2018

AGPA and IBCGP Agency Survey

Joint Agency Survey Task Force

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Agency Survey

The Agency Survey Task Force was initiated at the behest of the AGPA.

The Task Force for this survey was comprised of AGPA and IBCGP leadership, who utilized their contacts in agencies across the nation. They provided countless hours of service to AGPA in shaping questions, searching for appropriate contacts in each agency and following through with ensuring surveys were completed. They devoted many hours and weekends to this project, and without their enormous contributions, this project would have foundered. Agencies are notoriously busy and executives and administrators are seldom able to devote time to surveys unless they have a compelling reason to do so. The Task Force were relentless in their contacts with key personnel in agencies to communicate the importance of the project and to follow through with completion.

The Task Force members were:

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Thanks also go to Marsha Block, CAE, CFRE, Mallory Crisona and Leah Flood for their diligence in administration of the survey to completion.

Finally, thanks go to the agency personnel who took time out of their very busy schedules to complete the survey. It is our hope that this project results in a feedback loop wherein AGPA can articulate how its services might benefit group therapy provision across a wide range of treatment settings.

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Abstract

A survey of small, medium and large mental health agencies was taken (n=40, representing services provided to over 160,000 clients in inpatient and outpatient services), focusing on the role of group therapy in treatment. Agencies included, but were not limited to, inpatient, PHP/IOP and outpatient in hospital settings, university counseling centers, addictions units and child/adolescent agencies. Questions were asked about a range of topics, including, but not limited to, the competence of group therapy delivery, leadership qualifications, types of groups offered, and training needs.

Overall, group was at a high level of utilization by agencies. On aggregate, group was used as at least 50% of all treatment type 42.6% of the time. There were differences in group utilization by level of care. PHP/IOP had the highest rates, utilizing group treatment for between 50-75%+ of its services 100% of the time. Inpatient utilized group at variable rates (<25% - >75%), suggesting considerable differences in treatment philosophy at each agency. Outpatient utilized group at the lowest frequencies, with the modal score being <25%. However, figures overall show that group accounts for a considerable amount of treatment in agency settings.

In terms of type of groups, psychotherapy process groups are well utilized in PHP/IOP and outpatient, but less frequently in inpatient, albeit with some notable exceptions. Manualized group treatments are heavily utilized but seldom required at most agencies. Although some agencies expressed a preference for evidence-based treatment, use of manuals in a required, consistent, agency-wide way was seldom endorsed. More often, agencies leave treatment theory selection up to therapists. Support groups are highly utilized in outpatient with little usage in inpatient. Recreation groups are used at higher rates in inpatient than PHP/IOP and outpatient.

Group leadership qualifications ranged from BA level to MS and above. However, BA level practitioners may either have been certified (for example, in addictions counseling) or running recreation and psychoeducational groups. Competency and quality assurance was highly variable in this survey, with few agencies reporting either requiring certification in group therapy or measuring outcomes, and the most endorsed answer being an assumption that basic qualifications (such as a social work license) were a guarantee of proficiency in group. Supervision was the next most endorsed category, suggesting attention is being paid to quality of group leadership. However, more details are needed on this to determine how well trained the supervisors are in group. Equally, some open ended answers suggested that group supervision was limited to trainees and that there was little quality control over groups run by licensed therapists. The assumption of competence in group for experienced therapists may need exploring, particularly given a lack of corroborating outcome assessment.

Findings also included: 1) preference for curricula focused on core skills in group therapy rather than specific symptomology or population based texts; 2) an interest in training in a range of group topics using a variety of delivery methods; and 3) that evaluation of effectiveness of groups was generally poorly performed, with few sites utilizing outcome measures but with many requesting training and support in conducting evaluation.

Certification in group was not seen as desirable, yet assurance of basic competence in group was desired. Possible explanations for this are that certification may be seen as either a mastery qualification or too intensive or expensive a process. More education of agencies may be necessary as to the role of certification in core competency.

Methodology

This survey was conducted in several phases. First, a group of experts was formed on agency mental health, drawing from AGPA's membership. Their backgrounds included extensive experience in some of the largest and most prestigious agency settings in the country. From this group, and in collaboration with the Science to Service Task Force, a comprehensive list of possible content areas and questions was compiled. Questions were then refined by the first author and sent back to the Task Force. Questions were then reduced to make the questionnaire briefer and more compelling to agencies to complete.

The questionnaire was then tested on three agencies for content and format, as well as time to complete. It was then refined again and sent out in a large-scale first phase, targeting mental health agencies from a list of the largest mental health agencies in the country. It was anticipated that were would be a low response rate to the first phase, since administrators are typically very busy and have little time for unsolicited work. Agencies were guaranteed a curriculum from AGPA as a reward for completion of the survey. The response from phase 1 were 2 surveys.

To increase the *n*, a second phase was conducted, involving the Task Force members utilizing their professional connections to contact agency directors and program coordinators across the country. It was anticipated that response rates would be far higher for this phase due to the personal connections involved and the ability to obtain a free curriculum. In the second phase, another 38 surveys were collected, giving a grand total of 40 surveys. This second phase involved numerous follow up calls from Task Force members to ensure data was collected. To increase the sample size, a range of agencies of different types and sizes were sought.

Demographics

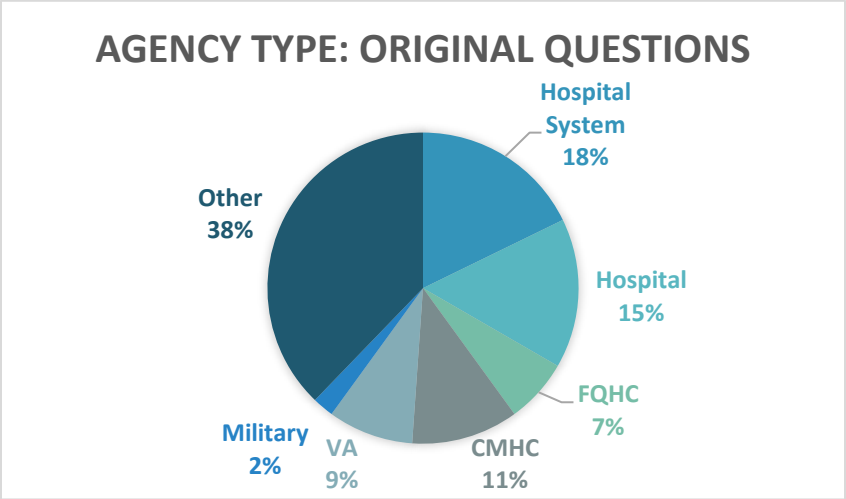
As can be seen from Figure 1., the agencies represented included a wide range of different entities. It should be noted that some identified in several categories, with larger systems sometimes overseeing, for example, hospital inpatient and outpatient and trauma centers. The largest identified groups were hospital (15%) and hospital systems (18%), representing 33% of all respondents when combined.

Agency types

The original categories are represented below with their responses. HMOs, ACOs and correctional settings received no endorsements. To compile the percentage breakdown into a pie chart, the lack of endorsed HMO, ACO, and correctional categories were omitted.

Figure 1.

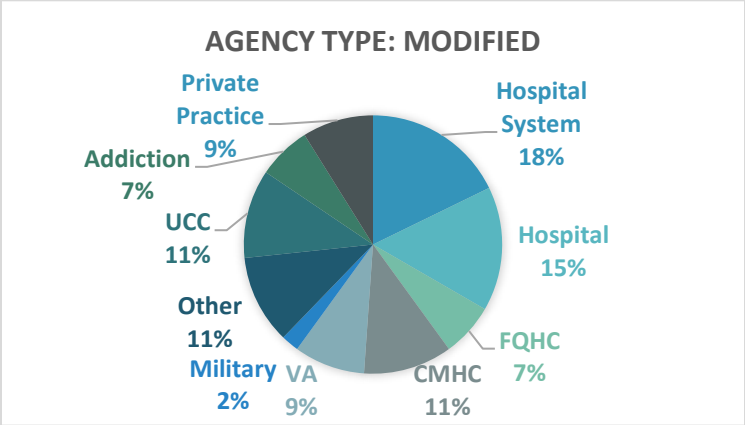
ANSWER CHOICES	RESPONSES	
Hospital system	20.51%	8
HMO	0.00%	0
Hospital	17.95%	7
Accountable Care Organization (ACO)	0.00%	0
Federally Qualified Health Center (FQHC)	7.69%	3
CMHC	12.82%	5
Correctional	0.00%	0
VA	10.26%	4
Military	2.56%	1
Other (please state)	43.59%	17
Total Respondents: 39		



FQHC = Federally Qualified Health Center; CMHC = Community Mental Health Center; VA = Veteran's Administration Site

Of note, University Counseling Centers (UCC) and Addictions are clustered under "other" in the original survey. However, were they to be partitioned out, they would have represented higher proportions of the overall total than many that were included on this pie chart. This is noteworthy since several of the questions later in the survey may have been impacted by the larger presence of these particular agency types. For example, UCCs typically make use of group coordination, and addiction centers may have asked for the addictions curricula and also may have had more BA level (but addictions certified) group counselors available. UCCs in particular represent the second largest discreet category (assuming hospitals and hospital systems are collapsed into one category) alongside CMHCs.

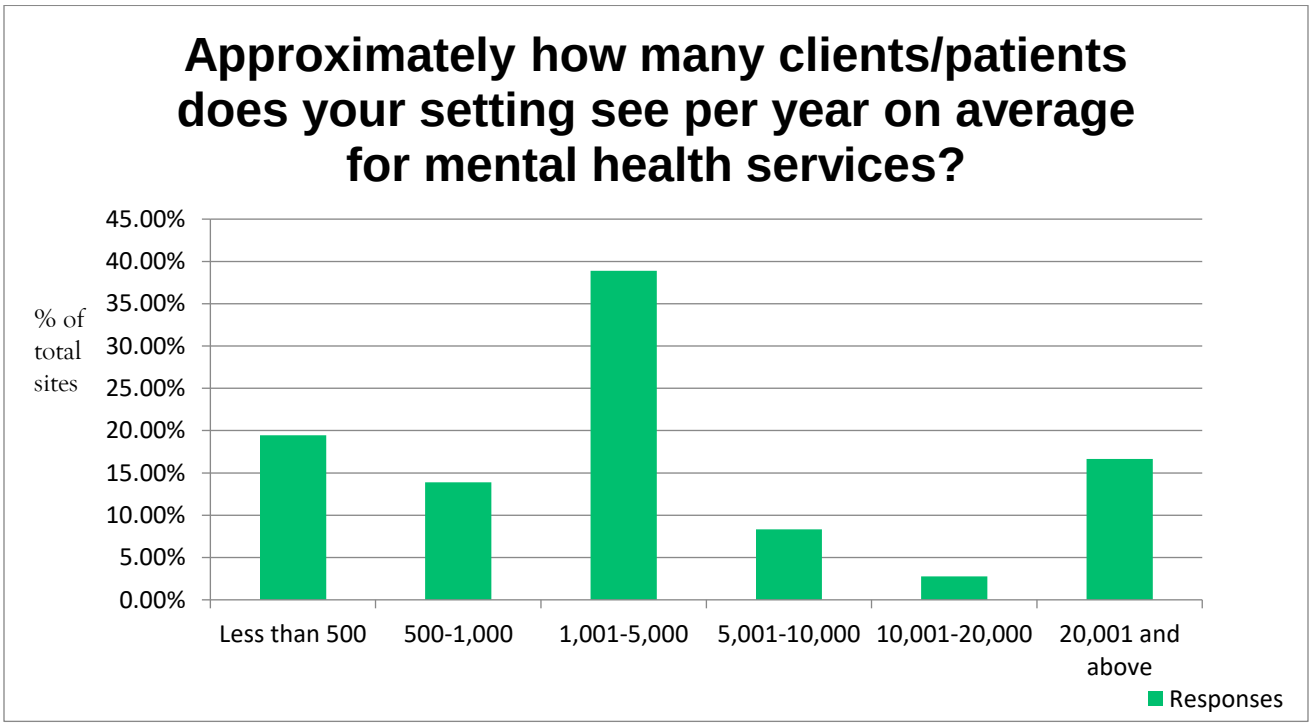
The following chart represents the modified version, with private practice, UCC, and Addictions broken out into their own categories.



In the modified chart, hospitals and hospital systems still represent the largest category by far (32%), with UCCs (11%) and CMHCs (11%) in joint second place. VAs (9%), private practice (9%) FQHCs (7%), and addiction centers (7%) represent the next largest agency types. Military sites represent a very small percentage of the sample, with only 1 survey.

Number of patients served

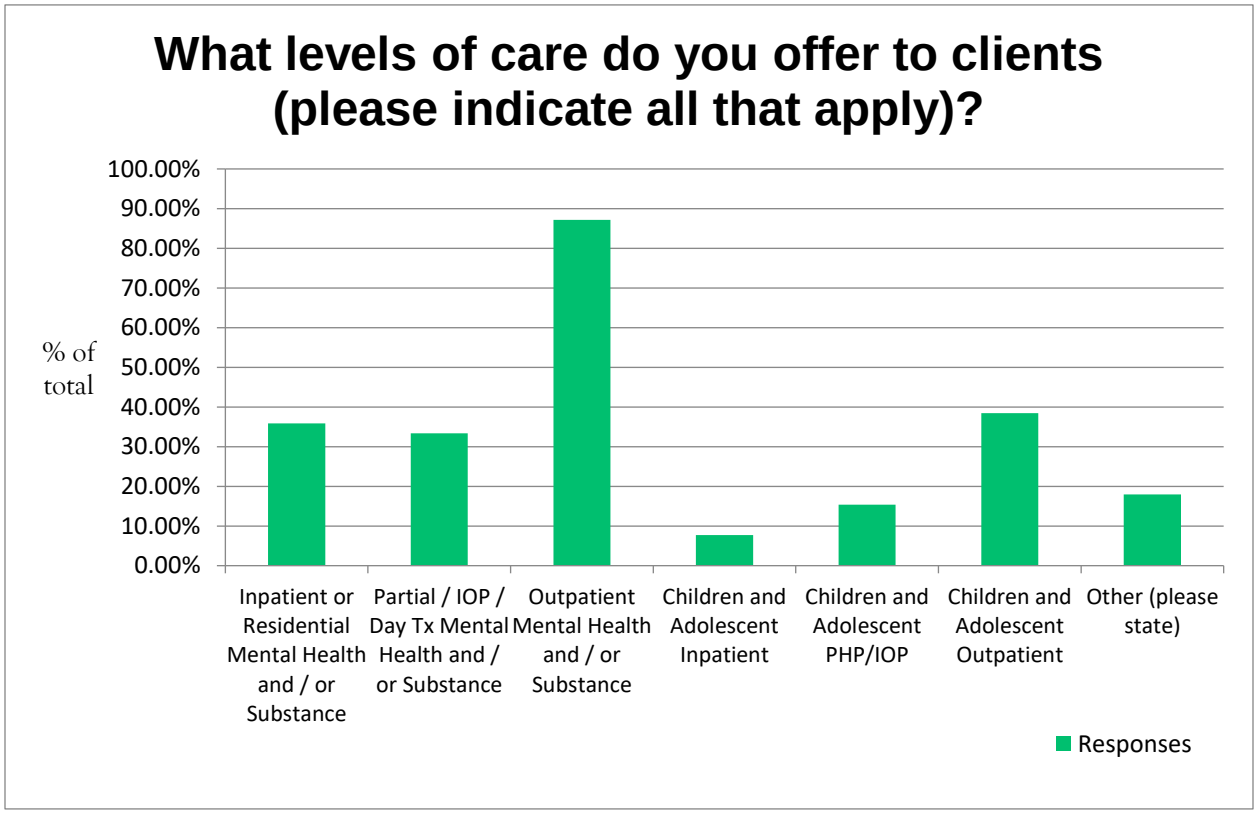
The number of patients served is stratified across categories, although with smaller representation in the 5,000-20,000 range, leaving it lacking a normal distribution. The modal range is 1,001-5,000. Interestingly, the category 20,001 and above is well represented in the sample. The survey, therefore, captures some of the larger mental health service providers in the nation.



Level of Care

87% of respondents indicated serving outpatients, making this the largest category by far. Inpatient represented 35.9%. It is worth noting that several agencies have both inpatient and outpatient services, leading to a percentage totaling more than 100%. Several agencies, therefore, serve both inpatient and outpatient. It is difficult to determine if they are in a progressive, step-down approach that well integrates the two or whether they are stand-alone units in separate regions. This would be useful to assess in future surveys.

A sizeable number of services offered were related to care for children and adolescents. If categories were collapsed, inpatient (child and adult) would total 17 sites, PHP/IOP (child and adult) would total 19 sites, and outpatient (child and adult) would total 49 sites, making this the largest category by far.



Overall, the sample can be seen to have a higher ratio of outpatient and PHP/IOP services than inpatient. Note: PHP is shorthand for Partial Hospitalization Program. It is a day treatment program that typically lasts all week, with patients returning home in the evenings. IOP is shorthand for Intensive Outpatient Programming and takes place for around three days of the week.

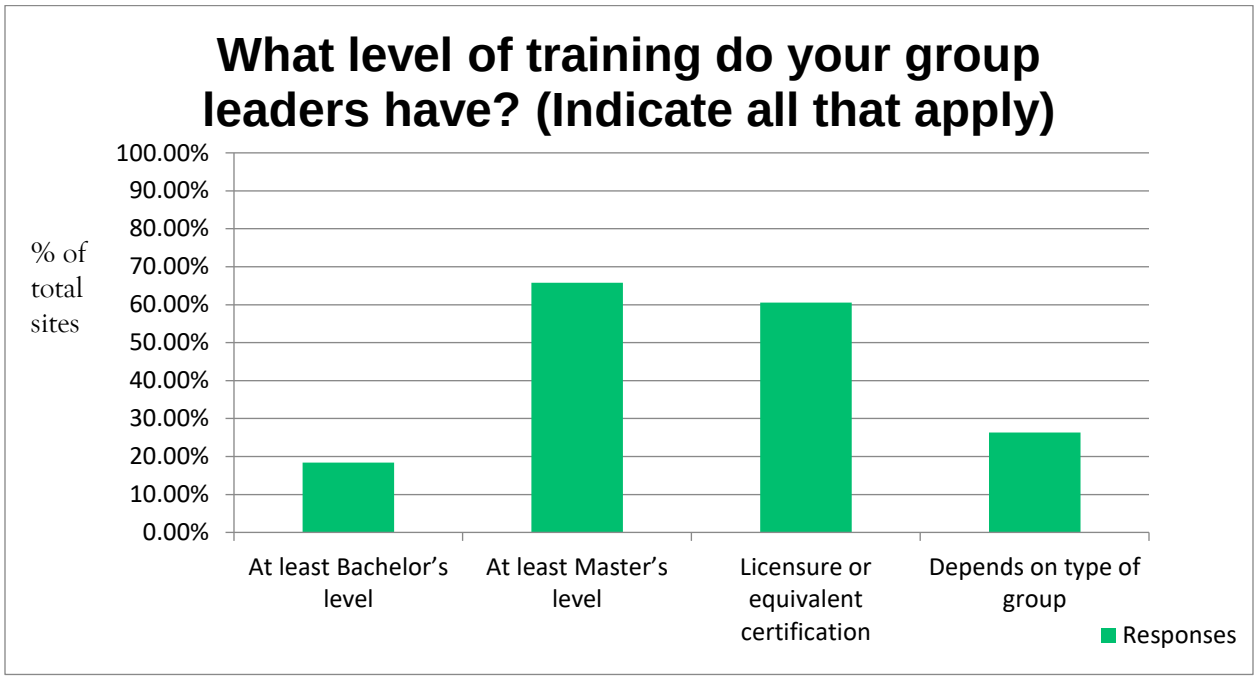
ANSWER CHOICES	RESPONSES	
Inpatient or residential mental health and / or Substance	35.90%	14
Partial / IOP / Day Tx Mental Health and / or Substance	33.33%	13
Outpatient Mental Health and / or Substance	87.18%	34
Children and Adolescent inpatient	7.69%	3
Children and Adolescent PHP/IOP	15.38%	6
Children and Adolescent Outpatient	38.46%	15
Other (please state)	17.95%	7
Total Respondents: 39		

Demographics, therefore, show a sample representing a wide range of agency types and sizes, providing a range of services from inpatient and PHP/IOP to outpatient. Outpatient is the largest single category of service provision in this sample.

Results

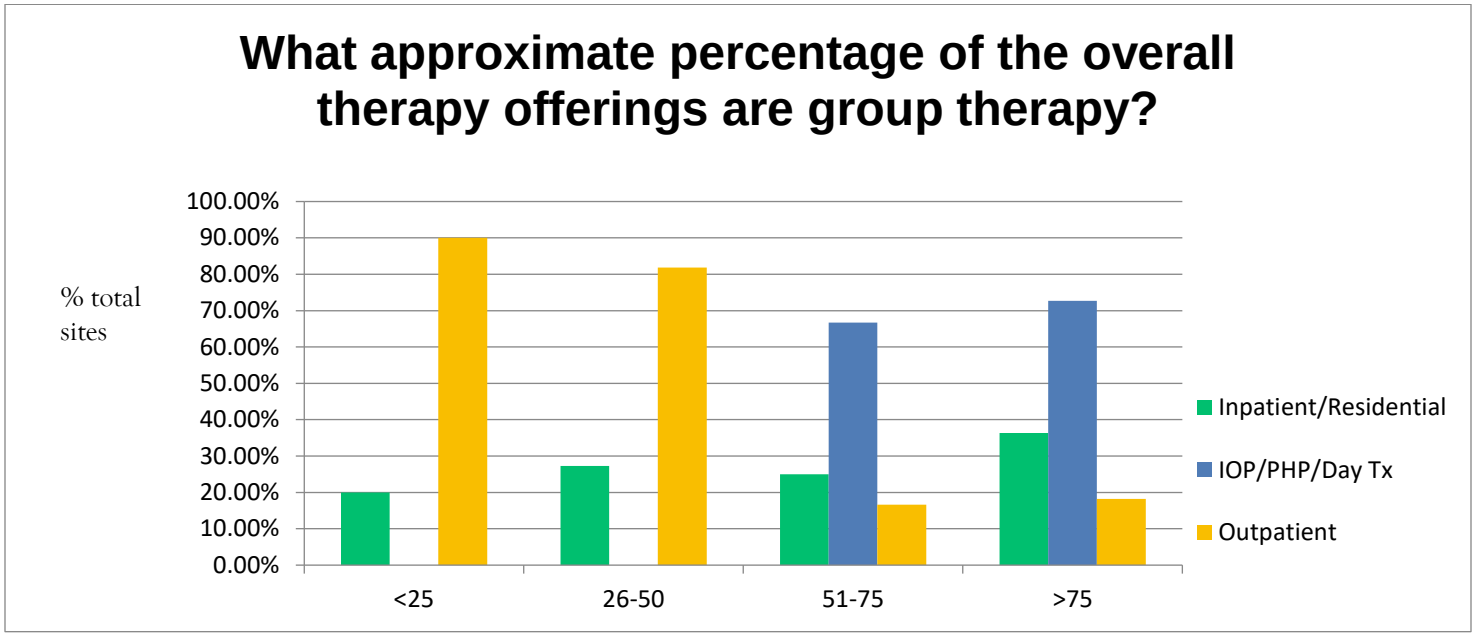
Leader Qualifications and Level of Training in Group

The level of training of group leaders is well spread out. Fewer report having BA degrees as their lowest level of training, with most (65%) reporting at least Master's level and requiring licensure or certification (60%). It is worth noting, however, that certification in addictions can be an alternative to Master's degrees for addictions work. Also of note, agencies do state that it can depend on type of group. For example, hospital inpatient and outpatient psychoeducation groups are typically led by nurses with BA degrees, and recreation groups are led by recreation therapists with CTRS certification.



These responses are often but not always due to regulatory agencies, with Joint Commission, CMS, and addictions accreditation driving hiring practices and requiring minimal training standards for each type of service delivery.

Group Utilization



23% (12 out of 53 total) of agencies report using group treatment between 50 and 75% of the time. 20% (11 out of 53 agencies) of agencies indicate using group for more than 76% of their treatment. Adding those numbers, it can be seen that 42.6% (23 out of 53) of agencies use group for 50-100% of their services. These figures are remarkably high. Clearly many agencies are utilizing group at far higher rates than might have been predicted.

Discussion

Percentages calculated above represent percentage as part of the total respondents, calculated on the horizontal. Figures are larger than 100% because agencies may endorse more than one category since they sometimes have multiple units within each agency. Percentages shown below represent calculation of the overall breakdown of utilization calculated for each treatment type.

	Inpatient	PHP/IOP	Outpatient
<25%	4 (28.5%)		18 (58%)
26-50%	3 (21.4%)		9 (29%)
51-75%	3 (21.4%)	8 (50%)	2 (6.45%)
76%+	4 (28.5%)	8 (50%)	2 (6.45%)
Total	14	16	31

This chart shows that for inpatient services, the distribution of group therapy provision is evenly spread. Some agencies use it for more than 75% of treatment, while an equal amount of others use it less than 25% of the time. This suggests significant variability in treatment philosophy. However, there are some important statistics to consider for inpatient. First, 49.9% of agencies use group for inpatient for at least 50% of their treatment. This is no small number and shows that group is highly utilized in inpatient in many agencies across the nation. However, due to the small sample size, caution should be used in interpreting this data.

Second, it is clear that PHP/IOP utilizes group at very high rates. Group appears to be the primary treatment modality for PHP/IOP in this sample, representing at least 50% of all treatment delivery in all instances.

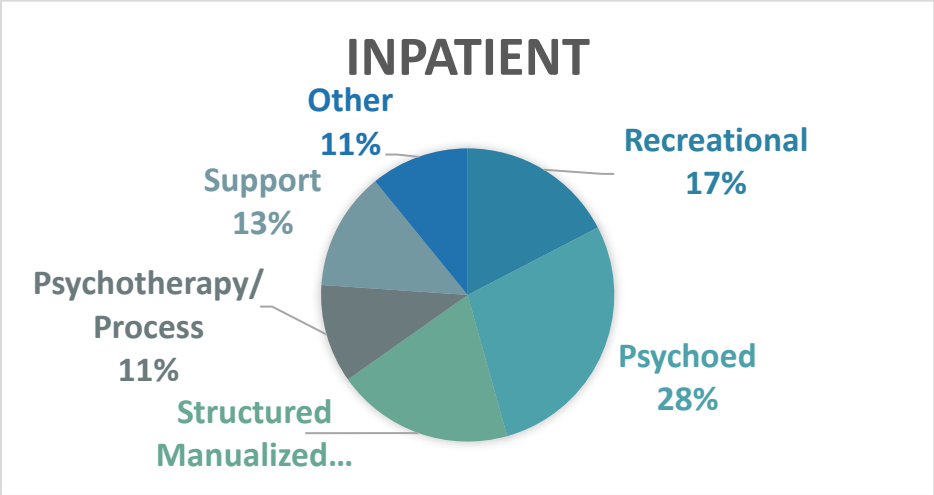
Finally, outpatient treatment appears to utilize group therapy as a lower percentage of overall treatment than inpatient and IOP/PHP. For example, it is only used as 75% of the treatment offered in 2 outpatient settings. Therefore, it is possible that many outpatient centers see group as adjunctive to another, primary treatment such as medication management and/or individual psychotherapy. There are many possible reasons for this, including treatment philosophy, lack of a group therapy culture, difficulty in starting groups in outpatient, and other issues regarding scheduling.

Type of Group Offered

Types of group offered vary considerably by type of service. The table below shows all comparisons in combination. The charts following, break down the percentages of type of group by treatment level.

	INPATIENT/RESIDENTIAL	IOP/PHP/DAY TX	OUTPATIENT	TOTAL RESPONDENTS
Recreational	66.67% 8	33.33% 4	41.67% 5	12
Psychoeducational	43.33% 13	50.00% 15	80.00% 24	30
Structured, Manualized treatment (e.g. CBT)	33.33% 9	40.74% 11	92.59% 25	27
Psychotherapy (e.g. unstructured, psychodynamic, process)	16.67% 5	33.33% 10	86.67% 26	30
Support group	24.00% 6	16.00% 4	88.00% 22	25
Other	55.56% 5	11.11% 1	77.78% 7	9

Inpatient Treatment: Group Type Utilization



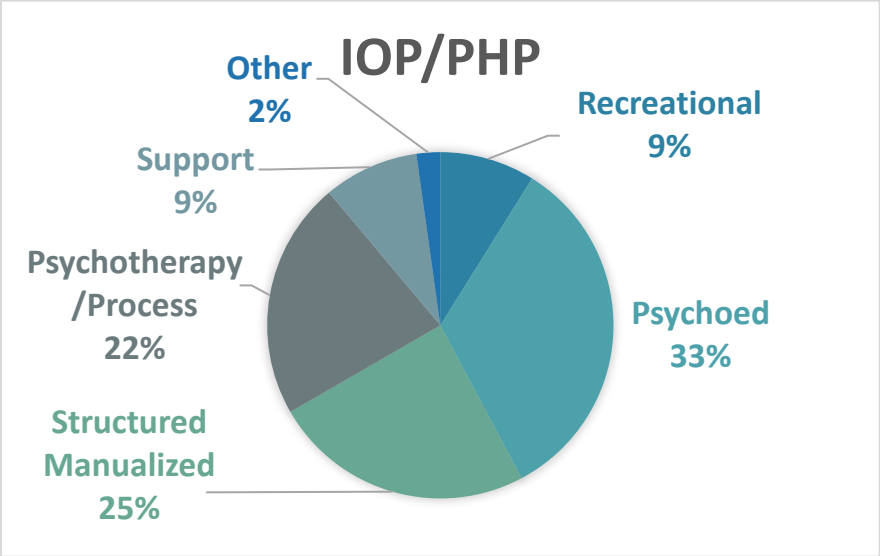
Inpatient group therapy is dominated by use of structured/manualized treatment and psychoeducation groups, with recreation groups also utilized as a higher percentage of treatment. Psychotherapy/process groups are less utilized, with only 11% of treatment endorsed for this type. This is unsurprising, in that many inpatient units prioritize downregulating approaches designed to minimize interaction and interpersonal connections and which focus on relaxation, recovery and cognitive, skills-based approaches. An exception to this might be the work at some agencies, such as Mercy Health, which uses agenda groups as its primary psychotherapy in inpatient, with strong results. Support groups are used in smaller numbers. This may need further analysis to determine if it is specific to some settings or agencies.

Discussion

Despite some evidence that agenda group psychotherapy can be highly effective as a treatment in inpatient settings, agencies favor psychoeducation, recreation, and manualized treatments, albeit not by a considerable amount.

There are several possible reasons for this, including: need for standardization of treatment due to high staff turnover; therapist training; desire to be seen as utilizing evidence-based treatments; assumption that manualization accounts for most of the variance in effectiveness of treatment; and a desire to achieve standardization for training purposes. Support groups are also typically seen as the proviso of outpatient treatment and therapists may perceive the clients in inpatient to be insufficiently functional to manage themselves without effective therapist leadership.

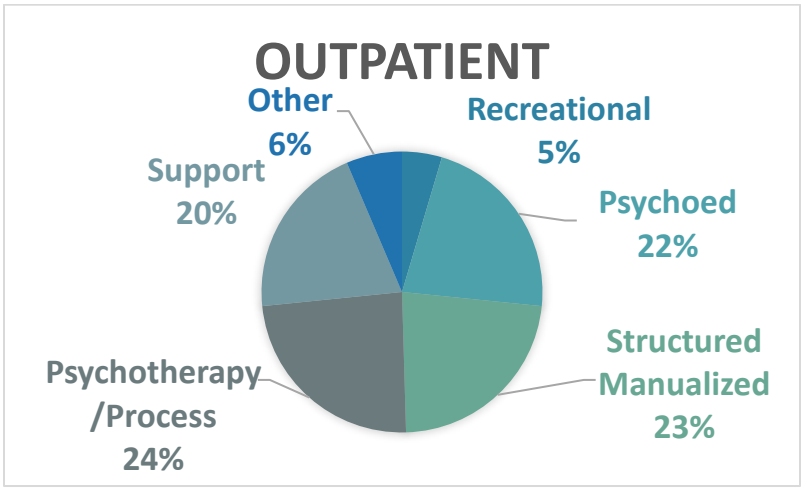
PHP/IOP Treatment: Group Type Utilization



PHP/IOP is a treatment setting designed to work as day treatment of varying length. The payment method for these services is chosen by the agency, and can impact how treatment is delivered. They can select bundled payments (one daily fee with wide latitude of treatment choice within that day) or fee-for-service (each treatment hour is billed depending on what treatment is delivered in that slot). Bundled payments offer more freedom in terms of treatment delivery but reimburse at lower levels.

PHP/IOP treatment appears on aggregate to use more psychotherapy/process than inpatient. It uses slightly more psychoeducation and structured manualized treatment than inpatient but half as many recreation groups as a percentage of treatment. This shift away from recreation and toward psychotherapy and other treatments are typical of this setting, which tends to increase upregulation in its therapies as it seeks to promote changes in behavior and insight.

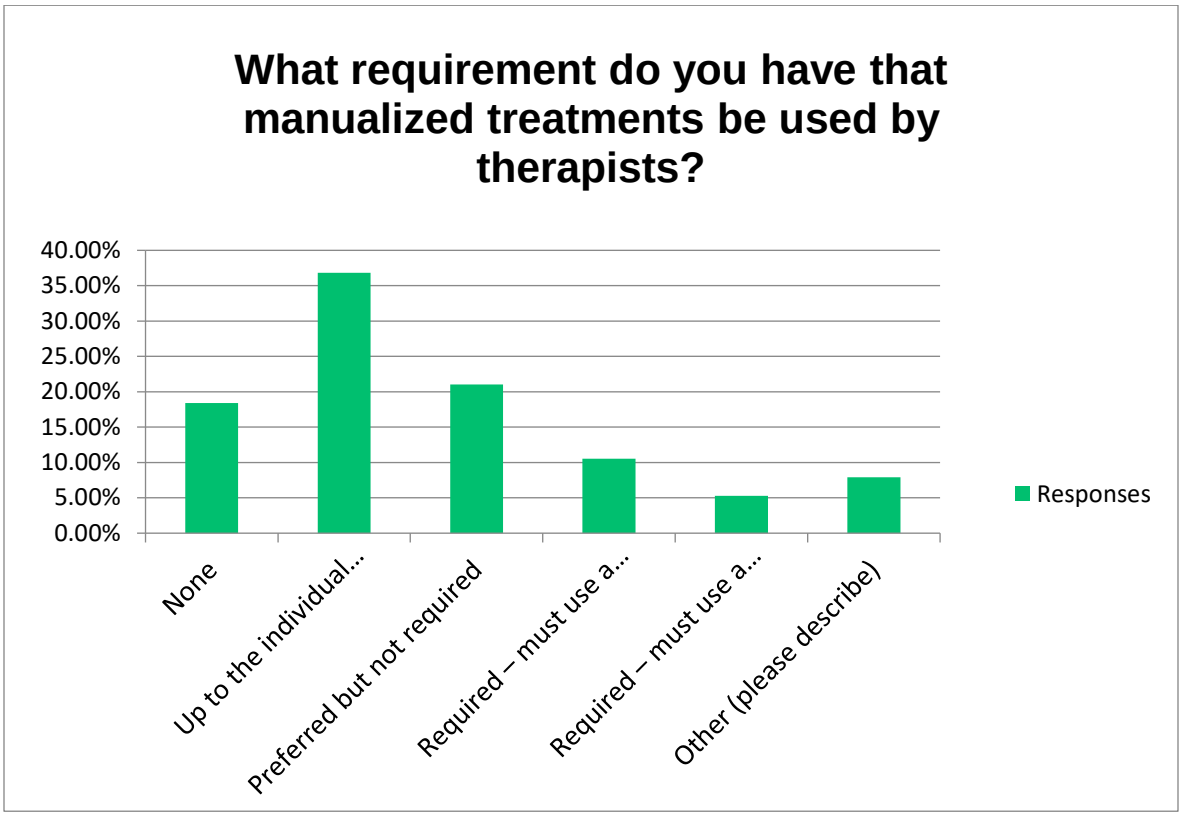
Outpatient Treatment: Group Type Utilization



Outpatient

Outpatient is typically a drop-in service that functions using intermittent appointments (such as weekly or bi-weekly) and can take place in a mixture of settings, such as Community Mental Health Centers, private practice, UCCs, or hospital-attached structured outpatient centers. There is another sharp reduction in recreation groups consistent with upregulation and efficient use of time for this setting, where clients are expected to be functioning at a far higher level. Psychoeducational groups appeared to reduce in frequency and support group usage increased considerably from 9% in PHP/IOP to 20% in outpatient. This is also consistent with models seeking to promote more independence and increase social support. However, it may also be an artifact of which programs are being evaluated. For example, addiction outpatient work often utilizes support groups at higher rates than some other agency types. Psychotherapy process groups run at approximately the same rates as in PHP/IOP, suggesting they remain a popular treatment choice in outpatient settings.

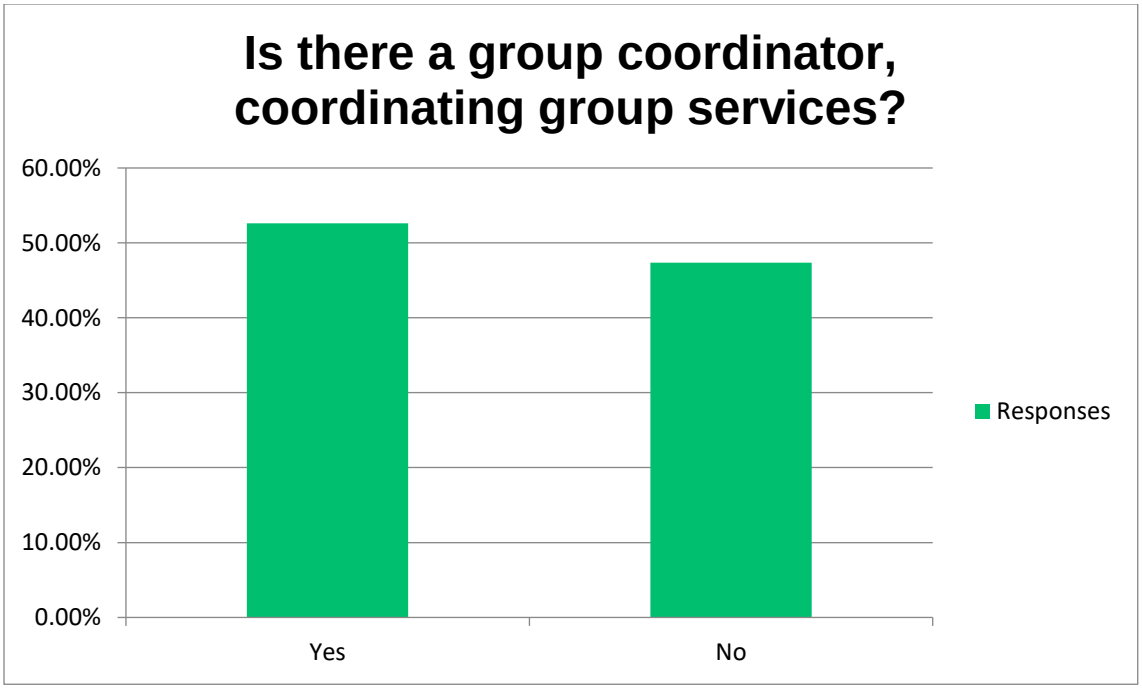
Manualization



ANSWER CHOICES	RESPONSES	
None	18.42%	7
Up to the individual therapist	36.84%	14
Preferred but not required	21.05%	8
Required – must use a specific manualized treatment prescribed by the agency for therapy groups (e.g theme groups, psychotherapy, etc.) only	10.53%	4
Required – must use a specific manualized treatment prescribed by the agency for all groups	5.26%	2
Other (please describe)	7.89%	3
TOTAL		38

"None," "up to the individual therapist," and "preferred but not required" are the three largest categories, suggesting that manualized treatments are far from omnipresent and seldom mandated. This may be a philosophical belief in evidence-based therapists who are best left to their preferred theory; a lack of belief in manualization; no overarching philosophy of treatment except allowing therapists to choose their preferred treatment modality; and lack of interest from administrators on standardizing treatment across settings. This finding is somewhat surprising, since anecdotal evidence suggested that manualized approaches were finding favor nationwide. However, this survey showed that while these approaches may be utilized, they are certainly not required or as all-pervasive as some may have thought.

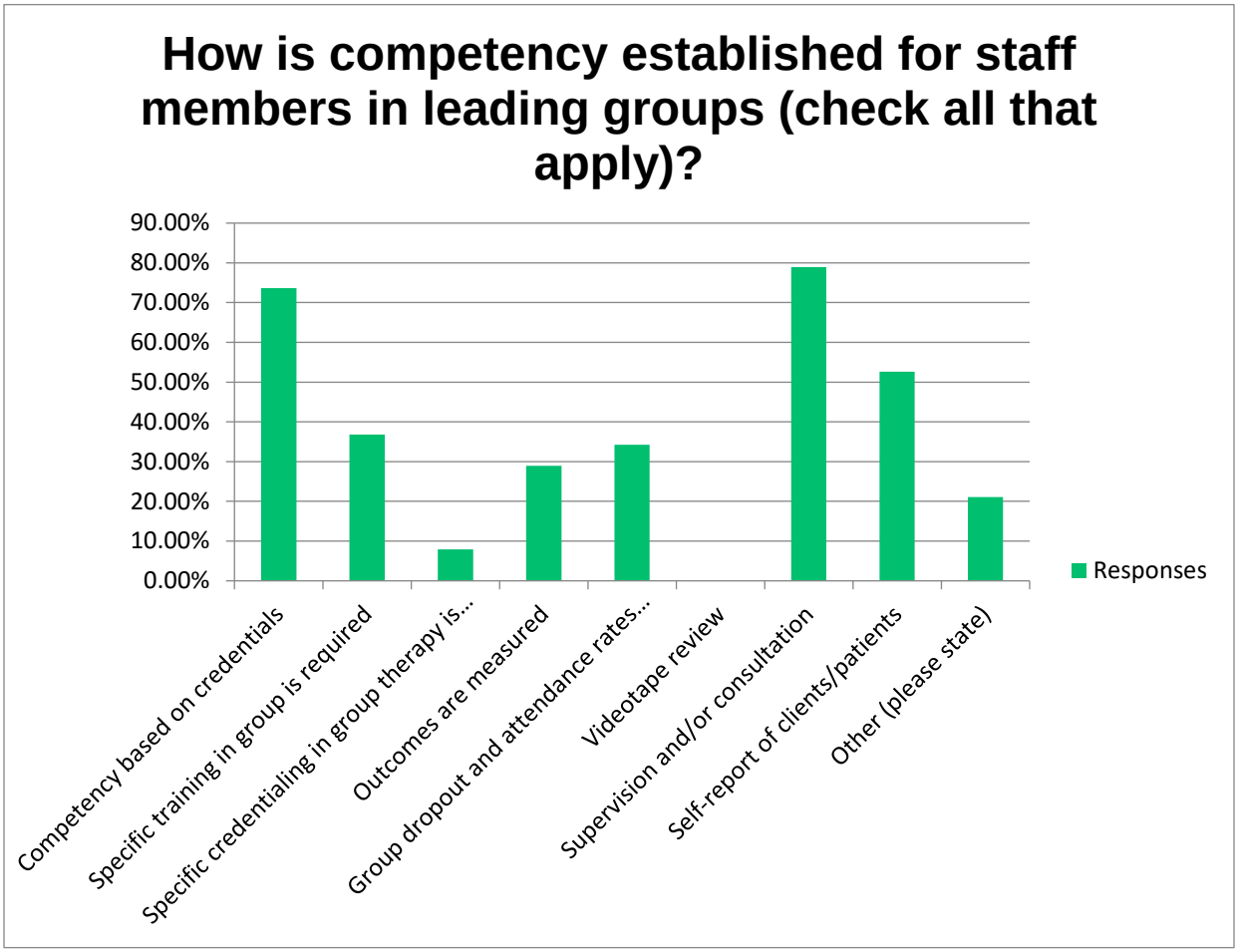
Group Coordination



The presence of a group coordinator has become *de rigeur* for University Counseling Centers, but is not as commonly used in other settings. The advantages of coordination include, but are not limited to: collecting and analyzing group data on access and quality; ensuring group training is rigorous; providing advocacy for the group program as a whole; and connecting to other group coordinators via listservs, with the aim of

improving quality and ensuring services are not reinventing the wheel. This survey showed an even split between those with and without group coordination. These numbers suggest that group coordination extends beyond UCCs and, therefore, begs the question as to what services might be provided to group coordinators in agencies that are not just UCCs. Of note, in the following question, an "other response" noted that the group coordinator has authority over residents but not therapists. Therefore, the format of types of group coordinator authority likely varies across setting.

Establishment of Competency and Quality



As can be seen in the diagram above, competency is established using a variety of methods. However, this survey question reveals a significant problem in terms quality assurance.

ANSWER CHOICES	RESPONSES	
Competency is assumed based on credentials (psychologist, social worker, etc)	73.68%	28
Specific training in group is required	36.84%	14
Specific credentialing in group therapy is required	7.89%	3
Outcomes are measured	28.95%	11
Group dropout and attendance rates monitored	34.21%	13
Videotape review	0.00%	0
Supervision and/or consultation	78.95%	30
Self-report of clients/patients	52.63%	20
Other (please state)	21.05%	8
Total Respondents: 38		

As can be seen from the table and chart above, the means to achieve competence can be divided into the top and bottom three categories.

50%-75% + of the time

1. **Reliance on supervision/consultation (78.95%)**

   This is heartening as it suggests that a large number of agencies are utilizing supervision to enhance group quality. It may be effective if there is at least one recognized group expert leading the supervision/consultation. In such cases, regular feedback on group skills, techniques, and attitudes can be a strong determinant of successful outcomes. However, anecdotally, the authors of this report have found that competent supervision is by no means guaranteed. In particular, self-serving bias can easily creep into this form of evaluation, whereby it is possible for successful group leadership to be defined by whether a group started, finished with all its members intact, and a self-report of clients stated it went well. While this may have some face validity that can correlate to positive outcomes, it is by no means a guaranteed formula for success.

2. **Reliance on general training/credentials (psychologist, social worker, etc.) (73.68%)**

   This category being the most endorsed is expected and only problematic if it is the only means of measuring competence. When social workers, counselors, and other Master's level practitioners undertake group, there is no guarantee as to the quality of the group training they received in their program, nor is there any evidence that they have had supervised experiences in group with experts in group therapy. Moreover, some programs do not require group therapy training. When they are in place, training experiences can be highly variable, and a terminal degree is no guarantee of competence in group therapy.

3. **Self-report of clients (52.63%)**

   Self-report of clients can be an important outcome. Patient satisfaction is a metric that IHI has made a part of its Triple Aim, and is, therefore, a desirable metric to achieve for many agencies, with hospitals and ACOS particularly invested in this statistic. However, what this question does not capture is whether the therapist is reporting a general feeling of well-being at the end of the group or a measurable item on paper that captures satisfaction. In some cases, these may be different. Anecdotal evidence suggests that some clients may be disinclined to deviate from the group uniformity of reporting group as a positive event during the last session. In these cases, clients may be inclined to please the therapist and other members with excessive positivity about

group, which secretly they feel is not reflective of their own experience. Therefore, it would be important to follow up with a written response individually.

25%-50% of the time

4. **Specific training in group is required (36.84%)**

   This percentage is quite low and suggests specific group training is not a priority for many agencies. More detail is needed as to the quality, type, and duration of group training when it is required. The survey did not measure how many agencies are also training sites and whether this specific training was provided in-house; expected to have been gained in practicum sites prior roles; or was part of the agency training budget for conventions and conferences.

5. **Group attendance and dropout are monitored (34.21%)**

   This is also a fairly low number, suggesting that most agencies do not monitor group attendance and dropout at all. This is problematic since attendance and dropout are the most basic levels of quality assurance. Failure to launch (members not starting group for example, due to lack of motivation or lack of belief in group) and failure to thrive (members dropping out prematurely) are demoralizing for group members and therapists alike, so important to monitor. What is not clear is whether, even for the 34.21% that do monitor, they aggregate, report, and track these figures as part of routine quality improvement, or whether this happens in a more ad hoc way?

6. **Assessment of outcomes (28.95%)**

   Fewer than 30% of those surveyed utilize outcome measures. Of the 28% that do use it, it is also not clear whether that assessment is ever aggregated and used for group therapy quality improvement initiatives. The Joint Commission, the regulatory body overseeing hospitals now requires outcome assessment and that CMS will do so from end of 2018-19. While some agencies in the survey are already working toward meeting that regulation, others are not subject to it. Issues, such as budget for outcome measures; ability to analyze outcomes; management desire to understand and/or report outcomes; technical issues in analysis; data collection and HIPPA and reliable benchmarking, remain a barrier to outcome measurement.

Below 25% of the time

7. **Specific credentialing in group (7.89%)**

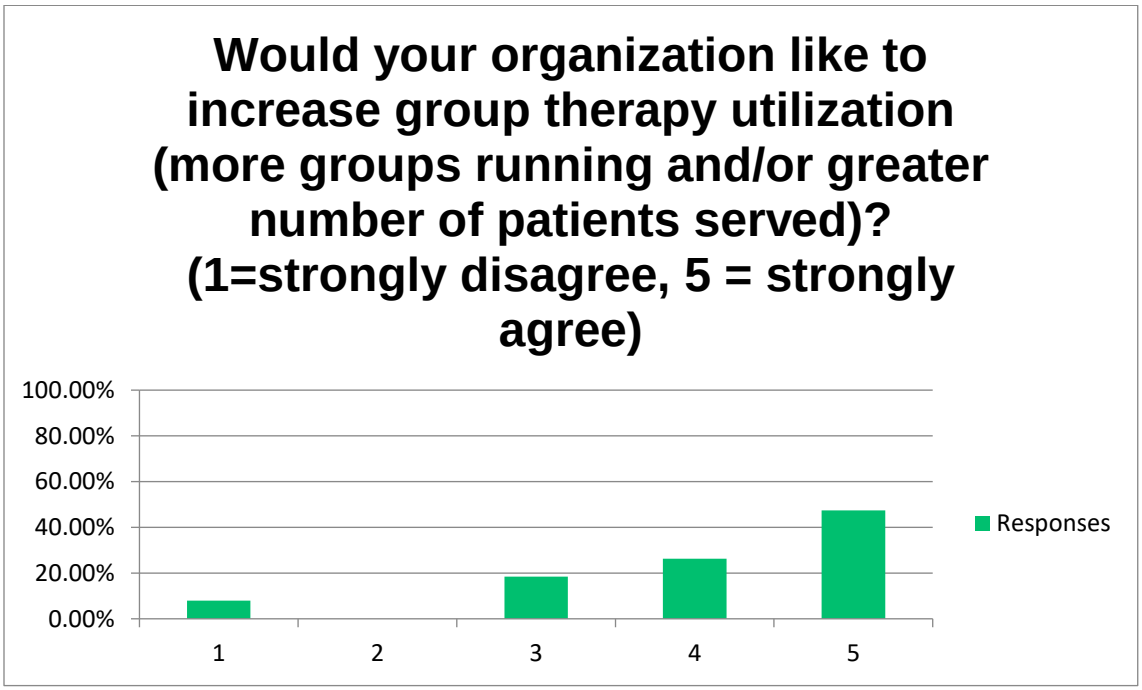
   The lack of CGP as an aspirational credential is notable in this survey. It is unclear why the certification does not have more adherents, but it is possible that many agencies do not see this as an indicator of quality assurance that is important to them. It is possible that the cost of certification, time to study, lack of CGP supervision, and general lack of incentive to become certified are all factors in the low ranking of this item. As the lead author noted, when working as an executive at a previous workplace, it was only when CGP was mandated as a part of practicing at the top of one's license and funding was provided for the application that staff applied for their CGP in significant numbers.

8. **Video (0%)**

   Use of video can enhance group supervision. However, likely due to legal restrictions such as HIPPA, lack of technology to do so and difficulty of implementation mean that few, if any, sites rely on video supervision. This method is seldom seen across the nation except in internship sites where it can form the basis for supervision. However, it is seldom used at sites for peer supervision due to legal complications surrounding HIPPA compliance and confidentiality.

Individualized "other" responses included noting that group training was provided in-house.

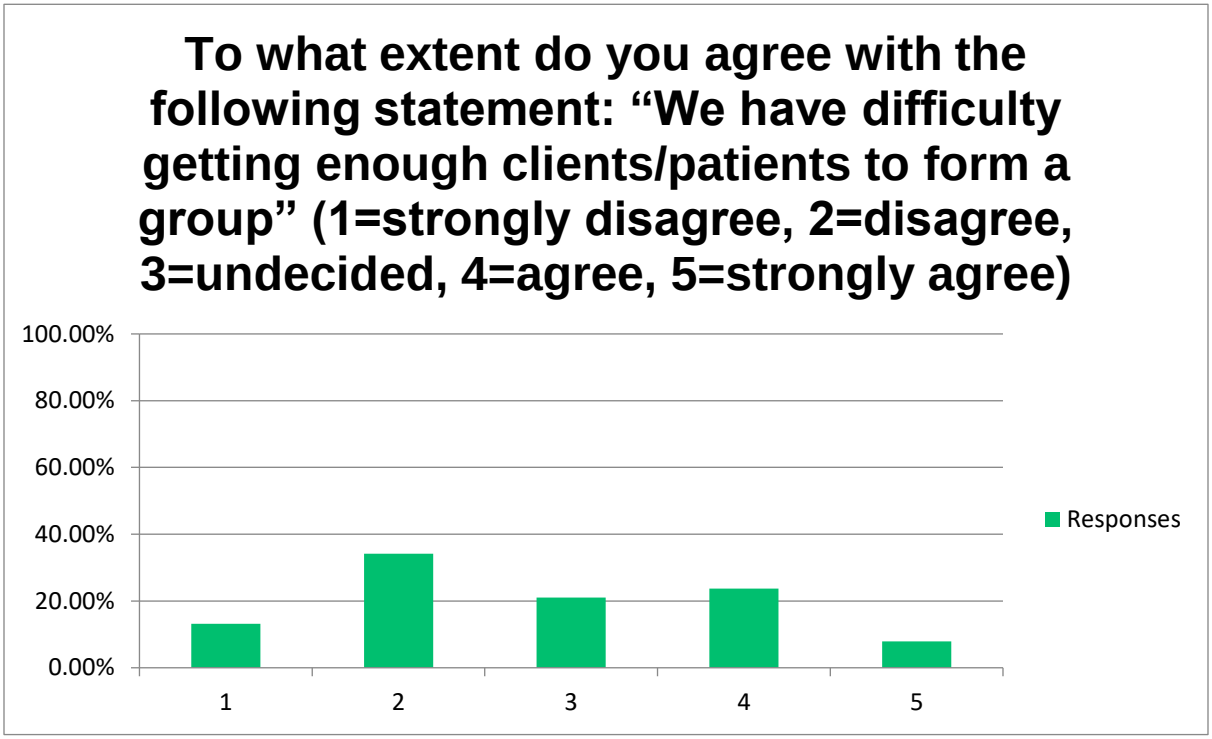
Utilization



Hope for increased utilization of group is one of the strongest findings of this survey. Agencies want to increase access/utilization to group services. 73% of respondents indicated "agree to strongly agree" that they wish to increase group utilization. Overall, this suggests either that agencies are unhappy with their patients' current access to group treatment levels or are wishing to expand existing, strongly attended treatment.

This speaks to a need for training in building a group culture, pre-group preparation, inclusion/exclusion criteria, screening, building a working alliance, effective evaluation of patterns of successful group referral, and successful referrals and leadership.

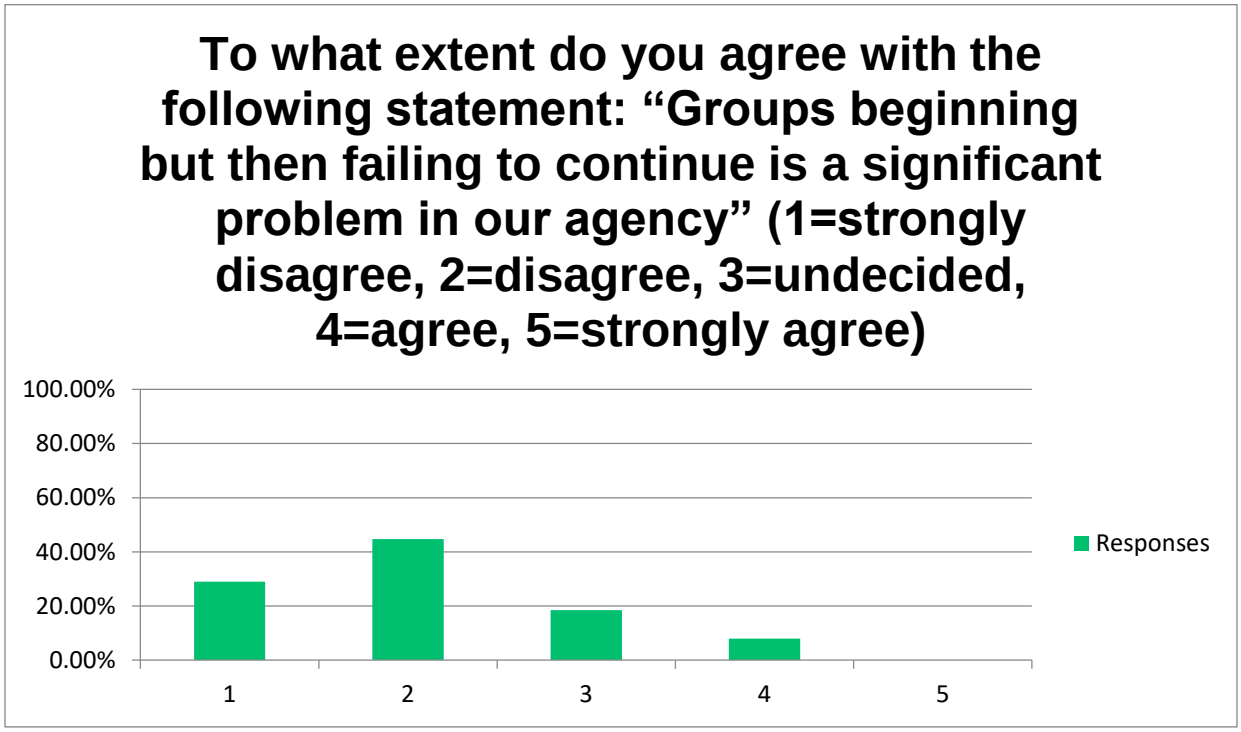
"Failure to Launch"



Building on the previous question, it can be seen that there are a wide range of responses to this question, ranging from those strongly disagreeing to those strongly agreeing. In other words, some agencies appear to have no problem forming and starting groups, whereas others seem to struggle with this considerably.

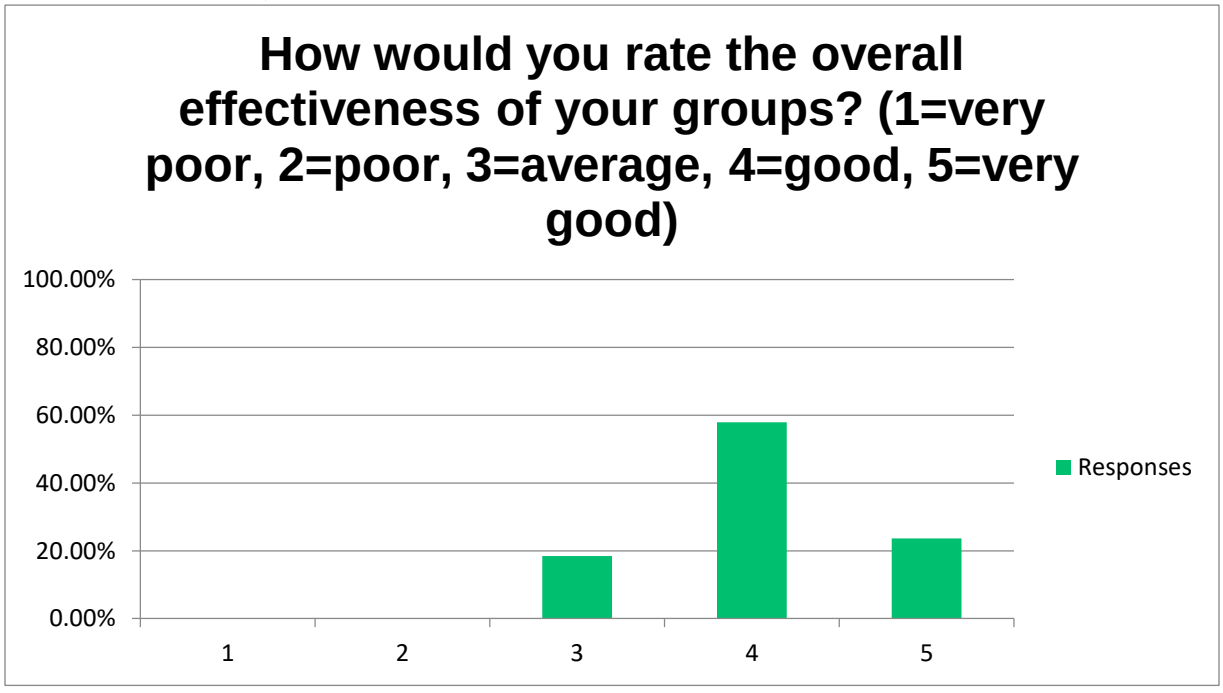
This is an area where training could be offered by AGPA.

"Failure to Thrive"



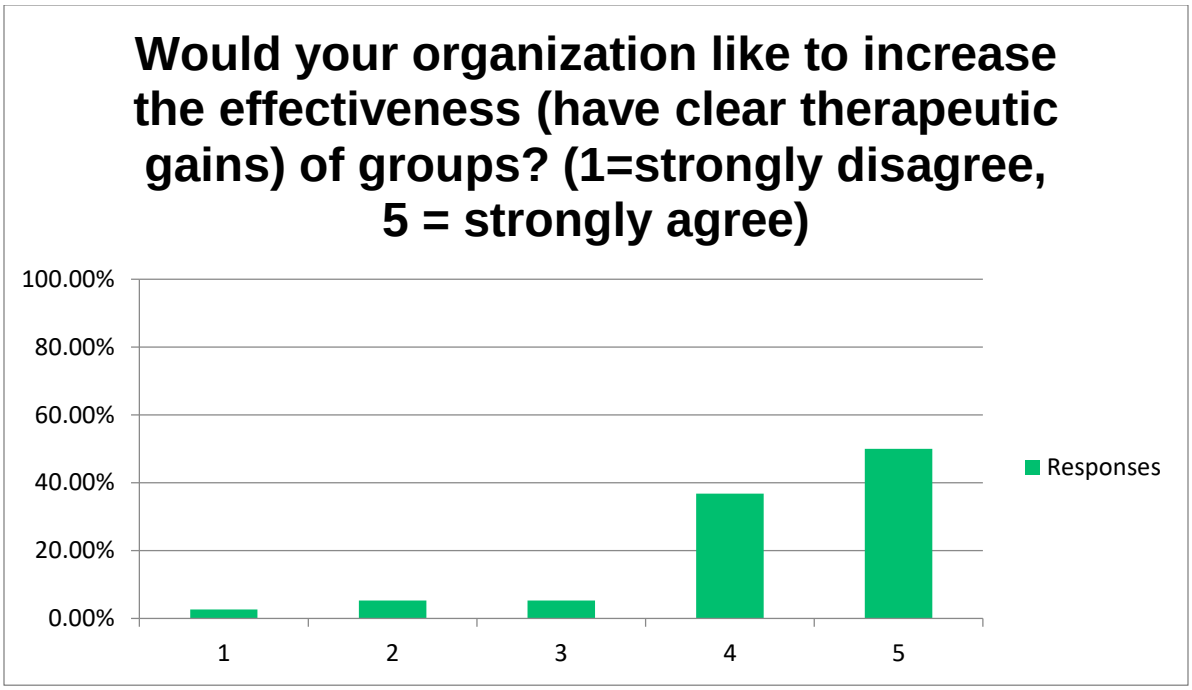
Per this survey, groups beginning and then failing is not a significant concern for many agencies. However, three agencies did endorse this as a significant issue in their practice and 7 more were undecided. Therefore, AGPA may wish to consider the training implications of this issue.

Effectiveness of Groups



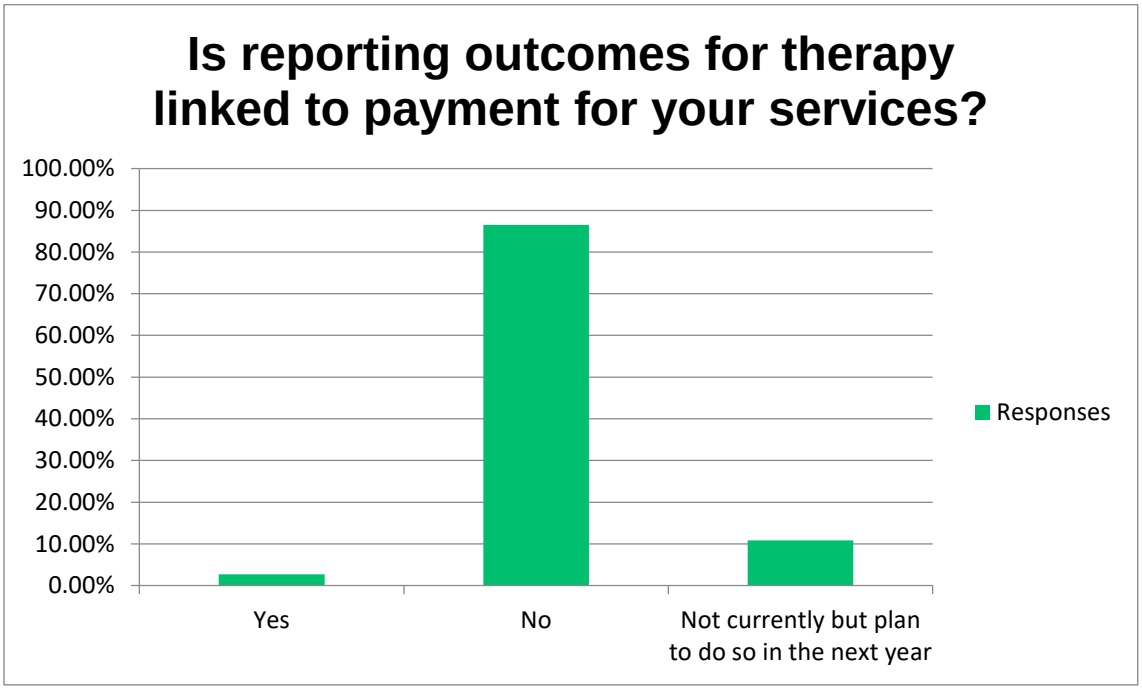
"Good" as highest rated evaluation is difficult to analyze. Although it is heartening that agencies endorse "good" as the modal score, and for some that may be an accurate estimate, it is also possible that there is some error in this evaluation, with agencies disinclined to rate their group programs poorly due to the social desirability effect. Equally, since previous questions showed measures of success are based on supervision and client evaluation but not outcome analysis, care should be taken in over-interpreting the results.

Effectiveness Improved/Gains Measured?



Reporting outcomes is a question that showed a clear pattern (>86%) of endorsement of either agree or strongly agree. In other words, most agencies favored an improvement in their ability to function well in this area. However, it is largely dependent on how the respondent defines and measures "clear therapeutic gains." Although the means to evaluate this, per previous questions, may seem unclear to them, it is a desired goal.

Outcomes Linked to Payment



This was generally not endorsed, although 10% are planning to do so. This may be a question of lack of awareness. Reporting outcomes is a goal for CMS (Medicare and Medicaid) and is being phased in over 2018-2020. The Joint Commission does not currently require assessment results for payment but is requiring administration of assessment tools.

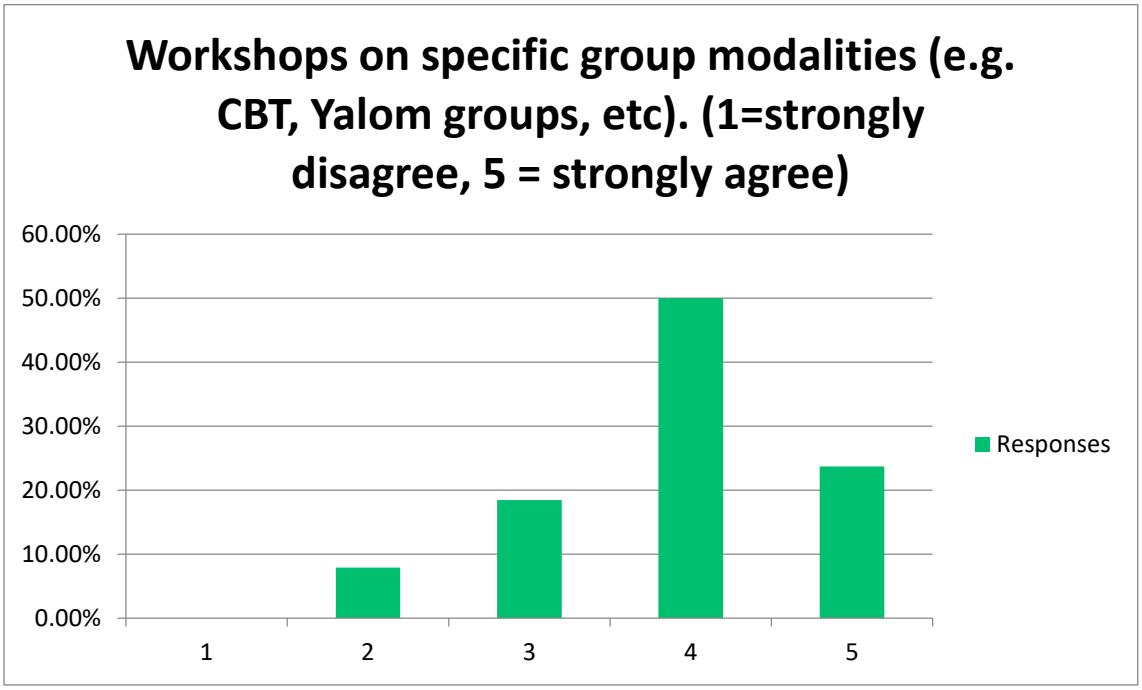
Training

Workshops on Evidence-Based Groups?

This is a clearly identified training need for some agencies, albeit with some differences in terms of how much this is a priority. Of the sample, 13 identify this as "very valuable," which suggests training in evidence-based group is a clear priority, while 12 report this to be undecided.

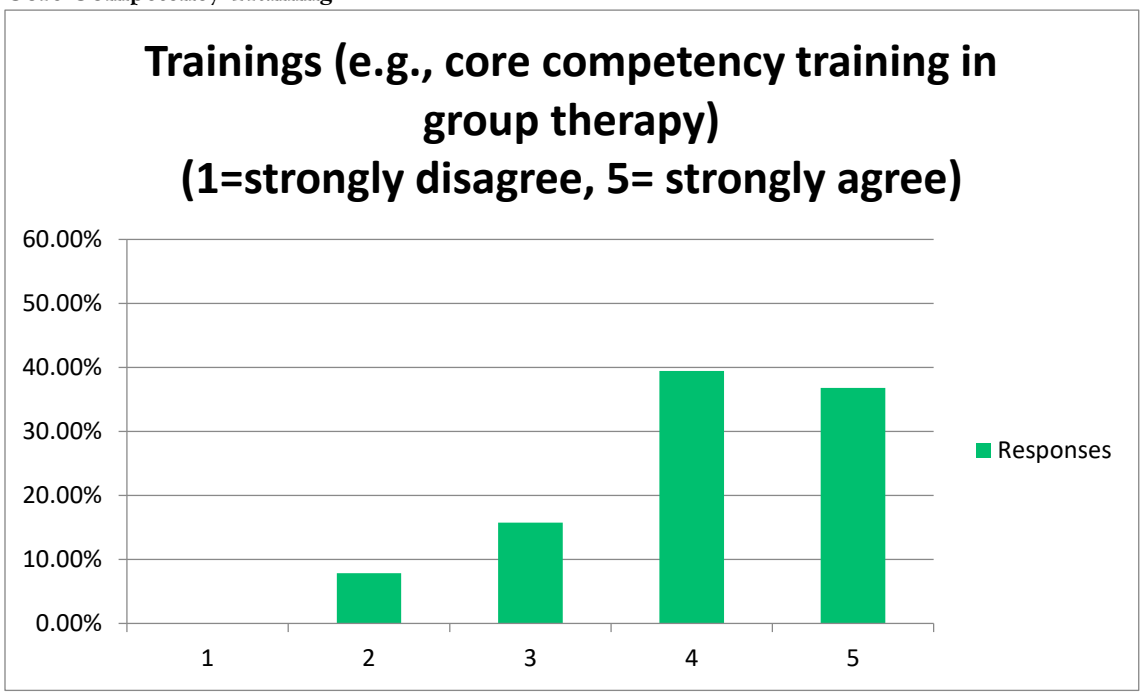
AGPA may need to clarify what is evidence-based (specific treatments versus practice guidelines on therapist effects, etc.?) actually is and discuss with agencies how they interpret the idea of evidence-based practice.

Workshops on Modalities



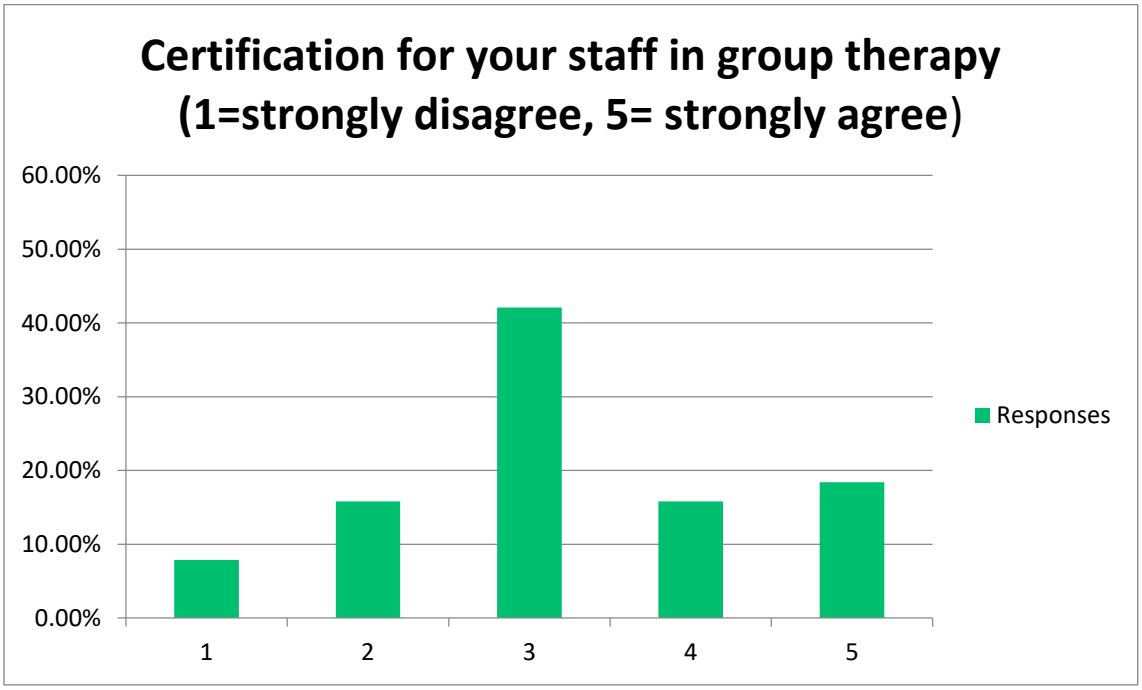
"Valued" is highest category identified for this answer. However, it is unclear which specific theories are sought. There seems to be a demand for specific trainings on groups such as CBT, Yalom, etc., however, more information is needed on which specific theories are desired as trainings.

Core Competency Training



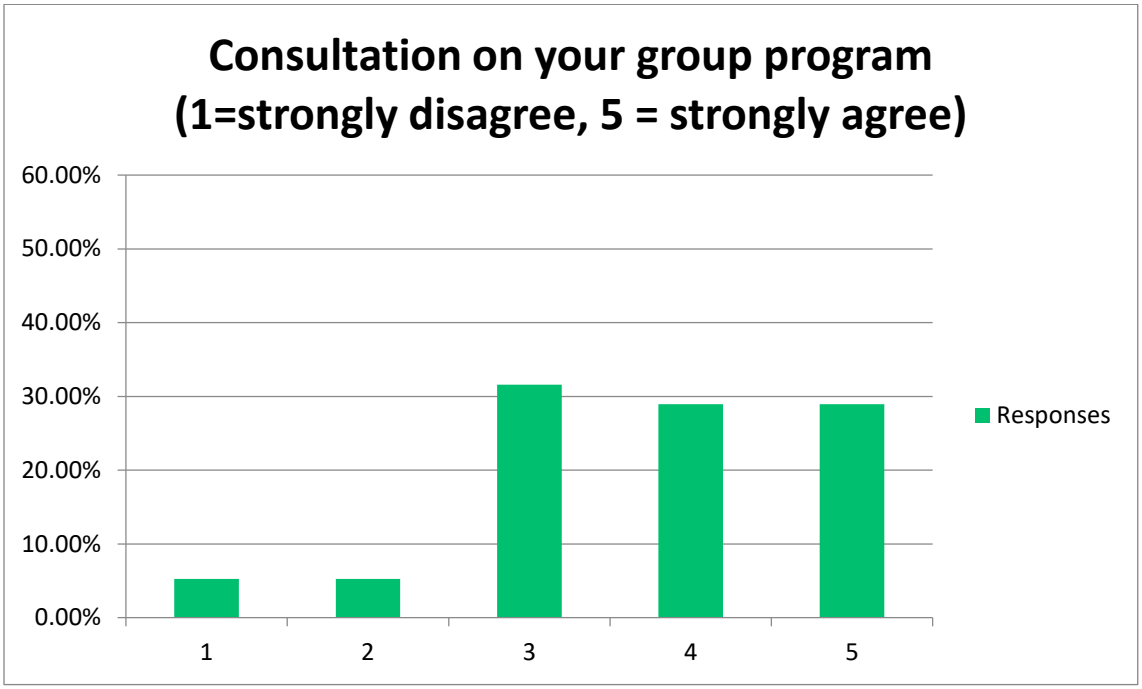
There is strong interest in core competency training. "Valued and highly valued" are the categories most endorsed, suggesting that agencies believe basic, competent group leadership is desired. This is an interesting finding since it could suggest that some agencies are not convinced that all their group offerings are competently led. It is also interesting that this category shows clearer endorsement for certification. This suggests that agencies value the idea of core competency of group leadership but either do not understand that certification provides this or see other barriers to certification such as cost or time.

Certification



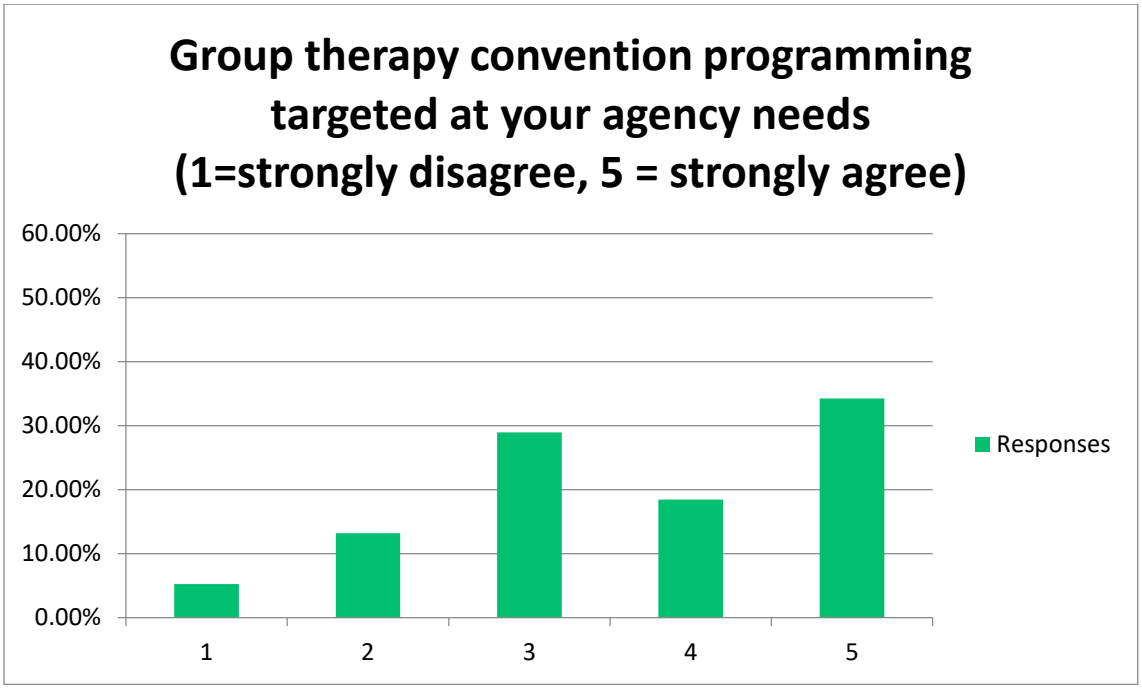
This question is reported out of sequence to how it was administered on the questionnaire to contrast it with the previous question. The modal answer is "undecided" for this answer. Several questions arise from this. Is certification more seen as an outward facing concern rather than an internal metric of competency? Is certification linked with mastery and not competency? Is certification seen as too much of a time demand? Monetarily expensive? Clearly, there is some ambivalence toward this idea, and it is less popular as an idea than other methods of training. However, there was strong interest from some settings. It is possible that the IBCGP Certification Program needs more marketing as a core group competency to distinguish it from a mastery qualification.

Consultation



The high number of "Somewhat-very valuable" responses suggest there is an appetite for this kind of intervention. However, follow-up questions should address funding. Whether there is a budget for this remains a key question.

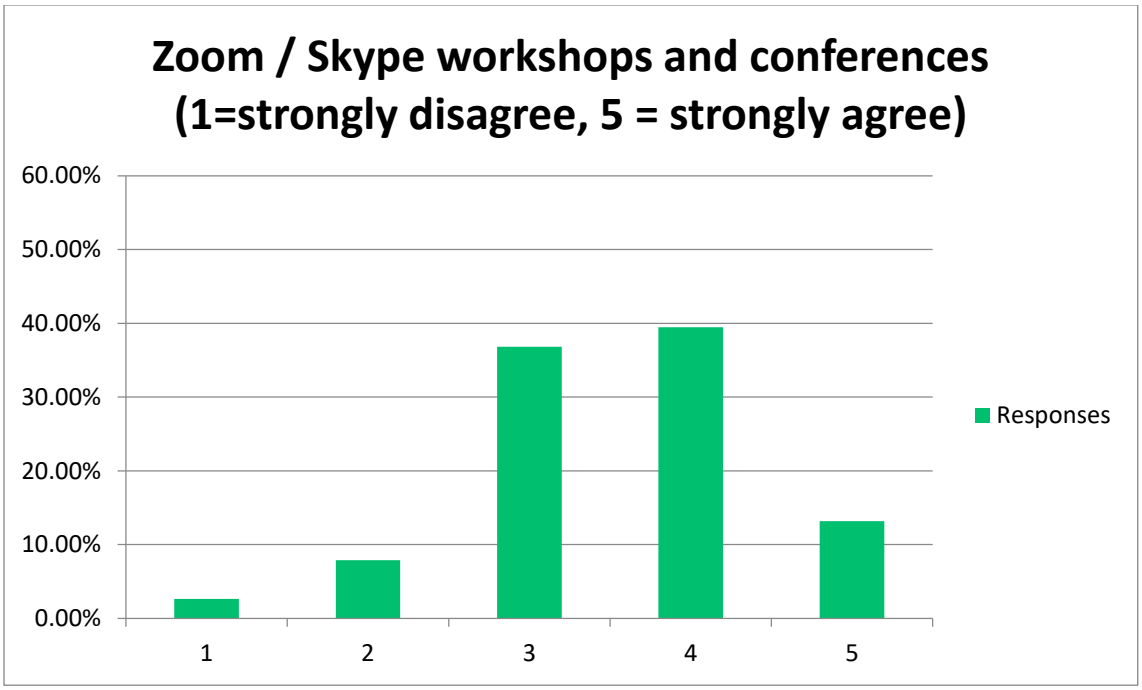
Convention Programming



There were mixed reactions to this question, with agencies reporting mixed feelings about convention programming. The highest score was still "strongly valued," with 34% endorsing this category. However, other agencies were more ambivalent or uninterested. It is possible that this result may be due to either a lack of funding for conventions; a lack of belief that programming for agencies will be useful due to lack of targeted material; or that training money is already allocated for other things.

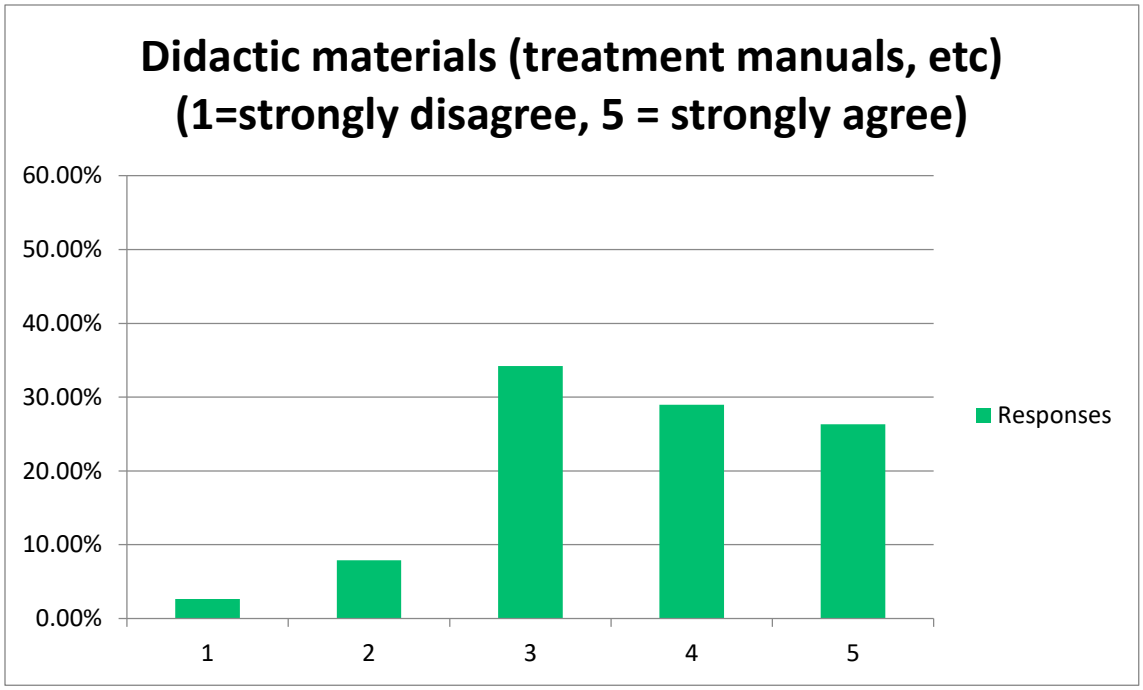
Some agencies do have very strong interest in convention programming, however. It is possible that the quality of agency programming may be key, and word of mouth and strong marketing may be needed.

Zoom/Skype



The range "Somewhat valuable – valuable" is the strongest response to this question, suggesting a demand for Zoom sessions. However, it is unclear why there are fewer "highly valuable" responses, suggesting interest is present, but somewhat weak. While there may be a market for this type of training, further investigation is needed as to the barriers and reasons for the lack of a strong interest in what, in theory, should be seen as a less expensive means of obtaining training and CEs. Possible reasons might include: lack of time to screen Zoom sessions, given the tight scheduling of many agencies' treatment sequences; scheduling issues that necessitate giving up existing meetings or treatments to facilitate Zoom trainings; and technology problems, such as lack of large screens and rooms to broadcast to a larger group or poor previous experiences with Zoom broadcasts.

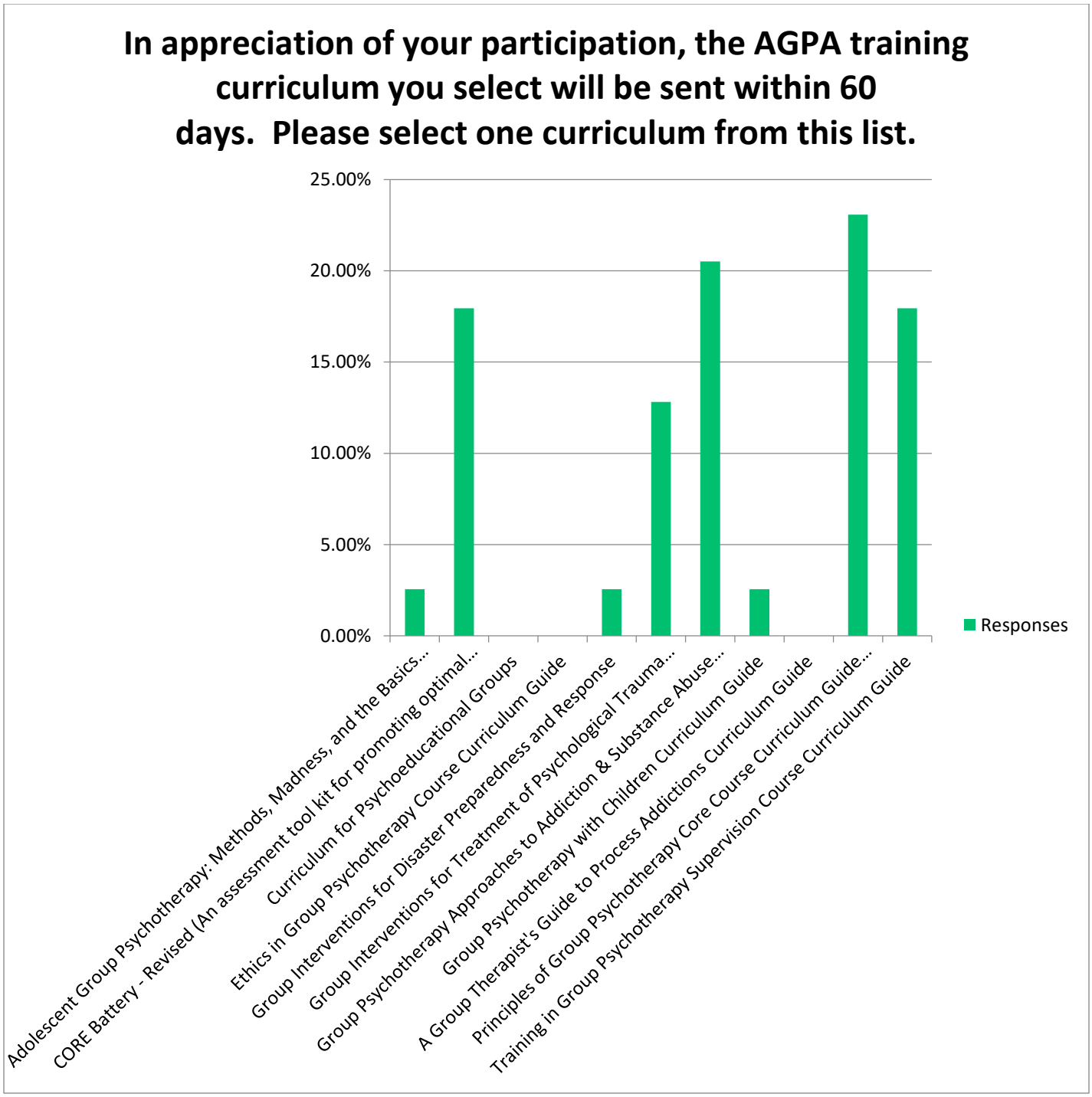
Didactic Materials



Treatment manuals and other training materials are ranked as "somewhat valuable – very valuable." This suggests that didactic materials may be helpful to agencies if marketed correctly. Finer grain detail is indicated in the following question that asked agencies to select training materials as a reward for participation. The following question is inserted here out of sequence since it is conceptually linked to training needs to Question 25.

Selection of Manuals

Question 2. In appreciation of your participation, the AGPA training curriculum you select will be sent within 60 days.



The most requested curricula are indicated below:

1. Principles (23%)

2. Addictions (21%) – *several agencies were specialty addictions-focused

3. CORE-R Assessment (18%)

4. Supervision (17%)

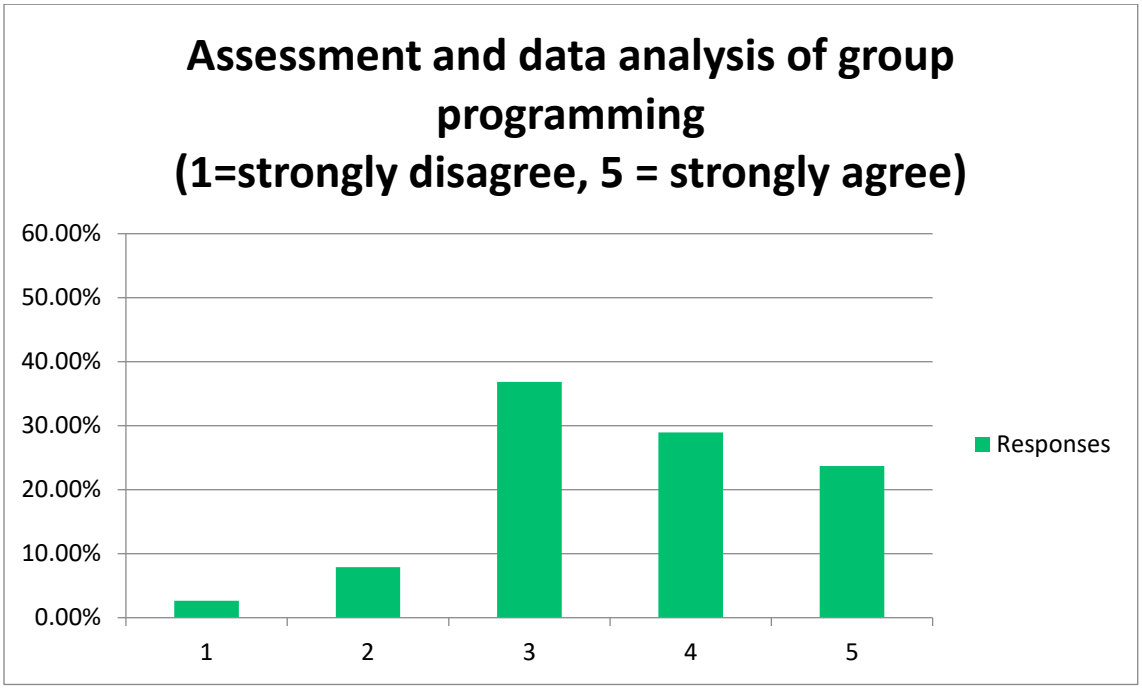
5. Trauma (12%)

Implications

Overall training using the Principles Course, CORE-R Battery for assessment, addictions, supervision, and trauma are the guides most requested by agencies. This suggests that within this sample, demand for guidance on basic group functioning – principles and supervision are higher than for specific populations and symptoms, with the exception of addictions. Equally, the demand for assessment guidance was also high, mirroring the expressed interest in assessment and data analysis for agencies. The interest in addictions may be a function of an overall agency focus on this issue or reflective of the relatively high number of addictions agencies participating in the survey overall.

This suggests a common literature base for all agencies and need for specific, targeted marketing for other products. However, a needs analysis for other products, such as those targeting specific populations and diagnoses, may be worth conducting.

Assessment/Data Analysis



This category is an interesting one in that there is a desire for a significant portion of agencies for greater use of assessment to evaluate group programming. It is difficult to know if this is aspirational and related to desire to provide evidence-based practice; a reaction to trends in the

field toward quality improvement; a response to existing and upcoming regulations; or something else. It is also unclear why agencies are not currently doing this. Assessment and data analysis takes time to implement and skill to administer and analyze. It is also possible that some agencies see this as aspirational but lack the time and resources to follow through in the face of competing priorities.

Question 27, below, asks for suggestions for group training and education. Few answers were supplied, however.

Other Comments

- One comment relates to a common issue seen in UCCs, that of high staff interest but low client enthusiasm for group. This idea is often a major differentiator between outpatient agencies with successful and unsuccessful group programs. The question relates to how to motivate clients toward group, build a culture of group through pre-group preparation and staff training and then to turn this into a working alliance through effective screening and pre-group interviews.
- The payment structure making group unsustainable is a major issue for agencies. Although beyond the scope of this study, it is an issue in need of further research.
- Variability in quality assurance is a frequent issue for larger agencies. This suggests an opportunity for AGPA to act as advisors and consultants on how to accomplish this.
- Train-the-trainer is often the preferred method of training for agencies. AGPA may wish to consider this as a part of convention programming.
- Staff turnover is a significant concern for many agencies and is reflected in one of the responses here. It is not uncommon for staff to transfer frequently, particularly in hospital settings. Therefore, maintaining group quality standards can be highly problematic. AGPA may need to consider how to meet these training needs by producing materials and programming that can get new staff up to speed quickly and at a lower cost.

Summary and Discussion

This survey provided a massive national sample (160,000+) of clients served by 40 agencies utilizing group therapy in a wide variety of settings. Six of these agencies served more than 20,000 clients per annum, making them among the largest in the country. The largest setting was hospitals and hospital systems, with university counseling centers, community mental health centers and the VA system also well represented in the sample. 87% of agencies indicated serving outpatients, although 36% indicated serving inpatient clients, with some overlap as several agencies served multiple populations at different levels of care.

Utilization rates for group varied widely depending on level of care in this sample. For inpatient, group was as likely to be used more than 75% of the time as it was less than 25% of the time, suggesting widely different treatment philosophies with regards to use of group. For PHP/IOP, the utilization rate was

uniformly very high, with all responses indicating between 50%-75%+ of treatment was group therapy. For outpatient, group showed the reverse pattern, with group used at lower rates – typically between 0 and <50% of the time.

Group training and assurance of competency was highly variable in the survey. Most sites indicated relying on professional qualifications (LCSW, MS) only as a guarantee of quality, while some did indicate utilizing supervision of group and also checking in with clients. However, outcome measurement was seldom used at any agency, therefore, the overall quality of group programming was difficult to verify. This is particularly problematic given the recent literature (Kivlighan, 2018; Whittingham, 2018) suggesting consistent monitoring of outcomes is essential to quality improvement.

Sites endorsed a modal score of only the second highest level for ratings of the quality of their group therapy. This may be due to a lack of benchmarking but in all likelihood reflects a social desirability – they are scoring higher than they might believe their groups deserve to maintain their reputation. Moreover, the following questions that ask if they wish to improve the effectiveness of their groups was endorsed at the highest level. Again, this may be due to a desire to continually improve and be reflective of already-present excellence, but could also be the reverse – a wish for greater quality assurance in their groups due to a perception of deficits in quality.

Agencies reported a strong desire for improvement in group therapy quality; a wish for outcome assessment; a desire for more training in core group skills; training of leaders in specific types of group (e.g., CBT or Yalom); didactic materials; telepresence training; and convention material targeted at agencies. In terms of didactic materials, agencies were allowed to choose a curriculum as a gift for participating in the survey. The Principles Course was the most favored, followed by the addictions, CORE-R and supervision. The CORE-R reflected an interest overall in analysis of data and measurement of outcomes. While very few agencies reported currently measuring outcomes or being paid for doing so by insurers, several noted that they intended to do so soon.

Manualized treatment was desired but seldom mandated by agencies. It was mostly left to individual practitioners to choose their treatment model. Psychoeducational groups and manualized groups were utilized in inpatient and PHP/IOP. Recreation groups were most used in inpatient, while support groups were most used in outpatient. Psychotherapy process groups were not uniformly utilized across levels of care, but occurred at the highest frequency in PHP/IOP.

Certification was somewhat desired but was endorsed at lower rates than a question of the desirability of core competence in group. This might suggest a perception that certification is a mastery and not a competence credential, or it could relate to financial or time-related obstacles to gaining certification. It may be that certification marketing needs to focus on time, money, and objectives-related (core competence emphasized) information.

Limitation of the Study

A key question is whether there is selection bias in the sample? The first list that was randomly selected from largest behavioral health services registered few responses. However, the second phase, utilizing existing contacts from Task Force members yielded far higher response rates. It is possible there may be selection bias in this method, with Task Force members more likely to be connected to and receive responses from agencies already invested in group therapy. Given that Task Force members may have become connected to AGPA as a result of work experiences with agencies and colleagues who see the

efficacy of group, it is possible that this sample is unrepresentative. However, several agencies have client populations of more than 20,000, representing some of the larger agencies in the country. Therefore, it could be said to represent some of the major players in the market and, therefore, is representative of trends overall for agencies of this size. It is also possible that agencies not reached were ones less invested in group therapy. Hospital inpatient agencies are still, in many cases, using a "meds and beds" model where little to no individual or group therapies are provided. Moreover, use of group in outpatient may also be quite variable for those outside of this sample. Assuming that this sample is, in fact, representative of some of the more group-invested sites, it is interesting that the demand for more training and overall focus on group quality is so meagre. If that is the case for this sample, then it may be that quality of group therapy elsewhere is even more problematic.

Suggestions for Future Research

There are several avenues for future research, including increasing the sample size for utilization, understanding training budgets (since this can impact therapy quality), and exploring each agency type in more depth and detail. Future research could also go into more specificity regarding which treatment theories are becoming more utilized. Further, questions regarding use of outcome assessment might become more urgent for agencies in one to two years, as third-party payers such as CMS begin to demand proof of outcome of treatment and use this to withhold payment or grant bonuses.