Advancing Evidence-Based Group Work in Community Mental Health Settings

Methods, Challenges, and Opportunities

Mark J. Macgowan and Alice Schmidt Hanbidge

The integration of research into practice has been a long-standing concern in group work. The most recent manifestation of the desire to integrate the best available research into clinical settings is evidence-based practice (EBP). Although there is now much literature on the dissemination and implementation of EBPs in community settings, only recently has the process and content of EBP for group work been articulated. Pollio (2002) defined evidence-based group work (EBGW) as "the conscientious and judicious use of evidence in current best practice" (p. 57). Macgowan (2006, 2008), building on Pollio's work, outlined a multistage process model of EBGW. In recent years, there have been special issues of scholarly journals dedicated to EBP in group work (Burlingame & Beecher, 2008; Klein, 2008; Pollio & Macgowan, 2010).

Group work has increasingly been utilized in community settings, including mental health centers, community agencies, and health maintenance organizations (CMHS). However, EBP has not been widely implemented in CMHS (Mullen & Bacon, 2004). This chapter describes the different perspectives on EBP in groups and discusses a process model (EBGW) for integrating the best available evidence into group work in CMHS. To illustrate the principles in practice, a case example is included showing how EBGW could be implemented in a community setting. Challenges and barriers to advancing EBGW in CMHS are presented with suggestions for overcoming them.

PERSPECTIVES ON EVIDENCE-BASED PRACTICE IN GROUPS IN COMMUNITY SETTINGS

The term evidence-based practice is rooted in medicine's effort to provide the best medical care to patients (Straus, Richardson, Glasziou, & Haynes, 2005). Today there are many terms representing EBP, which can be organized into three types: empirically supported group interventions; evidence-supported group processes, techniques, and guidelines; and EBGW, which critically incorporates the other two areas. This section reviews these three areas and notes how they connect with group work in CMHS.
Empirically Supported Group Interventions

Empirically supported group interventions (ESGs) have been shown to be efficacious for specific diagnostic groups (often using the DSM-IV) through randomized clinical trials (RCTs), meta-analyses, or through consensus of experts based on a critical review of the best research evidence. The term intervention is used broadly to include preventative interventions designed to prevent problems for at-risk populations. Some of the problem areas include alcohol and other drug (AOD) use, anxiety disorders, depression, schizophrenia, and co-occurring AOD with other disorders. A meta-analysis on the efficacy of group treatment for a wide range of diagnoses (e.g., depression, anxiety, eating disorders, personality disorder) reported a large pretreatment/posttreatment effect size of 0.71 from 111 studies (Burlingame, Fuhriman, & Mosier, 2003). The review noted that participants in group treatments were better off than 72% of those in untreated, wait-list control groups (effect size = 0.58).

Persons with serious mental illnesses (SMI) such as bipolar disorder, severe depression, or schizophrenia have impaired social functioning with prolonged disability and/or are in need of intensive treatment (Garvin, 2011). A review of thirteen studies reported that group rather than individual Cognitive-Behavioral Therapy (CBT) was a more effective modality for early psychosis (Saks, Cohen, Srilhari, & Woods, 2009). The researchers speculated that group work allows group member concerns to be more effectively integrated with CBT principles so that, for example, a member learns new ways to manage a personal problem by hearing how another member handled a similar concern.

Table 24.1 provides a summary of selected systematic reviews published in the past ten years, across a range of DSM-IV diagnoses often assigned to persons seeking services in CMHS. As indicated, group work is an effective modality, particularly for anxiety, depression, and eating disorders. Co-occurring SMI and AOD are commonly presented challenges in CMHS. Treatment seems to be effective in reducing AOD use, with some effects on mood disorders (Table 24.1). There are many types of groups that may be offered to persons with co-occurring disorders, including CBT, which focuses on the thought processes related to AOD use, motivational interviewing (MI), which enhances a desire for change and often combined with CBT, and specific group therapies such as "double trouble," which are intended to strengthen coping and interpersonal skills to stop AOD use (Cleary, Hunt, Matheson, & Walter, 2009). Given the prevalence of co-occurring disorders in the community, there is strong need for more RCTs with improvements in mental illness outcomes.

In addition to professionally led groups, self-help groups have an important place in community mental health. There is promising evidence that such groups can help persons with chronic mental illness, depression/anxiety, and bereavement (Pistrang, Barker, & Humphreys, 2010). A review of interventions for persons with co-occurring disorders (Mueser, Drake, Sigmon, & Brunette, 2005) noted that self-help groups were valuable if they included elements to address both AOD problems and psychiatric symptoms (e.g., dual recovery, double trouble groups).

Evidence-Supported Group Processes, Techniques, and Guidelines

Group workers in CMHS should also become aware of evidence-supported group processes, techniques, and guidelines endorsed through rigorous research and/or expert consensus. Two examples in this area include cohesion and practice standards.

Cohesion. One important area explored in the literature is the evidence-based psychotherapy relationship (Norcross & Lambert, 2011). Cohesion is "the therapeutic relationship in group psychotherapy emerging from the aggregate of member-leader, member-member, and member-group relationships" (Burlingame, Fuhriman, & Johnson, 2001, p. 373). A recent meta-analysis of 40 studies (n = 3323) reported that cohesion was significantly associated (r = 0.25) with reductions in symptom distress or improvements in interpersonal functioning across different settings and diagnoses (Burlingame, McClendon, & Alonso, 2011). Factors associated with cohesion include the following: (a) Cohesion is most strongly associated with client improvement in groups using an interpersonal, psychodynamic, or cognitive-behavioral orientation; (b) Group leaders who facilitate
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<thead>
<tr>
<th>Problem Area/Population</th>
<th>Sample</th>
<th>Theories/Models</th>
<th>Findings</th>
</tr>
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<tr>
<td><strong>DSM-IV-TR Axis I: Alcohol and Other Drug (AOD) Problems</strong></td>
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<td>Adolescents (Engle &amp; Macgowan, 2009)</td>
<td>13 GTs for adolescents reviewed (N=1751); mostly males, W. non-H/I, with a few including at least 30% H/L or AA.</td>
<td>CBT, CBT/MET hybrid, social learning, two types of PS, STG, IT, 12-step, AGT</td>
<td>10 GTs reported statistically sig reductions in AOD use (those that did not were supportive therapy group, DHP, AGT). Of 10 with positive outcomes, 2 were &quot;possibly efficacious&quot; by also outperforming comparison conditions on AOD use at 7 &amp; 10-month F/U</td>
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<td>Adults (Weiss et al., 2004)</td>
<td>24 studies (n=4075) comparing group work to other conditions; mostly adults (22 studies). Gender/race/ethnicity: NS</td>
<td>CBT, psychodynamic, social skills training, supportive GT, interactional</td>
<td>Study supported value of GT. Three specific findings: no difference in outcomes between GT &amp; IND; no evidence of one type of GT superior to another; supplemental GT can improve &quot;usual treatment&quot;</td>
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<td>Family members affected by AOD use (Templeton, Velleman, &amp; Russell, 2010)</td>
<td>34 studies, of which 5 group-based, in NA. 4 involved only family members w/o alcohol user, which included partners of heavy drinkers (n=194, almost all female); adult children of alcoholics (n=138); children ages 9–13 (n=271); race mostly W. One additional study included alcoholics &amp; spouses (n=33 couples); race mostly W</td>
<td>GT, coping skills training, 12-step facilitation, mutual help group, group preventive intervention</td>
<td>All group interventions reported positive findings across a range of outcomes</td>
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<td><strong>Anxiety/Phobia</strong></td>
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<td>Anxiety (Burlingame et al., 2003)</td>
<td>10 RCTs and quasi-experimental studies. CBT, BT, psychodynamic, eclectic. Sample: NS</td>
<td>Sig ES: AVG of 0.84 for PR/T to P/T anxiety disorder studies compared with 4 wait-list studies of overall average of 0.20 ES</td>
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<td>Social phobia, adult women (McEvoy, 2007)</td>
<td>N=153, 39% women; Race/ethnicity: NS</td>
<td>CBGT</td>
<td>Strong positive findings for community-based CBGT. CBGT compared well to individual CBT. CBGT effective within community mental health clinics, recommended as first-line treatment, time &amp; cost-effective</td>
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<td><strong>Autism Spectrum Disorder</strong></td>
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<td>(Reichow, Steiner, &amp; Volkmar, 2012)</td>
<td>5 RCTs; N=196; 172 males, 24 females, ages 6–17; U.S. participants; race/ethnicity: NS; average to above-average intelligence</td>
<td>SS groups</td>
<td>Some evidence SS groups improved social competence (ES = 0.47) &amp; quality of friendships (ES = 0.41). Decreases in loneliness (ES = 0.66) but no effect on child or parent depression</td>
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<td>Depression</td>
<td>25 RCTs &amp; quasi-experiments (sample characteristics &amp; theory/treatment, NS); 12% of studies conducted in outpatient mental health organizations</td>
<td>CBGT, BT, psychodynamic, eclectic</td>
<td>Statistically sig improvements in depression from PR/T to P/T, AVG ES = 1.10</td>
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<td>Adolescents</td>
<td>17 controlled studies (N = 2498); Adolescent boys &amp; girls; race/ethnicity: NS</td>
<td>PRP (type of CBGT)</td>
<td>Sig reductions in depression at P/T &amp; F/U compared with no intervention group (ES range 0.11 to 0.21). PRP no more effective than active control treatment that does not target cognitive factors</td>
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<td>Low income</td>
<td>11 RCTs, 5 group-based in U.S. (N = 266); low SES women, some pregnant or postnatal; mixed race/ethnicity, W, H/L, AA</td>
<td>CBT, BT, IGT, PS</td>
<td>Generally positive: 2 studies using CBT or BT reported AVG ES of 1.30 over controls. 2 studies reporting participant impressions/other indicators noted improvements after GT, though in one study no difference when compared with TAU GT. Third study no differences on depression but GT had better postpartum adjustment compared with control</td>
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<td>Eating Disorders</td>
<td>12 RCTs and quasi-experimental studies on eating disorders; Demographics: NS</td>
<td>CBT, BT, psychodynamic, eclectic</td>
<td>Large ES (1.38) for PR/T to P/T in contrast to 7 wait-list studies with ES = 0.00</td>
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<td>Binge eating</td>
<td>23 RCTs (N = 864); 90% female, AVG age 43.5 years; Race/ethnicity: NR</td>
<td>CBGT</td>
<td>Large ESs for CBGT addressing disturbed eating patterns, antecedents, &amp; associated symptoms. CBGT recommended as first treatment for binge eating</td>
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<td>Schizophrenia/Thought Disorders</td>
<td>13 RCT or quasi-experimental NA studies (N = 549); male and female ages range 28–57; race/ethnicity: NS</td>
<td>CBGT, BT, modular skills training, CST, PS</td>
<td>Generally positive. Longer term GT or modular skills training can be effective at improving overall symptoms. Intensive CBGT &amp; supportive counseling reduced # of psychiatric symptoms in those with short duration &amp; less symptoms of illness. CST effective at improving goal attainment. GT effective at decreasing social anxiety &amp; improving social interaction. BT effective at improving social functioning. Modular skills training effective at medication compliance but not group PS training</td>
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<td>Thought disorders</td>
<td>4 thought disorder RCTs and quasi-experimental studies; Demographics: NS</td>
<td>CBGT, BT, psychodynamic, eclectic</td>
<td>Some support for improvements for thought disorders from pretest to posttest with AVG ES = 0.64</td>
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<td>Caregivers of persons with psychotic disorders</td>
<td>3 experimental designs, 12 U.S. studies and 15 other areas of world; 19 quasi-experiments, non-experiments or qualitative studies (Western countries); mostly women (75%) and W (67%)</td>
<td>Mutual support groups</td>
<td>Supported the short-term sig positive effects (up to 1 year) of professional-facilitated or family-led mutual support groups</td>
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<td>Stress</td>
<td>7 stress RCT &amp; quasi-experimental studies</td>
<td>CBGT, BT, psychodynamic, eclectic</td>
<td>ES = 0.50 compared with 5 wait-list studies with AVG ES = 0.12</td>
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<td>(Burlingame et al., 2003)</td>
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<td>26 RCTs; (N = 1456); age 18+; Studies from Norway, Sweden, Germany, Switzerland, Holland &amp; U.S.; Race/ethnicity: NS</td>
<td>MBSR</td>
<td>P/T moderate ES = 0.56 for stress/distress. Intervention appeared to improve personal development, including empathy, coping, sense of coherence, &amp; enhancing mindfulness</td>
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<td>(de Vibe, Bjornadal, Tipton, Hammerstrom, &amp; Kowalski, 2012)</td>
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**DSM IV-TR Axis II: Personality Disorders**

| Borderline & avoidant personality disorder/ (Matusiewicz, Hopwood, Banducci, & Lejuez, 2010) | 16 RCTs for DBT treatment for BPD compared to TAU (N = 564 adults); Race/ethnicity: NS. 2 studies CBGT for AVPD (N = 98) | CBGT, DBT, SFT, STEPPS. | Considerable support for DBT group treatment for BPD across various symptoms, including suicidal behavior. Efficacy of short term CBGT for AVPD, anxiety, depression & overall social functioning |
|                                                                                       |                                                                 |                          |          |
| Obsessive-compulsive disorder (Jonnson & Henggaard, 2009) | 13 quantitative studies (N = 549); 63% females, AVG age 36.4 years; Race/ethnicity: NS | CBT, ERP | PR/T to P/T AVG = 1.18 & a between-group ES = 1.12, overall weighed mean = 1.18. CBGT or ERP is an effective treatment for OCD |

**Co-Occurring Disorders: Axis I & II**

| AOD & internalizing, youth (Bender, Springer, & Kim, 2006) | 7 studies of 6 RCTs; 2 studies of 3 GTs (N = 120); adolescents, mostly male (~66%); 90% W | CBGT, IGT, PS | “Moderate” to “large” effect size reductions from PR/T to P/T in internalizing disorders & AOD outcomes (all theories), maintained 15 months after treatment |
| AOD & SMI, adults (Cleary et al., 2009) | 54 studies; 5 used group exclusively, of these 1 RCT, 4 non-experimental (N = 316); Additional 5 included GT with other components (N = 242); Adults; Gender & race/ethnicity: NS | Integrated group therapy, staged group therapy; MI+CBT | Of the 5 using group alone, the RCT increased retention but no differences between groups on AOD or mental status outcomes. The 4 non-experiments had some reductions in some AOD use & psychopathology, fewer hospitalizations, & increased retention at long-term FU. However, results not uniform across non-experiments &designs weak. The additional 5 studies using group alone or with other modalities, had positive results |
| AOD & SMI, adults (Drake, O’Neal, & Wallach, 2008) | 45 controlled studies, 8 group-based (N = 601); Adults. Gender/race: NS | Education, peer support, & tools to manage AOD & mental illness (often combined) mostly including CBT | 7/8 group studies had positive results for AOD & non-mental health outcomes. For mental health outcomes 2/6 studies had positive outcomes. No negative outcomes |

AA = African American; AGT = Adolescent group therapy; AOD = Alcohol and other drug use; AVG = Average; AVPD = Avoidant personality disorder; BDI = Beck depression inventory; BE = Binge eating; BPD = Borderline personality disorder; BT = Behavioral therapy; CBGT = Cognitive-behavioral group therapy; CBT = Cognitive-behavioral therapy; CI = Confidence interval; CST = Coping skills training; DBT = Dialectical behavior therapy; DHP = Drug harm psychoeducation; ERP = Exposure and response prevention; ES = Effect size; FU = Follow-up; GT = Group therapy; H/L = Hispanic/Latino/a; IGT = Interpersonal group therapy; IDT = Individual therapy; IT = Interactional therapy; MBSR = Mindfulness based stress reduction; MBT = Mentalization-based therapy; MET = Motivational Enhancement therapy; NA = North America; NS = Not specified; OCD = Obsessive Compulsive disorder; PRP = Penn resiliency program; PR/T = Pretest; PS = Psychoeducation; P/T = Posttest; PTSD = Post traumatic stress disorder; RCT = Random controlled trial; SES = Socioeconomic status; SFT = Schema Focused Therapy; Sig = Significant; SMI = Serious mental illness; SS = Social skills; STEPPS = Systems Training for Emotional Predictability and Problem Solving; STG = Supportive therapy group; TAU = Treatment as usual; W = White.
member interaction, regardless of theoretical orientation, have higher cohesion-outcome links than groups that focused less on process; (c) Cohesion is related to outcome regardless of length but is strongest when a group has over 12 sessions and includes five to nine members; and (d) it contributes to outcomes regardless of inpatient and outpatient and diagnostic classifications (Burlingame, McClendon et al., 2011).

To build cohesion, specific methods have been suggested. Burlingame and colleagues (2001) identified six principles for building cohesion, across structure, interaction and emotional climate:

(a) conduct pre-group preparation to establish treatment expectations, define group rules, and instruct members in appropriate roles and skills needed for effective group participation and group cohesion; (b) establish clarity regarding group processes in early sessions since higher levels of early structure are predictive of higher levels of disclosure and cohesion later in the group; (c) model real-time observations, guiding effective interpersonal feedback, and maintain a moderate level of control and affiliation; (d) time the delivery of feedback based on the developmental stage of the group and the readiness of members; (e) effectively manage his or her own emotional presence in the service of others, which affects relationships with individuals in the group and as they vicariously see the workers' manner of relating with others; and (f), facilitate group members' emotional expression, the responsiveness of others. (p. 375)

Based on the three important areas related to cohesion (structure, interaction and emotional climate), the Group Psychotherapy Intervention Rating Scale (GPIRS; Chapman, Baker, Porter, Thayer, & Burlingame, 2010) was developed, which can be used by group workers to monitor the clarity of their cohesion-building strategies.

Practice Standards and Guidelines. Group workers in CMHS should also be aware of group work standards and practice guidelines, which have been developed by panels of experts to promote appropriate and effective practices. These standards and guidelines are rooted in professional values and codes of ethics of the respective professional organizations that developed them, such as the American Counseling Association and Professional Social Work Associations in the U.S. and Canada (ACA, 2005; CASW, 2005; NASW, 2008). The International Association for the Advancement of Social Work with Groups (formerly the Association for the Advancement of Social Work with Groups, AASWG, 2006) and the Association for Specialists in Group Work (ASGW, 2000, 2007) have their own set of practice and training standards. There are measures that have been developed to assess group workers' perceived importance of—and ability to perform—the AASWG and ASGW standards (Macgowan, 2012; Wilson & Newmeyer, 2008). Clinical practice guidelines have been developed by the American Group Psychotherapy Association (AGPA, 2007) and others have offered ways to utilize them in practice (Leszcz & Kobos, 2008).

A document that has had support from a consensus of group work experts from AGPA is the CORE–R Battery (Burlingame et al., 2006). The CORE–R Battery contains materials on pregrou separation preparation and a selection of measures for screening members, assessing group processes, and outcomes. According to the different standards and guidelines, it is important to include both process and outcome evaluations in group work. For example, the AGPA guidelines (among the others) recommend selecting clients for group work. One tool that could be used for the screening of group members for group psychotherapy is the Group Selection Questionnaire (GSQ; Burlingame, Cox, Davies, Layne, & Gleave, 2011), endorsed in the CORE–R Battery. The GSQ may be used to evaluate client expectancies for group work, which "may identify clients that could be 'at risk' for premature dropout, allowing more effective preparation of the client prior to group participation" (Burlingame, Cox et al., 2011, p. 71). The CORE–R Battery and the AGPA guidelines also recommend assessing group processes such as group climate and cohesion, to assess the functioning of the group and for workers to take action.

The ASGW has developed multicultural and social justice competence principles for group workers (ASGW, 2012). The principles fall into the following three main areas: (1) awareness of self and group members; (2) use of strategies and skills that reflect multicultural and social justice advocacy competence in group planning, performing, and processing; and (3) social justice advocacy. In working with increasingly culturally diverse populations, it is essential for group workers in CMHS to become familiar with these guidelines.
Evidence-Based Group Work
(Process Model)

The third type of EBP is a process model, which incorporates ESGs, evidence-based group processes and guidelines, or other relevant and appropriate evidence with the highest possible rigor. This model is fitting for practice in CMHS and underlies EBGW, which is defined as “a process of the judicious and skillful application in group work of the best evidence, based on research merit, impact, and applicability, using evaluation to ensure desired results are achieved” (Macgowan, 2008, p. 3). Each of the elements in this definition will be briefly discussed.

Evidence refers to “unobserved as well as observed phenomena if the former reflects signs or indications that support, substantiate, or prove their existence, accuracy, or truth” (Cournoyer, 2004, p. 3). Evidence may be research- or authority-based. Research-based evidence may be derived from quantitative or qualitative research but can also derive from systematic study of one’s own practice. Authority-based evidence is all other evidence, such as “the opinions of others, pronouncements of authorities, unchecked intuition, anecdotal experience, and popularity (the authority of the crowd)” (Gambrill, 1999, p. 7). Research and authority-based evidence may be weak or strong, and must be evaluated. Best available evidence is determined by an assessment of the evidence’s research merit (rigor), impact, and applicability to the group situation, described below.

The EBGW model has four stages in which group workers (a) formulate an answerable question derived from the practice context; (b) search for evidence; (c) undertake a critical review of the evidence to identify the best available evidence; and (d) apply the evidence with judgment, skill, and concern for relevance and appropriateness for the group, utilizing evaluation to determine if desired outcomes are achieved (adapted from Berg, 2000; Strauss et al., 2005). This process model provides the framework into which the other two parts of EBP fit. For a complete discussion about this process model, see Macgowan (2008).

Stage One: Begin With a Practice Question. A member-relevant, answerable, practice question (MAP) related to the group service is identified. Examples of MAP questions might be, “What is the briefest yet most effective group intervention for reducing depression among Latinas?” and “How can I increase cohesion among my group members?” Once the question is formulated and refined (detailed in Macgowan, 2008), then it is suitable for a search.

Stage Two: Search for Evidence. The second stage is to undertake a search for evidence, expanding beyond one’s convenient evidence (e.g., one’s own experience or one’s own possibly outdated library) and to systematically collect and appraise evidence. Searches should focus on research-based evidence rather than authoritative-based evidence. Macgowan (2008) details how and where to look for research. The website (www.EBGW.org) includes links to free sources of systematic reviews and other scholarly literature, terms to aid in the search for group-based literature, and links to the table of contents of nine major peer-reviewed group work journals, where users may subscribe to table of contents alerts of the latest group literature.

Stage Three: Critically Review to Identify “Best Available” Evidence. The third stage involves a critical review of the evidence, yielding the best available evidence. The evidence (e.g., article, book, material) must be evaluated for its rigor, impact, and applicability.

First, workers evaluate the rigor (research merit) of the evidence. Studies high in rigor minimize bias. In intervention research, the preference is for research evidence, which increases the confidence that the intervention was specifically responsible for beneficial effects, as opposed to evidence that is authority-based. The degree of confidence that an intervention or action will produce a desired outcome may be assessed using a “hierarchy of evidence,” with each level yielding a higher comfort level of certainty, from the most basic level of anecdotal or word-of-mouth testimonials to the highest level of scientific study, the controlled clinical trial with random assignment of subjects” (Hyde, Falls, Morris, & Schoenwald, 2003, p. 5). However, both sets of evidence, whether authority or research-based, should be evaluated for rigor.

Second, group workers also evaluate the impact of the evidence; that is, how significant (i.e., statistically and clinically) and in what direction are the findings. Ideally, there should be clinically meaningful change. For example, a study (Petry, Martin, & Simcic, 2005) using token reinforcement to improve attendance and abstinence rates gave strong evidence for both statistically significant and meaningful
change. The researchers noted that the number of group sessions attended was "correlated with cocaine abstinence, and each group session attended during treatment was associated with a 17% increase in the probability of reduced cocaine use 12 weeks after the study" (Petry et al., 2005, p. 358). Group interventions that have been replicated with the highest rigor and impact typically become labeled ESGIs, such as CBGT for social anxiety (Table 24.1).

In the applicability stage, group workers evaluate the evidence's relevance and appropriateness for their own groups for "clinical utility" or "clinical applicability." To evaluate applicability, the fit of the material with the clinical situation in three areas is assessed: agency setting (e.g., will the agency support the practice?), group worker (e.g., is the group worker qualified to do it?), and group members (e.g., does the material fit with group member values and preferences?). In particular, there is a growing literature on the importance of racial and cultural factors in the role of interventions and on client preferences in treatment (e.g., Chen, Kakkad, & Balzano, 2008; Swift, Callahan, & Vollmer, 2011). There are concerns about whether interventions developed and tested with dominant cultures are congruent with the values and worldviews of racial and ethnic minority groups. If the material is not consistent with group member values, or if group members are not going to support the intervention, it should not be applied. For example, the literature on youth violence prevention in Latino communities has noted the importance of attending to cultural values such as the central role of family (familismo), religiosity (religiosidad), and interpersonal relationships (personalismo; Mirabal-Colón & Vélez, 2006). Latino participants in studies have reported that they prefer a warm and expressive therapeutic relationship (reflecting personalismo) rather than a sterile, distant one (Mulvaney-Day, Earl, Diaz-Linhart, & Alegria, 2010). Group interventions that ignore these cultural values are not likely to be as successful as ones that do.

The three areas of rigor, impact, and applicability map well onto the nine "ideal features" of a mental health intervention in community settings described by Bond, Drake, and Becker (2010): (a) demonstrate effectiveness through rigorous research studies, (b) few side effects, (c) positive long-term outcomes, (d) well-defined for replication by the group worker, (e) reflect client goals and preferences for service, (f) consistent with societal goals, (g) reasonable costs, (h) relatively easy to implement, and (i) adaptable to diverse communities and client.

To evaluate rigor, impact, and applicability of evidence, group workers use a set of guides designed for group work. Developed from research and designed to be as brief as possible, Macgowan (2008) includes guidelines for evaluating quantitative studies, qualitative research, authorities, literature reviews (systematic and nonsystematic), multiple studies/reports, and measures. After assessing rigor, impact, and applicability, a decision must be made whether to apply or abandon the evidence. Conceivably, the best available evidence may not be the most rigorous or impactful but may be the most applicable. In some cases, the material may need to be abandoned, perhaps because the practitioner lacks the training to implement a specialized intervention, or the material is ill suited for the group members (see Macgowan, 2008, for examples).

Stage Four: Apply (Replicate, Adapt) the Evidence and Evaluate. This stage involves application of the evidence, which may involve replication or adaptation, and to evaluate if desired outcomes are achieved. As applied to EBGW, implementation is the integration of the best available evidence into group work. As a general guide, group workers should maintain the integrity of the original intervention/technique. Substantial research suggests that fidelity to interventions significantly increases favorable outcomes and a loss of fidelity reduces program effectiveness (e.g., Elliott & Mihalic, 2004; Henggeler, Schoenwald, Liao, Letourneau, & Edwards, 2002). However, group leaders serving minority communities may be faced with the situation of finding an intervention that has high rigor and impact, but it is not applicable as the study involved a different population group. La Roche and Christopher (2008) noted that no empirically supported treatment has met all the criteria set forth by the APA Task Force for treatment efficacy (American Psychological Association, 2006) for any minority group. In these cases, the material may need to be adapted.

There is a growing consensus that interventions adapted or tailored for race and ethnicity are advantageous (Benish, Quintana, & Wampold, 2011; Chen et al., 2008), although the finding with adolescents is inconclusive (Huy & Polo, 2008). An ESGI may be adapted by simply changing surface structures, such as language (e.g., translating materials) or ethnicity or race of role models, but deep structure elements that
deal with salience of the entire intervention approach should be considered. Deep structure reflects an understanding of “cultural, social, psychologic, environmental, and historical factors influence health behaviors differently across racial/ethnic populations” (Resnicow, Soler, Braithwaite, Ahluwalia, & Butler, 2000, pp. 274–275). For example, this would involve asking group members about their perceptions of their concerns, the helping process, and the group leader. Attending to, and showing respect for, clients’ worldviews and perspectives about their concerns and the helping process improves satisfaction with treatment and client outcomes (Benish et al., 2011) and is consistent with culturally competent group work (Chen et al., 2008; Comstock, Duffey, & St. George, 2002; also see Section III of this book).

For guidance in the adaptation, group workers should consult with a colleague, supervisor, and a prospective member (or an advisory group of prospective members) from the race or ethnic group for which the intervention is going to be applied. There are examples in the literature of effective cultural adaptation of both CBT and interpersonal psychotherapy for groups with Latino depressed youth (Rosselló, Bernal, & Rivera-Medina, 2008) and group interventions for depressed, low-income Latinas (Le, Zmuda, Perry, & Muñoz, 2010) and African American women (Kohn, Oden, Muñoz, Robinson, & Leavitt, 2002). When adapting the group model, the essential elements of the intervention should be retained, while at the same time adding cultural elements to maximize effects. However, group workers should be aware of the risk of “how much adaptation can occur before the practice no longer becomes ‘evidence-based’ but rather becomes ‘lost in translation’” (Palinkas & Soydan, 2012, p. 86). Thus, group workers should carefully examine the treatment manual or guidelines to determine if the authors identified the “essential elements.” If these are not retained in an adaptation, the original intervention is not being used and has become “lost in translation.” Instead, a highly adapted (if not novel) intervention has been developed, with dubious efficacy.

Once the intervention is applied, the group worker evaluates the effects of the action to determine whether the desired results are achieved using conventional methods for the evaluation of practice. Application and evaluation are not separate endeavors but are intertwined in a circular and iterative process. Thus, the process does not end with knowing whether the strategy “worked” but continues with a systematic, critical process of improving practice based on the ongoing results of the application in practice and evaluation.

In summary, the process model of EBGW flexibly and critically incorporates ESGIs and evidence-supported group processes, techniques, and guidelines. A case example provides applications of some of the principles outlined, followed by strategies for advancing EBGW in community settings.

Case Example

Rosa Gutiérrez is a newly hired group worker at a community mental health center (CMHC) in a large metropolitan area. She recently graduated with a master’s degree in social work and had prior experience working at another CMHC. She is fully bilingual and considers herself a bicultural Latina, the population mostly served by the CMHC. Rosa was asked to lead a group for Latinas diagnosed with depression and without medical insurance. To fulfill her mandate, Rosa felt she needed to get a better idea about the best available evidence to provide services that were culturally responsive to depressed Latina groups. Her supervisor’s limited knowledge about evidence-based practices caused Rosa some initial concern; however, she recommended Rosa speak with a field instructor who had access to relevant, summarized literature located in peer-reviewed journals. At a team meeting, Rosa advocated for and was supported by the organization in the development of a new EBGW intervention. A Spanish-speaking bilingual staff member named Maria, who was knowledgeable about EBP, volunteered to cofacilitate the Latina depression group with Rosa.

(Continued)
To begin the EBGW process, Rosa formulated a MAP question: In establishing a culturally relevant group for Latinas, what relatively brief (10–12 sessions) group intervention will best reduce depression? Next, evidence was collected from the literature about whether there was an effective group approach for low-income Latinas or if a mainstream option would need to be adapted. Group treatments for depression, primarily using CBT and interpersonal therapy, had been rated as “well-established” for adolescent and adults (Johnson, 2008; Levy & O’Hara, 2010, cf. Table 1). Other culturally appropriate material literature (Muñoz, Ippen, Rao, Le, & Dwyer, 2000; Muñoz & Miranda, 1986) was identified without the need for substantial modifications. Rosa and Maria critically appraised the evidence for its rigor, impact, and applicability and then applied the evidence to address Rosa’s MAP question. They related the three areas of rigor, impact, and applicability to Bond’s (2010) nine “ideal features” of a mental health intervention and decided to implement the CBGT model as it was developed specifically for low-income Latinos/as. They utilized the twelve-week model, which included the core elements of the intervention but not the extra four-week module related to health issues as it was not deemed relevant (Muñoz & Miranda, 1986). The manual was available electronically in Spanish and English (Muñoz et al., 2000). Rosa and Maria also included discussion about challenges in the acculturation process, which may contribute to depressive symptomatics (Levy & O’Hara, 2010), group content that recognized acculturation as a bidirectional process, and acculturation issues related to gender (e.g., mother and child challenges, financial stressors). Group sessions would also include information about accessing no-cost community resources.

In terms of process, Rosa and Maria reviewed the AGPA (2007) and AASWG (2006) practice standards and the ASGW (2012) multicultural and social justice competence principles to prepare and implement the intervention. Specifically, ethnically and linguistically matched therapists offering the group in client-preferred languages is important and improves outcomes (Smith, Rodríguez, & Bernal, 2011). It is also important to explicitly emphasize the cultural values of the clients throughout group sessions (Griner & Smith, 2006). Rosa would also selectively disclose personal information to enhance a personalized professional relationship with group members to build the therapeutic alliance, reflecting personalismo, or valuing the personal connection in relationships. In addition, they would monitor how the group received the material.

To secure referrals, Rosa shared information with the local hospital’s family health clinic noting that transportation vouchers would be offered (Stacciarini, O’Keeffe, & Mathews, 2007). The Group Selection Questionnaire (Burlingame, Cox et al., 2011) was administered to select group members. Additionally, to maximize cohesion, the maximum number of group members would be nine. Group orientation sessions were arranged so prospective group members could meet Rosa and Maria over coffee and pastries, with specific information shared about the group (AGPA, 2007). They discussed handouts (in Spanish) that oriented group members to the group experience. For an outcome measure, the Patient Health Questionnaire (PHQ-9) (available in English and Spanish) was used to measure both depression symptoms and their severity (Martin et al., 2006). The PHQ-9 was selected because it is brief, easy to administer, and free of charge (http://steppingup.washington.edu/keys/documents/phq-9.pdf). Depression scores would be measured every couple of weeks and charted over time. In addition, group members would complete a brief evaluation of each session, which asked to rate on a scale from 1 (not at all) to 5 (very highly satisfied), “How satisfied were you with today’s session?” (in Spanish) and to comment if they wished. These ratings were reviewed weekly. To assess cohesion, the CPIRS was used (Chapman et al., 2010).

At the end of the group sessions, Rosa and Maria reviewed both the outcomes and process of the group. Reflecting on the MAP question, the main purpose of the group was to reduce depression. She and Maria reviewed the depression progress chart, member satisfaction scores, and ratings from the CPIRS to determine group effectiveness and cohesion. Process and outcome results were communicated with the agency team to determine the implications for offering another Latina depression group.
ADVANCING EBGW IN COMMUNITY SETTINGS

EBGW is essential for advancing effective practices in CMHS. However, there are both challenges and areas of opportunities for implementing the best available evidence in CMHS. Some of the areas of opportunity include professional (practice, education, research) and organizational described next.

Professional Factors

Practice. Professional group work organizations require its members to integrate best evidence into practice. Group workers who are members of AASWG and ASGW should utilize measurement tools to determine how much they value, and are able to practice, those standards (Macgowan, 2012; Wilson & Newmeyer, 2008). AGPA (2007) has done an important service by clearly identifying the evidentiary support of group work practices and has contributed a series of articles on using the practice guidelines (e.g., Bernard et al., 2008; Leszcz & Kobos, 2008). There are also measures to evaluate practitioner knowledge, attitudes, and use of the EBP process: the Evidence-Based Practice Process Assessment Scale (for students, Rubin & Parrish, 2010) or the Evidence-Based Practice Process Assessment Scale—Short Version (for experienced practitioners, Parrish & Rubin, 2011b). Although these measures are not directly related to group work, they may be used to indicate readiness to do EBGW.

Education. When the research evidence is not there or is contradictory, group workers must decide what is best. Practitioners need help to develop knowledge and skills to formulate, access, and integrate the best evidence into practice. Training in EBP has been done successfully (Parrish & Rubin, 2011a), which has focused on a range of indicators such as participants’ knowledge and attitudes about the EBP process and their involvement in EBP. A website is available for training in EBP (http://www.ebpb.org/) and Macgowan (2008) suggests a workshop model on EBGW. McClosey (2011) suggests web-based booster sessions while Lopez, Osterberg, Jensen-Doss, and Rae (2010) advocate that ongoing supervision helps maintain effects. On-the-job coaching after training offers the largest gains in learning (Sholomskas et al., 2005).

Research. Good research evidence is a foundation of EBGW, and more high quality studies are needed to guide practice. Group work is generally effective, but much more research is needed concerning different problem areas and populations, especially involving racial and ethnic minority groups (Griner & Smith, 2006; La Roche & Christopher, 2008).

Organizational Factors

To advance EBGW in CMHS, there needs to be a favorable organizational culture. One of the major complaints to doing EBP is that it takes too much time (Baker, Stephens, & Hitchcock, 2010; Edmond, Megivern, Williams, Rochman, & Howard, 2006). Administrators must grant time for practitioners to adequately engage in EBGW, allocating staff for particular functions related to EBGW. For example, group workers could identify important clinical questions to be answered with particular staff designated to engage in the search and critical review of the evidence. Another team of practitioners could determine how to best apply the evidence.

To more effectively advance EBGW, organizations may partner with a university. Reciprocal, agency-academic partnerships can help overcome organizational challenges (Bellamy, Bledsoe, Mullen, Fang, & Manuel, 2008; Foucher & Lunt, 2009; Kazdin, 2008). One idea is to establish within the organization a knowledge-sharing team (“link officers,” Austin, Dal Santo, & Lee, 2012), which can both serve as a liaison with the university about emerging practice questions that need answers, and help group workers apply the best available evidence in practice. Alternatively, group workers could seek out institutes or centers for EBP that have generated local research that can be useful for EBGW (Regern, Stern, & Shlonsky, 2007). Practitioners might also approach the local chapter of their group work organization to form collaborative practice-research networks of practitioners and faculty (Borkovec, 2004).

SUMMARY AND CONCLUSION

With its emphasis on applying the best available evidence into practice, EBGW is a necessity for advancing EBGW in CMHS. This chapter has described a process model, which incorporates ESQIs and effective group processes, techniques, and guidelines. The
model is designed for group workers to find, critically assess, and integrate into practice the best available evidence, using evaluation to ensure desired effects are obtained. A case example illustrated how the principles are applied in CMHS. Yet there are challenges in doing EBGW in the community. Ideas for meeting these challenges were offered, requiring changes in training and in how organizations function to support EBGW. The recommended changes are expected to increase the likelihood of successful advancement of EBGW in community settings.

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