



An Evaluation of U.S. Military Non-Medical Counseling Programs

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Preface

The U.S. Department of Defense offers non-medical counseling through two programs: Military and Family Life Counseling (MFLC) and Military OneSource. These programs, established in 2004, are centrally managed in the Office of Deputy Assistant Secretary of Defense for Military Community and Family Policy (ODASD [MC&FP]). To date, assessment of non-medical counseling programs has primarily focused on process and satisfaction measures rather than program outcomes. Because of the lack of information on program outcomes, ODASD (MC&FP) asked RAND's National Defense Research Institute (NDRI) to evaluate MFLC and Military OneSource to better understand their impact on military members and their families. This study set out to answer the question of whether non-medical counseling programs are effective in improving program outcomes and if effectiveness varies by problem type and/or population.

This report provides detailed findings of RAND NDRI's analysis based on two surveys provided to program participants—the first two to three weeks after participating in counseling sessions and the second three months later. We designed the surveys to gain information on improvement in the problems for which the participant sought help; whether negative impacts on their work and daily lives had subsided; whether improvements were sustained in the short and long term (i.e., over three months); and participant perceptions about the program itself and the counselors with whom they worked.

The report should be of interest to policymakers and program leadership. Policymakers can use study findings as they make decisions about continuation and expansion of non-medical counseling provided through MFLC and Military OneSource. Program leadership can determine where the program is most effective and for whom, and can use the findings to pinpoint program areas in need of improvement or greater attention.

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Summary

Military families face normal stresses that most families face, such as financial strain, stressful life events, and relationship problems. But they also have to confront stresses that are more unique to military life, such as frequent moves and frequent separations from family and friends for military training, assignments, and deployments. The length and frequency of deployments can also place an unprecedented strain on military families. In addition to the emotional stress of worrying about a loved one overseas, the non-deployed spouse must take over more responsibility at home, including financial management and caretaking of children or other dependents. Extended absence from one's spouse or partner can also place added strain on relationships. While most families are able to successfully overcome the stresses and strains of deployment and military life with the assistance of family and friends, sometimes families need additional assistance from counseling and support services offered by the U.S. Department of Defense (DoD).

The DoD provides different counseling supports depending on the needs and preferences of service members and their families. Under the Assistant Secretary of Defense for Health Affairs, the DoD provides psychological counseling and psychiatric treatment for psychological problems that are likely to cause severe impairment or distress, including medically diagnosable mental health conditions such as major depressive disorder, posttraumatic stress disorder, traumatic brain injury, or drug and alcohol abuse. Most of these problems are biologically based conditions that involve longer-term treatment with medications and counseling to resolve or stabilize.

In addition, the DoD provides for short-term, solution-focused counseling for common personal and family issues that do not warrant medical or behavioral health treatment within the military health system. These counseling services, called *non-medical counseling* within the DoD, are typically implemented outside the traditional health care setting and are aimed at addressing a broad array of common problems such as stress management, marital or other relationship problems, employment issues, parenting, and grief and loss, along with the particular challenges associated with military life, including deployment adjustment issues associated with separation and reintegration. Non-medical counseling services within the DoD provide access to a trained professional who can help individuals address a range of problems and identify potential strategies that will help overcome them. These services include referrals to other resources that provide direct assistance for problems (e.g., spouse education and employment programs), training on managing problems (e.g., personal financial counseling), and counseling to help resolve family or personal problems that do not require medical or behavioral health treatment (e.g., marriage counseling, stress reduction). Non-medical counselors rely on different types of therapeutic or educational techniques aimed at preventing

problems (or stress resulting from problems) from developing into mental health conditions that may detract from military and family readiness.

The DoD offers non-medical counseling through two programs: Military and Family Life Counseling (MFLC) and Military OneSource. These programs, established in 2004, are centrally managed in the Office of Deputy Assistant Secretary of Defense for Military Community and Family Policy (ODASD [MC&FP]). Both the MFLC and Military OneSource programs are offered to members of the active and reserve components, and their families, for up to 12 sessions per person per presenting problem at no cost. Both programs offer confidential, free assistance to service members and their families seeking help with issues such as finances, employment and education, parenting and child care, relocation, deployment, reunion, family members with special needs, relationships, stress, and grief. Both programs employ counselors with a master's degree or Ph.D. in relevant fields (e.g., social work, counseling, psychology) who are licensed in a state, U.S. territory, or the District of Columbia as an independent practitioner. If the problem requires expertise in an area outside of the counselor's expertise, the individual seeking help can be referred to another counselor who possesses the required expertise. The MFLC program provides in-person confidential non-medical, short-term, solution-focused counseling services. A hallmark of the MFLC program is privacy and confidentiality. Military OneSource consultation and non-medical counseling services are offered in person, over the telephone, or via the Internet (e.g., online chat or video link).

To date, assessment of non-medical counseling programs has primarily focused on process and satisfaction measures rather than program outcomes; evidence on their effectiveness is limited, primarily due to the lack of coordinated monitoring and evaluation efforts. Because of the lack of information on program effectiveness, ODASD (MC&FP) asked RAND to evaluate MFLC and Military OneSource to better understand their impact on military members and their families. Specifically, RAND was asked to expand the focus of research beyond process measures to also include assessing the extent to which these counseling services result in successful resolution of clients' problems, explore whether there are notable differences in resolution by problem type or client characteristics, and identify areas for program improvement based on the findings reported by program participants. The findings and conclusions also will contribute toward the limited amount of research on the effect of non-medical counseling on military service members and their families.

Evaluation Design and Approach

This evaluation was designed as two separate but parallel studies. While both MFLC and Military OneSource provide non-medical counseling services to military-connected individuals and families, they operate separately and there are important differences in the ways in which services are delivered (e.g., Military OneSource counseling requires a referral but MFLC accepts walk-in participants). Despite their differences, however, their goals are the same: to provide short-term, solution-focused counseling to address general conditions of living and military lifestyle. As a result, our analytic approach was very similar for both programs; however, we report our results separately for each.

The objective of this study was to describe the effectiveness of and satisfaction with each non-medical counseling program. Given the wide range of non-medical counseling needs and approaches to supporting those needs, this study was not designed to assess the specific meth-

ods used by counselors to help participants resolve their problems. The study was also not intended to determine which of the programs is more or less effective. Differences in program delivery and the populations each serves can affect the results and so comparisons between the two programs on similar outcomes should not be made.

For both MFLC and Military OneSource, we conducted two online surveys referred to as Wave 1 and Wave 2. The Wave 1 survey, completed by participants approximately two to three weeks after their initial counseling session, was designed to capture participants' retrospective assessments of the severity of their problem and perceived impact on their life prior to counseling and an assessment of their problems' severity and perceived impact shortly after initiating non-medical counseling (i.e., short-term outcomes). Questions addressed respondents' problems, problem resolution, and their experience with non-medical counseling. The Wave 2 survey, completed by participants three months after completion of the Wave 1 survey, asked questions about the same measures but allowed us to examine changes over time in outcomes of interest, including problem severity, stress and anxiety, and effects on work and family life (i.e., long-term outcomes). Because the programs provide short-term, solution-focused non-medical counseling for 12 sessions, three months was considered a reasonable period of time to measure problem resolution. At each survey wave, participants were asked to provide open-ended responses to two questions assessing the perceived strengths and weaknesses of the MFLC or Military OneSource program.

Data collection occurred from October 2014 to November 2016 for MFLC and from April 2015 to November 2016 for Military OneSource. Both studies collected data for a minimum of a full calendar year to ensure that findings were not driven by any potential seasonal variation in non-medical concerns or service use. A total of 2,585 MFLC and 2,892 Military OneSource participants responded to the Wave 1 survey, and 614 MFLC and 878 Military OneSource participants responded to the Wave 2 survey. Participants in the study were limited to adults aged 18 years or older who received at least one in-person non-medical counseling session of 30 minutes or more in an individual or couples setting. Service members and eligible family members across the Air Force, Army, Marines, Navy, and National Guard participated in the study. Program staff from MFLC or Military OneSource initially recruited eligible participants, and those expressing interest in the study were invited by RAND via email to participate in an online survey. Counselors did not have access to participant responses.

Response rates for both MFLC and Military OneSource were low but not atypical for studies of military service members and their families (Miller and Aharoni, 2015). Comparisons to population-level characteristics of program users revealed that study participants were representative of the population on demographic characteristics and problem type, which suggests that the sample of participants was not biased (Miller and Aharoni, 2015). Where there were differences between the sample and population characteristics, we adjusted the data to be representative of the population.

Findings

Our findings focused on outcomes in six broad areas: 1) severity and overall problem resolution, 2) resolution of stress and anxiety, 3) interference with work and daily life, 4) connection to services and referrals, 5) perceptions of non-medical counseling programs, and 6) perceptions of non-medical counselors. This summary contains an overview of our analysis of

survey data in each of these areas;¹ detailed results are contained in the chapters and appendixes that follow. Although the MFLC and Military OneSource studies were conducted as separate evaluations, high-level findings about the potential impact of and experiences with non-medical counseling can be drawn from both studies; these findings may help to inform policy decisions.

Severity and Overall Problem Resolution

We examined the type of problems for which individuals were seeking non-medical counseling and assessed whether—over the short term—the severity of the problem tended to decrease following non-medical counseling. The most common problems participants reported were family or relationship problems, followed by stress, anxiety, or emotional problems, and problems with conflict resolution or anger management. In general, most people who used non-medical counseling reported being able to resolve their problem and reduce its effect on their lives. Participants reported improvements after initiating counseling, which were maintained after three months by the majority of participants. A small but important proportion of participants did not experience a reduction in problem severity as a result of non-medical counseling, especially in the short term. More specifically, our analysis indicated that

- participants reported a statistically significant overall reduction in problem severity following non-medical counseling
- over 65 percent of individuals experienced a reduction in problem severity after they initiated counseling
- reductions in problem severity were maintained long term with over 80 percent of individuals reporting the same or improved problem severity three months after receiving counseling
- women tended to report greater short-term problem resolution than men
- open-ended responses suggest that the broader community of service members and their families may lack awareness of the availability of non-medical counseling through these programs, particularly through the MFLC program.

Resolution of Stress and Anxiety

Both service members and their families may experience periods of heightened stress and anxiety as a result of the military lifestyle. Stress and anxiety affect everyone at some point, and can impact levels of productivity as well as military and family readiness. Military non-medical counseling is designed to help individuals with stress management, giving them tools and strategies to cope effectively when life's demands become excessive.

Results suggest that, among the majority of participants, the frequency with which individuals reported feeling stressed or anxious as a result of their problem declined following non-medical counseling, and that these improvements were maintained or continued to improve in the three months following receipt of non-medical counseling services. Key findings include the following:

¹ In the summary, results are reported across programs in that the numbers provided are for the smallest effect across results for the MFLC and Military OneSource programs (e.g., “over 65 percent” means that the effect for one program was 65 percent, and the effect for the other program was greater than 65 percent).

- After initiating counseling, over 70 percent of individuals experienced a reduction in the frequency of feeling stressed or anxious as a result of their problem.
- Improvements were generally maintained three months after receipt of counseling. Over 80 percent reported a reduction in feeling stressed or anxious as a result of their problem, compared to how they felt prior to receiving services.
- Reported levels of stress in one's work life and personal life were significantly lower following non-medical counseling. Over 60 percent of individuals reported that they experienced less or much less stress in their work life, and over 65 percent of individuals reported that they experienced less or much less stress in their personal life after initiating non-medical counseling.
- Approximately 20 percent of participants continued to report frequent or very frequent feelings of stress and anxiety three months after non-medical counseling, suggesting that they may not have benefited as much from counseling services.

Interference with Work and Daily Life

The problems that service members and their families experience not only cause them stress, but also can disrupt their work and daily life routines. We examined how the concerns of MFLC and Military OneSource participants affected three aspects of daily life: whether they interfered with work, interfered with daily routines, or made it difficult to cope with day-to-day demands. After receiving non-medical counseling, participants reported a statistically significant decrease in the frequency with which the problem interfered with work or daily routines, and a decrease in difficulty coping with day-to-day demands. These findings provide additional evidence that non-medical counseling facilitated short- and long-term problem resolution among the majority of participants. Our results showed that:

- Compared to how they felt before counseling, over 55 percent of individuals reported that their problems caused less interference with work in the short term, and over 65 percent reported less interference with work three months after receiving counseling.
- Compared to how they felt before counseling, over 65 percent reported decreased interference with daily routines in the short term, and over 74 percent reported decreases in interference with daily routines in the three months after receiving counseling.
- Compared to how they felt before counseling, over 60 percent of individuals reported less difficulty coping with day-to-day demands over the short term, and over 71 percent reported long-term reductions in difficulty coping with day-to-day demands in the three months after receiving counseling.
- MFLC participants reported short-term declines in problem interference with work and daily life that were maintained over the long term by the majority of participants. Military OneSource participants reported more modest short-term declines in problem interference with work and daily life, but the vast majority of Military OneSource participants reported declines three months later.

Connection to Services and Referrals

In addition to actively helping participants cope with stress, military non-medical counseling programs are intended to serve as a conduit for connecting participants to services for which they are eligible and referrals to medical or behavioral health services when needed. We examined the extent to which participants in non-medical counseling were connected to additional

services, how satisfied participants were with those referrals, and whether the program followed up with them to make sure they had connected with services. Our results indicated that, of the non-medical counseling participants who had sought additional support from other individuals or providers for their problem, most were connected with support and services outside of the program—although not necessarily to support they would not have found on their own. Moreover, the vast majority of participants were satisfied with program follow-up to make sure they connected with recommended services. Among participants who reported that each question was applicable to their problem (38–67 percent of all participants), key findings include:

- Of the 34 percent of MFLC and 37 percent of Military OneSource participants who reported that they needed support and services outside the program, over 65 percent indicated that they had been connected to those services.
- About 45 percent of participants reported that they needed referrals to medical services, and a little over half of those participants agreed that their counselor had connected them with medical services.
- Of the 38 percent of MFLC and 46 percent of Military OneSource participants who reported needing referrals to physical health services, only around 37 percent agreed that they had been connected with physical health services they would not have connected with on their own.
- A larger number of Military OneSource participants (67 percent) reported that they needed referrals to mental health services, and 69 percent of those participants agreed that they had been connected with mental health services they would not have connected with on their own.
- Over 81 percent of non-medical counseling participants who reported that their counselor referred them to outside services were satisfied or very satisfied with program follow-up to make sure they connected with recommended services.

Perceptions of Non-Medical Counseling Programs

MFLC and Military OneSource are meant to increase access to high-quality services and to help individuals connect to needed services that will address their problems. In addition to assessing the effectiveness of these services on outcomes related to problem resolution and impact of the problem on one's work and family life, we also examined the experiences individuals had with these non-medical counseling programs. At the program level, we examined perceptions related to ease of access, confidentiality, continuity of care, and overall satisfaction as measured by willingness to use services again or recommend them to others. Our findings suggest that a large majority of participants expressed favorable perceptions of non-medical counseling programs. While there is slight variability between the two programs, key findings across both MFLC and Military OneSource include the following:

- Over 90 percent of individuals reported that they were satisfied or very satisfied with the speed of being connected to a counselor and ease with which they could make an appointment.
- Over 90 percent of participants were satisfied or very satisfied with the level of confidentiality received.

- Over 90 percent of individuals reported being satisfied or very satisfied with the continuity of care they received.
- Over 90 percent of participants reported that they would be likely or highly likely to use non-medical counseling services again.
- Despite positive perceptions from the majority of participants, between 1 percent and 7 percent of participants reported being dissatisfied or very dissatisfied on the above program dimensions.

In addition, findings, particularly open-ended responses, point to the need for MFLC and Military OneSource leadership to assess where additional counselors may be warranted to alleviate stress on the system and ensure everyone can access services within a reasonable time frame. Other findings suggest that periodic reminders to counselors about confidentiality, and the appearance of confidentiality, may be warranted as this is a hallmark of the program and a continued concern for many. Results also indicate that program leadership may wish to examine concerns related to the continuity of care, reported by about 10 percent of the population, as this lack of continuity may serve as a barrier to faster problem resolution.

Perceptions of Non-Medical Counselors

In addition to the perceptions of the non-medical programs, we also asked individuals to report on their perceptions of their counselors. In this area, we examined perceptions related to professionalism, communication, cultural competency (i.e., sensitive to cultural/language differences of participants, understanding of military culture), knowledge of the presenting program, and whether the counselor met the client's needs. Our analysis shows that a large majority of participants expressed favorable perceptions of non-medical counselors. While there was slight variability between the two programs, key findings across both MFLC and Military OneSource include the following:

- Over 90 percent of participants reported being very satisfied with the level of professionalism of the counseling staff.
- Over 95 percent of participants strongly agreed that their counselor listened to them carefully and 90 percent agreed or strongly agreed that their counselor spent enough time with them.
- Over 75 percent of participants agreed or strongly agreed that their counselor addressed their cultural, language, or religious concerns.
- Over 75 percent of participants agreed or strongly agreed that their counselor understood military culture.
- Over 90 percent of participants agreed or strongly agreed that their counselor was knowledgeable about their presenting problem.
- Over 75 percent of participants were satisfied or highly satisfied with the number of materials and resources received and 80 percent were satisfied or highly satisfied with the types of materials and resources provided.
- About 90 percent of participants agreed or strongly agreed that their counselor provided the services they needed to address their non-medical problems and related concerns.

Conclusions and Implications

Findings from this study, though not causal, suggest largely positive outcomes for the participants of these programs who reported reductions in problem severity, stress and anxiety, and less problem interference with work and their personal lives after counseling. In most cases, these improvements were sustained or continued to improve in the three months after initiation of counseling services. Despite positive perceptions from the majority of participants, non-medical counseling was not universally successful and a small minority (between 1 percent and 7 percent of participants) expressed dissatisfaction with the program or their counselor. Collectively these findings suggest a number of policy implications and programmatic improvements of interest to program leadership in the Office of the Secretary of Defense (OSD).

Policy Implications

1. **The MFLC and Military OneSource programs should continue to be offered to service members and families.** MFLC and Military OneSource are two key components of the suite of services and programs offered by the DoD. With consideration of the programmatic changes suggested below, service members and their families would benefit from the continued availability of the MFLC and Military OneSource programs.
2. **Steps should be taken to increase awareness of the program.** Participants noted that the awareness of these programs—particularly the MFLC program—may be limited in the broader military community, suggesting that more work could be done to further disseminate information about the availability of these services.
3. **Consider opportunities to expand the program, though expansion should be informed by additional information or research that was beyond the scope of this project.** Given the strength of findings, the DoD may wish to consider opportunities for program expansion, particularly in locations where such services do not currently exist. For the MFLC program in particular, program and counselor perceptions were consistently higher for individuals working with MFLC counselors embedded within units, which may be worth expanding. We strongly recommend that the DoD conduct additional research on the cost-effectiveness of these programs before determining the scope of the expansion.

Programmatic Implications

4. **Provide opportunities for ongoing support, guidance, and training for counselors.** A small minority of participants reported that they were dissatisfied with a number of counselor characteristics. These concerns suggest that counselors might benefit from more opportunities to receive support and guidance from other non-medical counselors or from supervisors with more experience in the military community. This continuity in training and approach across counselors may be particularly important for counselors who are isolated from other military counselors and may also help to standardize high-quality, evidence-based non-medical counseling approaches and experiences.
5. **Strengthen non-medical counseling for child-related concerns.** Participants who sought counseling for child-related concerns, on average, reported lower levels of problem resolution and lower satisfaction with the continuity of care. By nature, these problems may be more complex and require additional providers as well as a specialized understanding of child and youth development that many adult counselors may not

- have. Programs may benefit from working to strengthen delivery of services potentially through warm handoffs to counselors who hold this more specialized level of training.
6. **Identify ways to systematically collect counselor-level feedback and incorporate findings into performance review.** While we did not collect information on individual counselors for the purposes of this study, both the MFLC and Military OneSource programs may benefit from systematically collecting counselor-level feedback to establish whether identified concerns are more prevalent for a given counselor or location. For example, participant feedback would help identify counselors who need additional instruction or reminders about maintaining confidentiality. Feedback on the counselor and program overall is critical for continued program improvement. Programs should develop a confidential procedure for participants to provide feedback.
 7. **Strengthen continuity of care.** Satisfaction with continuity of care varied across respondents. This was particularly true for the MFLC program, where counselors were more likely to rotate prior to the full resolution of an individual's problem. This rotation often resulted in a need to start over with a new counselor, which was viewed as inefficient and disrupting of progress.
 8. **Strengthen screening and connections to other services.** Survey results and open-ended comments from participants suggest that non-medical counseling could benefit from strengthening connections to other services. About a quarter of participants who sought additional help for their problem reported seeing a private counselor or specialist. Counselor training should focus on the process by which those with diagnosable mental health conditions are screened and referred to ensure timely access to the most appropriate treatment for their concerns. Additional training to help counselors identify and refer those who may benefit from clinical or more specialized services may be helpful. In addition, results suggest the need to strengthen the continuity of care during the referral process by establishing a more formalized, warm handoff and follow-up procedure.
 9. **Conduct research to better understand how to strengthen service delivery.** Despite improvements in severity, stress, and anxiety among many participants, about 20 percent reported that they did not experience problem resolution as a result of non-medical counseling. The outcome measures included in this study were general, by design, but our findings point to a need to examine what happens within a counseling session to ensure that approaches are evidence-based and to examine fidelity to training protocols and approaches in order to assess the quality of care delivered to participants. More insight may also be gained by examining alignment of non-medical counseling approaches with the presenting problem and by looking at outcomes more specific to the presenting problem. Collectively, these analyses may inform more specific training needs.

The MFLC and Military OneSource programs are designed to provide short-term, solution-focused counseling for common personal and family issues that do not warrant medical or behavioral health treatment within the military health system and to link participants with additional resources to help them resolve their problems. They are thus a key component of the broader support offered to military service members and their families. Findings from this study suggest that, overall, the programs are successfully providing short-term, confidential, solution-focused counseling to address general conditions of living and military lifestyle. Our findings also show some areas where the program could be improved, however. The recommendations offered here can be used by OSD to further strengthen these programs.

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Introduction

Military families face normal stresses that most families face such as economic strain, stressful life events, and relationship problems. But military families also have to confront the stresses related to military life, such as frequent moves, frequent separations for military training or assignments, and deployments. Over the past fifteen years, the length and frequency of deployments have placed an unprecedented strain on military families. In addition to the emotional stress of worrying about a loved one overseas, the non-deployed spouse must take over more responsibility at home, including financial management and caretaking of children or other dependents (Lara-Cinisomo et al., 2011). Extended absence from one's spouse or partner can also place a strain on relationships (Karney and Trail, 2017). While most families are able to successfully overcome the stresses and strains of deployment and military life, many do so with the informal assistance of friends and family and more formal assistance from counseling and support services offered by the U.S. Department of Defense (DoD).

The DoD provides different counseling supports depending on the needs and preferences of service members and their families. Under the Assistant Secretary of Defense for Health Affairs, the DoD provides psychological counseling and psychiatric treatment for psychological problems that are likely to cause severe impairment or distress, including diagnosable mental health conditions such as major depressive disorder, posttraumatic stress disorder (PTSD), traumatic brain injury, or drug and alcohol abuse. Most of these problems are biologically based conditions that involve longer-term treatment, medications, or other forms of counseling to resolve or stabilize.

In addition, the DoD provides short-term, solution-focused counseling for non-clinical issues. These counseling services, called *non-medical counseling* within the DoD, are typically implemented outside the traditional health care setting and are aimed at addressing common problems such as stress management, marital or other relationship problems, employment issues, parenting, and grief and loss, along with particular challenges associated with military life, including deployment adjustment issues associated with separation and reintegration. Non-medical counseling services within the DoD provide access to a trained mental health professional who can help individuals address a range of problems and identify potential strategies to resolve them. Similar to how social workers or marriage counselors work with civilian clients, non-medical counselors rely on their training and experience to assess the non-medical concern and provide individuals with education, resources, tools, and other problem-resolution strategies that best meet the unique needs of their clients, including referrals to other resources that provide direct assistance for problems (e.g., spouse education and employment programs), training on managing problems (e.g., personal financial counseling), and counseling to help resolve family or personal problems that do not require medical or behavioral health treatment.

(e.g., marriage counseling, stress reduction). These services are aimed at preventing problems (or stress resulting from problems) from developing into mental health conditions that may detract from military and family readiness.

Though non-medical counseling is also widely available via chaplains and National Reserve/Guard Family Support Centers, the DoD offers two formalized non-medical counseling programs: Military and Family Life Counseling (MFLC) and Military OneSource. These programs are centrally managed by the Office of Deputy Assistant Secretary of Defense for Military Community and Family Policy (ODASD [MC&FP]). Department of Defense Instruction 6490.06 (April 21, 2009) outlines policies and responsibilities for providing MFLC and Military OneSource counseling support in accordance with the authority in DoD Directive 5124.02 (June 23, 2008). Both programs are offered to members of the active and guard and reserve components and their families, for up to 12 sessions per person per issue, at no cost. While similar in objectives, the two programs are complementary in that the footprint and modes of service delivery differ across programs and individuals can seek services from both programs. Each program is described in more detail later in this chapter.

To date, assessment of non-medical counseling programs has primarily focused on process and satisfaction measures rather than program outcomes. Military OneSource, for example, tracks monthly and annual service use such as in-person and online consultation activity; referrals and warm handoffs to military treatment facilities or an MFLC; reasons for call; and number of financial consultations given. Similarly, MFLC uses an activity log to track the number of individuals seeking services; demographics of clients (e.g., geography, military service and rank); primary reason for use of MFLC services; referrals given to clients; and number of sessions provided. In addition to these process measures, Military OneSource employs voluntary satisfaction surveys to explore the extent to which users felt that their issue was addressed and the extent to which they encountered difficulties engaging with the counselor.

Evaluations of civilian non-medical counseling programs have been rare. Perhaps the most common instantiation of non-medical counseling in the civilian world are employee assistance programs (EAPs). EAPs are workplace-based services designed to provide emotional and practical support to employees and their families. In contrast to military non-medical counseling, EAPs also provide support for clinical concerns such as depression, and the most common reasons for using EAPs relate to relationship problems, stress at work, depression, or anxiety (Clavelle, Dickerson, and Murphy, 2012; Taranowski and Mahieu, 2013). Other issues include retirement concerns or physical health concerns (Csiernik, 2011). A 2010 survey found that EAPs in the United States cover over 58 million employees (Taranowski and Mahieu, 2013). The design and reach of EAPs vary widely, but the overarching goal of these programs is to assist with stress management and to prevent the development of mental health problems through assessment, short-term counseling, and referrals to longer-term treatment if necessary (Taranowski and Mahieu, 2013). In contrast to the current study, which focuses on in-person counseling by MFLC or Military OneSource counselors, civilian EAPs typically provide counseling over the phone, via online chat, as part of a web-based group, or via video counseling (Taranowski and Mahieu, 2013). Reviews of the EAP literature have concluded that, like non-medical counseling programs in the military setting, EAPs would benefit from more rigorous research and evaluation to determine their effectiveness for helping with problem resolution and providing cost savings to employers who sponsor them (McLeod, 2010; Csiernik, 2011; Taranowski and Mahieu, 2013). Still, the few published studies evaluating EAPs have found that use of the programs is associated with improvements in employee functioning, inter-

personal relationships, and reductions in employee feelings of distress (Clavelle, Dickerson, and Murphy, 2012; Collins et al., 2012; Dickerson, Murphy, and Clavelle, 2012). A recent study using a quasi-experimental design found that EAPs reduced worker absenteeism, though not workplace distress, and that EAPs are especially effective for people with lower levels of depression or anxiety at baseline (Richmond et al., 2017).

Purpose of This Study

The purpose of this study is to evaluate MFLC and Military OneSource to better understand their impact on military members and their families. Specifically, this study explores the extent to which these programs result in successful resolution of clients' problems and whether there are notable differences in resolution by problem type or client characteristics. The study did not focus on one specific type of problem addressed by non-medical counseling, but instead examined problem resolution across the broad array of problems addressed by these programs. The study did not include a control group that received no treatment or a different type of treatment; as a result, we cannot draw *causal* conclusions about the effectiveness of the program, and the study was not designed to evaluate specific therapeutic approaches or training provided by non-medical counselors. Instead, it seeks to understand whether the *availability* of non-medical counseling programs more broadly contributes to important outcomes related to military and family readiness, including problem resolution, reduction of stress and anxiety, and a reduction in interference with work and daily life. Additionally, this report will contribute toward the limited amount of research on the effect of non-medical counseling on military service members and their families. Key study aims include:

1. to assess whether participants report problem resolution or a reduction in symptoms or problem severity following engagement in MFLC or Military OneSource non-medical counseling
2. to explore whether problem resolution is similar across problem types and military populations
3. to summarize areas for improvement in program design and delivery, as reported by program participants.

The rest of this chapter describes the needs of military families, the proposed benefits of non-medical counseling in addressing those needs, and the development of the two largest non-medical counseling programs within the DoD: the MFLC and Military OneSource programs.

Needs of Military Families

Military life in general can be challenging for service members and their families. However, military deployments and other requirements associated with combat operations in Afghanistan and Iraq have added to the typical stresses of military life. Over 2.5 million service members have been deployed to these theaters since 2002, leading to strain on both service members and their families (Denning, Meisner, and Warner, 2014; Tanielian et al., 2014; Karney

and Trail, 2017). The mental and physical health burden on military service members is well documented, and research indicates that combat experience is associated with an increase in PTSD, depression, anxiety, alcohol and substance abuse, suicide rates, and select chronic diseases (Westwood et al., 2010; Denning, Meisnere, and Warner, 2014; Tanielian et al., 2014). Spouses and family of service members also face stressors related to the military lifestyle, including coping with their service member's physical and emotional issues as well as their own problems and stressors (American Psychological Association Presidential Task Force on Military Deployment Services for Youth, Families and Service Members [hereafter "Task Force"], 2007; Lara-Cinisomo et al., 2011; Tanielian et al., 2014).

Service Member Needs

There is a large literature documenting service members' health status specifically related to mental health issues including PTSD, depression, and anxiety. However, approximately half of service members experience additional difficulties associated with the military lifestyle such as deployment and adjustment issues, employment issues, or other concerns as a result of combat stress (Denning, Meisnere, and Warner, 2014; Castro, Kintzle, and Hassan, 2015). Military life may also place stressors on service members as a product of frequent relocations, heavy workloads, a mismatch between skills and job duties, and financial stressors (Hosek, Kavanagh, and Miller, 2006; Clemens and Milsom, 2008).

Service members who deploy and separate from their families may experience psychological trauma as well as environmental and physiological stressors in combat zones, as well as the negative consequences of working for extended periods of time without time off (Hosek, Kavanagh, and Miller, 2006; Tanielian et al., 2014). Upon return from deployment, reintegration with family and into civilian life can produce a "reverse culture shock" experience, and may manifest as feelings of guilt, insecurity, hypervigilance, or feeling "out of sync" or "out of control" (Hosek, Kavanagh, and Miller, 2006; Hassan et al., 2010; Koenig et al., 2014; Castro, Kintzle, and Hassan, 2015).

Spouse and Family Needs

According to the DoD, just over 50 percent of active, guard, and reserve service members are married and about 35 percent are married with children (Defense Manpower Data Center, 2016). According to a 2010 Department of Defense report, 44 percent of the deployed military personnel for Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) were parents, out of which 48 percent deployed at least twice (Sandoz, Moyer, and Armelie, 2015). Unique stressors military families face include separation as a result of training and deployment (sometimes unexpected, repeated, or extended), uncertainty about the service member's location or well-being, additional household responsibilities taken on by left-behind family members, frequent residential moves, a lack of understanding of the deployment experience in the surrounding community and media, readjusting the deployed parent into household routines, and caregiving for those experiencing mental illness and health care stigma (Weiss et al., 2010; Chandra et al., 2011; Davis, Ward, and Storm, 2011; Eskin, 2011; Denning, Meisnere, and Warner, 2014). Service member combat experiences have also shown to be linked with an increased risk of violence in military families—both spousal and child abuse (Rentz et al., 2007; Task Force, 2007; Danish and Antonides, 2009; Westwood et al., 2010; Sherman and Bowling, 2011; Gibbs, Clinton-Sherrod, and Johnson, 2012).

A number of studies have shown that a sense of family readiness—including financial and mental readiness of family members—is an important influence on service members' well-being and intention to stay in the military (Gambardella, 2008; Werber et al., 2008; Sandoz, Moyer, and Armelie, 2015; Meadows, Tanielan, and Karney, 2016). In contrast, service members who feel isolated and struggle to reconnect with family members and others after deployment are at a higher risk for developing PTSD symptoms (Pemberton et al., 2013; Sandoz, Moyer, and Armelie, 2015). It has also been estimated that about 50–65 percent of all active-duty soldier suicides from 2007 to 2011 were triggered by the end of an intimate relationship (Snyder et al., 2011). Thus, family well-being is not only important for families, but also has implications for service member well-being and the military as a whole.

Changing Needs over Time

As the nature and scope of military conflicts have shifted over time, so have the psychosocial needs of military populations and the programs designed to support them. U.S. military conflicts of the first decade of the twenty-first century (e.g., OEF, OIF) were characterized by a general increase in troop levels, as well as an increased operational tempo which resulted in longer and more frequent deployments and shorter “dwell times” between deployments for many service members (Hosek, Kavanagh, and Miller, 2006; Danish and Antonides, 2009). Reservists were called upon more than in previous years to deploy overseas, leaving civilian jobs and communities (Danish and Antonides, 2009). Moreover, more female service members and dual-military couples were engaged in active duty than in previous conflicts (Task Force, 2007; Koenig et al., 2014). These changes positioned more military families in the deployment cycle which, coupled with the greater psychological strain placed on service members during recent conflicts, resulted in an increased demand for deployment and transition services for families between 2001 and 2012 (Hosek, Kavanagh, and Miller, 2006; Danish and Antonides, 2009).

Military deployments reached a peak in 2009, and a drawdown of U.S. military presence in the Middle East since 2012 has shifted the needs of service members and their families. A large population of previously deployed service members and their families now face the challenge of dealing with the psychological aftermath of 15 years of combat while reintegrating into a more stable military life. Many service members and their families must also deal with the stress of preparing to transition to the civilian workforce and civilian life in general (Koenig et al., 2014). Thus, although the deployment tempo has slowed since 2009, there is a substantial number of service members and their families who are vulnerable from past deployment experiences (Trail et al., 2015) and continue to need counseling services to cope with their problems.

DoD's Response to Individual and Family Needs

With the growing and changing needs of service members and their families, the DoD has made it a priority to address the well-being of military families. The military health system provides mental and behavioral health services, including psychotherapy, suicide prevention, psychological screening, medication, tele-health, inpatient psychiatric care, residential treatment, and substance abuse treatment (Weinick et al., 2011; Denning, Meisnere, and Warner, 2014). However, many service members and their families may not have diagnosable psychosocial issues,

or they may be hesitant to seek care in a clinical setting (Castro, Kintzle, and Hassan, 2015). As a result, a number of programs also exist to support service members and their families in a non-clinical context. Examples of such programs include those that aim to improve health and well-being (Bowles and Bates, 2010; Meredith et al., 2011); increase unit strength and morale (Bowles and Bates, 2010; Meredith et al., 2011); create a ready force (Bowles and Bates, 2010; Meredith et al., 2011); and increase resilience (Meredith et al., 2011; “Ready Resilient,” 2016).

Two of the largest service delivery options for receiving non-medical counseling that are administered by the ODASD (MC&FP) are the MFLC and Military OneSource programs. Both programs were established in 2004 to respond to the non-clinical needs of service members in a certain geographic area or to individuals in a particular military service. These programs were developed to provide a confidential platform to address daily stressors and to reduce the stigma that is generally associated with military counseling. Since their inception, they have expanded to provide support services to military members and their families both domestically and internationally through different forms of delivery. Non-medical services are provided by counselors with a master’s degree or Ph.D. in a mental health-related field (e.g., psychology, counseling) and are licensed as an independent practitioner in a state, U.S. territory, or the District of Columbia. Prior to working under the MFLC contract, counselors receive training on all aspects of the contract and on military culture and customs. As employees of the contractor, counselors receive supervision from their contract supervisor.

Although part of non-medical counseling is focused on providing counseling services for non-clinical psychological issues such as stress, relationship problems, or bereavement, counselors are not trained on or required to use a specific type of assessment or structured therapy such as brief problem-solving therapy or cognitive-behavioral therapy. Rather, counselors use a psychoeducational counseling approach which teaches service members and their families how to anticipate and to address challenges and problems. The approach provides participants with specific information about what is happening; the meaning of specific symptoms; what is known about the causes, effects, and implications of their issues; and how to find treatment and/or resources. In this way, psychoeducation is grounded in a preventative model, in which the knowledge and skills provided by counselors facilitate members’ and their families’ readiness and resilience, reducing and ideally preventing escalation to clinically harmful levels.

From a prevention perspective, these programs can be conceptualized as selective interventions that target individuals or subgroups of the population whose risk of developing a mental disorder is higher than average, as evidenced by psychological or social risk factors (Mrazek and Haggerty, 1994). Non-medical counseling can help address risk factors that could otherwise cause problems to become more severe and endure for longer periods of time. Counseling can also help individuals strengthen or develop protective factors such as emotional resilience, positive thinking, problem-solving and social skills, stress management skills, and feelings of mastery (World Health Organization, 2004). Although most published articles on selective interventions are specific to a population, risk factor, or outcome and are not directly comparable to broader programs like MFLC and Military OneSource, selective interventions targeted at addressing major life events or stressors have shown significant and long-term reductions in mental health symptoms (Sörensen, Pinquart, and Duberstein, 2002; Wolchik et al., 2002; World Health Organization, 2004).

Military and Family Life Counseling

The MFLC program was established in 2004 at Fort Carson, Colorado, in response to the increasing need for education, information, and support services among service members serving in the Iraq and Afghanistan Wars and their families. The program was designed to provide non-medical counseling services that address issues specific to the military lifestyle and to prevent problems (or stress resulting from problems) from developing into mental health issues that may interfere with military readiness or reintegration. Non-medical counseling through MFLC is intended to supplement other existing military support programs and is not associated with clinical services through the military or other medical providers.

Under this program, individuals may receive up to 12 sessions of in-person counseling per issue. Each session may last from a few minutes to two hours based on individual's needs. Family, couple, and group modalities are also utilized. Non-medical counseling is available to address concerns related to deployment and reintegration; communication; coping with anger, grief, or stress; and education or work problems. Issues that cannot be resolved through brief or short-term interaction with MFLC are referred to appropriate behavioral or mental health services, or other TRICARE providers. These include issues related to sexual assault, mental health concerns that require inpatient care, substance abuse, and domestic violence.

A core feature of this program is that counselors do not keep clients' personally identifiable information. However, this confidentiality is not maintained in situations that involve domestic violence, child abuse, and duty to warn (harm to self or others); such situations are reported to the respective military, federal, and state authorities. Similarly, individuals who currently see another counselor, are in review for sexual assault or abuse, take prescribed psychotropic medication, or have a mental health concern that requires inpatient hospitalizations are not eligible to receive MFLC services.

MFLC counselors provide counseling on an as needed basis, with delivery of services tailored to meet the diverse needs of service members and families (e.g., outside of normal work hours, at off-base locations). Originally, MFLC rotated counselors at installations for 30, 60, or 90 days but has since expanded its methods of delivery to include rotational assignments of counselors for up to one year on military installations domestically or abroad; counselors embedded within military units (i.e., assigned to a specific unit of command versus providing temporary surge support or support across several units); immediate support for three days to reserve component members for predeployment, deployment, or reintegration activities; and counselors assigned to Army and Marine Corps recruit commands that may not be near a military installation and to the National Guard and reserve components. MFLC also provides access to "surge" counseling support in which commanders may request up to 20 MFLC counselors to provide 45 days of support to members of a unit returning from combat. In this setting, counselors meet individually with service members to discuss reintegration issues. For family members, MFLC offers child and youth behavioral services through military-connected child programs, schools, and summer programs.

Overall, MFLC consists of approximately 2,000 counselors serving on installations, in Child Development Centers, embedded in military units, schools, camps, and providing support for surge needs to units returning from combat. MFLC counselors provide support in 17 countries and all U.S. states and territories. In FY15, across all the services they provide, MFLC counselors had approximately 4.5 million in-person contacts. During the study time frame, MFLC counselors addressed about 7,400 new adult non-medical counseling cases each month

that fit the study specification (i.e., adults only, individual or couples sessions, 30 minute or longer session). That equates to 88,800 new adult non-medical counseling cases per year.

Military OneSource

Established in 2004, Military OneSource was designed to supplement existing family support resources (e.g., chaplains, family centers). Military OneSource offers confidential, free assistance to service members and their families—including those on active-duty and members of the National Guard and reserves, regardless of activation status—who are seeking help with a range of issues affecting service member and family well-being. Military OneSource support complements existing military family programs by offering resources and educational materials to individuals, along with non-medical counseling services. Non-medical counseling sessions may focus on an array of issues including finances, employment and education, parenting and child care, relocation, deployment, faith and spirituality, family members with special needs, family relationships, stress, grief, and decisionmaking or other general life skills. Individuals can receive at least 12 free sessions per person per issue. Military OneSource counselors use psychoeducational strategies to teach participants skills to resolve their issues and confidently approach future problems. Individuals with concerns that require more intensive support may be ineligible for non-medical counseling and can instead use Military OneSource to obtain information and referrals to more specialized services. These issues may be related to mental health diagnoses, substance use disorders, prescription medication, sexual assault, and fitness for duty.

Military OneSource is available 24 hours a day, seven days a week, and individuals can call Military OneSource to be connected to available resources or local non-medical counselors (within 15 miles or 30 minutes away within the contiguous United States). Along with in-person counseling, individuals have the flexibility to attend these 50-minute sessions over the phone, through online instant messaging or email, and via online video calls. Multiple modalities are available to ensure access to non-medical counseling services despite individuals' location. Records are not shared with any entity, including the military, unless a "duty-to-warn" situation occurs (i.e., child abuse/neglect, imminent safety of the counseling recipient or others, or illegal activities; DoD, 2009).

Military OneSource contracts with a network of counselors in all U.S. states and territories. Counselors are located in communities near military installations and National Guard and reserve activities for easy access by participants. While the number of counselors is considered proprietary to the contractor, Military OneSource counselors provide more than 170,000 non-medical counseling sessions annually.

Effectiveness of Military Support Programs

While many programs are available to support service members and their families, evidence on their effectiveness is limited due primarily to the lack of coordinated monitoring and evaluation efforts. For example, the National Academies of Science recently conducted an assessment of the programs available for preventing psychological disorders in service members and their families and found no comprehensive list of programs, systematic evaluation mechanisms, or standard measures used to track effectiveness (Denning, Meisner, and Warner, 2014). The review determined that while there were many programs addressing a wide array of

issues, many were duplicative of other programming, few were informed by evidence, and even fewer were regularly evaluated, if evaluated at all.

The 2014 National Academies of Science review also found that there is no mechanism to track programs for service members and their families, including monitoring program goals and impact (Denning, Meisnere, and Warner, 2014). Among programs that resembled counseling programs, evaluation efforts focused primarily on utilization patterns and client satisfaction ratings (Meredith et al., 2011). Moreover, while the cost of treating psychological problems among service members more than doubled between 2007 and 2012, systematic information on cost of programs to prevent psychological issues is not collected (Denning, Meisnere, and Warner, 2014). Combined with limited information on program outcomes, the military is generally unable to determine the cost-effectiveness of programs it currently funds (Denning, Meisnere, and Warner, 2014).

The few programs that have published effectiveness data show improvements in individuals' mental health symptoms, including distress, anxiety, and depression (Army Center for Enhanced Performance, Battlemind; Meredith et al., 2011; Task Force, 2007; Bowles and Bates, 2010); cognitive skills including attention (HeartMath; Meredith et al., 2011), memory improvements (HeartMath; Meredith et al., 2011) and cognitive performance (Mindfulness-Based Mind Fitness Training; Meredith et al., 2011); and stress level maintenance (Mindfulness-Based Mind Fitness Training; Meredith et al., 2011). Programs have also demonstrated increased career benefits among program participants, including higher promotion rates (Hudak et al., 2009) and higher rates of returning to duty following stressful experiences (Air Force Combat Stress Control and Prevention; Hassan et al., 2010).

A limited number of studies examined the impact of military support programs on families. Meadows, Tanielan, and Karney (2016) found that service members and spouses who were engaged in more preparation activities for deployment reported greater satisfaction in parenting after deployment. Additionally, Chandra et al. (2011) found that military families that utilized military support services reported fewer child mental health issues than their counterparts. Finally, Cozza et al. (2010) found that military families with higher levels of stress prior to a service member's injury are more likely to be negatively impacted by the injury than families with lower levels of stress before the injury. This suggests that providing stress-coping and resilience-building strategies may be beneficial in protecting families against military-related stressors.

Because of the general lack of studies examining whether non-medical counseling helps participants resolve problems, OSD asked RAND's National Defense Research Institute (NDRI) to conduct this study.

Organization of This Report

In the remainder of this report, we present the study approach and findings regarding the effectiveness of and satisfaction with non-medical counseling provided through the MFLC and Military OneSource programs in addressing participants' problems. In Chapter Two, we discuss the evaluation design, study methodology, and analytic approach. In Chapter Three, we discuss findings related to problem severity and overall problem resolution following non-medical counseling. Chapter Four examines the extent to which stress and anxiety resulting from the presenting problem lessened following non-medical counseling. Chapter Five examines the extent

to which problem interferences with work and daily life decreased following non-medical counseling. In Chapter Six, we examine connections to other services and referrals resulting from non-medical counseling. Chapter Seven describes the experiences individuals had with the non-medical counseling programs and counselors, including their perception of services received, level of satisfaction, and anticipated future use. Chapter Eight includes a summary of key findings with implications for the future direction of non-medical counseling.

Each chapter begins with a summary of key, top-level findings that may be most relevant to a policy audience. Top-level findings are reported for statistically significant effects on the same variable across programs. When percentages vary between programs, the smallest effect is reported in the top-level findings. Additional analytic detail and findings are presented in the remainder of each chapter. This additional detail may be more relevant for MFLC and Military OneSource program staff or those interested in the specific chapter topic. Additional information about the data collection and analysis, survey instruments, and study findings, including subgroup analyses, can be found in Appendixes A, B, and C, respectively.

Evaluation Design, Methodology, and Analytic Approach

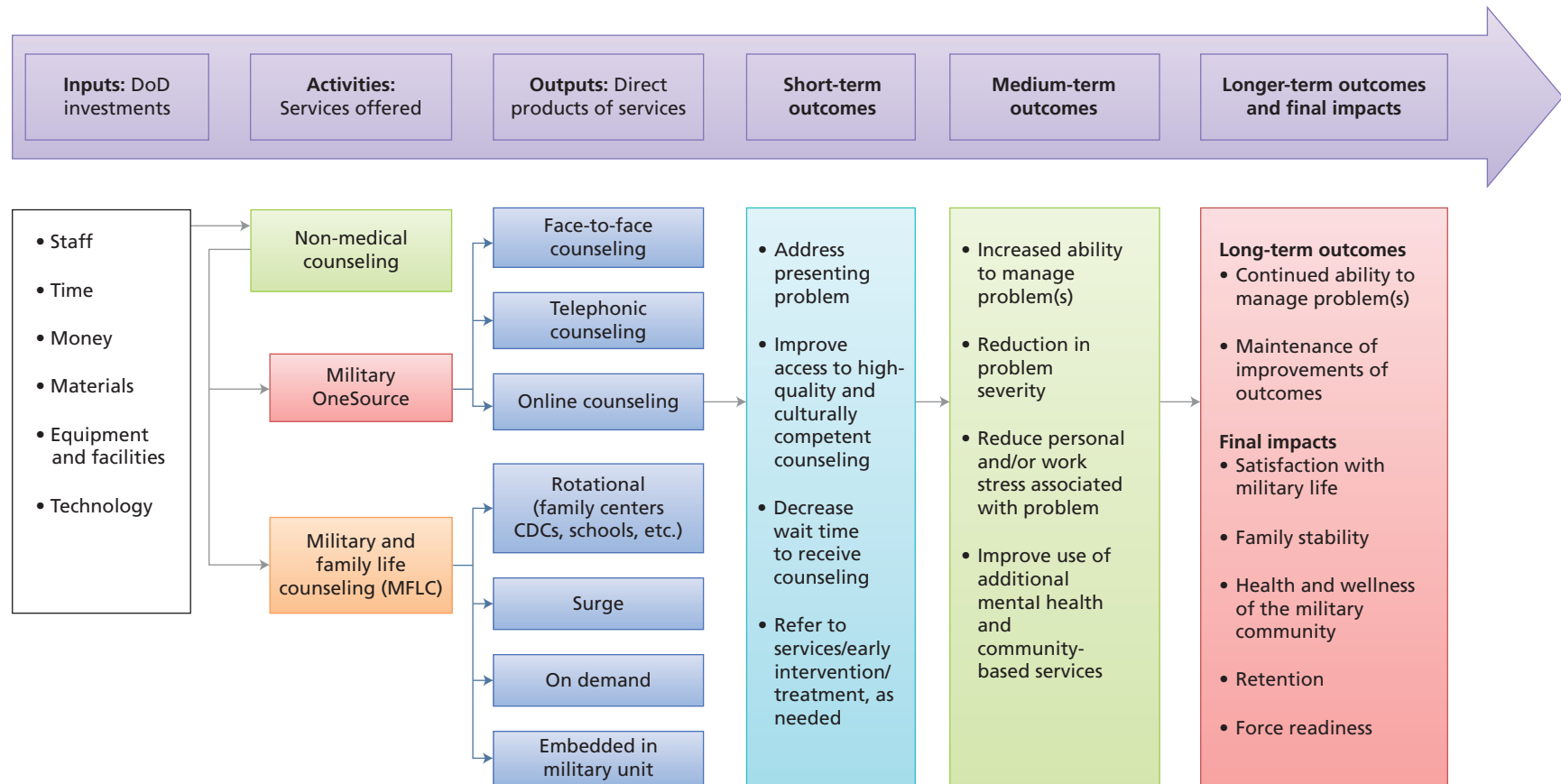
This evaluation was designed as two separate but parallel studies. While both MFLC and Military OneSource provide non-medical counseling services to military-connected individuals and families, as noted in Chapter One, they operate separately and there are important differences in the ways in which services are delivered. Despite their differences, their goals are the same: to provide short-term, solution-focused counseling to address general conditions of living and military lifestyle. As a result, the evaluation design, survey instruments used to collect data, the timeline for data collection, and our analytic approach were very similar for both programs.

The objective of this study is to describe the effectiveness of and satisfaction with each non-medical counseling program in addressing participants' problems overall. The study is not intended to examine the clinical effectiveness of specific therapies that may be provided to individuals, specific training techniques counselors might use (e.g., for personal financial counseling, anger management training) or to compare the outcomes of one program to the other. Because the mode of service delivery and the populations served vary by program, comparisons between the two programs on similar outcomes should not be made. Similarly, results across the programs cannot simply be averaged to identify the overall impact of non-medical counseling programs.

Evaluation Design

Our evaluation design was based on a logic model developed for this evaluation (Figure 2.1). The logic model starts with DoD investments to implement non-medical counseling. This takes the form of staff, time, money, materials, and equipment. There are two types of activities—non-medical counseling provided by either MFLC or Military OneSource, which should produce specific outcomes. In the short term, the availability of non-medical counseling should result in improved access to such services, earlier referrals to other services as indicated, and begin to address the immediate needs and concerns resulting from the presenting problem. Because some problems may require multiple sessions, and it may take time to learn how to effectively utilize the skills and approaches to problem resolution shared as part of non-medical counseling, it is expected that over time individuals will have an increased ability to manage their presenting problem, resulting in a reduction in problem severity and a reduction in stress and anxiety. In the longer term, it is expected that there would be a continued ability to manage non-medical problems, and a maintenance of or further improvement in problem severity and stress. In addition to these effects at an individual level, non-medical counseling

Figure 2.1
Logic Model for Evaluation of Non-Medical Counseling Programs



NOTE: CDC = child development center

RAND RR1861-2.1

has the potential to have a larger impact within military communities through improvements in force readiness, family stability, health and wellness, retention, and satisfaction.

We provide a brief overview of the study design here, with additional details provided in the remainder of this chapter and in Appendixes A and B. For both MFLC and Military OneSource, data collection occurred in two waves. Eligible individuals were invited to participate and completed the Wave 1 survey shortly after their first non-medical counseling session. Participants were asked to complete a similar survey three months later (Wave 2). Because non-medical counseling provides short-term, solution-focused counseling for 12 sessions, three months was considered a reasonable period of time to measure long-term problem resolution. Data collection occurred from October 2014 to November 2016 for MFLC and from April 2015 to November 2016 for Military OneSource. The data collection periods differed in length because of administrative challenges encountered in ensuring an adequate number of participants from each program. Both studies collected data for at a minimum a full calendar year to ensure that findings were not driven by potential seasonal variation in non-medical concerns or service use. Prior to analysis of the data, for both MFLC and Military OneSource, survey data were merged with a limited amount of administrative data for those individuals who consented to participate in the study.

Inclusion Criteria for Study Population

Non-medical counseling services, by design, are flexible in their length and mode of delivery and available to service members, spouses, and other family members, including military-connected children. While such flexibility can be beneficial in the implementation of a program and allow counselors to provide services to meet clients' needs, these types of differences present challenges for program evaluation. As such, we worked with program leadership from the outset to identify the most appropriate study participants. The study population for both MFLC and Military OneSource was limited to adults aged 18 years or older who received at least one non-medical counseling session of 30 minutes or more in an individual or couples setting.

Children were excluded from the study as the non-medical services available to them differ programmatically from those that adults receive (e.g., services are embedded in schools) and are provided by a different set of non-medical counselors with expertise in children and youth. The requirement that sessions be of 30 minutes or more was included to capture sessions where participants received more intensive non-medical counseling services (e.g., the study did not include brief chats with a counselor). As a result, findings from this report should not be generalized to other populations, modes of delivery (e.g., group counseling sessions, training, support groups), or length of counseling sessions, which should be evaluated separately. It is important to note that only individuals who used non-medical counseling services were included in this study. Although the inclusion of a comparison group would have strengthened the findings by allowing us to make causal inferences, the logistical challenges of finding individuals in need of non-medical counseling services but who did not engage with MFLC or Military OneSource made this option untenable within the scope of this project.

Recruitment of Participants

Recruitment of participants for the study took place in two phases. First, program staff from MFLC or Military OneSource introduced the study to potential participants and asked each individual whether he or she would be interested in receiving more information about the study. Then RAND NDRI followed up with official invitations to those individuals expressing interest.

MFLC counselors introduced the study to eligible participants and handed them a card where they indicated whether or not they were interested in learning more about the study. If they were, participants included their email address so that RAND NDRI could invite them to participate. Each card was stamped with a randomly assigned unique ID number which allowed us to link survey results for consenting participants to administrative data about their non-medical counseling session, while ensuring that the strictly confidential nature of the program was kept intact.

For Military OneSource, when individuals first contacted Military OneSource about their problem and were determined to be eligible for non-medical counseling services, triage consultants introduced the study and asked whether or not participants were interested in learning more. If the individual indicated interest, their email address was recorded and saved in a separate, secure database accessible to RAND NDRI researchers, and RAND NDRI used that information to invite them to participate in the study. The study team purposefully kept recruitment activities by program staff at a minimum to ensure potential participants felt comfortable accepting or declining study participation, without any perceived influence on counseling relationships. See Appendix A for a complete description of the recruitment methodology.

Survey Instruments

Wave 1

The Wave 1 survey was taken on average two weeks (for Military OneSource) to one month (for MFLC) after the participant's first counseling session. The survey was administered online and consisted of questions assessing several different domains related to respondents' problems, problem resolution, and their experience with non-medical counseling. Although many questions were developed for this study, we drew upon existing standardized measures in the civilian and military literature, where possible, related to problem resolution (e.g., Status of Forces Survey; Defense Manpower Data Center, 2012), provider satisfaction (e.g., CAHPS [Consumer Assessment of Healthcare Providers and Systems] Surveys and Guidance, 2017), and experiences with non-medical counseling programs like civilian employee assistance programs. We did not include standardized outcome measures specific to non-medical counseling concerns (e.g., grief, relationship challenges) given the variability in needs and presenting problems. Process and outcome measures selected for the study were intended to be broadly applicable to all participants.

Each survey topic corresponded to one or more components of the program logic model (see Figure 2.1). The survey was designed to capture both participants' retrospective assessments of the severity of their problem and perceived impact on their life prior to counseling, as well as an assessment of their problem's severity and perceived impact shortly after they began non-medical counseling (i.e., at the time of the survey). The survey also included participants'

Table 2.1
Survey Topics Matched to the Logic Model Outcomes

Logic Model Outcome	Survey Topic(s) Evaluated in Both Wave 1 and Wave 2 Surveys
Short-term outcomes	
Reduction in problem severity	Perceived severity, perceived stress, interference with work and personal life
Increase in access to high-quality ¹ services	Ease of access, perceived counselor quality, perceived competence, perceived alignment of treatment with need, adequacy of materials and information, satisfaction with service, perceived strengths and weaknesses of program
Increase in referrals to other services, as indicated	Referral to services, types of services accessed outside of MFLC/Military OneSource
Medium-term outcomes	
Increase in ability to manage problems and reduction in problem severity	Perceived severity
Reduction in stress	Perceived stress, interferences with work and personal life
Increase in mental health and other community services	Types of services accessed outside of MFLC/Military OneSource
Longer-term outcomes and final impacts	
Continued ability to manage problems	Problem severity, anticipated future use
Maintenance of improved outcomes	Perceived stress, interferences with work and personal life
Final impacts	Self and family felt more prepared for deployment, children felt better supported, retention in military, recommended use of non-medical counseling to others

NOTE: The outcomes in the left column correspond to the logic model presented in Figure 2.1.

¹ The logic model assumes that the specific services provided to participants are of high quality, but this evaluation does not directly assess the quality or appropriateness of the specific types of services or supports provided by non-medical counselors, as these vary considerably across participants. Rather, we use perceptions of quality, perceptions of adequacy and alignment of services to need, and overall satisfaction as universal indicators of program quality.

experiences with and perceptions of counseling, referrals to other resources, counselor quality, and their anticipated future use of the program. Table 2.1 contains a summary of survey topics and how they correspond to the outcomes in the logic model. The full survey is included in Appendix B.

Wave 2

The outcome domains and measures assessed by the Wave 2 survey were identical to those assessed at Wave 1 (Appendix B). The survey was also administered online and displayed the type of problem that the respondent identified on the baseline survey. It informed participants that “we are interested in learning more about your experiences with this issue/concern in the three months since you completed the initial survey.” Questions were anchored to the three months since respondents completed the baseline survey. This allowed us to examine changes over time in our outcomes of interest, including problem severity, stress and anxiety, and effects on work and family life. The survey also included questions related to help-seeking for the

same problem, including continued support from MFLC or Military OneSource or from other sources of treatment.

Administrative Data

In order to shorten the number of questions asked on the survey and to obtain the presenting problem for which participants sought help, we matched the survey data for participants who consented to the study with the administrative records for their counseling session. For MFLC participants, this involved matching the randomly assigned ID number printed on the study interest cards and recorded on the activity log for the session by counselors with survey data bearing the same number. For Military OneSource, survey data were matched with counseling session records via the participants' email address. The information from administrative records that was used in the current study included participant age, gender, marital status, relationship to the sponsoring service member (e.g., self, spouse, other family member), service, component, pay grade, number of prior sessions, whether or not the counselor was embedded within the sponsor's unit (MFLC only), and the presenting problem (often noted as "V code" in administrative records¹).

Response Rates and Study Participants

MFLC

In order to compute survey response rates, we used the total number of individuals who were offered the opportunity to take part in the study as the denominator to calculate response rates. For MFLC participants, the denominator is the total number of unique study solicitation cards returned to RAND NDRI, and included both those cards with requests for additional information about the study (i.e., marked "yes" with an email address) and those not requesting additional information about the study (i.e., marked "no"). The total number of cards received from MFLC was 40,494, with 14,903 cards indicating interest in the study (36.8 percent). Because individuals were given a card after every session, individuals with more than one counseling session were likely to receive multiple cards. RAND NDRI received 3,259 cards that included an email address identical to one already included in our list of interested participants (22 percent of cards indicating interest in the study). Since cards indicating no interest contained no identifying information, it is unclear how many of those cards were duplicates (e.g., one person declining interest twice).

In addition, emails to 1,080 interested MFLC participants were returned as undeliverable, and attempts to resolve the email addresses of these participants failed. Thus, subtracting the 3,259 duplicates and 1,080 individuals with undeliverable email addresses from the total left 36,155 potential participants for the study. A total of 2,585 MFLC participants completed one or more items on the survey, for a response rate of 7.1 percent, and 2,310 completed every item on the survey, for a response rate of 6.4 percent. For the Wave 2 survey, a total of 614

¹ V codes, as described in the ICD-9-CM "Official Guidelines for Coding and Reporting, Supplementary Classification of Factors Influencing Health Status and Contact with Health Services," are used by providers to classify patient visits when circumstances other than a disease or injury result in an encounter with a provider (e.g., relationship distress, parent-child relational problem; Kostick, 2011).

MFLC participants completed one or more items, and 541 completed all items on the survey (between 20.9 percent and 26.6 percent of Wave 1 participants).

Military OneSource

Military OneSource maintains a log of calls made to their triage consultants and records who receives a referral to a counselor, which is indicative of the need for a longer (30-minute or more) counseling session. Using this system, we identified 34,632 unique participants eligible for the study. Of these, 28,199 expressed interest in receiving more information about the study (81.4 percent of all eligible participants). Of those, a total of 2,892 individuals completed one or more items on the survey, for a response rate of 8.6 percent, and 2,417 completed all items on the survey, for a response rate of 7.2 percent. Since survey items are weighted and analyzed on an item-by-item basis, the response rate for any one question is between these two figures. For the Wave 2 survey, a total of 878 Military OneSource participants completed one or more items, and 793 completed all items on the survey (between 27.4 percent and 36.3 percent of Wave 1 participants).

Response rates for both MFLC and Military OneSource were low, but not atypical for studies of military service members and their families (Miller and Aharoni, 2015). As with all surveys, low response rates increase the potential for bias in the results because there is greater probability that the respondents are not representative of the population the survey is meant to assess (e.g., respondents could only represent those who are dissatisfied with non-medical counseling). However, comparisons to population-level characteristics of all program users who met eligibility criteria for the study revealed that study participants were representative of the population on demographic characteristics and problem type. Numerous studies have found that sample representativeness, and not the response rate, is the key indicator of a biased sample (see Miller and Aharoni, 2015). As discussed in detail below, where there were differences between the sample and population characteristics we adjusted the data to be representative of the population.

Demographic Information

Demographic information describing the MFLC and Military OneSource study participants is shown in Table 2.2. We used a process called “raking” to weight the data to be representative of the population of non-medical counseling participants. See Appendix A for a complete description of weighting procedures and comparison of the study sample to the population.

We should note that all MFLC participants recruited for this study met with their counselor in person, but Military OneSource participants were able to use different modes to communicate with their counselor (e.g., phone, web chats). At Wave 1, 85 percent of Military OneSource participants had met with their counselor in person, 12 percent had talked with them over the phone, just less than 2 percent had chatted online, and just over 1 percent had met with their counselor via video link.

Analytic Approach

We analyzed the survey results using both quantitative and qualitative methods.

Table 2.2
Demographic Characteristics of the MFLC and Military OneSource Study Samples

Characteristic	MFLC (%)	Military OneSource (%)
Age		
18–24	18.6	6.8
25–40	71.6	69.6
41 and over	9.8	23.6
Service affiliation		
Army	49.0	34.7
Marines	14.4	7.5
Air Force	31.7	21.9
Navy	3.8	19.1
Other	1.2	16.7
Rank (self or sponsoring family member)		
Enlisted	78.5	68.7
Officer	21.5	31.3
Service member status		
Family member	57.2	35.7
Service member	42.8	64.3
Component affiliation		
Active duty	98.1	73.4
Guard or reserve	1.9	26.6
Gender		
Women	60.4	56.8
Men	39.6	43.2

NOTE: Percentages are weighted to be representative of the MFLC and Military OneSource non-medical counseling population.

Quantitative Methods

We analyzed the survey data using two types of regression models: models that describe responses to survey questions at a single point in time (e.g., problem severity ratings at Wave 1) and models of changes over time (e.g., changes in problem severity from precounseling levels retrospectively assessed at Wave 1 to problem severity assessed at Wave 2). In order to explore whether there were notable differences by problem type or client characteristics, all models included the following covariates: gender; a three-category age variable (under 25 years; 25–40 years; 41 years and above); whether the respondent was a service member (as compared to a spouse or other family member); service affiliation (Air Force, Army, Marine Corps, Navy, or Coast Guard); component affiliation (active or reserve); officer or enlisted (self or sponsoring family member); and, in the case of MFLC, whether the counselor was embedded in the sponsoring service member's unit or not. We also included an indicator of the primary presenting

problem. Thus, all results reporting differences among client characteristics or problem type control for the other covariates in the model. Given the number of variables representing subgroups of client characteristics and problem type that were included as covariates, as well as the number of outcomes that we investigated, we set the criterion p -value for reporting significant subgroup differences at $p < .01$. Even though we use a more stringent cutoff than the typical $p < .05$, we do not control the overall error rate; hence, the subgroup analyses should be considered exploratory. Also, because fewer people responded to both the Wave 1 and Wave 2 surveys, we have less statistical power to detect long-term subgroup differences in outcomes.

We also use this type of model to report on distributions of outcome variables across all respondents in a survey wave. Because some individuals did not respond to every question when taking the survey, we wish to account for item non-response in these summaries. Accordingly, rather than report raw responses, we report estimated *probabilities* of providing a particular response for each respondent to a particular wave (regardless of whether the individual responded to the particular question of interest). Moreover, the estimated probabilities depend on the covariates mentioned in the previous paragraph. In cases where covariates are missing, we multiply impute plausible values, and the reported probabilities are averaged over the multiple imputations.

We examined differences in demographics between those who responded to the Wave 2 survey and those who did not. For surveys, the absolute standardized mean difference between groups is a common metric for measuring similarity between two groups. Typically, if the standardized mean differences are below 0.2 for all covariates, the two groups are considered to be similar (i.e., statistically well-balanced). Comparing the demographic characteristics between Wave 2 respondents and non-respondents, the only characteristic that was dissimilar between groups according to this metric was age (standardized mean differences of 0.25 for MFLC and 0.22 for Military OneSource). For both MFLC and Military OneSource samples, older participants were more likely to complete the Wave 2 survey than were younger participants. Since age was only modestly imbalanced for both MFLC and Military OneSource samples, and the regression models control for age, the potentially confounding effect of age is taken into account in our analyses of the Wave 2 data. See Appendix A for a complete description of the quantitative analytic approach used in this report.

Qualitative Methods

Survey respondents had the option to provide open-ended responses to two questions assessing the perceived strengths and weaknesses of the non-medical counseling program (“What do you see as the major advantages or strengths of non-medical counseling offered by Military and Family Life Counseling [Military OneSource]?”; “What do you see as the major concerns or challenges related to non-medical counseling offered by Military and Family Life Counseling [Military OneSource]?”). A total of 1,819 MFLC participants (79 percent) and 1,055 Military OneSource participants (44 percent) provided responses to the open-ended questions at Wave 1, and 420 MFLC participants (78 percent) and 619 Military OneSource participants (78 percent) provided responses to the open-ended questions at Wave 2. Researchers used an iterative process to develop codes for responses to each question based on recurring themes. Representative participant quotes from relevant open-ended codes are interspersed throughout the report to illustrate findings from the survey. See Appendix A for a complete description of the qualitative analysis used in this report.

Severity and Overall Problem Resolution

In this chapter, we first examine the types of problems for which individuals are seeking non-medical counseling. We then examine whether individuals experienced short-term decreases in problem severity and overall problem resolution following non-medical counseling, and whether these reductions were maintained long term. Short-term problem resolution was measured by comparing retrospective self-reports of precounseling problem severity with the ratings of problem severity at the time of the Wave 1 survey, taken approximately two to three weeks after a participant's initial counseling session. Longer-term problem resolution and impact were assessed at Wave 2 (three months after the Wave 1 survey). Statistically significant differences among subgroups are discussed in the text and subgroup differences are tabulated in Tables C3.1–C3.5 in Appendix C.¹

Key findings from this chapter include:

- The most common problems participants reported were family or relationship problems; followed by stress, anxiety, or emotional problems; and problems with conflict resolution or anger management.
- Participants reported a statistically significant reduction in problem severity following non-medical counseling.
- Over 65 percent of individuals experienced a reduction in problem severity in the short term.
- Reductions in problem severity were maintained long term with over 80 percent of individuals reporting the same or improved problem severity in the three months after receiving counseling.
- Women tended to report greater short-term problem resolution than men.
- Fifty percent or less of participants agreed or strongly agreed that non-medical counseling made them or their families feel more prepared for deployment. Between 30 percent (Military OneSource) and 44 percent (MFLC) of participants agreed or strongly agreed that non-medical counseling made reintegration after deployment easier.

¹ All subgroup differences described in this report were significant controlling for other variables in the regression model: gender; a three-category age variable (under 25 years; 25–40 years; 41 years and above); whether the respondent was a service member (vs. spouse or other family member); service affiliation (Air Force, Army, Marines, Navy, or Coast Guard); component affiliation (active, reserve); officer or enlisted (self or sponsoring family member); and, in the case of MFLC, whether the MFLC was embedded or not. We also included an indicator of the category for the V code of the primary presenting problem.

- Just under half of MFLC participants and 41 percent of Military OneSource participants agreed or strongly agreed that non-medical counseling had an impact on their desire to stay in the military (or remain a military family).
- Participant responses to open-ended items suggest that the broader community of service members and their families may lack awareness of the availability of non-medical counseling through these programs, particularly through the MFLC program.

Problem Type

As shown in Table 3.1, when asked to report the type of problem(s) participants had sought non-medical counseling to address, the majority of MFLC and Military OneSource participants indicated that they had sought counseling for family or relationship problems (68 percent and 74 percent, respectively), followed by stress, anxiety, or emotional problems (55 percent and 43 percent, respectively). A little over a quarter of MFLC respondents and 21 percent of Military OneSource respondents indicated that they had sought counseling for conflict resolution or anger management.

Of those whose current problem did not involve family or relationship issues, almost 22 percent and 24 percent had sought help from MFLC and Military OneSource counselors, respectively, for these kinds of issues in the past. Thus, approximately 90 percent of MFLC and Military OneSource respondents had sought help with family or relationship problems from MFLC or Military OneSource counselors, either currently or sometime in the past. Similarly, of MFLC or Military OneSource respondents whose current problem did not involve stress, anxiety, or emotional problems, just over 19 and 13 percent, respectively, had sought help for these kinds of issues in the past. Thus, about three quarters of MFLC respondents and 56 percent of Military OneSource respondents had sought help for stress, anxiety, or emotional problems from their respective counselors, either currently or in the past.

For this question, participants could select all problems for which they were seeing a non-medical counselor. For the remainder of our analyses, however, we examine group differences by primary problem type, which was obtained from the primary problem (reported in administrative records as ICD 9 “V codes”).² We used V codes instead of self-reports because the reported V code is the trained counselor’s professional judgment of the primary reason the participant is seeking counseling. Thus, we were able to assign each participant one primary problem type rather than several self-reported problem types. To ensure adequate sample size, we collapsed the primary V code problem type into six problem domains. V codes that represented subcategories of problems (e.g., “marital and partner problems, unspecified”) were collapsed into their larger overall ICD 9 problem domains (e.g., “family or relationship problems”). Two problem domains with fewer respondents—employment assistance and education assistance problems—were combined into an “education or employment” problem domain. The six problem domains were therefore child issues; deployment concerns; education or employment; family or relationship; loss or grief; and stress, anxiety, or emotional problems.

² V codes, as described in the ICD-9-CM “Official Guidelines for Coding and Reporting, Supplementary Classification of Factors Influencing Health Status and Contact with Health Services,” are used by providers to classify patient visits when circumstances other than a disease or injury result in an encounter with a provider (e.g., relationship distress, parent-child relational problem; Kostick, 2011).

Table 3.1**Type of Non-Medical Problem Reported by MFLC and Military OneSource Participants**

Problem Type	MFLC		Military OneSource	
	Most Recent Problem (%)	Sought Counseling for This Problem in the Past (%)	Most Recent Problem (%)	Sought Counseling for This Problem in the Past (%)
Child issues (e.g., academic, behavioral)	11.8	9.7	8.4	5.3
Family or relationship issues	67.8	21.6	73.6	23.6
Conflict resolution or anger management	26.1	14.5	20.8	8.8
Exceptional family member support ¹	7.0	6.6	2.8	2.2
Stress, anxiety, or emotional problems	55.3	19.2	43.1	13.1
Deployment concerns or support	8.3	10.1	7.6	5.0
Reintegration concerns or support	7.2	9.2	5.6	4.7
Relocation/permanent change of station (PCS) concerns or support	7.8	7.0	3.8	2.0
Wounded warrior concerns or support	2.3	3.2	1.0	1.0
Loss or grief	12.8	9.9	10.1	4.5
Personal financial management	5.9	8.2	2.7	3.0
Employment assistance	4.1	4.6	1.5	2.3
Education assistance (for self or spouse)	3.3	5.0	1.4	2.7
Care for disabled or elderly adult	1.2	2.3	0.6	1.1
Other	7.3	3.9	5.1	1.4

NOTE: Respondents were able to check all problem types that apply and so totals do not equal 100%. Percentages are weighted to be representative of the MFLC and Military OneSource non-medical counseling population. *n* sizes varied from 1,842 (other problem) to 2,524 (family or relationship) for MFLC and from 1,938 (other problem) to 2,650 (family or relationship) for Military OneSource.

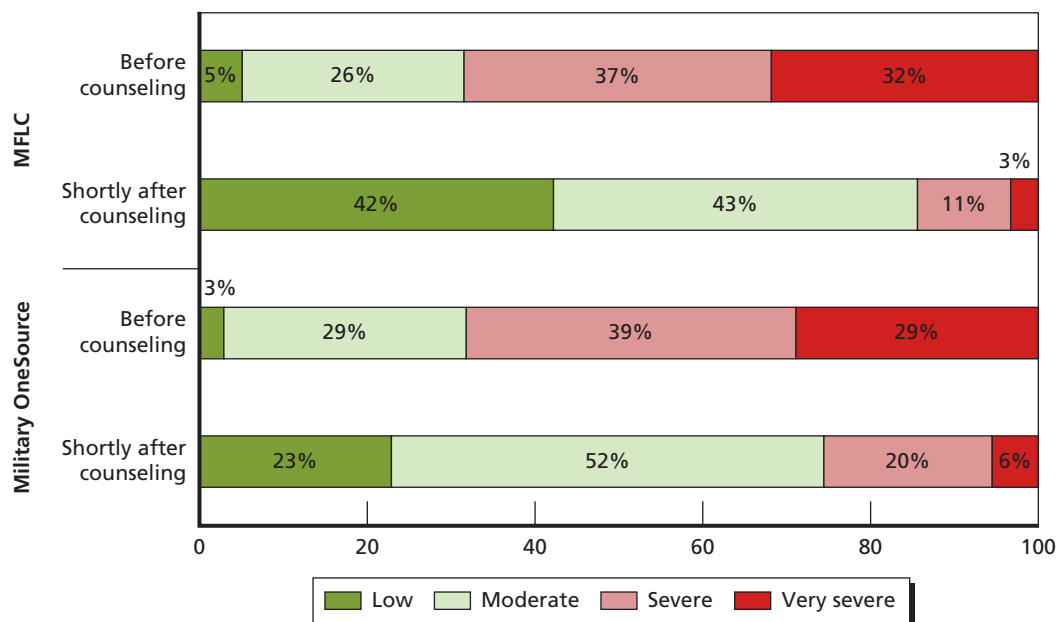
¹ The Exceptional Family Member Program is a program that works with other military and civilian agencies to provide comprehensive and coordinated community support, housing, educational, medical, and personnel services to families with special needs.

Short-Term Changes in Problem Severity

On the Wave 1 survey, administered shortly after the first non-medical counseling session, we asked participants to retrospectively assess the severity of their problem before receiving counseling and also to assess their level of problem severity at the time of the survey. Respondents rated the severity of their problem on a four-point scale: low, moderate, severe, or very severe. As shown in Figure 3.1, before receiving counseling, most participants rated their problems as severe or very severe (69 percent of MFLC and 68 percent of Military OneSource participants). After initiating non-medical counseling (Wave 1), only 14 percent of MFLC and 26 percent of Military OneSource participants rated their problem as severe or very severe.

To analyze short-term changes in problem severity, we examined the proportion of participants who reported improved versus worsened severity before and after initiating counsel-

Figure 3.1
Average Estimated Probability of Problem Severity Ratings Before and After Non-Medical Counseling, Wave 1



NOTE: $n_s = 2,358$ for MFLC and 2,519 for Military OneSource. Problem severity was assessed at Wave 1. Severity before counseling was retrospectively reported. Severity after counseling captured perceptions of problem severity at the time of the survey. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response. Rows may not add to 100% due to rounding.

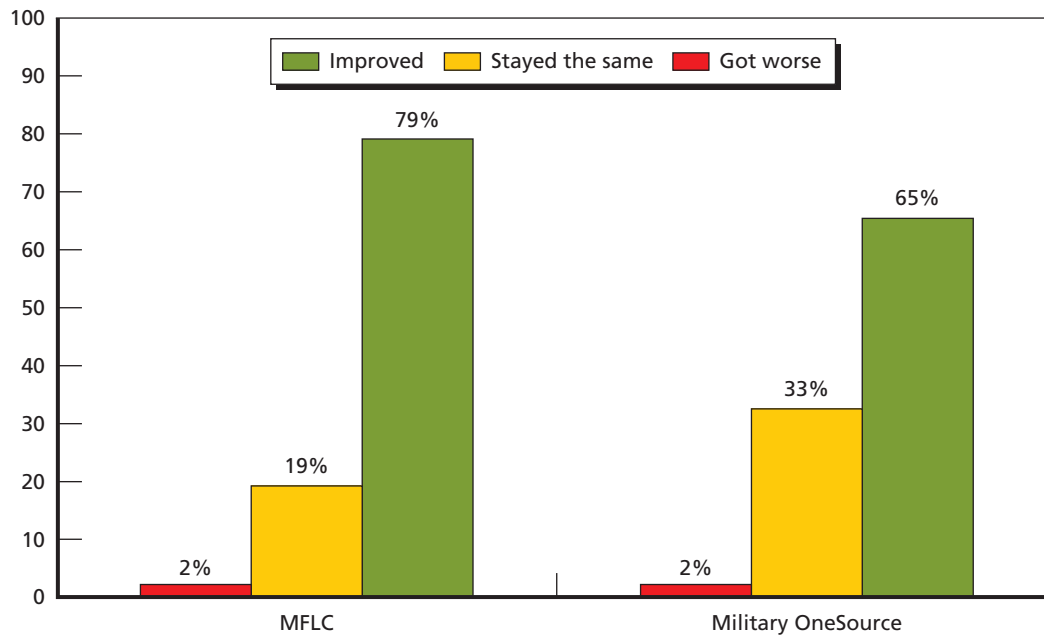
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ing, measured at Wave 1. The analysis tests whether the proportion of participants getting better versus worse differs from what one would expect from chance alone. Left to chance (if the counseling had no impact), the expectation is that as many participants' problems would improve as would get worse. However, our results indicated that in both programs, the severity of participants' problems was more likely to diminish after counseling than would be expected by chance alone. As shown in Figure 3.2, ratings of problem severity decreased after counseling for 79 percent of MFLC participants and 65 percent of Military OneSource participants. About 19 percent of MFLC and 33 percent of Military OneSource participants reported the same level of problem severity, and 2 percent of MFLC and Military OneSource participants reported an increase in problem severity.

Open-ended responses to the questions assessing strengths and weaknesses of the MFLC and Military OneSource programs were not directly compared to quantitative findings on changes in problem severity. However, excerpts from open-ended responses provide some context to observed data patterns. Many participants mentioned that the program was effective at helping them to resolve the issues for which they sought counseling.

Non-medical counseling offered by Military OneSource is an outstanding tool. The military has placed a lot of stress in my family. The help received via our counseling sessions has made our family stronger and resilient. I am extremely thankful for this service provided, the availability of the help, and the confidentiality of the process. I feel my

Figure 3.2
Average Estimated Probability of Short-Term Changes in Problem Severity Ratings, Wave 1



NOTE: $n_s = 2,358$ for MFLC and 2,519 for Military OneSource. Within-person changes of problem severity before and after counseling, both measured at Wave 1. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

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family's sacrifice (to support my service) has been acknowledged. (Military OneSource participant)

This program helped save my marriage, help guide me to proper mental health care, and gave me more resources than I thought were available to help me with other issues. (MFLC participant)

Despite reported improvements for many, for a large subset of participants, including over one-third of Military OneSource respondents, counseling did not help resolve the issues for which they were seeking help. This could be due to issues such as mismatches between counselor expertise and participant needs (e.g., a lack of knowledge about military families) or the participants seeking help for problems that are out of scope for non-medical counseling (e.g., clinical depression). These factors are explored further in Chapters Six and Seven of this report. Select open-ended responses indicated that some counselors had good intentions but lacked the skills necessary to have an impact on problem resolution, while issues with counselor competence hindered the resolution of issues for others.

This counseling did not address the issues that I had and was sadly of little or no use as we were limited by time and the counselor had NO experience with military family dynamics so half or greater amount of time I was explaining how it all worked. She was compassionate and wanted to assist me but NO work was done on my biggest problem. (Military OneSource participant)

I did not care for my counselor but after telling my story to her, I was too exhausted to change counselors and start over. I only went to three sessions with the counselor because I felt worse after I left each time. (Military OneSource participant)

The MFLC that we spoke with lacked compassion and concern. We felt uncomfortable opening up to this MFLC and were discouraged to see him again or any other MFLC, for that matter. Unfortunately, we continue to have unresolved issues. (MFLC participant)

I did not benefit from my experience in any way, so I do not see any advantages or strengths of using this resource. (MFLC participant)

Subgroup Differences

Before Non-Medical Counseling

We observed significant subgroup differences in ratings of problem severity before counseling by gender among MFLC participants, by service affiliation for Military OneSource participants, and by problem type for both MFLC and Military OneSource participants (see Tables C3.1 and C3.2 in Appendix C). Among MFLC participants, a larger proportion of women rated their problem as very severe compared to men (34 and 29 percent, respectively), while a larger proportion of men reported moderate severity compared to women (29 and 25 percent, respectively). Among Military OneSource participants, a smaller proportion of those affiliated with the Air Force reported that their problem was “very severe” compared to the other services (24 percent as opposed to 30–33 percent, respectively). The significant difference by problem type among MFLC participants was largely driven by 38 percent of individuals who rated their most recent family or relationship concern to be very severe, compared to 20–29 percent of participants with other types of problems.

Similar to MFLC, a large proportion of Military OneSource respondents with family or relationship problems rated their problem as very severe before counseling—32 percent—compared to 16–25 percent of participants with other types of problems.

In Short-Term Resolution of Problem Severity

Results revealed no subgroup differences in short-term problem severity changes for Military OneSource, but for MFLC, severity changes differed by problem type and gender (see Table C3.3 in Appendix C). MFLC participants seeing a counselor about problems with their children tended to be more likely than other groups to have the same severity rating over the short term (27 percent compared to 18–23 percent for other problem types), and tended to be less likely to report large improvements in severity over the short term (26 percent compared to 31–39 percent for other problem types). Still, about 70 percent of MFLC participants seeking help with child problems reported some decrease in problem severity over the short term.

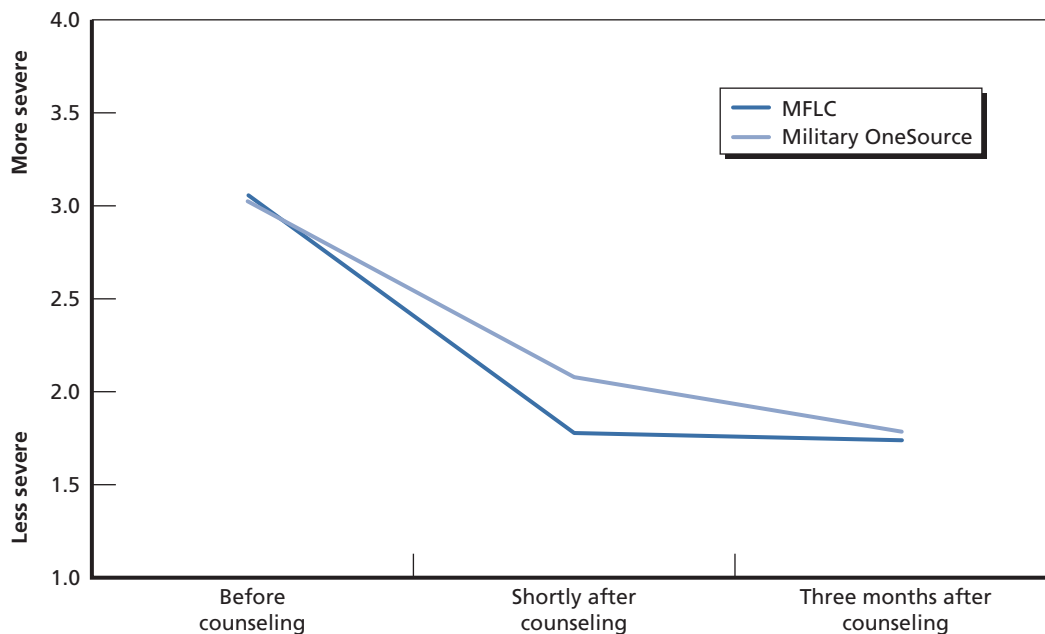
While a large percent of men did report a decrease in problem severity over the short term (77 percent), there were significant gender differences in problem severity over time. Compared to women, men were slightly more likely to have the same problem severity over the short term (21 percent and 18 percent, respectively). Women were more likely than men to report large reductions in severity over the short term (39 percent of women compared to 33 percent of men).

Long-Term Changes in Problem Severity

The Wave 2 survey, administered three months following the Wave 1 survey, used the same measure of problem severity. Successful long-term problem resolution would be evidenced by maintenance of short-term improvements in problem severity or further reduction of problem severity over time. A return to precounseling levels of problem severity would indicate that, although non-medical counseling resolved problems in the short term, those improvements were not sustained long term. This analysis was limited to the participants who completed these measures on both the Wave 1 and Wave 2 surveys ($n_s = 472$ for MFLC and 608 for Military OneSource).

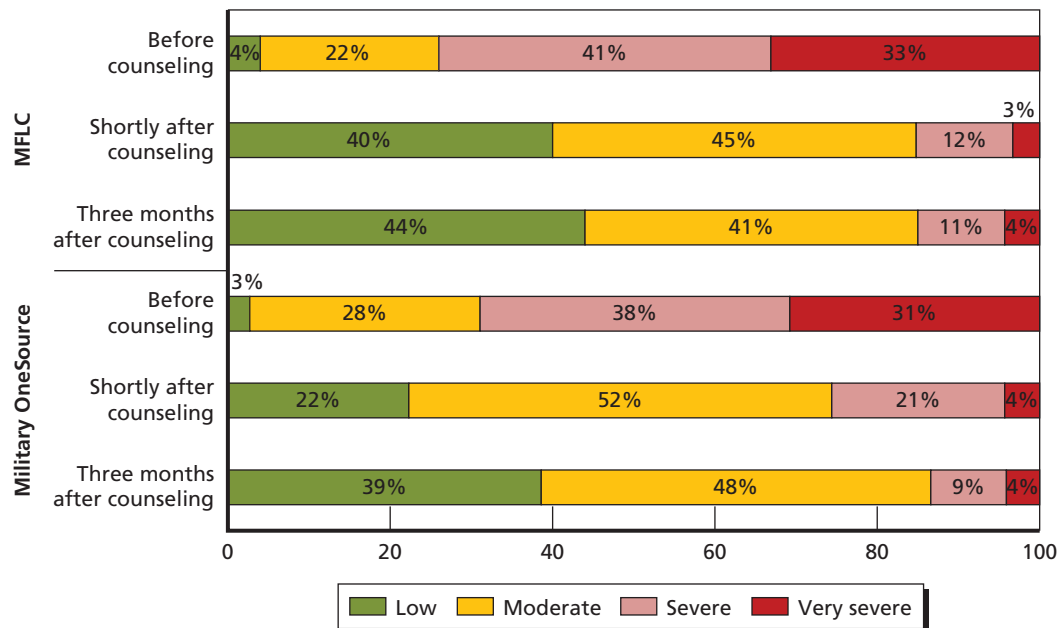
As shown in Figure 3.3, across both programs average problem severity decreased in the short term (Wave 1), especially among MFLC participants. At the three-month follow-up, average problem severity continued to improve among Military OneSource participants and average short-term reductions were maintained among MFLC participants: about 80 percent of MFLC and 88 percent of Military OneSource participants reported the same or improved problem severity after three months. Among Military OneSource participants, 38 percent demonstrated a further reduction in problem severity after three months. This suggests that short-term improvements in problem resolution were maintained by most participants, and that a substantial number of Military OneSource participants reported additional problem resolution in the long term.

Figure 3.3
Average Estimated Problem Severity over Time



NOTE: Average severity ratings were calculated for those who completed both Wave 1 (before and after counseling ratings) and Wave 2 (three months after counseling) surveys. $n_s = 472$ for MFLC and 608 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Figure 3.4
Average Estimated Probability of Severity Ratings over Time



NOTE: Severity ratings were calculated for those who completed both Wave 1 (before and after counseling ratings) and Wave 2 (three months after counseling) surveys. *ns* = 472 for MFLC and 608 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response. Rows may not add to 100% due to rounding.

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Compared to ratings of problem severity before counseling, 81 percent of MFLC and 77 percent of Military OneSource participants demonstrated a long-term reduction in problem severity after three months. About 15 percent of MFLC and 20 percent of Military OneSource participants reported problem severity that was similar to severity before receiving counseling. A small percentage of MFLC and Military OneSource participants reported increased severity relative to that which they were experiencing before counseling (3 and 4 percent, respectively).

Another way to look at long-term changes in severity is to examine the percent of participants who rated their problem severity as low, moderate, severe, or very severe across time. Figure 3.4 is similar to Figure 3.1, but includes responses from the Wave 2 survey. Numbers vary slightly from what is presented in Figure 3.1 as this figure includes responses only from those who completed both surveys. Similar to Figure 3.3, when examined over time, severity ratings remained stable among MFLC participants, and there was a continued reduction in problem severity among Military OneSource participants. Three months after counseling, about 15 percent of participants still reported that their problem was severe or very severe.

Subgroup Differences in Long-Term Problem Resolution

Results revealed no significant subgroup differences in reported problem resolution after three months for MFLC participants. But for Military OneSource, long-term changes in problem severity differed by rank (own or sponsoring family member; see Table C3.4 in Appendix C).

Officers and their families were more likely to report improved problem resolution from before counseling to the three-month follow-up than were enlisted participants and their families (83 percent and 74 percent, respectively). Enlisted participants and their families were more likely than officers and their families to report the same level of problem severity before counseling and after three months (23 percent and 15 percent, respectively), with 3 percent of enlisted and 2 percent of officers and their families reporting an increase in severity after three months.

Impact of Non-Medical Counseling on Deployment Preparedness and Retention Intentions

In addition to asking about problem resolution, we asked participants whether non-medical counseling had helped them and their families prepare for deployment and adjust to reintegration, and whether non-medical counseling made them want to stay in the military.

Deployment and Reintegration

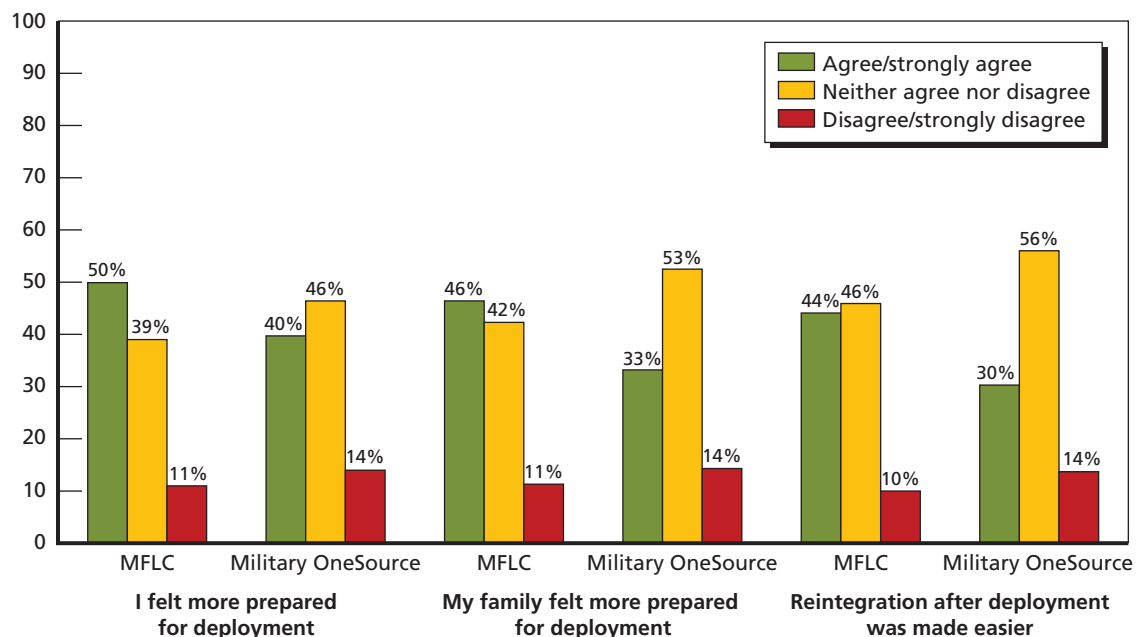
Participants were asked to report on the extent to which they agreed with the statement that “non-medical counseling made *them* feel more prepared for deployment.” About 50 percent of MFLC participants agreed or strongly agreed with this statement, but about 39 percent indicated that they neither agreed nor disagreed with this statement and over 10 percent disagreed or strongly disagreed (see Figure 3.5). Among Military OneSource participants, about 40 percent agreed or strongly agreed that non-medical counseling made them feel more prepared for deployment, but an even higher percentage (46 percent) reported that they neither agreed nor disagreed. About 14 percent of Military OneSource participants disagreed or strongly disagreed that non-medical counseling helped them feel more prepared for deployment.

A similar question was asked about whether non-medical counseling made *their family* feel more prepared for deployment. About 46 percent of MFLC participants agreed or strongly agreed that non-medical counseling made their families feel more prepared for deployment, another 42 percent neither agreed nor disagreed with this statement, and about 11 percent disagreed that non-medical counseling helped their family feel more prepared for deployment. For Military OneSource, about 33 percent of participants agreed or strongly agreed that non-medical counseling made their families feel more prepared for deployment, but over half neither agreed nor disagreed, and about 14 percent disagreed.

When asked whether they felt non-medical counseling made reintegration after deployment easier, 44 percent of MFLC and 30 percent of Military OneSource participants agreed or strongly agreed that it did help (Figure 3.5). However, about 46 percent of MFLC and 56 percent of Military OneSource participants neither agreed nor disagreed with this statement.

These measures are designed to capture longer-term impacts of non-medical counseling, which may explain why the findings are not as strong. However, participant responses did not significantly change between Wave 1 and Wave 2, suggesting that non-medical counseling does not have an additional impact on deployment and reintegration adjustment in the long term. These questions are also focused on deployment preparedness and reintegration, and responses may reflect the relatively slow military operation tempo at the time of the study. Non-medical concerns related to deployment were not as prevalent as others (see Table 3.1),

Figure 3.5
Average Estimated Probability of Perceived Impact of Non-Medical Counseling on Deployment Preparation and Reintegration, Wave 1



NOTE: $n_s = 579, 537, \text{ and } 517$ for MFLC; $606, 570, \text{ and } 550$ for Military OneSource, respectively. MFLC and Military OneSource estimates for each question were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

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suggesting that participants may have been less likely to endorse a positive impact of non-medical counseling on an outcome about which they were not currently concerned. There were no significant subgroup differences on these measures.

In open-ended responses, participants often mentioned utilizing non-medical counseling services to help cope with deployment, reintegration, and other transitions. Strengths of the program described in open-ended responses included the impact of counseling on service members and family preparation for transitions.

I have used this service for about a year. It has helped me cope with my husband's deployment, helped us re-connect now that he's home, helped our family dynamic, helped me as an individual. We would be so much worse off without this service. Our provider/counselor is awesome and has helped us gain a stronger marriage and has helped me to be a better spouse. (Military OneSource participant)

10 sessions is great but limits what can be done. I have used the services for both pre deployment and reintegration home to help the transitions. I wish my family could have had counseling sessions WHILE I was deployed. (Military OneSource participant)

However, open-ended responses also indicated that some service members may lack awareness of the availability of counseling for deployment preparation, based on their experiences with counselors promoting their services after deployment. Additionally, issues with quality and

continuity of counseling postdeployment may help to explain why half of respondents did not feel more prepared for deployment with the availability of non-medical counseling.

I found out about MFLC through a counselor that was walking around my camp going shop to shop introducing herself. And while that is great on her part, it should have been something widely publicized especially among military members that deploys and do so frequently. Also, emphasis should be placed on providing counseling to those who need it before deployment and not just post deployment. (MFLC participant)

The biggest time I see the MFLCs is right after a deployment and it turns into a check the box kind of thing. Everyone must take file through and talk with the MFLC upon redeployment but I think the real problems start 3–6 months after that and then there are too few MFLCs at that time. (MFLC participant)

[A weakness of the Military OneSource program is that it is] only 12 sessions, when many deployments are for an entire year and families may need more assistance to get through the many trials and rough patches. (Military OneSource participant)

In fact, a common theme in the open-ended responses was a general lack of awareness about the MFLC program among service members and their families in the broader military community.

They are not as known as they should be. They need to be advertised more. I've sought counseling, talked to other people on and off base and it took me a while to learn about this program. (MFLC participant)

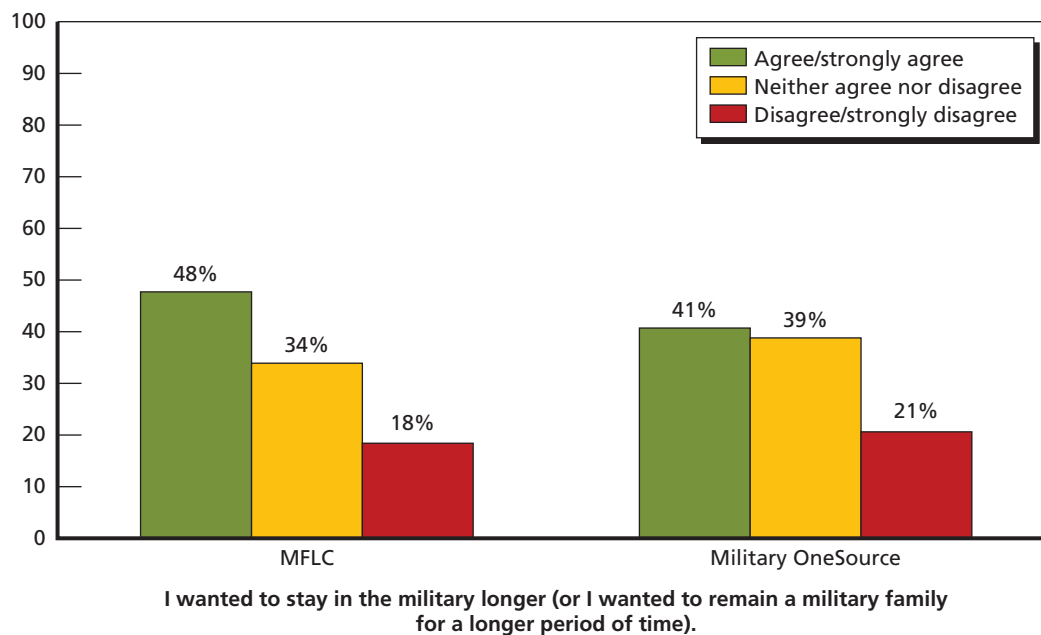
That the services are even available is not common knowledge; I stumbled upon this service . . . (MFLC participant)

Willingness to Stay in the Military

We asked participants to indicate their agreement with the statement, “because of non-medical counseling, I wanted to stay in the military longer (or I wanted to remain a military family for a longer period of time).” As shown in Figure 3.6, just under half of MFLC participants and 41 percent of Military OneSource participants agreed or strongly agreed that non-medical counseling had an impact on their desire to stay in the military (or remain a military family). About 34 percent of MFLC and 39 percent of Military OneSource were neutral on the impact counseling has had on their willingness to stay in the military. A sizable percentage of participants indicated that they disagreed or strongly disagreed that non-medical counseling made them want to stay in the military longer (18 percent of MFLC and 21 percent of Military OneSource participants). As with the questions on deployment and reintegration, this measure is designed to capture longer-term impacts of non-medical counseling, which may explain why the findings are not as strong. However, participants' responses did not substantially change between Wave 1 and Wave 2 (e.g., 49 percent of MFLC participants and 46 percent of Military OneSource participants agreed or strongly agreed at Wave 2), suggesting that participants' willingness to stay in the military was not further affected by non-medical counseling in the long term.

Open-ended responses include examples of the impact of non-medical counseling on participants' willingness to stay in the military:

Figure 3.6
Average Estimated Probability of Perceived Impact of Non-Medical Counseling on
Willingness to Stay in the Military, Wave 1



NOTE: $ns = 939$ for MFLC and 999 for Military OneSource. MFLC and Military OneSource estimates for each question were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

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I would recommend MFLC counselors to everyone. I think she has made me not hate the army and deployment nearly as much as I am SURE I would have hated it. Thank you!!! (MFLC participant)

It has given me a much needed way to vent and get help with no or low impact on my military career. This has made a major difference in my readiness to deploy and stay in the military. Thank you for this program!!!! (MFLC participant)

Subgroup differences

No significant subgroup differences emerged among MFLC participants, but there was a significant difference by active-duty status among Military OneSource participants. Compared to active-duty members and their families, a larger percentage of reserve and guard members and their families agreed or strongly agreed that they wanted to stay in the military longer as a result of non-medical counseling (38 percent and 48 percent, respectively; see Table C3.5 in Appendix C).

Chapter Summary

The results reported in this chapter suggest that non-medical counseling reduced problem severity and facilitated problem resolution among the majority of participants. Participants

reported short-term improvements, which were maintained over time by the majority of participants. There were no significant subgroup differences in short-term problem resolution for Military OneSource, but for MFLC, males and individuals presenting with child-related problems were less likely to experience problem resolution. Three months after counseling, the majority of participants experienced a reduction in problem severity relative to severity before counseling. However, a subset of participants did not experience long-term problem resolution after receiving non-medical counseling.

There were no significant group differences for MFLC over the long term but for Military OneSource officers and their family members were more likely to experience problem resolution compared to enlisted individuals and their family members. Overall, a small proportion of participants did not experience a reduction in problem severity as a result of non-medical counseling, especially in the short term. Responses to open-ended questions suggest potential barriers to problem resolution, including counselor's lack of understanding of military culture, poor counselor-participant rapport, and a mismatch between counselor expertise and participant needs; these issues will be further explored in Chapter Eight.

Non-medical counseling did not have a significant impact on feeling more prepared for deployment, reintegration after deployment, or participants' desire to stay in the military. It is possible that the lack of frequent and lengthy deployments during the study period contributed to these perceptions as only about 8 percent reported deployment-related concerns as their reason for seeking non-medical counseling. In the next chapter we examine the extent to which non-medical counseling results in a reduction of stress and anxiety over time.

Resolution of Stress and Anxiety

As noted in Chapter One, both service members and their families may experience periods of heightened stress and anxiety as a result of the military lifestyle, including frequent moves, deployment and reintegration, separation from one's family, and heavier workloads with fewer breaks for both the service member and the family members left to run the household (Hosek, Kavanagh, and Miller, 2006; Clemens and Milsom, 2008; Denning, Meisnere, and Warner, 2014; Castro, Kintzle, and Hassan, 2015). Upon return from deployment, challenges with reintegration into family and civilian life may also produce feelings of stress and anxiety (Hosek, Kavanagh, and Miller, 2006; Hassan et al., 2010; Koenig et al., 2014; Castro, Kintzle, and Hassan, 2015). Stress and anxiety affect everyone at some point, and can impact levels of productivity as well as military and family readiness. Military non-medical counseling programs are designed to help individuals with stress management, giving them tools and strategies to maintain control when life's demands become excessive.

This chapter examines the extent to which non-medical counseling affects problem-related stress and anxiety. Note that the anxiety results reported in this chapter are not indicative of anxiety disorder per se, but are based on self-reported anxiousness. Statistically significant differences among subgroups are discussed in the text and subgroup differences are tabulated in Tables C4.1–C4.5 in Appendix C).

Key findings from this chapter include:

- The frequency with which participants' problems caused them to report feeling stressed or anxious was significantly reduced following non-medical counseling.
- Over 70 percent of individuals experienced a reduction in the frequency of feeling stressed or anxious as a result of their problem.
- Improvements were generally maintained three months after receipt of counseling. Over 80 percent reported a reduction in feeling stressed or anxious as a result of their problem compared to how they felt before receiving counseling.
- Reported levels of stress in participants' work life and personal life were significantly lower following non-medical counseling. Over 60 percent of individuals reported that they experienced less or much less stress in their work life, and over 65 percent of individuals reported that they experienced less or much less stress in their personal life after initiating non-medical counseling.

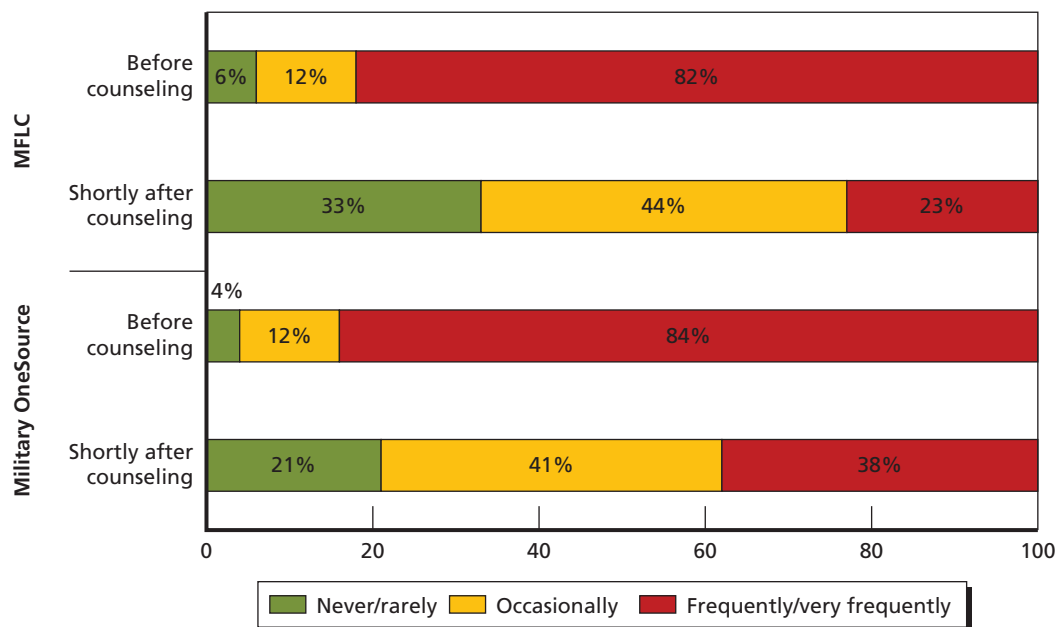
Short-Term Changes in Stress and Anxiety

In the survey administered at Wave 1, shortly after participants initiated non-medical counseling, we asked participants to retrospectively assess how often their concern made them feel stressed or anxious before receiving counseling and also assess how often their concern made them feel stressed or anxious after initiating counseling. Respondents rated frequency on a five-point scale ranging from “very frequently” to “never,” but we have collapsed it to a three-point scale for purposes of reporting.

After initiating non-medical counseling, there was a decrease in the proportion of individuals reporting that their concern caused frequent or very frequent stress or anxiety (Figure 4.1). Prior to non-medical counseling, about 80 percent of individuals reported that the concern caused frequent or very frequent stress or anxiety. After initiating non-medical counseling, this proportion dropped to between 23 percent and 38 percent among those who sought MFLC and Military OneSource services, respectively. Responses to open-ended survey questions reiterated these findings:

I believe that the tools that I was provided there by the counselors have helped me out in many ways. It helped allow me to problem solve much easier. Also has helped me manage my stress. (MFLC participant)

Figure 4.1
Average Estimated Probability of Frequency of Stress and Anxiety Before and After Non-Medical Counseling, Wave 1



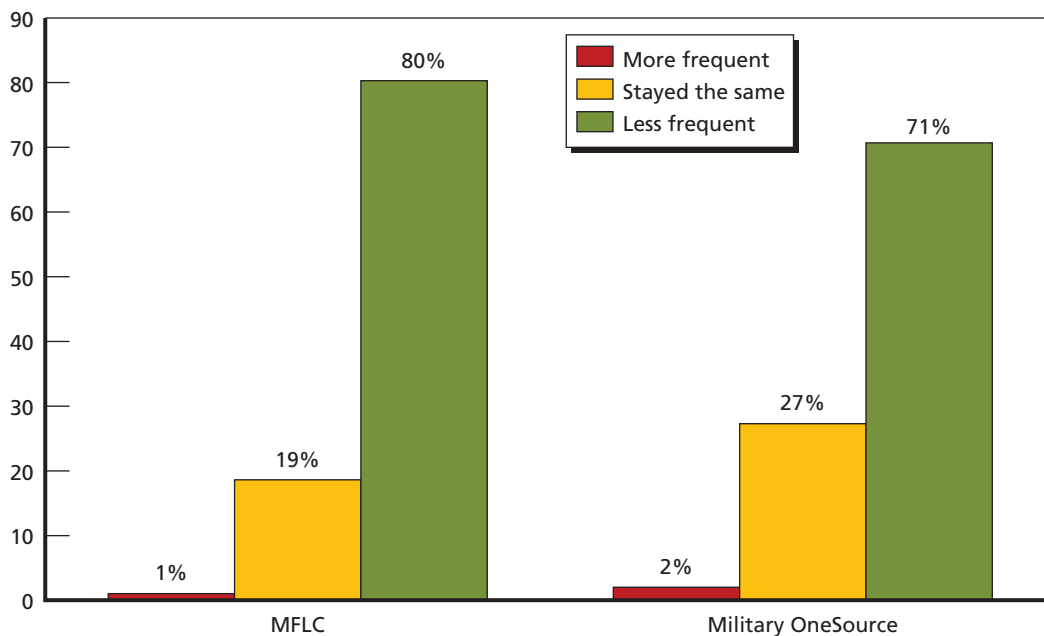
NOTE: The experience of stress or anxiety was assessed at Wave 1. The experience of stress or anxiety before counseling was retrospectively reported. The experience of stress or anxiety after counseling captured perceptions at the time of the survey. $n_s = 2,370$ for MFLC and 2,513 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

When I met with the MFLC I did not expect much. I was happily surprised to get real answers and advice. The week leading up to our meeting I had trouble sleeping. I had developed an eye twitch and was grinding my teeth. Afterwards I felt as if a huge weight was taken from me. I am truly grateful for what the MFLC program does for soldiers. (MFLC participant)

It just seems like he adds more stuff to my plate which does not stress me out less or help with anxiety or frustration. I know it is up to me to put forth the effort and change from within myself. I truly don't know what I need. (Military OneSource participant)

To analyze short-term changes in stress or anxiety, we examined the proportion of participants who reported improved or worsened frequency of stress or anxiety relative to those who reported the same level of severity before and after initiating counseling. The analysis tests whether the proportion of participants getting better or worse differs from what one would expect from chance alone. Results indicated that both MFLC and Military OneSource participants were significantly more likely to experience a reduction in the frequency of stress and anxiety after counseling than would be expected by chance alone. As shown in Figure 4.2, about 80 percent of MFLC participants and 71 percent of Military OneSource participants reported a reduction in the frequency of stress and anxiety. About 20–30 percent of participants experienced a similar frequency in stress and anxiety and only about 2 percent of MFLC and Military OneSource participants reported an increase in the frequency of experiencing stress and anxiety.

Figure 4.2
Average Estimated Probability of Short-Term Changes in Stress and Anxiety, Wave 1



NOTE: $n_s = 2,370$ for MFLC and 2,513 for Military OneSource. Within-person changes in the experience of stress or anxiety before and after counseling, both measured at Wave 1. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

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Subgroup Differences

Our results showed some significant differences among subgroups in the amount of stress experienced prior to non-medical counseling and in reported short-term resolution of stress and anxiety. Statistically significant subgroup differences are reported in the following sections.

Before Counseling

We observed subgroup differences in the frequency with which individuals felt stressed or anxious as a result of their concern before seeking non-medical counseling (see Tables C4.1 and C4.2 in Appendix C). Among MFLC participants, after adjusting for other variables in the regression model, women were more likely than men to experience frequent stress or anxiety (86 and 76 percent, respectively). There were also significant differences in the frequency of stress and anxiety before counseling by problem type, with 85 percent of those experiencing family or relationship concerns reporting frequent or very frequent stress and anxiety; followed by about 80 percent of those with deployment concerns, loss or grief, and more general stress or emotional concerns; 77 percent of those with education or employment concerns; and 72 percent with child issues or concerns.

Among Military OneSource participants, women were more likely than men to experience frequent or very frequent stress or anxiety before counseling (88 percent compared to 79 percent of men), as were younger individuals (88 percent of those aged 19–24, 85 percent of those aged 25–40, and 81 percent of those aged 41 and older). Among those seeking Military OneSource services, there were also differences by service affiliation, with Marines and their families experiencing stress and anxiety more often than those affiliated with other services (88 percent of Marines and their families reported frequent or very frequent stress or anxiety, compared to 86 percent of Navy, 84 percent of Army, and 81 percent of Air Force participants and their families).

In Short-Term Resolution of Stress and Anxiety

Analysis revealed several subgroup differences in whether feelings of stress or anxiety were resolved in the short term after participants initiated non-medical counseling (see Tables C4.3 and C4.4 in Appendix C). Among MFLC participants, there were differences again by gender. Although women were more likely to report a higher frequency of stress and anxiety before counseling, they were more likely to report an improvement after counseling (83 percent reported an improvement related to 77 percent of men). Significant differences were also observed by service affiliation, with Marines and their families less likely than those affiliated with other services to report a reduction in the frequency of stress and anxiety (74 percent compared to 81–84 percent in other services). Finally, significant differences were observed among individuals who received services from an MFLC at their installation. Those receiving services from an embedded MFLC more often reported a reduction in the frequency of stress and anxiety than those receiving services from MFLC counselors who were not embedded (84 and 79 percent, respectively).

Among Military OneSource participants, the only significant difference in reported short-term resolution of stress and anxiety was by gender. About 74 percent of women reported a reduction in the frequency of stress and anxiety, relative to 67 percent of men.

Short-Term Changes in the Level of Stress at Work and in One's Personal Life

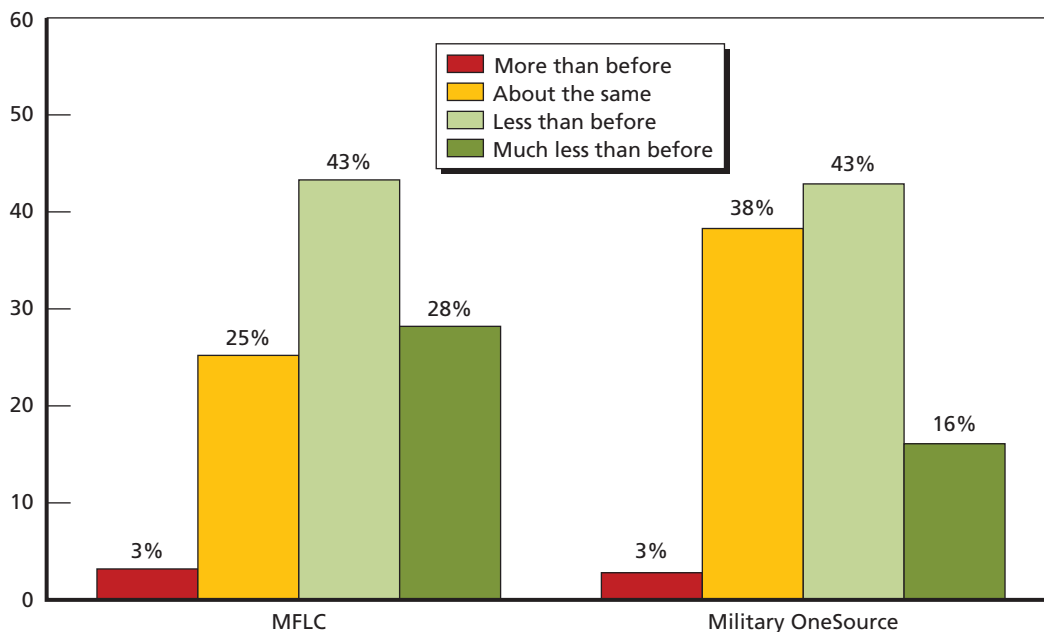
In addition to asking about the frequency with which individuals were experiencing stress and anxiety in general, we asked two additional questions related to changes in the level of stress at Wave 1. One question asked participants to rate the level of stress in their work life since they started receiving non-medical counseling services (e.g., much less than before, about the same, much more than before). A parallel question asked participants to rate the level of stress in their personal life.

After initiating non-medical counseling services, individuals reported reductions in the level of stress they experienced at work. Over 70 percent of MFLC participants and almost 60 percent of Military OneSource participants reported that they experienced less or much less stress than they did prior to seeking non-medical counseling services (Figure 4.3).

Similarly, close to 80 percent of MFLC participants and almost 65 percent of Military OneSource participants reported that they experienced less or much less stress in their personal life than they did prior to seeking non-medical counseling services. About 5 percent of individuals, however, reported an increase in stress in their personal life after counseling.

One significant subgroup difference emerged for changes in stress in one's personal life. Among Military OneSource participants, over 30 percent of those with deployment-related problems reported experiencing much less stress in their personal life than they had before receiving non-medical counseling services. In contrast, 10–13 percent of participants with

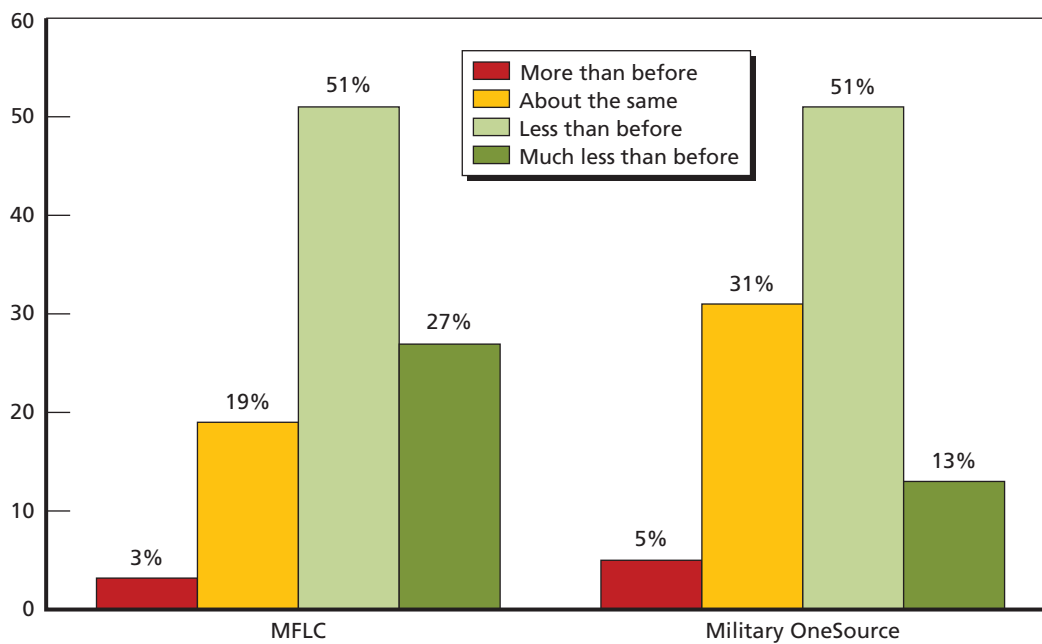
Figure 4.3
Average Estimated Probability of Changes in Level of Stress at Work After Non-Medical Counseling, Wave 1



NOTE: $n_s = 1,998$ for MFLC and 2,210 for Military OneSource. Changes in level of stress at work was measured by a single item assessed at Wave 1. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

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Figure 4.4
Average Estimated Probability of Changes in Level of Stress in Personal Life After
Non-Medical Counseling, Wave 1



NOTE: $ns = 2,316$ for MFLC and $2,479$ for Military OneSource. Changes in level of stress in personal life was measured by a single item assessed at Wave 1. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

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other types of problems reported much less stress in their personal lives than before receiving non-medical counseling.

Open-ended responses provide additional insight into the effectiveness of non-medical counseling in participants' work and personal life.

The counseling definitely helps with stresses brought on by the highly demanding military way of life. (Military OneSource participant)

It's really easy to feel a connection with the MFLC which is why most Soldiers that I have referred as well as myself leave our appointments with them feeling relief if not just a small bit. The MFLC has made the amount of work and personal stress drop drastically. I hope this program never goes away. (MFLC participant)

[I was] able to help cope and deal with the conflicts in our marriage in a more healthy way. [We have] better communication, and it is easier to deal with the stresses of daily life. (Military OneSource participant)

I have really seen improvement in my mental clarity and emotional state since I have been doing sessions with the MFLC. Before I started see the counselor I was a frazzled mother of 2 under 2 years of age, feeling like I was spiraling out of control. Now I feel much more

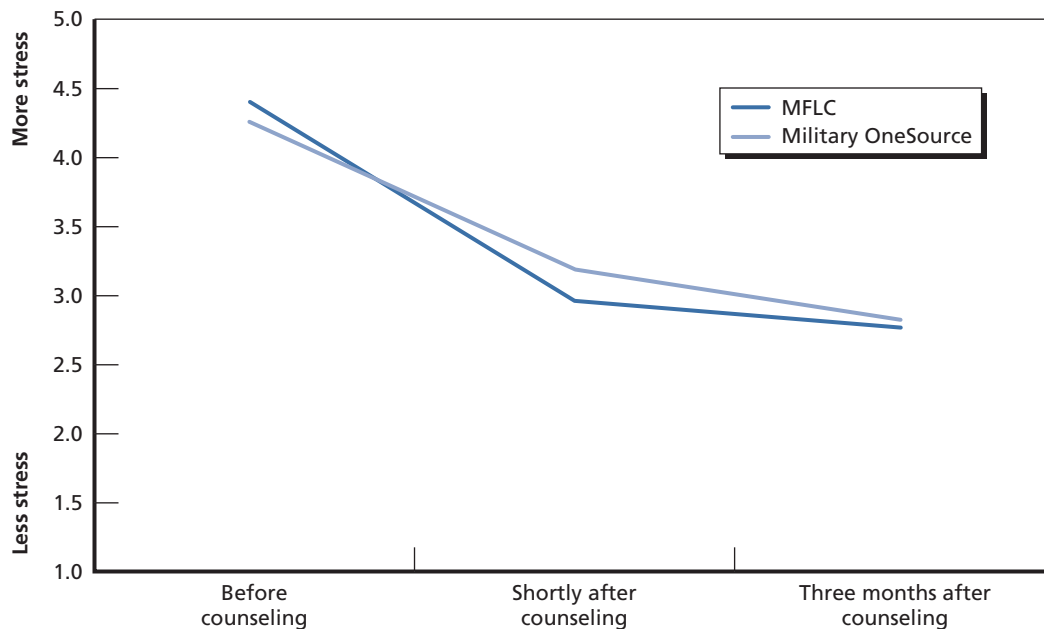
confident, in control, and I can see the positive side of things. I have laughed more. I have danced more. I really feel like my marriage and role as a wife and mother have come full circle. (MFLC participant)

Long-Term Changes in Stress and Anxiety

The Wave 2 survey used the same measures of stress and anxiety. This survey included both the question about how often the non-medical concern made the individual feel stressed or anxious and the two questions about rating the level of stress in one's work and personal life. This analysis was limited to the participants who completed both the Wave 1 and Wave 2 surveys ($ns = 436$ for MFLC and 617 for Military OneSource).

As noted earlier in the chapter, individuals were asked to rate how often their non-medical concern made them feel stressed or anxious. As shown in Figure 4.5, across both programs, average frequency of experiencing stress or anxiety decreased over time, especially among MFLC participants. After three months, average frequency of experiencing stress or anxiety continued to decline among Military OneSource and MFLC participants. Compared to ratings of stress or anxiety shortly after initiating counseling, after three months about 40 percent of participants reported a similar frequency (42 percent for MFLC and 41 percent for Military OneSource), and about 40 percent reported a continued reduction in the frequency of

Figure 4.5
Average Estimated Frequency of Stress or Anxiety over Time



NOTE: Average ratings were calculated for those who completed both Wave 1 (before and after counseling ratings) and Wave 2 (three months after counseling) surveys. $ns = 436$ for MFLC and 617 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

RAND RR1861-4.5

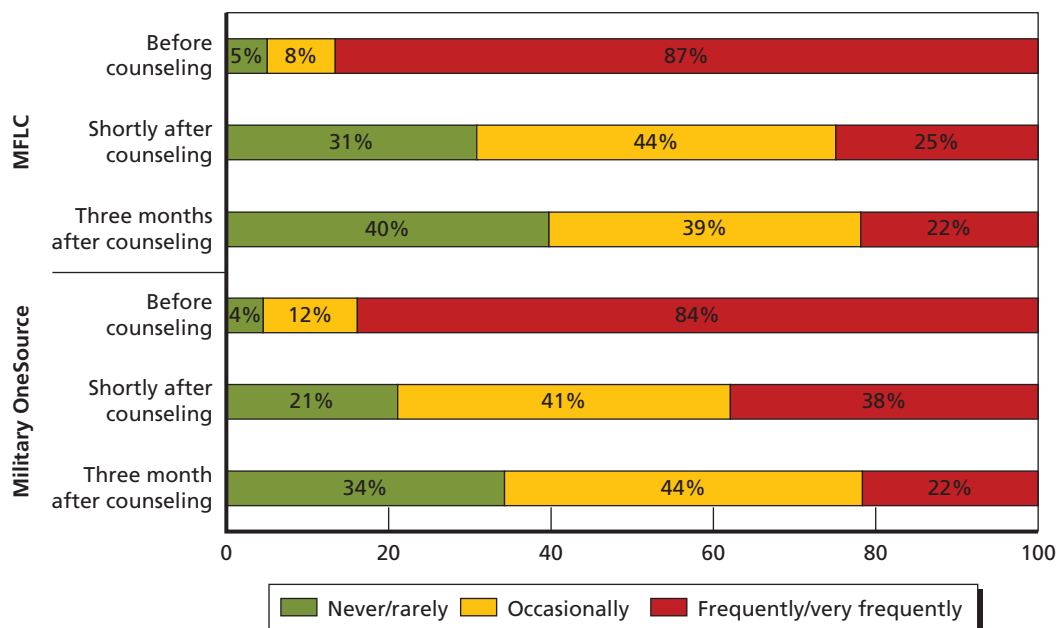
feeling stressed or anxious (37 percent for MFLC, 44 percent for Military OneSource). About 20 percent of the sample, however, reported an increase in the frequency with which they felt stressed or anxious as a result of their non-medical concern (21 percent for MFLC, 16 percent for Military OneSource).

Although about 20 percent of the sample did not maintain their short-term reduction in stress or anxiety, the majority of MFLC and Military OneSource participants reported significant improvements in the frequency of feeling stressed or anxious after three months relative to how they felt before counseling. Compared to ratings of stress or anxiety before counseling, about 85 percent of individuals reported a reduction in the frequency of feeling stressed or anxious, about 10 percent reported a similar level, and only 3 percent reported an increase in the frequency of feeling stressed or anxious after three months.

There were no significant differences by subgroup for reporting an increased frequency of feeling stressed or anxious over time.

Another way to look at long-term changes in stress or anxiety is to examine the percent of participants who experienced stress or anxiety frequently/very frequently, occasionally, or never/rarely across time. Figure 4.6 is similar to Figure 4.1, but reports responses from the three-month follow-up at Wave 2. Numbers vary slightly from what is presented in Figure 4.1 as this figure includes responses only from those who completed both surveys. When examined over time, there is a continued reduction in the frequency of stress and anxiety for both MFLC and Military OneSource participants. Three months after counseling, just over

Figure 4.6
Average Estimated Probability of Frequency of Stress or Anxiety over Time



NOTE: Frequency of stress or anxiety ratings were calculated for those who completed both Wave 1 (before and after counseling ratings) and Wave 2 (three months after counseling) surveys. *ns* = 436 for MFLC and 617 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response. Rows may not add to 100% due to rounding.

20 percent still reported frequent or very frequent experiences of stress and anxiety compared to more than 80 percent before counseling.

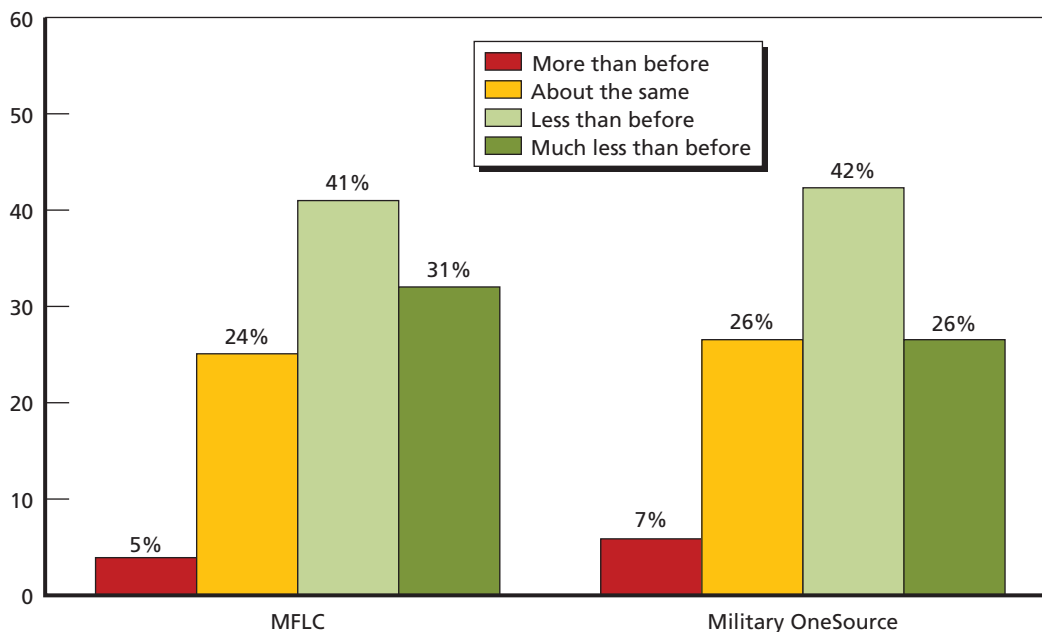
Long-Term Changes in the Level of Stress at Work and in One's Personal Life

As noted earlier in this chapter, in addition to asking about the frequency with which individuals were experiencing stress and anxiety in general, we asked two additional questions related to changes in participants' level of stress relative to how they felt before counseling. We describe the results for these questions at Wave 2, reported three months following counseling.

Three months after counseling, a little over 40 percent of MFLC and Military OneSource participants reported that their level of stress at work was less than it was before counseling, and an additional 31 percent and 26 percent of MFLC and Military OneSource participants, respectively, reported that they experienced much less stress at work than they did before counseling (Figure 4.7). A small proportion of participants, however, reported that their level of stress at work was higher three months after counseling than it was before counseling (5 percent for MFLC and 7 percent for Military OneSource). There were no significant subgroup differences in changes in stress at work over time.

Similarly, three months after counseling over 45 percent of MFLC and Military OneSource participants reported that the level of stress in their personal life was less than it was before counseling, and an additional 31 percent and 25 percent of MFLC and Military

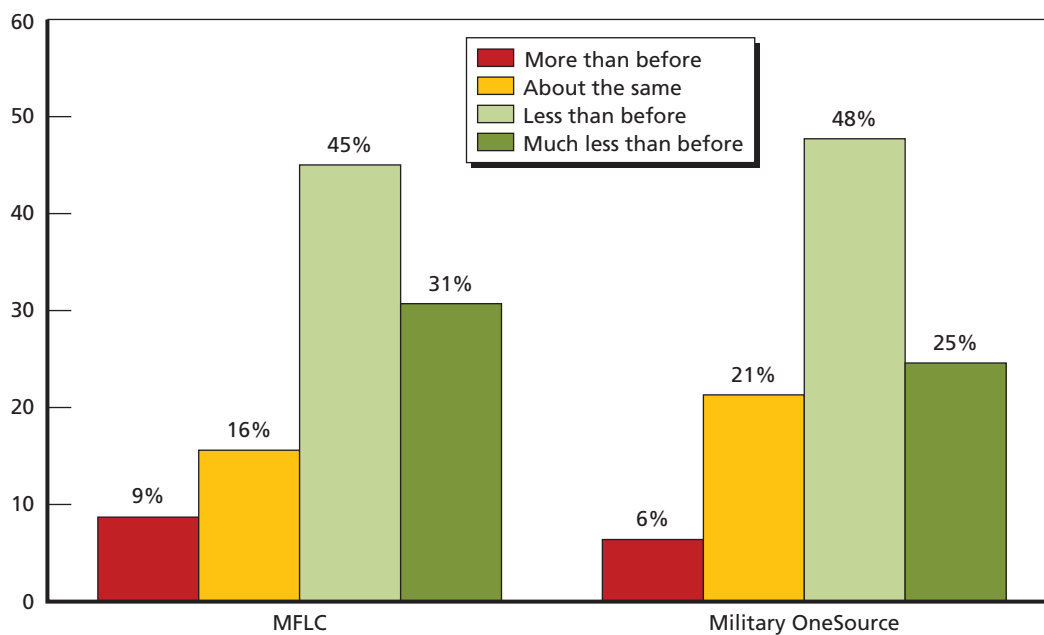
Figure 4.7
Average Estimated Probability of Changes in Level of Stress at Work After Non-Medical Counseling, Wave 2



NOTE: $ns = 403$ for MFLC and 483 for Military OneSource. Changes in level of stress at work was measured by a single item assessed at Wave 2. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

RAND RR1861-4.7

Figure 4.8
Average Estimated Probability of Changes in Level of Stress in Personal Life After
Non-Medical Counseling, Wave 2



NOTE: $ns = 459$ for MFLC and 586 for Military OneSource. Changes in level of stress in personal life was measured by a single item assessed at Wave 2. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

RAND RR1861-4.8

OneSource participants, respectively, reported that they experienced much less stress in their personal life than they did before counseling (Figure 4.8). Despite improvements for many, about 9 percent of MFLC participants and 6 percent of Military OneSource participants reported that the level of stress in their personal life was higher three months after counseling than it was before counseling. There were no significant subgroup differences in changes in the level of stress in one's personal life over time.

Chapter Summary

Results suggest that the frequency with which individuals reported feeling stressed or anxious as a result of their problem was reduced for the majority of participants following non-medical counseling, and these improvements were maintained and, for some, continued to improve over time. In the short term, women were significantly more likely than men to experience a reduction in feelings of stress and anxiety, for both the MFLC and Military OneSource programs. Among MFLC participants, those receiving services from MFLC counselors embedded in their unit were more likely to experience a reduction of stress and anxiety compared to those receiving services from other MFLC counselors, and Marines and their families were least likely to experience a reduction in stress and anxiety relative to individuals affiliated with other services. We detected no subgroup differences over the long term for either program. Changes

in the level of stress at work and in one's personal life were also observed, with at least 60 percent reporting that their level of stress was less or much less than it was before seeking non-medical counseling services. While the majority of individuals did experience a reduction in stress and anxiety following non-medical counseling, approximately 20 percent of participants reported frequent or very frequent feelings of stress and anxiety in their work or personal life, suggesting that they may not have benefited as much from non-medical counseling services.

Interference with Work and Daily Life

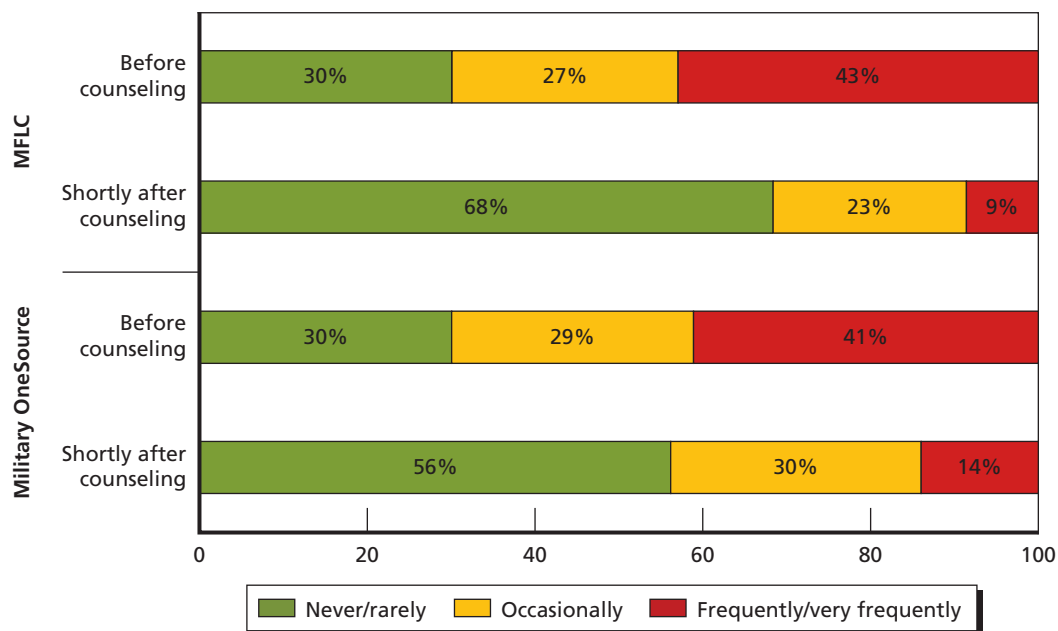
The problems that service members and their families experience not only cause them stress, but also can disrupt their work and daily life routines. We examined how MFLC and Military OneSource participants' concerns affected three aspects of daily life: whether they interfered with work, interfered with daily routines, or made it difficult to cope with day-to-day demands. Statistically significant differences among subgroups are discussed in the text and subgroup differences are tabulated in Tables C5.1–C5.10 in Appendix C.

Key findings from this chapter include:

- Following non-medical counseling, there was a statistically significant decrease in the frequency with which participants' problems were found to interfere with work or daily routines, and a decrease in difficulty coping with day-to-day demands.
- Compared to how they felt before counseling, over 55 percent of individuals reported that their problems caused less interference with work in the short term, and over 65 percent reported less interference with work three months after counseling.
- Compared to how they felt before counseling, over 65 percent reported decreased interference with daily routines in the short term, and over 74 percent reported decreased interference with daily routines in the three months after counseling.
- Compared to how they felt before counseling, over 60 percent of individuals reported less difficulty coping with day-to-day demands over the short term, and over 71 percent reported less difficulty coping with day-to-day demands in the three months after counseling.

Short-Term Changes in Problem Interference with Work

At Wave 1, respondents reported on the extent to which the problem for which they sought counseling interfered with their work both prior to receiving non-medical counseling and after initiating counseling. As shown in Figure 5.1, before counseling a little over 40 percent of MFLC and Military OneSource participants reported that their problem interfered very frequently or frequently with work, and about equal proportions reported that their problem interfered occasionally (30 percent) or rarely or never (30 percent). After initiating non-medical counseling, only 9 percent of MFLC and 14 percent of Military OneSource reported that their problem interfered with work very frequently or frequently. Furthermore, the percentage of respondents reporting that their problem either never or rarely interfered with work about doubled after counseling.

Figure 5.1**Average Estimated Probability of Ratings of Problem Interference with Work Before and After Non-Medical Counseling, Wave 1**

NOTE: Problem interference with work was assessed at Wave 1. Interference with work before counseling was retrospectively reported. Problem interference with work after counseling captured perceptions at the time of the survey. $n_s = 2,378$ for MFLC and 2,513 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

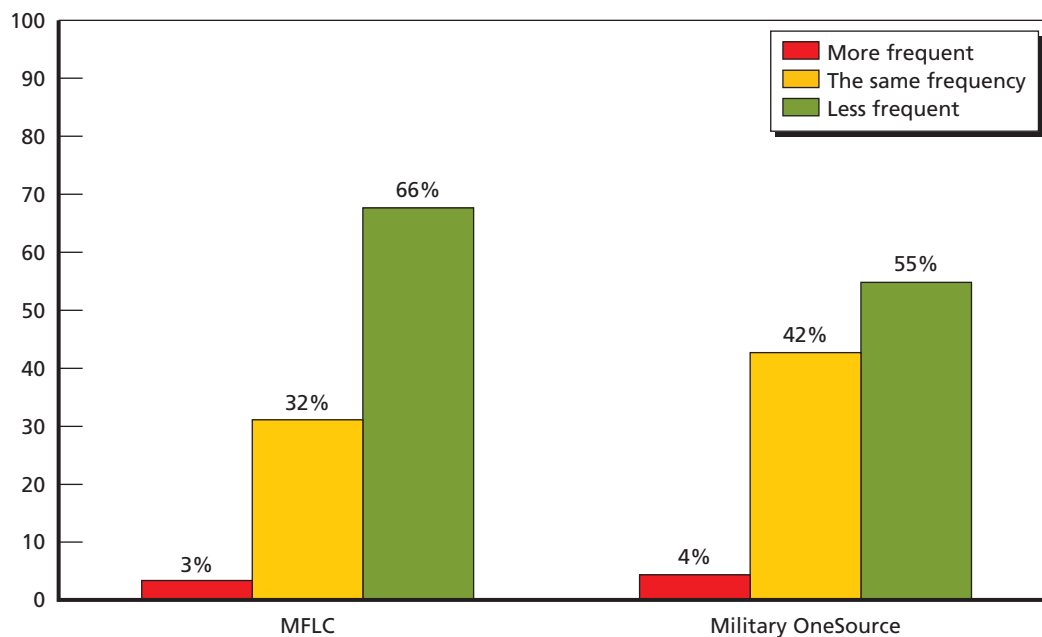
RAND RR1861-5.1

To analyze short-term changes in problem interference with work, we examined the proportion of participants who reported more or less frequency relative to those who reported the same level of frequency before and after initiating counseling, measured at Wave 1. Results indicated that both MFLC and Military OneSource participants were significantly likely to experience less problem interference with work after counseling than would be expected by chance alone. As shown in Figure 5.2, problems interfered with work less frequently for 66 percent of MFLC participants and 55 percent of Military OneSource participants after counseling. About 32 percent of MFLC and 42 percent of Military OneSource participants reported the same level of problem interference with work after counseling. Three percent of MFLC and 4 percent of Military OneSource participants reported an increase in problem interference with work.

The positive impact of non-medical counseling on problems interfering with work is supported by open-ended survey responses. Respondents highlighted the stress and anxiety they experienced, and the ways in which counseling supported them with the demands of their jobs in the military.

Marines need the MFLC. We are constantly stressed out. . . . If it wasn't for my MFLCs I wouldn't be able to do my job every day. I wouldn't be able to carry out normal duties. I don't cry in the bathroom anymore. I can face my fears. (MFLC participant)

Figure 5.2
Average Estimated Probability of Short-Term Changes in Problem Interference with Work, Wave 1



NOTE: Within-person changes in problem interference with work before and after counseling, both measured at Wave 1. $n_s = 2,378$ for MFLC and 2,513 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

RAND RR1861-5.2

My anxiety was really bad. . . . For the first time in my life I understood how people can slip into thoughts of suicide and depression (I was not there but now I understand how emotional issues, life changes, and stress affect how you think and see the world). I am very thankful. After being able to talk to someone, the improvement to my life was almost instant and I don't have to worry about my career which I hold dear. I actually feel normal again. I am on top of things at work. It's been life changing. (Military OneSource participant)

Subgroup Differences

Before Non-Medical Counseling

Among MFLC participants, we observed no significant subgroup differences in ratings of problem interference with work before counseling. However, we did observe significant differences by service, component, and problem type among Military OneSource participants (see Table C5.1 in Appendix C).

Among Military OneSource participants, after adjusting for other variables in the regression model, the majority of Marines and their families reported that their issues interfered with work frequently or very frequently (50 percent) before receiving counseling. A smaller proportion of individuals affiliated with the Army, Navy, or Air Force reported that their problems interfered with work frequently or very frequently (42, 44, and 34 percent, respectively). The difference between active-duty and guard and reserve components is accounted for by the 46 percent of guard and reserve participants and their families who reported that their problem

interfered with work frequently or very frequently, compared to a relatively lower 40 percent of active-duty participants and their families.

The difference by problem type is largely driven by the 55 percent of participants who reported that education or employment issues frequently or very frequently interfered with work before counseling. In comparison, 31–43 percent of participants with other problem types reported that their problem interfered with work frequently or very frequently before counseling.

In Short-Term Resolution of Problem Interference with Work

Analysis revealed several significant subgroup differences in short-term changes in problem interference with work among MFLC and Military OneSource participants (see Tables C5.2 and C5.3 in Appendix C).

Among MFLC participants, subgroup differences emerged for service affiliation and gender. Navy participants and their families demonstrated a larger decrease in problem interference with work (76 percent) compared to participants affiliated with other services, which ranged from 58 percent to 67 percent. Between genders, men were more likely to have the same frequency of problem interference with work before and after initiating counseling compared to women (35 percent compared to 30 percent). Women were more likely to report decreases in frequency with which their problem interfered with work (68 percent of women compared to 62 percent of men). About 2 percent of women and 3 percent of men reported increased frequency of problem interference with work.

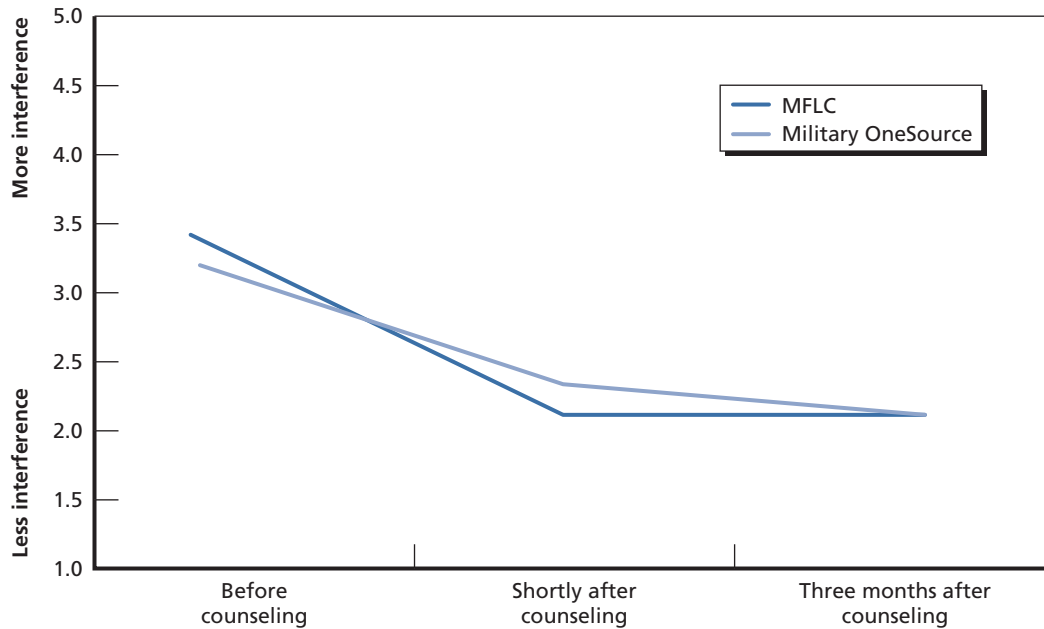
Among Military OneSource participants, subgroup differences emerged for service member status and gender. Service members seemed to benefit more than family members in terms of problem interference with work: compared to before receiving counseling, problem interference with work decreased for 57 percent of service members compared to 51 percent of family members. In addition, almost 40 percent of service members reported no change in how frequently their problem interfered with work compared to 45 percent of family members.

Regarding gender differences, men were more likely than women to have the same frequency of problem interference with work before and after receiving counseling (46 percent compared to 39 percent). Women were more likely than men to report decreases in frequency of problem interference with work (58 percent and 50 percent, respectively). About 3 percent of women and 4 percent of men reported that the frequency with which problem interference with work increased after receiving counseling. It is important to note that, although most service members are men, the analyses calculate subgroup differences controlling for other variables in the model. So the gender differences reported here are independent of the significant service member differences found in the same model.

Long-Term Changes in Problem Interference with Work

The Wave 2 survey used the same measure to assess whether participants' problems interfered with their work over time. We asserted that if long-term problem resolution is successful, reductions in problem interference ratings after counseling would be maintained or would further decline over time. This analysis was limited to the participants who completed both Wave 1 and Wave 2 surveys ($n = 614$ for MFLC and 878 for Military OneSource).

Figure 5.3
Average Estimated Frequency of Problem Interference with Work over Time



NOTE: Average ratings were calculated for those who completed both Wave 1 (before and after initial counseling) and Wave 2 (three months after counseling) surveys. *ns* = 431 for MFLC and 594 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

RAND RR1861-5.3

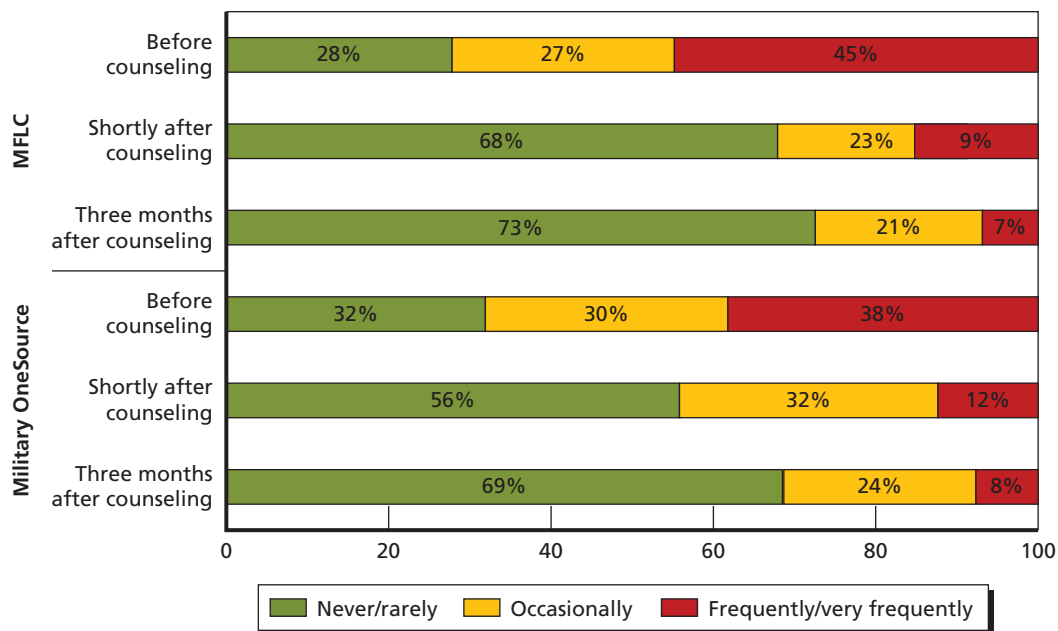
As shown in Figure 5.3, across both programs, average frequency of interference with work decreased over time, especially among MFLC participants. After three months, average frequency of interference with work continued to improve among Military OneSource participants and reductions reported shortly after initiating counseling were maintained among MFLC participants. Compared to ratings of problem interference with work shortly after participants initiated counseling, about 78 percent of MFLC and 81 percent of Military OneSource participants reported the same level or less interference with work after three months. A significant number of Military OneSource participants demonstrated continued improvement over time. This suggests that short-term decreases in problem interference with work were maintained or continued for most participants.

Compared to ratings of problem interference with work before counseling, 72 percent of MFLC and 65 percent of Military OneSource participants had reduced interference with work after three months. About 19 percent of MFLC and 25 percent of Military OneSource participants reported that problem interference with work after three months was similar to interference before receiving counseling. About 10 percent of MFLC and Military OneSource participants reported that their problem interfered with work more frequently than it did before counseling.

Results revealed no significant subgroup differences in long-term problem interference with work for MFLC or Military OneSource participants.

Another way to look at long-term changes is to examine the percent of participants who experienced problem interference with work frequently/very frequently, occasionally, or

Figure 5.4
Average Estimated Probability of Frequency of Problem Interference with Work over Time



NOTE: Frequency of problem interference with work was calculated for those who completed both Wave 1 (before and shortly after counseling) and Wave 2 (three months after counseling) surveys. $n_s = 431$ for MFLC and 594 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response. Rows may not add to 100% due to rounding.

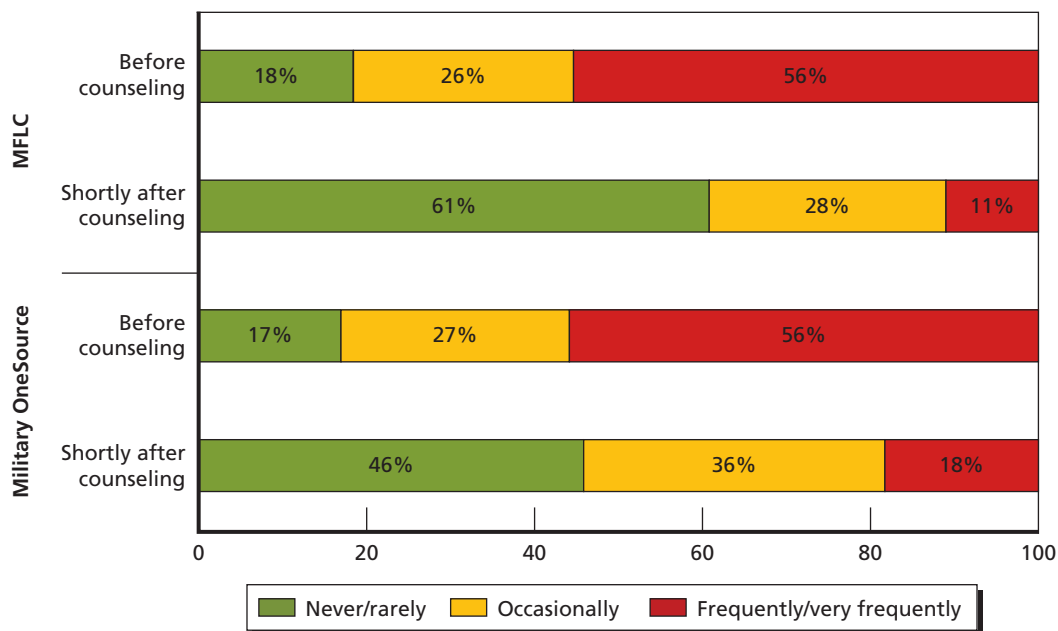
RAND RR1861-5.4

never/rarely across time. Figure 5.4 is similar to Figure 5.1, but includes responses from the Wave 2 survey. Numbers vary slightly from what is presented in Figure 5.1 as this figure includes responses only from those who completed both surveys. When examined over time, the frequency with which problems interfered with work declined after counseling for both MFLC and Military OneSource participants, and then remained steady for MFLC participants over the next three months. Military OneSource participants reported a continued decrease in frequency of problem interference with work over time: three months after counseling, only 7–8 percent still reported frequent or very frequent problem interference with work.

Short-Term Changes in Interference with Daily Routines

Similar to interference at work, respondents reported in the Wave 1 survey the extent to which their problem interfered with their daily routines before and after they initiated non-medical counseling. As shown in Figure 5.5, 56 percent of MFLC and Military OneSource participants reported that before receiving counseling their problems interfered very frequently or frequently with their daily routines. About 26 percent reported that it interfered occasionally, and about 17 percent reported rarely or never. After initiating non-medical counseling, 11 percent of MFLC and 18 percent of Military OneSource participants reported that their problem interfered with daily routines very frequently or frequently. Furthermore, the percentage whose problem rarely or never interfered with daily routines increased to 61 percent

Figure 5.5
Average Estimated Probability of Ratings of Problem Interference with Daily Routines
Before and After Non-Medical Counseling, Wave 1



NOTE: Problem interference with daily routines was assessed at Wave 1. Problem interference with daily routines after counseling captured perceptions at the time of the survey. $n_s = 2,381$ for MFLC and 2,513 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

RAND RR1861-5.5

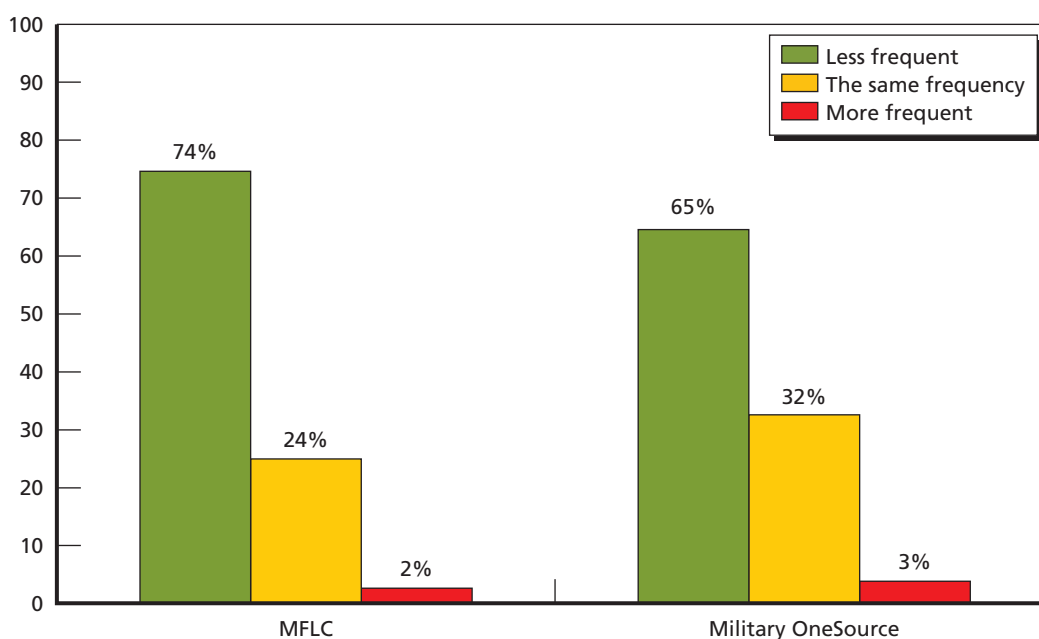
of MFLC participants and 46 percent of Military OneSource participants after counseling was initiated.

As shown in Figure 5.6, ratings of the extent to which the problem interfered with the participant's daily routines decreased in frequency for 74 percent of MFLC and 65 percent of Military OneSource participants. About 24 percent of MFLC and 32 percent of Military OneSource participants reported the same frequency of problem interference with daily routines before and after initiating counseling. About 2 percent of MFLC and 3 percent of Military OneSource participants reported an increase in frequency with which problems interfered with daily routines.

When describing strengths of the Military OneSource and MFLC programs, some participants mentioned in open-ended responses the ways in which non-medical counseling helped them cope with problems that interfered with their daily routines and family life.

Having someone on hand who both understands the military/aviation culture and the effects it has on family life immediately creates an atmosphere of understanding. This immediacy allowed me and my wife to get straight to the point. Our MFLC's in depth knowledge allowed for all three of us to flow through the problems that we were facing with ease. This facilitated a very rapid healing process for me and my wife. I cannot express how instrumental our counselor was in aiding my immediate return to duty. I also was given some very helpful tools to deal with similar issues in the future. (MFLC participant)

Figure 5.6
Average Estimated Probability of Short-Term Changes in Problem Interference with Daily Routines, Wave 1



NOTE: Within-person changes in problem interference with daily routines before and after counseling. $n_s = 2,381$ for MFLC and 2,513 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

RAND RR1861-5.6

Subgroup Differences

Before Non-Medical Counseling

Among MFLC participants, at Wave 1 we observed significant differences in ratings of interference with daily routines before counseling by gender and problem type. Military OneSource participants demonstrated significant differences by service affiliation and age (see Tables C5.4 and C5.5 in Appendix C).

Women who obtained counseling through the MFLC program were more likely to state that their problems interfered with daily routines frequently or very frequently (58 compared to 52 percent, respectively) before receiving counseling. Men were more likely to report that their problems interfered with daily routines never or rarely (22 percent compared to 17 percent of women).

Among MFLC participants, those experiencing problems with “loss or grief” or “family or relationships” were likely to report that their problem interfered with daily routines frequently or very frequently (62 percent and 58 percent, respectively).

For the Military OneSource program, Navy and Marine participants and their families had the highest rate of interference with daily routines before receiving counseling, with around 59 percent of the participants reporting frequent or very frequent interference. In addition, Military OneSource participants aged 41 and older were less likely to report that their problem interfered with their daily routines frequently or very frequently (51 percent compared to 58 percent of 18–24 year olds and 58 percent of 25–40 year olds) before receiving counseling.

In Short-Term Resolution of Problem Interference with Daily Routines

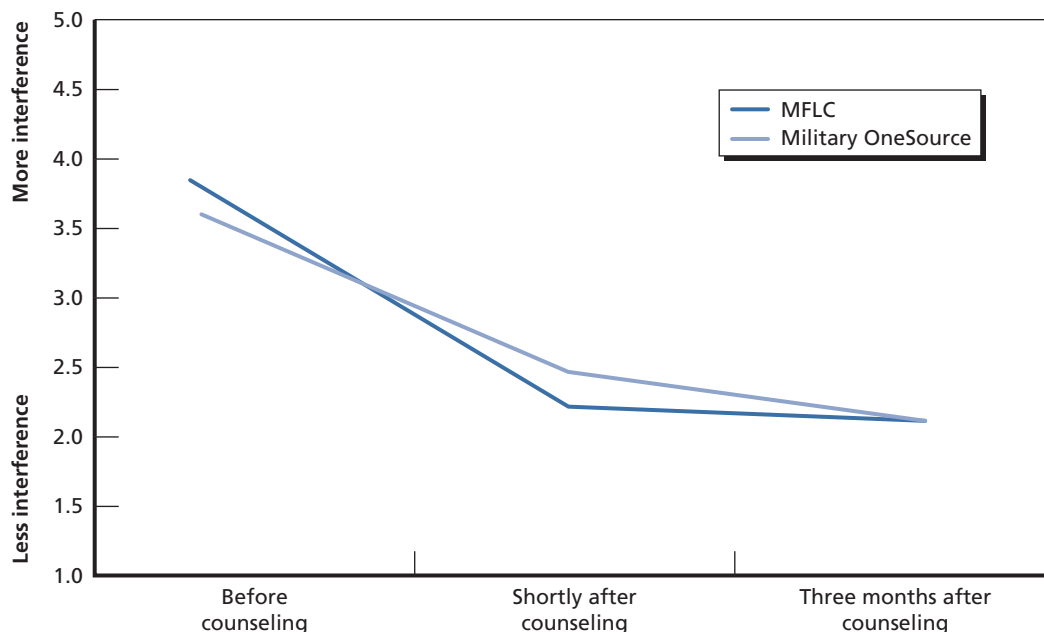
We observed no significant differences in changes in ratings of problem interference with daily routines by subgroups among Military OneSource participants at Wave 1. Among MFLC participants, we observed a significant difference in changes by gender (see Table C5.6 in Appendix C). Compared to women, men were more likely to have the same frequency of problem interference with daily routines before and after initiating counseling (27 percent compared to 23 percent, respectively). Women were more likely than men to report a decrease in frequency of problem interference with work (76 percent compared to 70 percent of men). About 2 percent of women and men reported increased frequency of problem interference with work.

Long-Term Changes in Problem Interference with Daily Routines

The Wave 2 survey used the same measure of problem interference with daily routines to assess whether participants' problems interfered with their daily routines over time. Successful long-term problem resolution would be evidenced by maintenance of reductions in reported post-counseling problem interference with daily routines after counseling or further reduction of interference with daily routines. This analysis was limited to the participants who completed both Wave 1 and Wave 2 surveys ($n_s = 434$ for MFLC and 594 for Military OneSource).

As shown in Figure 5.7, across both programs, average frequency of interference with daily routines decreased over time, especially among MFLC participants. After three months,

Figure 5.7
Average Estimated Frequency of Problem Interference with Daily Routines over Time



NOTE: Average ratings were calculated for those who completed both Wave 1 (before and after counseling ratings) and Wave 2 (three months after counseling) surveys. $n_s = 434$ for MFLC and 594 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

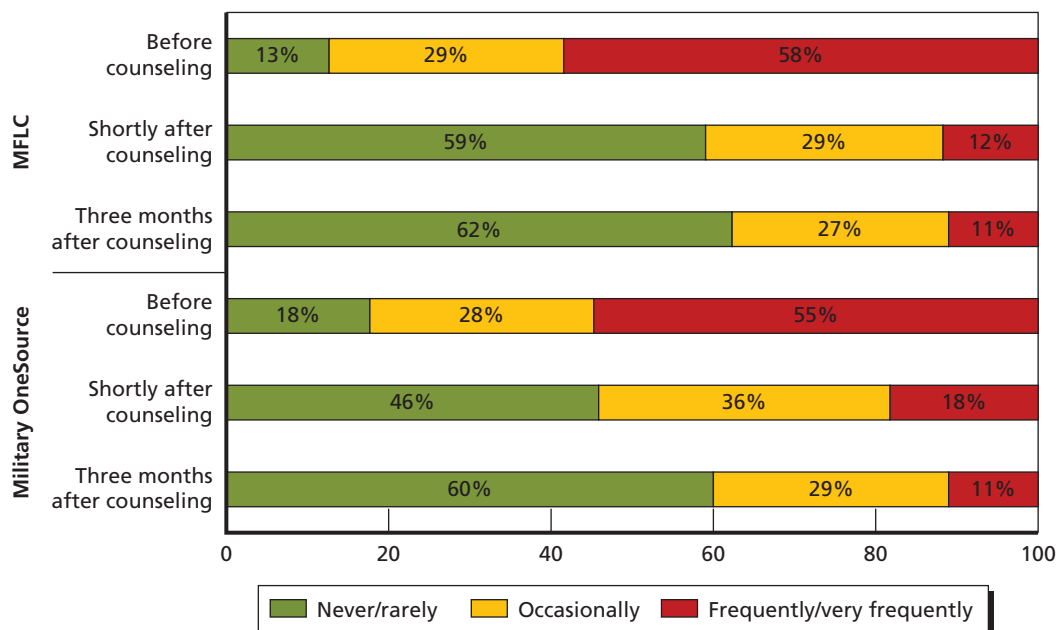
RAND RR1861-5.7

average frequency of interference with daily routines continued to improve among Military OneSource participants and reductions captured shortly after initiating counseling were maintained among MFLC participants. About 76 percent of MFLC and 78 percent of Military OneSource participants reported the same level or less interference with daily routines after three months. A significant number of Military OneSource participants also demonstrated continued improvement over time. This suggests that short-term decreases in problem interference with daily routines were maintained or continued to decrease over time for most participants.

Compared to ratings of interference with daily routines before counseling, 80 percent of MFLC and 74 percent of Military OneSource participants had reduced problem interference with daily routines after three months. About 14 percent of MFLC and 18 percent of Military OneSource participants reported that problem interference with daily routines after three months was similar to interference before receiving counseling. About 7 percent of MFLC and Military OneSource participants reported that their problem interfered with daily routines more frequently after three months than it did before receiving counseling.

Another way to look at long-term changes is to examine the percent of participants who experienced problem interference with daily routines frequently/very frequently, occasionally, or never/rarely across time. Figure 5.8 is similar to Figure 5.5, but includes responses from the Wave 2 survey. Numbers vary slightly from what is presented in Figure 5.5 as this figure includes responses only from those who completed both surveys. When examined over time,

Figure 5.8
Average Estimated Probability of Frequency of Problem Interference with Daily Routines over Time



NOTE: Frequency of problem interference with daily routines was calculated for those who completed both Wave 1 (before and shortly after counseling ratings) and Wave 2 (three months after counseling) surveys. *ns* = 434 for MFLC and 594 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response. Rows may not add to 100% due to rounding.

there is a reduction in the frequency of interference with daily routines for both MFLC and Military OneSource participants. MFLC participants reported similar interference with daily routines shortly after initiating counseling and after three months, while Military OneSource participants continued to report a decline in interference with daily routines over time. Three months after counseling, 11 percent of MFLC and Military OneSource participants still reported frequent or very frequent problem interference with daily routines.

Subgroup Differences in Long-Term Changes

Results revealed no significant subgroup differences in long-term changes in problem interference with daily routines for MFLC participants. For Military OneSource participants, ratings of problem interference with daily routines significantly differed over time by service member status (see Table C5.7 in Appendix C). Ratings of problem interference with daily routines shortly after initiating counseling were maintained or had decreased for 74 percent of service members after three months, compared to 83 percent of family members. However, roughly equal percentages of family and service members had reduced long-term interference in daily routines relative to before receiving counseling (72 and 75 percent, respectively), suggesting that differences in maintenance of short-term gains were counterbalanced by overall improvement by both groups in the long term.

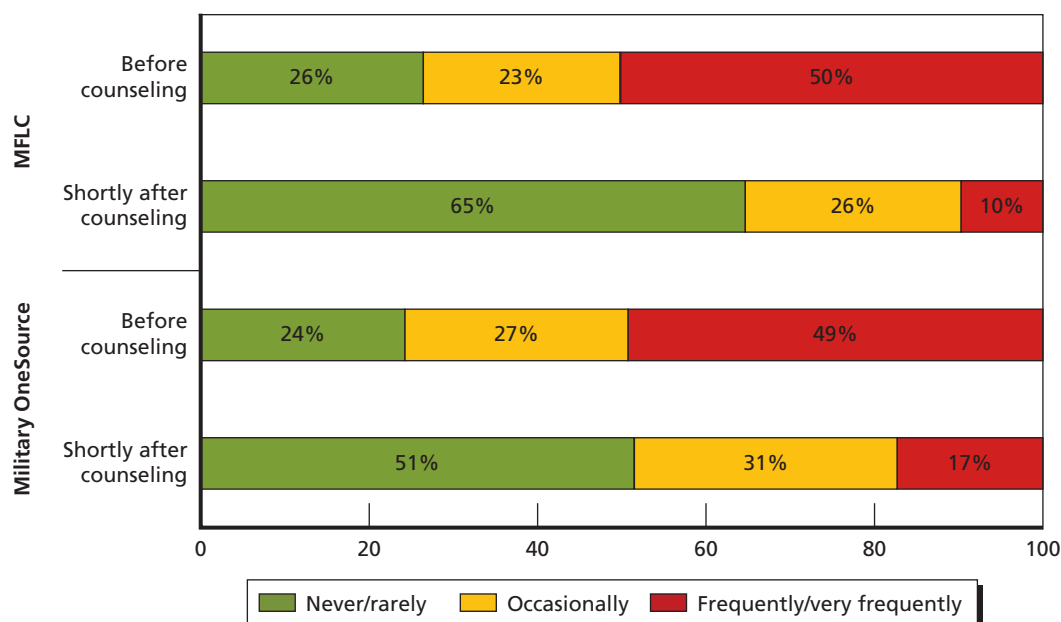
Short-Term Changes in Difficulty Coping with Day-to-Day Demands

Respondents reported at Wave 1 how often their problem made it difficult to cope with day-to-day demands before they received non-medical counseling and after initiating counseling. As shown in Figure 5.9, about 50 percent of MFLC and Military OneSource participants reported that their problems frequently or very frequently made it difficult to cope with day-to-day demands before receiving counseling. After initiating non-medical counseling, 10 percent of MFLC and 17 percent of Military OneSource participants reported that their problem made it difficult to cope with day-to-day demands frequently or very frequently. Furthermore, the percentage whose problem rarely or never made it difficult to cope with day-to-day demands increased from 26 to 65 percent of MFLC participants and from 24 to 51 percent of Military OneSource participants. In open-ended responses, participants reiterated the value of non-medical counseling for helping them handle day-to-day demands.

I am so profoundly grateful that Military OneSource is available. As a result of these services, which are still ongoing, I feel more fit in both my personal and professional life, and only regret that I did not take advantage of them sooner. (Military OneSource participant)

As shown in Figure 5.10, the extent to which the problem made it difficult for participants to cope with day-to-day demands decreased in frequency for 69 percent of MFLC and 60 percent of Military OneSource participants. About 28 percent of MFLC and 37 percent of Military OneSource participants reported the same level of difficulty coping with day-to-day demands before and after initiating counseling. About 2 percent of MFLC and 3 percent of Military OneSource participants reported an increase in difficulty coping with day-to-day demands.

Figure 5.9
Average Estimated Probability of Ratings of Difficulty Coping with Day-to-Day Demands,
Wave 1



NOTE: Difficulty coping with day-to-day demands assessed at Wave 1. Difficulty coping with day-to-day demands after counseling captured perceptions at the time of the survey. $n_s = 2,382$ for MFLC and 2,516 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response. Rows may not add to 100% due to rounding.

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Subgroup Differences

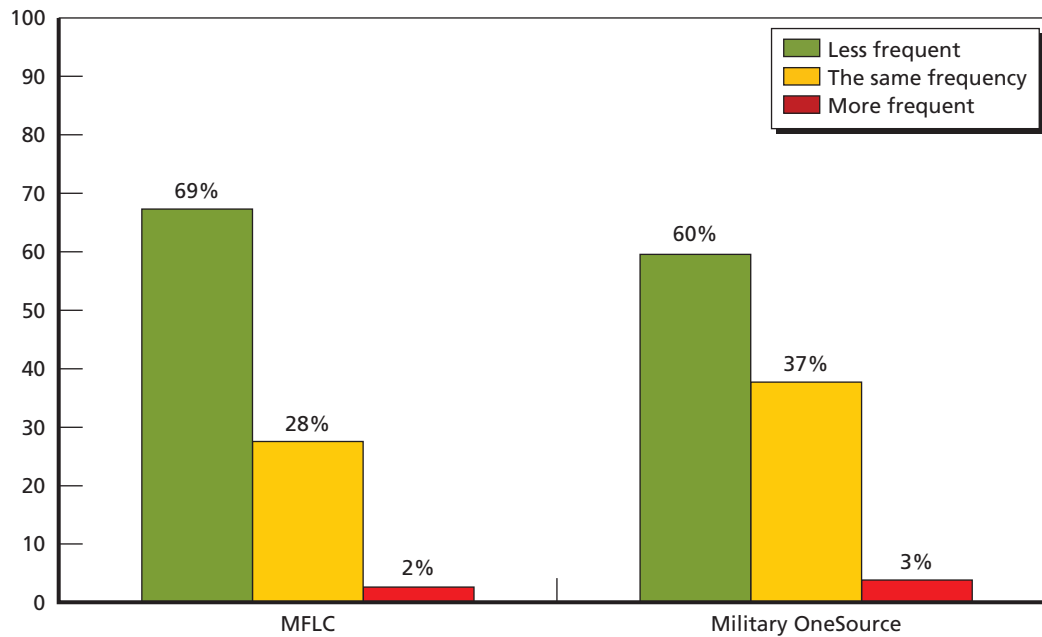
Before Non-Medical Counseling

Among MFLC participants, we observed significant differences in difficulty coping with day-to-day demands before counseling by gender and problem type, and Military OneSource participants demonstrated significant differences by service affiliation and gender (see Tables C5.8 and C5.9 in Appendix C).

Among MFLC participants, women were more likely than men (54 and 44 percent, respectively) to report frequent or very frequent difficulty coping with day-to-day demands. Among MFLC participants with different problem types, those seeking help with child issues were less likely to say that their problem made it difficult to cope with day-to-day demands compared to participants with other problem types (36 percent compared to 46–58 percent for other problem types).

Similar to MFLC participants, women seeking Military OneSource services were more likely to report frequent or very frequent difficulty coping with day-to-day demands compared to men (52 and 46 percent, respectively). Among participants affiliated with different services, Air Force participants and their families were less likely to report frequent or very frequent difficulty coping with day-to-day demands compared to participants affiliated with other services (43 percent compared to 52–54 percent for other services).

Figure 5.10
Average Estimated Probability of Difficulty Coping with Day-to-Day Demands, Wave 1



NOTE: Within-person changes in difficulty coping with day-to-day demands before and after counseling. $n_s = 2,382$ for MFLC and 2,516 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

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In Short-Term Resolution of Difficulty Coping with Day-to-Day Demands

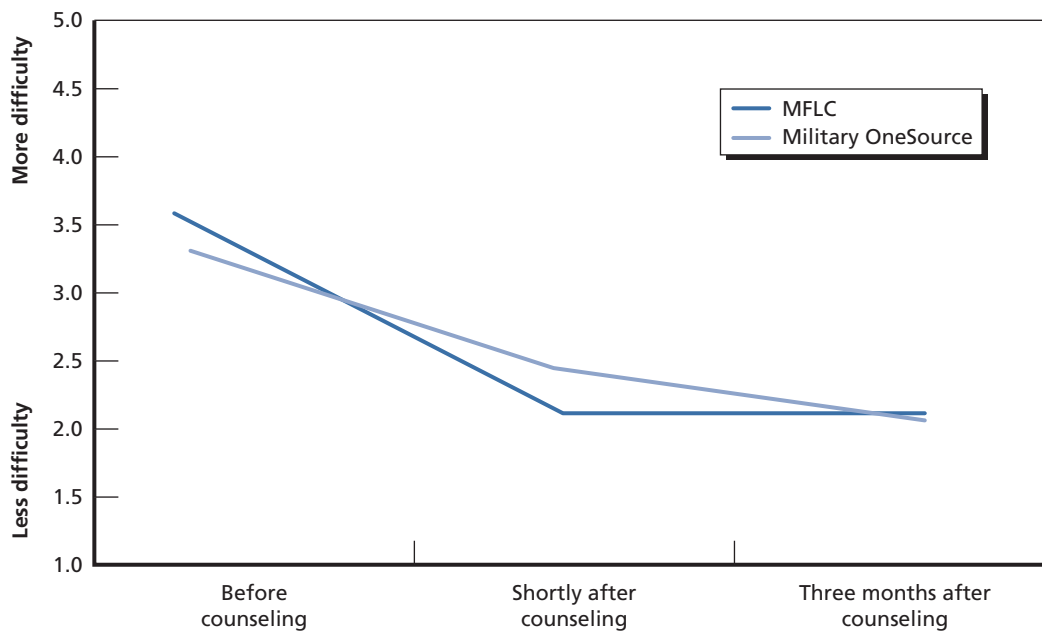
For both MFLC and Military OneSource, we observed significantly different short-term changes by gender. Across both programs, compared to women, men were more likely to have the same difficulty coping with day-to-day demands before and after initiating counseling (26 percent of women compared to 33 percent of men for MFLC; 35 percent of women compared to 40 percent of men for Military OneSource). Women were more likely than men to experience an improvement in their ability to cope with day-to-day demands (72 percent compared to 65 percent, respectively, for MFLC; 62 percent compared to 56 percent of men, respectively, for Military OneSource).

Long-Term Changes in Difficulty Coping with Day-to-Day Demands

The Wave 2 survey used the same postcounseling measure of difficulty coping with day-to-day demands to assess whether the ability to cope changed over the long term. We again examined whether short-term changes in difficulty coping were maintained after three months (i.e., did not change or less difficulty over time), followed by whether ratings of difficulty coping before counseling decreased in the three months after receiving counseling.

As shown in Figure 5.11, across both programs, average frequency of interference with day-to-day demands decreased shortly after initiating counseling, especially among MFLC participants. After three months, average frequency of interference with day-to-day demands

Figure 5.11
Average Estimated Frequency of Difficulty Coping with Day-to-Day Demands over Time



NOTE: Average ratings were calculated for those who completed both Wave 1 (before and after counseling ratings) and Wave 2 (three months after counseling) surveys. $n_s = 433$ for MFLC and 594 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

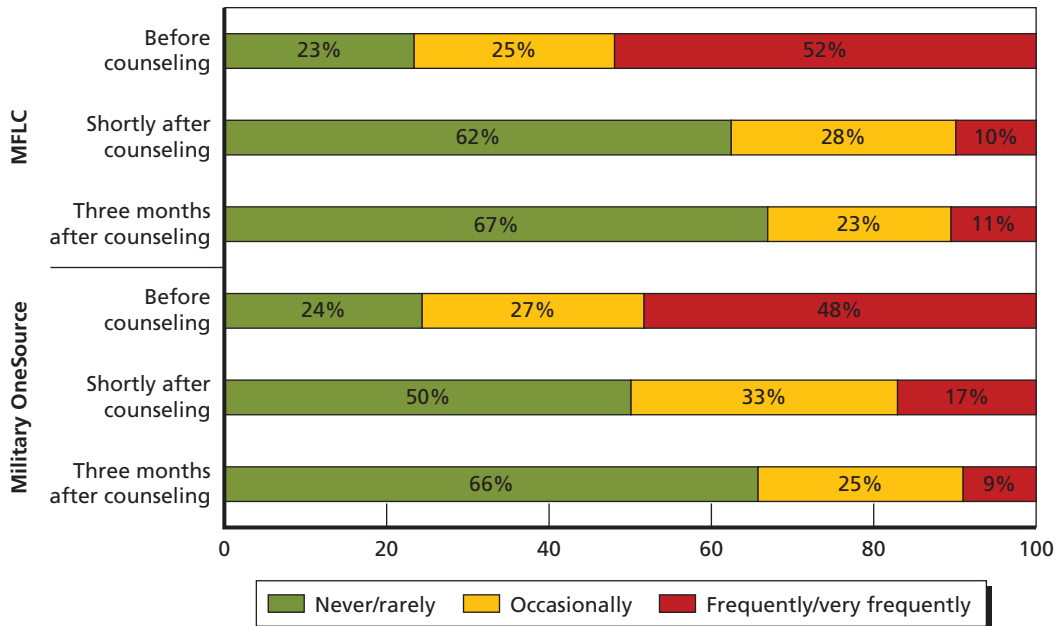
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continued to improve among Military OneSource participants and reductions captured shortly after initiating counseling were maintained among MFLC participants. About 76 percent of MFLC and 79 percent of Military OneSource participants reported the same level or less difficulty coping with day-to-day demands after three months. A significant number of Military OneSource participants demonstrated continued improvement over time. This suggests that short-term decreases in difficulty coping with day-to-day demands were maintained or continued to decrease over time for most participants.

Compared to ratings of difficulty coping with day-to-day demands before counseling, 72 percent of MFLC and 71 percent of Military OneSource participants reported experiencing less difficulty coping after three months. About 19 percent of MFLC and Military OneSource participants reported that difficulty coping with day-to-day demands after three months was similar to before receiving counseling. About 9 percent of MFLC and Military OneSource participants reported more frequent difficulties coping with day-to-day demands after three months compared to before they received counseling.

Another way to look at long-term changes is to examine the percent of participants who experienced problem interference with day-to-day demands frequently/very frequently, occasionally, or never/rarely across time. Figure 5.12 is similar to Figure 5.8, but includes responses from the Wave 2 survey. Numbers vary slightly from what is presented in Figure 5.8 as this figure includes responses only from those who completed both surveys. When examined over time, there is a reduction in the frequency of difficulty coping with day-to-day demands for

Figure 5.12
Average Estimated Probability of Frequency of Difficulty Coping with Day-to-Day Demands over Time



NOTE: Frequency of difficulty coping with day-to-day demands was calculated for those who completed both Wave 1 (before and shortly after counseling) and Wave 2 (three months after counseling) surveys. $n_s = 433$ for MFLC and 594 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response. Rows may not add to 100% due to rounding.

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both MFLC and Military OneSource participants. MFLC participants reported similar difficulty coping shortly after initiating counseling and after three months, while Military OneSource participants continued to report a decline in difficulty coping with day-to-day demands. Three months after counseling, 9–11 percent of participants still reported frequent or very frequent difficulty coping with day-to-day demands.

Subgroup Differences in Long-Term Changes

There were no significant subgroup differences in long-term changes in coping with day-to-day demands for Military OneSource participants, but long-term changes differed among MFLC participants with different problem types (see Table C5.10 in Appendix C). This difference was driven by participants with child-related problems: compared to ratings of difficulty before receiving counseling, almost 39 percent of participants with child-related problems demonstrated improved coping with day-to-day demands after three months, compared to 67 to 86 percent of participants with other problem types.

Chapter Summary

The results reported in this chapter demonstrate that participants' problems interfered less with their work and daily lives following non-medical counseling, both in the short and long term.

While MFLC participants reported short-term improvements that were maintained over the long term by the majority of participants, Military OneSource participants reported more modest short-term improvements but experienced continued improvement over time. For many of the outcomes examined, women experienced significantly less interference in their work and daily life for both programs. Furthermore, individuals affiliated with the Navy, compared to other services (for MFLC only) and service members, compared to family members (for Military OneSource only) experienced greater problem resolution at work. These findings provide additional evidence that non-medical counseling facilitated short- and long-term problem resolution among the majority of participants.

Connection to Services and Referrals

In addition to actively helping participants cope with the stress and impact of their problems, non-medical counseling serves as a conduit for connecting participants to services for which they are eligible and referrals to medical or behavioral health services when needed. This chapter examines the extent to which participants in non-medical counseling were connected to additional services, how satisfied participants were with those referrals, and whether the program followed up with them to make sure they had connected with services. Importantly, each question was examined among participants who reported that the question was applicable to their problem (i.e., they did not indicate that the question was “not applicable”). The number of respondents reporting that a question was not applicable to their problem varied widely, ranging from 33 to 62 percent. Statistically significant differences among subgroups are discussed in the text and subgroup differences are tabulated in Tables C6.1–C6.4 in Appendix C. Key findings from this chapter among participants who reported that each question was applicable include:

- Of the 34 percent of MFLC and 37 percent of Military OneSource participants who reported that they needed support and services outside the program, over 65 percent indicated that they had been connected to those services.
- About 45 percent of participants reported that they needed referrals to medical services, and a little over half of those participants agreed that their counselor had connected them with medical services. Of the 38 percent of MFLC and 46 percent of Military OneSource participants who reported needing referrals to physical health services, only around 37 percent agreed that they had been connected with physical health services they would not have connected with on their own.
- A larger number of Military OneSource participants (67 percent) reported that they needed referrals to mental health services, and 69 percent of those participants agreed that they had been connected with mental health services they would not have connected with on their own.
- Over 81 percent of non-medical counseling participants who reported that their counselor referred them to outside services were satisfied or very satisfied with program follow-up to make sure they connected with recommended services.

Connection to Services Outside of Non-Medical Counseling

At Wave 1, participants were asked about their use of other resources to help with their problem (e.g., family or friends, religious or faith-based community), and the connections their

Table 6.1**Percent of Participants Using Support Services in Addition to Non-Medical Counseling to Address Their Problem, Wave 1**

	MFLC (%)	Military OneSource (%)
Private counselor or specialist	31.0	24.9
Military family support program	9.8	6.6
Military OneSource	11.3	—
MFLC	—	12.0
Religious or faith-based community	33.3	32.1
Extended family members or friends	50.9	54.1
Other	20.8	14.5

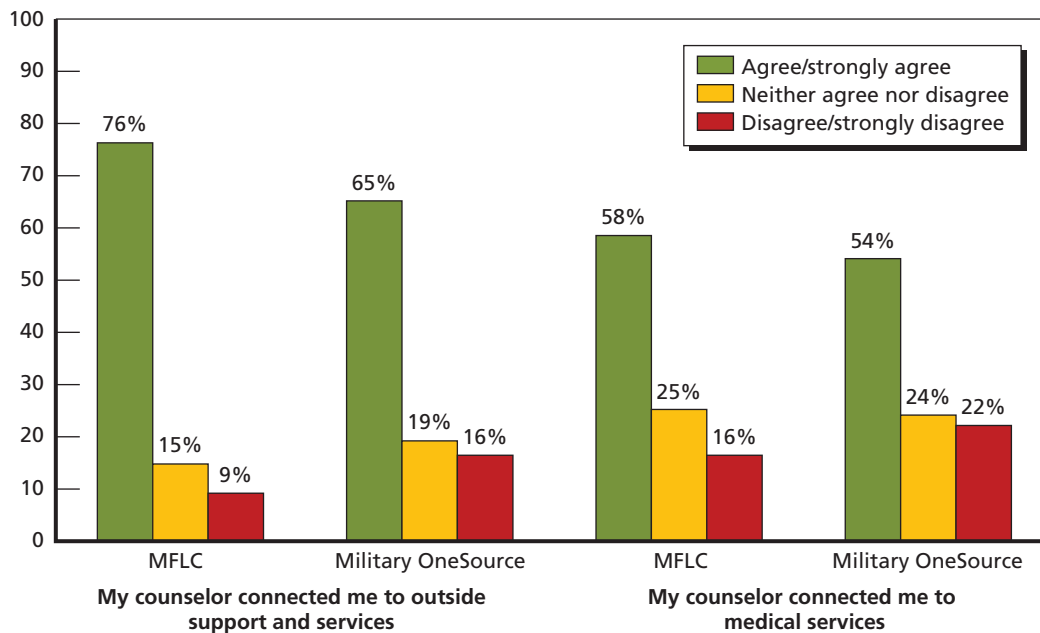
NOTE: Among individuals who reported seeking support from individuals or providers other than MFLC ($n=991$) or Military OneSource ($n=1,027$), respectively. Percentages are weighted to be representative of the MFLC and Military OneSource non-medical counseling population.

counselor provided to services outside of non-medical counseling, including general support and services, medical care (physical and psychological), and community services.

We found that 40 percent of MFLC participants and 38 percent of Military OneSource participants had sought additional support from other individuals or providers for their problem. Of those who had sought additional support, 54 percent of MFLC and 61 percent of Military OneSource participants sought help from one additional source, and 43 percent of MFLC and 37 percent of Military OneSource participants sought help from two or three additional sources. The most frequently cited sources of additional help sought by MFLC and Military OneSource participants are shown in Table 6.1. About half of MFLC and Military OneSource participants sought help from extended family members or friends for their problem, and about a third sought help from a religious or faith-based community. Although there may be a concern about duplication of services, the varied nature, emphasis, and approach of these supports are likely quite different (e.g., support of friends as compared to one's faith leader as compared to a non-medical counselor) and this minimizes this concern. However, between 11 percent and 12 percent of participants sought help from both Military OneSource and MFLC. Given that the approaches of these two programs are quite similar, it is not clear why individuals felt the need to seek services from both non-medical counseling programs. About a quarter of Military OneSource and 31 percent of MFLC participants who sought additional help for their problem reported seeing a private counselor or specialist. However, the timing (e.g., before or after MFLC/Military OneSource services) and nature (e.g., a result of an MFLC/Military OneSource referral) of this additional help is unclear.

To assess counselor-initiated connections to general outside resources, we asked participants the extent to which they agreed with the statement "My counselor connected me to outside support and services." About 34 percent of MFLC and 37 percent of Military OneSource participants indicated that this question was not applicable to their problem. Of those who responded that it was applicable, 76 percent of MFLC and 65 percent of Military OneSource participants agreed or strongly agreed that their counselor had connected them with outside support and services (see Figure 6.1). About 9 percent of MFLC and 16 percent of Military

Figure 6.1
Average Estimated Probability of Connection to Services Outside of Non-Medical Counseling, Wave 1



NOTE: $n_s = 1,531$ and 990 for MFLC; $1,488$ and $1,015$ for Military OneSource, respectively. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

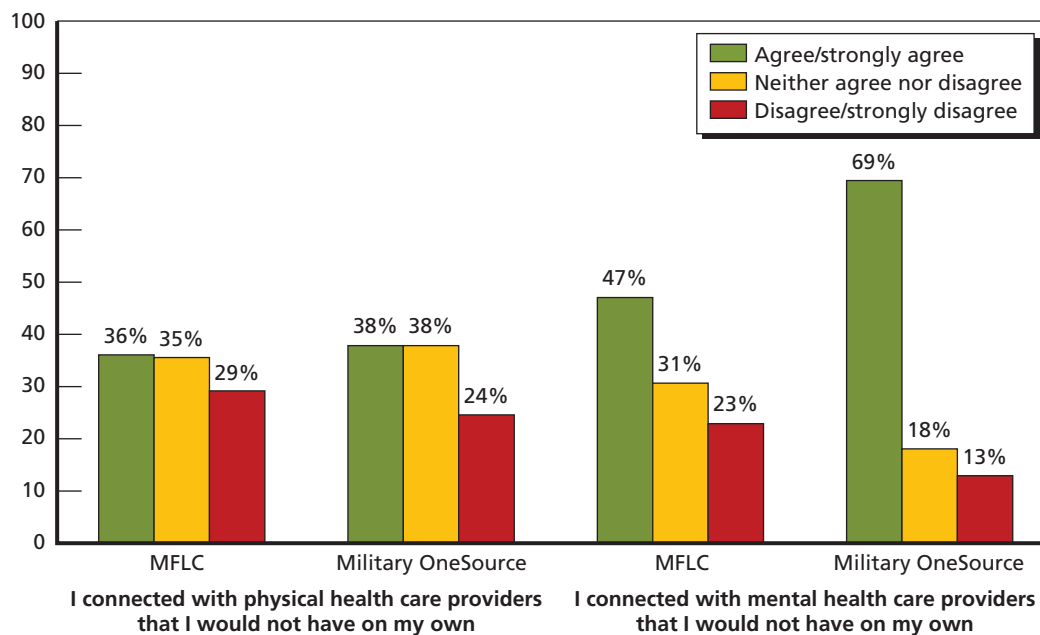
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OneSource participants disagreed or strongly disagreed that they had been connected to outside support and services.

To assess counselor-initiated connections specifically to medical resources, we asked the extent to which they agreed with the statement “My counselor connected me to medical services.” Fifty-five percent of MFLC and 53 percent of Military OneSource participants indicated that this question was not applicable to their problem. Of those who responded that it was applicable, 58 percent of MFLC and 54 percent of Military OneSource participants agreed or strongly agreed that their counselor had connected them with medical services (see Figure 6.1). About 16 percent of MFLC and 22 percent of Military OneSource participants disagreed or strongly disagreed that they had been connected to medical services.

In addition to the general question about connection with medical services, we asked participants whether they had been “connected with physical health care providers that I would not have on my own” and whether they had been “connected with mental health care providers that I would not have on my own.” About 38 percent of MFLC and 46 percent of Military OneSource participants indicated connection with a physical health provider was relevant for addressing their concern. Of these, roughly equal proportions of participants indicated that they agreed or strongly agreed (36 percent of MFLC and 38 percent of Military OneSource) or neither agreed nor disagreed (35 percent of MFLC and 38 percent of Military OneSource) that they had connected with physical health providers with the help of MFLC or Military

Figure 6.2
Average Estimated Probability of Connection to Physical and Mental Health Providers
Due to Non-Medical Counseling, Wave 1



NOTE: $ns = 713$ and 855 for MFLC; 839 and $1,476$ for Military OneSource, respectively. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

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OneSource counselors (see Figure 6.2). About 29 percent of MFLC and 24 percent of Military OneSource participants disagreed or strongly disagreed that they had connected with physical health providers with the help of the counselors.

As shown in Figure 6.2, participants were more likely to agree that they had connected with mental health providers with the help of MFLC or Military OneSource counselors. About 44 percent of MFLC participants and 67 percent of Military OneSource participants reported that this question was applicable to their problem. Of those, 47 percent of MFLC and 69 percent of Military OneSource participants agreed or strongly agreed with this statement, while 23 percent of MFLC and 13 percent of Military OneSource participants disagreed or strongly disagreed.

Non-medical counselors also connect individuals with community-based resources. In response to the question about how much they agreed with the statement that, because of non-medical counseling, they “connected with additional community services that I would not have on my own,” 56 percent of MFLC and 39 percent of Military OneSource participants stated they agreed or strongly agreed. About 18 percent of MFLC and 23 percent of Military OneSource participants disagreed or strongly disagreed with this statement, and 26 percent of MFLC and 38 percent of Military OneSource participants neither agreed or disagreed (about 50 percent of MFLC and Military OneSource participants indicated that this question was not applicable to their problem).

For both MFLC and Military OneSource participants, significant subgroup differences emerged by service member status for connections with outside support and services

(see Tables C6.1 and C6.2 in Appendix C). Compared to family members, service members were more likely to agree or strongly agree with the statement “My counselor connected me to outside support and services” (73 percent compared to 80 percent for MFLC; 60 percent compared to 68 percent for Military OneSource, respectively).

While open-ended responses mentioned the value of referrals offered by non-medical counselors as one of the strengths of the program, responses also highlighted logistical difficulties participants experienced with trying to obtain referrals from non-medical counselors. Some of the comments highlight related challenges of the program, including frequent rotation of MFLC counselors and a lack of continuity between military service providers (discussed further in Chapter Seven).

[A strength of the program is] their considerable ability to highlight and pinpoint specific issues and refer clients to other sources for more targeted treatment. (MFLC participant)

[A strength of the program is that it is] easy to get referrals. (Military OneSource participant)

My MFLC recommended referral for particular testing for my son and sent me to my PCM [primary care manager] for that referral. It took 2 months to get a referral because the PCM didn’t understand what I was asking for and the MFLC was no longer at the base to be able to contact for assistance or guidance with the referral. Therefore I feel one of the greatest challenges is the disconnect between mental health and medical health. (MFLC participant)

They need to know how to talk to people, how to be impartial, and how to refer customers to adequate help. (MFLC participant)

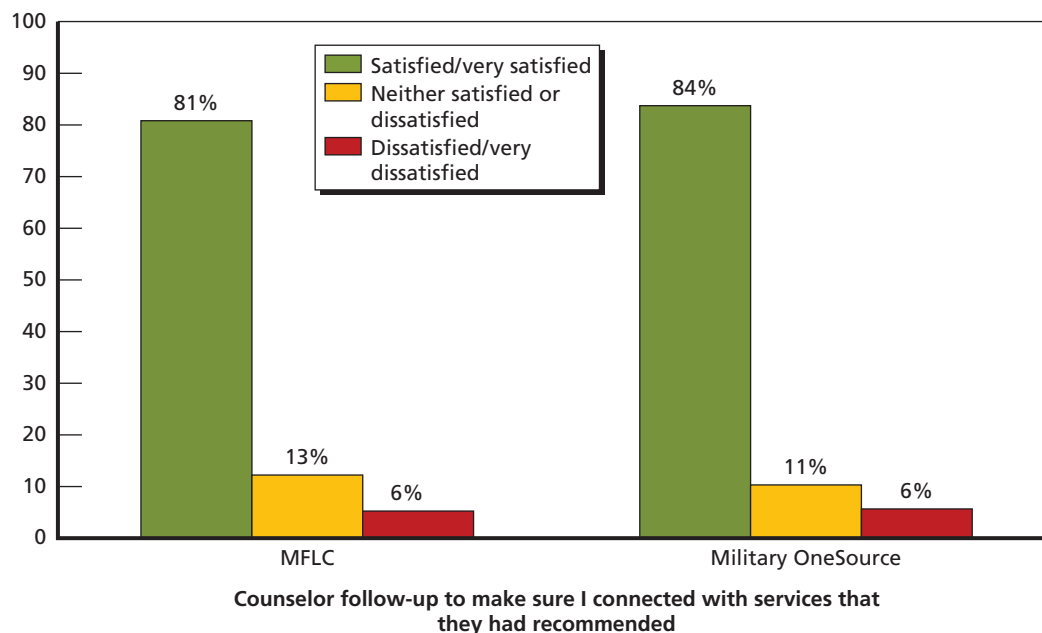
Program Follow-Up with Connections to Outside Services

Although many participants did not perceive that their counselor had connected them with outside services, those who were referred to outside services generally said that their counselor followed up with them to make sure that the connection was made. In response to the question of how much they agreed with the statement that “My counselor [or Military OneSource call center] followed up with me to make sure I was able to connect with the outside supports and services they recommended,” 74 percent of MFLC and 76 percent of Military OneSource participants agreed or strongly agreed. About 12 percent of MFLC and 11 percent of Military OneSource participants disagreed or strongly disagreed with this statement, and 14 percent of MFLC and 13 percent of Military OneSource participants neither agreed nor disagreed (about 37 percent of MFLC and 33 percent of Military OneSource participants indicated that this question was not applicable to their problem). Furthermore, over 81 percent of non-medical counseling participants were satisfied or very satisfied with program follow-up to make sure they connected with recommended services (see Figure 6.3).

Subgroup Differences

Significant subgroup differences emerged for satisfaction with counselor follow-up on connecting with recommended services (see Tables C6.3 and C6.4 in Appendix C). Among MFLC participants, participants seeing counselors embedded within the unit tended to be more satisfied with counselor follow-up than those whose counselor was not embedded

Figure 6.3
Average Estimated Probability of Satisfaction with Program Follow-Up on Connections to Recommended Outside Services, Wave 1



NOTE: $n_s = 1,448$ for MFLC and 1,587 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

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(85 percent compared to 80 percent were satisfied or very satisfied, 10 percent compared to 14 percent were neither satisfied nor dissatisfied, and 5 percent compared to 7 percent were dissatisfied or very dissatisfied).

Among Military OneSource participants, service members tended to be more satisfied than family members: 85 percent of service members and 81 percent of family members were satisfied or very satisfied with counselor (or Military OneSource) follow-up for connection with recommended services. Almost 10 percent of service members and 12 percent of family members were neither satisfied nor dissatisfied with follow-up, and 5 percent of service members compared to 7 percent of family members were dissatisfied or very dissatisfied with counselor or program follow-up for connection with recommended services.

Chapter Summary

The results reported in this chapter suggest that there was considerable variation in the extent to which non-medical counseling participants were connected with support and services outside of the program, but, when recommendations were made, the vast majority of participants were satisfied with program follow-up to make sure they connected with recommended services. Among participants who reported that each question was applicable, over 65 percent of non-medical counseling participants indicated that their counselor had connected them with support and services outside the program, although smaller percentages indicated that they

were connected to medical services or physical health services they would not have connected with on their own. Military OneSource participants were likely to agree that they had been connected with mental health services they would not have connected with on their own. Over 81 percent of non-medical counseling participants were satisfied or very satisfied with program follow-up to make sure they connected with recommended services, and MFLC participants seeing counselors embedded within the unit tended to be more satisfied with counselor follow-up than those whose counselor was not embedded. About a quarter of participants who sought additional help for their problem reported also seeing a private counselor or specialist. Although the timing and nature of this additional help is unclear, the fact that participants sought help from other counselors raises questions about the severity and nature of their problem, including whether participants with serious mental health problems are screened out of non-medical counseling and directed to more appropriate sources of care.

Note that each question examined in this chapter was analyzed for those participants who reported that the question was applicable to their problem (i.e., they did not indicate that the question was “not applicable”), and the number of respondents reporting that a question was not applicable to their problem varied widely, ranging from 33 to 62 percent. This suggests that only participants who needed connections to outside services answered the questions. However, it is possible that those who did not need outside services answered the questions anyway, perhaps indicating that they did not agree that they had been connected to outside services. This could partly account for the lower ratings of agreement with these questions relative to participants’ higher levels of satisfaction with follow-up on these connections. The next chapter further explores participants’ experiences with non-medical counseling programs and with the counselors themselves.

Experiences with MFLC and Military OneSource Programs

MFLC and Military OneSource are meant to increase access to high-quality services and help individuals connect to needed services that will help them to address their problems (see Figure 2.1 for the full logic model). Earlier chapters in this report examined the reported effectiveness of these services on outcomes related to problem resolution and impact of the problem on one's work and family life. This chapter examines the experiences individuals had with these non-medical counseling programs. At the program level, we examine perceptions related to ease of access, confidentiality, continuity of care, and overall satisfaction as measured by willingness to use services again or recommend them to others. Statistically significant differences among subgroups are discussed in the text and subgroup differences are tabulated in Tables C7.1–C7.4 in Appendix C.

While there is slight variability between the two programs, key findings across both MFLC and Military OneSource include the following:

- Over 90 percent of individuals reported that they were satisfied or very satisfied with the speed of being connected to a counselor and ease with which they could make an appointment.
- Over 90 percent of participants were satisfied or very satisfied with the level of confidentiality received.
- Over 90 percent of individuals reported being satisfied or very satisfied with the continuity of care they received.
- Over 90 percent of participants reported that they would be likely or highly likely to use non-medical counseling services again.
- Despite positive perceptions from the majority of participants, between 1 percent and 7 percent of participants reported being dissatisfied or very dissatisfied on the above program dimensions.

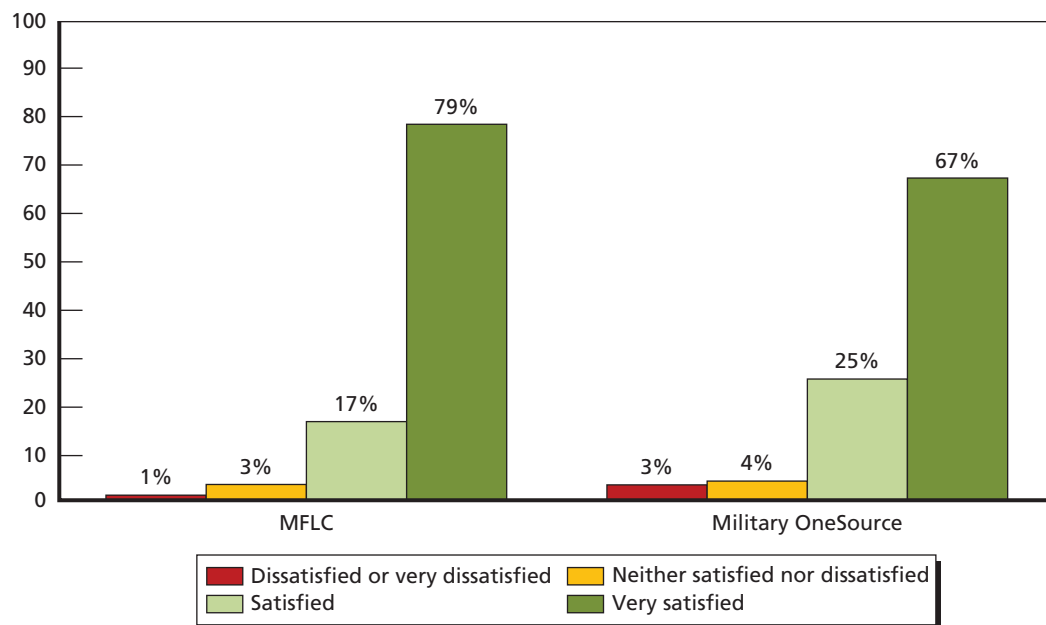
Ease of Access

In Wave 1, respondents reported on their satisfaction with the speed at which they were connected to counseling staff, as well as how easy it was to make an appointment with their counselor that fit their schedule.

Speed of Connecting to Counseling Services

Over 90 percent of individuals reported that they were satisfied or very satisfied with the speed of being connected to a counselor. About 1 percent of MFLC participants and 3 percent of Military OneSource participants reported being dissatisfied or very dissatisfied with the speed

Figure 7.1
Average Estimated Probability of Satisfaction with the Speed of Connecting to Non-Medical Counseling Services, Wave 1



NOTE: $n_s = 2,165$ for MFLC and 2,314 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

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of which they were connected to a counselor (Figure 7.1). There were no subgroup differences related to the speed of connecting to non-medical services. The high level of satisfaction was reiterated in the open-ended survey responses.

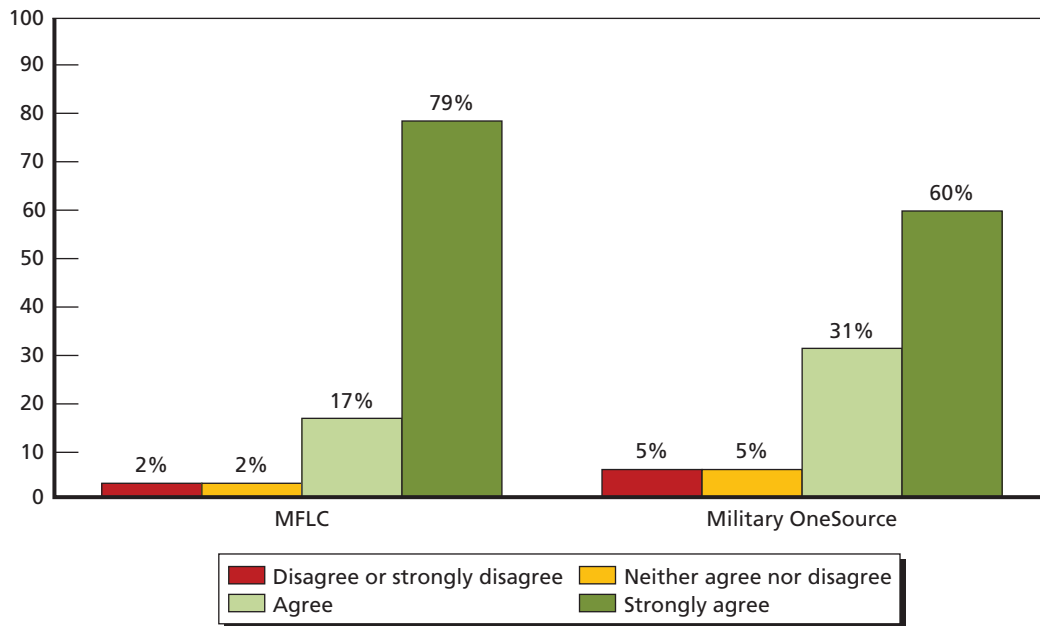
It is quicker to get together with an MFLC counselor than it is to get in with a psychiatrist. It is very nice to be able to speak to someone right away. (MFLC participant)

Military OneSource was able to find a counselor that specialized in what I was looking for and near me. It would have taken me hours/days to figure it out. I called very late in the evening and was able to speak to someone right away. I got the contact info for a counselor and left a message for them. They called back the next morning even though it was a weekend and was able to get an appointment very quickly. (Military OneSource participant)

Despite the majority of participants being satisfied with the speed of services, not everyone was equally satisfied. Given that individuals often reach out in time of crisis, it is not surprising that individuals with wait times of several weeks or more expressed much higher dissatisfaction.

The counselors that I have been in contact with did not seem to have the appropriate time available to schedule appointments. I have had to wait in excess of 3 or more weeks for the first appointment, and many times more than 2 weeks in between appointments. (Military OneSource participant)

Figure 7.2
Average Estimated Probability of Ease of Making Appointments, Wave 1



NOTE: $n_s = 2,328$ for MFLC and 2,492 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

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Ease of Making Appointments That Fit with Participant Schedule

In addition to capturing perceptions on the length of time it took to connect to non-medical counseling services, we also asked participants about the extent to which they felt they were able to make appointments with their counselor to fit their schedule (Figure 7.2). Over 90 percent of non-medical counseling participants felt that it was easy to make an appointment that worked with their schedule, with 79 percent of MFLC and 60 percent of Military OneSource participants strongly agreeing with the statement “It was easy to make appointments with my counselor to fit my schedule.” About 2 percent of MFLC and 5 percent of Military OneSource participants, however, disagreed or strongly disagreed that it was easy to make convenient appointments. While there were no significant differences by subgroups for Military OneSource, MFLC participants whose counselors were embedded in their unit were more likely to agree that it was easy to make an appointment, as compared to those whose counselors were not embedded (see Table C7.1 in Appendix C).

Beyond the ability to schedule appointments at convenient times, open-ended responses indicate that participants appreciated the flexibility to meet with counselors at convenient locations to them, either in their communities (Military OneSource) or at a place on base or somewhere else of their choosing (MFLC).

This is a huge advantage to those who are not near a military installation where medical services are readily available. I enjoy the non-medical approach too because this has become a major concern within the military community. (Military OneSource participant)

A major advantage using the MFLC system is that they are very easy to work with. My appointments are made within the time that I need them and locations are convenient for me. (MFLC participant)

However, as 10 percent of Military OneSource survey respondents indicated, some participants did not agree that they were able to easily schedule counseling services, particularly given the hectic schedules of military life.

[A weakness of the MFLC program is the] restrictions of coordinating a regular civilian appointment schedule with a chaotic and fluid military schedule. (MFLC participant)

It was difficult to get an appointment scheduled after leaving numerous providers voice-mails, getting calls returned saying they're not taking new patients, or they didn't have the hours we needed. (Military OneSource participant)

Confidentiality

One of the hallmarks of these two non-medical counseling programs is the confidential nature of services being offered. As such, we asked individuals to rate their level of satisfaction with the confidentiality of personal and family information held by the program. Over 95 percent of MFLC participants and over 90 percent of Military OneSource participants were satisfied or very satisfied with the level of confidentiality received (Figure 7.3). One percent of clients in both programs, however, reported being dissatisfied or very dissatisfied. There were no subgroup differences in the level of satisfaction.

In the open-ended responses, confidentiality was mentioned frequently as the primary reason for participants' choice of non-medical counseling and their interest in continued use.

[A strength of the program is] the fact that MFLC counselors are not plugged into the same healthcare recording systems as medical services which leads me to believe confidentiality is better and makes me feel more comfortable about using the service. (MFLC participant)

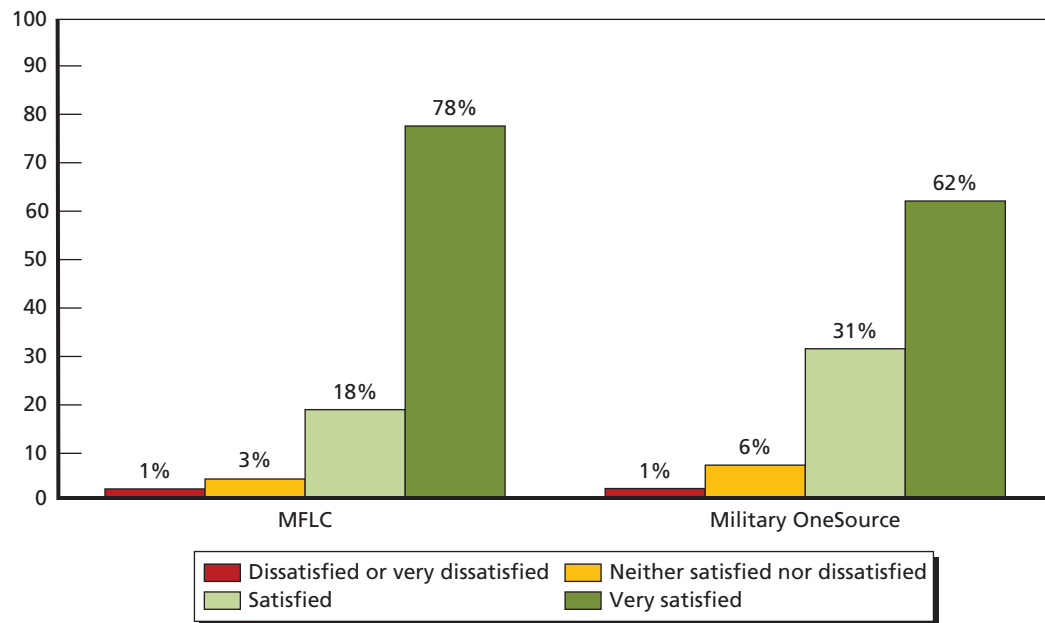
The major strengths are having confidentiality outside of your duty station to get the assistance needed. There's no fear of your supervision/leadership getting in your business while you work through some of life's events. (Military OneSource participant)

However, open-ended responses summarizing weaknesses of the programs revealed that concerns about a lack of confidentiality are still a major factor and can influence participants' perceptions of both programs.

Counselors need to make sure the patient feels that everything is confidential (close the door) for privacy. (Military OneSource participant)

The location of the MFLC in the [a specific building on base]. . . . Entering the room doesn't feel very private. . . . It might be a barrier for some, to enter a room with such a high flow of traffic. (MFLC participant)

Figure 7.3
Average Estimated Probability of Satisfaction with the Confidentiality of Personal and Family Information, Wave 1



NOTE: *ns* = 2,175 for MFLC and 2,267 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

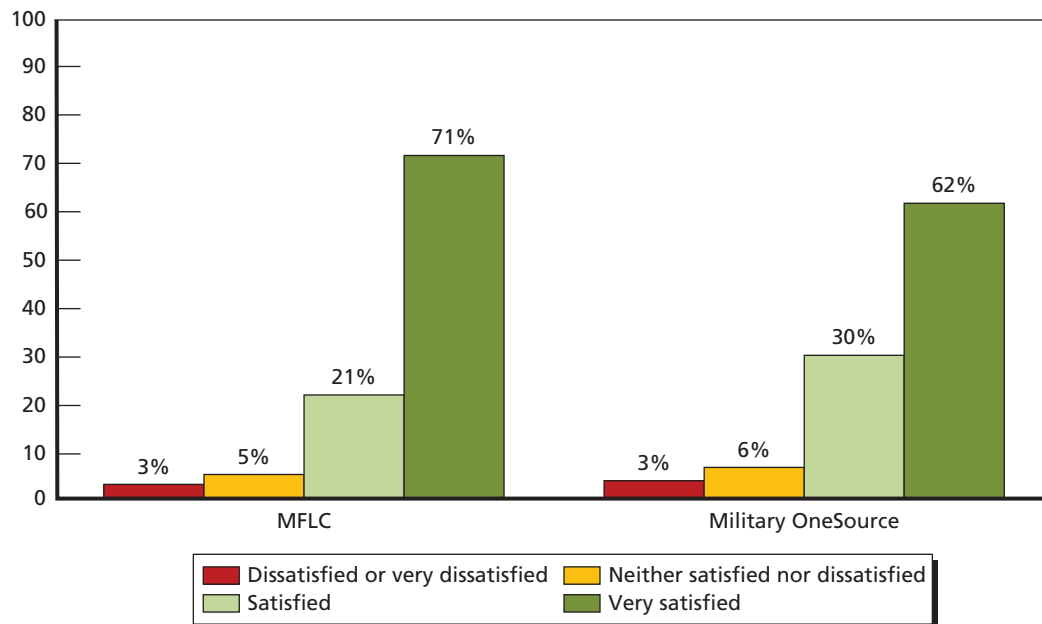
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Continuity of Care

Individuals were also asked to report on their level of satisfaction with continuity of care, which included seeing the same counselor for each session or another counselor who knew about the individual's concern and what had been discussed during a previous counseling session. Individuals reported on whether the counselor or a member of the program staff reached out if an individual missed a scheduled appointment. For both MFLC and Military OneSource, just over 90 percent of individuals reported being satisfied or very satisfied with the continuity of care they received (Figure 7.4).

Significant subgroup differences were observed for both MFLC and Military OneSource (see Tables C7.2 and C7.3 in Appendix C). For MFLC, participants whose counselor was embedded in their unit were more likely to report being very satisfied with the continuity of care compared to those whose counselors were not embedded. For Military OneSource, there was a significant difference in continuity of care by presenting problem. Close to 80 percent of individuals with deployment concerns were very satisfied with the continuity of care received. Between 60 percent and 65 percent of individuals with education and employment problems, family or relationship issues, loss or grief, or general stress, anxiety or emotional problems reported being very satisfied with the continuity of care. For individuals with child-related problems, only 45 percent reported being highly satisfied with the continuity of care provided.

Figure 7.4
Average Estimated Probability of Satisfaction with the Continuity of Care, Wave 1



NOTE: $ns = 1,969$ for MFLC and $2,184$ for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

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Open-ended responses provided more detail on the ways in which programs maintained continuity of care.

We discussed the problem, possible solutions, and plan for the next step forward to include follow-up sessions. Continuity is extremely important so being able to stay with the same counselor made a big impact. (MFLC participant)

It was a fast and seamless process. There was great communication with the text messages, email, and follow-up to ensure I had scheduled an appointment. (Military OneSource participant)

While the majority of participants were satisfied with the continuity of care they received through MFLC and Military OneSource, there was a significant subset of respondents who were not satisfied. Weaknesses mentioned in open-ended responses provide some insight into the reasons why roughly 10 percent of participants were not satisfied with the continuity of the program. While we cannot directly compare the frequency of themes mentioned in open-ended responses between programs, this issue was more commonly mentioned by Military OneSource participants.

My only complaint is that when we move (as we often do) finding a new counselor means explaining my entire life story again. I don't even know if there is a work-around for this, and maybe it's best to repeat things and gain other perspectives, but I do feel like a lot of time is spent the first session or two repeating things I told a previous counselor. (Military OneSource participant)

No notes taken so on more detailed issues some of the information is lost or forgotten.
(MFLC participant)

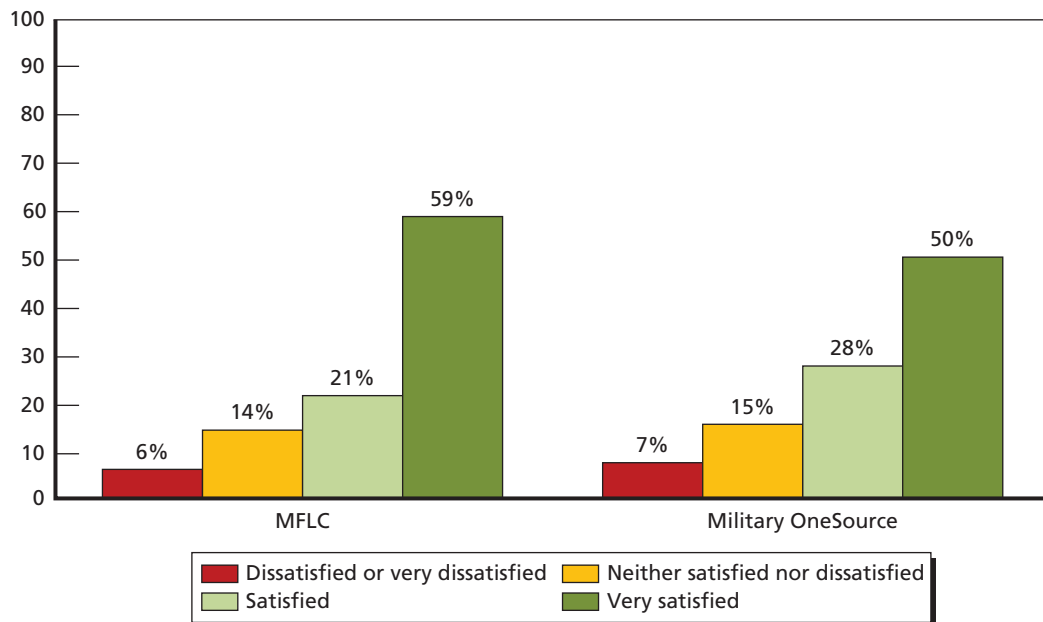
Related to concerns with continuity of care, respondents, particularly those who sought counseling through MFLC, were concerned about the impact of frequently rotating counselors from installation to installation. In fact, the most frequently mentioned weakness of the MFLC program was a lack of stability of MFLC counselors, one that seemed to influence participants' perceptions of the value of the program as a whole.

The major disadvantage is MFLC counselors rotate a lot. I would like to see the same counselor for all of my session because I already have a rapport with them. (MFLC participant)

There's a policy to move our MFLCs after a year. We've had some outstanding counselors who have become strong members of the team. I hate losing them after they've established trust and rapport. (MFLC participant)

In addition to overall continuity of care, individuals also provided feedback related to outreach by the program or counselor after a missed appointment. About half of participants (59 percent of MFLC and 50 percent of Military OneSource) reported being very satisfied with follow-up from program staff if they missed an appointment (Figure 7.5). Between 6 percent and 7 percent, however, were dissatisfied with the follow-up. There were no significant group differences in the level of satisfaction among MFLC or Military OneSource participants.

Figure 7.5
Average Estimated Probability of Satisfaction with Follow-Up After Missed Appointment, Wave 1



NOTE: $ns = 1,144$ for MFLC and $1,107$ for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Future Use and Recommendation of Program to Others

Anticipated Future Use of Program

As an overall indicator of program satisfaction, we asked individuals how likely it is that they would use non-medical counseling the next time they experienced a non-medical problem. Over 90 percent of participants reported that they would be likely or highly likely to use non-medical counseling services again if the need arose (91 percent for MFLC and 93 percent for Military OneSource) (Figure 7.6).

Approximately 5 percent were not sure and about 3 percent said that they would not likely use non-medical counseling services in the future. There were no significant differences by subgroup in the reported likelihood of future program use.

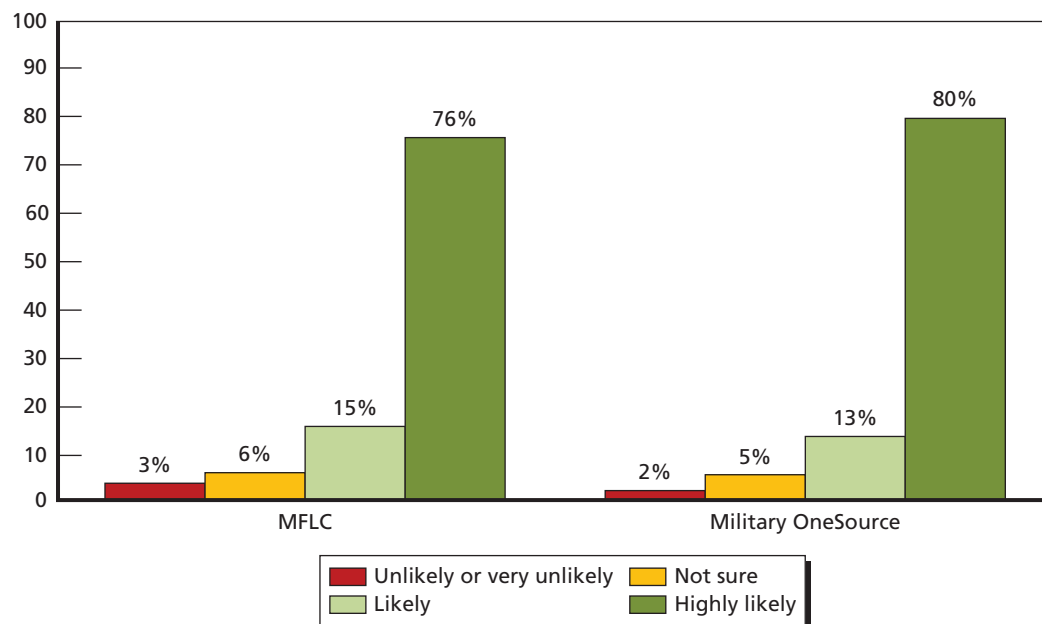
In response to the open-ended question about strengths of the program, participants took the opportunity to affirm their plans for future use.

My counselor knew me and counseled me in a way I responded well to. Appointments were flexible and encouraged me to come back. I would definitely use an MFLC again when I needed support. (MFLC participant)

The support was excellent and would use the services again if needed. (Military OneSource participant)

Participants also noted that they appreciated the fact that the non-medical counseling services were offered to them free of charge. Many reported that this eliminated the financial

Figure 7.6
Average Estimated Probability of Likelihood of Future Program Use, Wave 1



NOTE: $n_s = 2,314$ for MFLC and 2,432 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

barrier that they had faced when trying to access similar services elsewhere and, as a result, they were able to get the services they needed.

I would not have sought counseling services without Military OneSource because my civilian medical insurance does not cover it until our deductible is met, and then only covers half of the cost. I wouldn't take money from our family budget for myself like that. I also had no idea (as a professional in the community on the civilian side) how to access any lower-cost or free services. (Military OneSource participant)

Despite positive experiences by many, other participants reported that they did not intend to use MFLC or Military OneSource services again. Reasons provided in these responses reflect other concerns identified in survey data, including issues with access, while others reflect a general lack of confidence in the efficacy of the program.

It is such a pain to receive treatment through Military OneSource. The initial phone call takes entirely too long, and they'll only send the names of up to three providers at a time. I then have to research those three providers, decide if they're worthy, and then call back and request three more if I don't like them. This is time consuming, mentally draining, and an effective barrier to me wanting to find treatment. . . . I will never utilize Military OneSource again for myself or for my family. (Military OneSource participant)

The same stuff that caused the stress is still present after the counselor left and will continue to be present until this duty is over. So why talk about it with someone about your problems, if you know your problems won't change. I'm not a threat to myself so there is no need in the future for me to talk with a counselor again. (MFLC participant)

Likelihood of Recommending Non-Medical Counseling to Others

We also asked how likely individuals would be to refer a friend to non-medical counseling services. Although this question was asked of Military OneSource only due to the highly confidential nature of the MFLC program, some MFLC participants noted in their open-ended responses that they do recommend MFLC services to others. Among Military OneSource participants, about 95 percent reported that they would be likely (11 percent) or highly likely (84 percent) to recommend Military OneSource to a friend in need of services. About 3 percent were not sure and about 2 percent reported that they would be unlikely to recommend Military OneSource services.

I am a HUGE advocate of the MFLC program and recommend their services whenever I can. (MFLC participant)

If it was just my husband and I were just talking to each other, it was difficult to move past the issue we each wanted to address and go parallel, but our counselor was able to help us communicate better. . . . I recommend the service to anyone who is suffering from marital problems. (Military OneSource participant)

There were significant differences in the likelihood of recommending Military OneSource services among service members and family members, and this was driven largely by differences in the extent to which they reported being "highly likely" to recommend Military

OneSource services (86 percent of service members and 80 percent of family members), with little difference in the proportion reporting that they would not recommend services (1 percent of service members and 2 percent of family members; see Table C7.4 in Appendix C).

Chapter Summary

Overall, participants were generally pleased with the ease with which they were able to access services, confidentiality of services, and continuity of care. Among MFLC participants in particular, those working with an embedded MFLC counselor reported significantly higher satisfaction along several program domains. However, not all participants had an equally positive experience or perception of non-medical counseling services. Findings, particularly open-ended responses, point to the need for MFLC and Military OneSource leadership to assess where additional counselors may be warranted to alleviate stress on the system and ensure everyone can access services within a reasonable time frame. Other findings suggest that periodic reminders to counselors about confidentiality, and the appearance of confidentiality, may be warranted as this is a hallmark of the program and a continued concern for many. Results also suggest that program leadership may wish to examine concerns related to the continuity of care, reported by about 10 percent of the population, as this lack of continuity may serve as a barrier to faster problem resolution. For example, there were significant differences among Military OneSource participants by problem type, with those presenting with child-related issues reporting the lowest level of continuity. Despite these concerns, about 90 percent of individuals noted that they would be likely to use non-medical counseling services again if the need arose.

Perceptions of Non-Medical Counselors

In addition to the perceptions of the non-medical programs (Chapter Seven), we also asked individuals to report on their perceptions of their counselors. Feedback on issues of professionalism, clarity of communication, cultural competency (i.e., sensitive to cultural/language differences of participants, understanding of military culture), knowledge of the presenting problem, and whether the counselor met the client needs may help to further strengthen non-medical counseling programs and the experiences of individuals seeking services. Statistically significant differences among subgroups are discussed in the text and subgroup differences are tabulated in Tables C8.1–C8.7 in Appendix C.

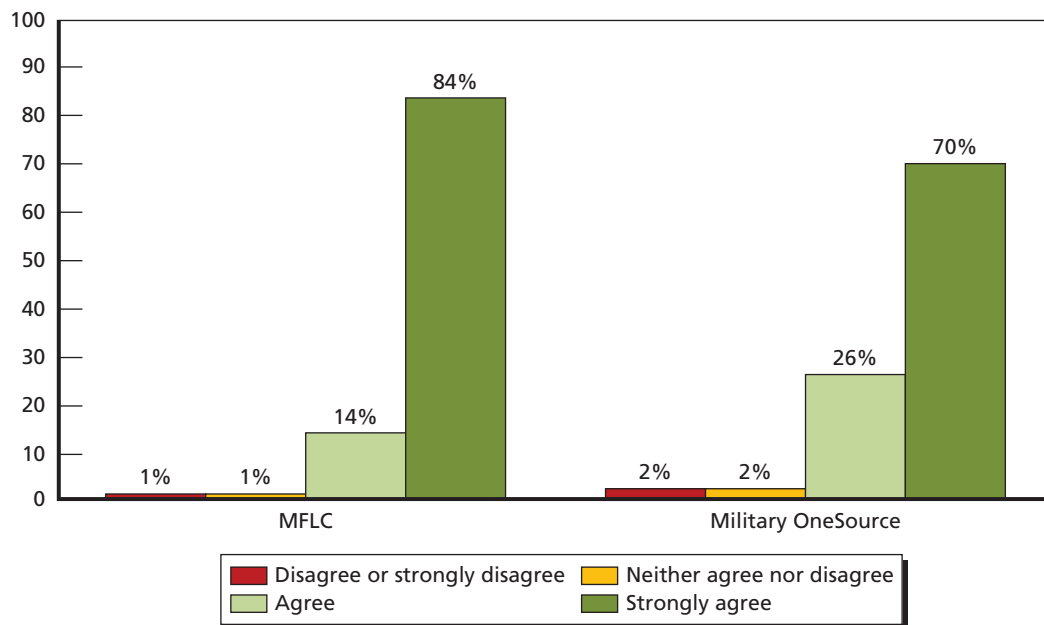
While there is slight variability between the two programs, key findings across both MFLC and Military OneSource include the following:

- Over 90 percent of participants reported being very satisfied with the level of professionalism of the counseling staff.
- Over 95 percent of participants strongly agreed that their counselor listened to them carefully and 90 percent agreed or strongly agreed that their counselor spent enough time with them.
- Over 75 percent of participants agreed or strongly agreed that their counselor addressed their cultural, language, or religious concerns.
- Over 75 percent of participants agreed or strongly agreed that their counselor understood military culture.
- Over 90 percent of participants agreed or strongly agreed that their counselor was knowledgeable about their presenting problem.
- Over 75 percent of participants were satisfied or highly satisfied with the number of materials and resources received, and 80 percent were satisfied or highly satisfied with the types of materials and resources provided.
- About 90 percent of participants agreed or strongly agreed that their counselor provided the services they needed to address their non-medical problems and related concerns.

Professionalism

Professionalism was assessed with two questions, including the extent to which participants felt the counselor showed interest in their questions and concerns, and their satisfaction with the level of professionalism of counseling staff.

Figure 8.1
Estimated Share Agreeing That Counselor Showed Interest in Questions and Concerns,
Wave 1



NOTE: $n_s = 2,379$ for MFLC and 2,540 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

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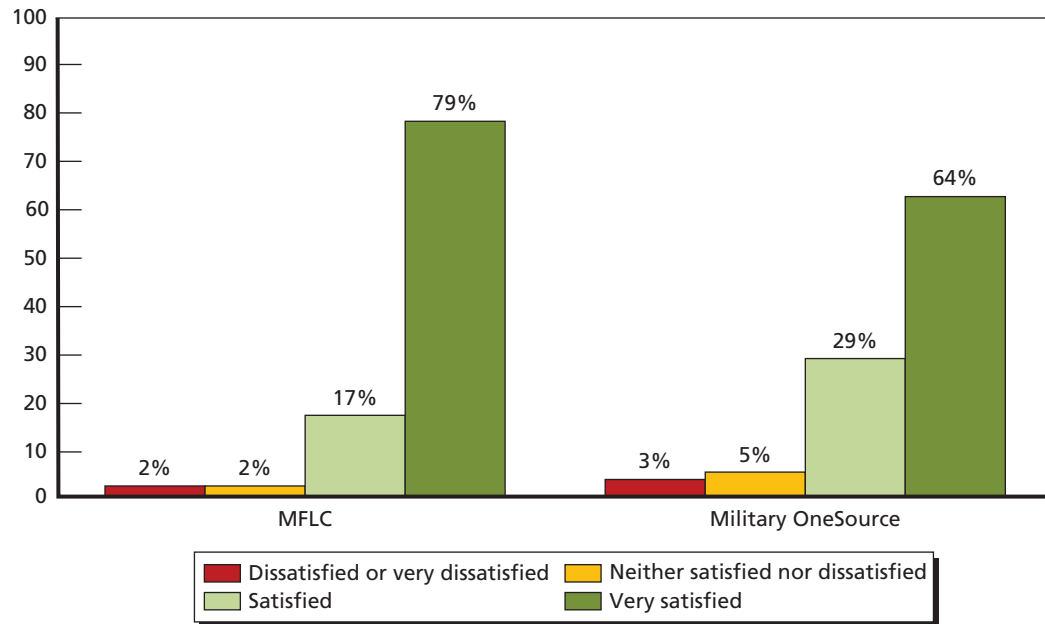
Counselor Showed Interest

About 84 percent of MFLC and 70 percent of Military OneSource participants strongly agreed that their counselor showed interest in their questions and concerns (Figure 8.1). While there were no group differences for MFLC, for Military OneSource there were significant differences by gender and rank (see Table C8.1 in Appendix C). More women than men strongly agreed that their counselor showed interest in their concerns (72 percent compared to 66 percent, respectively). Also, a higher proportion of officers and their families strongly agreed that their counselor showed interest in their questions and concerns compared to enlisted respondents and their families (73 as compared to 68 percent, respectively).

Level of Professionalism

Approximately 80 percent of MFLC participants and 65 percent of Military OneSource participants reported being very satisfied with the level of professionalism of the counseling staff (Figure 8.2). It is important to note, however, that between 4 percent and 8 percent reported either feeling neutral or dissatisfied with the level of professionalism, suggesting that there may be a need for additional training or oversight for some counselors. While there were no significant differences by subgroups for Military OneSource, for MFLC, those working with a MFLC counselor who was embedded in their unit reported significantly higher levels of satisfaction than those working with MFLC counselors who were not embedded (84 percent as compared to 78 percent, respectively; see Table C8.2 in Appendix C).

Figure 8.2
Estimated Share with Satisfaction with Level of Professionalism, Wave 1



NOTE: *ns* = 2,202 for MFLC and 2,300 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

RAND RR1861-8.2

Open-ended responses frequently included the value of having access to a professional resource through Military OneSource and MFLC, and participants mentioned the professionalism of the counselors they met with as strengths of the MFLC and Military OneSource programs.

I really like using MFLC because of the assistance they give and how professional and knowledgeable they are. They assess situations in a calm manner that helps deal with stressful situations and give valuable information to take with me as I leave. I find their guidance extremely helpful due to the stressful life of being in the military. I wish more military members would seek out their help. (MFLC participant)

This is the best benefit of my 24 years of service. I am very thankful for the professionalism and promptness of both Military OneSource and our counselor. (Military OneSource participant)

However, responses to open-ended questions also revealed that some participants experienced inconsistency in the professionalism of the counselors they saw, including some extreme cases of unprofessional behavior on the part of counselors. A subset of responses, predominantly from Military OneSource participants but including MFLC participants as well, included recommendations that counselor performance reviews emphasize the importance of professionalism.

This particular counselor was a joke. She was unprofessional she would discuss other clients in front of you. Give negative attitude about people who are wanting and needing helping. Made an appointment and she never showed up nor did she call. (MFLC participant)

There were some definite positives with the first counselor I saw, but I needed to find a new one due to unprofessional behaviors. (Military OneSource participant)

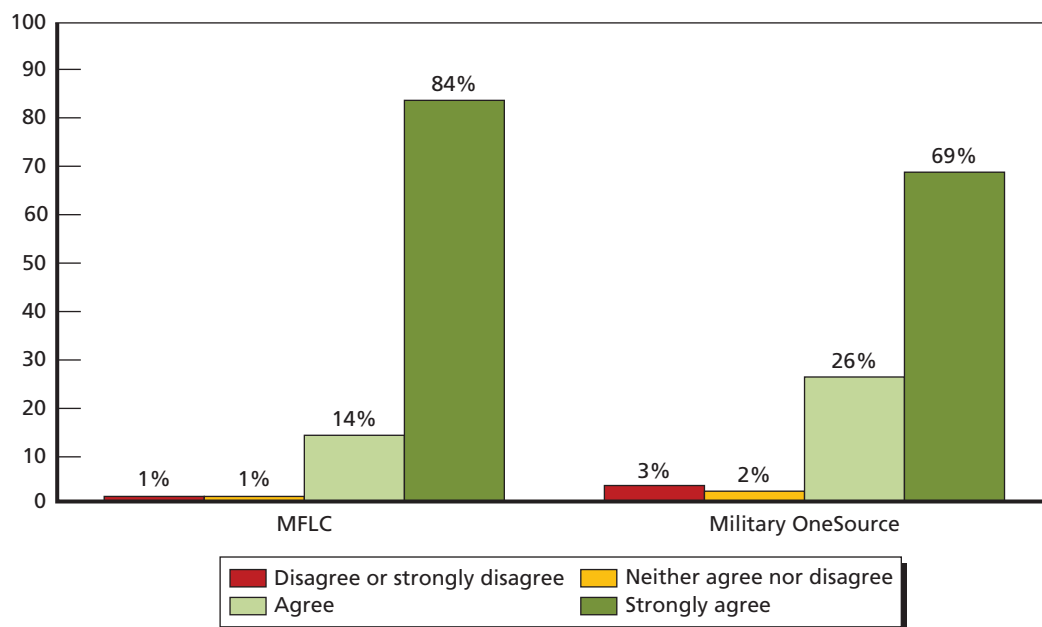
Communication

We asked participants several questions about the communication skills of their counselor. Participants were asked the extent to which they agreed that their counselor listened carefully, spent enough time with them, and explained things in a way that was easy to understand. Participants were also asked whether they left their counselor's office with all of their questions answered.

Counselor Listened Carefully

Approximately 95 percent of MFLC and Military OneSource participants agreed or strongly agreed that their counselor listened to them carefully, but about 1–3 percent disagreed with this statement (Figure 8.3). While there were no subgroup differences among MFLC participants, among Military OneSource participants, service members and women were more likely

Figure 8.3
Estimated Share Agreeing That Counselor Listened to Them Carefully, Wave 1



NOTE: $ns = 2,380$ for MFLC and $2,538$ for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

RAND RR1861-8.3

to strongly agree that their counselor listened to them carefully (72 percent of service members as compared to 65 percent of family members; 72 percent of women compared to 66 percent of men; see Table C8.3 in Appendix C).

Through their open-ended responses, participants mentioned the listening skills of counselors as one of the most notable strengths of non-medical counseling programs.

It offers an opportunity to identify my personal and work-related grievances with a patient and tactful human being with actual listening and communication skills. (MFLC participant)

She listened and identified the real need. Because of my personality, she was truthful and got to the need so more time could be spent. She didn't give homework, but things to think about until the next session that were on point. (Military OneSource participant)

However, a small subset of survey respondents indicated that they did not agree that their counselors listened carefully to them during their sessions. Open-ended responses related to weaknesses of MFLC and Military OneSource provide insight into the issues that some participants had with counselors' listening skills.

I felt she wasn't qualified because in the same session she would ask the same question several times, which made me feel like she wasn't listening. This was a huge concern for me because as a counselor, I feel like active listening is the main skill one needs to succeed. (MFLC participant)

I was not happy with the provider of my non-medical counseling. I felt she did not listen to me at all and I will not be returning to her. (Military OneSource participant)

Counselor Spent Enough Time with Participant

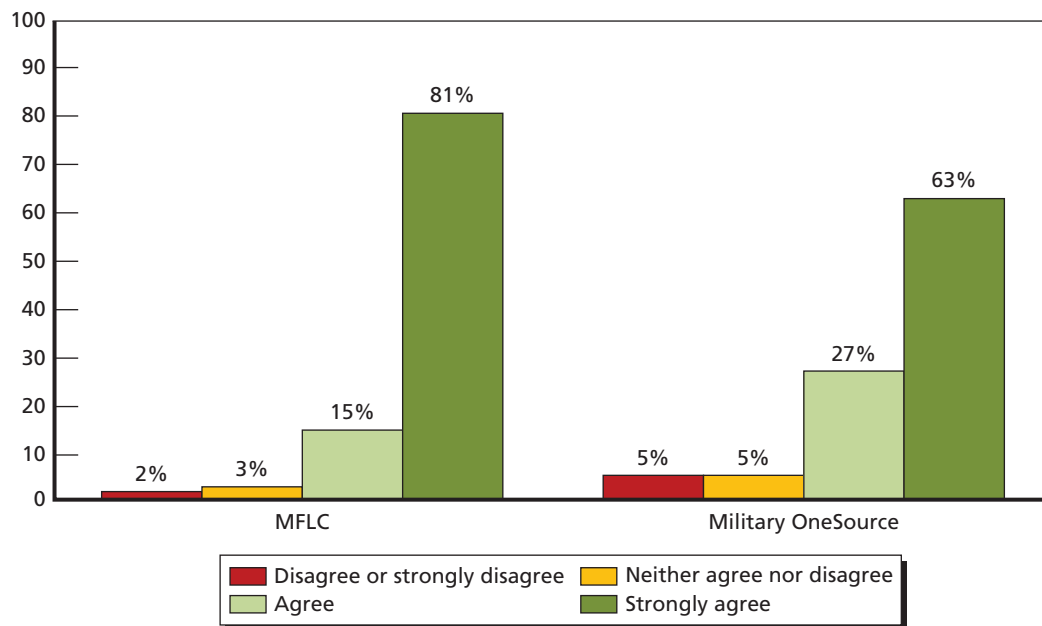
In relation to how much time the counselor spent with the participant, about 81 percent of MFLC and 63 percent of Military OneSource participants strongly agreed that their counselor spent enough time with them to address their concern (Figure 8.4). For MFLC, participants were more likely to strongly agree if their counselor was embedded in their unit (86 percent) compared to those where their counselor was not embedded in their unit (80 percent). For Military OneSource, service members (66 percent as compared to 58 percent of family members) and women (67 percent as opposed to 59 percent of men) were more likely to strongly agree that their counselor spent enough time with them.

Respondents described the amount of time that counselors spent with them as one of the program's strengths through their open-ended responses.

The counselor spent hours at a time with me, didn't take sides or push me to do things I didn't want to do, and showed that he actually cared. (MFLC participant)

When I saw a provider at mental health I felt that they were eager to diagnose and prescribe, but going to a non-medical provider through Military OneSource for the exact same issues, I felt that the Military OneSource was more open to talking through some of the problems I was facing and really took the time to understand what I was struggling with, without pathologizing everything. (Military OneSource participant)

Figure 8.4
Estimated Share Agreeing That Counselor Spent Enough Time with Them, Wave 1



NOTE: $ns = 2,375$ for MFLC and $2,531$ for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

RAND RR1861-8.4

Between 5 percent and 10 percent of respondents, however, did not agree that their counselors spent enough time with them. Responses detailing weaknesses of MFLC and Military OneSource provided some insight into the situations in which respondents were concerned about the amount of time they spent with particular counselors.

My counselor doesn't seem inviting to talk to. . . . I feel that a counselor should be inviting because many people would like to talk, but may not have the courage to take that first step like myself. She did not seem to dig when asking about personal information. . . . This seems to be a waste of time and money for what turned into a 10–15 minute visit to each Marine. . . . I also feel that the next counselor should spend more time talking with the individual asking more questions and building good rapport. (MFLC participant)

Our sessions with our counselor were absolutely too short. . . . When you've been in the military for 10 years with a half dozen deployments, it takes awhile to give our complete history and background and touch on the issues AND have time for the counselor to give us tools. We had so much 'material' to communicate, our counselor wouldn't have time to actually help us sort things out before the end of our appointment . . . causing us, many times, to leave even more disgruntled with each other than when we entered. (Military OneSource participant)

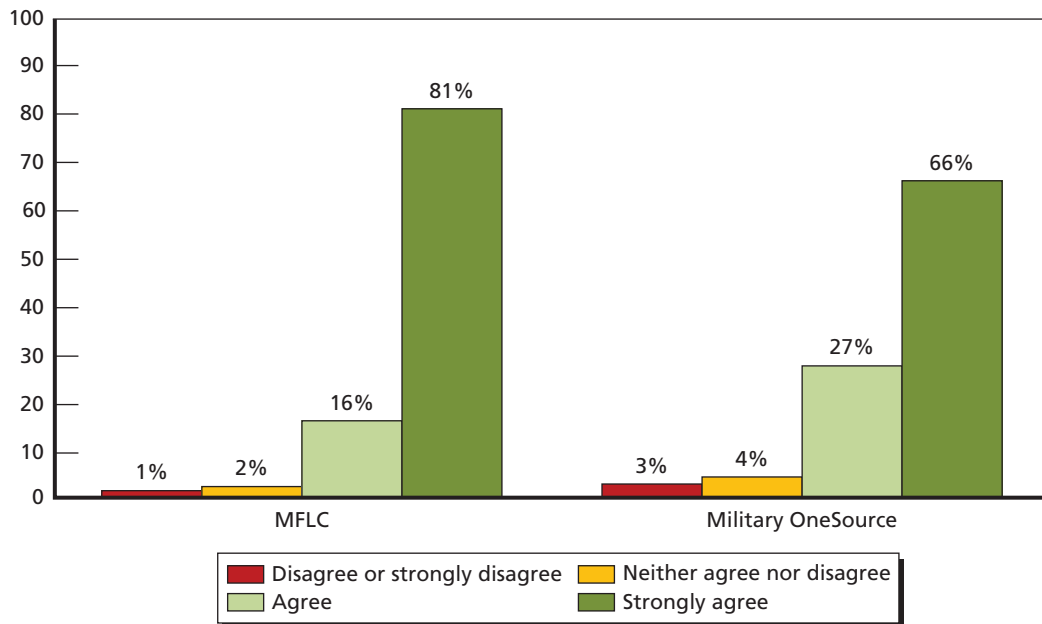
Information Was Explained in a Way That Was Easy to Understand

When participants were asked about whether information was explained to them in a way that made it easy for them to understand, just over 80 percent of MFLC and about two-thirds of Military OneSource participants strongly agreed (Figure 8.5). About 3 percent of MFLC and 7 percent of Military OneSource participants either felt neutral or did not agree that they received information in a way that was easy to understand. One participant shared her positive experiences:

The counselor that I am seeing has an open mind and the ability to listen and understand how I am feeling and why. There have been several occasions that I was guided through the mix of thoughts and emotions and was able to better understand them and why I was having them. My counselor is very approachable, friendly and kind. I feel very comfortable with her and that I can talk about anything. She also does not sugar coat things but she is still kind in the words that she uses. (MFLC participant)

Subgroup differences for this item were similar to other communication items (see Tables C8.4 and C8.5 in Appendix C). Participants working with an embedded MFLC counselor were more likely to strongly agree that their counselor explained things in a way that made it easy to understand (85 percent relative to 80 percent for non-embedded MFLC counselors). For Military OneSource, service members and women were also more likely to strongly agree that the counselor explained things in a way that made it easy to understand (69 percent of

Figure 8.5
Estimated Share Agreeing That Counselor Explained Things in a Way That Was Easy to Understand, Wave 1



NOTE: $n_s = 2,367$ for MFLC and 2,524 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

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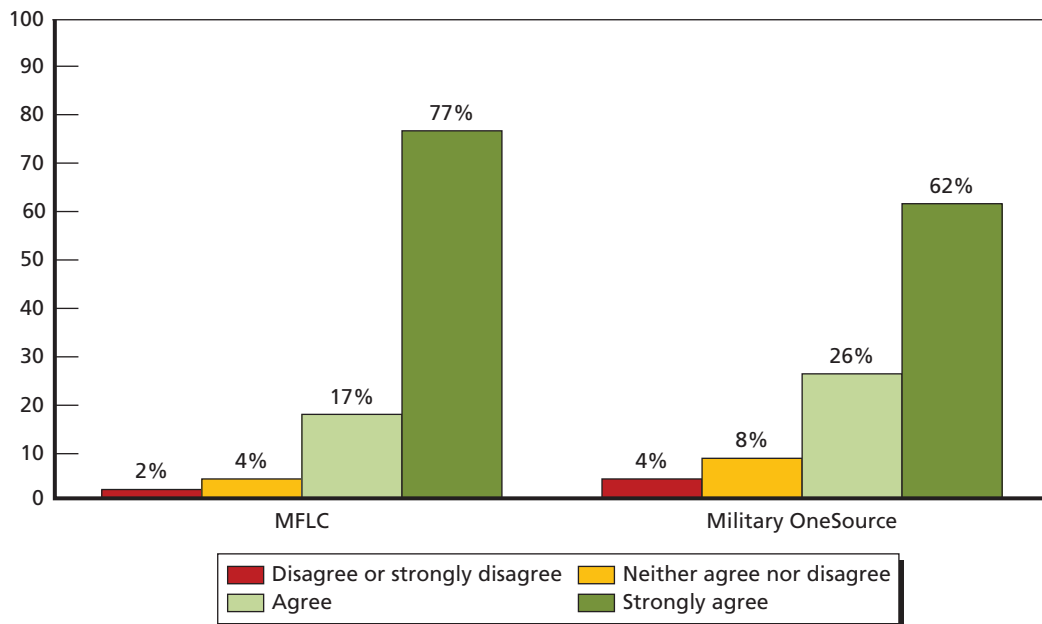
service members compared to 62 percent of family members, and 69 percent of women compared to 63 percent of men).

Left Counselor's Office with Questions Answered

We asked individuals to report on the extent to which they felt their questions had been answered when they left their counselor's office. Consistent with other measures of communication presented in this section, a strong majority agreed or strongly agreed that they left their counselor's office with all of their questions answered. Of MFLC participants, 77 percent strongly agreed that their questions had been adequately answered and 62 percent of Military OneSource strongly agreed with this statement (Figure 8.6). Again, there was a small minority (2 percent of MFLC and 4 percent of Military OneSource) who disagreed or strongly disagreed with this statement, indicating that they did not feel their questions were answered.

There were no subgroup differences for MFLC participants in the level of agreement with this statement, but Military OneSource participants differed by gender and service member status (see Table C8.6 in Appendix C). For Military OneSource, service members and women were more likely to strongly agree that their questions had been adequately answered (64 percent of service members compared to 57 percent of family members, and 65 percent of women compared to 58 percent of men).

Figure 8.6
Estimated Share Who Left Counselor's Office with All of Their Questions Answered, Wave 1



NOTE: $n_s = 2,354$ for MFLC and 2,497 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

RAND RR1861-8.6

Open-ended responses confirmed that participants were generally satisfied with the ability of their counselors to answer the questions they brought to the appointment.

I felt that the areas I had (albeit minor) concern were addressed, my questions answered, and my quality of life (which was already good) was improved further. (MFLC participant)

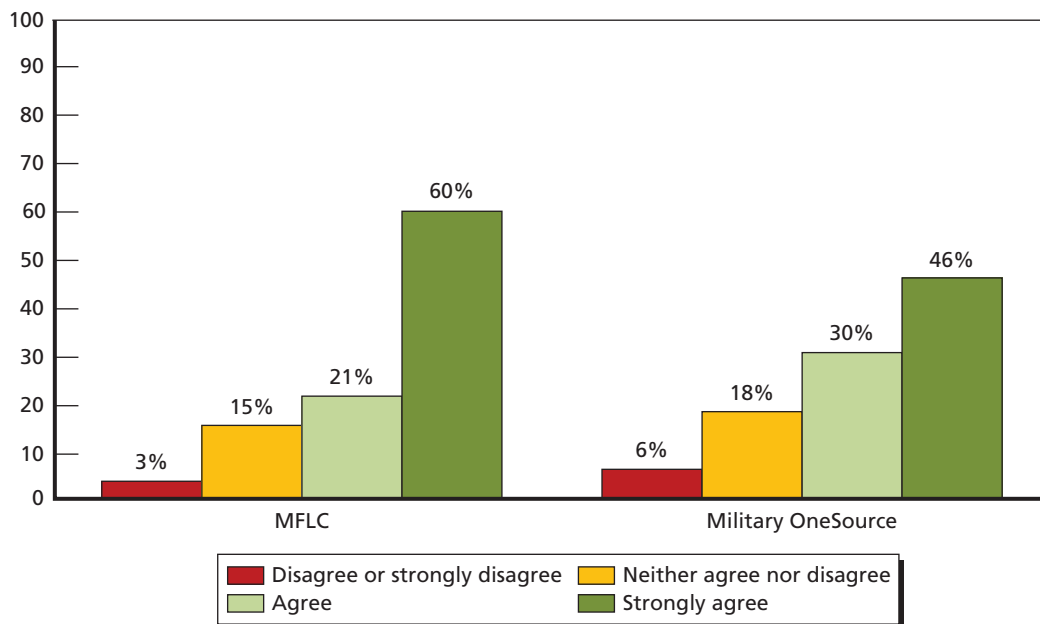
Cultural Competency

For non-medical counseling to be effective, it must provide services in a way that aligns with and is respectful of the culture, background, language, or religion of the individual seeking the services. Cultural competency also includes a strong understanding of military culture, and the unique experiences and stressors facing service members and their families. To assess the cultural competency of counselors within MFLC and Military OneSource, we asked individuals to report on two aspects: the extent to which the participant felt their counselor addressed their cultural, language, or religious concerns, and whether the counselor understood military culture.

Cultural, Language, or Religious Concerns

About 81 percent of MFLC and 76 percent of Military OneSource participants agreed or strongly agreed with the statement “My counselor addressed my cultural, language or religious concerns” (Figure 8.7). While about 15 percent felt neutral about the statement, 3 percent of

Figure 8.7
Estimated Share Agreeing That Counselor Addressed Cultural, Language, or Religious Concerns, Wave 1



NOTE: $n_s = 1,383$ for MFLC and 1,450 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

RAND RR1861-8.7

MFLC and 6 percent of Military OneSource participants disagreed or strongly disagreed with this statement. While there were no subgroup differences for MFLC, among Military OneSource participants, officers and their families were more likely than enlisted service members and their families to strongly agree that their counselor addressed their cultural, language, or religious concerns (51 percent compared to 44 percent, respectively; see Table C8.7 in Appendix C).

Respondents were somewhat divided about whether or not counselors addressed their cultural, religious, or language concerns. Some participants felt as though counselors were well trained and sensitive to cultural competency issues, while others had concerns about their counselor's level of sensitivity.

I also appreciate . . . the separation of religion and counseling, as my husband and I subscribe to a different set of beliefs than the prominent set in this area, and (in religious counseling settings) do not appreciate the disrespect of being evangelized while sorting through our differences. It has been very freeing to speak to a counselor who prioritizes our personal needs over any religious motivation. (MFLC participant)

Counselor understands my issue and is helping me to walk through it. She understands my cultural and moral background and keeps on guiding me to success despite my challenges. I feel very comfortable. (Military OneSource participant)

[Counseling] seemed to be more 'Christian' than I wanted. I was able to pull out things that could help me in the examples he gave me. I feel like general religious references would be fine, but hinting at organized religion as a solution was a bit much for me. (MFLC participant)

In the military, there are a lot of international couples so counselors need to understand about the culture differences and language barriers and have knowledge about them. (MFLC participant)

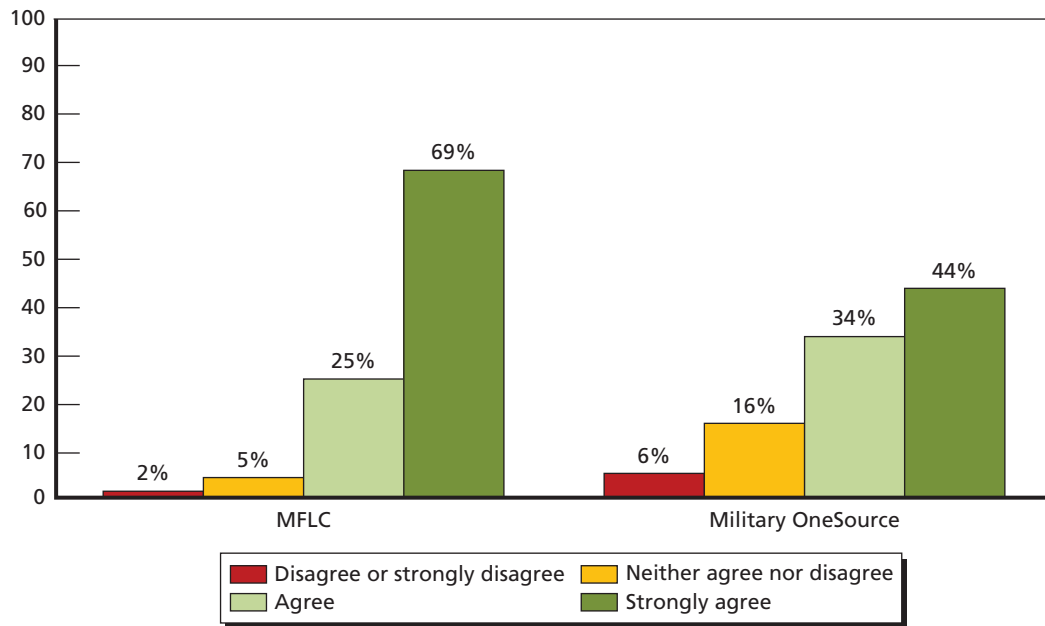
Understood Military Culture

One of the concerns often expressed by service members seeking services is that providers, particularly in the civilian population, often don't understand military culture. Given the wide variation in type and location of providers, we asked MFLC and Military OneSource participants to rate the extent to which their counselor understood military culture. Among MFLC participants, 25 percent agreed and 69 percent strongly agreed that their counselor understood military culture (Figure 8.8). Among Military OneSource participants, 34 percent agreed and 44 percent strongly agreed that their counselor understood military culture. However, 2 percent of MFLC and 6 percent of Military OneSource participants disagreed or strongly disagreed that their counselor understood military culture. There were no subgroup differences for either MFLC or Military OneSource in the assessment of their counselor's understanding of military culture.

Open-ended responses on the strengths and weaknesses of the program support these data. While having an understanding of military culture was noted as a strength of non-medical counseling programs for some, others felt this was an area that could be improved upon.

The MFLC offers an out that a Marine normally does not have. Someone that (needs to/ does) understand the lingo, gets the Jarhead things we go through and understands the chaotic but structured way we do things. If you need someone to listen or to talk to, or to seek help with something, the last person you want to say it to is one of your seniors or

Figure 8.8
Estimated Share Agreeing That Counselor Understood Military Culture, Wave 1



NOTE: $ns = 2,311$ for MFLC and 2,526 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

RAND RR1861-8.8

one of your subordinates and depending on the work environment your peers may not be suitable either. That is where the MFLC pays off. They are a trusted, certified, command endorsed, reputable source for young and old Jarheads. (MFLC participant)

The situation my husband and I are in with the Navy is very unique and has caused a lot of stress for over a year in both our professional and personal life. Having a Military OneSource counselor and the third party resource to talk to who has knowledge of military life and culture has been so helpful to my emotional well-being. (Military OneSource participant)

The only challenge I ran into was the knowledge of the military and my job in particular. That is not something I would expect them to know but have to explain the situation and how the chain of command was not helping and the difference between a crew boss and a supervisor along with other tedious things like records and the weekly evals [evaluations] that we receive was the only thing that I felt held me back a bit. (MFLC participant)

Not too significant, but [one weakness is] the lack of understanding of military culture. . . . Civilian counselors would benefit from some education. (Military OneSource participant)

Knowledge of the Presenting Problem and Adequacy of Resources

In addition to assessing the level of professionalism, clear communication, and cultural competency of the counselor, we assessed participant perceptions of their counselor's knowledge of

their presenting problem and the adequacy of the resources provided to address the participants' concerns.

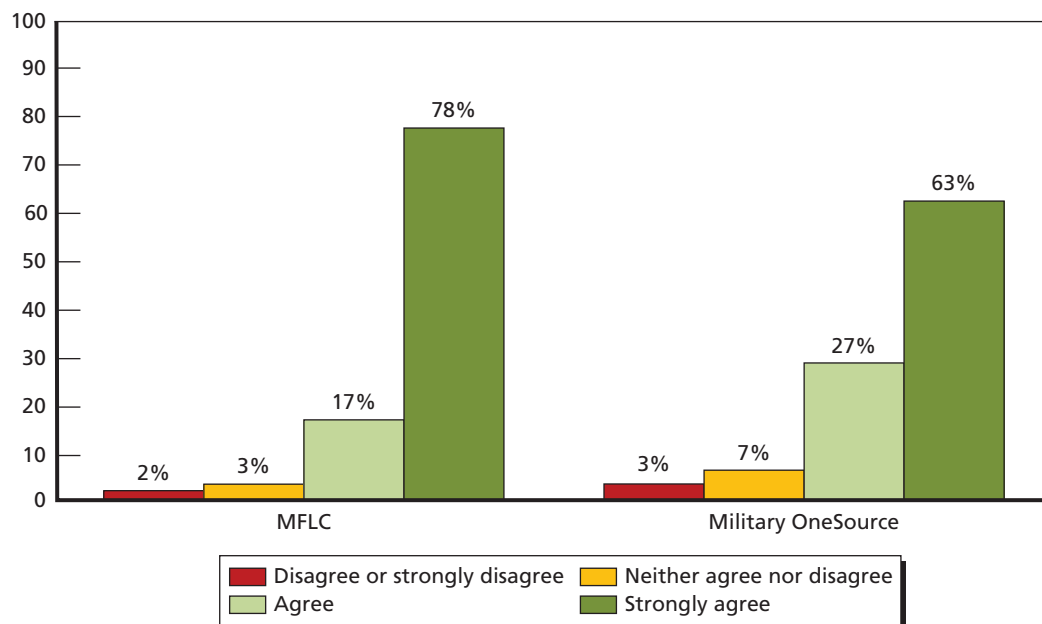
Counselor Knowledge of Presenting Problem

Individuals were asked two separate but related questions about counselor knowledge. The first asked participants to rate the extent to which they agreed with the following statement, “My counselor was knowledgeable in the area of my specific concern.” About 95 percent of MFLC participants agreed (17 percent) or strongly agreed (78 percent) that their counselor was knowledgeable (Figure 8.9). Similarly, about 90 percent of Military OneSource participants agreed (27 percent) or strongly agreed (63 percent) that their counselor was knowledgeable about their presenting problem. There were no subgroup differences in the perception of counselor knowledge.

The second question asked participants to report their level of satisfaction with their counselor's knowledge about their non-medical concerns. Over 90 percent of MFLC participants were satisfied (21 percent) or very satisfied (71 percent) with the level of their counselor's knowledge (Figure 8.10). Similarly, about 89 percent of Military OneSource participants were satisfied (33 percent) or very satisfied (56 percent) with the level of their counselor's knowledge. There were no subgroup differences for MFLC or Military OneSource in level of satisfaction related to their counselor's knowledge about their non-medical concern.

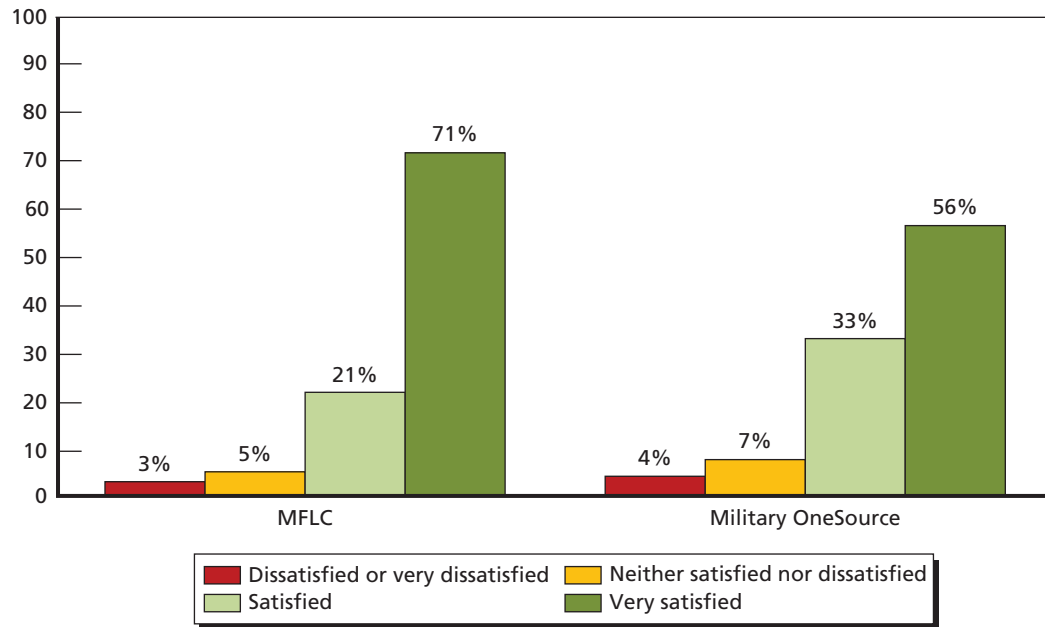
Open-ended responses reiterate the patterns observed in the survey data showing that participants generally agree that non-medical counselors have sufficient knowledge to help

Figure 8.9
Estimated Share Agreeing That Counselor Was Knowledgeable in the Area of Their Concern, Wave 1



NOTE: $n_s = 2,369$ for MFLC and 1,587 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Figure 8.10
Estimated Share with Satisfaction with Level of Counselor Knowledge, Wave 1



NOTE: $n_s = 2,164$ for MFLC and 2,274 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

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with their problems. However, some participants described a lack of counselor knowledge as one of the main weaknesses of the program.

He had great knowledge on everything I spoke about. He provided me with tools to lower stress levels and build better communication with family. (MFLC participant)

When my family situation became acute Military OneSource was there immediately and stayed connected until they connected me with assistance. It was the care and lifeline that I needed and am very thankful as is my family because the tools and resources I learned also benefit them. (Military OneSource participant)

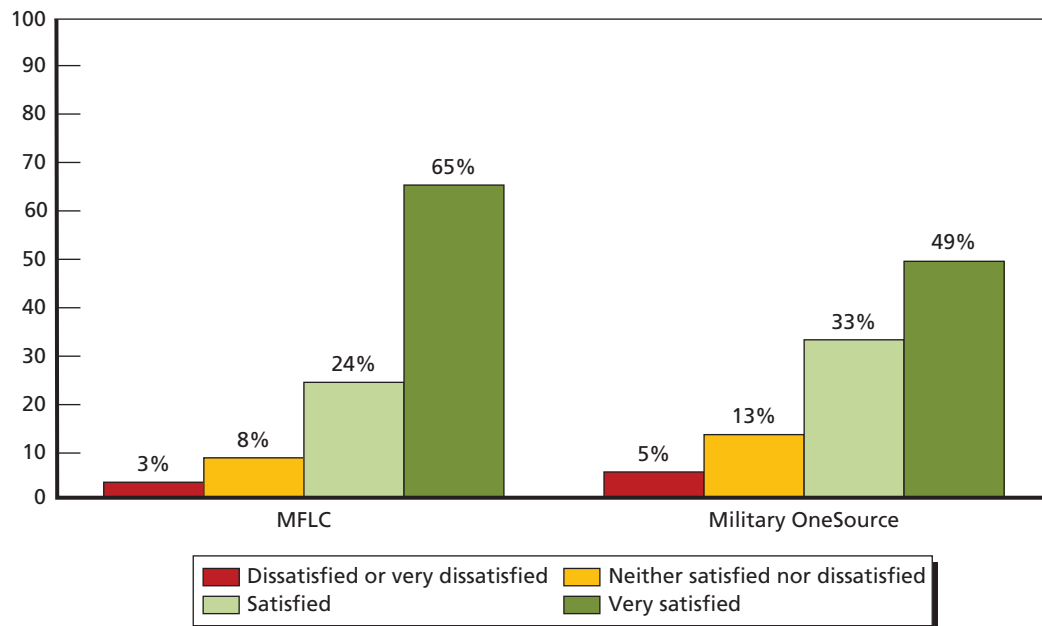
Difficult issues . . . didn't seem to be rectified with counselor due to either lack of knowledge or different perspective/way of dealing with things. Aspects [were] helpful but not very much. (MFLC participant)

It seemed that our counselor did not receive specialized training in our specific situation and was not as helpful as I had expected. (Military OneSource participant)

Number and Types of Resources Provided

Individuals were asked to report on their level of satisfaction related to the types of resources and materials received by the counselor, whether materials were relevant to the participant's concern, and the number of resources provided. Overall, participants were satisfied with the types of materials provided and felt that they were relevant to their needs (Figure 8.11). About

Figure 8.11
Estimated Share with Satisfaction with the Types of Materials Provided, Wave 1



NOTE: $n_s = 1,812$ for MFLC and 1,732 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

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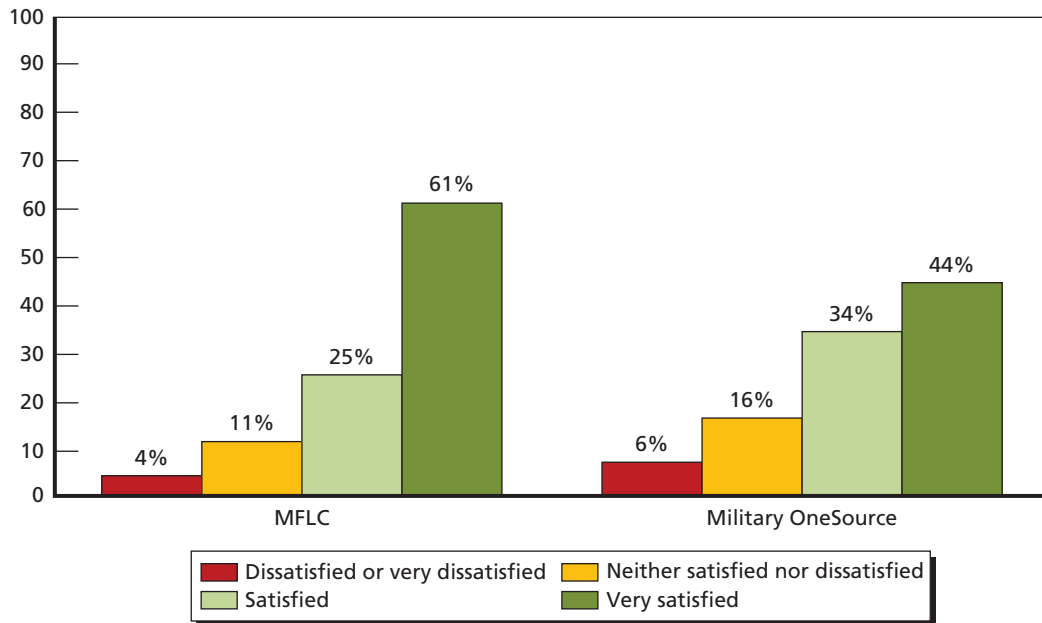
89 percent of MFLC participants reported being satisfied (24 percent) or very satisfied (65 percent) with the types of materials and 82 percent of Military OneSource participants reported being satisfied (33 percent) or very satisfied (49 percent). About 3 percent of MFLC and 5 percent of Military OneSource participants, however, reported being dissatisfied or very dissatisfied with the types of resources and materials provided. There were no subgroup differences in the level of satisfaction with the types of resources provided for either MFLC or Military OneSource participants.

In addition to reporting on their level of satisfaction related to the types of resources and materials provided, and whether those aligned with their current needs and presenting problem, participants reported on their level of satisfaction related to the number, or amount, of resources and materials provided by their counselor. About 86 percent of MFLC and 78 percent of Military OneSource participants were satisfied or highly satisfied with the number of resources and materials (Figure 8.12). However, about 4 percent of MFLC and 6 percent of Military OneSource participants reported not being satisfied. Due to how the question was worded, however, it is not clear whether individuals who were dissatisfied would have preferred more or fewer resources or materials. There were no subgroup differences in the level of satisfaction related to the number of resources provided by non-medical counselors.

Open-ended responses provide more insight into the types of resources counselors provided and how well they worked for participants.

[We] thought our marriage was over and the MFLC helped us recover and grow stronger, and recommended relationship materials. . . . Overall we regained our marriage and got

Figure 8.12
Estimated Share with Satisfaction with the Number of Resources Provided, Wave 1



NOTE: $n_s = 1,781$ for MFLC and 1,697 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

RAND RR1861-8.12

better as individuals and improved our communication and relationship skills. (MFLC participant)

My counselor was able to relieve some of the stress I was experiencing by giving me self-care tools and new stress reduction techniques to try out. (Military OneSource participant)

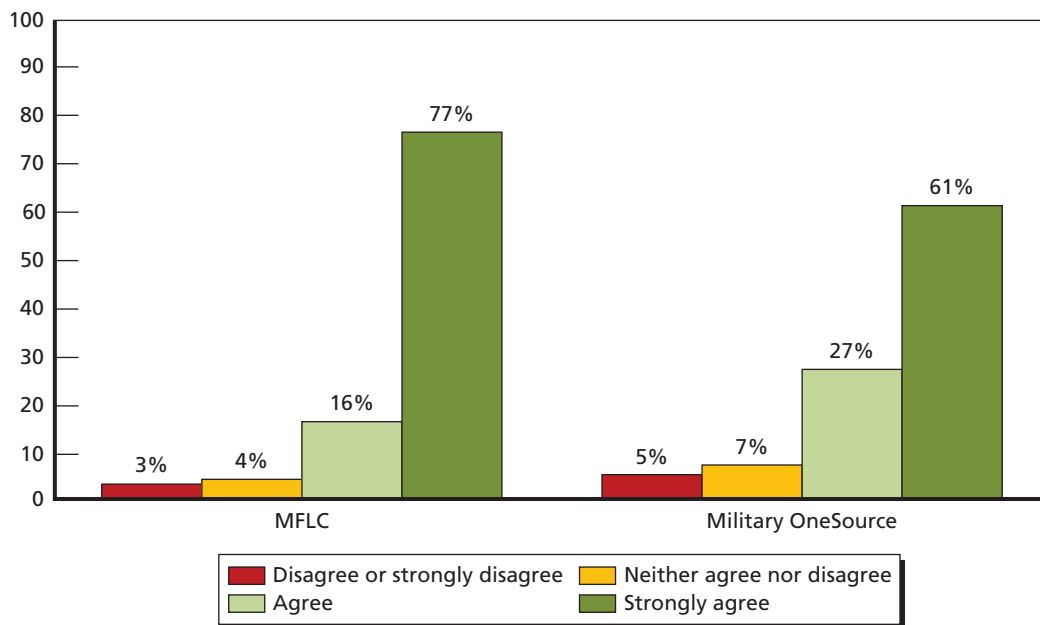
She gave us no materials to help us and only a vague referral as to where a certain building on post was that could help us. (MFLC participant)

Our counselor did not provide us with any materials or exercises that we could have used as a couple. (Military OneSource participant)

Met Client Needs Overall

A final question related to counselor quality asked participants to rate the extent to which they agreed with the statement “My counselor provided the services I needed.” About 93 percent of MFLC participants agreed (16 percent) or strongly agreed (77 percent) with this statement (Figure 8.13). Among Military OneSource participants, 88 percent agreed (27 percent) or strongly agreed (61 percent) that their counselor provided the services they needed to address their non-medical problems and related concerns. A small minority, however, disagreed or strongly disagreed with this statement (3 percent of MFLC participants and 5 percent of Military OneSource

Figure 8.13
Estimated Share Agreeing Counselor Provided the Services They Needed, Wave 1



NOTE: $ns = 2,331$ for MFLC and 2,500 for Military OneSource. MFLC and Military OneSource estimates were generated in separate regression models. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

RAND RR1861-8.13

participants) and about 4 percent and 7 percent of MFLC and Military OneSource participants, respectively, neither agreed nor disagreed with this statement, suggesting that non-medical counselors did not meet the needs of about 10 percent of individuals who sought services. There were no significant subgroup differences for either MFLC or Military OneSource.

Chapter Summary

This chapter provides important insights into the experiences participants had while interacting with non-medical counselors. Counselor professionalism, clear communication, cultural competency, and knowledge and handling of presenting problems can have a significant impact on both the efficacy of the program to address problems and the perception of MFLC and Military OneSource more broadly. While the majority did have a positive experience with their counselor, approximately 10 percent had concerns, and in some cases they were serious concerns. Across the dimensions assessed, there were a number of significant subgroup differences. Among MFLC participants, counselors embedded within the participant's unit generally received higher ratings than counselors who were not embedded. Among Military OneSource participants, women and service members were more likely to report higher satisfaction with their counselor than men or family members, respectively. Determining which counselors are performing well and which may be in need of additional training and oversight was outside of the scope of this project. However, these findings point to the need for more regular feedback on counselor performance so that concerns that do arise can be quickly addressed.

Summary and Conclusions

This report detailed research evaluating non-medical counseling provided through two large programs under the DoD—MFLC and Military OneSource—with the purpose of better understanding the impact of non-medical counseling on military service members and their families. The study focused on the extent to which participants report that their problems were resolved following non-medical counseling, the degree to which program participants were able to connect with other services, and participants’ experiences with counseling. For each research question, we examined whether there were notable differences by provider or client characteristics (e.g., problem type, service, gender). Although the MFLC and Military OneSource studies were conducted as separate evaluations, high-level findings about the potential impact of and experiences with non-medical counseling can be drawn by examining results across both studies; these findings may help to inform policy decisions. The previous chapters contain additional details about the potential impact of each program, which may help to inform programmatic changes. Key high-level findings from the study include the following:

- In general, most people who used non-medical counseling experienced a reduction in problem severity and its impact on their lives over the short and long term.
- There was a statistically significant decrease in the frequency with which a participant’s problem interfered with work or daily routines following non-medical counseling, and a decrease in stated difficulty coping with day-to-day demands.
- Most non-medical counseling participants were connected with support and services outside of the program—although not necessarily to support they would not have found on their own.
- Across most measures, over 90 percent of participants expressed favorable perceptions of non-medical counseling programs.
- Over 90 percent of participants expressed favorable perceptions of the professionalism and knowledge of non-medical counselors, thought that their counselor listened to them and spent enough time with them, and agreed that their counselor provided the services they needed to address their problem.
- Despite positive perceptions from the majority of participants, between 1 percent and 7 percent of participants reported being dissatisfied or very dissatisfied with non-medical counseling, and about 15 percent continued to rate their problem as severe or very severe, suggesting that there is room for improvement.

In addition to the survey questions, participants were also given the opportunity to complete open-ended questions related to the strengths or weaknesses of non-medical counseling. Two of the most commonly mentioned strengths related to the non-military counseling

environment were appreciation of confidentiality and ability to seek services without engaging the chain of command. Participants also reported that they appreciated non-medical counseling as a “forum to discuss issues” and noted that it was particularly helpful to have a neutral party from whom to seek advice and guidance.

Some individuals, however, noted a preference for more sessions or more continuity in non-medical counselors over time, so that they could continue to work together as opposed to “starting over” with a new counselor. Another common weakness noted by participants was a broader lack of awareness about non-medical counseling within military-connected individuals, suggesting that additional work could be done to disseminate information about the availability of non-medical counseling through these programs for service members and their families. Lack of awareness was a particular theme for comments about the MFLC program.

Given the limited literature on non-medical counseling programs, this is one of the first studies of the effectiveness of non-medical counseling for addressing participants’ problems. Other research has found that specific treatments were effective in improving mental health symptoms such as distress, anxiety, and depression (e.g., Army Center for Enhanced Performance, Battlemind), and a few studies have found that military support programs for families are effective for improving parenting (Meadows, Tanielan, and Karney, 2016) and child (Chandra et al., 2011) outcomes. But the current study is one of the first to examine the short- and long-term outcomes and experiences of service members and their families seeking non-medical counseling. The findings for this study can therefore serve as a starting point for establishing future benchmarks for judging the success of other non-medical counseling programs.

The overall pattern of results from this study, though not causal, suggests that the programs are largely effective in helping program participants resolve their problems. The majority of participants of these programs reported reductions in problem severity, stress and anxiety, and less problem interference with work and their personal lives after counseling. For most participants, these improvements were sustained or continued to improve in the three months after initiation of counseling services. In addition, most participants were satisfied with the way the program connected them to applicable outside services and resources (including medical or behavioral health services), and had positive perceptions of their experiences with the non-medical counseling programs and with their own counselor. Given the challenges that service members and their families face (e.g., Lara-Cinisomo et al., 2011; Tanielian et al., 2014) and the need in this population for short-term, confidential services for resolving non-clinical problems (Castro, Kintzle, and Hassan, 2015), results from the current study suggest that non-medical counseling provided through the MFLC and Military OneSource programs serve a key role in helping military families cope with the common stresses of military life.

Even though the majority of participants experienced problem resolution and had positive perceptions of the programs and counselors, non-medical counseling was not universally successful. A small but important proportion of participants did not experience a reduction in problem severity, stress and anxiety, and problem interference with work and their personal lives as a result of non-medical counseling. Across several of the outcomes, men were less likely than women to experience problem resolution and had less positive perceptions of their counselors (although these differences were often small in magnitude, they were statistically significant). In addition, participants who sought non-medical counseling for child-related problems reported lower levels of problem resolution and lower satisfaction with the continuity of care than those participants with other types of problems. Additional research is needed to investigate why

these participants reported not being able to resolve their problems through non-medical counseling. Furthermore, a small proportion of participants reported that their counselor did not connect them to support and services outside of non-medical counseling, and a small minority (between 1 percent and 7 percent of participants) expressed dissatisfaction with the program or their counselor. We make specific recommendations below for how program managers can address these issues by improving counseling consistency and quality across counselors and strengthening connections to other services.

Limitations

This study is limited in important ways that constrain the strength of the conclusions that can be drawn from the results. First, the study did not include a control group that received no treatment or a different type of treatment; as a result, we cannot draw *causal* conclusions about the effectiveness of the program. Without a control group to compare against, it is unclear whether participants in the study would have resolved their problems on their own. However, given the diversity of needs and likely approaches offered by non-medical counselors to MFLC and Military OneSource participants, the focus of this study was not to assess the clinical effectiveness of specific interventions or treatments that were offered within the non-medical counseling sessions. Rather, the objective was to assess whether the *availability* of non-medical counseling programs to service members and their families resulted in problem resolution and outcomes particularly relevant for military and family readiness, including reduction in stress and anxiety and reduced interference with work and daily life. While a randomized controlled trial is widely accepted as the gold standard for assessing the clinical effectiveness of a specific treatment, it is most appropriate for assessing causal influences at an individual level in a highly controlled context (World Health Organization, 2004). However, preventive and health promotion programs such as these are designed for diverse groups of individuals in need of a range of services, so time series designs such as this one, where individuals serve as their own control over time, are valuable strategies for developing evidence of program effectiveness (World Health Organization, 2004).

Because this is the first study to assess changes in participant outcomes over time, it is difficult to assess whether the observed changes over time are consistent with, better, or worse than other non-medical counseling programs. However, this study can serve as a useful benchmark for future monitoring and evaluation of these programs over time.

Another limitation of this study is that we were not able to collect a baseline assessment of problem severity or impact (i.e., measured before participants received counseling). Instead, we asked participants at Wave 1 to retrospectively assess precounseling levels of problem severity and impact. It is possible that the retrospective assessments of severity and impact were biased, although it is unclear which direction the bias would have occurred—toward perceiving more severity prior to counseling or less severity. Given that identification of potential study participants was initiated by their first non-medical counseling session, obtaining a true baseline was not possible. While we sought to overcome this limitation and minimize recall bias by inviting participants as soon after their first non-medical session as possible (in most cases within a week), individuals varied in the time between invite and survey completion. Those that waited for the last reminder, for example, took the survey about a month after their initial non-medical counseling session.

It is also important to recognize that the type and intensity of counseling given at each session likely varied between participants and across programs. Furthermore, there was variability in the number of counseling sessions used by participants up to the maximum of 12. Follow-up analysis on the relationship between number of non-medical counseling sessions and problem severity revealed, however, that the observed relationship between non-medical counseling and reduced severity occurred after the first 1–3 sessions and then tended to level off, suggesting that the number of sessions with a counselor may not be a strong explanatory factor for observed patterns.

Response rates for both MFLC and Military OneSource were low, but not atypical for studies of military service members and their families (Miller and Aharoni, 2015). Low response rates can raise concerns about sample bias and representativeness of the study population relative to the broader non-medical counseling population. However, comparisons to population-level characteristics of all program users who met eligibility criteria for the study revealed that study participants were representative of the population on demographic characteristics and problem type. In addition, where there were differences between the sample and population characteristics, we adjusted the data to be representative of the population. Numerous studies have found that sample representativeness, and not the response rate, is the key indicator of a biased sample (see Miller and Aharoni, 2015).

Policy Implications

Non-medical counseling provided through MFLC and Military OneSource was designed and implemented to provide short-term, solution-focused counseling to address general conditions of living and military lifestyle. Despite the face validity of these programs, to date there has been little empirical evidence of their effectiveness or the perception of these services among those who have accessed them. Findings from this study, though not causal, suggest that non-medical counseling is associated with reductions in problem severity, and stress and anxiety both at work and at home, and that these improvements are generally maintained over time. These findings suggest the following implications for OSD policy:

1. **Non-medical counseling should continue to be offered to service members and families through the MFLC and Military OneSource programs.** Non-medical counseling provided through MFLC and Military OneSource is a key component of the suite of services and programs offered by the DoD. As our findings indicate, service members and their families felt they derived considerable benefit from these programs in an environment that is compatible with their military obligations and that they would benefit from the continued availability of these programs. Furthermore, the programmatic changes suggested below would help strengthen the program to benefit those for whom non-medical counseling has been less effective in resolving their problems.
2. **Steps should be taken to increase awareness of the program.** Although we did not formally assess awareness of the program among military families, in the open-ended items participants noted that the awareness of these programs in the broader military community may be limited, suggesting that more work could be done to further disseminate information about the availability of these services. This is especially true of the MFLC program. Such dissemination should go beyond direct awareness campaigns

to service members and families to include efforts to further engage chain of command and installation leadership, particularly for locations where MFLC services are available. Although participants did not note lack of command support as a concern or barrier, there may be more that leadership could be doing to actively support engagement with non-medical counseling programs. This may include periodic reminders of the availability of such support during “off-peak” times, such as two to three months after return from deployment, when non-medical counseling needs may be high but the dissemination of information on resources is low (e.g., after postdeployment briefings have ended).

3. **Expansion of the program should be informed by additional research that was beyond the scope of this project.** For the MFLC program in particular, program and counselor perceptions were consistently higher for individuals working with counselors embedded within units, the number of which may be worth expanding. However, findings suggest that there is a need for more research on how to strengthen service delivery. Data from this report provide less input on opportunities for within-site expansion (e.g., adding non-medical counselors to an existing footprint). By design, we did not collect information on the counselor or location of services and, as such, are unable to identify locations where convenient appointment times were more difficult to obtain, for example. Because this study focused on individual and couples sessions, additional studies may be warranted to similarly examine the effectiveness of other activities or modes of delivery (e.g., groups, services specific for children). Additionally, before expanding the program, it would be important to better understand how well non-medical counseling fits into the larger military health system, and specifically behavioral health. For example, does this type of counseling offset demand for more traditional behavioral health or clinical services, either by preventing psychological problems from escalating in severity or by providing a substitute treatment for less severe psychological problems? Are individuals who seek non-medical counseling those who would have alternatively accessed the military health system more formally, or would they have gone without care? Part of this assessment would involve research demonstrating the cost-effectiveness of non-medical counseling programs relative to other solutions. We strongly recommend that the DoD conduct this kind of cost-effectiveness research before determining the scope of any expansion of these programs.

Programmatic Implications

Findings in Chapter Seven suggest that many individuals were satisfied with the program, their counselor, and the non-medical counseling services they received. However, it was also clear that not everyone had a positive experience. These findings suggest the following implications for programmatic improvement:

4. **Provide opportunities for ongoing support, guidance, and training for counselors.** A small minority of participants reported that they were dissatisfied with a number of counselor characteristics, including professionalism, communication, cultural competency, knowledge, and treatment of the presenting problem. These concerns, expressed through survey responses and open-ended items, along with the number of participants

whose problem severity, stress, or problem interference with their daily lives did not improve with counseling, suggest that counselors might benefit from more opportunities to receive support and guidance from other non-medical counselors or from supervisors with more experience in the military community. This could include regularly scheduled case review sessions where counselors and supervisors provide advice on current participant cases; provision of guidance on how to set up client expectations for brief, solution-focused treatment and make the most efficient use of time; mentoring of new counselors by more experienced counselors; sharing best practice documents or tips; and provision of ongoing training with a toolkit to address problems using multiple counseling techniques. These activities could be done telephonically, virtually via web-based platform, or in person. Continuity in training may be particularly important for counselors who are isolated from other military counselors (e.g., the only MFLC counselor assigned to a base; Military OneSource counselors with solo practices). These activities may also help to provide consistent counselor support and supervision and standardize high-quality non-medical counseling approaches and experiences across counselors.

Findings also suggest the need for additional training on how to handle child-related concerns (implication 5), and how to strengthen referrals and connections to other services (implication 8).

5. **Strengthen non-medical counseling for child-related concerns.** For this study, we did not include children or counselors that provided services to children and youth. However, many participants sought non-medical counseling through MFLC and Military OneSource for child-related problems. These participants, on average, reported lower levels of problem resolution and lower satisfaction with the continuity of care. This suggests a need to focus on how child-related issues are handled in non-medical counseling for adults. By nature, these problems may be more complex and require additional providers (e.g., education professionals, Child and Youth Services counselors), as well as a specialized understanding of child and youth development that many adult counselors may not have. Programs may benefit from working to strengthen delivery of services for individuals presenting with child-related concerns, potentially through warm handoffs to counselors who hold this more specialized level of training.
6. **Identify ways to systematically collect counselor-level feedback and incorporate findings into performance review.** While we did not collect information on individual counselors for the purposes of this study, both the MFLC and Military OneSource programs may benefit from systematically collecting counselor-level feedback to establish whether identified concerns are more prevalent for a given counselor or location. For example, some participants expressed concerns about confidentiality and the appearance of confidentiality by their counselor, and participant feedback would help identify counselors who need additional instruction or reminders about maintaining confidentiality. While Military OneSource does currently conduct quality improvement surveys and encourages feedback, MFLC does not, due to the confidential nature of the program. While this does pose a barrier, feedback on the counselor and program overall is critical for continued program improvement. Programs should develop a confidential procedure for participants to provide feedback.
7. **Strengthen continuity of care.** Satisfaction with continuity of care varied significantly across respondents. While most participants were satisfied, others noted a preference for

greater continuity of care. This was particularly true for the MFLC program, where counselors were more likely to rotate prior to the full resolution of an individual's problem. This rotation often resulted in a need to start over with a new counselor, which was viewed as inefficient and disrupting of progress. Program officials should consider extending MFLC assignment periods to provide less frequent rotations, and arrange for warm handoffs of cases from current counselors to incoming counselors. Frequent MFLC rotations were originally implemented to allow additional confidentiality for MFLC users, but it is unclear whether rotations actually help preserve confidentiality. Program officials should weigh whether the trade-off of possibly compromised confidentiality for less continuity of care is worthwhile. Even if current MFLC rotation schedules are maintained, additional accommodation should be provided for outgoing counselors to brief incoming counselors about their current caseload. In doing so, current counseling participants would be able to continue their trajectory of care without having to reinform the incoming counselor of their problem and progress to date.

8. **Strengthen screening and connections to other services.** Survey results and open-ended comments from participants suggest that non-medical counseling could benefit from strengthening connections to other services. In some cases, the line between problems that can be treated effectively through non-medical counseling and those that may require more specialized mental or behavioral health services may be difficult to discern. For example, about a quarter of participants who sought additional help for their problem reported seeing a private counselor or specialist, raising questions about the severity and nature of their problem. Future research and counselor training should focus on the process by which those with diagnosable mental health conditions are screened and referred to ensure timely access to the most appropriate treatment for their concerns (e.g., through the military medical mental health care system, TRICARE, or other providers of professional mental health care). Connection to other services could benefit those participants who do not have a clinical need, but whose problem severity, stress, or problem interference with their daily lives did not improve with counseling. In addition, results suggest the need to strengthen the continuity of care during the referral process for both clinical and more specialized non-medical supports. On average, perceptions of continuity of care were lower among individuals whose problems may require referrals or working with multiple professionals (e.g., child-related problems, stress), suggesting that programs may be improved by establishing a more formalized warm handoff and follow-up procedure to ensure continuity of care.
9. **Conduct research to better understand how to strengthen service delivery.** Despite improvements in severity, stress, and anxiety among many participants, about 20 percent reported that they did not experience a reduction in problem severity as a result of non-medical counseling, and between 11 percent and 12 percent sought help from both MFLC and Military OneSource for the same concern. While this evaluation did not assess the types of counseling approaches or supports provided to participants, a stronger, more detailed understanding of what happens during a non-medical counseling session may provide insight into areas for improvement or gaps that are not being adequately addressed. This includes an assessment of whether those who did not experience improvements in problem severity would gain value from traditional behavioral health services. The outcome measures included in this study were general by design (e.g., problem resolution, interference at work or daily life), but these findings point to a need

to examine in more detail what happens within a counseling session to ensure that approaches are evidence-based and appropriate and delivered as intended. More insight may also be gained by examining alignment of non-medical counseling approaches with the presenting problem and by looking at outcomes more specific to the presenting problem. Collectively, these analyses may inform more specific training needs.

Conclusions

Non-medical counseling services offered through the MFLC and Military OneSource programs are a key component of the broader support offered to military service members and their families. Findings from this study suggest that, overall, the programs are providing short-term, confidential, solution-focused counseling to address general conditions of living and military lifestyle. Participants reported reductions in problem severity and stress and anxiety at work and in their personal life after counseling, and, in most cases, these improvements were sustained or continued to improve in the three months after initiation of counseling services. While many participants reported that their problem was resolved following counseling, non-medical counseling was not universally successful and a small minority expressed dissatisfaction with the program or their counselor. Collectively, these findings point to a number of key policy and programmatic recommendations that can be used by the OSD to further strengthen these programs.

Data Collection, Weighting, and Analytic Approach

In this appendix we provide additional information on data collection, weighting of the sample to be reflective of the larger population eligible for non-medical counseling services, and our analytic approach. This appendix expands upon information provided in Chapter Two. All methods, procedures, and instruments used in the study were approved by the RAND Human Subject Protection Committee. The survey instruments are licensed by the DoD Washington Headquarters Services in December 2010 (Record Control Schedule DD-P&R [OT] 2562 and DD-P&R [OT] 2580).

Identification of Eligible Participants and Introduction to the Study

MFLC

Individuals interested in MFLC services may call an MFLC directly to make an appointment or they may simply walk into the counselor's office without a prior appointment. Because no personally identifiable information is kept by the program to facilitate direct recruitment by RAND NDRI, individual MFLC counselors were tasked with recruiting participants for the study. At the end of counseling sessions that met study eligibility, counselors introduced the study to participants using a script developed by RAND NDRI:

We want to know how well this program is working for you so that we can improve it. To help us, the RAND Corporation, a nonprofit research organization, is conducting an independent study of the MFLC program. They would like to send you more information about their study. This study will also help to highlight the importance of these services for you and your family.

After reading the script, MFLC counselors handed participants a card where participants could indicate whether they did or did not want additional information about the study. It was made clear to potential participants that this card did not indicate consent, but simply an interest in learning more about the study.

Each card was stamped with randomly assigned unique ID number. This number was entered in the online reporting form that MFLC counselors use to capture information about the session. This ID allowed us to link survey results for consenting participants to administrative data about their non-medical counseling session, while ensuring that the strict confidential nature of the program was kept intact.

If participants indicated that they did want more information, there was a space for them to include their email address on the card. If participants did not want more information, they

checked “no” and did not provide an email address. To ensure confidentiality of participants and their interest in the study, participants placed their cards in envelopes, sealed them, and either returned them to the counselor for shipment to RAND or dropped them in the mail themselves (all envelopes were postage paid). Once cards were received by RAND, the ID number, “yes” or “no” response, and email address (if “yes”) were entered into a secure database. Those participants who were interested in the study were contacted via email and invited to participate (the average time between card receipt by RAND and solicitation email was six days). MFLC counselors were trained, and reminded on an ongoing basis, of eligibility criteria for the study to ensure fidelity to study protocols.

Military OneSource

For Military OneSource, initial introduction to the study occurred through the Military OneSource triage consultants when individuals first contacted Military OneSource. Triage consultants assessed individuals’ needs and their eligibility for non-medical counseling services. Once the consultant determined that the individual was eligible for non-medical counseling services, the consultants read a script that introduced the study and asked about their interest in learning more. If the individual indicated interest, their email address was recorded and saved in a separate, secure database accessible to RAND NDRI researchers. Interested participants were emailed an invitation for the study approximately one week after attending their first non-medical counseling session.¹

Recruitment Emails for Interested Military OneSource and MFLC Participants

Interested Military OneSource and MFLC participants received email invitations to participate in the study using the same procedure. The email reinforced the confidential nature of the study and asked for participants’ help in understanding whether the respective program worked well and helped them resolve their problem or issue. The email contained a link to the survey and a randomly assigned login code for respondents to input at the survey website. Participants affirmed their consent to participate in the study on the first screen after logging into the online survey. Reminder emails were sent to non-respondents at three, seven, fourteen, and twenty-one days after the initial invitation email.

Respondents who consented to the study and completed the Wave 1 survey were emailed an invitation to complete the Wave 2 survey. (Survey instruments are described in the following appendix.) This email was sent three months following the participant’s initial consent to participate in the study. As with the Wave 1 survey, reminder emails were sent to non-respondents at three, seven, fourteen, and twenty-one days after the initial follow-up invitation email.

¹ We initially emailed interested Military OneSource participants within two to three days of their first contact with Military OneSource counselors, but some respondents reported on the survey that they did not feel that they had enough experience with their counselor to properly evaluate their services. We therefore extended this period to one week.

Study Population and Sample Weights for Tables

One potential threat to the generalizability of study results is that the group of survey respondents may differ in important ways from the target population. For example, if women were more likely to respond to the survey than men, and if women and men have differing average responses for key survey questions, reporting raw counts of survey outcomes may result in biased estimates. In order to address this concern, we received administrative data on several key client characteristics: a three-category age variable (under 25; 25–40; 41 and above), whether the respondent was a service member (as opposed to a spouse or other family member), service affiliation (Air Force, Army, Marines, Navy, or Coast Guard), component affiliation (active or reserve), and officer/enlisted status (self or sponsoring family member). We also included an indicator of the category for the V code of the primary presenting problem.² V codes that represented subcategories of problems (e.g., “marital and partner problems, unspecified”) were collapsed into their larger overall problem domains (e.g., “family or relationship problems”). Two problem domains with fewer respondents—employment assistance and education assistance problems—were combined into an “education or employment” problem domain. For the data reported in this report, we performed a process called raking that produces statistical weights to ensure that the distributions of weighted client characteristics equal the distributions of the characteristics in the population. The raking process was performed using the “survey” package in R.

Moreover, we used raking to account also for item non-response. Rather than calculating a single set of weights for all of the survey questions, we calculated separate sets of weights for each survey item. That is to say, even though a given number of individuals may have responded to the baseline survey, not every one of those respondents answered each individual survey question. Therefore, we produced weights so that the weighted distributions of client characteristics for respondents to each question equal the distributions in the target population.

Although we believed (before looking at the data) that the weighted tables should be more accurate, we did examine unweighted tables that did not include any adjustments for differential survey or item non-response. Comparisons of the unweighted and weighted tables for individual survey questions showed that the two versions of the estimates were generally quite similar: individual cell percentages were almost always within a few percentage points of each other when comparing the weighted and unweighted percentages. This is due to some combination of the respondents being similar in their characteristics to the population, and because clients whose characteristics were underrepresented in the population nonetheless responded to the survey questions in a similar manner to those who were overrepresented. See Tables A.1 and A.2 for a comparison between demographic characteristics of the sample and the eligible population.

While we believe that we weighted for characteristics that were likely to induce selection bias, we emphasize that our weighting approach only accounts for the variables that were included in raking (as listed above). It is possible that there are other client characteristics that should have been included in the weighting process (if they were available for the full popula-

² V codes, as described in the ICD-9-CM “Official Guidelines for Coding and Reporting, Supplementary Classification of Factors Influencing Health Status and Contact with Health Services,” are used by providers to classify patient visits when circumstances other than a disease or injury result in an encounter with a provider (e.g., relationship distress, parent-child relational problem; Kostick, 2011).

Table A.1
Comparison of MFLC Population to Study Sample

Characteristic	Population (%)	Sample (%)
Age		
18–24	35.0	18.6
25–40	56.7	71.6
41 and over	8.2	9.8
Service affiliation		
Army	60.3	49.0
Marines	20.3	14.4
Air Force	16.8	31.7
Navy	2.3	3.8
Other	0.3	1.2
Rank (self or sponsoring family member)		
Enlisted	84.1	78.5
Officer	15.9	21.5
Service member status		
Family member	37.6	57.2
Service member	62.4	42.8
Component affiliation		
Active duty	98.1	85.3
Guard or reserve	1.9	14.7
Problem type		
Education or employment	18.3	12.1
Family or relationship	49.9	66.7
Loss or Deployment	10.1	6.9
Stress, anxiety, or emotional problems	21.7	14.3

tion and for the sample). While concerns related to unobserved confounding cannot ever be fully eliminated, the fact that weighting on observed potential confounders only resulted in small changes in the survey estimates may be reason to believe that weighting on unobserved potential confounders would only result in relatively minor changes, too.

Further, it is possible that the outcome measures themselves are predictive of the probability that an individual responded to the survey, which could bias the results. For example, if individuals who were displeased with the non-medical counseling services were more motivated to respond to the survey, we would expect even the weighted tables to reflect a more negative overall sentiment than would be found if all clients had responded to the survey. However, we will see that the survey responses for many of the questions were almost uniformly positive. For such survey items, selection effects that could change overall, qualitative conclusions would have to be exceptionally strong.

Table A.2
Comparison of Military OneSource Population to Study Sample

Characteristic	Population (%)	Sample (%)
Age		
18–24	12.9	6.8
25–40	72.6	69.6
41 and over	14.5	23.6
Service affiliation		
Army	37.2	34.7
Marines	9.8	7.5
Air Force	21.3	21.9
Navy	17.8	19.1
Other	13.9	16.7
Rank (self or sponsoring family member)		
Enlisted	80.5	68.7
Officer	19.5	31.3
Service member status		
Family member	28.9	35.7
Service member	71.1	64.3
Modality		
In person	92.3	89.4
Other (e.g., phone, online chat)	7.7	10.6
Gender		
Women	48.8	56.8
Men	51.2	43.2
Problem type		
Education or employment	2.8	3.5
Family or relationship	64.4	67.4
Loss or deployment	4.7	5.1
Stress, anxiety, or emotional problems	28.0	24.0

Quantitative Methods

In our analyses, we do not have any control group, or a group that was unexposed to non-medical counseling services. Consequently, we are not able to make any claims about whether the program “works” or not. For example, we are unable to make a determination as to whether more clients found problem resolution than would have been the case if they had not had access to the non-medical counseling services. Even so, we are able to assess whether there is evidence of differences in survey outcomes by client-level characteristics, and whether there is evidence of change over time. We divide our models into two types: cross-sectional models that describe a response at a single point in time, and models of changes over time.

All models that control for client-level characteristics contain the following covariates: gender; a three-category age variable (under 25 years; 25–40 years; 41 years and above); whether the respondent was a service member (as opposed to spouse or other family member); service affiliation (Air Force, Army, Marines, Navy, or Coast Guard); component affiliation (active; reserve); officer or enlisted (self or sponsoring family member); and, in the case of MFLC, whether the counselor was embedded in the sponsoring service member's unit or not. We also included an indicator of the category for the V code of the primary presenting problem.

Some of the covariates have missing data elements. Although the rates of missingness are generally modest, excluding observations that have any missing covariate values would substantially reduce our available sample size and may bias results (e.g., Schafer, 1999). Accordingly, we performed multiple imputation to account for missing data at both Wave 1 (used in the cross-sectional models described below) and Wave 2 (used in the models examining change over time described below). Multiple imputation produces completed datasets so that data from all respondents to a particular question may be used in estimating the model. The multiple imputation process produces several complete datasets, and models are estimated on each completed dataset. By producing multiple completed datasets, the technique is able to express additional uncertainty due to the missing data in confidence intervals and p -values. The resulting estimates from each model are combined according to Rubin's (1987) rules. We used the "mi" package in R to perform the multiple imputation to create 20 completed datasets. We used the "micombine.chisquare" function from the "miceadds" package in R to combine chi-squared p -values for the multiply imputed datasets, and we used the "MIcombine" function in the "mitools" package in R to combine regression coefficient estimates and calculate 95 percent confidence intervals.

Cross-Sectional Models

Our primary model for the outcome variables of interest are ordered categorical models called proportional odds logistic regression models, which we fit using the "polr" function in the "MASS" package in R (Venables and Ripley, 2002). For these models, if the outcome categories Y are labeled $k=1, \dots, K$, a representation of the model is given by $\Pr(Y_i \leq k) = \exp(\alpha_k - x_i\beta) / (1 + \exp(\alpha_k - x_i\beta))$. Here, α_k are "cutpoints" that determine the relative probabilities of the outcome categories for a given set of covariates. From the model we can see that if, say, men have a higher probability of reporting the "worst" outcome for a given outcome measure than otherwise identical women (e.g., rating their satisfaction with counselor knowledge as "very dissatisfied," as measured through the covariates x_i), the model assumes that men also have a higher probability of reporting the worst or second worst category (e.g., rating their satisfaction as "dissatisfied") compared to the otherwise identical women. For ease of interpretation in tables and figures, we translate the fitted parameter values into marginal averages (i.e., averages that adjust for covariates included in the model). To calculate these, for each imputed dataset we generated the fitted probabilities and averaged the fitted probabilities from the imputed models across individuals. Finally, to calculate the estimated percentages included in the tables and figures, we averaged fitted probabilities across the imputed datasets.

Additionally, we calculated p -values related to excluding a characteristic from the model. For example, we consider whether service affiliation explains a significant amount of variation in the outcome scale. Low p -values (typically $p < 0.05$) suggest a significant association between the characteristic in question and the outcome probabilities. However, we kept in mind that we were performing dozens of such tests, and that we would expect approximately one in 20 com-

parisons to be “significant” by chance alone (if there were no true, underlying differences). For this reason, we opted for a more stringent p -value ($p < 0.01$) for reporting of significant associations. Even with the more stringent cutoff, we would expect some false positives due to chance alone given the large number of tests. Hence, we view the “significant” subgroup differences as exploratory findings that merit future surveillance rather than immediate action. Moreover, highlighted differences should be interpreted as associations rather than causal effects; it is possible that other unmeasured factors are driving apparent associations. Even so, these significance tests are useful for highlighting groups of respondents that may be experiencing more or less favorable outcomes than others.

Changes over Time

We also considered several methods for analyzing change over time. The simplest version of our analysis does not include any covariates: it simply asks whether there is evidence that individuals tend to report an improvement for a particular measure over time. If there were no systematic change over time, we would expect roughly the same number of individuals to improve as to worsen. On the other hand, if a significantly greater number of individuals report improvements than the number who report a worsening, we have evidence that there was systematic change over the time period in question. More specifically, we focused on the total number of individuals that reported an improvement for a particular question, which we denoted m . We then calculated the probability that the number of individuals who saw an improvement was greater than or equal to m (out of the number who reported a change), plus the probability that the number of individuals who saw a worsening was greater than or equal to m , if there were in fact no trend over time. (This assumes that the number of individuals who improved is greater than or equal to the number who worsened; if the opposite is true, m would be defined as the number who worsened.) As stated above, evidence of a change over time does not necessarily mean that the non-medical counseling program is responsible for that change. We might expect more problems to improve over time than to get worse, even if individuals were not able to access counseling services. Even so, this approach allowed us to quantify the evidence that there was a change over time, even if we could not statistically identify the root cause of that change.

We also considered models that describe differences in a scale of changes. We began by calculating the change between a measure at one time point versus another. In most cases, reported worsening was rare. Because of this we used the following categories: Worsen, Stay same, Improve 1 point, Improve 2 points, etc. We then applied the ordered categorical model described above to describe this ordered outcome.

Qualitative Methods

Survey respondents had the option to provide open-ended responses to two questions assessing the perceived strengths and weaknesses of the non-medical counseling program (“What do you see as the major advantages or strengths of non-medical counseling offered by Military and Family Life Counseling [Military OneSource]?”; “What do you see as the major concerns or challenges related to non-medical counseling offered by Military and Family Life Counseling [Military OneSource]?”). Researchers used an iterative process to develop a codebook and code the strength and weakness responses according to recurring themes, based on the method for

coding open-ended survey questions described in Ryan and Bernard (2003). This approach involves reading text for themes and subthemes, determining a manageable list of codes to capture themes, building hierarchies of codes (codebook), and applying the codebook to a full dataset.

The procedure for open-ended coding involved four research team members—two coders, a team leader, and a project leader—who met on a weekly or biweekly basis to review the current coding scheme, develop new codes to reflect newly observed themes, consolidate or eliminate codes that seemed to be less common or overlapping, resolve any coding discrepancies to ensure consistent coding, and discuss the data collection timeline. The procedure led to two separate codebooks—one for the MFLC open-ended responses and one for the Military OneSource open-ended responses. Separate codebooks were necessary to account for the programmatic differences between the MFLC and Military OneSource programs. However, the team attempted to preserve consistency across the two codebooks as much as possible by using the same codes for common themes present across the programs (e.g., confidentiality, counselor skills, stigma, lack of follow-up).

Two team members coded the MFLC and Military OneSource responses independently (one specifically coded MFLC responses and the other specifically coded Military OneSource responses). To check for intercoder reliability, the percent agreement score and Cohen's kappa score was calculated for a sample set of MFLC and Military OneSource responses coded by both coders. Adequate reliability was determined with a percent agreement score of 85.5 percent and a kappa of 0.85. The score calculations were followed by a team discussion of coding discrepancies and strategies to maintain consistency. Additionally, ongoing discussions and iteration during the coding process preserved consistency. The qualitative analysis team calculated the frequency of each code and when possible, collapsed low frequency codes ($n < 7$) with an overlapping existing code or under a new code. The team then transferred the final codebooks, open-ended responses, and select demographic data and survey responses to the qualitative data analysis program Dedoose (version 7.0.23).

Survey Instruments

B.1 Wave 1 Survey

Instructions on screen: We are interested in learning more about your recent experience with non-medical counseling through Military OneSource. We use the term “non-medical” to mean services that relate to behavioral concerns, stress reduction, educational and other non-clinical issues.

SECTION 1: PROBLEM TYPE

PT1: Have you ever received non-medical counseling from a Military OneSource non-medical counselor for any of the following concerns? *Check all that apply per row.*

	1. Yes, this was my most recent issue/concern	2. Yes, I have connected with a Military OneSource counselor about this in the past	3. I have never contacted a Military OneSource counselor about this issue
a. Child issues (e.g., academic issues, behavioral concerns)	1	2	3
b. Family or relationship issues	1	2	3
c. Conflict resolution or anger management	1	2	3
d. Exceptional family member support	1	2	3
e. Stress, anxiety, or emotional problems	1	2	3
f. Deployment concerns or support	1	2	3
g. Reintegration concerns or support	1	2	3
h. Relocation/PCS concerns or support	1	2	3
i. Wounded warrior concerns or support	1	2	3
j. Loss or grief	1	2	3
k. Personal financial management	1	2	3
l. Employment assistance	1	2	3
m. Education assistance (for self or spouse)	1	2	3
n. Care for disabled or elderly adult	1	2	3
o. Other topic (specify_____)	1	2	3

Instructions on screen: For these next questions, please think about how your concern affected you or your family **BEFORE** you connected with Military OneSource.

PT2: Thinking about your most recent concern (e.g., behavioral, family), before you connected with Military OneSource for non-medical counseling, how would you rate the severity of your concern? **Select one.**

1. Low
2. Moderate
3. Severe
4. Very severe
9. Don't know

PT3: Think about how your concern made you feel before you reached out to a Military OneSource counselor. How often did the concern . . . ? **For each item in the table below, select one response per row.**

	1. Very frequently 2. Frequently 3. Occasionally 4. Rarely 5. Never				
a. Make you feel stressed or anxious?	1	2	3	4	5
b. Interfere with your work?	1	2	3	4	5
c. Interfere with other daily routines?	1	2	3	4	5
d. Make it difficult to cope with day-to-day demands?	1	2	3	4	5

PT4: Thinking about your most recent concern, in addition to the Military OneSource counselors, did you also seek support from other individuals or providers? **Select one.**

1. Yes
0. No [*skip to SR1*]

PT5: What other support services helped you with this concern? **Check all that apply.**

- a. Private counselor or specialist
- b. Military family support program
- c. Military and Family Life Counseling
- d. Religious, or faith-based community
- e. Extended family members or friends
- f. Other? (Specify) _____
- g. Don't know

SECTION 2: SERVICE RECEIPT AND PROBLEM RESOLUTION

Instructions on screen: We are interested in learning more about your experience with the Military OneSource counselor and the ways in which your counselor has helped you address your non-medical concern. For the following questions, please think about your interactions with the Military OneSource counselor for your most recent non-medical concern.

SR1 [Military OneSource only]: How did you meet with your counselor?

1. I met in-person with a counselor
2. I talked to a counselor over the telephone
3. I chatted online with a counselor
4. I met over a video link with a counselor

SR2: Please rate the extent to which you agree or disagree with the following statements. **Select one response per row.**

	1. Strongly agree 2. Agree 3. Neither agree nor disagree 4. Disagree 5. Strongly disagree 9. Not applicable					
a. My counselor showed interest in my questions and concerns.	1	2	3	4	5	9
b. My counselor listened to me carefully.	1	2	3	4	5	9
c. My counselor spent enough time with me.	1	2	3	4	5	9
d. My counselor explained things in a way that was easy for me to understand.	1	2	3	4	5	9
e. I left my counselors office with all of my questions answered.	1	2	3	4	5	9
f. My counselor was knowledgeable in the area of my specific concern.	1	2	3	4	5	9
g. My counselor provided the services I needed.	1	2	3	4	5	9
h. My counselor connected me to outside support and services.	1	2	3	4	5	9
i. My counselor connected me to medical services.	1	2	3	4	5	9
j. My counselor (or Military OneSource call center) followed up with me to make sure I was able to connect with the outside supports and services they recommended.	1	2	3	4	5	9

SR3: Please rate the extent to which you agree or disagree with the following statements. **Select one response per row.**

	NUMBER 1. Strongly agree 2. Agree 3. Neither agree nor disagree 4. Disagree 5. Strongly disagree 9. Not applicable					
a. My counselor addressed my cultural, language, or religious concerns.	1	2	3	4	5	9
b. My counselor understood military culture.						
c. It was easy to make appointments with my counselor to fit my schedule.	1	2	3	4	5	9
d. It was hard for me to get to my appointments with my counselor (e.g., due to lack of child care, transportation, office hours that didn't work with my schedule).	1	2	3	4	5	9

PR1: How many Military OneSource sessions have you had to date related to this non-medical concern?

1. One
2. Two
3. Three
4. Four
5. Five
6. Six or more
7. Don't know

PR2: How would you rate the severity of this concern now? *Select one.*

1. Low
2. Moderate
3. Severe
4. Very severe
9. Don't know

PR3: Now that you have received non-medical counseling from Military OneSource, please rate how often this concern . . . ? *Select one response per row.*

	1. Very frequently 2. Frequently 3. Occasionally 4. Rarely 5. Never				
a. Makes you feel stressed or anxious?	1	2	3	4	5
b. Interferes with your work?	1	2	3	4	5
c. Interferes with other daily routines?	1	2	3	4	5
d. Makes it difficult to cope with day-to-day demands?	1	2	3	4	5

PR4: Since receiving non-medical counseling services from Military OneSource, how would you rate the level of stress in your work life?

1. Much less than before
2. Less than before
3. About the same as before
4. More than before
5. Much more than before
9. Not applicable

PR5: Since receiving non-medical counseling services from Military OneSource, how would you rate the level of stress in your personal life?

1. Much less than before
2. Less than before

3. About the same as before
4. More than before
5. Much more than before
9. Not applicable

PR6: Please rate the extent to which you agree or disagree with the following statements.

	1. Strongly agree	2. Agree	3. Neither agree nor disagree	4. Disagree	5. Strongly disagree	9. Not applicable
Because of non-medical counseling provided by Military OneSource:						
a. I connected with physical health care providers that I would not have on my own.	1	2	3	4	5	9
b. I connected with mental health care providers that I would not have on my own.	1	2	3	4	5	9
c. I connected with additional community services that I would not have on my own.	1	2	3	4	5	9
d. I felt more prepared for deployment.	1	2	3	4	5	9
e. My family felt more prepared for deployment.	1	2	3	4	5	9
f. Reintegration after deployment was made easier.	1	2	3	4	5	9
g. My children felt better supported in school.	1	2	3	4	5	9
h. I wanted to stay in the military longer (or I wanted to remain a military family for a longer period of time).	1	2	3	4	5	9

PR7: Please describe your level of satisfaction with the following areas? *Select one response per row.*

	1. Very satisfied	2. Satisfied	3. Neither satisfied nor dissatisfied	4. Dissatisfied	5. Very dissatisfied	9. Not applicable
a. Continuity of care—(For example, seeing the same counselor for each session or another counselor who knew about my concern and what we had discussed during previous counseling sessions)	1	2	3	4	5	9
b. Counselor (or Military OneSource call center) follow-up to make sure I connected with services that they had recommended	1	2	3	4	5	9
c. Counselor or program follow-up with me if I missed an appointment	1	2	3	4	5	9
d. Confidentiality of personal and family information	1	2	3	4	5	9
e. The types of resources and materials they gave to me (the materials were relevant to my concerns)	1	2	3	4	5	9
f. The number of resources and materials they gave to me	1	2	3	4	5	9
g. Counselor knowledge about my non-medical concerns	1	2	3	4	5	9
h. Professionalism of counseling staff	1	2	3	4	5	9
i. Speed with which I was connected to counseling staff	1	2	3	4	5	9

PR8: How likely is it that you will use Military OneSource the next time you have a non-medical concern?

1. Highly likely
2. Likely
3. Not sure
4. Unlikely
5. Very unlikely

PR9 [*Military OneSource only*]: How likely is it that you would tell a friend to call Military OneSource for services?

1. Highly likely
2. Likely
3. Not sure
4. Unlikely
5. Very unlikely

PR10: What do you see as the major advantages or strengths of non-medical counseling offered by Military OneSource? [*Open ended*] ***Please do not include any personally identifiable information.***

PR11: What do you see as the major concerns or challenges related to non-medical counseling offered by Military OneSource? [*Open ended*] ***Please do not include any personally identifiable information.***

Instructions on screen: If you have not been satisfied with your experience with Military OneSource, we encourage you to reach out to them directly by calling: 1-800-342-9647. This will allow Military OneSource to become aware of the specific situation, and to allow for better help with any problem you may have experienced.

SECTION 3: PERSONAL INFORMATION

Instructions on screen: This last set of questions asks a few questions about you so we can have a better understanding of who completed this survey.

PI1: What is your gender? ***Select one.***

- a. Male
- b. Female

PI2: What is your military affiliation? ***Select one.***

- a. Active duty
- b. Reserve
- c. National Guard
- d. Veteran
- e. Spouse/family member [*skip to PI4*]

PI3. What is your service?

- a. Army
- b. Navy
- c. Marine Corps
- d. Air Force
- e. Coast Guard

PI4: What is your current relationship status? *Select one.*

- a. Married
- b. Separated
- c. Divorced
- d. Widowed
- e. Single, living with partner
- f. Single

PI5: How many children do you have? *Select one.*

- a. None
- b. 1
- c. 2
- d. 3
- e. 4
- f. 5 or more

PI6: What is the highest grade or year of school that you completed? *Select one.*

- a. Less than a High School Diploma/Equivalent (GED)
- b. High School Diploma/Equivalent (GED)
- c. Vocational/Technical Program After High School But No Vocational/Technical Diploma
- d. Vocational/Technical Diploma After High School
- e. College Coursework But No Degree
- f. Associate's Degree
- g. Bachelor's Degree
- h. Graduate or Professional Degree
- i. Other? (Specify) _____

Instructions on screen: Thank you for taking the time to fill out this important survey.

B.2 Wave 2 Survey

Instructions on screen: About three months ago you completed a survey on the web asking about a recent experience you had with non-medical counseling through Military One-Source and how the issue/concern you sought help with had been addressed. We use the term

“non-medical” to mean services that relate to behavioral concerns, stress reduction, educational and other non-clinical issues.

The issue/concern you indicated that you received counseling for was:

[FILL IN PT1 = 1 RESPONSES FROM BASELINE]

We are interested in learning more about your experiences with this issue/concern in the three months since you completed the initial survey.

PR2: How would you rate the severity of this concern now? ***Select one.***

1. Low
5. Moderate
6. Severe
7. Very severe
9. Don't know

PR3: Now that you have received non-medical counseling from Military OneSource, please rate how often this concern . . . ? ***Select one response per row.***

	1. Very frequently 2. Frequently 3. Occasionally 4. Rarely 5. Never				
a. Makes you feel stressed or anxious?	1	2	3	4	5
b. Interferes with your work?	1	2	3	4	5
c. Interferes with other daily routines?	1	2	3	4	5
d. Makes it difficult to cope with day-to-day demands?	1	2	3	4	5

PR4: Since receiving non-medical counseling services from Military OneSource, how would you rate the level of stress in your **work life**?

1. Much less than before
2. Less than before
3. About the same as before
4. More than before
5. Much more than before
9. Not applicable

PR5: Since receiving non-medical counseling services from Military OneSource, how would you rate the level of stress in your **personal life**?

1. Much less than before
2. Less than before
3. About the same as before
4. More than before
5. Much more than before
9. Not applicable

Instructions on screen: We are interested in learning more about your experience with the Military OneSource counselor and the ways in which your counselor has continued to help you address your non-medical concern.

PR1: How many Military OneSource sessions have you received in the last three months related to **your initial non-medical concern**?

1. One
2. Two
3. Three
4. Four
5. Five
6. Six or more
7. Don't know
8. I did not meet with a Military OneSource counselor in the past three months.

SR1 [*Military OneSource only*]: How did you meet with your counselor? **Check all that apply.**

1. I met in-person with a counselor
5. I talked to a counselor over the telephone
6. I chatted online with a counselor
7. I met over a video link with a counselor
8. N/A. I did not meet with a Military OneSource counselor in the past three months.

PT4: Thinking about this concern, in addition to the Military OneSource counselors, did you seek support from other individuals or providers in the past three months? **Select one.**

1. Yes
0. No (*skip to SR1*)

PT5: What other support services helped you with **this** concern in the past three months? **Select all that apply.**

- a. Private counselor or specialist
- b. Military family support program
- c. Military and Family Life Counseling
- d. Religious, or faith-based community
- e. Extended family members or friends
- f. Other? (Specify) _____
- g. Don't know

SR2: For the following questions, please think about your interactions with the Military One-Source counselor for your initial non-medical concern. Please rate the extent to which you agree or disagree with the following statements. *Select one response per row.*

	1. Strongly agree	2. Agree	3. Neither agree nor disagree	4. Disagree	5. Strongly disagree	9. Not applicable
a. My counselor showed interest in my questions and concerns.	1	2	3	4	5	9
b. My counselor listened to me carefully.	1	2	3	4	5	9
c. My counselor spent enough time with me.	1	2	3	4	5	9
d. My counselor explained things in a way that was easy for me to understand.	1	2	3	4	5	9
e. My counselor answered all of my questions.	1	2	3	4	5	9
f. My counselor was knowledgeable in the area of my specific concern.	1	2	3	4	5	9
g. My counselor provided the services I needed.	1	2	3	4	5	9
h. My counselor connected me to outside support and services.	1	2	3	4	5	9
i. My counselor connected me to medical services.	1	2	3	4	5	9
j. My counselor (or Military OneSource call center) followed up to make sure I was able to connect with the outside supports and services they recommended.	1	2	3	4	5	9

SR3: Please rate the extent to which you agree or disagree with the following statements. *Select one response per row.*

	1. Strongly agree	2. Agree	3. Neither agree nor disagree	4. Disagree	5. Strongly disagree	9. Not applicable
a. My counselor addressed my cultural, language, or religious concerns.	1	2	3	4	5	9
b. My counselor understood military culture.						
c. It was easy to make appointments with my counselor to fit my schedule.	1	2	3	4	5	9
d. It was hard for me to get to my appointments with my counselor (e.g., due to lack of child care, transportation, office hours that didn't work with my schedule).	1	2	3	4	5	9

PR6. Please rate the extent to which you agree or disagree with the following statements.

	1. Strongly agree 2. Agree 3. Neither agree nor disagree 4. Disagree 5. Strongly disagree 9. Not applicable					
Because of non-medical counseling provided by Military OneSource:						
a. I connected with physical health care providers that I would not have on my own.	1	2	3	4	5	9
b. I connected with mental health care providers that I would not have on my own.	1	2	3	4	5	9
c. I connected with additional community services that I would not have on my own.	1	2	3	4	5	9
d. I felt more prepared for deployment.	1	2	3	4	5	9
e. My family felt more prepared for deployment.	1	2	3	4	5	9
f. Reintegration after deployment was made easier.	1	2	3	4	5	9
g. My children felt better supported in school.	1	2	3	4	5	9
h. I wanted to stay in the military longer (or I wanted to remain a military family for a longer period of time).	1	2	3	4	5	9

PR7: Please describe your level of satisfaction with the following areas. *Select one response per row.*

	1. Very satisfied 2. Satisfied 3. Neither satisfied nor dissatisfied 4. Dissatisfied 5. Very dissatisfied 9. Not applicable					
a. Continuity of care (For example, seeing the same counselor for each session or another counselor who knew about my concern and what we had discussed during previous counseling sessions)	1	2	3	4	5	9
b. Counselor (or Military OneSource call center) follow-up to make sure I connected with services that they had recommended	1	2	3	4	5	9
c. Counselor or program follow-up with me if I missed an appointment	1	2	3	4	5	9
d. Confidentiality of personal and family information	1	2	3	4	5	9
e. The types of resources and materials they gave to me (the materials were relevant to my concerns)	1	2	3	4	5	9
f. The number of resources and materials they gave to me	1	2	3	4	5	9
g. Counselor knowledge about my non-medical concerns	1	2	3	4	5	9
h. Professionalism of counseling staff	1	2	3	4	5	9
i. Speed with which I was connected to counseling staff	1	2	3	4	5	9

PR8: How likely is it that you will use Military OneSource the next time you have a non-medical concern?

1. Very likely
2. Likely
3. Not sure
4. Unlikely
5. Very unlikely

PR9 [*Military OneSource only*]: How likely is it that you would tell a friend to call Military OneSource for services?

1. Highly likely
2. Likely
3. Not sure
4. Unlikely
5. Very unlikely

PT1: Think about the three months since you completed the first survey. During that time, did you receive non-medical counseling from a Military OneSource non-medical counselor for any of the following concerns? ***Check all that apply per row.***

	1. Yes, I connected with a Military OneSource counselor about this issue/concern in the past three months, since I completed the first survey 2. No, but I have connected with a Military OneSource counselor about this in the past 3. I have never contacted a Military OneSource counselor about this issue		
a. Child issues (e.g., academic issues, behavioral concerns)	1	2	3
b. Family or relationship issues	1	2	3
c. Conflict resolution or anger management	1	2	3
d. Exceptional family member support	1	2	3
e. Stress, anxiety, or emotional problems	1	2	3
f. Deployment concerns or support	1	2	3
g. Reintegration concerns or support	1	2	3
h. Relocation/PCS concerns or support	1	2	3
i. Wounded warrior concerns or support	1	2	3
j. Loss or grief	1	2	3
k. Personal financial management	1	2	3
l. Employment assistance	1	2	3
m. Education assistance (for self or spouse)	1	2	3
n. Care for disabled or elderly adult	1	2	3
o. Other topic (specify_____)	1	2	3

PR10: What do you see as the major advantages or strengths of non-medical counseling offered by Military OneSource? ***Please do not include any personally identifiable information.***

[Open-ended]

PR11: What do you see as the major concerns or challenges related to non-medical counseling offered by Military OneSource? ***Please do not include any personally identifiable information.***

[Open-ended]

Instructions on screen: If you have not been satisfied with your experience with Military OneSource, we encourage you to reach out to them directly by calling: 1-800-342-9647. This will allow Military OneSource to become aware of the specific situation, and to allow for better help with any problem you may have experienced.

Instructions on screen: Thank you for taking the time to fill out this important survey.

Tables of Significant Subgroup Differences

All models reported in this appendix control for client-level characteristics using the following covariates: gender; a three-category age variable (under 25 years; 25–40 years; 41 years and above); whether the respondent was a service member (as opposed to spouse or other family member); service affiliation (Air Force, Army, Marines, Navy, or Coast Guard); component affiliation (active; reserve); officer or enlisted (self or sponsoring family member); and, in the case of MFLC, whether the counselor was embedded in the sponsoring service member's unit or not. We also included an indicator of the category for the primary presenting problem. See the relevant chapter text for a description of each effect reported in this appendix.

Subgroup Differences in Problem Severity (Chapter Three)

Prior to Non-Medical Counseling

As noted in Chapter Three, we observed significant subgroup differences in precounseling problem severity by gender among MFLC participants, by service affiliation for Military OneSource participants, and by problem type for both MFLC and Military OneSource participants. Tables C3.1 (MFLC) and C3.2 (Military OneSource) provide additional detail on these significant differences.

Table C3.1

Precounseling Ratings of Problem Severity by Gender and Problem Type Among MFLC Participants

Subgroup	Low (%)	Moderate (%)	Severe (%)	Very Severe (%)
Gender				
Women	4.6	24.8	36.8	33.9
Men	5.8	28.9	36.7	28.5
Problem type				
Child issues	8.3	36.6	35.2	19.8
Deployment concerns	8.1	36.0	35.4	20.5
Education or employment	8.2	36.3	35.4	20.1
Family or relationship	3.5	21.2	37.2	38.1
Loss or grief	5.2	27.8	37.9	29.1
Stress, anxiety, or emotional problems	6.8	32.8	36.9	23.5

NOTE: $N=2,358$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Table C3.2**Precounseling Ratings of Problem Severity by Problem Type Among Military OneSource Participants**

Problem Type	Low (%)	Moderate (%)	Severe (%)	Very Severe (%)
Service affiliation				
Air Force	3.7	33.8	38.7	23.9
Army	2.6	27.0	39.5	30.9
Marines	2.4	25.2	39.4	33.0
Navy	2.7	27.5	39.5	30.3
Problem type				
Child issues	3.9	35.2	38.4	22.5
Deployment concerns	5.9	43.7	34.5	15.9
Education or employment	3.4	32.3	39.2	25.2
Family or relationship	2.4	25.8	39.6	32.1
Loss or grief	3.4	32.4	39.2	25.0
Stress, anxiety, or emotional problems	3.6	33.6	38.9	23.9

NOTE: $N=2,519$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Table C3.3**Short-Term Changes in Problem Severity by Gender and Problem Type Among MFLC Participants**

Subgroup	Worsened (%)	Stayed the Same (%)	Improved a Little (%)	Improved a Lot (%)
Gender				
Women	1.5	17.8	42.3	38.5
Men	1.9	21.4	43.8	33.0
Problem type				
Child issues	2.5	26.8	44.4	26.3
Deployment concerns	1.7	20.2	43.5	34.7
Education or employment	2.0	23.0	44.2	30.8
Family or relationship	1.5	17.7	42.4	38.5
Loss or grief	1.5	18.6	42.9	36.9
Stress, anxiety, or emotional problems	1.6	19.2	43.1	36.1

NOTE: $N=2,358$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

In Short-Term Resolution of Problem Severity

In Chapter Three we also noted that there were significant subgroup differences in short-term change in severity among MFLC participants. Table C3.3 provides additional detail on these significant differences.

Table C3.4**Long-Term Changes in Problem Severity by Rank Among Military OneSource Participants**

Subgroup	Worsened (%)	Stayed the Same (%)	Improved (%)
Rank (self or sponsoring family member)			
Officer	2.0	15.1	82.9
Enlisted	3.4	22.7	73.9

NOTE: $N=608$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Table C3.5**Willingness to Stay in the Military by Active-Duty Status Among Military OneSource Participants**

Subgroup	Agree/Strongly Agree (%)	Neither Agree nor Disagree (%)	Disagree/Strongly Disagree (%)
Active duty	37.8	39.9	22.3
Reserve and guard	48.3	36.0	15.7

NOTE: $N=999$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

In Long-Term Resolution of Problem Severity

We observed significant differences by rank in long-term change in severity among Military OneSource participants. Table C3.4 provides additional detail on these significant differences.

Subgroup Differences in Retention Intentions

We also noted subgroup differences by active-duty status among Military OneSource participants and their willingness to stay in the military as result of non-medical counseling (Table C3.5).

Subgroup Differences in the Resolution of Stress and Anxiety (Chapter Four)***Prior to Non-Medical Counseling***

In Chapter Four, we noted that some groups of individuals were significantly more likely to report frequent or very frequent stress and anxiety than others prior to non-medical counseling. Tables C4.1 (MFLC) and C4.2 (Military OneSource) provide additional detail on these significant differences.

In the Short-Term Resolution of Stress and Anxiety

In Chapter Four we also noted that there were significant subgroup differences in the short-term problem resolution of stress and anxiety. Tables C4.3 (MFLC) and C4.4 (Military OneSource) provide additional detail on these significant differences.

Table C4.1**Precounseling Frequency of Stress or Anxiety by Subgroups; MFLC**

Subgroup	Never or Rarely (%)	Occasionally (%)	Frequently or Very Frequently (%)
Gender			
Women	4.5	9.0	86.4
Men	8.9	15.3	75.8
Problem type			
Child issues	10.7	17.2	72
Deployment	7.3	13.1	79.6
Education or employment	8.6	14.8	76.5
Family or relationship	5.0	9.6	85.4
Loss or grief	7.2	12.9	79.9
Stress, anxiety, or emotional problems	7.7	13.7	78.6

NOTE: $N=2,370$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Table C4.2**Frequency of Stress and Anxiety by Subgroups; Military OneSource (Marginal Means)**

Subgroup	Never or Rarely (%)	Occasionally (%)	Frequently or Very Frequently (%)
Service affiliation			
Air Force	5.4	13.9	80.7
Army	4.3	11.6	84.1
Marines	3.1	9	87.9
Navy	3.9	10.7	85.5
Age			
18–24	3.3	9.2	87.5
25–40	4.1	11.2	84.7
41 and over	5.2	13.5	81.2
Gender			
Women	3.1	9.1	87.7
Men	5.8	14.9	79.3

NOTE: $N=2,513$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Table C4.3**Short-Term Problem Resolution of Stress and Anxiety by Subgroups; MFLC**

Subgroup	Got Worse (%)	Stayed the Same (%)	Improved (%)
Gender			
Women	0.9	16.5	82.7
Men	1.2	21.8	81.2
Service affiliation			
Air Force	0.9	17.4	81.7
Army	1.0	17.8	81.2
Marines	1.4	24.6	74.1
Navy	0.8	15.3	83.9
Counselor embedded			
Yes	1.1	19.7	79.3
No	0.8	15.0	84.3

NOTE: $N=2,370$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Table C4.4**Short-Term Problem Resolution of Stress and Anxiety by Subgroups; Military OneSource**

Subgroup	Got Worse (%)	Stayed the Same (%)	Improved (%)
Gender			
Women	1.7	24.6	73.6
Men	2.4	31.0	66.6

NOTE: $N=2,513$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

In the Short-Term Changes in the Level of Stress in One's Personal Life**Table C4.5****Short-Term Changes in Level of Personal Stress; Military OneSource**

Subgroup	Much More Than Before (%)	More Than Before (%)	About the Same (%)	Less Than Before (%)	Much Less Than Before (%)
Problem type					
Child issues	1.3	4.2	32.7	50.1	11.7
Deployment	0.4	1.3	14.0	53.7	30.6
Education or employment	1.3	4.3	33.2	49.7	11.5
Family or relationship	1.2	3.8	30.9	51.3	12.8
Loss or grief	1.5	4.8	35.6	47.9	10.2
Stress, anxiety, or emotional problems	1.1	3.7	30.2	51.8	13.2

NOTE: $N=2,479$. Changes in level of stress in personal life was measured by a single item assessed at Wave 1. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Subgroup Differences in Interference with Work and Life (Chapter Five)

Problem Interference with Work Prior to Non-Medical Counseling

We observed no significant differences in precounseling ratings of problem interference with work by subgroups among MFLC participants at Wave 1. Among Military OneSource participants, we observed significant precounseling differences by service affiliation, component, and problem type (see Table C5.1).

In Short-Term Resolution of Problem Interference with Work

Analysis revealed several significant subgroup differences in short-term changes in problem interference with work. Tables C5.2 (MFLC) and C5.3 (Military OneSource) provide additional detail on these significant differences.

Problem Interference with Daily Routines Prior to Non-Medical Counseling

Among MFLC participants, at Wave 1 we observed significant differences in precounseling ratings of interference with daily routines by gender and problem type (see Table C5.4). Military OneSource participants demonstrated significant differences by service affiliation and age (see Table C5.5).

Table C5.1

Precounseling Ratings of Problem Interference with Work by Service, Active-Duty Status, and Problem Type Among Military OneSource Participants, Wave 1

Subgroup	Never or Rarely (%)	Occasionally (%)	Frequently or Very Frequently (%)
Service affiliation			
Air Force	36.8	29.5	33.7
Army	29.2	29.0	41.7
Marines	22.7	27.2	50.1
Navy	27.2	28.6	44.2
Active duty			
Yes	31.3	29.2	39.5
No	26.2	28.2	45.6
Problem type			
Child issues	35.3	29.5	35.2
Deployment	39.3	29.3	31.4
Education or employment	19.3	25.4	55.3
Family or relationship	30.4	29.1	40.5
Loss or grief	32.5	29.4	38.1
Stress, anxiety, or emotional problems	28.2	28.8	43.1

NOTE: $N=2,513$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Table C5.2**Short-Term Changes in Problem Interference with Work by Gender and Service Among MFLC Participants, Wave 1**

Subgroup	More Frequent (%)	The Same Frequency (%)	Less Frequent (%)
Gender			
Women	2.4	29.7	67.9
Men	3.1	35.2	61.7
Service affiliation			
Air Force	2.7	32.2	65.1
Army	2.5	30.9	66.6
Marines	3.6	38.0	58.4
Navy	1.6	22.7	75.7

NOTE: $N=2,378$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Table C5.3**Short-Term Changes in Problem Interference with Work by Gender and Service Member Status Among Military OneSource Participants, Wave 1**

Subgroup	More Frequent (%)	The Same Frequency (%)	Less Frequent (%)
Gender			
Women	3.1	38.8	58.1
Men	4.2	45.5	50.3
Service member status			
Family member	4.1	45.1	50.8
Service member	3.2	39.8	56.9

NOTE: $N=2,513$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Table C5.4**Precounseling Ratings of Interference with Daily Routines Among MFLC Participants, Wave 1**

Subgroup	Never or Rarely (%)	Occasionally (%)	Frequently or Very Frequently (%)
Gender			
Women	16.5	25.1	58.4
Men	20.7	27.7	51.7
Problem type			
Child issues	25.5	29.7	44.9
Deployment	19.5	27.1	53.4
Education or employment	21.8	28.3	49.9
Family or relationship	16.6	25.2	58.1
Loss or grief	14.6	23.5	61.9
Stress, anxiety, or emotional problems	19.2	27	53.8

NOTE: $N=2,381$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Table C5.5**Precounseling Ratings of Interference with Daily Routines Among Military OneSource Participants, Wave 1**

Subgroup	Never or Rarely (%)	Occasionally (%)	Frequently or Very Frequently (%)
Service affiliation			
Air Force	19.8	29.5	50.7
Army	15.6	26.5	57.9
Marines	15.2	26.1	58.7
Navy	15.0	26.0	59.1
Other	17.7	28.1	54.1
Age			
18–24	16.1	26.9	56.9
25–40	15.7	26.7	57.5
41 and older	19.7	29.4	51

NOTE: $N=2,513$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Table C5.6**Short-Term Ratings of Interference with Daily Routines Among MFLC Participants**

Subgroup	Less Frequency (%)	Same Frequency (%)	More Frequently (%)
Gender			
Women	75.6	22.6	1.9
Men	70.4	27.2	2.4

NOTE: $N=2,381$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Table C5.7**Long-Term Ratings of Interference with Daily Routines Among Military OneSource Participants**

Subgroup	Less Interference (%)	Same (%)	More Interference (%)
Service member status			
Family member	44.9	37.9	17.2
Service member	33.0	41.4	25.7

NOTE: $N=594$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Short-Term Resolution Problem Interference with Daily Routines

We observed no differences for Military OneSource and significant differences by gender in short-term changes among MFLC participants (Table C5.6).

Long-Term Resolution Problem Interference with Daily Routines

We observed differences by service member status in long-term changes among Military OneSource participants (see Table C5.7). There were no subgroup differences for MFLC.

Difficulty Coping with Day-to-Day Demands Prior to Non-Medical Counseling

Among MFLC participants, at Wave 1 we observed significant differences in difficulty coping with day-to-day demands by gender and problem type (see Table C5.8), and Military OneSource participants demonstrated significant differences by service affiliation and gender (see Table C5.9). There was a significant difference in changes from precounseling to three-month follow-up among MFLC participants with different problem types (see Table C5.10).

Table C5.8**Precounseling Ratings of Difficulty Coping with Day-to-Day Demands Among MFLC Participants, Wave 1**

Subgroup	Never or Rarely (%)	Occasionally (%)	Frequently or Very Frequently (%)
Gender			
Women	23.3	22.6	54.2
Men	30.9	24.7	44.4
Problem type			
Child issues	38.7	25.1	36.3
Deployment	27.4	23.9	48.7
Education or employment	29.3	24.3	46.4
Family or relationship	24.1	23	52.8
Loss or grief	20.6	21.4	57.9
Stress, anxiety, or emotional problems	28.8	24.2	46.9

NOTE: $N=2,382$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Table C5.9**Precounseling Ratings of Difficulty Coping with Day-to-Day Demands Among Military OneSource Participants, Wave 1**

Subgroup	Never or Rarely (%)	Occasionally (%)	Frequently or Very Frequently (%)
Gender			
Women	22.4	26.0	51.6
Men	26.3	27.4	46.2
Service affiliation			
Air Force	28.9	28	43.1
Army	22.4	26	51.6
Marines	20.7	25.2	54.1
Navy	21.9	25.8	52.3

NOTE: $N=2,516$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Table C5.10**Long-Term Changes in Ratings of Difficulty Coping with Day-to-Day Demands Among MFLC Participants**

Subgroup	More Frequent (%)	The Same Frequency (%)	Less Frequent (%)
Problem type			
Child issues	28.7	32.5	38.8
Deployment	11.0	21.8	67.2
Education or employment	5.3	12.9	81.7
Family or relationship	9.1	19.3	71.6
Loss or grief	3.9	10.0	86.1
Stress, anxiety, or emotional problems	9.5	19.9	70.6

NOTE: $N=433$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Table C6.1**Perception of Connection to Services Among MFLC Participants**

Subgroup	Strongly Agree (%)	Agree (%)	Neither Agree nor Disagree (%)	Disagree or Strongly Disagree (%)
Service member status				
Family member	56.6	16.8	16.2	10.3
Service member	65.6	14.6	12.6	7.3

NOTE: $N=1,531$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Subgroup Differences in Connection to Services and Referrals (Chapter Six)

For both MFLC and Military OneSource participants, significant subgroup differences emerged by service member status for connections with outside support and services (see Table C6.1 for MFLC and Table C6.2 for Military OneSource). Compared to family members, service members were more likely to agree or strongly agree with the statement “My counselor connected me to outside support and services” (73 percent compared to 80 percent for MFLC; 60 percent compared to 68 percent for Military OneSource, respectively). We also observed subgroup differences by whether the MFLC counselor was embedded in the unit (see Table C6.3) and by service member status for Military OneSource participants (see Table C6.4) who responded to the statement that “My counselor [or Military OneSource call center] followed up with me to make sure I was able to connect with the outside supports and services they recommended.”

Table C6.2

Perception of Connection to Services Among Military OneSource Participants

Subgroup	Strongly Agree (%)	Agree (%)	Neither Agree nor Disagree (%)	Disagree or Strongly Disagree (%)
Service member status				
Family member	39.8	20.6	21.0	18.6
Service member	47.7	20.1	18.0	14.2

NOTE: $N=1,488$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Table C6.3

Satisfaction with Follow-Up Among MFLC Participants

Subgroup	Very Satisfied (%)	Satisfied (%)	Neither Satisfied nor Dissatisfied (%)	Dissatisfied or Very Dissatisfied (%)
Counselor embedded				
Yes	65.5	19.8	10.2	4.5
No	56.2	23.5	13.8	6.5

NOTE: $N=1,448$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Table C6.4

Satisfaction with Follow-Up Among Military OneSource Participants

Subgroup	Very Satisfied (%)	Satisfied (%)	Neither Satisfied nor Dissatisfied (%)	Dissatisfied or Very Dissatisfied (%)
Service member status				
Family member	49.1	31.9	12.2	6.8
Service member	56.8	28.5	9.6	5.1

NOTE: $N=1,587$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Subgroup Differences in Non-Medical Counseling Experience (Chapter Seven)

Ease of Making Appointments That Fit with Participant Schedule

When asked about the extent to which they felt they were able to make appointments with the counselor so that it fits their schedule, we observed a significant difference among MFLC participants whose counselors were embedded in their unit (see Table C7.1).

Table C7.1
Ease of Making Appointments Among MFLC Participants

Subgroup	Strongly Agree (%)	Agree (%)	Neither Agree nor Disagree (%)	Disagree or Strongly Disagree (%)
Counselor embedded				
Yes	83.8	13.3	1.6	1.3
No	76.9	18.6	2.4	2.1

NOTE: $N=2,328$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Table C7.2
Continuity of Care Satisfaction for MFLC Participants

Subgroup	Very Satisfied (%)	Satisfied (%)	Neither Satisfied nor Dissatisfied (%)	Dissatisfied or Very Dissatisfied (%)
Counselor embedded				
Yes	76.3	17.2	3.9	2.5
No	69.2	21.8	5.4	3.6

NOTE: $N=1,969$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Table C7.3
Continuity of Care Satisfaction for Military OneSource Participants

Subgroup	Very Satisfied (%)	Satisfied (%)	Neither Satisfied nor Dissatisfied (%)	Dissatisfied or Very Dissatisfied (%)
Presenting problem				
Child issues	44.7	39.2	10.4	5.8
Deployment concerns	79.9	16.4	2.5	1.2
Education or employment	65.1	27.3	5.1	2.6
Family or relationship	61.4	29.7	5.9	3.0
Loss or grief	64.3	27.8	5.3	2.7
Stress, anxiety, or emotional problems	62.5	29.0	5.6	2.9

NOTE: $N=2,184$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Continuity of Care

We observed that MFLC participants whose counselor was embedded in their unit were more likely to report being very satisfied with continuity of care, relative to those whose counselors were not embedded (see Table C7.2). Among Military OneSource participants, there was a significant difference in continuity of care in presenting problem (see Table C7.3).

Table C7.4
Recommendation of Military OneSource Services

Subgroup	Highly Likely (%)	Likely (%)	Neither Likely or Unlikely (%)	Unlikely and Very Unlikely (%)
Service member status				
Family member	80.5	13.9	3.6	2.1
Service member	86.0	10.2	2.5	1.4

NOTE: $N=2,426$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Table C8.1
Level of Satisfaction with Counselor Level of Professionalism Among MFLC Participants, Wave 1

Subgroup	Very Satisfied (%)	Satisfied (%)	Neither Satisfied nor Dissatisfied (%)	Dissatisfied or Very Dissatisfied (%)
Counselor embedded				
No	77.9	17.7	2.5	1.9
Yes	83.8	13.3	1.7	1.3

NOTE: $N=2,202$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Recommendation of Program to Others

We noted significant differences in the likelihood of recommending Military OneSource services by service member status (see Table C7.4).

Subgroup Differences in Perceptions of Non-Medical Counselors (Chapter Eight)

Professionalism

Respondents were asked if their counselors showed interest in their concerns or questions. Among MFLC participants, we observed a significant difference by subgroup when asked about their satisfaction with their counseling staff's level of professionalism (see Table C8.1). We observed a significant difference among Military OneSource participants by service member status and gender (see Table C8.2).

Communication

Respondents were asked the extent that they agreed that their counselor listened to them carefully. Significant subgroup differences were observed among Military OneSource participants in officer status and gender (see Table C8.3)

Table C8.2**Counselor Showed Interest in Questions and Concerns Among Military OneSource Participants, Wave 1**

Subgroup	Strongly Agree (%)	Agree (%)	Neither Agree nor Disagree (%)	Disagree or Strongly Disagree (%)
Service member status				
Family member	66.1	29.0	2.5	2.3
Service member	71.7	24.5	2.0	1.8
Gender				
Women	72.2	24.1	1.9	1.8
Men	66.3	28.8	2.5	1.4

NOTE: $N=2,540$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Table C8.3**Level of Agreement That Counselor Listened Carefully; Military OneSource**

Subgroup	Strongly Agree (%)	Agree (%)	Neither Agree nor Disagree (%)	Disagree or Strongly Disagree (%)
Rank (self or sponsoring family member)				
Enlisted	68.1	27.4	2.3	2.1
Officer	73.3	23.2	1.8	1.6
Gender				
Women	72.0	23.7	2.0	2.3
Men	65.5	28.8	2.6	3.1

NOTE: $N=2,538$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Information Was Explained in a Way That Was Easy to Understand

Respondents reported the extent to which they agreed that information was explained to them in a way that made it easy for them to understand. Among MFLC participants, we observed a significant difference whether or not the counselor was embedded in their unit (see Table C8.4). We observed a significant difference among Military OneSource participants by service member status and gender (see Table C8.5).

Left Counselor's Office with Questions Answered

Respondents reported their perceived level of counselor adequacy in addressing participant issues or concerns by session completion. We observed significant differences across Military OneSource service member status subgroups and Military OneSource gender subgroups (see Table C8.6).

Table C8.4**Level of Agreement That Information Was Explained in a Way That Was Easy to Understand Among MFLC Participants, Wave 1**

Subgroup	Strongly Agree (%)	Agree (%)	Neither Agree nor Disagree (%)	Disagree or Strongly Disagree (%)
Embedded in unit				
Not embedded	79.8	16.8	2.2	1.2
Embedded	85.3	12.4	1.5	0.8

NOTE: $N=2,367$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Table C8.5**Level of Agreement That Information Was Explained in a Way That Was Easy to Understand Among Military OneSource Participants, Wave 1**

Subgroup	Strongly Agree (%)	Agree (%)	Neither Agree nor Disagree (%)	Disagree or Strongly Disagree (%)
Service member status				
Family member	62.0	30.4	4.8	3.0
Service member	68.6	25.6	3.6	2.2
Gender				
Women	68.9	25.3	3.6	2.1
Men	62.7	29.9	4.6	2.8

NOTE: $N=2,524$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Table C8.6**Level of Agreement That Counselor Answered Questions Among Military OneSource Participants**

Subgroup	Strongly Agree (%)	Agree (%)	Neither Agree nor Disagree (%)	Disagree or Strongly Disagree (%)
Service member status				
Family	57.1	28.3	9.7	4.8
Service member	64.1	24.6	7.6	3.7
Gender				
Women	64.6	24.3	7.5	4.5
Men	57.6	28.1	9.6	4.8

NOTE: $N=2,497$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Table C8.7**Perceived Cultural, Language, and Religious Competence Among Military OneSource Participants**

Subgroup	Strongly Agree (%)	Agree (%)	Neither Agree nor Disagree (%)	Disagree or Strongly Disagree (%)
Rank (self or sponsoring family member)				
Enlisted	43.7	30.7	19.2	6.4
Officer	51.2	28.5	15.5	4.8

NOTE: $N=1,450$. All results are adjusted for covariates and represent averaged fitted probabilities across the imputed datasets to account for item non-response.

Cultural Competency

Respondents reported their level of agreement with the statement that “My counselor addressed my cultural, language or religious concerns.” A significant difference in the responses to this question was observed by rank for Military OneSource participants (see Table C8.7).

Abbreviations

DoD	Department of Defense
EAP	employee assistance programs
MC&FP	Military Community and Family Policy
MFLC	Military and Family Life Counseling
ODASD (MC&FP)	Office of Deputy Assistant Secretary of Defense for Military Community and Family Policy
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OSD	Office of the Secretary of Defense
PTSD	posttraumatic stress disorder

References

- American Psychological Association Presidential Task Force on Military Deployment Services for Youth, Families and Service Members, *The Psychological Needs of U.S. Military Service Members and Their Families: A Preliminary Report*, Washington, D.C., 2007.
- Bowles, Stephen V., and Mark J. Bates, "Military Organizations and Programs Contributing to Resilience Building," *Military Medicine*, Vol. 175, No. 6, 2010, pp. 382–385.
- "CAHPS Surveys and Guidance," *Agency for Healthcare Research and Quality*, February 2017. As of August 1, 2017: <http://www.ahrq.gov/cahps/surveys-guidance/index.html>
- Castro, Carl A., Sara Kintzle, and Anthony M. Hassan, "The Combat Veteran Paradox: Paradoxes and Dilemmas Encountered with Reintegrating Combat Veterans and the Agencies That Support Them," *Traumatology*, Vol. 21, No. 4, 2015, pp. 299–310.
- Chandra, Anita, Sandraluz Lara-Cinisomo, Lisa Jaycox, Terri L. Tanielian, Bing Han, Rachel M. Burns, Teague Ruder, "Views from the Homefront: How Military Youth and Spouses Are Coping with Deployment," Santa Monica, Calif.: RAND Corporation, EP-201000-67, 2011. As of August 1, 2017: http://www.rand.org/pubs/research_briefs/RB9568.html
- Clavelle, Paul R., Shirley J. Dickerson, and Margaret Welch Murphy, "Counseling Outcomes at a U.S. Department of Defense Employee Assistance Program," *Journal of Workplace Behavioral Health*, Vol. 27, No. 3, 2012, pp. 127–138.
- Clemens, Elysia V., and Amy S. Milsom, "Enlisted Service Members' Transition into the Civilian World of Work: A Cognitive Information Approach," *Career Development Quarterly*, Vol. 56, No. 3, 2008, pp. 246–256.
- Collins, Jill, Alison Gibson, Sarah Parkin, Rosemary Parkinson, Diana Shave, and Colin Dyer, "Counselling in the Workplace: How Time-Limited Counselling Can Effect Change in Well-Being," *Counselling and Psychotherapy Research*, Vol. 12, No. 2, 2012, pp. 84–92.
- Cozza, Stephen J., Jennifer M. Guimond, Jodi B. A. McKibben, Ryo S. Chun, Teresa L. Arata-Maiers, Brett Schneider, Alan Maiers, Carol S. Fullerton, and Robert J. Ursano, "Combat-Injured Service Members and Their Families: The Relationship of Child Distress and Spouse-Perceived Family Distress and Disruption," *Journal of Traumatic Stress*, Vol. 23, No. 1, 2010, pp. 112–115.
- Csiernik, Rick, "The Glass Is Filling: An Examination of Employee Assistance Program Evaluations in the First Decade of the New Millennium," *Journal of Workplace Behavioral Health*, Vol. 26, No. 4, 2011, pp. 334–355.
- Danish, Steven J., and Bradley J. Antonides, "What Counseling Psychologists Can Do to Help Returning Veterans," *Counseling Psychologist*, Vol. 37, No. 8, 2009, pp. 1076–1089.
- Davis, Jennifer, David B. Ward, and Cheryl Storm, "The Unsilencing of Military Wives: Wartime Deployment Experiences and Citizen Responsibility," *Journal of Marital and Family Therapy*, Vol. 37, No. 1, 2011, pp. 51–63.
- Defense Manpower Data Center, *June 2012 Status of Forces Survey of Active Duty Members: Tabulations of Responses*, Alexandria, Va., Report 2012-058, 2012.

———, *2015 Demographics Profile of the Military Community*, Washington, D.C., 2016. As of November 29, 2016: <http://download.militaryonesource.mil/12038/MilitaryOneSource/Reports/2015-Demographics-Report.pdf>

Denning, Laura Aiuppa, Marc Meisnere, and Kenneth E. Warner, *Preventing Psychological Disorders in Service Members and Their Families: An Assessment of Programs*, Washington, D.C.: National Academies Press, 2014.

Dickerson, Shirley J., Margaret W. Murphy, and Paul R. Clavelle, "Work Adjustment and General Level of Functioning Pre- and Post-EAP Counseling," *Journal of Workplace Behavioral Health*, Vol. 27, No. 4, 2012, pp. 217–226.

Eskin, Vivian, "Ladies in Waiting: A Group Intervention for Families Coping with Deployed Soldiers," *International Journal of Group Psychotherapy*, Vol. 61, No. 3, 2011, pp. 415–437.

Gambardella, Lucille C., "Role-Exit Theory and Marital Discord Following Extended Military Deployment," *Perspectives in Psychiatric Care*, Vol. 44, No. 3, 2008, pp. 169–174.

Gibbs, Deborah A., A. Monique Clinton-Sherrod, and Ruby E. Johnson, "Interpersonal Conflict and Referrals to Counseling Among Married Soldiers Following Return from Deployment," *Military Medicine*, Vol. 177, No. 10, 2012, pp. 1178–1183.

Hassan, Anthony M., Robert J. Jackson, Douglas R. Lindsay, and Michael G. Rank, "Combat Stress Control and Prevention: What Can Be Learned from an Application of Workplace Behavioral Health in a Deployed Combat Environment?," *Journal of Workplace Behavioral Health*, Vol. 25, No. 3, 2010, pp. 169–180.

Hosek, James R., Jennifer Kavanagh, and Laura L. Miller, *How Deployments Affect Service Members*, Santa Monica, Calif.: RAND Corporation, MG-432, 2006. As of August 1, 2017: <http://www.rand.org/pubs/monographs/MG432/>

Hudak, Ronald P., Christine Morrison, Mary Carstensen, James S. Rice, and Brent R. Jurgensen, "The U.S. Army Wounded Warrior Program (AW2): A Case Study in Designing a Non-Medical Case Management Program for Severely Wounded, Injured, and Ill Service Members and Their Families," *Military Medicine*, Vol. 174, No. 6, 2009, pp. 566–571.

Karney, Benjamin R., and Thomas E. Trail, "Associations Between Prior Deployments and Marital Satisfaction Among Army Couples," *Journal of Marriage and Family*, Vol. 79, No. 1, 2017, pp. 147–160.

Koenig, Christopher J., Shira Maguen, Jose D. Monroy, Lindsay Mayott, and Karen H. Seal, "Facilitating Culture-Centered Communication Between Health Care Providers and Veterans Transitioning from Military Deployment to Civilian Life," *Patient Education and Counseling*, Vol. 95, No. 3, 2014, pp. 414–420.

Kostick, Karen M., "From V Codes to Z Codes: Transitioning to ICD-10 (Updated)," *Journal of AHIMA*, Vol. 82, No. 11, 2011, pp. 60–63.

Lara-Cinisomo, Sandraluz, Anita Chandra, Lisa H. Jaycox, Terri Tanielian, Rachel M. Burns, Teague Ruder, and Bin Han, "A Mixed-Method Approach to Understanding the Experiences of Non-Deployed Military Caregivers," *Maternal and Child Health*, Vol. 16, No. 2, 2011, pp. 374–384.

McLeod, John, "The Effectiveness of Workplace Counselling: A Systematic Review," *Counselling and Psychotherapy Research*, Vol. 10, No. 4, 2010, pp. 238–248.

Meadows, Sarah O., Terri L. Tanielian, and Benjamin R. Karney, *The Deployment Life Study : longitudinal analysis of military families across the deployment cycle*, Santa Monica, Calif.: RAND Corporation, RR-1388-A, 2016. http://www.rand.org/pubs/research_reports/RR1388.html

Meredith, Lisa S., Cathy Donald Sherbourne, Sarah Gaillot, Lydia Hansell, Hans V. Ritschard, Andrew M. Parker, and Glenda Wrenn, *Promoting Psychological Resilience in the U.S. Military*, Santa Monica, Calif.: RAND Corporation, MG-996, 2011. As of August 1, 2017: <http://www.rand.org/pubs/monographs/MG996.html>

Miller, Laura L., and Eyal Aharoni, *Understanding Low Survey Response Rates Among Young U.S. Military Personnel*, Santa Monica, Calif.: RAND Corporation, RR-881-AF, 2015. As of August 1, 2017: http://www.rand.org/pubs/research_reports/RR881.html

Mrazek, Patricia J., and Robert J. Haggerty, eds., *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research*, Washington, D.C.: National Academy Press, 1994. As of August 1, 2017: <https://www.ncbi.nlm.nih.gov/books/NBK236319/>

Pemberton, Joy R., Teresa L. Kramer, Joaquin Borrego Jr., and Richard R. Owen, "Kids at the VA? A Call for Evidence-Based Parenting Interventions for Returning Veterans," *Psychological Services*, Vol. 10, No. 2, 2013, pp. 194–202.

Ready Resilient, homepage, November 30, 2016. As of August 1, 2017:
<http://www.army.mil/readyandresilient/>

Rentz, E. Danielle, Stephen W. Marshall, Dana Loomis, Carri Casteel, Sandra L. Martin, and Deborah A. Gibbs, "Effect of Deployment on the Occurrence of Child Maltreatment in Military and Nonmilitary Families," *American Journal of Epidemiology*, Vol. 165, No. 10, 2007, pp. 1199–1206.

Richmond, Melissa K., Fred C. Pampel, Randi C. Wood, and Ana P. Nunes, "The Impact of Employee Assistance Services on Workplace Outcomes: Results of a Prospective, Quasi-Experimental Study," *Journal of Occupational Health Psychology*, Vol. 22, No. 2, 2017, pp. 170–179.

Rubin, Donald B., *Multiple Imputation for Nonresponse in Surveys*, New York: John Wiley and Sons, 1987.

Ryan, Gery W., and H. Russell Bernard, "Techniques to Identify Themes," *Field Methods*, Vol. 15, No. 1, 2003, pp. 85–109.

Sandoz, Emily K., Danielle N. Moyer, and Aaron P. Armelie, "Psychological Flexibility as a Framework for Understanding and Improving Family Reintegration Following Military Deployment," *Journal of Marital and Family Therapy*, Vol. 41, No. 4, 2015, pp. 495–507.

Schafer, Joseph L., "Multiple Imputation: A Primer," *Statistical Methods Medical Research*, Vol. 8, No. 1, 1999, pp. 3–15.

Sherman, Michelle, and Ursula Bowling, "Challenges and Opportunities for Intervening with Couples in the Aftermath of the Global War on Terrorism," *Journal of Contemporary Psychotherapy*, Vol. 41, No. 4, 2011, pp. 209–217.

Snyder, Douglas K., Molly F. Gasbarrini, Brian D. Doss, and David M. Scheider, "Intervening with Military Couples Struggling with Issues of Sexual Infidelity," *Journal of Contemporary Psychotherapy*, Vol. 41, No. 4, 2011, pp. 201–208.

Sörensen, Silvia, Martin Pinquart, and Paul Duberstein, "How Effective Are Interventions with Caregivers? An Updated Meta-Analysis," *Gerontologist*, Vol. 42, No. 3, 2002, pp. 356–372.

Tanielian, Terri L., Benjamin R. Karney, Anita Chandra, and Sarah O. Meadows, *The Deployment Life Study: A Methodological Overview and Baseline Sample Description*, Santa Monica, Calif.: RAND Corporation, RR-209, 2014. As of August 1, 2017:
https://www.rand.org/pubs/research_reports/RR209.html

Taranowski, Chester J., and Kathleen M. Mahieu, "Trends in Employee Assistance Program Implementation, Structure, and Utilization, 2009 to 2010," *Journal of Workplace Behavioral Health*, Vol. 28, No. 3, 2013, pp. 172–191.

Trail, Thomas E., Sarah O. Meadows, Jeremy N. Miles, and Benjamin R. Karney, "Patterns of Vulnerabilities and Resources in U.S. Military Families," *Journal of Family Issues*, June 30, 2015.

U.S. Department of Defense, Department of Defense Directive 5124.02, Washington, D.C., June 23, 2008.

———, *Report of the 2nd Quadrennial Quality of Life Review*, Washington, D.C., 2009.

———, Department of Defense Instruction 6490.06, Washington, D.C., April 21, 2009.

Venables, W. N., and B. D. Ripley, *Modern Applied Statistics with S-PLUS*, 4th ed., New York: Springer, 2002.

Weinick, Robin M., Ellen Burke Beckjord, Carrie M. Farmer, Laurie T. Martin, Emily M. Gillen, Joie D. Acosta, Michael P. Fisher, Jeffrey Garnett, Gabriella C. Gonzalez, Todd C. Helmus, Lisa Jaycox, Kerry A. Reynolds, Nicholas Salcedo, and Deborah M. Scharf, *Programs Addressing Psychological Health and Traumatic Brain Injury Among U.S. Military Service Members and Their Families*, Santa Monica, Calif.: RAND Corporation, TR-950, 2011. As of August 1, 2017:
http://www.rand.org/pubs/technical_reports/TR950.html

Weiss, Eugenia L., Jose E. Coll, Jennifer Gerbauer, Kate Smiley, and Ed Carillo, "The Military Genogram: A Solution-Focused Approach for Resiliency Building in Service Members and Their Families," *Family Journal*, Vol. 18, No. 4, 2010, pp. 395–406.

Werber, Laura, Margaret C. Harrell, Danielle M. Varda, Kimberly Curry Hall, Megan K. Beckett, and Stefanie A. Stern, *Deployment Experiences of Guard and Reserve Families: Implications for Support and Retention*, Santa Monica, Calif.: RAND Corporation, MG-645, 2008. As of August 1, 2017: <http://www.rand.org/pubs/monographs/MG645/>

Westwood, Marvin J., Holly McLean, Douglas Cave, William Borgen, and Paul Slakov, "Coming Home: A Group-Based Approach for Assisting Military Veterans in Transition," *Journal for Specialists in Group Work*, Vol. 35, No. 1, 2010, pp. 44–68.

Wolchik, Sharlene A., Irwin N. Sandler, Roger E. Millsap, Brett A. Plummer, Shannon M. Greene, Edward R. Anderson, Spring R. Dawson-McClure, Kathleen Hipke, and Rachel A. Haine, "Six-Year Follow-Up of Preventive Interventions for Children of Divorce: A Randomized Controlled Trial," *Journal of the American Medical Association*, Vol. 288, No. 15, 2002, pp. 1874–1881.

World Health Organization, *Prevention of Mental Disorders: Effective Interventions and Policy Options: Summary Report*, Geneva, 2004. As of August 1, 2017: http://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf

This report evaluates two programs offered by the U.S. Department of Defense (DoD) that provide short-term, solution-focused counseling for common personal and family issues to members of the U.S. military and their families. These counseling services are collectively called *non-medical counseling* within the DoD and are offered through the Military and Family Life Counseling (MFLC) and Military OneSource programs. RAND's National Defense Research Institute was asked to evaluate these programs to determine whether they are effective in improving outcomes and whether effectiveness varies by problem type and/or population. Two online surveys were provided to program participants—the first two to three weeks after their initial session and the second three months later. Surveys were designed to gain information on 1) problem severity and overall problem resolution, 2) resolution of stress and anxiety, 3) problem interference with work and daily life, 4) connection to other services and referrals, 5) experiences with MFLC and Military OneSource programs, and 6) perceptions of non-medical counselors. The majority of participants experienced a decrease in problem severity and a reduction in reported frequency of feeling stressed or anxious as a result of their problem following counseling. These improvements were sustained or continued to improve in the three months after the initiation of counseling. Non-medical counseling was not universally successful, however, and a small minority expressed dissatisfaction with the program or their counselor. Collectively these findings suggest a number of policy implications and programmatic improvements of interest to program leadership in the Office of the Secretary of Defense.



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