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### **Developing an Outpatient Group Program in an Institutional Setting**

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Within today's mental health therapeutic practice environments, organizations are looking for the most effective way to deliver care to the greatest number of clients, because of increasing demand and in order to reduce costs. For these reasons, outpatient group therapy is staging a comeback from its rampant popularity in the 1960s and 1970s. From the client's perspective and from our experience, it is also true that many of the problems in living that clients face are interpersonally related and groups provide an opportunity for them to learn to establish more intimate connections. Hence, outpatient group therapy can be even more effective than individual therapy, in enhancing the quality of lives and even improving longevity, as in the case of cancer and heart disease patients.

However it is not easy to establish outpatient group programs that meet both organizational and client needs without research and planning. When attempting to implement group programs within medium to large organizational environments, we have found it is important to use a step-by-step, structured approach to establishing and maintaining programs (1). The following is a sequential compilation of strategies that we have found to be most useful in implementing successful groups within organizations. These strategies, with modification, may also be applied to small outpatient and inpatient programs. Following are 10 strategies to use in planning outpatient groups.

### **1. Demonstrate a clear administrative mandate to gain broad program**

**support.** A concrete mandate from an organization's administration is essential to a successful group program. This can be demonstrated through the organizational planning process. Therapeutic psychotherapy programs in an outpatient setting require concrete goals. In a clinic setting, management can foster the development of such programs by creating achievable annual goals for the type, number of groups, and number of patients seen in groups. A reasonable goal in the first year of creating an outpatient group therapy program is 20 percent of all patient visits to be scheduled. The maximum in any stage of development would be 40 percent. In larger networked organizations where management articulates the vision of an increased role for groups, clinicians have the advantage of working in teams, where they can educate other clinicians about the value of group treatment and can encourage colleagues to steer appropriate patients to the group process.

**2. Appoint a clinical group coordinator to serve as focal point for program design, implementation and evaluation.** Someone must serve as the focal point for all planning, marketing, and coordinating activity, otherwise the program will not get implemented, nor will it develop shape and direction. This becomes most important in medium-to-large treatment settings. A clinical practice has a real advantage over managed networks in developing a group psychotherapy program. The role of coordinator includes basic management tasks such as determining the needs for groups, establishing guidelines for referral, identifying group therapists, helping staff to prepare to lead groups, marketing groups, and measuring group effectiveness via pre- and post-group testing, and patient evaluation of groups.

**3. Improve quality of service through a population-based approach.** A population-based approach satisfies organizational and client needs, as well as meeting current best practice standards. Using this approach to develop groups identifies the main diagnostic groupings in the clinic's patient population and determines needs that could be met in the group format (2). Many outpatient clinics have been in the habit of establishing groups that reflect the interests of the therapists but do not represent the patients' needs. For example, although 50 percent of adult patients requesting services report depression or anxiety as a condition, a clinic may offer only a limited number of groups in these areas. Creating a group program based on the needs of the target population not only enhances the clinic's effectiveness and efficiency, but it contributes to the longevity of the clinic's funding and programs.

**4. Maintain client engagement in group therapy through group screening and orientation.** Group screening is often avoided in organizations due to either a real or perceived lack of time. However clinicians forget to consider how a lack of screening can adversely contribute to dropout rates. Orientation and screening should always be included in establishing groups. Before the group begins, the patient may be sent a letter describing what to expect in the group. This information may help reduce the patient's resistance to participating. Face-to-face screening again affords the clinician an opportunity to engage therapeutically with a patient's resistance to treatment and establishes the therapeutic bond. Orientation and screening can be done in either individual or group sessions. If groups are not a familiar mode of treatment for the population being served, research seems to suggest that it is best to begin with individual sessions.

According to Corey and Corey (3) the overwhelming consensus of considerable research on the value of pre-therapy preparation is that it seems to affect both early therapeutic processes and later client improvement. These authors mention several ways in which therapists can assist members become more informed about what behaviors are expected of them and thus become more successful as they participate in the group process. The authors also note that pre-group training helps to reduce anxiety for patients and group leaders, as well as helping group leaders to better organize themselves by setting goals and acting on them.

**5. Use clear referral criteria to select group members and to market the group.** When information about a group is conveyed solely by word of mouth, colleagues in an organization may have difficulty in making targeted referrals to select groups. This is why it is important to provide clearly written guidance about the programs being offered. This procedure not only helps reduce clinicians' resistance to making referrals, it promotes effective use of groups and increases the patients' acceptance of the referral.

A clearly written description of each group's purpose, content, goals and criteria for referral allows the referring clinician to begin orienting the patient at the time of the referral. By citing the written document, the explanation of why the patient is being referred for group is made more explicit and complete.

**6. Use regular status reports to provide information to the organization and help in marketing groups.** Marketing of groups should be a fundamental practice in outpatient settings. We cannot over-emphasize the importance of regular status reports that contain a frequently updated list of groups being offered as a significant tool in

accomplishing this goal. In a clinical practice, when referring clinicians are updated weekly about the dates and times groups meet and the number of openings available, they can make timely referrals. The status report reminds colleagues of the availability of groups and ultimately helps the group program grow and sustain itself. Information on the status report should also include the name and number of a contact person clinicians can call when they need pertinent and timely information about groups.

**7. Measure the group effectiveness through testing and evaluation.** Both clients and clinicians can benefit from measuring change in symptoms associated with the client's participation in a therapy group. Quality improvement cannot take place without such measurements. Pre- and post-group testing helps to clarify the client's response to treatment and allows clinicians and managers to follow in an objective way the progress of treatment. Demonstrating the effectiveness of groups is the best way to decrease resistance to group treatment and to increase referrals for the process within organizations. Many good reference books outlining evaluation measures are available today.

**8. Enhance the success of group programs through the use of varied treatment models.** When a group program relies on a variety of group models that match the needs of the population, it is more effective. These models may include approaches such as psycho-educational, social skills training, relapse prevention, cognitive-behavioral, interpersonal semi-structured, and process-oriented psychodynamic groups (4). Patients are more receptive to groups that are themed to match their own sense of the presenting problem. For clients with moderate to severe problems, the opportunity to repeat a group can reduce resistance to participation. One issue that often

goes neglected is the formation of reciprocal groups expressly for the treatment of children and family systems. Groups for children are more effective when a parent-training component exists and vice versa. Furthermore, in the case of all groups, a flexible- structured model that combines the interpersonal as well as cognitive and behavioral elements has been found to be more effective than rigid stereotypical formats because it allows for member interaction as well as group learning.

**9. Provide uniformity of execution and promote group acceptance in the organization through staff training.** An in-house training program for group leaders and referring clinicians will ultimately increase clinical effectiveness, create acceptance of overall acceptance of group therapy and hone the appropriateness of referrals. Training also promotes a learning culture. The experience of apprenticeship in which clinicians preparing to lead groups observe, assist, and are observed by practiced group leaders, is an efficient and time-honored training format. This training practice also fosters the development of a learning culture within an organization, in which colleagues can share the best of what they have learned with one another, thus improving the quality of care in the organization.

**10. Assure the program success by allocating adequate resources.** Three necessary resources for a successful group therapy program include: a) a benefit structure and fees that encourage the use of therapy groups (i.e., charging less for group sessions than for individual); b) adequate time for clinicians to develop and conduct groups; and c) adequate and appropriate physical space. When the benefit structure is equal for individual and group treatment, there is little incentive for clients to choose groups. When two-for-one benefit and fee structures are implemented for group over

individual treatment, this helps to promote group participation. Additionally, for a group program to be successful, group therapists must be given adequate time for planning, screening, session preparation and charting. Our experience suggests that allowing as much as eight hours for developing a new group can be advantageous. At least 30 minutes should be allotted for charting at the end of each group session. Finally, in developing a group program, designating appropriate physical space is crucial. In a clinic, lack of available rooms can significantly affect the number of groups offered, as well the personal comfort of group members if they are relegated to small congested spaces, thus not taking into consideration an anxious Axis I diagnosis, for example.

### **Conclusions**

Disorganized and poorly managed group therapy programs may create an even more detrimental effect on organizations than not implementing programs at all. When programs are poorly managed, clinicians eager to lead groups can become demoralized—especially if faced with low referrals, high patient resistance and a large amount of wasted time around the process of setting up the programs themselves. Groups without screening and orientation can lead to lower group attendance, higher drop out rates and poorer therapeutic outcomes. Group offerings that are not matched with target populations fall far short of best clinical practice guidelines and can threaten the very existence of organizations. On the other hand, the establishment of an organization-sanctioned and –recognized self-sustaining group program is greatly enhanced by the principles of good clinical practice. Thorough planning, clearly stated objectives, and careful structuring can build a solid and effective clinical outpatient group program through implementation of the ten strategies outlined above.

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## **References**

1. Crosby, G., & Sabin, J.E. (1996). A planning checklist for establishing time-limited groups. *Psychiatric Services, 47(1)*, 25-26.
2. Sabin, J.E. (1991). Clinical skills for the 1990s: Six lessons from HMO practice. *Hospital and Community Psychiatry, 45(5)*, 608.
3. Corey, M.S., & Corey, G. (2002). *Groups process and practice (6th ed., p. 115)*. Pacific Grove, CA: Brooks/Cole.
4. MacKenzie, R. (1997). *Time-limited group psychotherapy*. Washington, D.C.: American Psychiatric Press.