Group Appointments in Psychiatry+

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Introduction

In recent decades, the demand for treatment with psychotropic medications has increased faster than psychiatric clinicians (psychiatrists, psychiatric nurse practitioners, and physician assistants) have been trained to properly prescribe their use. Primary care settings have stepped up to respond to some of this demand, but access to timely psychiatric and medication-assisted substance abuse treatment is strained even in urban areas of the USA where specialty clinicians tend to congregate. Group medical appointments for patients with mental illness or substance use problems are a powerful treatment vehicle for combining medical and psychosocial treatments in an efficient and accessible format. Group appointments were once widespread as the focus of treatment for persons with severe psychiatric illness as they were rapidly shifted from state hospitals to community mental health centers following the development of Medicare, Medicaid, and social security disability benefits. The availability of more effective medications for psychiatric disorders allowed longer tenure in the community for many of these individuals (Stone 1993). Despite significant clinical evidence for their effectiveness, few prescribers currently run groups for their patients. Today, group psychotherapy is rarely part of psychiatric education. Despite this, as economics and clinician shortages create pressure for systems change, group medical visits as an alternative to individual appointments will likely be encouraged. As medical providers are pressured by systems and patient demand to see patients for a steady stream of relatively brief appointments, burnout is a threat. Longer group sessions in partnership with another member of the treatment team can be a relieving change of pace. Likewise, as mental health and primary care systems converge, group treatments offer an attractive and efficient option for people seeking care outside traditional behavioral health settings.

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History

In 1927 Pratt applied group treatment originally developed for tuberculosis patients in 1905 to patients with medically unexplained physical symptoms and found improved outcomes with

W. E. Sowers et al. (eds.), *Textbook of Community Psychiatry*,
https://doi.org/10.1007/978-3-031-10239-4_18

increased efficiency (Pratt 1953; Sabin 1990). Pratt incorporated a biopsychosocial model that included outreach, an interdisciplinary involvement, spirituality, relaxation, and meditation. Group psychotherapy became a prominent intervention in mental health services in England and the USA during World War II. In the period between the world wars, the effects of exposure to the traumas of war on both civilians and combatants came to be appreciated, and it was hoped that mental health services would reduce morbidity in both populations. However, the number of trained clinicians could not meet the demand for one to one treatment sessions, so group psychotherapy was attempted and proved to be helpful for many. After the war, theories of group psychotherapy reflected the overall dominance of psychoanalytic theory, but in psychiatric hospitals and within growing community mental health centers, the development of supportive and psychoeducational group therapy continued. In 1970 Yalom (1970) identified ten curative factors resulting from group therapy:

- Imparting of information
- Instillation of hope
- Universality
- Altruism
- The corrective recapitulation of the primary family group
- Development of socializing techniques
- Imitative behavior
- Interpersonal learning
- Group's cohesiveness
- Catharsis

Although there are a variety of formats used for group therapy, and some variability in structure and emphasis, most groups do incorporate some or all of these curative factors, including the medication management groups that will be the focus of discussion in this chapter.

Since the establishment of Alcoholics Anonymous (AA) in the 1930s, groups became increasingly important to persons attempting to recover from substance use problems. Although these group experiences initially developed independently of professional clinicians, since the middle of the twentieth century, they were increasingly incorporated into professionally run substance use treatment programs. With the reduction in long-term state hospital stays in the 1960s, outpatient group therapy for patients with severe mental illness was used in many community programs to treat patients now living in the community (Stone 1991; Abrahamson and Fellow-Smith 1991).

When clozapine began to be used in the USA in the early 1990s for patients with treatment-resistant psychotic or manic symptoms, treatment groups for patients taking this medication were developed to meet the demand for the special monitoring and psychoeducation required for recipients. Often a single doctor-nurse team would manage all the patients in a large clinic taking clozapine. A similar scenario was observed in the early days of lithium use. Groups were also developed for the treatment of anxiety and depression. Some of these grew out of marketing trials for antidepressant or anti-anxiety medications, which often offered treatment at little or no cost. The people who participated could access some ongoing services that were available with limited staff or expense. Groups that combined ongoing prescribing of medication with behavioral and cognitive therapy were often organized to manage these service users. Groups have been used for a variety of other special populations including medical patients, psychiatric patients in medical settings, personality disorders, trauma-induced disorders, substance use disorders, and premenstrual syndromes, to name a few (Gise 1989). Recently, group treatments have been used increasingly for patients receiving medication-assisted treatments (MAT) for substance use disorders, and shared medical visits have even been used for patients receiving the off-label use of sublingual ketamine for depression (Mcinnes 2020).

Efficacy

Reviews of psychotherapy for schizophrenia suggest that outpatient group treatment may improve social functioning and result in better outcomes

(Gise 1989; Mosher and Keith 1980; Schooler and Keith 1993; Stone 1997). A pilot study found reduction in suicide risk factors with a 20-week group intervention (Bergmans and Links 2009). Some data suggest better outcomes with group over individual treatment. In a study of patients discharged from a state hospital, group therapy patients were significantly less likely to be hospitalized than those receiving individual therapy (Bergmans and Links 2009). In a review of randomized controlled trials, group psychoeducation was more effective than individual psychoeducation at preventing relapse in patients with bipolar disorder (Bond and Anderson 2015).

With regard to medication adherence, group psychotherapy has been shown to maximize the benefit from psychopharmacology. For example, one study found higher, more stable serum lithium levels for patients with bipolar disorder (Abrahamson and Fellow-Smith 1991) among group participants. For patients with both mental illness and substance use disorders, better medication adherence and better outcomes, including less psychiatric hospitalization, have been reported with dual-focus self-help groups (Gise 1989). In a pilot study, group treatment was found to increase sobriety in bipolar substance-dependent patients (Mcinness 2020).

Several controlled trials of patients with schizophrenia have found better outcomes for group over individual treatment (Ward 1975), with fewer hospitalizations (Herz et al. 2000) and less frequent relapse (Colom et al. 2003a). Recent randomized controlled studies with 5-year follow-up have found group psychoeducation for patients with bipolar disorder to have a long-lasting prophylactic effect with an increase in adherence and retention and a decrease in recurrence, time acutely ill, number of days in the hospital, frequency of hospitalization, and cost (Colom et al. 2009; Scott et al. 2009; Barrowclough et al. 2006). Controlled trials of group treatment of patients with schizophrenia have found significant positive effects on auditory hallucinations, social functioning, self-esteem, self-assertion, and coping, with a reduction in hopelessness as compared to traditional care (Borras et al. 2009; Wykes et al. 2005). Barrowclough used group cognitive behavioral therapy for psychosis. Clinical evidence supports a positive association between group treatment and better outcomes including improved medication adherence, retention in treatment, less hospitalization, and shorter hospital stays (Bright et al. 1999).

While there is a great deal of evidence regarding the effectiveness of group treatment, relatively little research looks specifically at prescriber-led group treatment of psychiatric patients. As a result, definitive statements cannot be made regarding its effectiveness relative to other forms of medication management or therapy. Anecdotally, we know that this approach is more promising in its capacity to help people make social connections and in expanding the amount of contact prescribers have with their clients. More studies of groups which incorporate psychiatrists and other prescribers for medication management are needed to establish a sound evidence base for group medication visits.

Advantages of Psychiatric Group Medication Visits

Reduced Stigma and Balance of Power

Group expands the psychiatrist's knowledge of patients and their lives because of the potential for more frequent contacts and the opportunity to observe group members in a social context. Meeting in a group reduces the intensity of the therapist-patient relationship and the difference in power and status between the therapist and patient. Thus the leader becomes a member of the group, not only an authority figure. These dynamics serve to reduce the disparity in power in the therapist-patient relationship somewhat and reduce the social stigma and alienation associated with emotional problems. The group leader may begin to shift roles to some degree as they identify with their clients' struggles, recognizing their application of recovery principles in their personal lives. This identification process is

quite distinct from the traditional role of prescribers.

Desmond is a middle-aged man with long-standing symptoms of schizophrenia, social anxiety disorder, mild intellectual disability, and a past history of polysubstance abuse. For years he said little in group, but one day when asked directly how he felt about the group, he says "I like that people say whatever they want. I feel like I can relax a little and like I'm more normal...not afraid. I listen to people and I understand them, and I don't feel so alone. I don't talk much, but I like to see everybody, and I feel better after group. Sometimes it helps me think about what I can do about my problems." Groups members were surprised to hear him say so much and told him how glad they were to hear him speak and that he was part of the group. The psychiatrist noted that he "also feel(s) comfortable in the group and that it's nice for everyone to have a group of people they can feel comfortable with. It never feels good to be lonely."

In group, content, emotions, interactions, and opportunities are expanded beyond those of the 1:1 dyad, broadening the perspective of the therapist. Because the leader has an interaction in group which is more egalitarian and active, an enriched experience results that allows a more profound knowledge of the individuals in the group. This interaction is satisfying and productive, bringing out the strengths of even the most disabled participants. Most groups develop a degree of solidarity that facilitates shared decision-making. Because groups with co-therapists or multiple clinical participants demonstrate aspects of team dynamics, they allow patients to see the psychiatric clinician in a social nexus and allow the clinician to demonstrate collaborative team interactions and mutual support.

Bertha, an elderly woman with persisting psychosis, faithfully attends group but speaks little. At the holiday party, she came to life leading all the singing with a great voice, knowing all the words. She had never told anyone that she was a choir leader when she was younger. Subsequently when asked about her church involvement, she eagerly belted out a favorite hymn. This made her feel good. She got a lot of praise, and others were encouraged to share their talents. In contrast, before joining the group, she shared that her periodic visits to her psychiatrist tended to be brief. There was seldom enough time for the psychiatrist to ask much about her life, and the focus of the visits was mainly on the status of her psychotic symptoms, suicidal ideation, and medication.

Focus on Rehabilitation, Recovery, and Psychosocial Issues

Group treatment facilitates recovery and addresses the task of reintegration into the community that confronts every patient after an episode of mental illness. In addition to independent living and employment, reintegration includes restoring and forming relationships, which are facilitated by group.

Audrey is bright, but quite depressed and sometimes psychotic with disorganized and disordered thought. Although she comes to group regularly, she does not seem to enjoy them and says she comes for her shots. In her 57 years, her paranoia has resulted in impulsive flight and moving every 2–5 years. For the past 11 years in group, she has stayed in one place in her independent housing, gone to school, and worked part-time. When pressed, she reluctantly admits that she likes being with the other group members and the staff, but she can't say why.

Psychiatry has recently been dominated by psychopharmacology with a disproportionate emphasis on medications in psychiatric training, continuing medical education, and the media. While medication can be invaluable in reducing symptoms, it is cognitive deficits and difficulties with interpersonal relations that interfere with recovery most. Both group cognitive behavior therapy and group psychoeducation have been found to improve quality of life in patients with schizophrenia (Bechdolf et al. 2010). Medication groups provide one opportunity to integrate psychosocial care with medication treatment. Such groups also reduce the problems associated with treatment split between psychiatrists, therapists,

addiction counselors, and primary care providers.

Recent studies show that people with severe mental illness get worse medical care and have higher morbidity and mortality than the general population (NASMHPD 2006; Faglioni and Goracci 2009). In group, when a medical issue comes up, it provides an opportunity for the psychiatrist to address a variety of issues related to prevention and health management. The group can be polled about their health practices and their involvement with a primary care doctor. It is an opportunity to encourage regular primary care visits and the monitoring of important health indices. There is seldom enough time to address these issues as thoroughly in individual sessions. Screening, triage, and education can be accomplished more effectively in group, allowing the psychiatrist to do some basic medical monitoring, detection, and referral. Patients may both over- and under-use medical treatment and often communicate poorly with other medical providers. Group provides an opportunity for coaching effective self-advocacy and to rehearse the interaction with other providers.

Group work also provides an opportunity to integrate psychosocial rehabilitation and medication management. Activities may include social skills training, practicing assertiveness, vocational counseling, life skills training, problem-solving, role-playing, networking, linking patients to resources, and accessing multiple sources of support (Stone 2000). Psychoeducation is an important way to promote recovery and is done more efficiently in group (Liberman 2008). It also provides an opportunity to enhance members' understanding of the interaction of drug use with psychiatric symptoms and the common recovery principles that can be applied in overcoming both.

Socialization and Recovery

Social isolation is one of the hallmarks of severe mental illness. Psychiatric patients feel different and distressed by their isolation. Ignorance and fear of mental illness is prevalent in our society. People who hear voices or think about killing themselves feel alienated from friends and family and are reluctant to reveal these things. Sitting in a room with other people who have these symptoms and face the same stigma and exclusion may be the only place a person can talk about such symptoms and feelings. When people with mental illness hear others talk about side effects or disruptive symptoms, it makes it easier for them to share their own symptoms and face and accept their own illness, which they may have denied previously. Furthermore, participants feel good and are empowered when they are able to help their fellow group members. Group helps individuals feel like people, not just "patients." Many find the one-on-one therapy experience too intimidating and feel more comfortable and less threatened in group where they can gradually learn trust and build relationships.

Wendy, a woman with a history of depression and domestic abused said, "I didn't like the first meetings. But I listened to the other women with the same problems I was having, and I began to tell them things I'd never told anyone." As a person of color, she did not feel that what she said was being dismissed, as she often had in the past, and was glad that there were others in the group that she could identify with. "The therapist asked us questions to change how we thought, and I felt myself changing and getting stronger." After 2 months, Wendy got out of her abusive relationship and 2 months later, she got a job. (Solomon 2001).

An atmosphere develops which is like a family or a club with a great deal of mutual help. Members' concern and willingness to help each other is a revelation and makes both those receiving and those giving help feel better. Even people who are very impaired can be amazingly supportive and nonjudgmental, creating an atmosphere where members are appreciated and empowered. Sometimes the pain and despair of these chronic illnesses emerge clearly. In contrast to psychodynamically oriented groups where socializing outside of group is sometimes discouraged, just the opposite is usually the case in shared medication management groups. More often than not, members' socializing outside the group is beneficial

and in no way undermines the goals of treatment (Stone 1996, 2000).

Ed and Jim are quite different but both socially awkward. Ed is older, often depressed, and has been drinking most of his life, but has been able to hold jobs nonetheless. Jim is a younger man with a diagnosis of bipolar disorder, frequently psychotic, who functions poorly and has had difficulty sticking with his treatment plan, especially psychotropic medication. Ed needs to lose weight and Jim needs to get out of the house. They live near one another, so after a year in group, members suggested that they start walking together. They agreed to try and after some fits and starts, they fell into a pattern of walking 3 days a week and rarely missed a day.

Treatment group experiences can prepare patients to join freestanding community support groups and otherwise participate in recovery activities that go beyond the realm of clinical services.

Improved Adherence to Medication Plan

Some people with mental illness don't take their medication because they do not believe that they are sick. Group can confront denial, increasing insight and easing the sting of acknowledging the presence of illness. Failure to adhere to medication plans is associated with poor outcomes and is the most common reason cited for hospital admissions (Ayuso-Guttierez and del Rio Vega 1997; Weiden and Glazer 1997; Weiden and Olfson 1995). A growing body of evidence indicates that psychosocial interventions can improve adherence and outcomes (Kane 1997). Group increases client investment in the plan through healthy engagement and by providing information, validation, and psychosocial support.

Scott was shocked when lithium was recommended for his mood problems. He refused to take it. He associated lithium with patients much sicker than he thought he was and was afraid of bad side effects. When Dennis said lithium was "good stuff" and that he had been helped by taking it, he reported few side effects and urged Scott to give it a try. After listening to Dennis, Scott said he would try it.

The give and take of the group that plays out place between the clinicians leading it and other group members support and demonstrate the process of shared decision-making, which improves adherence. Group fosters engagement and the establishment of long-term therapeutic relationships based on trust. Medication in the context of a positive and trusting relationship with the clinician has been found to be associated with better adherence to formulated plans (Beck 2001). Review of the literature shows three elements that are associated with good outcomes: (1) positive therapeutic relationships, (2) psychosocial rehabilitation, and (3) medication adherence. All three are facilitated by group treatment (Colom et al. 2003b).

Shared Group Leadership

Mental illness has a course that often lasts through life, like high blood pressure or diabetes, and is rarely cured in a few sessions. Thus continuity of care is an important factor in treatment. In addition, many people with mental illness are extremely sensitive to loss. Groups facilitate continuous healing relationships with individuals and with the institution. Shared group leadership provides continuity over time as clinicians come and go and allows the group to proceed if one therapist is absent. When one therapist is a trainee, shared leadership facilitates training. Other members of the clinical team such as nurses, psych techs, and medical assistants can also take the role of co-therapist. Clinical work in behavioral health can be stressful and co-therapists can provide emotional support for each other. When the co-therapists are from different disciplines, co-leadership provides a broader spectrum of experience. A co-therapist arrangement allows an opportunity to more effectively move beyond content issues and to discuss group process. This type of de-briefing fosters teamwork and the capacity to work effectively together. Finally, with two people, the tasks of leading the group, observing, making chart notes,

Table 1 Advantages of shared group leadership

Continuity
Training
Support
Feedback on process
Multidisciplinary teamwork

and writing prescriptions can be divided. In some instances, a scribe can attend the group to do most of the documentation, freeing the clinician to focus on the patients (Table 1).

Barriers and Limitations

Frequently billing rules regarding Medicaid are different for hospital-based and freestanding mental health clinics, and Medicare also has rules about the number of patients that can be treated in a group. A new billing code has been suggested to make psychiatrist-led group treatment more attractive financially, but since 2013 psychiatric providers have used the same E&M codes as other medical practitioners, and CMS has stated that these codes can be used in shared medical visits (Eisen 2017). In some instances the psychiatric practitioner can meet briefly with group participants individually during the group, but this detracts from their ability to follow the group process. In another model that avoids this distraction, the prescriber only meets with patients briefly after the group to manage their medications. In capitated or semi-capitated settings such as health homes or residential treatment settings, billing for group prescribing should not be a problem. With some imagination and flexibility, medication groups can be financially practical work despite current fee for service billing strictures.

Community and public psychiatry is often practiced in organizations in which the group format is unfamiliar, and thus not supported by administrative staff. The lack of suitable sized waiting and treatment rooms may be barriers to group treatment. Administrators need to be convinced of the advantages of group treatment, such as patient satisfaction, clinical care, increased productivity, and improved access. As traditional agencies face the challenges of competitive and capitated contracting with payers, they need the support of consumer and advocacy groups who appreciate the role of groups in supporting a recovery culture and access to services. Bringing medication groups into a clinic requires administrative as well as clinical champions.

Training in group psychotherapy is not a core part of psychiatric education today, and many other professionals working in mental health systems also have little training in group work. Some clinicians are better suited to this kind of work and are naturally drawn to it, i.e., those with a good capacity for multitasking, a high tolerance for ambiguity and chaos, and good social skills. These skills can be taught, but this is done most easily in the early part of a practitioner's career. In any case, direct participation in groups is the best way to train future group leaders. Trainees from various disciplines can observe experienced group leaders as they assist in the facilitation of treatment groups and as they make prescribing decisions with the patients. This approach provides opportunities for supervision and processing as well.

In small, rural clinics, confidentiality issues may limit patient's willingness to attend psychiatric groups. If patients are prescribed controlled substances, shared decision-making regarding these medications may be awkward in the group setting and should probably be avoided. In some cases, all the patients are prescribed the same medications, as in benzodiazepine discontinuation groups or buprenorphine (Sokol et al. 2018) groups.

How to Start a Group

Recruitment, Intake, and Preparation

Planning for shared medical visits involves first reviewing caseloads in the clinic for likely group participants. Many psychiatric clinics retain large numbers of stable patients who ideally could be referred to primary care for ongoing prescribing. However, patients often resist this, wanting to

maintain a connection to the clinic. Offering patients participation in shared medical appointments as an alternative to referral to primary care can be a way to free up some clinician time to accommodate new acute patients. Transitions such as the redisposition of a caseload when a psychiatric clinician leaves and is not replaced, or when they reduce their time in the outpatient clinic due to other responsibilities, can be a good time to offer patients group visits. However, overall the group experience should not be presented as an inferior treatment, but rather as the best treatment available to the client. Sokol (2019) suggests six core components for groups in which patients are being prescribed buprenorphine. They are likely pertinent to planning any medication group: create clear expectations for patient conduct in group, regarding confidentiality and attendance. Group treatment should be part of a team-based approach, with clear plans for billing and adherence monitoring.

Patients who are new to group treatment should be interviewed before being invited to join a group (Stone 2000). When the patient is already being treated by the group leader, they may be invited directly into the group. In other cases, the prescribing clinician and co-therapist who is leading the group should do an intake. The intake assesses the patient's interest in group and their capacity to benefit from it. It is also an opportunity to point out the advantages of group treatment for the patient's individual concerns. Many individuals are resistant at first, some because they feel anxiety about talking in front of others. Others resist because they do not want others to know their problems. It may be helpful to reassure prospective members that when they start group, they don't necessarily have to talk. They can also be assured that what is said in group stays in group and the group will regularly be reminded of this rule. Some patients may benefit from coaching before starting group about how to use the group. It is sometimes helpful to note that people can discuss treatment and recovery issues without having to disclose sensitive personal issues. Over time, when their symptoms of anxiety, depression, and paranoia are reduced and they become more comfortable with the leader, some people who were initially resistant become more comfortable with group participation. Clinicians are more persuasive in getting clients to try groups if they themselves believe that groups are a superior modality, not a second-class alternative for people who function at a low level.

Those individuals referred from inpatient, partial hospital, and intensive outpatient programs that utilize group treatment may be more accustomed to groups and can more easily be encouraged to continue group work as outpatients. It is often helpful to discuss the advantages and disadvantages of group participation and to then allow people to make their own choice about participation. By simply asking, "Are you willing to try it once?" and promising "If you don't like it, you don't have to come any more," many people will be willing to start. In most cases, after they come once, feel the nonjudgmental atmosphere, and find that they are not forced to talk, they continue. Those who refuse should be seen individually, but the invitation to group can be repeated every 6–12 months, especially if the doctor-patient relationship is stronger and the individual's symptoms are reduced.

Once several patients indicate a willingness to try group visits, meetings can be initiated. Groups can range from 45 to 90 min depending on the number of participants and their level of tolerance and attention. An ideal group is 8–12 patients, but larger and smaller groups may function effectively. Some time should be allocated after each session for leaders to de-brief and review and for individual meetings with patients about issues that could not be resolved in the group.

Group Composition, Membership, Exclusionary Criteria

Most psychiatric patients are suitable for inclusion in shared medication management visits (Stone 2000). A few people who are especially needy or those with particular personality traits (such as mood instability, impulsivity, entitlement, distrustfulness) may have difficulty tol-

erating groups. They may refuse to participate or become too disruptive to continue. Individuals with a variety of psychiatric conditions can benefit from groups, however, including those with acute psychosis, suicidal ideation, substance problems, and cognitive deficits. Even group candidates who say that they only come to group because they are forced (e.g., the law and entitlements) often become engaged in the group over time and can definitely benefit from this treatment format. If space permits, a few patients who do not take psychotropic medication or who get their medication prescribed by their PCP may wish to attend in order to participate in the psychosocial aspects of the group.

Members are discouraged from bringing their children, but if child care is unavailable outside the treatment facility or within it, children can be accommodated on an "as needed" basis. Bringing children on a regular basis is generally discouraged, however, unless group members specifically approve it. Multifamily psychoeducation groups that include a psychiatric specialist have been shown helpful to recovery in psychotic disorders. In a small, rural settings, a highly heterogeneous group can be successful and may meet less frequently than would normally be the case. In centers that serve larger numbers of people, candidates can be invited to groups based on specific characteristics or experiences or based on the issues that will be addressed. Diagnostic categories and level of cognitive ability are also sometimes used for that purpose. In homogeneous groups, patients are more likely to form supportive relationship outside of group, while in heterogeneous groups, patients can appreciate the universality of human feelings and problems despite differences in background, diagnosis, and/or level of functioning. Homogeneous groups facilitate sharing, bonding, and cohesiveness, while heterogeneous groups promote tolerance, understanding, and sensitivity. These are generalizations though, and these characteristics are not mutually exclusive.

Acute Transition Groups

Acute stabilization groups can help provide frequent contact for patients stepping down from hospital or intermediate services or in situations where there is a delay in being assigned outpatient providers. These will generally be heterogeneous regarding diagnosis because of the need to accommodate a heterogeneous stream of patients seeking service. Patients should be encouraged to come weekly to acute groups with rolling admission until they can be picked up by individual providers or more homogeneous treatment groups that focus on a particular node of the diagnostic spectrum.

Flexibly Bound-Model

Many people have difficulty keeping regular appointments. The frequency of group meetings varies between weekly and monthly scheduling. Groups that meet frequently and have a fixed membership require the most discipline and commitment. Ultimately, the scheduling of groups sessions will depend on the resources available and the characteristics of group members. Some people may want to come to group weekly, but for others, irregular or infrequent attendance is the norm. Individuals who are more stable may prefer to come every few months. A "flexibly-bound model" empowers patients by allowing them to choose the frequency with which they attend (Stone 2000) and helps them learn to get help when they need it. Some groups may be flexible enough to permit some patients to come late and leave early. However, a certain minimum frequency of visits is usually required, along with limits on providing refills to persons who are not attending group. In large clinics with patients who often miss individual appointments, very open "refill groups" can offer frequent face-to-face opportunities for people to get their medications refilled without having to wait for an available individual appointment.

How to Run a Group

Content, Setting, and Duration

If the psychiatric clinician is billing E&M codes, they should make sure to address each member of the group individually about symptoms, medication adherence, and side effects, whether or not a prescription is actually written. In stable groups of patients, this may only take up half the allotted time, leaving time for psychoeducation, skills development, cognitive-behavioral treatment, support, and/or interpersonal process. Kanas suggests that groups should focus on the "here-and-now" and can be effective in helping patients cope with a variety of symptoms, including psychosis (Gise 2004; Kanas 1996). Groups may start with some socializing around "coffee and snacks," but informal pre-group contact may go on in the waiting room anyway.

Some groups have a specific agenda for each session, and some are time-limited and/or manualized. Although these groups are easier to study and require less improvisation and skill on the part of the leaders, there are advantages to ongoing groups with no set topics starting "where the patients are at" (Jensen et al. 2010). With ongoing groups, new members can be added at any time. With an open agenda, the leader can start with "Does anyone have anything special they would like to bring up before we start?" This lets members bring up something of special interest or concern and teaches them to prioritize urgent issues from routine ones. The leader can also initiate topics (e.g., psychoeducation on flu shots, disaster preparedness, relationship with spirituality). Since the distress and disability associated with many psychiatric diagnoses may persist, especially in populations with high social and economic stress, there are advantages to ongoing groups. Long-term treatment is required for many disabling psychiatric conditions, and today the treatment of people with a variety of psychiatric diagnoses involves medication. For disorders that tend to be more phasic, like some affective and anxiety disorders, flexibly bound groups offer long-term involvement in a familiar treatment setting.

Groups that combine psychotherapy and medication and which are more structured offer some advantages as well. Some examples of these include groups that combine cognitive behavior therapy (CBT) and medication for OCD or phobias, trauma-focused CBT, and medication for PTSD or groups using interpersonal therapy to address persistent depression.

A variety of formats may be used for groups focused on substance use. Because the use of medications in substance abuse treatment is open-ended and frequency of clinician contact is often mandated in the case of buprenorphine, prescribing groups fit in well with a variety of treatment plans. As community psychiatric clinics become behavioral health clinics, the group treatment culture of substance abuse treatment can be incorporated into the clinic style. Frequent, flexibly bound groups for substance use treatment can accommodate differing treatment intensity needs depending on the patient's stability (Eisen 2019).

Universalizing: Combating Stigma

Groups are de-stigmatizing. The group format allows the leader to poll the group, a technique called universalizing. For example, when a patient describes a problem, the leader can poll the group and ask who has had a similar problem, i.e., hearing voices, having suicidal thoughts, having a problem with alcohol or drugs, not taking medication, etc. When others indicate that they have had similar experiences, the member feels less stigmatized and less ashamed, and the stage is set for an open discussion of that problem. Various techniques for coping with auditory hallucinations are frequently shared, and the leader can offer alternatives to distraction and keeping busy such as talking back to the voices as if they were a nosey neighbor. A small randomized controlled trial found that group cognitive behavioral therapy reduces

auditory hallucinations (McLeod et al. 2007). With a less intense relationship between members and the group leader, controlled staff disclosure is typically increased because it has less intense personal meaning than in a one-to-one session.

"Go Rounds"

By going around and checking in with each patient, the leader can address the problem of patients who don't talk and also of monopolizers who need to be contained (Stone 1997, 2000). But even with this format, feedback and discussion are encouraged. Patients don't have to talk at first and those who don't talk benefit from listening to others and feel encouraged to participate at their own pace. For groups with open attendance with little continuity in membership, starting the group by asking each participant to give a brief account of their lives can be a way to establish familiarity. It may be helpful for the clinician to start this process off with their own introduction to model self-disclosure and indicate their willingness to share. Members can be asked to provide information about their place of origin, significant people in their lives, activities that they enjoy, or other things that are important in their lives. Rather than focusing on problems at this point, asking clients to identify their best qualities or strengths can set a positive, nonjudgmental tone for the group.

Addressing Poor Adherence

In relatively acute medication groups much of the focus will be on adjusting medicines and monitoring treatment response. In more chronic, less frequent groups, unless a patient is having a problem, medication is only addressed when prescriptions need to be renewed or if new symptoms or side effects present. Using medication properly is usually more important than the medication itself. In a periodic review of medication use the leader can ask, "How many times in the last week did you forget to take your medication, one? two? three?". Asking the question in this way normalizes non-adherence and facilitates an honest response. After hearing other patients admit that they did not take their medication as prescribed, it is easier to have an open discussion of this problem. If a person has only forgotten to take medication once or twice during the week, they can be praised for taking it most of the time. When non-adherence is a problem, it can be broken down into forgetting or not wanting to take it. Forgetting can be addressed in a variety of ways such as medication boxes, notes, convenient placement of medication, etc. Group members can give suggestions and share their successes. Developing a willingness to keep open communications about medicine is a long-term process which is facilitated by an ongoing, open-ended, group format.

The second reason for non-adherence, not wanting to take medication, must be addressed in a nonjudgmental manner using motivational interviewing techniques and shared decision-making. Patients who have decided to stop taking medications can be encouraged to keep attending group so the outcome of this decision can be monitored and medication can be resumed quickly if need be. Group functions as a periodic wake-up call, reminding members that they need to take care of themselves. Many people with distressing symptoms need to work around their symptoms in their daily lives so that they can function. Conflicts and feelings may build up over time such that the outlet provided by the group can help them avoid becoming overwhelmed in their usual setting.

Individual Appointments

Group members should be told that they can have an individual appointment any time. They may rarely need to ask, but this availability can be reassuring. If they have something to say that is very personal and private, which they do not want to discuss in group, access to a more private outlet is appropriate. In many cases, however, when

asked "Is there some reason you could not say that in group?", most will recognize that they actually could have raised it in group. Nevertheless, some patients prefer to discuss some things in private such as sexual problems, threatening thoughts or thoughts with otherwise disturbing content. Vagueness is a technique which can be used to discuss private material in group by using non-specific labels for these problems. For example, a high functioning man with bipolar disorder and a disturbing, disruptive addiction to Internet pornography may disclose this issue privately to the psychiatrist but does not want to mention it in group. However, he could be monitored in group without disclosing what his symptom was by posing the question "How have you been doing with your 'time management' this week?"

There will be instances in which a group member does not use the group well or is disruptive despite frequent interventions. In such cases, it is reasonable to suggest that the struggling individual take a vacation from group and refer them for individual treatment until they are better able to use the group format.

Conclusion

Group psychiatric appointments for patients across the spectrum of psychiatric disorders can be more efficient, more fun, more stimulating, and invigorating, for both therapists and patients, than individual treatment. Evidence suggests that group treatment is associated with better outcomes including retention in treatment, better medication adherence, fewer hospitalizations, and shorter hospital stays. Groups for psychiatric patients can provide psychotherapy, psychosocial rehabilitation, and medication management in a flexible, open, one-stop-shopping environment, which can enhance medication adherence and provide a safety net for persons with mental illness and substance use disorders living in the community. Better recovery outcomes have been associated with group treatment including improved social functioning, better self-esteem, more self-assertion, better coping, and less hopelessness. Group is an underutilized modality which supports recovery with clinical evidence of effectiveness and which deserves further development. Widespread participation of psychiatrists and other prescribers in group processes can only be accomplished if training programs provide adequate preparation for doing so.

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