How to make a success of group education

Rosie Walker and Jill Rodgers

ARTICLE POINTS

1 Group education is increasingly advocated in diabetes care.

2 Group education is no less effective than one-to-one education and has the additional benefit of giving people the opportunity of sharing their experiences.

3 Careful planning and preparation and consideration of the educational 'conceptual framework' are needed for groups to be successful.

4 Skills of facilitation rather than didactic teaching are needed when working with groups.

KEY WORDS
- **Group education**
- **Conceptual framework**
- **Planning**
- **Facilitation**
- **Support**

Introduction

Group education is increasingly being advocated as being as (or more) successful as individual education. This article discusses some of the issues involved in establishing and running groups for people with diabetes, and the skills that are needed to make them a success. Practical advice is outlined about the why, what, where, when and how to run group education sessions. Planning, preparation and consideration of the conceptual framework are essential if groups are to achieve their aims.

Consider this scenario – at one of your team meetings it is decided that due to the increasing numbers of people with type 2 diabetes, you will start group education for people who are newly diagnosed, rather than one-to-one education. You are given the lead role in setting this up. Do you:

A) Book a large room for 4 weeks time and ask the appointments secretary to send an appointment for that afternoon to the next 20 people who are referred with newly diagnosed type 2 diabetes. You plan to give them the same information as a group as you would give them individually.

B) Go through your records of newly diagnosed people that you have seen recently and decide which of them would be suitable for invitation to a group education session.

C) Find out more about running groups because you are not experienced in this area.

Option A looks like a time and labour-saving way of going about things; you may believe that providing group education is simply a way of saving time by providing the same information to many as to few.

If you chose option B you may believe one or more of the following:

- Not everyone wants to join a group or would come if invited.
- A group session might be intrusive or too self-revealing.
- Groups can get 'out of hand'.
- Groups are associated with mental health where therapy groups are extensively used.
- Some people should be excluded from groups.

If you chose option C you may recognise that running a group education session requires planning and forethought and different skills from those used in one-to-one consultations.

The answer most likely to result in group education successfully achieving your aim and running smoothly, is option C. This is because there are too many virtual 'banana skins' in the other two. For example, in option A, there is a possibility that one of the following scenarios may occur:

- No-one can find the venue.
- The venue is not suitable for someone who cannot climb stairs.
- People turn up with their partners, amounting to 40 participants instead of 20.

In option B, you might decide that all people invited need to share similarities (such as age) or decide to exclude people because you think they would not benefit from a group situation. However, this means that you might end up with people with apparent similarities who do not see eye to eye, or be excluding people who would benefit from the session.

Option C will give you the chance to reflect on what you already know about groups. You can find out more about how groups work, and then establish the who, what, where, when and how of your new group education sessions. The remainder of this article will deal with some of the issues involved in setting up and running groups, and in particular the skills needed for them to be successful.

Why group education?

Provision of services for people with

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diabetes in a group setting is increasingly being advocated for reasons additional to managing numbers (DoH, 2002; Diabetes UK, 2003; NICE, 2003). Evidence indicates that adults learn most effectively when they can: relate their learning to their own experiences; identify their feelings, emotions and beliefs about their experiences; and look at information objectively in relation to their own circumstances (Rogers, 2001; Coles, 1989).

Despite the evidence, much education in healthcare (and other arenas) is delivered in the traditional way with the teacher as the 'expert' who imparts information to those on the receiving end. Traditionally, diabetes education has been delivered in the same way; information is provided based on what we know as healthcare professionals in the expectation that those being educated will believe all we say and will change their lifestyles accordingly. However, this often does not happen – people will absorb a limited amount of information (particularly if delivered in lecture style) and will compare it with their own reality, and then make a decision as to whether or how they need to change their lifestyle.

A typical example is if a person with diabetes is told that they should not eat chocolate because it raises their blood glucose level, but that wholemeal bread is good for them. However, they may have tested their blood glucose after eating wholemeal bread and found it to be raised. Therefore, they are likely to disbelieve the healthcare professional and to believe that chocolate is as good for their blood glucose as wholemeal bread. Although this is an oversimplified example of a complex topic, it serves as a good reminder of the messages that people may get from us and how they might apply them in real life.

In contrast, if people are asked in a group to discuss foods that raise blood glucose levels more than others, the knowledge within the group as a whole is likely to lead to the generation of more varied and sensible answers. More information can be added in response to identified needs rather than because the healthcare professional feels that people need to know something. This approach is based on the evidence that people will act on ideas and goals which they have made themselves rather than those that have been made for them. Williams et al (1998) calls it an 'autonomy supportive' approach.

Even though diabetes affects over 3% of the population (DoH, 2001), people who have diabetes rarely get the chance to meet and have discussions with others with the same condition, and often benefit as greatly from that opportunity as they do from the content of the education session. Many people feel isolated and confused at diagnosis, and find it difficult to understand why lifestyle and treatment changes are necessary. Those with type 2 diabetes can find it hard to come to terms with the need to transfer to insulin injections.

Group education allows people to compare their experiences with others, share the variation in how daily situations can be managed and feel similar to others instead of being 'different' from others. John Keeler (2004) powerfully described this when talking about his first experience of being with others with diabetes after having it for many years:

'A huge burden was lifted from me, just on hearing that there were others who had experienced the same troubles, difficulties, fears and emotions which I had previously imagined only I experienced. I kept telling myself you are not alone. You are not alone!'

What aspects of diabetes care are suitable to be covered in a group setting?

Although group education is not a wholesale replacement for one to one consultations, all aspects of diabetes can be covered in a group situation; education at diagnosis and ongoing, starting on insulin or an insulin pump, intensifying control for those at high risk or planning a pregnancy. The benefits of group education have long been recognised and provided for in certain groups such as adolescents and parents of children with diabetes, but it has not been widely implemented in other groups of people, such as adults with type 2 diabetes. When such people do get together, 'meeting others in the same boat' is regularly cited as being of importance, as is participation in a group purely for support, sharing of experiences and feelings (Meakin, 2003). There seems to be no evidence that providing group education is less effective than in one to one consultations (NICE, 2003; Rickheim et al, 2002). Evidence suggests that group education can result in

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1 The way to ensure that people feel secure enough in the group to get the maximum benefit is to create an environment of trust, honesty and equality by using facilitation skills.

2 Primarily, the conceptual framework (the principles by which you are going to run the group) need to be decided.

3 The evidence indicates that people learn best in a framework which encourages making connections.

4 Setting the scene involves telling people exactly where the sessions will take place, what they should bring, what they can expect to happen and that the sessions will start and finish promptly.

behaviour change (Arundel et al, 2003).

A common worry for healthcare professionals who are considering providing group education (especially in terms of starting insulin or covering aspects of sexuality in mixed-sex groups) is that privacy and confidentiality will be compromised. However, it is possible to ensure that this rarely happens and the concern is far outweighed by the pleasure and reassurance people get from the opportunity to hear the experiences of others (Almond et al, 2001; Morrison et al, 2003). The way to ensure that people feel secure enough in the group to get the maximum benefit is to create an environment of trust, honesty and equality by using facilitation skills.

Where and when to run group education

There will never be a place or a time that is exactly right for everyone. It is important that the accessibility of the venue (in terms of location and entry points) is considered, along with the facilities and availability of refreshments. The latter are often overlooked, even though those who are recently diagnosed with diabetes or who are transferring treatment to improve control are almost always in need of drinks and toilets. Organisers may need to provide refreshments themselves. The location does not have to be glamourous, but the environment can give messages about the importance that is attached to the activity taking place. It is worth finding out in advance whether morning, afternoon or evening is the best time of day for most people, but the important thing is to start and finish at the times stated. This principle is frequently not adhered to, much to the frustration of participants.

Figure 1. A seating arrangement in a semi-circle works better than desks or tables in group education.

How to run a group education session

Primarily, the conceptual framework (the principles by which you are going to run the group) need to be decided. Is the purpose simply for you to give information to everyone there in a lecture style? Or is it to enable people to learn from each other through discussion and activities, with you filling in the gaps as they arise? The latter is a facilitative rather than didactic approach and is likely to be more successful, although it can feel very different, even a bit scary, to let go of the more common approach of telling and giving advice. These two approaches have respectively been likened to 'pot filling' and 'making connections' by some authors (Coles, 1989). The evidence indicates that people learn best in a framework which encourages making connections.

The skills needed to facilitate learning as opposed to giving education are related to setting the scene, creating a secure environment and introductions and ground rules.

Setting the scene involves telling people exactly where the sessions will take place, what they should bring, what they can expect to happen and that the sessions will start and finish promptly. This can be done by prior information, but also needs to be reinforced on the day.

Creating a secure environment. When people arrive introduce them to others, perhaps use name badges and invite them to be seated (a semi-circle of chairs works better than desks or tables; see *Figure 1*). Tell people the 'domestics' including where the toilets and fire exits are and what time refreshments will be served.

Introductions and ground rules. Ensure that each person has the opportunity to say something as an introduction. This does not have to be detailed and there are many ways of making introductions comfortable. Participants can talk together in pairs first and then introduce each other. Alternatively, participants can say their name and then name a feeling they are having that starts with the same letter as their name. Criss-cross the room rather than working round the circle. Once everyone has spoken, a sense of equality is created. Introduce yourself and say something about the session and invite ground

rules to be set. These are crucial, as once agreed they can be used to ensure the discussions run smoothly. The idea of ground rules is sometimes unfamiliar to people, so giving some examples (such as a rule of confidentiality) or inviting the group members to choose from a list and then add their own is a good start.

Getting started

For the group to meet the needs of the participants the facilitator needs to find out early what issues they have about the meeting and ensure that these are covered. Techniques might include asking everyone to write down what they would like to get out of the session.

If there is a specific topic for the session, you will have an idea of the areas you would like to be covered, so another way to get started could be to share these with the participants. For example:

'Today is our first time together and I thought we could discuss what diabetes is and the ways it is treated. Perhaps we could start by working out what we all know about diabetes already. Who would like to say one thing that they know about diabetes?'

If you then wait a few seconds, someone will say something and others will follow. You could then make a list on a flip chart which you can use to summarise what diabetes is (and is not) when everyone has had the chance to contribute. This works well with a small group. With larger groups, breaking down into smaller groups for discussion is often effective, as people can feel intimidated by speaking in a large group. Activities for small groups to work together on can include making a list of collective thoughts on a post-it-note or flip chart. An important principle of group facilitation is not to single out, embarrass or humiliate individuals or their beliefs (Rodgers, 2001).

As a facilitator you are responsible for the process rather than the content, which will be decided much more by the group. This does not mean that you ignore any need you have for dealing with specific issues – if the group was brought together to discuss insulin initiation it would be inappropriate to not cover that topic.

Running the group

Once discussion has started, you may have concerns that people might say the wrong things or share bad experiences, and feel that you will be unable to cope with these. Using a facilitative approach, you can use the group as a whole to deal with these situations, using phrases such as:

'What experience have others had of that situation?'

'That doesn't seem to fit with what we were discussing earlier – do you feel it is a logical action to take?'

Through this approach, you will often find that people will contradict others, and between the group members they will be able to work out what is correct and what is more likely to be successful. Facilitating discussions in this way is an active process and requires skills that are different from those used

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2 Part of the preparation for the provision of group education could include thinking about what could go wrong and working out how to would deal with potential scenarios.

3 Planning and preparation are essential if groups are to work successfully and this needs to include consideration of the conceptual framework that underpins the provision of groups.

to deliver information lecture style. These include:

- Using open questions and giving time for people to answer. In the examples given above, the open question might be challenging and people will need time to consider what they think about it, before continuing with the discussion.
- Summarising. If you feel that part of the discussion has highlighted some main points, stop the discussion and provide a summary. This prevents the discussion from going off at a tangent. For example, in a discussion about treatment for diabetes, you could say:

  'Several people have mentioned the names of tablets they are on, and they are all different. Shall we make a list of all of them and work out what they do?'

  If the purpose of a group is to discuss any aspect freely, a summarising comment might be:

  'So far you have mentioned eating, losing weight and monitoring as areas of concern. Which would you like to discuss in more detail first?'
- Ensure that all participants are included in the discussions. Some people are quiet because they are happy to take in what other people are saying. Others may be desperate to say something but cannot get a word in edgeways! Your role is to find out which is the situation by perhaps asking:

  'Can I ask anyone who has not yet said anything to comment?'

  'I am aware that some people have not said much. Can we give them a chance to speak now if they want to?'
- Timekeeping. It is important to give people information about the length of time the group session will last in the invitation and at the start of the session, which should start and finish promptly. During the group session, reminders of the time that remains can keep discussion on track, especially near refreshment breaks and towards the end:

  'We have about 5 minutes left before tea; perhaps we can summarise where we have got to so far and plan what to do next.'

Troubleshooting

Part of your preparation for the provision of group education could include thinking about what could go wrong and working out how you would deal with potential scenarios. For example, you might be worried that too many or too few people will arrive, that they will not talk or will talk too much, that one person will dominate or that people might get angry or upset during the session. Whatever your concern there will be a way of dealing with it. Planning what you will do will mean it is less of a problem should it arise, but will probably ensure that it does not happen in the first place.

Conclusion

Groups are increasingly advocated as a way of providing education and support for people with diabetes, and they can be extremely rewarding for facilitators and participants alike. Planning and preparation are essential if groups are to work successfully and this needs to include consideration of the conceptual framework that underpins the provision of groups. We have discussed particular facilitation skills that can be used which enable a move away from the traditional information-giving approach and towards engaging people and helping them to reflect on their own situations. This helps people to relate information much more closely to how they organise their own lives and their diabetes and thereby increases their ability to self manage their condition. ■

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