Effects Of A Group Intake Procedure On Productivity And Delivery Of Services In A Community Mental Health Setting

Virginia Lee Douglas

University of Nevada, Las Vegas

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EFFECTS OF A GROUP INTAKE PROCEDURE ON PRODUCTIVITY AND DELIVERY OF SERVICES IN A COMMUNITY MENTAL HEALTH SETTING

University of Nevada, Las Vegas

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in a Community Mental Health Setting

A dissertation submitted in partial fulfillment of the
requirements for the degree of Doctor of Education

by

Virginia Lee Douglas

December, 1981
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TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>ACKNOWLEDGEMENTS</th>
<th>ii</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIST OF TABLES</td>
<td>v</td>
</tr>
<tr>
<td>CHAPTER</td>
<td></td>
</tr>
<tr>
<td>I. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Problem Statement</td>
<td>6</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>6</td>
</tr>
<tr>
<td>Statement of Purpose</td>
<td>7</td>
</tr>
<tr>
<td>Assumptions</td>
<td>8</td>
</tr>
<tr>
<td>Limitations</td>
<td>9</td>
</tr>
<tr>
<td>Significance of the Study</td>
<td>9</td>
</tr>
<tr>
<td>II. REVIEW OF THE LITERATURE</td>
<td>11</td>
</tr>
<tr>
<td>Comparison of Group and Individual Therapy</td>
<td>11</td>
</tr>
<tr>
<td>Outcomes</td>
<td></td>
</tr>
<tr>
<td>Advantages of Group Therapy</td>
<td>15</td>
</tr>
<tr>
<td>Selection and Preparation</td>
<td>19</td>
</tr>
<tr>
<td>Approaches to Reduction of Waiting Time</td>
<td>31</td>
</tr>
<tr>
<td>and No Show Rates</td>
<td></td>
</tr>
<tr>
<td>Summary of the Literature Review</td>
<td>36</td>
</tr>
<tr>
<td>III. METHODS</td>
<td>40</td>
</tr>
<tr>
<td>Setting and Subjects</td>
<td>40</td>
</tr>
<tr>
<td>Group Intake Procedure</td>
<td>41</td>
</tr>
<tr>
<td>Design and Data Collection Procedures</td>
<td>43</td>
</tr>
<tr>
<td>IV. RESULTS AND DISCUSSION</td>
<td>51</td>
</tr>
<tr>
<td>Impact on Agency Productivity</td>
<td>52</td>
</tr>
<tr>
<td>Impact on Client Services</td>
<td>58</td>
</tr>
<tr>
<td>Discussion</td>
<td>67</td>
</tr>
</tbody>
</table>
V. SUMMARY, CONCLUSIONS, RECOMMENDATIONS AND IMPLICATIONS FOR FURTHER RESEARCH .................. 78

   Summary ........................................ 78
   Conclusions ....................................... 79
   Recommendations ................................. 80
   Implications for Further Research .............. 82

REFERENCES ........................................ 85

APPENDICES

   A. Distribution of Clients by Age and Sex .......... 93
   B. Highest Level of Education of Clients by Site .... 95
   C. Instructions for Telephone Contact ............... 97
   D. Telephone Contact — Intake Notes ............... 99
   E. Precounseling Questionnaire ..................... 101
<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Ratio of Contact Hours Relative to Scheduled Therapists' Hours</td>
<td>53</td>
</tr>
<tr>
<td>1b</td>
<td>Ratio of Reimbursable Hours Relative to Scheduled Therapists' Hours</td>
<td>54</td>
</tr>
<tr>
<td>1c</td>
<td>Ratio of Number of People Seen for Intake Relative to Hours Scheduled for Intake</td>
<td>56</td>
</tr>
<tr>
<td>1d</td>
<td>Agency Costs of Group Intake Compared to Waiting List Costs</td>
<td>57</td>
</tr>
<tr>
<td>2a</td>
<td>Percent of Telephone Calls Resulting in Attendance at Intake</td>
<td>59</td>
</tr>
<tr>
<td>2b</td>
<td>Average Number of Days Between Telephone Contact and First Appointment</td>
<td>61</td>
</tr>
<tr>
<td>2c</td>
<td>Percent of Scheduled Intakes Resulting in Treatment Agreement at Site I</td>
<td>63</td>
</tr>
<tr>
<td>2d</td>
<td>Percent of Clients Returning for Varying Lengths of Treatment</td>
<td>64</td>
</tr>
<tr>
<td>2e</td>
<td>Client Progress Ratings at Three Months or Termination</td>
<td>66</td>
</tr>
</tbody>
</table>
Chapter I
INTRODUCTION

Community Mental Health Centers, like other public service agencies, are struggling with new demands at the worst of times. A major policy shift, empowered by the Mental Health Systems Act of 1980, has diverted staff and funding from outpatient services to the care of the chronically mentally disabled (Levine, 1979). The population of patients who once remained in state institutions for long-term custodial care are being discharged to the community centers. Deinstitutionalization, as the policy is called, has increased demands for crisis intervention, medical services, brief hospitalization, transitional housing and case management services in the community setting (Lamb, 1981).

These demands coincide with reduced federal funding of the community mental health centers (Association for the Advancement of Psychology, 1981; Blum, 1980; Hodge, 1976). Funds for treatment of the chronic population were not transferred from state institutions to community programs as the number of institutional patients dropped, nationally, from 600,000 in the early 1950's to 160,000 in the mid-70's (Budman, 1981).

In 1955, before the Community Mental Health Centers Acts, the ratio of inpatient to outpatient treatment was three to one. By 1975 the community mental health centers movement had reversed that
ratio (Budman, 1981). Demand for outpatient services continues to climb, especially in periods of rising unemployment (Ahr, Gorodzky & Cho, 1981).

The community mental health centers are currently struggling to meet their responsibilities to two distinguishable populations. Langsley (1980) made the distinction between mentally ill "patients" in need of "treatment" following the medical model and "clients" in need of counseling about problems in daily living suited to a social service model.

Outpatient services are best suited to serving "client" needs. While deinstitutionalization has changed the structure of community mental health programs and reversed priorities, the number of "clients" seeking service continues to exceed the number of chronic "patients" (Budman, 1981).

As a consequence of changed priorities, outpatient services are not expanding to keep pace with demand. Therefore, adults voluntarily seeking psychological services are placed on waiting lists until appointments become available. While waiting lists certainly predate the 1980 Mental Health Systems Act, the proportions of the problem have been drastically altered. A reasonable wait for service has not been clearly defined but waits of more than 15 days appear to be therapeutically undesirable (Luborsky, Chandler, Averback & Cohen, 1971; Meltzoff & Kornreich, 1970; Raynes & Warren, 1971).

The Problem

Outpatient services offered by community mental health centers appear to have reached a ceiling on growth (AAP, 1981; McPheeters,
Waiting lists as a means of coping with the discrepancy between demand and resources have proven to be inefficient and untherapeutic in community mental health settings (Gordon & Cartwright, 1954; Roth, Rhudich, Shaskan, Slovin, Wilkinson & Young, 1964; Stein, Karasov & Charles, 1974; Uhlenmuth & Duncan, 1968). Waiting lists often defeat the purpose of mental health programs by contributing to client distress. A long wait for services encourages the client to remain a passive victim of circumstances which may be deteriorating. Long waiting lists are negatively related to client outcome (Luborsky, et al., 1971; Stein, et al., 1974; Wolkon, 1972).

In addition to client disservice, waiting lists are wasteful. A brief telephone contact often fails to identify immediate needs best served by a timely referral to another agency. Furthermore, clients scheduled after a long wait are more likely to miss their first appointment than are those scheduled more promptly (Mannino & Rooney, 1965; Raynes & Warren, 1971).

Folkins, Hersch and Dahlen (1980) demonstrated a causal relationship between waiting lists and rate of no shows for first appointments. By experimentally increasing waiting time between initial contact and first visit, their study yielded results showing that people miss first appointments at an increasing rate as waiting time increases.

Missed appointments suppress productivity in mental health centers. Overall, about 30% to 35% "no show" rates appear to be fairly stable (Abrahams & Enright, 1965; Errera, Devenport & Decker, 1965; Parloff, Washaw & Wolfe, 1979). With waiting lists, the
probability of missed first appointments is increased; reportedly ranging from 50% to 60% (Hochstadt & Trybala, 1980; Rosen et al., 1980; Stein et al., 1979). Consequently, even if therapists' appointments are booked to the maximum amount of time available, the no show rate will suppress the productivity of therapists' time significantly.

Outpatient services are in need of alternative strategies for responding to new requests for services because of the problems inherent in long waiting lists. Diservice to clients and inefficient use of therapists' time due to excessive no show rates for first appointments have been shown to increase with increased length of time between requests for service and the initiation of service.

Productivity achieved at the expense of client outcome would clearly not be acceptable in a mental health setting (Wagenfeld, Rabin & Jones, 1974). A program change which staff perceive as detrimental to the quality of treatment compounds management problems (Feldman, 1980). Thus, management decisions affecting client services are more readily implemented if clinical merit can be shown.

Program change, as a research problem in an agency setting, brings to light the many complications of field research (Campbell, 1975). As pointed out by the National Institute of Mental Health (Davidoff, Guttentg & Offcett, 1977) the analogy between an independent variable and a program is not tenable. Agency goals, rather than hypotheses, determine what is to be investigated. Subgoals of a program, during the course of implementation, change rapidly. The program itself may change even though the primary goal remains the same. Randomization and control over who enters or leaves the program
does not rest with the researcher. Thus, statistical tests of significance applied to data collected under these conditions are likely to lead to faulty inferences.

Inasmuch as community mental health centers are constantly changing in terms of funding, demands, needs, staffing and approaches, Blum (1980) emphasized that research in this kind of setting must respond to the needs of the agency rather than to the needs of the researcher.

In place of traditional methods of controlled sampling and manipulation of independent variables, program evaluation methods are selected primarily to assess the desirability of retaining a program change (Leithwood & Montgomery, 1980). Whether or not the change facilitates the functions of the agency in meeting its objectives can be specified by observing changes in selected outcomes.

Connolly and Porter (1980) proposed a "user-focused" model in which a single decision maker controls both innovation and evaluation. Implementation could then be managed to provide contrasts on the key points of concern. These authors recommended Campbell and Stanley's (1963) Design 15 because of its capacity to exploit normal agency cycles to obtain useful control groups.

Since the data, in the absence of controlled observation, are not amenable to statistical analyses, Smith and Caully (1979) approached the problem of generalizability from a standpoint of "ecological validity". The most important variables of the setting are identified by including a detailed description of the setting along with the report of the results achieved in the original setting.
Problem Statement

The problem with which this study is concerned is the disservice to clients and the lowered productivity of therapists' time inherent in the waiting lists of community mental health centers. The study includes the development, implementation, and evaluation of an intake program change in a community mental health center. Due to the nature of the setting, the design of the study should be drawn from program evaluation models rather than from traditional research designs.

Definition of Terms

For the purposes of this study, the following terms are defined below:

Client Progress: rating of treatment outcome as improved, worse, or no change.

Contact Hour: time spent by therapist with client(s) regardless of number of people seen.

First Appointment: first appointment scheduled with assigned therapist.

Group Intake: multi-purpose procedure used in place of waiting list for setting up treatment appointments for new clients. No fee is charged for this time.

Individual Intake: appointments scheduled for individuals for initiating treatment with assigned therapist. Fee is charged.

Reimbursable Hour: therapists' time for which fee is charged. Reflects number of people seen during contact time.
Return Rate: number of individual or group sessions following intake.

Waiting List: system for monitoring which callers, who have requested service, were or were not given appointment.

Statement of Purpose

The present study was undertaken to assess the feasibility and desirability of replacing the waiting list for outpatient services in a community mental health setting with a group intake procedure. The primary management goals of the change were two-fold: (1) to increase the productive use of therapists' time in the outpatient program and (2) to decrease the time gap between clients' requests for services and initiation of treatment.

In order to more specifically assess the impact of changing from a waiting list for individual intake to a group intake procedure, changes in the following indices will be observed:

1. Impact on Agency Productivity
   a. Ratio of contact hours relative to scheduled therapists' hours.
   b. Ratio of reimbursable hours relative to scheduled therapists' hours.
   c. Ratio of number of people seen for intake relative to hours scheduled for intake.
   d. Costs of group intake compared to costs of waiting lists.
2. Impact on Client Service
   a. Percent of telephone contacts resulting in attendance at intake.
   b. Average number of days between telephone contact and first appointment.
   c. Percent of scheduled intake resulting in treatment agreement.
   d. Percentages of clients returning for varying lengths of treatment.
   e. Client progress rating at three months or termination.

Assumptions

1. Productivity gained at the expense of client service would render the program change undesirable.

2. Failure to improve productivity would result in lack of feasibility for continuing the change.

3. Greater use of group treatment formats was expected in the course of the study given a more rapid influx of new clients and improved notification of the availability of groups.

4. The primary use of the data to be collected would be to assist this particular agency in deciding whether or not to retain the change to group intake beyond the period of the study.

5. To the extent that other agencies share the same problem, goals, clientele and patterns of staffing and programming, the results could serve to provide a method for adapting group intake to specific needs in other similar agencies.
Limitations

1. The design of the study was limited to a set of program management questions in a specific setting. Features of the setting exploited by the design were the decentralized site locations and the autonomy of each site in selecting intake procedures. Generalizability to other settings was not incorporated into the design of the present study. Therefore, the adaptation of group intake to other settings should be accompanied by evaluation for that setting.

2. A global program change was enacted without provisions for evaluating specific components of the complex procedure. Screening, client preparation for therapy and orientation to the agency were attempted as a package. Thus, the results of the present study would not be predictive of the utility of any single component.

3. In raising questions related to client outcome, such as return rate and treatment progress, the study did not attempt to measure process nor outcome of treatment per se. These additional data were collected in a limited manner only to check for signs of detrimental effects of the program change on client outcome. The system of entry, rather than the treatment program itself, was the focus of the study.

Significance of the Study

The utility of evaluation research is best demonstrated by its ability to inform the decision-making process how to improve the accessibility and quality of specific programs. Thus, the primary
significance of this study lies in its answering a narrow set of questions with respect to decisions to be made in a specific setting.

In so doing, the study is intended to fill in the gap between literature about "user-focused" evaluation in community mental health and the scarcity of studies in which such a model has been applied. The study will investigate the development of methods for adapting group intake, a promising innovation whose empirical base has been weak, to a specific setting.

By means of user-focused field research, such innovations can be shared among common settings. The responsibility for supplying the empirical data base is placed on the setting in which the innovation is used rather than on the originator of the innovation. Such a view of evaluation research is consistent with recognition of the important differences between the manipulation of independent variables in the laboratory and evaluation of programs committed to helping people in the field.
Chapter II

REVIEW OF THE LITERATURE

The intent of this study was to select and evaluate an alternative to the problematic waiting list as a solution to the discrepancy between demand and resources in mental health settings. Beginning with comparisons of outcome of individual and group therapy, the review which follows examines special advantages offered by groups, diverse functions of groups in mental health settings and variables relevant to selection of group tasks and group candidates. Finally, different intake procedures are reviewed.

Comparison of Individual and Group Therapy Outcome Studies

Clients who applied for psychotherapy generally preferred individual treatment to groups (Dickoff & Lakin, 1963). Client resistance to group therapy was related to the belief that troubled people would only pull each other down (Yalom, 1975), fear of emotional contagion (Nicholas, 1976), devaluation of cheaper treatment (Mullan & Rosenbaum, 1978), lack of acceptance of group tasks to resolve individual problems (Nicholas, 1976) and social anxiety or hostility (Meltzoff & Kornreich, 1970).

A bias also existed among mental health practitioners against group therapy. Most often the bias was attributed to the predominantly individualistic paradigm of academic and applied psychology (McClure, Cannon, Belton, D'Ascoli, Sullivan, Allen, Connor, Stone,

Meltzoff and Kornreich (1970) undertook an extensive review of all controlled studies of outcomes in psychotherapy which had been published in the United States. One chapter (8) of their book was devoted to the comparison between individual and group treatments:

Without regard to therapeutic technique, therapist variables, or temporal or patient variables, a simple summation of adequately controlled studies we have reviewed shows roughly 80% of investigations to yield primarily positive results with individual and group therapy alike. (p. 178)

The authors cited the few research projects that made direct comparisons of outcome achieved with group and individual methods and recommend group therapy "...on grounds of economy since both kinds produce comparable results" (Meltzoff & Kornreich, 1970, p. 181).

Luborsky, Chandler, Averback, Cohen & Bachrach (1971) reviewed 166 quantitative studies which examined patient treatment and therapist variables related to therapeutic outcomes. Only three studies were cited which compared individual versus group treatment. The authors refrained from drawing conclusions about the relative efficacy of group versus individual treatment.

Another extensive review of outcome research by Bednar and Kaul (1978) drew the conclusion that "group treatments work", overall, as well as individual treatments. This statement was qualified by the evidence of null results as well as of some casualties reported
in the group literature. They added that group treatments compare favorably to individual treatments but there is still inadequate information for the differential selection of any type of group treatment.

Smith, Glass and Miller (1980) analysed the results of 475 outcome studies. They found similar effects for group and individual treatments in their aggregation of 1600 outcome measures. Their method yields the effect size, a statistic derived from the mean difference on any particular outcome measure between treated and control subjects, divided by the standard deviation of the control group. The effect sizes of competing therapies can be summed across studies to provide a quantitative measure of their comparative effectiveness.

By way of context for the outcome surveys, Halleck (1978) wrote:

It is interesting to note that available research indicates that it makes little difference what type of psychotherapy is used in treating neuroses or personality disorders. Group psychotherapy seems as effective as individual psychotherapy, brief psychotherapy as effective as long-term, and client-centered psychotherapy as effective as more traditional psychoanalytically oriented therapy. (p. 16)

Barron and Leary (1955) compared MMPI scale scores before and after therapy using 85 adult outpatients in group and 42 subjects in individual therapy. Similarities, in general, were greater than differences between individual therapy and group. Both individual and group psychotherapy yielded improved scores on depression, hypochondriasis and ego strength. Group scores showed a small advantage on the paranoia and psychasthenia scales while individual treatment was favored on only one scale (K), a control scale.
Fifty-four psychoneurotic adults randomly assigned to individual or group treatment in a study by Frank, Ghedman, Imber, Stone & Nash (1959) changed independently of type of treatment.

Male children were subjects of another comparison (Novick, 1965) which yielded no treatment effects differentiating group and individual modes. Children with good initial prognosis fared equally well in group or individual methods while those with poor initial prognosis demonstrated equal ineffectiveness of group and individual treatments.

Behavior therapy in individual and group treatment with test anxious students showed equivalent anxiety reduction for the ten students treated in nine group sessions and the ten treated in five individual sessions (Paul & Shannon, 1966). Fewer sessions appeared, in this study, to favor individual and behavior therapy.

Gelder, Marks & Wolff (1967) undertook a four celled comparison between behavior therapy versus analytic therapy in group versus individual treatment. There was slightly less improvement with group therapy. Analytic therapy favored individual treatment more than did behavior therapy.

A group condition yielded results equivalent to individual treatment but required less than half the therapist's time in a study using behavioral family therapy. Thirty-six families with problem children of elementary school age all received pre-therapy information about behavioral management of children. They were then randomly assigned to individual or group conditions. Parent attitudes, behavioral data collected by the parents and ratings of audio home
tape recordings were not significantly different between conditions (Christensen, Johnson, Phillips & Glasgow, 1980).

Assertion training was yet another behavioral technique which yielded similar positive results whether offered in group or individual conditions. In their study of women, Linehan, Walker, Bronheim, Haynes & Yerzeroff (1979) found that at three month follow-up, anxiety reduction and gains in assertion were maintained equally for both conditions. Both yielded significantly better results than the control condition.

An experimental study (Fairweather, 1964) of hospital ward treatment programs crossed three diagnostic groups (nonpsychotic, acute psychotic and chronic psychotic) with four treatment conditions involving group and individual therapy activities. Group therapy resulted in briefer hospitalization. Post-hospital adjustment, however, at three month follow-up, was not related to type of treatment.

The body of outcome research comparing group with individual treatments revealed no consistent evidence in support of the individual treatment bias shared by many clinicians as well as clients. In the words of Meltzoff and Kornreich (1970), "Pending contradictory future evidence, we must conclude that individual or collective treatment or a combination of the two, are equally effective or ineffective as the case may be" (p. 183).

**Advantages of Group Therapy**

Pattison (1970) surveyed community mental health centers, nationwide, to query their use of group methods in each of the ten
functional areas of a comprehensive program. The greatest use of group methods was in outpatient services. Treatment philosophy ranged from exclusion of group methods to group-oriented programs placing all patients in group therapy if at all possible.

Only intensive outpatient psychotherapy groups were used by a large majority of community mental health centers (CMHC). Family therapy and parent groups were reported by half of the centers. Only one-fourth used multiple family groups. About half the centers provided supportive groups for crisis or chronic patients. Medication groups, diagnostic intake groups, large discussion groups and social networks were used in a small percentage of centers.

The advantages reported by the centers which endorsed group methods were grouped into three categories: (1) Pragmatic—savings in time and money and less cost to the client, (2) Individual—opportunities for peer confrontation, ego-support, modification of interpersonal behaviors and insight into interpersonal relations, and (3) Systems—replication of real-life problems, breaking down barriers between sick and well, patient and staff, socialization, fostering awareness of how the individual interacts in his environment.

The most frequent advantages cited were pragmatic. Centers which gave pragmatic reasons for using groups actually used groups least. Those CMHC which listed systems advantages used the most groups with a wider range of group activities.

Compared to the broad social systems view of Pattison, Guttmacher and Birk (1971) based their analysis on a dynamically oriented interpretation of groups as catalysts for a more rapid working
through of conflicts. From their clinical perspective, groups contributed "...a particularly fertile setting for the revelation and treatment of problems through their expression in the here and now" (p. 546). Treatment advantages not available in individual psychotherapy included: in vivo social learning with a wider range of elicited behaviors, cohesion which can allay anxiety, confrontation of distortion and antisocial behaviors and multiple transference.

Coming from a Sullivanian perspective, Fidler (1972) was interested in the growth of the social self concept. He claimed a niche for group psychotherapy in the treatment of those patients suffering an impairment of their ability to conceive of themselves as members of a group. The more deviant and rejected by society, the more in need of group therapy were these "sick" patients, in Fidler's view.

The social distance between normals and the mentally ill was similarly recognized by Ewalt (1963) who argued the importance of groups in the correction of disturbed interpersonal relationships. Group therapy offered qualities lacking in individual therapy, according to Ewalt, for overcoming isolation, altering egocentricity, and providing a sense of belonging which promoted more altruistic behaviors in a more life-like setting.

Combining the theories of Hill, Yalom, Corsini and Rosenberg, Hill (1975) listed the therapeutic mechanisms of groups as consensus, ventilation, acceptance, spectator therapy and intellectualization. Universalization, reality testing, altruism, and socialization were secondary.
The choice of a heterogeneous group treatment format might be especially beneficial to the client whose problem involves current interpersonal relationships. Loneliness, social and work inhibitions, difficulty caring about or understanding the needs of others, excessive dependency and certain personality disorders indicated the choice of group treatment (Frances & Clarkin, 1981).

One study of patients' views of group psychotherapy was reviewed. Dickoff and Lakin (1963) analyzed verbal reports of former group therapy patients. Subjects had participated in group therapy at a university hospital from one to two and a half years prior to the study. The same group leader treated all of the patients using a Rogerian method. Those who negatively appraised their group experience were more likely to have complained of not having experienced meaningful social contact with other group members. Members who experienced support and social contact attended more group sessions and attributed more relief or improvement to group therapy. The results suggested that cohesiveness, in itself, was a therapeutic component.

In summary, this group of studies offered a plausible argument that group therapies provide more than the pragmatic saving of time and money. The member to member social contact inherent in group therapy distinguishes group treatment from individual treatment in a way which is vitally connected to the alleviation of suffering caused by disturbances in interpersonal relationships. Alienation, social anxiety, certain characterological and personality problems and psychoses resulting in the disruption of supportive relationships
in the community logically would indicate group therapy as the
treatment of choice. Disturbance in communicating and making contact
are seen by clients who seek group therapy as the essential problem.
Communication-contact problems are best solved in groups (Ermann,

Selection and Preparation

Returning to the question raised in the Pattison study previously
cited, how are the appropriate members, techniques and goals selected
in implementing group programs in community mental health settings?
This section reviewed special purpose groups and criteria for patient
screening. When groups are designed for a special purpose, the goals
of the group determine what individual goals can be subsumed in that
group. Preparation of naive group candidates is another approach
in which the suitability of the candidate for group therapy can be
manipulated by the therapist prior to placement in the group.

Hampson and Tavormina (1980) demonstrated differential effects
of behavioral and reflective group training with foster mothers.
Those assigned randomly to the behavioral conditions improved in
use of skills. Reflectively trained mothers improved in parent
attitudes. Both conditions positively affected outcome while
method was shown to define goal with a surprising degree of precision.
The behavioral mode appeared to have greater effects in client satis­
faction and application areas.

A model for the expansion of service delivery offered by
Christensen et al, (1978) suggested the use of groups for prevention,
treatment and maintenance functions. Examples of preventive groups
were those organized for both support and change—T-groups, consciousness raising groups, and the Good Neighbor Project which organized six-person "families" which met weekly to practice communication skills.

In treatment, group therapy and Alcoholics Anonymous (AA) were examples. Peers practiced desired behaviors together, provided mutual feedback, non-contingent support, encouragement and social contact. Other treatment strategies have included peers working as teams so that reinforcement was contingent upon the progress of both individuals, taking advantage of natural social pressures to accelerate behavioral change. Alumni associations for therapy graduates and continued contact with AA among ex-drinkers was thought to be important in maintaining gains. The authors suggested that a possible use of the alumni might be to sponsor persons newly entering the program.

Psychoeducational or self-control groups have been shown to be effective in minimal therapist intervention in depression (Feecks & Rehm, 1977; Lewinsohn, Munoz, Youngren & Zeiss, 1978), controlled drinking (Miller, 1978), stress management (Brown, 1980) and desensitization (Cohen, 1969).

Relevant to aftercare programs in community mental health, medication groups and socialization groups were held to be preferable to individual treatment, both for advantages to therapists and clients "...since the group provides more opportunity to break up the withdrawal and passivity that characterize the medication patient" (Schaye & Garmiza, 1976, p. 34). Long-term open-ended groups for relatives of hospitalized psychotic patients were helpful
in buttressing the support required to maintain these patients in the community and lower the rate of return to the hospital (Bailis, Lambert & Bernstein, 1980).

Treatment of patients in homogenous groups that focus on specific symptoms has been described as effective, acceptable to patients, and less expensive. Obesity, addictions, criminal behavior, agoraphobia, homosexuality, and problems specific to the developmental phases of childhood, adolescence and old age were some of the target symptoms for group work (Frances & Clarkin, 1981).

The spectrum of group treatment applications in a community mental health system is potentially broad, ranging from traditional intensive group psychotherapy to aftercare groups for patients and their relatives and psychoeducational groups of diverse purposes.

Selection. Selection of group participants is a matter of concern in the prevention of casualties or the disruption of the group. Another potential use of screening lies in the deliberate composition of working groups. At this time the application is not very practical, however, due to the crudeness of predictors, the complexity of factors involved and the vast pool of clients required (Adrian, 1980).

Studies of diagnostic, personality, general functioning, intelligence, affect, defensiveness, insight, and social achievements (Garfield & Bergin, 1978; Luborsky et al., 1971; Meltzoff & Kornreich, 1980; Slavson, 1956; Yalom, 1966) mainly demonstrated the
trend that those who start treatment with greater assets do better: "the rich get richer" ...whether in individual or group therapy.

Inclusion criteria suggested by Adrian (1980) were (1) match between goals and objectives of the group and the needs of the client; (2) positive motivation and expectations about therapy; (3) client capacity to operate within the norms of the group; and (4) client capacity for verbal expression, responsiveness to others and ability to tolerate conflict. Criteria for exclusion included: (1) overuse of denial, somatization or externalization as defense mechanisms; (2) active, lethal suicidal ideation; (3) standing out as deviant member (acutely psychotic, paranoid, schizophrenic, brain damaged, addicted to drugs or alcohol); (4) sociopathic style or relating to others that would distract the group from its primary objective.

Adrian elaborated on the importance of clarifying an individual's needs and willingness to meet his needs in a group. Without attending to motivation, the individual and the group were not likely to be successful. Resistant members diverted the group's attention from its purpose.

The emphasis placed by Adrian on the capacity of the client for verbal expressiveness and adherence to group norms was extended in Kotkov's (1958) empirical study. Kotkov sought to discriminate between continuers in therapy and those who dropped out. Verbal-emotional participation ranked first in confidence level. Those who continued actively sought to establish relationships in the group. Drop outs were either extremely hostile or extremely placid and required prodding. Both extremes elicited negative responses from
fellow group members and so these individuals missed out on the reinforcement and support necessary to maintain their attendance.

Group psychotherapy, Kotkov concluded, was too demanding for patients lacking an ability to relate verbally in a spontaneous and friendly manner, those whose aggression was inhibited, or those who were pressured into treatment. Alternative group treatments, Kotkov recommended, should be more systematically developed.

Slavson (1955) stressed the dangers of exposing patients with defective ego organizations to experiences in groups which prove to evoke more anxiety than the patient can manage. Contraindications for analytic groups in Slavson's discussion were: incapacity for object relationships, gross ego and superego deficiency, and severe sexual disturbance.

Johnson and Gold (1971) applied different criteria in their study of groups of latency aged boys. Since negative behaviors were learned as readily as positive behaviors, the authors emphasized group management to minimize the contagion effect of negative behavior observed in the empirical investigation of leadership in boys' groups. Prior knowledge of the boys' behavioral and interactional patterns were helpful, not for excluding individuals, but for matching goals and techniques to the presenting problems.

Screening for encounter groups was discussed in a study by Hartley, Robach and Abramowitz (1976) which identified the following correlates of encounter group casualties: unrealistic expectations, low self-esteem, hostility, low in interpersonal adequacy and high in sensitivity, felt need for growth and change, deviant role in the
group, less expression of attraction for the group. The author recommended facilitators of encounter groups use screening, preparation of clients, use of community resources and guidance toward reasonable goals retaining the option of elective termination.

In reviewing approaches to the question of selection of group members, one of the more clear indications was that intensive group psychotherapy required the safeguarding of the individual and the group through selection and screening. Casualties were more likely to result in intensive group experiences due to the intimacy involved, the power of the group to reinforce or punish, and the provocation of anxiety (Adrian, 1980; Kotkov, 1958; Lieberman et al., 1973; Slavson, 1955; Yalom, 1975). In these groups, dropping out acted as a form of self-selection (Aronson, 1967; Slavson, 1955; Yalom, 1966) which provided a secondary safeguard where clinical judgment failed.

Most, if not all, of the categories of clients deemed unsuitable for intensive groups could possibly benefit from a specially structured group where techniques and goals were adapted to client level of functioning and where therapists assumed a direct role in maintaining a group climate where all members were accepted (Johnson & Gold, 1971; Kanfer & Grimm, 1980; Slavson, 1955; Yalom, 1975).

Preparation. Tied to the selection issue was the concern with motivation. One of the factors previously associated with premature termination of therapy was inaccurate conceptions about the therapist role, the nature of treatment or client role. Orne and Wender (1968), in agreement with the general consensus, stated:
There is a strong positive relationship between a patient's perception of psychotherapy and its ultimate success. Some patients who appear to lack motivation for treatment may be capable of profiting from psychotherapy if they are taught what to expect—if they understand the "rules" of the game. (p. 1203)

Wollersheim, McFall, Hamilton, Hickey and Bordewick (1980) noted the importance of assessing initial attitudes regarding treatment and providing precounseling information to promote accurate and positive expectation. Her study substantiated the notion that exposure to the rationale of therapy enhanced willingness to enter therapy and a more accurate perception of the nature of psychological problems and the requirements of treatment.

Pretreatment information about treatment strategy produced better results than did information about expected outcomes in an experimental study by Seidner and Kirschenbaum (1980). Both kinds of information, as well as having clients sign explicit intention statements, all enhanced client involvement and behavior change more than did control conditions.

Treatment failed in many instances, according to Kanfer and Grimm (1980) because therapists neglected to establish appropriate prerequisites to change by role structuring. On the other hand, expectancy effects and placebo effects were credited by Bednar and Kaul (1978) with much of the positive results of group research. They encouraged therapists to take time to shape the expectations of members before therapy.

Rabin (1970) reviewed the literature for studies of preparation of subjects for psychotherapy. Methods included presentation of
basic information, recordings which provided samples of group
sessions, typed protocols or written instructions, preparatory
interviews and group experience through intake or diagnostic groups.
Individualized preparation involved a more careful exploration of
dynamics, patterns of resistance, transference and the nature of the
patient's fears. One or many sessions were used as needed. Prediction
of destructive ways of dealing with anxiety in the group were consi­
dered an important component. Clients should be prepared to handle
destructive urges so as to avoid self-defeating behaviors in the group.
Issues of resistance, Rabin pointed out, were profitably brought out
in preparation for therapy to help the client anticipate periods of
difficulty and to persist in group therapy.

The method of preparation provided by Orne and Wender (1969)
began with a preliminary interview in which the therapist actively
sought out the notions the client brought to the situation and directly
stated what the client might expect to occur in the therapy to follow,
along with a rationale for treatment. The roles of patient and
therapist were clarified. After the preliminary interview the client
joined his peers to view a videotaped model of group interaction.

The first phase of treatment, whether individual or grup, in
Kanfer and Grimm's (1980) model was devoted to role structuring and
creation of a therapeutic alliance. The therapist deliberately
attempted to modify motivation by presenting himself as a potential
source of reinforcement, anticipating a favorable outcome, and helping
the client to understand and accept the rules governing the client-
therapist relationship. These goals were accomplished through direct
statements, modeling and shaping the client's behavior in session.
This early phase was most critical in the treatment of passive, dependent clients. It was important, they emphasized, to help the client understand that he would be responsible for active participation in providing information and in carrying out between-session assignments and exercises and would jointly consider appropriate therapy goals.

A role induction interview was conducted by a prestigious senior psychiatrist in the HoeHü-Saric, Frank, Imber, Nash, Stone and Battle (1964) experiment. The results of the experimental condition were more favorable in measures of desired therapeutic behaviors, attendance rates and therapist ratings of improvement than were equivalent measures for the non-preparation control. The effective treatment consisted of a general exposition of psychotherapy, explanation of the behavior expected of therapist and patient, and induction of an expectation to see improvement within four months. Control patients were given an appointment with a therapist and told to try to terminate within four months.

The steps involved in Weigel and Uhlemann's (1975) model were: exploration of the problem and establishing rapport, setting general and specific goals, stating failure criteria, reality and importance checks, contract and evaluation procedure. These steps were used in both individual and group therapy.

Heitler (1976) developed a preparatory technique for use with lower class, unsophisticated clients which improved attendance and progress in therapy. A rationale for how talking therapy helps was stressed.
Written instructions were developed by Martin and Shewmaker (1962). The brief mimeographed sheet was distributed to group applicants to read prior to their first meeting and keep for periodic review during therapy. The paper was later quoted by members as a support for risk taking and critical evaluation of group process as cohesion developed. The authors also believed it served as an aid to self-selection for prospective members prior to that first session.

Interviews and written instructions were compared for effectiveness in outpatient client preparation by Garrison (1978). Both were more effective in improving attendance from first to sixth session, as well as in improving first session role behavior as judged by therapists, than no preparation control. The less time consuming written instructions were equally effective as compared to the interview.

A more novel approach was attempted at a university counseling center (Goldstein, Gassner, Greenberg, Gustin, Land, Liberman & Steiner, 1967). Graduate students were planted in each of two groups. One group was composed of students, the other of adult outpatients from a county clinic. During the experiment, the plant was carefully coached to model member group behaviors five sessions ahead of the group. The authors reported that the plants were effective in moving the group toward more rapid disclosure. Sociometric ratings revealed that group members perceived the plants as markedly more therapeutic than other members, but not as best liked or most popular.

Videotaped modeling was productively used in a child psychiatric clinic for family therapy. Day and Reznikoff (1980) developed the videotape for the study. A number of therapists and clients similar
to the viewers were depicted. The models were shown talking to therapists about themselves and their feelings. The structure of the therapy was shown in the scenes. Children involved in expressive or play therapy were represented. The issue of resistance was explicitly dealt with in the film. Pre-post measures of expectations about treatment at the center showed improved scores. Prepared families had fewer cancelled and failed appointments than did controls.

In their review of preparation studies, Parloff, Washow and Wolfe (1978) noted that the relationship between congruence of client-therapist expectations and patient improvement had not been demonstrated. What had been shown was that preparation efforts pay off in client's increased involvement and remaining in therapy. Induced expectations, as opposed to post-hoc measurement of congruency of expectations, showed a stronger effect on patient improvement than either naturally occurring or experimentally established congruency-incongruency.

In the studies presently reviewed, preparation has been shown to improve client behaviors in the first few sessions of therapy (Day & Reznikoff, 1980; Garrison, 1978; Goldstein, Hiller & Sechrest, 1966; Heitler, 1976; Martin & Shewmaker, 1962; Rabin, 1970; Rothaus et al, 1964; Seidner & Kirschenbaum, 1980; Wullersheim et al, 1980; Yalom et al, 1967). Dropout rates were not always affected, however, as shown by Martin and Shewmaker (1962) study. It was hypothesized that preparation could also serve as an aid in client self-selection (Lothstein, 1978; Martin & Shewmaker, 1962; Yalom, 1966). It might be speculated that dropout rates declined most when subjects of
preparation efforts were psychologically unsophisticated. Many of the studies were directed at lower and working class patients whose dropout rates were very high (Parloff et al., 1978) in contrast to the patients in Martin and Shewmaker's (1962) study. More sophisticated clients might use the information for selection among alternatives known to them.

Several instructional methods for client preparation were reviewed: interview, group intake, videotapes, film, audiotapes, written instructions, use of plants, and written protocols of groups in session. Objectives have included presentation of basic information, clarification and structuring of roles and expectations, modeling and shaping client-role behaviors, making resistance recognizable and anticipating the need for renewed effort when it appears and presenting to the client a rationale for treatment along with setting a positive outcome expectancy.

A few studies have compared method or content. Rationale for treatment carried more weight than outcome expectancies with Seidner and Kirschenbaum's (1980) sample of students. Written instructions were equally as effective as interviews in Garrison's (1978) study.

Clinical opinion stressed the importance of dealing with resistance in preparation for dynamic therapy in several papers (Aronson, 1967; Day & Reznikoff, 1980; Hoehn-Saric et al., 1964; Martin & Shewmaker, 1962; Rabin, 1970; Strupp & Bloxom, 1973; Yalom et al., 1967). Behaviorally oriented programs placed their emphasis on the activity of the client in jointly determining goals, carrying out assignments,
providing information, contracting, etc. (Kanfer & Grimm, 1980; Seidner & Kirschenbaum, 1980; Weigel & Ullenmann, 1975; Whalen, 1963).

The rationale for preparation of clients for therapy was that client expectancies were related to passive versus active participation in treatment, that the role of the client involved attitudes and behaviors specific to therapy which could be taught, that anticipating resistance enabled the client to deal with it and that transfer of learning and maintenance were facilitated by structuring the procedure so that the client was recognized as the originator of change rather than the recipient.

Adapting preparation methods to a particular program depended on treatment philosophy, type of treatment and entry level of functioning of the target population. As Luborsky et al. (1971) pointed out, although amount of motivation tended to be positively related to outcome, type of motivation was not predictive. Clients changed their perspective as treatment progressed. But without an initial conception of therapy as relevant to their needs, they were unlikely to remain in treatment long enough to benefit.

**Approaches to Reducing Waiting Time and No Show Rates**

Of the efforts reported in the literature to reduce waiting lists or no show rates, the approaches included prompting attendance, varying length of time between telephone request and first appointment, group intake and multiple entry systems.

A study carried out in a large mental health center affiliated with a medical school compared two procedures for the scheduling of
first appointment (Levenson & Pope, 1981). One procedure resulted in the caller being given an appointment during the initial contact; the other required the therapist to call back to schedule the first appointment. There was no waiting list due to the availability of students and interns in addition to regular staff. An average of 4.4 days elapsed between initial contact and first appointment for those called back by therapists. The no-show rate did not differ significantly between the two procedures: 21 versus 23%. This no-show rate was lower than that usually reported. Fewer incidents of loss of contact resulted when scheduling was transacted at the time of the initial call.

An experiment carried out by Hochstadt & Trybala (1981) yielded strongly favorable results for prompting prospective clients. Four treatments, including a no-prompt control, were used for 88 subjects. Phone calls the day before the appointment resulted in 9% nonattendance; phone calls three days in advance yielded a 32% no-show rate; while letters and the control produced a 55% no-show rate.

Folkins, Hersch and Dahlen (1980) systematically varied the length of time between initial contact and first scheduled appointment. They found a positive relationship between no-show rate and length of time elapsing between request and appointment.

Stein, Karasov and Charles (1974) compared 100 patients who did not keep their initial appointments with 100 patients who kept appointments. Eighty-two of the no-show group responded to a mail and telephone inquiry. Assessing the results of a change from a "walk-in" entry system to an appointment system, the authors concluded that an
appointment system favors females who are self-referred. During the "walk-in" period, the male-female ratio was 3 to 2; after changing to the appointment system, the ratio was 2\(\frac{1}{2}\) to 1. Of the callers, 57% of the females and 37% of the males kept their appointment even though the wait time had been reduced from 2 to 4 weeks to 5 to 7 working days. The authors concluded that a "multiple entry" system should be used since different systems result in different utilization patterns.

Group intake procedures were reviewed by Hare-Mustin (1976). Group intake was concluded to be as effective as individual intake in terms of clinical outcomes. Clients who dropped out after group sessions did not differ from clients who dropped out after individual intake sessions. Group intake resulted in a clear savings of staff time and a shorter waiting period for clients. Orientation to psychotherapy was facilitated by group intake. Several reports cited by the author indicated that group intake enhanced the communication of problems when clients were dissimilar to professionals in social class, age or race. The communication advantage was attributed to peer support.

A diagnostic group strategy was devised by Stone and his associates (1954) to overcome a costly dropout problem in their group therapy program. The initial procedure involved a ten hour work-up followed by a long wait for an opening. Since 30% of the clients dropped out before therapy was initiated, the lengthy work-ups were being wasted. The innovation was to place clients in diagnostic groups of up to fifteen men and women clients. The groups met one hour a week for four to six weeks and were transferred into therapy
groups as openings were available. No orientation was provided except to inform members that they would be transferred in a few weeks.

No advantage was gained in terms of dropout rates. The advantages cited by the authors were the great savings in diagnostic costs and the rapid accumulation of clients ready for group therapy. The authors further commented that the direct observation of social interactions provided more useful data for classification of patients for therapy than did the prior individual testing and interviewing.

An intake group procedure reported by Dibner, Palmer, Cohen and Gofstein (1963) provided the opportunity for observation of interpersonal behavior along with a method for preparing clients for participation in therapy. An active therapist introduced the members, explained therapeutic processes and arranged an individual session to discuss patient behavior and reactions in the group.

An inpatient setting use of intake groups was described by Abrahams and Enright (1965). Dropout and no-show problems existed even in hospital settings. Again, there was no difference in the dropout rates (about 30%) between patients participating in intake groups and those in individual intake. Despite the expressed reluctance of the patients to attend group, it was found that they were, in fact, no more likely to avoid group than individual intake. The authors reported the groups to be particularly helpful for diagnostic and preparation purposes.

A review of the efforts to reduce no-show rates for first appointments, on the whole, would indicate that whatever procedure is used, a proportion of those who call clinics will not follow through. Thus,
individual intakes can be expected to inefficiently tie up a certain amount of costly professional time.

Silverman and Beech (1979) argued that the dropout phenomenon in outpatient services may not be related to dissatisfaction with services offered. He found that, among dropouts who attended only the initial session, "...an impressive 79% reported that the problems for which they came to the mental health center had been solved" (p. 238). Changes in their life situation and help from family and friends had resolved the problems of 84% of those who were no longer interested in services.

The Silverman and Beech study lends further credence to the crisis hypothesis of Folkins, Hersch and Dahlen (1981) who found a positive relationship between length of wait and rate of no-show. Their explanation was that most people call as a crisis peaks; as changes occur their motivation to follow through is reduced in a matter of a few days to the few weeks of most waiting lists.

Since a major contributing factor to the change from walk-in to appointments in the Stein et al. (1974) study was the crisis situations being inappropriately presented in their clinic, it appeared that crisis intervention was a frequent need of those who called who would not show up for a scheduled appointment at a later time.

The disadvantages of group intake have included the reluctance of clients to talk about sexual problems (Abrahams & Enright, 1965), initial disappointment (Hare-Mustin, 1976) and the desire of therapists to hold onto their clients in a study where intake groups were extended to six weeks (Stone, Parloff & Frank, 1954).
The first problem related to privacy and self-disclosure in group, the second to failure to define the purpose of the intake group in advance and the third to transferring clients after a therapeutic relationship had been formed.

Tantum and Klerman (1979) added some information on the relationship between transferring clients from one clinician to another. They followed 137 new patients for six months. The initial dropout rate was 32%. Of those who kept their first appointments, they found that transfer doubled the probability that patients would drop out before their eighth visit.

The studies reviewed would suggest that a feasible alternative to waiting lists would be to: (a) screen for crisis situation at the time of the call and make arrangements for the client to be seen immediately in the appropriate program, (b) schedule self-referred clients to intake groups within no more than 15 days (Hare-Mustin, 1976; Levonson & Pope, 1981; Raynes & Warren, 1971; Stein et al., 1974), (c) structure the group intake to facilitate prompt scheduling with the actual therapist who will take the case rather than to facilitate rapport with the intake worker (Stone, Parloff & Frank, 1954; Tantum & Klerman, 1979) and (d) use the intake time to foster peer support or orientation to therapy (Goldstein, Heller & Sechrest, 1966; Hare-Mustin, 1976; Heitler, 1976; Rothaus, Johnson & Lyle, 1964).

Summary of the Literature Review

The literature review began by examining outcome studies pertaining to the relative efficacy of individual versus group therapies.
The outcome research in psychotherapy did not differentiate effectiveness by type of treatment. In general, similarities in outcome were greater than differences between individual and group treatments. It was learned that client assets before treatment predicted outcome more consistently than did type of treatment. The research base did not provide adequate data for matching specific treatment to specific types of client or problems in mental health.

There was some evidence that group methods achieved comparable results with less therapist time in behavioral treatments while analytic methods may have favored individual treatment.

Therapists who used group treatments emphasized certain therapeutic components at their disposal which were absent in individual treatment. Components included those which were related to cohesion (such as consensus, peer acceptance, support, altruism, socialization and reality testing), dynamics (the revelation of problems or conflicts in the here and now) and learning (modeling, contingent and noncontingent reinforcement and motivation). Other advantages for dealing with problem patients in a group setting were suggested which helped therapists control the level of demands to which they were often subjected by the chronically disabled and dependent clients. Group treatment would logically appear to be the treatment of choice for communication-contact problems.

The spectrum of group treatments applicable to the community mental health setting was potentially broad. Traditional small psychotherapy groups continued to be the most frequently reported type of group activity in mental health centers. More varied
strategies have been appearing for helping those clients who did not fit the bright, verbal, inhibited mold which did best in these traditional groups. Multiple family groups were appearing in family therapy groups. Psychoeducational groups have been encouraged by the popularity of parent training and assertiveness training and have been expanding to include self-help group programs in the control of drinking, depression, anxiety, stress, weight and smoking. Relevant to hospitalization and aftercare programs for the severely impaired were groups for relatives of patients, medication groups and socialization groups. Diagnostic or intake groups were reported but did not appear to be gaining wide acceptance to date.

Intake groups were attempted mainly to overcome the problems inherent in long waiting lists. Even though the studies reviewed corrected the overly optimistic expectation that group intake will effect a reduction in the number of dropouts (ranging from 30% in most studies to 60% in clinics serving lower socio-economic populations) certain advantages were highlighted:

1. Intake groups permit direct observation of the coping styles of clients in social interaction and, therefore, permit better treatment planning (Abrahams & Enright, 1965; Stone et al, 1954).

2. Intake groups provide opportunities for correcting client expectancies and motivation prior to therapy (Heitler, 1976; Martin & Shewmaker, 1962; Orne & Wender, 1968; Strupp & Bloxom, 1973; and others).

3. Actually participating in groups helps some clients overcome an initial reluctance to participate (Abrahams & Enright, 1965;
4. Intake groups allow rapid accumulation of clients ready for group therapy (Stone et al., 1954).

5. Intake groups reduce the amount of therapist time required for scheduled intakes (Hare-Mustin, 1976).

6. Group intake screens out those unwilling or unready to come even though they have applied for psychotherapy (Hare-Mustin, 1976).
Chapter III

METHODS AND PROCEDURES

The study was conducted in a state-funded, decentralized mental health center serving a mixed urban-small town catchment area with a population of approximately 238,000. The center provided outpatient and continuing care services through leased space in three satellite locations. Residential, hospital and crisis services were regionalized programs to which the center allocated a portion of its funding and positions.

Setting and Subjects

For the purposes of this study, the satellites were identified as follows: Site I, the originator of the change from waiting list to group intake; Site II, the office which introduced group intake two months later; and Site III, the office which continued the waiting list.

The outpatient therapists were distributed among the three satellites with 37% of available therapists hours at Site I, 43% at Site II and 20% at Site III. A full-time clinical psychologist was available at Site II while Site I had a half-time Ph.D. clinical psychologist. All other therapists were Masters level clinicians. Medical services are provided through limited medication hours at each site.
Each site serves a distinctive population. Site I was in a commercial urban area near a university. Site II was located in a small, industrial town. Site III was characterized by lower income urban and middle class suburban neighborhoods.

The subjects of the study were 837 callers requesting clinical outpatient services such as individual or group therapy, and marriage or family counseling through any of the three sites from December 1, 1980 through August 31, 1981. Ages ranged from 13 to 74 years. The average age was 30. Females made up 62% of the clients served by the agency. Clients were 5% Black and 3% Hispanic. Ninety percent were white. Others seen were American Indian or Oriental. The median family income was between $14,500 and $15,500. By educational level, the sample consisted of 17% minors, 24% adults with less than a high school diploma, 34% high school graduates, 20% adults with some post-high school education and 5% adults with a college degree. Appendix A shows age by sex and Appendix B gives educational level by site.

**Group Intake Procedure**

The group intake procedure being assessed in this study was devised by the evaluator who also carried a full-time clinical caseload as well as office management responsibilities in Site I.

To implement the change from a waiting list for individual intake to group intake, the plan was presented at a staff meeting with the director's support. Implementation began in December, 1980, a period of decreased intake activity. The new telephone procedure was rehearsed and written out for reference at the reception
Those people already on the waiting list were called and informed when they could be seen in group intake. Letters were mailed to those not reached by telephone. As new calls were received, prospective clients were scheduled for group intake. Daily intake sessions were reduced to two to three per week as the backlog of names was eliminated. Other modifications were made as implementation continued. The final status of the procedure may be described as follows:

As calls were received, callers were informed of morning and late afternoon intake sessions. It was explained that they would not be charged for the intake session. The callers were told that the purpose of the meeting was to inform them about services and to provide brief individual interviews with a counselor in order to identify the most suitable program for their needs. The caller's name, telephone number, type of problem and times they could be reached were noted on a telephone contact sheet (Appendix D). If the caller indicated that the situation was urgent, special arrangements were made.

Six to twelve callers were scheduled for each intake session. Those who arrived early for the intake were greeted by the receptionist and given the precounseling questionnaire before the therapist appeared (Appendix E). At the scheduled time the therapist introduced herself to those waiting. The therapist offered a brief statement identifying the agency, its purpose, programs (including outpatient groups, individual and family or marital counseling) and staff. A general description of the therapeutic process, client involvement
and client's rights was offered. The sliding fee scale was described with reassurance that any difficulties with the fee could be discussed and negotiated. Precounseling questionnaires were distributed to those who had not received them. In the meantime, latecomers were given the questionnaires by the receptionist and told that they would be seen in turn.

Clients were interviewed in the order of their arrival, with the aid of another therapist when possible. The therapist filled out the intake sheet during the interview. Appointments were scheduled by the receptionist as indicated on the bottom of the intake sheet (Appendix D). Completed sheets were then used to track contact and disposition of the intake. The completed sheets and questionnaires were given to the receiving therapist to be included in the case record. Sheets for missed appointments for intake were kept for six months and subsequent requests and missed appointments were recorded until the client attended or the six month follow-up time expired and the sheets were destroyed.

Design and Data Collection Procedures

The recurrent institutional cycle design (Campbell & Stanley, 1966) was modified by the incorporation of a multiple time series component to provide a further check on history and selection-treatment interactions. Thus, three kinds of comparisons were provided for the study of the three major indices of the impact on agency productivity and on the two most important measures of impact on client accessibility.

Additional observations were not included in the full design format due to limitations in the availability of data caused by the
fire, which will be described later in this section. Also, there were changes in agency reporting requirements which curtailed the use of data from terminated cases regarding return rate and the outcome of treatment goals in 1981. Therefore, supplemental information on agency costs and clients' post-intake treatment participation deviated from the overall design of the study. These supplemental efforts were included because they were judged to be of interest in filling out the agency's perspective on the impact of the change on the clients' post-intake involvement and on costs. Thus, the study as a whole, attempted to fit the agency's needs for information within the basic design to the extent permitted by agency constraints and consideration of non-interference with delivery of direct services.

The group intake procedure was initiated two months earlier at Site I than at Site II. This situation provided both a longitudinal and cross-sectional approach to the questions having to do with productivity and with length of clients' wait for service and proportions of clients served. Additionally, comparison data were retrieved from the previous year for each site. Thirdly, Site III provided a nonequivalent control group.

Site III, the control group, was equivalent with respect to agency functions but dissimilar with respect to staffing and size of caseload. The control group was more similar to Site II than to Site I with respect to population income and educational level. Sites I and II were more similar with respect to staffing and caseload.

Data were collected on all callers at all three locations from December, 1980, through August, 1981. However, where clinical records
beyond intake were required, only those records located at Site I were inspected due to the time and disruption to office routine required by current record reviews.

The precounseling questionnaire at the time of group intake was the only data provided directly by clients. These data were not used other than for the purpose of checking consistency between therapists' and clients' perception of the problem and goals. The telephone contact sheet was completed by the receptionist at the time the call was received at each site. Therapists completed the intake sheet during the interviews. Case records were uniformly problem focused in format for all three sites.

Each office maintained standard weekly tabulations and monthly reports of client activity which were completed by the clerical staff. All offices used the same method of recording calls, appointments and attendance status as well as staff hours. Data were summarized weekly and monthly.

Two mishaps in the preceding year affected the baseline data at one site. At Site I a fire destroyed the office and records stored there, including a waiting list and reports for the months of January, February, March and April. Later that year, at the same site, one of the two full-time therapists was on medical leave for the months of September, October and November, which reduced the available therapists' hours significantly. These events did not result in changes in staffing. Routines at the two other sites were relatively normal. Outpatient staff turnover was not a problem during the two year period of the study. However, adult outpatient positions were affected by
the diversion of some staff time to crisis and continuing care services. This resulted in Site III's outpatient staff being reduced to one full-time clinician.

The procedures for collection of the data are described, more specifically, by order of the indices for evaluation given in Chapter I:

1. Impact on Agency Productivity

   a. **Ratio of contact hours relative to scheduled therapists' hours.**

      For each site, scheduled hours were tabulated by month from appointment books for 1980 and 1981. Sessions attended were counted. Attended sessions were then divided by scheduled sessions by month for each site.

   b. **Ratio of reimbursable hours relative to scheduled hours.**

      The attendance posted for billing to client accounts was obtained from the 1980 and 1981 appointment books by month. These numbers were divided by the therapists' scheduled hours obtained above.

   c. **Ratio of number of people seen for intake relative to hours scheduled for intake.**

      The number of new clients attending scheduled intake sessions was obtained from the 1980 and 1981 appointment books. All scheduled sessions marked as "new" or "intake" were counted as the denominator.

   d. **Costs of group intake compared to waiting list.**

      The number of calls received by each site for comparable four month periods for 1980 and 1981 were totaled. The cost
study was based on the months for which complete data were available after the fire in 1980 at Site I. These data provide comparison of costs for waiting list only to costs for group intake only.

The average amount of therapists' time required to call back was estimated at ten minutes per caller based on the consensus of the participating therapists. Call back was multiplied by the agency's hourly cost ($60.00 per hour for both years). First appointment "no shows" were totaled for each site and multiplied by cost for each year.

The number of hours scheduled for group intake were multiplied by agency cost since clients were not charged for this time. Total costs were computed and costs per caller were compared. The average percent of callers opening cases for 1980 and 1981 was computed at 50% and used to estimate costs per 100 cases opened.

2. Impact on Client Service
   a. Percent of telephone contacts resulting in attendance at intake.

The number of callers at each site was totaled monthly from 1980 and 1981 waiting lists. The number of callers attending the intake session was found by checking the appointment book for the intake date indicated. Group intake involved comparing the number of telephone contacts with the number of intake summaries completed.
b. **Average number of days between telephone contact and first appointment.**

The number of days between the date of call and the date of intake were averaged by month from waiting lists. For group intake, the number of days between the call and the first appointment scheduled after the group intake were averaged by month.

c. **Percent of scheduled intake resulting in treatment agreement.**

The number of callers who were given an intake appointment was totaled by month for Site I during the months of May through August of 1980 and 1981. Those whose billing statement showed at least three sessions were counted since treatment agreements were required by the third session. This step was not taken for the other two sites due to the time required and the disruption to office routine of reviewing a quantity of current files. The sampling of one site was used to supplement other information.

d. **Percentage of clients returning for varying lengths of treatment.**

Billing statements at Site I were used for the return rate of clients who began treatment after December 1, 1980. The return rate for terminated clients, used as a basis for comparison, was taken from administrative monthly reports of 1980. The results were totaled across sites for the agency observations. Site I observations were also summarized separately for 1980 terminated cases. The monthly reports did
not include this kind of data after January, 1981. Clients were sorted into discrete categories by the highest number of sessions which they attended.

e. Client progress rating at three months or termination.

A list of names was drawn up for Site I from (c) above. The list included those who had attended at least three sessions and who had opened between December 1, 1980, and July 31, 1981, allowing a period of three months of treatment prior to the review of progress. Thirty names were randomly selected. These case records were reviewed by the evaluator for treatment goals and three month progress reviews or termination summaries. The case was rated "improved" if progress was noted on the major treatment goal, "no change" if neither progress nor regression were noted, and "worse" if case notes showed that the major focus of treatment was changing in a negative direction. Cases reviewed for 1981 included both active and inactive clients.

For purposes of comparison, monthly reports for December to August of the previous year's terminated cases for the agency and for Site I only were used. The data already available showed the total number of treatment goals identified and the therapists' rating of progress at termination on these multiple goals. Since the study of treatment outcome is beyond the scope of the present study, a more conservative rating, based only on the major problem, was used in 1981 in
order to attempt to bring to light any negative differences in subsequent treatment that might otherwise be overlooked.
Chapter IV
RESULTS AND DISCUSSION

A modified institutional cycle design was used for the collection of evaluation data. The results to follow describe what differences on selected indices were observed when the mental health center in which the study was conducted changed from waiting lists to group intake in two of its three sites. The results were divided into two parts according to (1) the impact on agency productivity and (2) the impact on client service. For clarity, the presentation of the results will follow the order of the indices of change as listed in chapters one and three. The tables, therefore, have been enumerated 1 "a" through "d" and 2 "a" through "e", rather than 1 through 9.

It will be noted that gaps occur in the 1980 data for Site I as a result of the fire in that office. All available data are shown. Cost comparisons were based only on the months for which complete data were available. The data dependent on access to current clinical records were restricted to Site I in which the researcher was based. This was necessitated by the disruptive nature of that aspect of the study to office routine. The primary agency-wide objectives were to assess the impact of group intake on productivity and client wait for treatment. Beyond intake, the study of clients’ continuation in treatment and outcome was attempted at Site I only to provide some additional quality assurance information beyond the central focus of the study.
1. Impact on Agency Productivity

a. **Ratio of contact hours relative to scheduled therapists' hours.**

Three comparisons should be examined in the ratios presented in Table 1a. The overall contact hour proportions for Sites I and II increased from .71 at each site in 1980 to .77 and .79 in 1981 when group intake was used. In Site III the total proportions were about the same for both years. Computing the overall ratio for Site II from the initiation of group intake onward, the observed overall ratio was .81. Comparing Sites I and II in January of 1981 affords a cross-sectional observation of a site which had already initiated the change with a site that was about to initiate the change; .74 prior to the change at Site II and .81 for Site I which had already changed to group intake. The February, 1981, ratio when the change was made at Site II resulted in a ratio of .81 and the month following the change the observed ratio was .92.

b. **Ratio of reimbursable hours relative to scheduled therapists' hours.**

Table 1b demonstrates that all three sites showed an overall gain from 1980 to 1981 in the ratios of reimbursable hours to scheduled hours. The overall ratios reflected an apparently sizable difference between 1980 and 1981 for Site I and II; from an overall .67 and .91 to 3.94 and 3.72 respectively. The change for Site III was less, from .63 to .73.
Table 1a

Ratio of Contact Hours Relative to Scheduled Therapists' Hours

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec.</td>
<td>* .72</td>
<td>.67</td>
<td></td>
<td>.74</td>
<td>.74</td>
<td>.61</td>
</tr>
<tr>
<td>Jan.</td>
<td>* .76</td>
<td>.68</td>
<td></td>
<td>.81</td>
<td>.74</td>
<td>.71</td>
</tr>
<tr>
<td>Feb.</td>
<td>* .74</td>
<td>.67</td>
<td></td>
<td>.77</td>
<td>.81</td>
<td>.59</td>
</tr>
<tr>
<td>Mar.</td>
<td>* .75</td>
<td>.81</td>
<td></td>
<td>.72</td>
<td>.92</td>
<td>.60</td>
</tr>
<tr>
<td>Apr.</td>
<td>* .61</td>
<td>.51</td>
<td></td>
<td>.74</td>
<td>.80</td>
<td>.65</td>
</tr>
<tr>
<td>May</td>
<td>.71</td>
<td>.73</td>
<td>.61</td>
<td>.80</td>
<td>.80</td>
<td>.72</td>
</tr>
<tr>
<td>June</td>
<td>.76</td>
<td>.62</td>
<td>.61</td>
<td>.78</td>
<td>.80</td>
<td>.50</td>
</tr>
<tr>
<td>July</td>
<td>.69</td>
<td>.78</td>
<td>.55</td>
<td>.79</td>
<td>.81</td>
<td>.62</td>
</tr>
<tr>
<td>Aug.</td>
<td>.71</td>
<td>.70</td>
<td>.73</td>
<td>.78</td>
<td>.80</td>
<td>.71</td>
</tr>
<tr>
<td>Overall</td>
<td>.71</td>
<td>.71</td>
<td>.64</td>
<td>.77</td>
<td>.79²</td>
<td>.63</td>
</tr>
</tbody>
</table>

* Missing data due to fire
1 Group intake initiated
2 Feb. to Aug. after group intake = .81
### Table 1b

Ratio of Reimbursable Hours to Scheduled Hours

<table>
<thead>
<tr>
<th>Month</th>
<th>1980</th>
<th>1981</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I</td>
<td>II</td>
</tr>
<tr>
<td>Dec.</td>
<td>* .62</td>
<td>.67</td>
</tr>
<tr>
<td>Jan.</td>
<td>* .71</td>
<td>.68</td>
</tr>
<tr>
<td>Feb.</td>
<td>* .72</td>
<td>.67</td>
</tr>
<tr>
<td>Mar.</td>
<td>* .86</td>
<td>.81</td>
</tr>
<tr>
<td>Apr.</td>
<td>* 1.30</td>
<td>.51</td>
</tr>
<tr>
<td>May</td>
<td>.67</td>
<td>.78</td>
</tr>
<tr>
<td>June</td>
<td>.76</td>
<td>1.39</td>
</tr>
<tr>
<td>July</td>
<td>.61</td>
<td>1.13</td>
</tr>
<tr>
<td>Aug.</td>
<td>.70</td>
<td>.73</td>
</tr>
<tr>
<td>Overall</td>
<td>.67</td>
<td>.91</td>
</tr>
</tbody>
</table>

* Missing data due to fire

1 Group intake initiated

2 Feb. to Aug. with group intake = 3.95
In Site II, 1981, the gain occurred in March, the month following the initiation of group intake. The overall post-group intake ratio was 3.95 in Site II. Please note that the January ratio for Site II, just prior to initiating the change, was 1.24. For Site I, which had already changed, the ratio was 6.06.

c. Ratio of number of people seen for intake relative to hours scheduled for intake.

Table 1c reflects an increase in the ratio of utilization of total intake time overall from 1980 to 1981 at two sites. At Site I the ratio increased from .63 to 1.59. For Site II, from February to August, the ratio increased from .68 to 1.37 overall with group intake. By contrast, Site III showed a modest decrease from .60, overall, to .44. In Site I, group intake registered a modest gain, .84, in December, with increasing gains subsequently. In Site II, group intake in February resulted in a more immediate gain in productivity of intake time. The gain tapered off somewhat in subsequent months in Site II, while it tended to build in later months in Site I.

d. Costs of intake groups compared to waiting lists.

The months May through August are compared in Table 1d using the complete data available. The total number of calls received in the three sites for those months in 1980 was 372. In 1981, Sites I and II received 377 calls during May through
Table 1c

Ratio of Number of People Seen for Intake Relative to Hours Scheduled for Intake

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dec.</td>
<td>*</td>
<td>.79</td>
<td>.62</td>
<td>.84</td>
<td>.47</td>
<td>.55</td>
</tr>
<tr>
<td>Jan.</td>
<td>*</td>
<td>.57</td>
<td>.76</td>
<td>1.55</td>
<td>.60</td>
<td>-0-</td>
</tr>
<tr>
<td>Feb.</td>
<td>*</td>
<td>.88</td>
<td>.70</td>
<td>1.36</td>
<td>2.00</td>
<td>.50</td>
</tr>
<tr>
<td>Mar.</td>
<td>*</td>
<td>.81</td>
<td>.70</td>
<td>1.76</td>
<td>1.27</td>
<td>.50</td>
</tr>
<tr>
<td>Apr.</td>
<td>*</td>
<td>.48</td>
<td>.50</td>
<td>1.31</td>
<td>1.08</td>
<td>.38</td>
</tr>
<tr>
<td>May</td>
<td>.48</td>
<td>.44</td>
<td>.57</td>
<td>1.50</td>
<td>1.39</td>
<td>.60</td>
</tr>
<tr>
<td>June</td>
<td>.78</td>
<td>.80</td>
<td>.50</td>
<td>1.50</td>
<td>1.31</td>
<td>.60</td>
</tr>
<tr>
<td>July</td>
<td>.75</td>
<td>.74</td>
<td>.58</td>
<td>2.33</td>
<td>.95</td>
<td>.50</td>
</tr>
<tr>
<td>Aug.</td>
<td>.67</td>
<td>.73</td>
<td>.43</td>
<td>2.00</td>
<td>1.38</td>
<td>.21</td>
</tr>
<tr>
<td>Overall</td>
<td>.63</td>
<td>.68</td>
<td>.60</td>
<td>1.59</td>
<td>1.27</td>
<td>.44</td>
</tr>
</tbody>
</table>

* Missing data due to fire
1 Group intake initiated
2 Feb. to Aug. with group intake = 1.37
Table 1d
Agency Costs of Group Intake
Compared to Waiting List Costs

<table>
<thead>
<tr>
<th>Year</th>
<th>Component Costs</th>
<th>Total Agency Costs</th>
<th>Costs per 100 Cases Opened</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting List</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>May-Aug. 1980</td>
<td>Call back time $3,720$</td>
<td>$9,390$</td>
<td>$5,048.38$</td>
</tr>
<tr>
<td>372 calls</td>
<td>No shows $5,670</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group Intake</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>May-Aug. 1981</td>
<td>Group Intake time $4,080$</td>
<td>$7,380$</td>
<td>$3,915.20$</td>
</tr>
<tr>
<td>377 calls</td>
<td>No shows $3,300$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Call back time = $10/call

2 Agency costs = $60 per hour
August. Site III was dropped from the 1981 cost analysis in order to compare waiting lists only with group intake.

The costs of call-back time for the 372 waiting list calls totaled $3,720 while the time scheduled for group intakes for 377 calls cost the agency $4,080. However, the cost of missed first appointments was $5,670 with waiting lists for individual intake compared to $3,300 for those first screened in group intake. The total costs for 372 callers on the waiting list was $9,390. For 377 callers given group intake, the total cost was $7,380. Per caller, waiting list cost was $25.24 and group intake cost was $19.58. With an average of 50% of callers opening cases both years, it cost the agency $5,048 to open 100 cases using the waiting list compared to $3,915 to open 100 cases using group intake.

2. Impact on Client Services
   a. Percent of telephone calls resulting in attendance of intake.

   Table 2a shows that, on the average, the proportion of callers who attended intake increased after group intake was initiated in Sites I and II from about half (47% and 53%) in 1980 to over 70% in 1981. At Site II, the overall proportion with group intake from February to August, 1981, was 75%. The proportion of intakes completed in Site II data show a loss from 28%, overall, in 1980, to 19% in 1981.

   The ratio for Site II in January, 1981, was 63%, just before group intake was introduced, compared to 68% for the same time at Site I, which was using group intake for the
Table 2a
Percent of Telephone Calls
Resulting in Attendance at Intake

<table>
<thead>
<tr>
<th>Month</th>
<th>1980</th>
<th>1981</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I</td>
<td>II</td>
</tr>
<tr>
<td>Dec.</td>
<td>*</td>
<td>60</td>
</tr>
<tr>
<td>Jan.</td>
<td>*</td>
<td>61</td>
</tr>
<tr>
<td>Feb.</td>
<td>*</td>
<td>62</td>
</tr>
<tr>
<td>Mar.</td>
<td>*</td>
<td>71</td>
</tr>
<tr>
<td>Apr.</td>
<td>*</td>
<td>35</td>
</tr>
<tr>
<td>May</td>
<td>49</td>
<td>47</td>
</tr>
<tr>
<td>June</td>
<td>52</td>
<td>63</td>
</tr>
<tr>
<td>July</td>
<td>47</td>
<td>50</td>
</tr>
<tr>
<td>Aug.</td>
<td>43</td>
<td>43</td>
</tr>
<tr>
<td>Overall</td>
<td>53%</td>
<td>47%</td>
</tr>
</tbody>
</table>

* Missing data due to fire

\(^1\) Group intake initiated

\(^2\) Feb. to Aug. with group intake = 75\%
second month. In December, when group intake was begun at Site I, 77% of callers attended intake compared to 48% in Site II in December when the waiting list was still in use. Within Site II, January to February, the proportion increased from 63% to 81% with the first month of group intake. An accelerated rate of attendance through April was observed at Site II in 1981. After group intake was introduced, percentages ranged from 63 to 77 in Site I and from 54 to 96 in Site II's data.

b. Average number of days between telephone contact and first appointment.

With reference to Table 2b, differences in clients' average waiting time for first treatment sessions at Sites I and II were observed. Site I waiting time decreased from an average of 27 days (May to August, 1980) to an average of 16 days (December to August, 1981). At Site II clients waited 30 days, on the average, in 1980 compared to 16 days in 1981. The average computed for Site II from its initiation of group intake in February, through August, was 12 days. At Site III clients waited 25 days in 1980, on the average, and 30 days in 1981.

Looking at the months in which group intake was introduced, it was seen that at Site II the average for January, 1981, just prior to introduction of group intake, was 27 days compared to 8 days at Site I which was already using group intake. The next month at Site II, when group intake was
Table 2b

Average Number of Days Between
Telephone Contact and First Appointment

<table>
<thead>
<tr>
<th>Month</th>
<th>1980</th>
<th></th>
<th>1981</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I</td>
<td>II</td>
<td></td>
<td>I</td>
</tr>
<tr>
<td>Dec.</td>
<td>* 35</td>
<td>17</td>
<td></td>
<td>71</td>
</tr>
<tr>
<td>Jan.</td>
<td>* 42</td>
<td>30</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Feb.</td>
<td>* 27</td>
<td>39</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Mar.</td>
<td>* 24</td>
<td>22</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Apr.</td>
<td>* 22</td>
<td>19</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>May</td>
<td>14</td>
<td>20</td>
<td>19</td>
<td>14</td>
</tr>
<tr>
<td>June</td>
<td>20</td>
<td>27</td>
<td>32</td>
<td>21</td>
</tr>
<tr>
<td>July</td>
<td>25</td>
<td>32</td>
<td>28</td>
<td>18</td>
</tr>
<tr>
<td>Aug.</td>
<td>47</td>
<td>28</td>
<td>29</td>
<td>25</td>
</tr>
<tr>
<td>Average</td>
<td>27</td>
<td>30</td>
<td>25</td>
<td>16</td>
</tr>
</tbody>
</table>

* Missing data due to fire
1 Group intake initiated
2 Feb. to Aug. with group intake = 12
begun, the average wait was 16 days. Waiting time seemed to increase again at Site I with the passage of time, while at Site II improvement appeared to maintain itself better over time.

c. Percent of scheduled intake resulting in treatment agreement.

Table 2c shows Site I results only. Of 79 clients offered individual intakes at Site I in the summer of 1980, one third established a written treatment agreement. When 117 new clients were offered orientation through group intake (May through August) in 1981, about half of those scheduled for intake persisted to establish a written treatment agreement.


A total of 131 clients, who had requested services at Site I between December 1, 1980, and August 31, 1981, had established billing statements. The distribution of these clients into maximum number of sessions attended (discrete categories) is shown in the last row of Table 2d. It was observed that 41 of these clients (31%) attended one or two sessions but no more. Another 39 (30%) attended the third session but terminated before the sixth. Twenty (15%) attended the sixth session but terminated before the tenth session. Finally, 31 of the clients (24%) were in treatment for 10 or more sessions.

As a basis for comparison, the return rates similarly sorted, for the agency as a whole and for Site I's own previous base rate were computed for cases terminated in 1980.
Table 2c

Percent of Scheduled Intakes Resulting in Treatment Agreement at Site I

<table>
<thead>
<tr>
<th>Month</th>
<th>1980 Number Scheduled</th>
<th>1980 Number of Treatment Agreements</th>
<th>Percent</th>
<th>1981 Number Scheduled</th>
<th>1981 Number of Treatment Agreements</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>May</td>
<td>13</td>
<td>5</td>
<td>38%</td>
<td>19</td>
<td>11</td>
<td>57%</td>
</tr>
<tr>
<td>June</td>
<td>17</td>
<td>5</td>
<td>29%</td>
<td>31</td>
<td>14</td>
<td>45%</td>
</tr>
<tr>
<td>July</td>
<td>33</td>
<td>10</td>
<td>30%</td>
<td>34</td>
<td>16</td>
<td>47%</td>
</tr>
<tr>
<td>Aug.</td>
<td>16</td>
<td>6</td>
<td>37%</td>
<td>30</td>
<td>15</td>
<td>50%</td>
</tr>
<tr>
<td>Total</td>
<td>79</td>
<td>26</td>
<td>33%</td>
<td>114</td>
<td>56</td>
<td>49%</td>
</tr>
</tbody>
</table>
Table 2d
Percent of Clients Returning for
Varying Lengths of Treatment*

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>First</td>
</tr>
<tr>
<td>1980</td>
<td>N</td>
</tr>
<tr>
<td>Site I</td>
<td>n=150</td>
</tr>
<tr>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Agency</td>
<td>181</td>
</tr>
<tr>
<td>1981</td>
<td></td>
</tr>
<tr>
<td>Site I</td>
<td>n=131</td>
</tr>
<tr>
<td></td>
<td>41</td>
</tr>
</tbody>
</table>

* Discrete categories

1 Agency reported data in 1980 but not in 1981.
These data are shown in the upper part of Table 2d. The categories of interest in the agency are found in the first and last columns of the table.

Comparing the percentages of clients in the categories for 1980, it is seen that proportionately more clients (24%) attended ten or more sessions at Site I in 1981, compared to the agency as a whole or compared only with Site I in 1980 (14%). Another difference appeared to be indicated in the proportion of clients attending only one or two sessions; in 1980 that category accounted for 40% of Site I's clients, and for 37% of clients in the agency as a whole, compared to 31% of clients entering treatment through group intake in 1981.

e. **Client progress ratings at three months or termination.**

The basis of comparison in Table 2e was taken from 1980 monthly report data on terminated cases from December through August for Site I and for the agency as a whole. As shown in the upper half of Table 2e, clinicians had rated their own clients as improved with respect to 68% of 348 treatment goals for 293 cases closed. Of the specified goals, 2% of the combined agency ratings indicated that clients were worse at termination in those areas rated. In Site I, 67% of the goals were rated as improved and 6% were rated as worse in 1980.

Thirty cases reviewed at Site I by the evaluator at the end of the study showed improvement in 60% of the major treatment goals. One case was rated as worse with respect to the
### Table 2e
Client Progress Ratings at Three Months or Termination

<table>
<thead>
<tr>
<th>Year</th>
<th>Improved</th>
<th>No Change</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Site I(^1)</td>
<td>67%</td>
<td>27%</td>
<td>6%</td>
</tr>
<tr>
<td>Agency(^2)</td>
<td>68%</td>
<td>30%</td>
<td>2%</td>
</tr>
<tr>
<td>1981</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Site I(^3)</td>
<td>60%</td>
<td>37%</td>
<td>3%</td>
</tr>
</tbody>
</table>

\(^1\) n=87 treatment goals for 105 cases

\(^2\) n=348 treatment goals for 293 cases; agency reported data in 1980 but not in 1981.

\(^3\) n=30 cases = 30 major goals of treatment
major goal of treatment. Other cases included active cases who were not showing progress or for whom progress remained indeterminate as well as some cases which were inactive and no progress in treatment was shown by the record.

Discussion

The results of the study of a change from a waiting list to a group intake procedure were divided into two parts: impact on agency productivity and impact on client services. Key contrasts provided by the recurrent institutional cycle design included the comparisons of 1980 baseline data with 1981 data in two sites where the change was implemented and also against 1980 and 1981 data in a third site which continued the waiting list. The two month delay in changing to group intake for one of the sites afforded immediate pre-post contrasts. Results are discussed by order of their presentation:

1. Impact on Agency Productivity

   a. Ratio of contact hours relative to scheduled therapists' hours.

      This index of agency productivity resulted in an increase following the introduction of group intake in two sites. The third site, which continued the waiting list both years, did not show an increase in this ratio. Thus, it would seem unlikely that events other than changing to group intake would account for the increase observed in both sites which implemented the new procedure. Furthermore, the increase occurring in Site I between January and February of 1981 continued through the subsequent months at a rate higher than was obtained for any month prior to the introduction of the group
intake procedure.

Group intake, begun in December in Site I, resulted in an apparent increase from its incomplete baseline in the previous year. The increase overall was less impressive and less consistent than was observed in Site II. The contact hour index was a general indication of productivity which included all types of sessions scheduled for client contact. While it was not affected by the number of clients seen, it was influenced by missed appointments for treatment or for intake. For whatever reasons, comparison of Site I with Site II indicated a more persistent now show problem in Site I. The problem appeared to have improved as the study continued. Productive use of therapists' time appeared to have been favorably influenced by the change to group intake in two sites.

b. Ratio of reimbursable hours relative to scheduled therapists' hours.

Reimbursable hours, in contrast to contact hours, reflected the number of clients seen in groups. This index was not affected by the number of family members because only one fee was charged. Neither was it influenced by group intake itself since no fee was charged.

More groups were conducted in all three sites in 1981 compared to 1980. It is interesting to note, in examining Table 1b, that this index peaked first in Site III, two months later in Site I and two months after that in Site II. The magnitude of the increase appeared much greater in Sites
I and II where group intake presumably provided a more rapid influx of new clients who could be placed in groups.

The explanation for the two month cycle was not clear in these data. It should be noted, however, that discussion of groups and of waiting lists was predominant in staff meetings in December and January. Thus, a possible Hawthorne-type effect may have roused group efforts in Site III. Considering that group intake was first initiated in December in Site I and in February in Site II, it is plausible that group intake generated a buildup of group membership through taking people off the pre-existing waiting lists along with new callers. As dropouts occurred and those who had been waiting were absorbed, the current callers provided a more modest pool of group members.

Disregarding the cyclical bulges in the data, the results, nevertheless, suggest that group intake might offer advantages for use of group treatment. The effects appeared to have held up beyond possible agency "Hawthorne" effects during the novelty period of group intake. Whereas, in the waiting list site, the index declined to levels of the previous year. In the group intake sites the monthly index following the bulge remained well above the level of the previous year.

c. Ratio of number of people seen for intake relative to number of hours scheduled for intake.

Not unexpectedly, this index showed the difference between waiting lists and group intake most clearly. The index was
derived only from intake activities. In Site II, the February, 1981, index stands out in Table 1c. The response of callers who had previously been on the waiting list contributed to elevation of the index for the first month. In Site I, group intake registered a modest gain in December with increasing gains subsequently. The waiting list response at Site I was minimal.

There appeared to be opposite tendencies in the data of Sites I and II with one beginning lower and ending higher while the reverse looked to be the case for the other. It is not possible to extrapolate from these data and no factors have been identified which would deter Site II from continuing to benefit from group intake with respect to productive use of intake time. The variability appears to reflect the difficulty of predicting how many of those who schedule for intakes will appear on any given day. Attendance at group intake can range from 0% to 100% of six to 12 people scheduled. Additionally, a varied number of individual intakes continued to be used in both sites to accommodate those who refused group intake.

For both Sites I and II, overall, the gain in productive use of intake time was observed. Site III continued to experience the waste of a high proportion of hours scheduled for individual intake during the same period of time.
d. Costs of group intake compared to costs of waiting lists.

The nonreimbursable time involved in waiting lists and group intake was converted to the costs of that time to the agency. The time required for callbacks was less than the time required to provide group intake sessions for a comparable number of callers. However, the greatest cost of the agency was for no shows for first appointments. Group screening provided a savings to the agency with respect to the number of missed first appointments following group intake as compared to the number of missed first appointments following therapists calling to schedule first appointments. This savings, prorated per 100 cases opened, amounted to $1,143.

2. Impact on Client Services

a. Percent of telephone calls resulting in attendance at intake.

The results of Table 2a were consistent with the findings reported earlier in Table 1c which compared attendance to hours scheduled for intake. Both sets of data showed improved intake attendance for the two group intake sites in contrast to poorer attendance in the waiting list site from 1980 to 1981. The present set of data differs from the previous data in that all callers, rather than just those scheduled, were included. The waiting list inevitably results in callers being lost before they are scheduled, thus the Site III data showed that attendance was low for callers scheduled through the telephone call-back system.
The impact of group intake on intake attendance of all callers appeared clearly in the discontinuities of the time series percentages for Sites I and II when group intake was initiated and in the overall differences from 1980 to 1981.

The effect of the pre-existing waiting list was observed in Site II's 1981 data. Group intake was introduced in February with existing waits of up to three months for service. It appears that January callers were more responsive than December callers to the opportunity to initiate contact through intake groups. Thus, the January increase may be explained partially by the availability of group intake in the following month. The rate increased noticeably again for February when the intake groups began. For the next two months nearly all who called came in for the intake group. The rate of attendance dropped after three months, rising again in the last month for which the data were collected. These observations remain unexplained.

Site I's data showed a modest yet steady rate of improved intake attendance for callers in 1981 when compared to callers at any of the sites in 1980. There was no indication, from these data, that clients would prefer to wait for individual intake rather than to accept a timely group intake. That the length of wait is more relevant to intake attendance than is group or individual method is further suggested by re-examination of Table 2b.
b. **Average number of days between telephone contact and first appointment.**

Even though the group intake appointment was not counted as a first appointment, the two sites using group intake succeeded in reducing the average number of days between clients initial telephone contact and their first appointment with the assigned therapist. Site II achieved the shortest span between call and appointment—from 30 to 12 days for virtually all callers. The decrease at Site I was from an average of 27 days to 16 days. At Site III the average wait appeared to increase somewhat from 25 to 30 days.

When the decrease in wait time is considered along with the greater gains in intake attendance and contact hours in Site II as compared to Site I, the importance of waiting time is strongly suggested.

c. **Percent of scheduled intakes resulting in treatment agreement.**

Since this data required access to individual case records and was disruptive of office routines, the investigator was limited to the review of records at Site I. May, June, July and August data were compared for 1980 and 1981. The results showed an improvement in the rate of treatment agreements obtained for clients who had been scheduled for group intake compared to individual intake. Since treatment agreements were required by the third visit, this finding also reflected a decrease in the dropout rate for the first two sessions from 1980 to 1981 which also was suggested again in Table 2d.

Once clients have entered treatment, the length of time they remain in treatment has some relation to outcome. Therefore, the length of treatment was observed as a quality control component. Since data obtained directly from clients' personal records were most difficult and time consuming to collect, this aspect was examined only at Site I. Compared to a base rate obtained from monthly reports of cases terminated agency-wide in the previous year, it was seen that clients entering through group intake were no more likely to dropout of treatment prematurely than clients previously entering through individual intake. While the data were only suggestive, due to limitations of the research methods, they pointed to a tendency for more of the sample at Site I entering through group intake to remain in treatment for more than ten sessions.

e. Client progress ratings at three months or termination.

These ratings were the least quantifiable aspect of the study. The outcome of treatment was beyond the scope of the present study which focused on the entry system rather than on treatment. Nevertheless, any change in the programs of a mental health center must be assessed for possible detrimental effects on client outcome. In order to make this task more manageable, 30 cases were selected at random from the list of eligible cases for Site I where group intake first went into effect. The base rate was drawn from monthly reports of agency-wide terminations for December through August of the
preceding year. On the basis of a random sample of cases opened during group intake compared to previously terminated cases, client progress does not appear to be related to method of intake for Site I.

Summary of the Results

The impact of changing from a waiting list to a group intake procedure was found to favorably affect the productive use of costly professional time. Following the introduction of group intake in two sites, the monthly ratio of contact to scheduled hours improved. An improvement was also found in the ratio of reimbursable hours. No improvement was observed in the third site which maintained the waiting list during the period of study. As expected, the productive use of intake time was increased by the introduction of group intakes while the site using the waiting list continued to experience a waste of a large proportion of intake time. More people were seen for intake following the introduction of group intake. It was found that the total costs of group intake were less than the costs of individual intake per 100 cases opened.

The impact of group intake on client services was also evaluated. It was found that a larger proportion of clients attended group intake than attended individual intake. Group intake resulted in a shorter span of time, on the average, between clients' initial telephone contact and first appointment with the assigned therapist. The shortest time span occurred in the site which also yielded the most improvement in productivity and client attendance. Clients' return rate and outcome was not shown to be negatively affected by group
intake. Results tentatively suggested that group intake may have facilitated a more timely response to clients' requests for services, assisted clients to identify the most appropriate program to meet their needs and thus increased the probability that those who made appointments for counseling or psychotherapy would attend scheduled sessions.

Although there was no systematic attempt to evaluate the impact of group intake on staff morale in the final analysis of the data, it was interesting to note the reactions among this small staff with whom the evaluator interacted frequently. Those involved with group intake said they could not imagine returning to the waiting list and the necessity to call clients back to schedule appointments. One staff member commented that the change to group intake "saved our ***" because of the marked increase in demand for services in the months following the study when more referrals were being received as a result of increase of staff in other programs. The staff have shown interest in seeing the results of the study and have stated that they think Site III should begin group intake immediately.

While not all staff conducted group intake sessions for any length of time, all outpatient staff did provide some coverage of group intakes when vacations interrupted the usual arrangement. No staff member complained to the evaluator about the nature of the task. It was noted that group intake intensified counselor's face to face contact. No complaints were heard regarding the contact aspect of the workload. However, more client contact meant more paperwork.
Combined with previous dissatisfaction with new paperwork require-
ments, complaints about paperwork were heard more frequently following
the introduction of group intake.
Chapter V

SUMMARY, CONCLUSIONS, RECOMMENDATIONS AND IMPLICATIONS FOR FURTHER RESEARCH

Summary

This study was undertaken to assess the feasibility and desirability of replacing waiting lists with a group intake procedure in a community mental health center. Previous reports of attempts to do away with waiting lists indicated that savings of staff time and reduction of waiting time for clients were the primary advantages of group intake. Reduction of no-shows or dropouts was not found in most studies of group intake. However, other studies suggested a relationship between length of wait time and no-show rates or between transfer of clients from one therapist to another and dropout rates. Combined, previous studies were helpful in the design of a potentially feasible group intake procedure.

A modified institutional cycle design was used to evaluate the feasibility and desirability of the change to group intake. Primarily, the goals of the change from waiting list to group intake were to (1) increase the productive use of therapists' time in the outpatient program and (2) to decrease the time gap between clients' requests for service and initiation of treatment. Four indices of the impact of group intake on agency productivity were selected to assess feasibility: (a) total contact hours, (b) total reimbursable hours, (c) intake attendance and (d) intake costs. The desirability of the
change to group intake was assessed by examining the impact of client service: (a) percent of calls resulting in attendance at intake, (b) number of days between call and first treatment appointment, (c) percent of scheduled intake resulting in treatment agreements, (d) return rate and (e) progress ratings.

Conclusions

The findings of this evaluation study strongly supported the feasibility of group intake from the standpoint of its impact on improving the productivity of scheduled therapists' time. Results favored group intake over waiting lists for individual intake on the four indices of productivity and cost.

With regard to impact on client services, it was found that a larger proportion of callers were seen for intake, that the average wait for services was reduced and that a larger proportion of applicants entered into treatment. With respect to impact on the quality of service, beyond the initiation of treatment, the findings, based on a subsample of clients, did not reveal any deleterious effects of group intake on the return rate nor on therapists' ratings of clients' progress.

Additionally, group intake appeared to have an impact on the modality of service delivery. Following the introduction of group intake, there was an increase in group therapy service hours.

The findings of this study were consistent with earlier findings that similar outcomes are obtained by group or individual therapy (Bednar & Kaul, 1978; Luborsky et al., 1971; Meltzoff & Kornreich, 1970; Smith, Glass & Miller, 1980). Findings with respect to first
appointment no-show rates were consistent with the relationship between no-show rate and length of time between request and appointment reported by Folkins, Hersch & Dahlens (1980). Dropout rates appear to have been somewhat decreased in the present study. Some of the previous studies (Abrahams & Enright, 1965; Levenson & Pope, 1981; Martin & Shewmaker, 1962; Stone, Parloff & Frank, 1954) did not find a change in dropout rate with the use of group intake and client preparation. Other studies aimed at lower and working class patients (Day & Reznikoff, 1980; Heitler, 1976) did result in fewer dropouts. The present study of a sample of public mental health clients appears to fit with the latter.

Overall, findings were similar to the results of studies reviewed by Hare-Mustin (1976) in that group intake resulted in a clear savings of staff time and a shorter waiting period for clients. Thus, the primary management goals of the agency were achieved in this study.

Recommendations

The study was undertaken for practical rather than for theoretical purposes. As such, recommendations are directed only to the agency in which the study was conducted. The following recommendations were supported by present findings for this agency.

1. Group intake should be continued for adult outpatient counseling services in Sites I and II. This recommendation is supported by improved productivity and responsiveness to requests for services.

2. Site I should exert more effort in the utilization of appropriate group treatment modalities. This recommendation is supported by the comparatively greater success shown at Site II in reducing
waiting time for initiation of treatment, increasing number of clients served and maintaining client progress.

3. Site III should begin developing a group intake procedure for adult outpatient services. Since this site presently has only one outpatient therapist and a long wait for treatment, the no-show rate for first appointments has been excessive. Group intake would afford the therapist an opportunity for timely screening, referral and orientation of clients to better utilize mental health services.

4. For all sites, in addition to group intake for non-emergency callers, it is recommended that 30 minute individual intake screenings be made available for callers who appear very distressed, suicidal or extremely fearful. Presently, hourly sessions are offered on an emergency basis and these sessions continue to show a high no-show rate. Since crisis services are available in the community, these needs can be met on a walk-in basis if clients accept referral to the Crisis Unit. The agency could remain flexibly responsive to client needs while minimizing no show costs by offering briefer individual screening for special needs of clients.

5. The objectives of group intake presently should remain the provision of timely screening for appropriate referral or assignment to treatment, orientation to agency services and procedures and client preparation for active participation in treatment.

The brief individual interviews appear to be clinically advantageous and should be continued pending future evidence that
clients are equally willing to discuss the nature of their problems in a group of strangers as contrasted to speaking to a professional in private.

6. It is recommended that the distribution of outpatient staff be reconsidered in light of the number of calls received at each site. The Site III data suggested that additional therapist time may be critical in order to improve responsiveness to demand for services regardless of intake procedure. Site III had the least available staff hours, the longest wait for service and the lowest rate of callers served both before and after group intake was introduced in the two other sites.

   During the period of the study, a disproportionate amount of therapists hours were available at Site II, while the number of total calls received was greatest in Site I. Site II was also most successful in reducing the wait time between call and first appointment. It appeared that Site II used group treatment more effectively than did Site I. However, it was also found, in an aborted attempt to procure data from client files at Site II, that casenotes were not kept up to date. Combined, these data suggest that all adult outpatient staff are finding it necessary to make trade-offs between important aspects of their workload. Time expended in one area is not available in another.

**Implications for Further Research**

1. Further research is needed to investigate the impact of group intake on client satisfaction and staff morale. The nature of the intake format would not be expected to exert a direct influence
on the outcome of treatment. The perceptions of clients and staff regarding group intake should be investigated, however, as an important source of ideas to improve the utility of group intake.

2. Further work is needed in the development and evaluation of methods for client preparation. Presently this function is given minimal attention at group intake. Audio-visual materials conceivably could be developed for clients' use during the wait for individual interviews.

3. Bibliotherapy in "self-help" waiting groups may offer a partial solution to the problem of post-intake waits for openings in therapy. An apparent return to longer waits for service was observed in the monthly data following group intake at one site. An educational model could be tried to mitigate the problems noted in other studies caused by the transfer of clients from extended intake groups to therapy groups. A crisis group model is another promising alternative worthy of consideration. Evaluation of available options should be undertaken. By means of user-focused field research, the utility of these and other promising innovations can be investigated by the community mental health centers in need of means to expand services without increasing staff.

4. Continued monitoring of demand for services and agency responsiveness is recommended. As intake needs change, evaluation data would be helpful in adjusting methods to accommodate needs more efficiently. It is not assumed that everyone calling the center
is in "need" of mental health services. Group intake, as an exchange of information, helps client and therapist jointly determine "need".

Based on current fiscal restraints and changed community mental health priorities, it is projected that the demand for outpatient services will continue to exceed the staffing capacity for traditional, individual psychotherapy models. Continued evaluation studies are recommended to maximize the use of present resources as well as to provide feedback for the future alignment of policy, budget and community needs. The accumulation of practical, agency-based field studies, along with a broader spectrum traditional research, at the state and federal level should be facilitated by the community mental health system as a whole.
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Appendix A

Distribution of Clients by Age and Sex
## Age Distribution of Male and Female Clients

<table>
<thead>
<tr>
<th>Sex</th>
<th>0-17</th>
<th>18-25</th>
<th>26-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65+</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>Male</td>
<td>54</td>
<td>43</td>
<td>47</td>
<td>42</td>
<td>18</td>
<td>9</td>
<td>4</td>
<td>217 (38%)</td>
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<tr>
<td>Female</td>
<td>69</td>
<td>62</td>
<td>83</td>
<td>89</td>
<td>36</td>
<td>14</td>
<td>5</td>
<td>358 (62%)</td>
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<tr>
<td>Totals</td>
<td>123</td>
<td>105</td>
<td>130</td>
<td>131</td>
<td>54</td>
<td>23</td>
<td>9</td>
<td>575 (100%)</td>
</tr>
</tbody>
</table>
Appendix B

Highest Level of Education of Clients by Site
Percent of Clients at Different Educational Levels by Site*

<table>
<thead>
<tr>
<th>Site</th>
<th>Minor</th>
<th>Adult, High School</th>
<th>High School Graduate</th>
<th>Post High School</th>
<th>College Graduate</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>17%</td>
<td>14%</td>
<td>34%</td>
<td>27%</td>
<td>8%</td>
</tr>
<tr>
<td>II</td>
<td>17%</td>
<td>26%</td>
<td>40%</td>
<td>14%</td>
<td>3%</td>
</tr>
<tr>
<td>III</td>
<td>17%</td>
<td>34%</td>
<td>24%</td>
<td>20%</td>
<td>5%</td>
</tr>
</tbody>
</table>

* n = 575
Appendix C

Instructions for Telephone Contact
INITIAL CONTACT RESPONSE

When you answer a call requesting services;

1. Take information and fill out contact form (as before).

2. If emergency, schedule with available therapist. If aftercare, schedule for Monday afternoon group. If another agency is more appropriate, make referral.

3. Inform client of soonest INTAKE time (see appointment book) and schedule by writing client name in group intake space which they accept. Ask client to arrive at the beginning of the intake time (for example, if client accepts 9 to 11, ask them to be here at 9:00).

4. Explain to client that they will not be charged for their first meeting. The purpose of the meeting is for their information about our services, costs and procedures. They will be asked to make a brief, general statement about the problem to help us arrive at a treatment plan.

In response to questions or objections, if needed;

We do not maintain a waiting list. Intake meetings are held each week. If they wish to receive services, they will need to attend one of these meetings. After the initial meeting we will do our best to work out a continuing plan that fits their schedule.

If we cannot immediately schedule them into the program they prefer, we will provide "self-help" classes until there is an opening in the program which will serve them best.

If other questions or objections come up, please note and put in intake therapist's mailbox.

If client rejects intake meetings and you feel our services are needed, ask them if they would like to be called back by the therapist in charge of intake. Put note in therapist's mailbox.

5. If former client is calling and requesting previous therapist who is available in this office, arrange for that therapist to call client back for scheduling. Otherwise, schedule "reopen" client for intake meeting.
Appendix D

Telephone Contact -- Intake Notes
TELEPHONE SCREENING

Date: ____________________

Applicant's Name: ____________________________________________
Address: ______________________________________________________
Home Phone: ——— Work Phone ____________________________________
Times you can be reached: _________________________________________
If a child: DOB: ——— Age: ——— Sex: _____________________________
Grade: ——— School: _____________________________________________
What is the problem? ___________________________________________

Duration of problem: ____________________________________________
Do you feel that this is an emergency? ____ Yes ____ No
What is the nature of the emergency? _______________________________

Disposition:
( ) Intake Appointment - time & date: _____________________________
( ) Emergency Appointment - time & date: ___________________________
( ) Referred to: _________________________________________________
( ) Other: _____________________________________________________

Interviewer's Signature __________________________________________

CLINICAL SCREENING NOTES

Date: ____________________

Referral Source:_________________________________________________

May Need:
Information Release: ——— Yes ——— No
Written Assessment: ——— Yes ——— No
Referral: ——— Yes ——— No
Other: _________________________________________________________

Applicant's employment or other source of income: _______________________

Living situation: _________________________________________________
Problem focus: Indiv. ____ Parent/Child ____ Couple ____
Description: ______________________________________________________

Related factors: _________________________________________________
Observations: ____________________________________________________

Disposition:
( ) Scheduled Initial Interview ( ) Referred to
for Group Individual __________ Program
Office Location __________ Clinician
Date & Time: ____________________________ ( ) No further services
( ) Placed on Waiting List for

Clinician's Signature ____________________________________________
Appendix E

Precounseling Questionnaire
PRECOUNSELING QUESTIONNAIRE

The purpose of this questionnaire is to obtain a general picture of the problem(s) which brings you to Valley Counseling Center. This information will help your intake group leader provide materials relevant to your problem. More detailed information will be brought out when you begin your therapy program. While you are waiting for an opening in therapy, your intake group will continue to meet to provide support and "self-help" suggestions.

It is understandable that you might be concerned about what happens to the information about you because much of this information is highly personal. All records are strictly confidential. No outsider is permitted to see your records without your permission.

If you do not desire to answer any of the questions, merely write, "do not care to answer".

* * * * * * * * * * * * * *

Name ________________________________ Date __________________

Address ____________________________ City ________________ Zip Code _____

Telephone Numbers Days ______________ Evenings ________________

Age ______ Marital Status (circle answer) Single; engaged; married; remarried; separated; divorced; widowed.

State in your own words the nature of your problems and how long the problems have been bothering you.

Give a brief account of how you have been dealing with these problems.

Describe any recent event which may have made you decide to seek help.
On the scale below, please estimate the severity of your problem(s).

Mildly upsetting _____
Moderately severe _____
Very severe _____
Extremely severe _____
Totally incapacitating_____

List your five main fears.

1. 
2. 
3. 
4. 
5. 

Underline any of the following that apply to you.

headaches  stomach trouble  insomnia
palpitations  fatigue  alcoholism
bowel disturbances  take sedatives  tremors
anger  feel panicky  take drugs
nightmares  conflict  allergies
feel tense  suicidal ideas  shy with people
depressed  sexual problems  can't make decisions
unable to relax  overambitious  home conditions
don't like weekend vacations  inferiority feelings  bad
vacations  memory problems  unable to have a good time
can't make friends  lonely  concentration difficulties
can't keep a job  often use aspirin  dizziness
or painkillers
financial problems  fainting spells  no appetite
excessive sweating  anxiety

Present interests, hobbies and activities_________________________
How is most of your free time occupied? ________________________________

Do you make friends easily? _______ Do you keep them? ________

What is the last grade of school that you completed? ________________

What sort of work are you doing now? ________________________________

What kinds of jobs have you held in the past? _______________________

Does your present work satisfy you? (If not, in what ways are you dissatisfied?) ________________________________

If living with a spouse or partner:
   a. In what areas do you get along well?
   b. What are the major conflicts?
   c. Is your spouse or partner supportive of your personal goals?

Do any of your children present special problems? ___________________

Are there any other members of the family about whom information is relevant? ________________________________

If living alone (or single parent)
   a. What is most satisfying to you about being single?
   b. What is most distressful?
   c. Are there other adults with whom you talk about personal matters?

Have you ever lost control (e.g., temper, crying or aggression)? If so, please describe.

What is there about your present behavior that you would like to change?
What feelings do you wish to increase or decrease?

List any situations which make you feel calm or relaxed.

What do you think therapy will do for you and how long do you think your therapy should last?

In a few words, what do you think therapy is all about?
CHECKLIST OF STRESS SIGNALS

IN THE PAST WEEK, HOW OFTEN DID YOU:

1. ______ Have a headache
2. ______ Upset or sour stomach
3. ______ Tension in neck, back or other muscles
4. ______ Feel faint or dizzy
5. ______ Sweat when not exercising or overheated
6. ______ Notice your hands trembling
7. ______ Have to avoid certain things, places or activities because they frighten you
8. ______ Have your heart pound or race when not physically active
9. ______ Feel nervous or shaky inside
10.____ Have trouble getting your breath
11.____ Feel tense or keyed up
12.____ Feel fearful or afraid
13.____ Lack enthusiasm for doing anything
14.____ Have a poor appetite
15.____ Feel lonely
16.____ Feel bored or have little interest in doing things
17.____ Lose sexual interest or pleasure
18.____ Cry easily or feel like crying
19.____ Feel downhearted or blue
20.____ Have trouble getting to sleep or staying asleep
21.____ Feel low in energy or slowed down
22.____ Feel hopeless about the future
23.____ Have any thoughts of possibly ending your life
Abstract

Effects of a Group Intake Procedure on Productivity and Delivery of Services in a Community Mental Health Setting

by

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A modified institutional cycle design was used for the evaluation of the impact on productivity and client services of a change from a waiting list to a group intake procedure. Subjects were 837 callers requesting outpatient services including individual, group and family or marital counseling in a decentralized, state-funded community mental health center.

Key contrasts comparing cross-sectional and longitudinal differences between two sites, which began group intake at different times, and a third site which continued a waiting list, were observed for three indices of agency productivity and two indices of client service. A comparison was also made between the costs to the agency of group intake versus a waiting list. Clients' return rate and progress in treatment were tentatively explored at one site as a check for harmful effects.

The results of this "user-focused" study favored group intake over waiting lists in agency productivity as measured by the ratio of contact hours relative to scheduled hours, the ratio of reimburs-
able hours relative to scheduled hours and the ratio of number of people seen for intake relative to hours scheduled for intake. The percent of telephone calls resulting in attendance at intake and the average number of days between telephone contact and first treatment appointment showed that group intake improved service to clients compared to waiting list results.

Additional findings supported the feasibility and desirability of group intake for the agency studied. Group intake resulted in savings in costs to the agency due to a reduction in missed first appointments. Tentative findings on clients' return rates suggested that a larger proportion of clients entering through group intake remained in treatment ten or more sessions, compared to the previous year. No harmful effects of group intake were indicated by an examination of progress ratings before and after group intake at one site.