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Implementation of Empirically Validated Interventions in Managed Care Settings: The Premarital Relationship Enhancement Program (PREP)

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Abstract

In an age of managed care, how does the clinician best help couples in marital distress? Do the short-term protocols developed and tested in the laboratory really work in the average clinical setting? This project examined the feasibility and effectiveness of implementing a laboratory-based program designed to prevent the development of relationship distress within a health maintenance organization. Both men and women reported high satisfaction with the program and a subjective sense that it was helpful for their relationships. Specific suggestions are made for assisting therapists in using effective treatments for couples in managed care settings.

Implementation of Empirically Validated Interventions in Managed Care Settings:

The Premarital and Relationship Enhancement Program (PREP)

Many couples and family therapists are facing new challenges to treating relationship problems within the pervasive managed care model. The model typically emphasizes prevention, coordination of treatment across levels of care, and implementation of innovative and shorter-term treatments for patients. While these characteristics are designed to enhance patient care, some mental health care professionals have expressed concern that the emphasis on cost reduction in managed care settings will actually compromise quality of care (Miller, 1996).

In order to provide effective treatments for couples at lower costs, two important steps must be followed. First, controlled outcome studies must be conducted in order to identify treatments for couples that are efficacious. Second, these empirically-validated laboratory programs must be implemented and evaluated in clinical settings. There are a number of differences between laboratory interventions and more typical clinical interventions that may reduce the clinical effectiveness of treatments, including client characteristics (e.g., research participants often have only one diagnosis, have higher socioeconomic status, and are more homogeneous than patients in clinical populations), clients' motivation (i.e., those who choose to be a participant in a research study may be very different from those who come to a clinic for help), therapists' characteristics (professional therapists often have less training in the specific technique, heavier caseloads and less time than university-based therapists), and therapy characteristics (therapy in clinical settings is often less focused and monitored than in laboratory settings; for an extended discussion, see Weisz & Weiss, 1993). Implementation in clinical settings may therefore require a good deal of flexibility in conducting the treatment, which may have implications for the effectiveness of the intervention in the new setting.

The Relationship Enhancement and Prevention Project

The purpose of the Relationship Enhancement and Prevention Project was twofold. First, it was to examine the feasibility of disseminating a program designed and tested in a controlled laboratory setting to a health maintenance organization (Kaiser Permanente, in Los Angeles). Throughout the project, the process of obtaining referrals and implementing the program within a managed care setting was carefully noted to evaluate feasibility. The second purpose was to evaluate the success of the program, by collecting data about the clients' satisfaction with the treatment program.

The Premarital and Relationship Enhancement Program (PREP; see Markman, Floyd, Stanley, & Lewis, 1986) was selected as the treatment program for several reasons. First, PREP provides educational training designed to enhance couples' relationships before they are distressed or when they are only mildly distressed in order to prevent future decline and divorce; this fit in well with Kaiser Permanente's emphasis on preventive care. It conserved valuable individual treatment hours in treating the present couples and eventually may prevent referrals for more serious relationship problems. Second, it filled an important need in the department, where relationship problems have been among the most frequent referral complaints for many years. Third, PREP has been empirically tested in the laboratory and shows some promising results (see next paragraph for a description of results). Fourth, PREP training materials are available, including a weekend workshop, a leader's manual, and materials for conducting the program such as videotapes (with demonstrations with actual couples), couples' manuals, and overheads. Finally, PREP is a short-term, preventive intervention and easily adapted to a Saturday model, one which Kaiser was very interested in using. A more thorough description of PREP and the advantages of premarital prevention follows.

PREP is one of the most promising empirically examined programs to date. It is a 15-hour program designed to teach couples communication and problem-solving skills, clarifying and sharing expectations, and sensual enhancement. In a study that compared engaged couples randomly selected to receive PREP to control couples, couples who participated in PREP reported significantly higher relationship satisfaction 18 months later; three years later, they reported significantly higher sexual satisfaction, less intense marital problems, and higher relationship satisfaction than couples who did not receive the treatment (Markman, Floyd, Stanley & Storaasli, 1988). Five years after the intervention, PREP couples reported more positive and fewer negative communication skills and less marital violence than control couples (Markman, Renick, Floyd, & Clements, 1993).

Implementation of PREP at Kaiser Permanente not only fills a need for the HMO, but will also allow us to determine how easily PREP can be disseminated to clinical settings and whether it will be effective in those settings. Another distinct advantage of implementing PREP at Kaiser Permanente in Los Angeles is that the client population is at much higher risk demographically than couples who typically receive counseling in the community. Thus it will allow us to test whether the program is as effective for the couples with demographic risk variables (e.g., lower socio-economic status, lower education level) as it has been for couples who do not have such risk factors.

Referrals for the program came through the triage model in use in the Department of Psychiatry. Whenever a couple called for relationship counseling, the triage person determined their relationship status. If they were seriously dating, engaged, or married less than one year, they were referred to the Engaged/Newlywed Couples Group. Referrals for the program were also requested from practitioners in the Departments of Psychiatry, Obstetrics and Gynecology, and Family Practice at Kaiser Permanente in Los Angeles[1]. The program was also advertised at another Kaiser site. All patients who participated were referred by the Department of Psychiatry at Kaiser Sunset. Identified couples were screened by telephone to ensure that they were not married for more than one year. Subjects were offered the program at no fee in exchange for research participation.

Participants referred to the program via triage or other clinicians were screened by telephone to insure that they were seriously dating, engaged, or newlywed (married less than one year). If the client had been seen in the department previously, the folder was screened to insure the client had no serious mental disorders that would preclude him or her from participating in the group. To date, two programs have been run at Kaiser Permanente, with 22 total participants. Couples participated in a 2 or 3-session program based on the Premarital Relationship Enhancement Program (PREP). Sessions were led by two leaders, one of whom attended the weekend leader-training workshop offered by the original developers of the program (Markman and his colleagues). The second leader was trained by the first, using the materials provided at the workshop. Topics covered in the sessions were: danger signs for future problems, communication and problem-solving skills, clarifying and sharing beliefs and expectations, how to keep the fun alive in a relationship, ground rules to follow for a successful relationship, identifying deeper issues the underlie conflicts, maintaining friendship, sensual enhancement, forgiveness and commitment. The first group was conducted for 8 hours on a Saturday with two 2-hour follow-up sessions on weekday evenings about one week apart. The second group was conducted for 9 hours on a Saturday with one 2½-hour follow-up session on a weekday evening about a week later. Participants completed questionnaires during the first half hour of the first session and during the last half hour of the final session.

Participants completed a program evaluation form immediately following the intervention. This form asked spouses to rate the usefulness of different topics (e.g., problem-solving techniques) and different aspects (e.g., roleplays) of the program on a 10-point scale. Four opened-ended questions were also included: "What did you like best about the program," "What did you find least helpful about the program," "Are there any other topics you would have liked to have addressed in the program," and "Any suggestions for making the program more useful for you?"

Preliminary results of couples' evaluations of the program can be seen in Figures 1 and 2. Couples were asked to rate the twelve content areas covered by the program by how useful they found them (Figure 1). Generally, usefulness ratings were very high, with mean ratings ranging from 7.17 to 8.83 for women and 8.33 to 9.67 for men on a 10-point scale where 1 represented "not at all useful" and 10 represented "very useful". Both men and women rated communication skills training as the most useful of the content areas. Men also rated problem-solving skills training very highly, while women found sensuality and sexuality training very useful. The content areas that were rated the lowest in usefulness were danger signs (exploring potential danger signs for relationships) for women and relationship expectations, fun (how to keep the fun alive in relationships), and ground rules (basic rules for relationship behavior) for men.

Couples were also asked to rate the various techniques used for conveying the information. These included videotaped lectures and examples of real couples on videotape, presentations by the therapists, roleplay exercises, in-session practice, and homework assignments. Preliminary findings can be seen on Figure 2. Again, usefulness rating were generally very high (Ms ranged from 7.5 to 9.5 for men and from 6.7 to 8.7 for women). Men and women found the therapists' presentations and in-session exercises the most useful. Men found the homework the least useful of all the techniques, whereas women found the videotaped lectures to be the least useful.

When asked what couples liked best about the programs, participants identified the leaders (their lectures, insights, competence, and feedback), the identification of important relationship issues and problems, specific techniques (especially communication skills) and practicing the skills with their partners during the program. When asked what they liked least about the program, several couples identified "nothing," though others identified the videotaped lectures and examples, not enough time devoted to practicing with their partner, and the presentation being "too scripted." When asked if they had any suggestions for making the program more useful for them, couples identified more individual counseling by program leaders, more frequent availability of program, and more interaction between and couples and the leaders.

Implementation issues and suggestions

While the philosophy of Kaiser is one that supports and encourages integrated care, marketing the program to other departments and facilities proved challenging. Though everyone (physicians, nurses, social workers, etc.) who heard about the program appeared very enthusiastic, there was no centralized structure to present material about the program to staff across departments. The somewhat fragmented structure of the organization limited effective interdepartmental advertising for and referral to programs such as PREP. In fact, all the referrals to date have come from within the Department of Psychiatry, either through triage or from other clinicians. It seems likely, however, that initial relationship difficulties may often come to the attention of primary care physicians and nurses first. Thus, increasing the awareness of the program across departments is critical to successfully implementing a truly preventive program. As advertising in individual departments has proven ineffective in the Kaiser model, higher-level administrative support may be necessary to effectively market the program to other professionals. Administrative support may be even more necessary within other managed care models, where, unlike at Kaiser, patients' physical health care and mental health care take place at different facilities.

Leader training. One potential obstacle to the ongoing implementation of programs such as PREP is the training needed for the leaders. Managed care settings and the individual therapists who conduct these programs may be less motivated to do so if on-site training is required. Programs might be more successfully implemented with the use of self-teaching manuals that do not require the time and money that on-site training requires. Feedback given by clients in the current study indicate that the standardization of programs, while useful for insuring that they are conducted in the same way is in the laboratory, may not have clinical utility. In the current study, participants clearly found the structured part of the intervention (i.e.,

videotaped lectures and examples, overheads, etc.) the least helpful. Rather, participants felt they benefitted the most from individual attention from the clinician, and the clinician's expertise and experience with the various problems that were addressed.

Drop out. About half of those who attended the Engaged/Newlywed Couples Group at Kaiser missed at least one session. Our subjective impression from talking to the couples was that scheduling was the primary difficulty. Therefore, the program was modified from 3 sessions to two longer sessions, but no change in drop out rates occurred. One possibility is to conduct the entire intervention in one day, and offer it more frequently. This would prevent scheduling problems for the follow-up sessions, but would require shortening or eliminating parts of the program.

Programs need to be consistent with the needs of the population being served. Though prevention is clearly valued by Kaiser, the need to respond to patients who are in crisis can severely limits professionals' time to engaged in preventive therapy. Clearly patients who are in severe distress, or couples who are experiencing extremely conflict must take precedence over mildly distressed dating, engaged, or newlywed couples. Particularly when resources are limited, they must be allocated to tertiary care to meet the immediate needs of patients, making the delivery of programs like PREP a lower priority. Though implementation of program such as PREP may reduce that number in the future, the department still needs to respond to the needs of currently distressed couples. Therefore, to help insure the continued implementation of the Engaged/Newlywed Program, an additional couples group for distressed couples, based on the PREP model, has been initiated as well.

Need for flexibility. The HMO environment requires a great deal of flexibility in implementing new programs, making it difficult to maintain the integrity of the laboratory program. For example, we were unable to limit our program to engaged couples, as the population need and the needs of the department required that we respond to all those with young relationships who called for help. Thus we included dating couples and newlywed couples, and made the program available to gay and lesbian couples. The disadvantage of this is it restricts the generalizability of earlier efficacy findings to the program at Kaiser Permanente. The advantage, of course, is that this affords us the opportunity to examine the effectiveness of the program using a more heterogeneous sample.

Expanding services for couples who need it. Based on the suggestions made by the participant couples, it seems clear that some couples required more intensive treatment following the program. These couples appear to be able to self-identify as a result of the program, but may

also be identified by leaders based on interactions during the in-class exercises. Providing additional services for these couples either in the form of more interaction with the leaders during the program or through couples therapy may prove challenging if this is seen by the managed care facility as evidence that the preventive intervention is not working. Increasingly, however, evidence is emerging that follow-up or "booster" sessions as a part of the prevention intervention increases the long-term efficacy of the treatment (Hahlweg, Markman, Thurmaier, Engl, & Eckert, 1998). Therefore, the inclusion of such sessions as a normal part of the program from the onset may circumvent any problems with the managed care facility and provide a structure for distressed couples to get the extra attention they require.

Implications and Applications

Our experiences in implementing the PREP program at Kaiser Permanente highlight several general characteristics of the managed care model that may affect the successful implementation of laboratory-developed programs in managed care facilities. Characteristics of these facilities that make them settings particularly receptive to many laboratory-developed interventions include the emphasis on preventive, short-term, and efficacious treatment. Characteristics that create challenges for implementation include limited resources and the need to modify programs to better fit the needs and schedules of treatment providers and patient populations. In addition, managed care facilities that lack a centralized structure may also experience the difficulties in marketing and referrals encountered at Kaiser Permanente.

This paper also presents some initial findings regarding client satisfaction, though this is only the first step in determining the effectiveness of PREP in a clinical setting. Satisfaction ratings indicate that the program was well-received and seemed helpful to both the men and women who participated. There were some gender differences in identifying the least helpful aspects of the program, but the differences in actual ratings for these areas between men and women were minimal and all satisfaction and usefulness ratings were high (average ratings above 6.5 on a 10-point scale). Therefore, changes in program content do not seem warranted at this time; keeping the program content and methods diverse provides men and women the information and techniques they prefer.

While initial satisfaction and usefulness ratings are encouraging, additional data is needed to determine whether the program is actually effective in preventing future relationship distress and thereby reducing the need for couples therapy services (as well as related mental health and physical health problems) in the population. Toward this end, 6-month post-treatment follow-up data are being collected on participant couples, which will provide some evidence of the lasting effects of the intervention. Additional data is also needed to allow for comparison among ethnic groups.

The critical next step for this, and any program implemented in clinical settings, is to conduct long-term comparison studies and cost-benefit analyses to determine whether couples who participate in the program are less likely to use mental health services in the future, and whether the resulting savings outweighs the cost of providing the program. Given the importance of identifying effective, short-term, and preventive treatments to managed care facilities, it seems likely that such research is not only feasible, but is likely to receive institutional support. Possible methods for conducting such research include 1) long term follow-up of participants to evaluate program effectiveness over time and use of mental health services following the preventive intervention, 2) use of wait-list controls as comparison groups, 3) comparison of total number of couples counseling sessions at the managed care facility during periods before and after the preventive intervention is implemented, and 4) cost comparisons between the prevention program and typical tertiary interventions.

As a result of our experiences implementing PREP at Kaiser, the following general recommendations are made for the implementation of new programs in managed care settings.

Take advantage of the strengths of the managed care model. Prevention and innovative treatments are uniquely supported in the managed care environment, especially those that promise to treat problems that have traditionally required long-term, individual psychotherapy. Take advantage of this managed care philosophy in selecting and implementing you treatment protocol.

Be responsive to the needs of the patient population and the treatment team in the current setting. In these days of heavy client loads, be aware of how your program will affect the clinical staff. Administrators and fellow clinicians are going to be much more open to a program that has the potential to alleviate the often heavy workloads many professionals experience than one that will add to those workloads. In addition, those who market the managed care system will support protocols that can be shown to address a demonstrated need of the population they are marketing to. One way to identify client needs is the frequency of referral complaints for different kinds of problems.

Be flexible during implementation. Managed care settings and client populations are often much more complex than those used for laboratory studies. You must be willing to revise the program to meet the current needs of the department and the patients. An important addendum to this, though, is to be sure to collect data regarding the effectiveness of the protocol in the current setting (such as client satisfaction and usefulness ratings of the program), once these changes are made. Collecting satisfaction and effectiveness data in particular clinical settings is important to ensure good treatment in that setting, and is an essential element for an overall strategy, along with efficacy trials, to improve the health care system in this country.

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Footnotes

[1]Kaiser Permanente in Los Angeles serves the Hollywood and Downtown areas. The populations in these areas include high percentages of ethnic minorities and people of lower socio-economic status than many of the more affluent areas in Los Angeles.

Figure Caption

Figure 1. Mens' and Womens' Satisfaction Ratings of Program Content.

Figure 2. Mens' and Women' Satisfaction Ratings of Program Techniques