

## CHAPTER 12

# Group Work in Health Care Settings

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Since the early 20th century social workers have played an important role in the coordination and provision of services in various health care settings, including primary care facilities, hospitals, specialty clinics, schools, home health care settings, hospice care settings, continuing care settings, private physician groups, and research settings. Although, historically, social casework and social diagnosis have been the predominant model of social work practice in health care coordination and provision, group work has played an important role in health promotion and the assessment and treatment of diseases and disorders within health care settings.

Social workers and group workers in health care settings incorporate a biopsychosocial perspective in their practice, which seeks to recognize the whole person as she or he exists within her or his environment. Although this holistic approach allows the consideration of clients' strengths, the majority of research and literature on group work in health care settings is grounded in a problems-based approach, in which the primary focus of intervention is the client's disease and its related problems. This critique is not to say that group work interventions for illness prevention, treatment, care, and support are not needed. Rather, it suggests that there is room within the literature on group work in health care settings to explore existing strengths-based models of group work practice and explore their utilization, particularly with vulnerable and oppressed populations.

This chapter explores the use of group work in health care settings. It begins with a brief review of group typologies and dynamics, with particular attention to their qualities, relevance to group work in health care settings, and examples of their application in these settings. Grounded in these important elements of group work practice, the chapter continues with a review of group work in health care settings, with particular attention to the predominance of problems-based approaches and the need for more strengths-based approaches. Following an overview of the strengths perspective and its relevance to social work with groups, the chapter reviews examples of strengths-based group work practice with vulnerable and oppressed populations in health care settings, including (1) motivational interviewing groups with LGBTQ people abusing substances, (2) nondeliberative

groups with young people experiencing homelessness, and (3) interprofessional practice with various vulnerable and oppressed populations.

## **TYOLOGIES OF GROUP WORK**

Toseland and Rivas (2012) define group work as “goal-directed activity with small treatment and task groups aimed at meeting socioemotional needs and accomplishing tasks. This activity is directed to individual members of a group and to the group as whole within a system of service delivery” (p. 11). This definition frames the focus of group work: the individual, the group in its entirety, and the group environment (Toseland & Rivas, 2012). This frame presents an important distinction for group work in health care settings, in which practice tends to focus on the individual member and less on the group as a whole and its surrounding environment.

### ***Treatment Groups***

Various types of treatment groups are used for various functions within health care settings. In terms of treatment groups, psychoeducational groups provide members with opportunities to gain information regarding their health and well-being through didactic presentations, group discussions, and experiential exercises. Examples might include a tobacco prevention group for young people at a community health center. Following a presentation on risks associated with use, the worker might facilitate a brief discussion for members to process their reactions to the material. Skill-building and growth groups are also content-focused but tend to be more action-oriented, with a strong emphasis on members practicing newly learned skills and behaviors. Examples might include teaching mindfulness exercises for individuals living with terminal illnesses in hospice care or educating expecting parents on prenatal care at a local hospital. Both of these examples would include opportunities for members to rehearse newly learned behaviors, such as deep breathing and healthy eating, respectively.

Therapy groups provide members with opportunities to address behavior change through cognitive-behavioral techniques. For example, a facilitator might work with a group in early recovery from heroin on challenging negative and faulty thinking around methadone maintenance treatment. Therapy groups also provide members with opportunities to explore personal issues through process-oriented techniques, such as working with trans youth as they navigate negative family reactions to their decision to begin hormone treatment. Support groups help members identify coping strategies for dealing with stressful life events, often in a caring and empathic environment, such as a support group for people living with a chronic illness. Self-help groups offer a similarly supportive environment without formally trained facilitators. Examples of these include Alcoholics Anonymous, Narcotics Anonymous, and several other 12-step fellowships. These various types of treatment groups offer members important opportunities to experience all the benefits groups have to offer, including empathy, feedback, mutual aid, and support (Toseland & Rivas, 2012).

Yalom and Leszcz (2005) identify several therapeutic factors to consider when designing and implementing treatment groups in health care settings. Groups offer members opportunities to experience the instillation of hope, a phenomenon that allows members to access and harness their hope by experiencing and witnessing the hopes, dreams, and successes of other group members. Groups also afford members opportunities to experience universality, whereby members' perceived uniqueness is challenged and they ultimately recognize the

commonalities that exist among them. Yalom and Leszcz fittingly refer to this phenomenon as members realizing they are all in the same boat. Groups allow members to experience altruism by creating opportunities for members to help each other work through challenges and accomplish their goals, which is particularly important in groups whose members experience disempowerment. In addition, groups allow members to engage in important forms of imitative behavior, whereby members learn from observing the facilitator's and other members' behaviors in the group. Instillation of hope, universality, altruism, and imitative behavior are all particularly relevant to group facilitation in health care settings, where members are often coping with chronic and life-threatening illnesses and their related physical and psychological side effects. Exploiting these factors allows members opportunities to experience and offer support.

### **Task Groups**

Health care settings also utilize various types of task groups. Teams work collaboratively, often across disciplines, on behalf of the clients they serve. Examples include attending physicians, residents, nurses, social workers, and unit staff meeting weekly to review clients' records on a burn injury unit. Team members often participate in treatment conferences to develop and evaluate patient treatment plans, such as meeting to determine whether clients of an outpatient clinic are meeting their treatment goals. Health care settings hold staff meetings to address administrative tasks, develop goals, and attend to personnel issues. Committees are often established to manage tasks within health care settings, such as a multidisciplinary team charged with hiring new staff. Health care settings also provide staff development trainings on best practices in relevant fields for working with clients. Examples include providing harm reduction and motivational interviewing training for primary care physicians working with young people experiencing homelessness. Although task groups are often time-consuming for overworked health care setting staff, they provide opportunities for medical, nursing, social service, and support staff to engage, experience multiple and alternate points of view, and work toward team-based problem solving and solution development (Toseland & Rivas, 2012).

## **GROUP DYNAMICS**

Group dynamics play an important role in the development and implementation of treatment and task groups in health care settings. Building on the work of early group work scholars (see Coyle, 1930, 1937; Elliot, 1928; Northen, 1969), Toseland and Rivas (2012) identify four dimensions of group dynamics: (1) communication and interaction patterns, (2) cohesion, (3) social integration and influence, and (4) group culture. Group communication and interaction patterns refer to the unique patterns of verbal and nonverbal communication and interaction among group members. While leader-centered patterns are effective at keeping members on-task, group-centered patterns increase members' commitment to group decision-making processes and goals. These patterns evolve throughout the life of the group and influence group cohesion, which is shaped by members' attraction to the group and each other, their capacity to envision the group as a whole, and their ability to work as whole (Forsyth, 2010). In groups with high levels of cohesion, members demonstrate strong attendance, participation, and progress toward goals. Groups with low levels of cohesion experience decreases in member commitment, participation, and attendance.

Social integration and influence refer to members' fit within the group and how the group accepts members' fit (Toseland & Rivas, 2012). This process is influenced by group norms that develop through the interactions of members and guide their behavior across the life span of the group. Members' roles are often shaped by these norms and represent the anticipated behavior of members in relation to a particular function within the group. As norms and roles develop over the course of the group, they both shape and are further refined by group culture. Toseland and Rivas (2012) define group culture as the "values, beliefs, customs, and traditions held in common by group members" (p. 87, citing Olmstead, 1959). The emergence of group culture is often expedited by homogenous group membership, which is described as members having a shared purpose and life experience. Heterogeneous group membership, which is described as members having divergent purposes and life experiences, may slow the development of group culture.

Group communication and interaction patterns, cohesion, social integration and influence, and group culture shape and are shaped by individual members, the group as a whole, and the group environment. Monitoring this dynamic process in treatment and task groups is essential to the life and overall success of the group. Attending to member strengths enhances the development of healthy group dynamics and allows members to experience the benefits of the group process. The following section reviews the use of group work in health care settings, noting the predominance of problems-based approaches and the need for more strengths-based approaches.

## **A REVIEW OF GROUP WORK IN HEALTH CARE SETTINGS**

### ***Early to Mid-20th-Century***

Group work developed out of the leisure and recreation movement of the late 19th and early 20th centuries (Meyer, 1934; Pangburn, 1924; Reid, 1981) and community-oriented forms of social work practice, such as those located within the settlement house movement (Andrews, 2001). Rather than focusing on treating individual, family, and community problems, early group work practitioners used activity and other forms of recreation to engage members, increase their communication and cooperation, and build community. Hull House programming during the early 20th century prioritized the use of recreational, art, and music-based groups for young people and adults (*Hull-House Year Book: September 1, 1906–September 1, 1907* [1907]; *Hull-House Year Book: May 1, 1910* [1910], *Hull-House Year Book: 1921* [1921]). These groups provided the community and its members with important opportunities to engage their talents, strengths, and interests (Kelly & Doherty, 2017). As social work became professionalized throughout the early part of the 20th century, a growing majority of group workers were less comfortable with activity-based groups and turned instead to social casework to inform their practice. This trend was particularly prevalent in health care settings.

In reviewing the use of group work in health care settings throughout the 20th century, Getzel (1986) notes, "Social work in health care has a long and close association with social casework, but group work has been used more peripherally" (p. 25). Developed by Mary Richmond, social casework involves the structured diagnosis of individual and family problems, followed by an examination of community factors that contribute to the diagnosed problems (Turner & Jaco, 1996; Wenocur & Reisch, 2001). Once identified, these problems and factors are more fully considered and provide the foundation of what Richmond (1917) defines as a social diagnosis. Once a social diagnosis is identified, the social caseworker

develops a treatment plan that systematically addresses the problems and factors through appropriate interventions. Although social casework may consider individual, familial, and community strengths, the strong focus on problem identification, social diagnosis, and intervention guides the practice model. Given the strong focus on diagnosing individual and family problems, it is clear to see how social casework more closely aligns with medically driven models of intervention prominent in health care settings, where health care professionals seek to diagnose, treat, and care for patients.

Although social casework was the predominant model of social work practice in health care settings in the early and mid-20th century, group work played an important role in health care service delivery and coordination. In her analysis of social work in hospitals in the early 20th century, medical social work founder Ida Cannon (1923) argued that there is clearly room for “*social work with groups* [italics in original] such as we see in the neighborhood associations, settlements, and clubs” (p. 205). Cannon documented the effective use of group work in medical care during this time in her thoughtful analysis of the work of physician Joseph Pratt, who cofacilitated groups with social workers as a means to educate patients about chronic illness, including tuberculosis, diabetes, and heart disease. The group work approach successfully provided patients with important opportunities to share difficulties related to the management of their illnesses and to receive peer and professional feedback in an encouraging and supportive environment. Providing additional context for members’ experiences, Cannon included the following quote from a social worker:

The group treatment helps to build loyalty and cooperation, which brings patients back to the clinic and makes them ready to follow advice. The habit of doing things that are hard or monotonous is much more easily done when others are doing them. New patients soon lose their shyness; those consumed in self-pity seldom fail to find others making less of greater handicaps; and the discouraged man or woman hears how someone else gained when conditions seemed quite hopeless. (pp. 76–77).

It is important to note the presence of group dynamics and therapeutic factors in the social worker’s assessment of this early form of group work in a health care setting, specifically group cohesion as evidenced in members’ loyalty and cooperation, and hope and universality in their realizations that they are not alone.

### **Mid-20th-Century to the 2000s**

In her review of social work in health care settings, Bartlett (1961) noted the growing importance of group work for social workers in the health care field. Getzel (2006) notes that the use of groups in health care settings increased during the 1960s and that groups were used extensively in the treatment of behavioral health disorders throughout this time as well. Frey (1966) developed the first systematic review of group work in health care settings and found that groups were often developed and implemented to fulfill the needs of larger organizational structures of the health care settings and systems in which they resided. Getzel (1986) makes a similar observation in his analysis of social work groups in health care settings, labeling this trend the *compliance-marketing model*, whereby “organizational considerations predominate” and “the group reflects the hierarchical organization structure of the large health care system with clients in subordinate position to the social workers and other professionals and social workers subordinate to physicians” (p. 26).

Rosenberg and Neil (1982) reviewed 51 articles on group work in health care settings published between 1964 and 1979 and found that the majority of groups were cofacilitated

(e.g., by a social worker with a nurse or physician) and formed around client illness with the primary purpose of supporting medical treatment through client and family education. Getzel (1986) updated this analysis, reviewing 38 additional articles on group work in health care settings published between 1978 and 1982 and found similar trends in the literature, adding “few groups dealt with the context of changing the patient’s environmental conditions, in or outside the hospital” (p. 28). Speaking to this gap, Schopler and Galinsky (1990) posited that groups have the potential to humanize growingly complex and expensive health care systems in cost-efficient ways and to provide clients with important opportunities to experience mutual aid and support.

In a review of the use of groups in health care settings during the 1990s and early 2000s, Getzel (2006) argues for a “disregard of the Cartesian mind-body dichotomy by simultaneously addressing health and mental health as a focus for social work with groups” (p. 195). Findings from his review demonstrate the use of groups in addressing chronic and complex illnesses, including sickle cell disease, cancer, severe and persistent mental illness, and HIV/AIDS. The use of cognitive-behavioral approaches was prevalent in the field during this time, as the use of activity-based groups continued to lose favor in the rapidly growing field of evidence-based practice. Groups also played an important role in staff supervision, support, and collaboration during this time, as models of multidisciplinary teams and practice are described and evaluated in the literature.

### **Current Uses**

A review of the recent literature on group work in health care settings demonstrates similar trends in the field. Cognitive-behavioral groups are used in addressing cancer and its related effects. In a longitudinal experimental study, Antoni and colleagues (2006) found cognitive-behavioral groups to be effective in reducing intrusive thoughts and anxiety with women undergoing breast cancer treatment 1 year past group participation. Cohen (2010) presents a practice-informed cognitive-behavioral model developed in Israel that focuses on reducing emotional distress in cancer patients and increasing their skills in coping with the illness and chemotherapy over the course of six meetings.

Support groups are used internationally in helping clients and their families cope with the effects of cancer. In a descriptive study from Australia, Butow and colleagues (2006) found leaders’ facilitation skills and educational and personal qualities contribute to effective leadership in support groups for cancer patients. In a qualitative study from Australia, Ussher, Kirsten, Butow, and Sandoval (2008) explored factors related to cancer support group attrition and nonattendance. They report that lack of referrals or knowledge of groups, existing forms of support, and resistance to a cancer patient identity influence respondents’ decisions to participate in cancer support groups. Lounsberry, MacRae, Angen, Hoerber, and Carlson (2010) longitudinally investigated the effects of a telehealth videoconferencing group for survivors of allogeneic hematopoietic stem cell transplant in Canada. Findings suggest that although participants gain some benefit from participation, they do not report any significant improvements. In a cross-sectional study exploring the use of financial incentives in support groups for children with cancer in India, Srinivasan, Tiwari, Scott, Ramachandran, and Ramakrishnan (2015) found that participants who are not provided with incentives are more likely to abandon cancer treatment after initiating therapy.

Groups continue to be used in addressing chronic illnesses and their related effects. In an intervention research study, Comer (2004) worked with an interdisciplinary team of health care providers to facilitate cognitive-behavioral groups using self-management

techniques for clients living with sickle-cell disease and depression. Findings demonstrate that group members reported a decrease in symptoms related to their depression. Vail and Xenakis (2007) facilitated expressive writing and assertiveness training groups for women living with disabilities. Results from self-administered surveys suggest members appreciated the opportunity to explore their issues and learn new skills. Charlton, Gabriel, Munsinger, Schmaderer, and Healey (2010) evaluated the feasibility and effectiveness of a modified exercise group for people living with multiple sclerosis. Findings suggest that participants enjoyed the group and experienced improvements in their physical and mental health.

Céspedes-Knadle and Muñoz (2011) describe the development and implementation of a group for young people with type 1 diabetes and a parallel support group for their caregivers. The proposed group intervention is designed to improve young people's psychosocial well-being and medical adherence, whereas the support group is designed to reduce caregiver stress. Hess (2011) presents a practice-informed psychoeducational group treatment for clients with noncardiac chest pain, many of whom live with chronic anxiety and panic disorders. The proposed model offers members opportunities to challenge their faulty beliefs and learn new breathing techniques and coping skills to break the cycle of panic and anxiety.

Groups are employed in substance use treatment and recovery. Little and Franskoviak (2010) describe the use of harm-reduction drop-in groups in community settings, including primary care clinics. Practice-informed findings from their work with over 1,000 clients suggest these groups help reduce the harmful effects of drug use, stabilize psychiatric symptomatology, and as a result often lead to permanent housing placements. Garte-Wolf (2011) describes the use of narrative therapy in groups for people living with HIV who are also in recovery from addiction. Findings suggest the reframing technique found in narrative therapy and the relational process and mutual aid found in group therapy combine to create supportive, less stigmatizing environments than traditional 12-step recovery groups.

There is increasing attention on the use of parenting groups in health care settings. Berge, Law, Johnson, and Wells (2010) piloted a 2-week parenting psychoeducational group in a primary care clinic in an underserved urban area. Participants experienced significant improvements in managing child behavior problems and overall family functioning. In addition, findings suggest the model may be useful and replicable in other primary care settings interested in offering similar parenting training services. Knox, Burkhart, and Cromly (2013) evaluated effective parenting training groups in health care settings and found the groups increased positive parenting behaviors. This suggests that health care settings may be an effective place to train parents in positive parenting skills, which may lead to reduced rates of child maltreatment.

In an essay, Drum, Swanbrow Becker, and Hess (2011) identify the evolving nature of the health care marketplace, increases in chronic conditions, and the rising prominence of health psychology as important factors in the increasing prevalence and relevance of groups in health care settings. They offer the following guidelines as a conceptual framework for developing group interventions in health care settings:

1. Make the change strategy explicit.
2. Give explicit consideration to the composition of the group.
3. Consider use of facilitative conditions (i.e., therapeutic factors).
4. Consider to what degree the interpersonal group process is facilitated.
5. Consider key elements of the intervention.

In describing the key elements of the intervention, they ask the questions, “What are the hypothesized key informational deficits, faulty beliefs, emotional barriers/fears, or other factors that prevent participants from naturally coping effectively with this disease or condition? How does the change strategy help them overcome/cope more effectively with these factors?” (Drum et al., 2011, p. 261).

Much of the reviewed literature considers members’ health-related problems as the primary purpose and focus of group work in health care settings. Reviewed group models offer members and their families training and/or support in coping and living with their health-related problem(s) and its related effects. Even those models that attend to the development of group dynamics and the exploitation of therapeutic factors tend to do so from a problems-based perspective (i.e., treating the disease/problem and its related effects). It is unclear if and how groups in health care settings consider members’ strengths. Of the literature reviewed, only one theoretical model explicitly emphasized clients’ strengths and focused on their empowerment (Cohen, 2010). While the setting and context of group work in health care settings may suggest an inherently problems-based approach, there is clearly room in the literature to propose and explore strengths-based approaches, particularly with vulnerable and oppressed populations in health care settings. The following section reviews the strengths perspective and places it within the context of social work with groups.

### **THE STRENGTHS PERSPECTIVE AND SOCIAL WORK WITH GROUPS**

Building on the strengths-based approaches practiced in the settlement house movement (*Hull-House Year Book: September 1, 1906–September 1, 1907* [1907]; *Hull-House Year Book: May 1, 1910* [1910], *Hull-House Year Book: 1921* [1921]) and further developed and refined in social group work (Coyle, 1930, 1937) and humanistic (Rogers, 1957) and social constructivist (White & Epston, 1990) psychology, the strengths perspective suggests that all individuals have inherent abilities and capacities and that, regardless of presenting challenges, it is the practitioner’s duty to recognize and work with these strengths. Saleebey (2012) outlines several principles of the strengths perspective, including:

1. All client systems, including individuals, groups, families, and communities, have strengths.
2. While presenting challenges may be harmful (e.g., abuse, illness, and or trauma), they may also be opportunities for growth.
3. Never assume the upper limits of client systems’ capacity for growth and change.
4. Client systems are best served through collaboration.
5. All environments, regardless of perceived deficiencies, are full of resources.

Lietz (2007) stresses the importance of incorporating the strengths perspective in social work with groups, noting the potential to address factors related to group cohesion, including members’ negative attitudes toward the group, poor attendance, and early termination. Hudson (2009) incorporates the principles of the strengths perspective in empowerment-based models of social work with groups, and Moyse Steinberg (2014) makes similar connections between the mutual aid model for social work with groups and the strengths perspective. Malekoff (2014, p. 43) applies the strengths perspective to group work with adolescents, articulating seven evidence-guided practice principles:

1. Form groups based on members' felt needs and wants, not diagnoses.
2. Structure groups to welcome the whole person, not just the troubled parts.
3. Integrate verbal and nonverbal activities.
4. Develop alliances with relevant other people in group members' lives.
5. Decentralize authority and turn control over to group members.
6. Maintain a dual focus on individual change and social reform.
7. Understand and respect group development as a key to promoting change.

Malekoff (2014) notes, "the principles are overlapping and interrelated" (p. 50), and they are essential components of group work practice with young people "regardless of the practitioner's theoretical or ideological orientation" (p. 43). Although Malekoff frames the principles within a model of strengths-based group work with adolescents, as the following examples demonstrate, these principles may also be applied to group work with vulnerable and oppressed young people and adults through a variety of theoretical orientations/perspectives and practice settings.

### **MOTIVATIONAL INTERVIEWING GROUPS FOR LGBTQ PEOPLE**

Lesbian, gay, bisexual, transgender, and queer (LGBTQ) people are disproportionately represented in substance-abusing populations (McCabe, West, Hughes, & Boyd, 2013). Historically, social pressures for sexual orientation and gender identity conformity shaped opportunities for LGBTQ people to socialize, often limiting their options to bars, clubs, and cruising areas where substance use was often the norm (Boyd, 2003; Chauncey, 1994). Easy access to alcohol and other drugs in these spaces often served as a coping mechanism for LGBTQ people to manage internalized homophobia and transphobia and to cope with overtly hostile and at times violent forms of homophobia, transphobia, and heterosexism. While acceptance of LGBTQ people has increased over time, the combination of internalized homophobia and transphobia, institutional stigmatization, and discrimination against LGBTQ people may continue to contribute to disproportionate rates of LGBTQ substance abuse (McCabe et al., 2013). LGBTQ people also experience barriers to substance use treatment, including internalized homophobia and transphobia; homophobic, transphobic, and heterosexist attitudes and practices among substance use treatment providers; and overall deficiencies in LGBTQ-affirming substance use treatment (Cochran, Peavy, & Robohm, 2007).

Strengths-based approaches to group work offer LGBTQ people important opportunities to engage in substance use treatment in an affirming environment. Strengths-based psychoeducational, skill-building, and growth groups offer LGBTQ people who abuse substances opportunities to learn about the health effects of their drug use, methods to reduce the harm of their use, coping skills and strategies for managing internalized homophobia and transphobia, and advocacy skills for combating oppression that may be contributing to their use. Strengths-based therapy groups provide members with opportunities to affirm and celebrate their sexual and/or gender orientation and to explore opportunities to liberate themselves from negative thinking as a result of institutional homophobia, transphobia, and heterosexism. Support and self-help groups offer LGBTQ people who abuse substances opportunities to explore their use and decisions about recovery in caring, empathic, and supportive environments.

Although not explicitly framed as a strengths-based approach to substance use treatment, motivational interviewing incorporates several principles of the strengths perspective. Developed by Miller and Rollnick (2013) to address limitations in alcohol abuse treatment, motivational interviewing assumes that all clients are responsible for and capable of change and that it is the worker's role to facilitate conditions in order to enhance clients' motivation for and commitment to change. The goal of motivational interviewing is to explore clients' ambivalence toward change efforts and to identify appropriate interventions that match their current level of readiness to change. The spirit of motivational interviewing incorporates several principles of the strengths perspective, including the worker's unconditional recognition of clients' absolute worth, affirming clients' experiences, and practicing deep acceptance and compassion for clients. The worker's role in motivational interviewing is to express empathy for clients, develop discrepancies within their narrative, avoid argumentation, roll with resistance, and support clients' self-efficacy. The worker accomplishes this by asking clients open-ended questions, affirming their efforts to change, listening reflectively, and summarizing.

As the following brief example demonstrates, motivational interviewing offers opportunities to address the strengths of LGBTQ people who abuse substances. At the outset of a group session exploring the effects of alcohol and other drugs at an LGBTQ community health center, the facilitator welcomes participants and informs them that all are welcome, regardless of their level of use and/or resistance to looking at their use. As the session gets under way, some members begin to express ambivalence about engaging in a discussion about the effects of their alcohol and drug use, arguing that it is their only social outlet and that they are unwilling to give it up. Rather than argue with members and challenge their resistance, the facilitator lets the members know he or she hears them, reflects back their concerns about losing something that is important to them and their social environment, and moves the discussion along, looking for opportunities to engage the members in a productive, nonconfrontational exchange. As the session continues, some of the same members discuss negative health effects they have experienced as a result of their use, including loss of sleep, poor diet, and sexually transmitted infections. Here, the facilitator pauses and highlights the discrepancies in the members' statements: They do not want to change their alcohol and drug use, yet they are experiencing negative health effects as result of their use.

From here, the facilitator may work with members to identify any changes the members are willing to make in their use, remaining fully sensitive to members' attachment to their alcohol and drug use as a means of social engagement and perhaps as a coping mechanism for internalized and/or systemic oppression. By listening to members' needs and wants and recognizing their self-worth, facilitators will experience greater success in identifying realistic change goals that are sensitive to the needs of LGBTQ people. In doing so, the facilitator welcomes the whole person, never assumes their capabilities or capacities, and collaborates with the group members.

### **NONDELIBERATIVE GROUP WORK WITH YOUNG PEOPLE EXPERIENCING HOMELESSNESS**

Over half a million young people experience an episode of homelessness for 1 week or more annually (National Alliance to End Homelessness, 2014). Given this prevalence, the majority of the literature on homeless youth is framed from a risks-and-consequences perspective.

Research focuses on identifying populations of young people at risk for homelessness, including young people who identify as LGBTQ (Ray, 2006) or who experience trauma (Coates & McKenzie-Mohr, 2010) or family conflict (Alvi, Scott, & Stanyon, 2010). Research also focuses on examining the consequences young people experience as a result of being homeless, including increased health problems (Beharry, 2012), exposure to violence (Finkelstein, 2005), sexually transmitted diseases (Kennedy, Tucker, Green, Golinelli, & Ewing, 2012), and substance use (Ferguson & Xie, 2012). A growing body of qualitative research challenges this risks-and-consequences perspective by exploring the survival narratives of homeless youth and framing their narratives as demonstrations of strength and resilience (Bender, Thompson, McManus, Lantry, & Flynn, 2007; Karabanow, Hughes, Ticknor, Kidd, & Patterson, 2010; Kidd & Davidson, 2007; Kidd & Evans, 2011).

Lang (2016) proposes a model of nondeliberative group work, which is well suited to creating opportunities for young people experiencing homelessness to explore and express their strengths. Nondeliberative practice is a creative, intuitive, and spontaneous form of group work that emerges from members' lived experiences. It employs "artful, actional and analogic forms of solution-seeking" (Lang, 2016, p. 103), such as dance, drama, games, music, and the visual arts, in an effort to engage members in cognitive and conative methods of problem solving. The purpose of the use of activity in nondeliberative group work is to do and then think. Members are invited to participate in the group process and consider how the process applies to other areas of their lives. Through this theoretical lens, the worker's role is to identify activities that further the work of the group and facilitate the group process.

Kelly (2013) explored the use of a music studio in a transitional living program for young people experiencing homelessness and found that young people's engagement with the studio and affiliated projects brought out their strengths. In one of those affiliated projects, Kelly (2015) coproduced an audio documentary with some of the same young people. The audio documentary group incorporated the artful, actional, and analogic forms of solution seeking found in nondeliberative group work practice. As a result, members not only coproduced an audio documentary but also engaged in a dynamic group process that engaged their strengths and provided them with opportunities to consider how their strengths might apply outside the group (Kelly & Hunter, 2016).

The same agency provides health care for young people through its onsite clinic, which is staffed by a nurse practitioner. Access to an onsite music studio and health care clinic provides unique opportunities to explore nondeliberative, audio-based group work practice with young people experiencing homelessness. For example, residents are required to attend weekly life skills groups, which include sessions on health and well-being facilitated by the onsite nurse practitioner. As part of the group, the nurse practitioner and young people might work together to compose a song. In doing so, the nurse practitioner presents young people with an opportunity to address something through activity (e.g., songwriting) that may be seemingly unrelated to or beyond the scope of a presenting issue (e.g., learning new skills for health and well-being, such as safe sex practices or smoking cessation). As members engage in the activity and identify creative solutions, they have opportunities to reflect upon problem resolution in relation to the activity and how their experiences may relate to other issues in their lives (e.g., young people develop a song about health and well-being and subsequently may develop additional creative solutions for making decisions about safe sex and smoking cessation outside the group). In addition, it provides young people with opportunities to engage their music-related talents, strengths, and interests.

## **INTERPROFESSIONAL PRACTICE WITH VULNERABLE AND OPPRESSED POPULATIONS**

Although the majority of literature exploring the use of groups in health care settings tends to focus on client/patient-centered groups, some literature explores the use of team-based interprofessional practice in health care settings. Interprofessional practice involves health care workers from various professional backgrounds working together in a coordinated fashion with patients, families, caregivers, and communities to deliver the highest quality of care. Interprofessional practice teams are often intentionally created, relatively small work groups of health care professionals who are recognized by others as well as by themselves as having a collective identity and shared responsibility for a patient or a group of patients. Roles within an interprofessional health care team may include physicians, psychiatrists, psychologists, nurse practitioners, registered nurses, social workers, care coordinators, dietitians and nutritionists, community mental health workers, and clinical coordinators. Examples of interprofessional teams within health care settings include rapid response teams, palliative care teams, primary care teams, operating room teams, and community-based mental health teams.

Several studies have explored the use of interprofessional practice with vulnerable populations. Westheimer, Capello, McCarthy, and Denny (2009) explored the use of doctor interactive group medical appointments (DIGMAs) with hypertensive male veterans. Findings indicate participants' blood pressure was reduced significantly between pre- and posttests and that participants increased their health-promoting behavior. Counsell and colleagues (2007) evaluated an interprofessional model for assessment and care coordination of low-income seniors. In this model, a certified nurse practitioner and a clinical social worker complete an in-home, comprehensive assessment of the patient and collaborate with an interprofessional team to develop individualized care plans. Findings indicate patients reported significant improvements in general health and had reduced emergency department visits. In addition, high-risk participants had lower admission rates when compared with the treatment-as-usual group.

Tataw, James, and Bazargan (2009) present the conceptual framework for an interprofessional practice program that addresses the financial and nonfinancial aspects of health care access and health status for low-income urban children and families in South Central Los Angeles. Using educational and case management strategies, the program is designed to increase health services utilization, improve preventive health techniques, and boost disease self-management, with the ultimate goal of attaching children to medical homes. In 2010 the Veterans Health Administration launched the Patient-Aligned Care Team (PACT) model to transform the way military veterans receive their care (U.S. Department of Veterans Affairs, 2015). The PACT model is built on the well-known concept of a patient-centered medical home staffed by interprofessional teams. The goal of PACT is to provide patient-driven, proactive, personalized, team-based care oriented toward wellness and disease prevention in an effort to improve veteran health care satisfaction, health outcomes, and costs.

Assertive Community Treatment (ACT) is an evidence-based mental health service delivery model that combines treatment, rehabilitation, and support for severely mentally ill individuals. ACT is provided by multidisciplinary teams, which often include psychiatrists, nurses, social workers, and rehabilitation counselors who are available 24 hours a day, 7 days a week, thereby creating an intensive approach model to community mental health services. ACT has been found to reduce hospitalizations, increase housing stability, reduce

symptomology, improve quality of life, and engage severely mentally ill individuals in treatment (Bond, Drake, Mueser, & Latimer, 2001). Forensic ACT (FACT) is an adaptation of the ACT model. It serves individuals with serious mental illness who are also involved with the criminal justice system. FACT programs differ from ACT programs in several ways, including the prioritization of services to prevent recidivism and incarceration and the greater use of legal leverage (Lamberti, Weisman, & Faden, 2004). In addition, models may incorporate residential substance abuse treatment, supervised residential settings, and the inclusion of a probation officer on the FACT team (Lamberti et al., 2004).

Of the models reviewed, only ACT programs explicitly incorporate strengths-based approaches in interprofessional practice (McGrew & Bond, 1995). Furthermore, there is little information in the literature regarding the use of strengths-based approaches within interprofessional practice teams and their management. Rather, the literature offers recommendations on the levels of integration in interprofessional care, where greater integration of services and systems leads to greater level of care (Heath, Wise Romero, & Reynolds, 2013). Additional literature notes challenges in developing and implementing interprofessional practice teams, including conflict among team members and their respective disciplines, lack of team culture and leadership, and the lack of organizational support (Tataw, 2011). Increased attention to strengths-based approaches in interprofessional practice in health care settings may offer important benefits. Developing and implementing healthy, respectful, and communicative interprofessional teams in supportive organizational environments may lead to greater levels of care integration, which will positively affect the health and well-being of the clients teams serve (Heath et al., 2013).

## CONCLUSION

As this chapter demonstrates, groups are used extensively within health care settings. While social casework may have been the predominant model of social work in health care settings in the early 20th century, groups played an important role in health care service delivery and coordination during that time. Groups continued to play an important role in health care settings throughout the 20th century and continue to do so today, albeit from a problems-based orientation. There is a need for more strengths-based approaches in group work in health care settings, particularly with vulnerable and oppressed populations. Motivational interviewing groups, nondeliberative group work practice, and interprofessional practice teams are but a few accessible, collaborative, and creative ways to incorporate greater attention to members' inherent strengths.

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