpers. 2003. Examining the effects of prevention programs on the incidence of new cases of mental disorder: the lack of statistical power. *American Journal of Psychiatry*; 160, 8.

Despite the multiple outreach efforts and enrollments into the pilot, engagement in the pilot services was extremely low. Additionally, this pilot was not able to evaluate the impact of a program on reducing CAN due to the low volume of participants and the low base-rate of CAN in the military. Therefore, the HS model may not be ideal for implementation within the DoD for reducing rates of CAN. The DoD has several existing programs designed to address CAN as well as other prevention and clinical programs that provide support and resources to the target population.

HS Program

The Office of the Assistant Secretary of Defense for Health Affairs, in collaboration with ODASD(MC&FP), launched the initial HS pilot program in December 2017 at two military medical treatment facilities (MTFs), Naval Medical Center San Diego at Naval Base San Diego, California and Madigan Army Medical Center at Joint Base Lewis McChord, Washington. The Department expanded the HS pilot at three additional sites to execute section 578 of NDAA for FY 2019.

The pilot leveraged the existing HS model,^{3,4} which was designed as an integrated pediatric primary care program offering proactive support to families in a non-stigmatizing, clinically accessible space. This civilian program interweaves the medical support of the pediatrician's office with the integrated assistance of a non-clinical child development counselor called a HS Specialist to ensure babies and toddlers receive nurturing parenting. The HS model is designed to identify child and family needs early, as well as provide educational resources and referrals to support services addressing developmental delays and improve age-appropriate parent-child interactions and child social-emotional development. The civilian HS model has demonstrated a reduction in severe physical discipline, emergency room utilization, and externalizing behaviors in young children, as well as increasing compliance with well-child visit and vaccination schedules and positive parenting behaviors (e.g., breast feeding, reading with infants).^{5,6}

The HS Specialist is part of the pediatric team and partners with families during well-child visits, coordinates needed screenings, and problem-solves with parents for common and complex challenges. HS Specialists are trained to provide tailored guidance and referrals, care coordination, and support families between visits. Consistent with the existing HS model, the role and credentials of a HS Specialists are flexible so each pediatric team can select the type of specialist that best fits the needs of the staff and families. The core components of the HS model offer a stepped approach to service provision within three tiers of care.

³ HealthySteps National Office, 2018, <https://www.healthysteps.org/who-we-are/the-healthysteps-national-office/>.

⁴ ZeroToThree, 2024,

https://www.zerotothree.org/?_gl=1*149b1bw*_ga*MTU2ODY1NTM5NS4xNzMyMTA3OTQ0*_ga_JGW29BDN22*MTczMjEwNzk0NC4xLjAuMTczMjEwNzk0NC42MC4wLjA.

⁵ Guyer, B., et al. (2003). HealthySteps: The first three years Women's and Children's Health Policy Center, Department of Population and Family Health Sciences, Johns Hopkins Bloomberg School of Public Health.

⁶ HealthySteps National Office. (2018). HealthySteps Implementation Guide. <https://www.healthysteps.org/get-started/become-a-healthysteps-site/implementation-process/>.

Tier 1 services include:

- Universal services to all families with children 0-3 years of age enrolled for healthcare at a participating pediatric clinic.
- Basic services to screen for children's social and emotional development, as well as for family needs identified as social determinants of health (SDOH) (e.g., food, housing, or transportation insecurity, parental mental health, or substance misuse).
- Parental access to a child development support line available. Finally, all clinic staff are trained in the integrated HS model and can share parenting educational handouts and resources available through the program with patient families.

Families identified through initial screening or pediatric consult with specific parenting issue(s) that can be resolved with short-term assistance are offered Tier 2 services. Tier 2 services include:

- One to two consultations with a HS Specialist to provide services as needed such as specific educational information, referrals to additional services and resources, or help with care coordination.
- Families offered Tier 2 services are also able to take advantage of all services available at Tier 1.

Following screening and initial consultation, families identified as most at risk who require more comprehensive services are offered Tier 3 support. Tier 3 services include:

- All the services available at Tiers 1 and 2 (e.g., screening, educational consultation, resource referrals, care coordination).
- Regular integrated participation of the HS Specialist with pediatric healthcare teams at all well-child visits.

Specific services that are offered at individual HS sites vary and can be tailored to complement existing community services. Common HS practices include the following elements: well-child pediatric visits to promote parent learning; child development check-ups to detect any risks or problems; written materials on parenting topics, such as discipline and nutrition; parent support groups; and submission of referrals for children and parents who need specialized medical care or other services.

Comprehensive Pilot Assessments

In alignment with the HS model, the DoD pilot was designed to implement the tiered model and provide broad support to new parents by offering educational information about child development and positive parenting, by assessing individual family needs (e.g., SDOH), and by providing targeted resources and services.

In accordance with section 578, oversight of the pilot was delegated to the Director, DHA in partnership with ODASD(MC&FP). Due to the coronavirus disease 2019 pandemic, the pilot ran from January 2022 through December 2023. Program assessments and the evaluation of

pilot program elements were executed by the Naval Health Research Center (NHRC), U.S. Navy, Bureau of Medicine and Surgery. Roles and responsibilities of the stakeholders included the following:

- DHA provided support to NHRC and ODASD(MC&FP), and facilitated access to the MTFs during the pilot.
- ODASD(MC&FP) provided oversight regarding the contract execution of the HS Specialists, as well as the training and ongoing supervision of HS Specialists.
- NHRC developed the study and was responsible for data collection and analysis. NHRC will also be publishing an article with the full findings of this pilot.

ODASD(MC&FP) utilized its existing Military and Family Life Counselors (MFLCs) Program personnel to fill the role of the HS Specialists at participating clinics. MFLCs were hired and trained in the HS model at the beginning of the pilot at all selected MTF pediatric clinics. An initial 2-day training in the HS model was provided by ZeroToThree.org (ZTT). The HS Institute offered in-person and virtual training options to pediatric clinic staff and the HS Specialists prior to implementing the HS program. MFLC supervisors received training certification to train subsequent hires. In addition to the HS Institute Training, ZTT required each pediatric clinic to:

- Conduct universal screening at check-in for the Well Baby/Child appointment, which includes a developmental, social-emotional/behavioral, autism, maternal depression, and family needs screening. The results of this screening must be shared with the HS Specialist.
- Fully embed and integrate HS Specialist into the clinic (not housed in an office outside of the clinic).
- Designate a pediatric champion to provide ongoing feedback to ODASD(MC&FP) and the HS Specialist.

This pilot executed all three tier levels of targeted care defined by the HS model. At Tier 1, the standard screenings used in DoD healthcare well-baby appointments were augmented to include screenings for child social emotional development and family needs. At Tier 1, the DoD program did not include a separate HS support line as part of this pilot, but rather used existing technology to facilitate communication between the family and HS Specialist in between visits. Tiers 2 and 3 targeted services were available to all eligible families. All pediatricians and other medical staff could refer eligible families to a HS Specialist for services either to address a specific issue at Tier 2 or for comprehensive Tier 3 services. Additionally, HS Specialists also offered Tier 3 services to all families with a newborn within 30 days of birth to comply with section 578.

In compliance with the final report requirements, the following sections summarize the comprehensive description and findings of the assessments under subsection (d) of section 578: comparison installations and program assessments.

Participating Installations

Pilot sites were selected in accordance with the requirements set forth in section 578 (see full section reference for details regarding site selection criteria). Changes were made following the initial selections due to some MTFs not being able to participate (e.g., low target population enrollment, low MTF engagement). The final list of pilot sites included:

- Fort Bragg and Pope Airfield, North Carolina – Joel Health Clinic/Womack Army Medical Center
- Joint Base Lewis-McChord, Washington – Madigan Army Medical Center
- Honolulu, Hawaii – Tripler Army Medical Center
- Naval Base Pearl Harbor, Hawaii – Naval Health Clinic Hawaii
- Marine Corps Base Hawaii – Kaneohe Bay Branch Health Clinic
- Maxwell Air Force Base, Alabama – 42nd Medical Group

Comparison sites were selected to implement treatment as usual. Five sites were initially identified that closely matched the characteristics of the proposed pilot sites. All initially selected comparison locations agreed to participate and launched on-site data collection. On-site recruitment was discontinued early in three locations because of the low numbers of eligible beneficiaries served by those clinics (Joint Base Charleston, Seymour Johnson Air Force Base, Fort Jackson). However, mail outreach to eligible beneficiaries served by those clinics continued throughout the baseline study enrollment period. Furthermore, several additional large comparison clinics were added to the evaluation through mail recruitment procedures to bolster comparison enrollment numbers (Walter Reed, Brooke, Martin, Portsmouth, Wilford Hall, Blanchfield). The final list of participating comparison sites include:

- Fort Cavazos , Texas – Carl R. Darnall Army Medical Center
- Camp Pendleton, California – Naval Hospital Camp Pendleton
- Joint Base Charleston, South Carolina – 628th Medical Group
- Seymour Johnson Air Force Base, South Carolina – 4th Medical Group
- Fort Jackson, South Carolina – Moncrief Army Health Clinic
- Bethesda, Maryland – Walter Reed National Military Medical Center
- Fort Sam Houston, Texas – Brooke Army Medical Center
- Fort Moore, Georgia – Martin Army Community Hospital
- Portsmouth, Virginia – Naval Medical Center Portsmouth
- Lackland, Air Force Base, Texas – Wilford Hall Medical Center 59th Medical Wing
- Fort Campbell, Tennessee – Blanchfield Army Community Hospital

Program Assessment

Program Contacts

When the pilot launched at each location, initial announcements about the availability of the HS program were sent, via email, to all beneficiary families with a baby or young child aged zero to three years enrolled for healthcare at a participating pilot clinic. These email

announcements included information about the availability and purpose of the HS pilot as well as instruction on how to contact their military pediatric clinic directly for more information or to enroll in services. A total of 10,544 emails were sent to eligible pilot-site beneficiaries to initiate the pilot period. MTF staff could also refer families who might benefit from the program following well-baby visits.

Covered Households Electing to Participate

HS Specialists enrolled approximately 52 percent of eligible families with newborns into the HS Pilot. On average, participating beneficiaries engaged in two HS sessions.

Participating Covered Households Connection to Services

The HS Specialists' case management tracker documented referrals for enrolled families. Families with newborns were offered a range of services relevant to their specific needs. Referral resources included developmental, childcare, counseling, deployment, financial, or food resources. Primary referral resources are listed in Appendix 1: Table 1. Over a 1-year period of HS Specialists' case management notes documentation, 1,837 families with newborns were enrolled in the HS pilot. Based on HS Specialists' documentation, almost all families (99 percent) received at least some educational information on a variety of topics relevant to child development or parenting consistent with section 578 identified education areas. Examples of educational information include, but are not limited to, infant nutrition, safe sleeping, parent stress, and available community resources. Of the total families with newborns documented as enrolled in the caseload records and that the HS Specialist recorded the tier level, 50 percent of newborn families enrolled were at Tier 3. On average, HS Specialists reported covering approximately six different topics ($M = 6.38$, $SD = 3.43$) across sessions with pilot eligible families. HS Specialists' documentation also indicated that almost all families (91 percent) were provided at least some referral resources. On average, HS Specialists reported making three different referrals for resources ($M = 2.82$, $SD = 1.83$) per enrolled family.

Participating Covered Households' Utilization of Referred Services

In order to meet this element, the pilot leveraged the existing New Parent Support Program (NPSP), a standardized secondary prevention program which falls under the authority of the Family Advocacy Program. The primary goal of NPSP is to enhance the lives of infants, toddlers, young children and parents; promote safety, health and well-being; and help families thrive by empowering parents with information to meet the challenges of parenthood while maintaining a military lifestyle. NPSP offers a variety of services, primarily through home visits, focused on parenting education and support. Topics include infant care, early child development, bonding with your baby, safe sleep environments, and how to keep your child healthy and safe.

Based on the HS Specialists' records, NPSP referrals were frequently provided to families enrolled for pilot services, with about half of all documented HS families receiving NPSP referrals. Deployed families were of particular interest in the pilot in accordance with the execution of section 578 of the NDAA for FY 2019. Therefore, when HS Specialists identified a

family with a deployed parent at the time of an infant's birth, referrals were made to NPSP. Subsequently, the HS Specialists were directed to follow-up with the family to confirm if the family connected with the NPSP staff and received home visits. However, few parents (N=26) were deployed at the time of their infant's birth. Therefore, almost no information regarding this follow-up was documented across the HS Specialist case management trackers.

Comprehensive Description and Assessment of the Pilot

The pilot program outcomes were assessed through the Well Baby, Well Family Study, completed by NHRC, surveying eligible caregivers seeking care for an infant aged 0-4 months at both pilot and comparison sites. Recruitment for the study was conducted in multiple ways to maximize enrollment opportunities. In addition to email announcements to all eligible beneficiaries, the HS pilot flyer was handed out by in-person data collectors and by clinic administrative staff. When beneficiaries expressed immediate interest, a tear-off contact information form at the bottom of the flyer was collected by those distributing the forms to facilitate follow-up phone/email enrollment. If beneficiaries had time in the clinic and expressed willingness to volunteer on-site, in-person data collectors were trained to enroll them and facilitate baseline survey completion immediately. Additionally, beneficiaries were solicited for the study via mail invitation using contact information obtained from clinic records for families with initially scheduled well-baby visits. Finally, a study flyer was available in the clinic waiting rooms; therefore, interested and eligible beneficiaries could also request information and assistance for enrolling in the study via a study website. The total number of participants in the Well Baby, Well Family study included 4,826 beneficiaries at the pilot sites, and 4,979 beneficiaries at the comparison sites.

Caregivers were required to be the biological parent or legal guardian of the focal infant, English speaking, and the parent/guardian planning to regularly attend well-baby appointments at a participating clinic with their infant. Following recruitment efforts, participants were also screened by in-person and phone contact to ensure they planned to continue care at their participating clinic for at least 6 months. Those who agreed to participate were asked to complete surveys at three points in time: (a) 0-2 months after the infants' birth (baseline) (b) 6-months after baseline (first follow-up); and (c) 12-months post-baseline (second follow-up). The purpose of the prospective survey was to evaluate the impact of the pilot service across 16 outcomes in the areas of Caregiver, Infant Health, and Referral outcomes (see Appendix 1: Tables 6-8 for outcomes). All surveys were completed in a de-identified fashion through an online platform. Contact information and potentially identifying demographics were collected separately on paper forms by in-person/phone collectors or were extracted from archival records if participants were recruited by mail from clinic enrollment lists. At baseline, participants could complete their survey in the clinic on a tablet provided to them by the in-person data collectors, or on their own mobile device if they preferred. Local data collectors were also able to facilitate enrollment by conducting an interview with participants and enter responses on the study tablets on behalf of enrollees, if requested; however, participants generally chose to complete the baseline survey independently. When solicited by mail (33 percent of baseline enrollment and 100 percent of follow-up survey collection), participants completed their surveys independently on their own computer or mobile device.

The total survey participation rate of the pilot and comparison groups (10 percent) approximates enrollment success across all recruitment methods for families with infants receiving care at participating sites whose contact records were received from DHA within the age eligibility window for enrollment (0-2 months of age).⁷ Separate participation rates also were computed for the pilot (7 percent) versus the comparison (13 percent) sites, as pilot site recruitment relied more heavily on in-person and phone enrollment, while comparison sites were more dependent on mail recruitment.⁸

Methodology

A total of 1,181 eligible caregivers completed the baseline survey. Of those who completed the baseline survey, 55 percent completed the 6-month survey and 45 percent completed the 12-month survey. Overall, 60 percent completed one or both follow-up surveys. Participants' self-report survey data were supplemented by matching them with DoD archival data, as well as HS pilot program data submitted by the HS Specialist.

All statistical analyses of HS pilot outcomes were conducted using repeated-measures regression models with random intercepts to account for the nesting of longitudinal measurements within individual participants. Linear regression models were used to analyze continuous outcome variables, logistic regression models were used for binary outcomes, and Poisson regression models were used for outcomes measured as counts. Maximum likelihood estimation was used for all statistical models which utilizes all available data on each outcome. All regression models included binary indicators to account for clinic-specific effects for clinics containing at least 10 percent of the HS or comparison samples. In addition, a set of demographic covariates was incorporated within all models including caregiver sex, caregiver age, sponsor race-ethnicity, sponsor military branch, and sponsor military rank (enlisted or officer). All regression models were implemented using the SAS NLMIXED software program (version 9.4).

Two types of program effects were estimated and reported. First, the analysis estimated the intent-to-treat (ITT) effect which compares outcomes between all study participants at sites assigned to the HS and comparison conditions. Second, the analysis estimated the effect of exposure to the HS intervention among the subgroup of participants having one or more documented contacts with an HS Specialist. This latter effect is known as the *complier average causal effect* (CACE) in that it estimates the effect of an intervention among participants

⁷ Population participant rates were limited by that fact that DHA health record keeping is sometimes delayed, and some eligible families seeking care at participating sites did not have contact information submitted to the study team during the data collection period; this was evidenced by the fact that about 10 percent (Comparison) to 13 percent (Pilot) of families enrolled in the Well Baby, Well Family Study did not have an eligibility record submitted by DHA. Furthermore, a number of the records received from DHA were received after families were no longer eligible for baseline recruitment (i.e., after infants were greater than 2 months of age). Therefore, some records for eligible beneficiaries were not available for timely recruitment. Because of this, the population study representation rates above include only unique families for whom contact information was received from DHA within 2 months of infant birth in the denominator; they also exclude any families from the numerator for whom DHA records were never received, or were not received in a timely fashion.

⁸ Three out of five of the originally select comparison sites were too small to sustain adequate recruitment numbers necessitating the addition of additional large comparison recruitment sites during the course of baseline recruitment; due to time constraints, these late additions were only set up for mail recruitment.

“complying” with the assigned intervention, where compliance typically is indexed by a prescribed level of intervention exposure. In the CACE analysis, participants in the comparison condition were weighted based on values of baseline characteristics predictive of contact with an HS Specialist. The purpose of this weighting was to balance the HS and comparison groups on characteristics associated with contact with an HS Specialist, thereby minimizing potential biases in the estimation of effects of the HS intervention among participants having contact with an HS Specialist. The CACE analysis estimates the impact of exposure to the HS intervention through contact with a HS Specialist, whereas the ITT analysis estimates the overall public health impact of making the HS program broadly available within the target population.

In the HS pilot clinics, almost half (48 percent) of the caregivers were from Joel Health Clinic (Womack), followed by Tripler Army Medical Center with 22 percent, and Madigan Army Medical Center with 19 percent. All other HS pilot sites contributed less than 5 percent each. Among the comparison sites, the largest group of caregivers was recruited from Naval Hospital Camp Pendleton Clinic (34 percent), followed by Carl R. Darnall Army Medical Center (26 percent), Brooke Army Medical Center (9 percent), and Naval Medical Center Portsmouth (9 percent). The remaining comparison sites contributed 5 percent or less (Appendix 1: Table 2).

Data on the characteristics of military sponsors for focal infants in the study were obtained from DoD personnel records (via the Defense Manpower Data Center) for the households represented in the study (Appendix 1: Table 3). The large majority (90 percent) were active duty Service members, while 8 percent were Reserve Component, and 1 percent were National Guard. The majority of participants were enlisted (73 percent), Army-affiliated (60 percent), and non-Hispanic white (59 percent). A little over one third (37 percent) had less than 5 years of service; 38 percent had 5 to 10 years of service; and 25 percent had more than 10 years of service.

The majority of participating caregivers were female (77 percent), aged 21-35, and non-Hispanic white (57 percent). Twenty percent of the caregivers had a high school diploma, but the majority had some college (25 percent) or a bachelor’s degree (24 percent). The large majority of caregivers were married (93 percent) and living with their spouse (94 percent). Almost half (48 percent) of the caregivers had only one child under the age of 18, while 32 percent had two children, and 20 percent had three or more. Almost half of caregivers were active duty (46 percent), while 45 percent were not the military sponsor. The remaining 9 percent were either in the Reserve Component, retired, or designated as “other.” More than half (58 percent) of the caregivers were employed full-time, while 21 percent were homemakers. In terms of annual household income, 23 percent reported \$25,000-\$49,000, 27 percent reported \$50,000-\$74,000, 21 percent reported \$75,000-\$99,000, and 27 percent reported an annual household income over \$100,000. See Appendix 1: Table 4 for a summary of the caregiver demographics.

Results/Findings

The analysis tracked the number of contacts with an HS Specialist in the first 6 months of the infant’s life (Appendix 2: Figure 1). Based on both participant self-report and HS Specialist records, 39 percent had no documented contact, while 61 percent had one or more documented

contacts (25 percent one contact, 19 percent had two contacts, 9 percent had three contacts, and 9 percent had four or more contacts).

Additionally, the analysis noted that there were some baseline differences between caregivers at pilot sites with one or more documented contacts with an HS Specialist compared to those without HS Specialist contact (Appendix 2: Figure 2). Specifically, caregivers who were enrolled into the study at a clinic site and whose sponsor was enlisted in the Army were over twice as likely to have contact with an HS Specialist within 6 months compared to those enrolled by mail or whose sponsor was enlisted in a branch other than the Army. Other characteristics associated with increased likelihood of having contact with an HS Specialist within 6 months were caregiver reports of military life being very or extremely stressful over the past 6 months at baseline as well as sponsor and caregiver race-ethnicity being other than non-Hispanic White. Finally, caregivers whose sponsors were enlisted in the Air Force or Navy were significantly less likely to have contact with an HS Specialist within 6 months than caregivers with sponsors enlisted in other branches.

The analysis evaluated the baseline differences between caregivers in the HS and comparison groups with respect to parenting and child characteristics (Appendix 1: Table 5). For three characteristics, there were statistically significant baseline differences between study conditions: Infant Difficulty (e.g., parent perception of how difficult infant is to care for), Family Functioning/Resilience (e.g., conflict resolution, cohesion, and expressiveness), and Nurturing and Attachment (e.g., quality and strength of parent-child bonding). These differences suggested slightly better parental functioning and less infant difficulty at baseline for the pilot condition. However, effect sizes on these baseline measures were small and unlikely to be clinically meaningful or introduce any potential biases into the outcomes analyses.

The study examined differences at follow-up between caregivers in the HS versus comparison conditions with respect to eleven different caregiver-reported parenting and child outcomes (Appendix 1: Table 6). Analyses were conducted to estimate both ITT and CACE effects. Results indicated statistically significant ITT and CACE effects on the Parenting Sense of Competence – Efficacy subscale at follow-up in favor of HS. Specifically, caregivers in the HS condition reported larger increases in parenting efficacy compared to caregivers in the control condition in both the CACE and ITT analyses. However, effect sizes for both types of effects were modest. None of the other ten caregiver survey outcomes were statistically significant (e.g., Food Insecurity, Patient Health Questionnaire-2 Depression, or any of the Protective Factors).

Well-childcare engagements were evaluated across study conditions (see Appendix 1: Table 7). In the ITT analysis, there were no significant differences between study conditions on any infant health outcome. In the CACE analysis, the number of routine well-child exams attended, and vaccinations received during the infant's first year were significantly higher on average for infants in the HS pilot sites compared to those in comparison sites. The average number of emergency room visits during the infant's first year did not differ between HS and comparison sites. Infants receiving care at HS sites whose caregivers had at least one contact with an HS Specialist received 4.2 routine vaccinations on average compared to 3.3 for infants at comparison sites.

The final set of study outcomes addressed caregiver referrals to the NPSP as well as a referral to any type of service (Appendix 1: Table 8). In both the ITT and CACE analyses, referrals to the NPSP were significantly higher for the HS group relative to the comparison group. Likewise, in the ITT analysis referral to any service was significantly more likely in the HS group than the comparison group. The results of the ITT analysis indicate that 38.5 percent of HS families were referred to the NPSP, whereas 8.7 percent of the families in the comparison group were referred.

SUMMARY

The HS pilot was executed at select MTFs and enrolled 4,826 eligible beneficiaries. An additional 4,979 beneficiaries were offered surveys at the comparison sites. Approximately 10 percent of both groups completed baseline survey data, consistent with survey data collection rates. While there was some evidence of pilot program impacts, of the 16 outcomes evaluated, there were only significant effects for five outcomes, and effect sizes were modest and may not represent clinically meaningful findings (Appendix 1: Table 6-8).

No legislative action is necessary. Despite the multiple outreach efforts and enrollments into the pilot, engagement in the pilot services was extremely low. As found in Appendix 2: Figure 2, more than half (64 percent) of participants in the HS group did not take advantage of the HS services (39 percent did not engage with the HS Specialist after enrollment, and 25 percent met with the HS Specialist only one time). Additionally, this pilot was not able to evaluate the impact of a program on reducing CAN due to the low volume of participants and the low base-rate of CAN in the military. Therefore, the HS model may not be ideal for implementation within the DoD for reducing rates of CAN.

The DoD has several existing programs designed to address CAN as well as other prevention and clinical programs that provide support and resources to the target population. For example, DoD's Military OneSource and the MFLC programs provide comprehensive non-medical counseling support and information to Service members and their families on every aspect of military life including parenting, deployment, reunion, relationships, and grief. Of the approximate 2,600 MFLCs, half are Child and Youth Behavioral MFLCs specially trained to support military connected children and their families world-wide who are embedded in MTFs, schools, Child Development Centers, and Youth Centers. Military OneSource offers additional resources for families, including Spouse Education and Career Opportunities, Thrive, Financial Counseling, Building Healthy Relationships, New MilParent Specialty Consultation and support for families that have children with special needs. Furthermore, the DoD's Family Advocacy Program and NPSP are targeted to prevent CAN as well. NPSP providers support families by providing parenting education, information, and referral during home visits. In addition, the Military Health System provides TRICARE eligible beneficiaries access to a wide range of medically and psychologically necessary and appropriate services ranging from primary care such as well-child visits to specialty service such as behavioral health and forensic healthcare services. During the well-child visits, providers complete screenings such as the Survey of Well-being for Young Children, who then make appropriate referrals to various clinical and non-clinical services.

The DoD is committed to providing support for Service members and their families to enhance the readiness and resiliency. There is a zero tolerance when it comes to child abuse and neglect.

APPENDIX 1: TABLES

Table 1: Primary Referral Sources

Developmental Resources	Childcare
Military OneSource	Military OneSource
Babies on the Homefront	Child Development Center
Bright Futures	Family Day Care
Early intervention services	Prevention Services
Exceptional Family Member Program	Military OneSource
Healthychildren.org	Family Advocacy Program (Family life enhancement and life skills)
Zero to Three/HealthySteps	New Parent Support Program
Counseling Resources	Financial/Food Resources
Military OneSource	Military OneSource
Non-medical counseling	Navy Marine Corps Relief Society
Families Over Coming Under Stress	Army Emergency Relief
TRICARE	Air Force Aid Society
Behavioral health center	Financial Readiness Program
Social work	Women, Infants, and Children
Deployment Support	Local Resources (fill in the blank)
Military OneSource	..
Childcare planning	..
Ombudsman	..
Family Readiness Groups	..
Red Cross	..

Table 2: Samples Sizes by Study Condition and Clinic

Study Condition	Clinic	Sample Size	Percent
HealthySteps	Joel Health Clinic/Womack Army Medical Center	375	48
	Tripler Army Medical Center	176	22
	Madigan Army Medical Center	150	19
	42nd Medical Group	31	4
	81st Medical Group	26	3
	Makalapa Clinic	17	2
	Kaneohe Bay Clinic	8	1
HealthySteps Total		783	100
Comparison	Naval Hospital Camp Pendleton	134	34
	Carl R. Darnall Army Medical Center	104	26
	Brooke Army Medical Center	35	9
	Naval Medical Center Portsmouth	34	9
	4th Medical Group	21	5
	Moncrief Army Health Clinic	18	5
	Walter Reed National Military Medical Center	17	4
	Martin Army Community Hospital	13	3
	Blanchfield Army Community Hospital	12	3
	628th Medical Group	9	2
	Wilford Hall Medical Center 59th Medical Wing	1	0
Comparison Total		398	100
Study Total		1,181	100

Table 3: Demographics of Military Sponsor of Focal Infant

Characteristic	Percent
Military Component	
Regular	90
Reserve	8
National Guard	1
Unknown	1
Rank	
Enlisted	73
Officer	25
Warrant Officer	2
Branch	
Army	60
Navy	13
Marine Corps	12
Air Force	14
Coast Guard	1
Years of Service	
<5 years	37
5-10 years	38
>10 years	25
Race/Ethnicity	
Non-Hispanic White	59
Hispanic	17
Black	15
Hawaiian/Pacific Islander	6
Asian	2
Other/Multiple	1

Table 4: Demographics of Caregiver to Focal Infant

Characteristics	Percent
Sex	
Female	77
Male	23
Age	
≤20 years	1
21-25	24
26-30	33
31-35	25
36-40	13
>40	4
Race/Ethnicity	
American Indian	1
Asian	1
Black	14
Hawaiian/Pacific Islander	5
Hispanic	15
Non-Hispanic White	57
Other/Multiple	7
Education	
Less than High School Diploma	0
High School Diploma	21
Some College	25
Associate Degree	10
Bachelor's Degree	24
Graduate Degree	20
Marital Status	
Married	93
Long-Term Relationship	3
Separated	0
Divorced	1
Single	3
Living Situation	
With Spouse	94
With Parents	1
Alone	3
Other	2
Number of Children Under 18	
One	48
Two	32

Three or more	20
Military Status	
Active Duty	46
Reserve	3
Retired	3
Other	3
None	45
Employment Status	
Employed Full-Time	58
Employed Part Time	5
Homemaker	21
Unemployed, Looking for Work	3
Unemployed, Not Looking for Work	9
Retired	1
Disables	0
Other	3
Household Income	
<\$25,000	2
\$25,000 - \$49,999	23
\$50,000 - \$74,999	27
\$75,000 - \$99,999	21
\$100,000 - \$124,999	11
\$125,000 - \$149,999	6
≥\$150,000	10

Table 5: Differences Between Study Conditions on Survey Outcomes at Baseline

Caregiver Outcome ¹	Study Condition				Test Statistic ²	<i>p</i> -value	Effect Size ³
	HealthySteps		Comparison				
	Number	Mean	Number	Mean			
Baby Care Questionnaire - - Attunement	739	2.7	347	2.7	0.18	0.8586	0.01
Baby Care Questionnaire - - Structure	739	2.4	347	2.4	0.52	0.6065	0.03
National Survey of Children's Health -- Infant Difficulty	743	0.7	353	1.0	3.38	0.0008*	0.25
Overall Military Life Stress	752	3.3	367	3.3	-0.17	0.8668	0.01
PHQ-2 Depression	749	17.6	364	19.5	0.58	0.4456	0.07
Parenting Sense of Competence -- Efficacy	741	2.9	353	2.9	-0.45	0.6542	0.03
Parenting Sense of Competence --Satisfaction	741	2.6	353	2.5	-1.36	0.1739	0.09
Protective Factors Survey -- Family Functioning/Resilience	745	3.3	357	3.2	-1.97	0.0490*	0.13
Protective Factors Survey -- Nurturing and Attachment	744	3.4	356	3.2	-3.17	0.0016*	0.22
Protective Factors Survey -- Social Support Subscale	743	3.1	355	3.1	-1.53	0.1253	0.10
Work-Family Conflict Scale	485	1.8	201	1.9	1.23	0.2210	0.11

¹ All outcome variables are subscale mean scores except PHQ-2 Depression which is the percentage of caregivers scoring above the threshold for mild/moderate depression.

² All statistical tests are t-tests except for PHQ-2 Depression which is a chi-square test (df=1).

³ All effect sizes are Cohen's d.

*Represents a statistically significant *p*-value <0.05

Table 6: Caregiver Survey Outcomes

Caregiver Outcome ¹	Effect Type					
	Intent-to-Treat			CACE		
	Estimate ²	<i>p</i>	Effect Size ³	Estimate ²	<i>p</i>	Effect Size ³
Baby Care Questionnaire -- Attunement	0.05	.1125	0.05	0.05	.1815	0.07
Baby Care Questionnaire -- Structure	-0.01	.8310	0.01	0.00	.9003	0.01
Food Insecurity	-0.65	.0549	0.36	-0.51	.2114	0.28
National Survey of Children's Health -- Infant Difficulty	0.15	.1806	0.04	0.20	.1539	0.07
PHQ-2 Depression	-0.23	.4702	0.13	-0.42	.2560	0.23
Parenting Sense of Competence -- Efficacy	0.09	.0252*	0.07	0.13	.0099*	0.13
Parenting Sense of Competence -- Satisfaction	0.01	.7299	0.01	-0.00	.9699	0.00
Protective Factors Survey -- Family Functioning/Resilience	-0.04	.4913	0.02	-0.07	.2868	0.06
Protective Factors Survey -- Nurturing and Attachment	-0.04	.4582	0.02	-0.01	.8513	0.01
Protective Factors Survey -- Social Support Subscale	-0.04	.4596	0.02	-0.08	.2701	0.06
Work-Family Conflict Scale	0.04	.6845	0.01	-0.00	.9913	0.00

Note: CACE = complier average causal effect; *p* = *p*-value.

¹ All outcome variables are measured on a continuous scale except PHQ-2 Depression and Food Insecurity which are binary indicators.

² Each estimate is the mean difference between the HS condition and the control condition on the outcome at follow-up. Positive estimates indicate a higher mean on the outcome at follow-up in the HS condition relative to the control condition. Negative estimates indicate a lower mean on the outcome at follow-up in the HS condition relative to the control condition.

³ All effect sizes are Cohen's *d*.

⁴ The estimates for PHQ-2 Depression and Food Insecurity are log-odds ratios.

* Represents a statistically significant *p*-value <0.05

Table 7: Infant Health Outcomes

Health Outcome	Effect Type					
	Intent-to-Treat			CACE		
	Estimate ¹	<i>p</i>	Effect Size ²	Estimate ¹	<i>p</i>	Effect Size ²
Number of well-child exams attended	0.10	.2287	0.04	0.28	.0415*	0.08
Number of routine vaccinations received	0.16	.0961	0.05	0.47	.0033*	0.11
Number of emergency room visits	0.08	.6169	0.01	-0.28	.2942	0.04

Note: CACE = complier average causal effect; *p* = *p*-value.

¹ All estimates are natural logarithms of the ratio of the expected value of the outcome in the HS condition over the expected value of the outcome in the control condition. Positive estimates indicate a higher expected value in the HS condition relative to the control condition.

² All effect sizes are pseudo-Cohen's *d* estimates.

* Represents a statistically significant *p*-value <0.05

Table 8: Referral Outcomes

Referral Type	Effect Type					
	Intent-to-Treat			CACE		
	Estimate ¹	<i>p</i>	Effect Size ²	Estimate ¹	<i>p</i>	Effect Size ²
NPSP	2.46	.0218*	1.36	4.02	.0026*	2.22
Any Service	1.56	.0142*	0.86	1.65	.1246	0.91

Note: CACE = complier average causal effect; *p* = *p*-value.

¹ All estimates are log odds ratios. Positive estimates indicate a higher odds of referral in the HS condition relative to the comparison condition.

² All effect sizes are Cohen's *d* estimates.

* Represents a statistically significant *p*-value <0.05

APPENDIX 2: FIGURES

Figure 1: Number of Contacts with a HS Specialist at 6 Months Among HS Participants

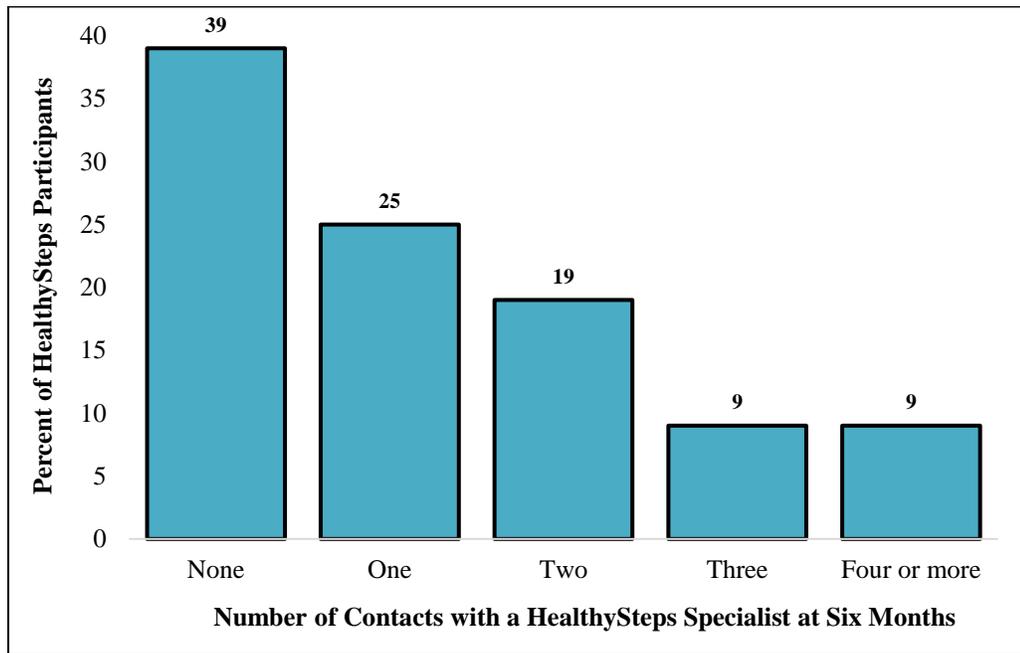
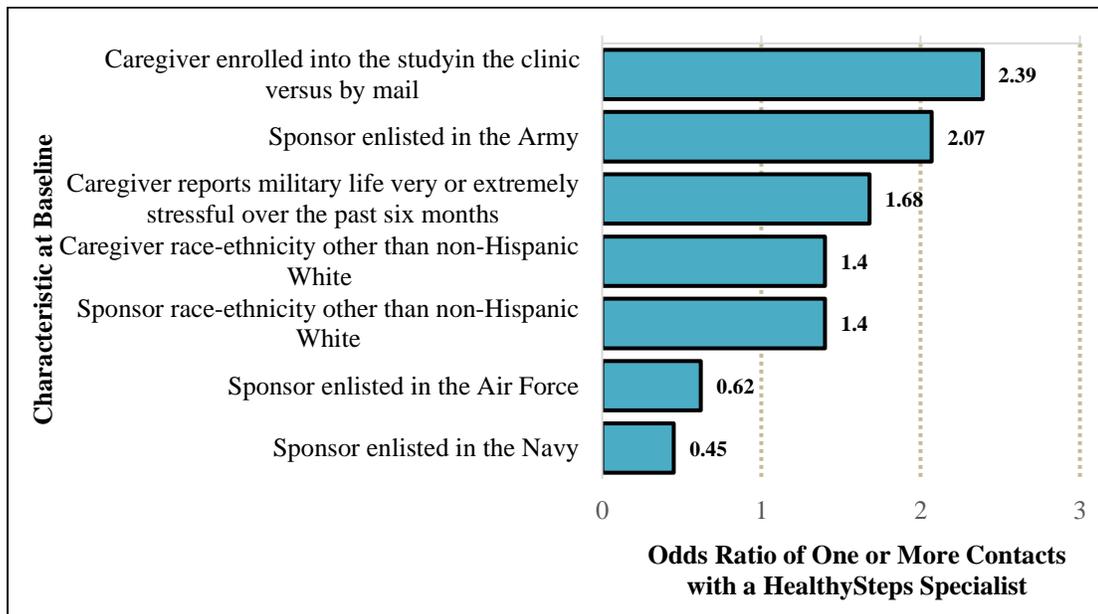


Figure 2: Parent Characteristics Associated with One or More Contacts with a HS Specialist at 6 Months



Note: Characteristics with *p*-values < 0.05 are reported.