

Psycho-educational group therapy in acute psychiatric units: creating a psychosocial culture.

An update of spread and effectiveness of a psychosocial intervention in Italian psychiatric wards

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Abstract

The implementation of a Cognitive-Behavioural Group Intervention (CBGI) in Italian general hospital psychiatric units started in the years 2000-2001 in two Italian regions. Over the years it has become more and more popular also in other psychiatric units located in the rest of the country. Based on the “stress-vulnerability-coping” theory, the CBGI is a replicable and innovative psychosocial intervention that promotes the active involvement of inpatients in decisions concerning their individual objectives and care. In the present article, the authors briefly describe this intervention and the main findings regarding its implementation in several psychiatric units in different Regions of Italy. The authors emphasize that such a psychosocial approach to inpatient care is needed because it can produce improved clinical outcomes, reduction in untoward events and increased staff and inpatient satisfaction. However, its introduction and use still represent a major cultural and managerial challenge in our country.

Key words

- psycho-educational group therapy
- mental health services
- general hospital psychiatric unit
- effectiveness
- empowerment

INTRODUCTION

Cognitive-behavioural therapy (CBT) and other psychosocial treatments play an important role in the treatment of schizophrenia and other psychoses, including the management of symptoms and prevention of relapses [1]. Currently, CBT is, for example, the most widely recommended and integrated psychological intervention for psychosis community mental health settings in the UK National Health Service [2]. A number of meta-analyses have previously demonstrated the effectiveness of CBT and psycho-education interventions for schizophrenia [3]. In addition to CBT and psycho-education treatments, social skills training (SST) has also recently been indicated as an effective and cost-effective approach with a potential for wider clinical application that can be offered to patients diagnosed with schizophrenia-spectrum disorders or psychosis [4].

CBT for psychosis overlaps with psycho-education programs and SST in that they all focus on teaching more effective coping strategies for managing stress and persistent symptoms, not to mention improving the ability to build social and independent living skills. However, CBT tends to focus less on education about schizophrenia, and more on styles of cognitive restructuring aimed at changing individuals' negative beliefs and assumptions. On the contrary, psycho-education was conceived as a tool to help people improve the course of their disorders by providing information concerning the nature and treatment of their disorder, upon which it is possible to build additional programs or interventions such as self-assertiveness training, problem-solving training, communication training, and further family therapy interventions [5].

CBT [6], psycho-education [3] and SST interventions

are almost exclusively delivered on an outpatient basis [4]. Also in Italy, despite a strong “socio-therapeutic” orientation, no psychosocial approach to inpatient treatment has been largely and systematically adopted. Inpatient treatment tends to be crisis-oriented, with the aim to stabilize clinical conditions and control positive symptoms. In almost all psychiatric acute inpatient services, the approach adopted (mainly pharmacological with a minimal psychological support) diverges from that of the community mental health centres (mainly psychosocial). This creates considerable confusion for patients.

Based on this rationale, in the year 2000, the Mental Health Department (MHD) of Roma 1 (North Rome, Italy), San Filippo Neri Hospital, developed a cognitive behavioural group based intervention to be implemented in psychiatric inpatient units. The intervention had a psycho-educational matrix focusing on the didactically skilful communication of key information within the framework of a cognitive-behavioural approach. It was based on the stress-vulnerability theory and consisted mainly in providing information regarding the disorders and teaching skills to guide disorder management efforts aimed at modifying psychosocial factors that could potentially precipitate relapses (e.g., poor coping abilities, lack of social support). A preliminary study supported the feasibility of the intervention and suggested positive results in reducing compulsory and voluntary readmissions, physical restraints and inpatients escapes [7].

Following these promising findings, the intervention was also applied in the psychiatric ward of Campobasso (Molise Region, South Italy). The findings obtained were so equally encouraging that some professionals of Campobasso (three psychiatrists) in collaboration with the two pioneers psychologists of Roma 1, and a psychiatric epidemiologist coming from the Italian National Institute of Health (INIH), decided to develop a Manual concerning this Cognitive Behavioural Group based Intervention (CBGI) to guide other professionals and other MHDs in a more wide-ranging and comprehensive dissemination of the intervention in inpatients psychiatric care units [8].

In the present article, the authors briefly describe the contents of this Manual, which is now in its third edition [9], and the main findings regarding the implementation of the CBGI in several psychiatric units of various Regions of Italy. The authors would also like to emphasize that such a psychosocial approach to inpatient care is needed, because it can produce improved clinical outcomes, reduction in untoward events and increased staff and inpatient satisfaction. However, the use of GBGI still represents a major clinical, cultural and managerial challenge in our country.

THE COGNITIVE BEHAVIOURAL GROUP-BASED INTERVENTION FOR INPATIENTS PSYCHIATRIC UNITS

Theoretical background and main contents

The description of the intervention has been extensively reported in previous articles [10-14]. Briefly, it is based on a cognitive behavioural approach within the stress-vulnerability model and coping oriented pro-

grams [15, 16]. Specifically, it combines the elements of disorder management of the Falloon's psycho-educational approach [17] with the cognitive restructuring individual therapy model for psychosis [16]. In Falloon's approach, in particular, psychiatric patients and their families are trained to use structured problem solving to address problems that cause the most stressful situations in their life and to use their social network to obtain the support of the people who are most willing and able to assist them in resolving problems.

Group meeting sessions are provided to teach inpatients to recognize events and situations that they find very stressful and also to recognize their early warning signs (preferably with their relatives). The importance of optimal adherence to medications is emphasized, as well as the use of effective strategies to cope with specific stresses. Inpatients are also encouraged to define their individual measurable objectives and plans to be dealt with after they leave hospital. These also include any problems they might encounter in accessing and accepting outpatient treatment programs. Persisting symptoms are normalized as experiences that most people may have when they are under extreme biological or psychosocial stress. The personal strengths of inpatients are reinforced, rather than their defects and disabilities.

Organization of the intervention

The intervention group is offered to acute inpatients during their hospitalisation in General Hospital Psychiatric Units (GHPUs), and usually includes 6-10 inpatients per group. A professional (called the “conductor”) with the assistance of another professional (the “co-conductor”), who are trained in the intervention and experienced in cognitive-behavioural techniques, conduct the group sessions. The team of Campobasso mainly organizes the training of conductors. Conductors complete the training in two-days training sessions, where they also receive the Manual of CBGI regarding how to implement the programme.

Inpatient groups meetings are held every weekday, usually from around 09.00 to 11.00 a.m. and mostly include 5 sessions per patient, provided over 1 week. More sessions are provided to long stay inpatients (with a length of stay of more than 2 weeks) during admission. For these inpatients, additional sessions run as booster sessions for consolidating the degree of acquisition and maintenance of skills and strategies. Sessions follow a didactic treatment guideline presented in the Manual for professionals. The order of the topics provided in the different sessions usually follows the structured table of contents included in the Manual (*Table 1*).

Every session is structured in the following way: 1) presentation of the session aim, presentation of structure and rules of the group session; 2) introduction of all newly admitted inpatients; 3) summary of the last session and review of *homework*; 4) topic of the day; 5) summary of the principal points and assignment of *homework* exercises for the afternoon. These exercises are mainly personal-goal oriented and they are performed by inpatients with the help of nursing staff in the afternoon. Solutions to the practical exercises of each session are reviewed in the following session.

Table 1

Current modules of the Cognitive Behavioural Group based Intervention (CGBI) for inpatients psychiatric units

Module	Basic/Optional	Topic
1	Basic	What occurred before the admission? Identifying symptoms of psychosis Identifying individual stressors and stressful situations Interrelationship between stressors and psychosis
2	Basic	Education regarding the disorder and its treatment options based on the stress-vulnerability model
3	Basic	Role of medication in preventing relapse Modes of action in antipsychotics, antidepressants and mood stabilizers
4	Basic	Dealing with stigma
5	Optional	Definition and identification of early warning signs. Coping with early signs
6	Optional	Personal goals and plans to achieve them
7	Optional	Coping with alcohol dependence. Medication and psychosocial strategies
8	Optional	Coping with hallucinations
9	Optional	Coping with anxiety symptoms
10	Optional	Coping with delusions and psychotic thinking
11	Optional	Coping with aggressive behaviour
12	Optional	Bipolar disorders: coping with sadness and happiness
13	Optional	Personality disorders: coping with anger
14	Optional	Personality disorders: coping with histrionic behaviours
15	Optional	Suicidal ideation
16	Optional	Understanding emotions
17	Optional	Awareness and insight of disorder
18	Optional	Physical Well-being: diet and physical activities

The conductors come from various professional backgrounds, but our experience suggest that the presence of a physician (often as a co-conductor) is helpful when discussing detailed information about symptoms, mental state and cognitive impairment. Additional professionals of the unit are invited to attend the groups as observers and may be solicited by the conductors to make suggestions. Two blackboards are used to make notes during the sessions.

Manual

As mentioned above, there is a manual for professionals. The manual, first published in 2003, is now in its third edition [9]. It provides guidelines for professionals regarding how to convey information and teach skills and mainly consists of operative Modules (divided into two categories of Modules: fixed or basic Modules and optional Modules) to be conducted during the sessions (Table 1). The fixed Modules are educational and concern topics concerning the stress-vulnerability model, psychopathology, pharmacological treatment and stigma. They seek to improve an understanding of disorders and their treatments. In addition, other optional additional modules are provided, which focus on topics of greatest concern to inpatients, such as managing specific symptoms and stressors, as well as improving ability to identify practical solutions.

Rules and group strategies

All rules and strategies are used in a flexible way. The main strategies are: 1) encouraging direct communication and dialogue among inpatients rather than professionals giving information and advice to inpatients; 2) Socratic questioning [18]; 3) helping inpatients make connections between their thoughts, emotions and behaviours; 4) normalizing symptoms; 5) modelling and role-playing; 6) positive reinforcement and constructive feedback; 7) structured problem solving (5 steps: description of the problem; list of possible solutions; evaluation of pros and cons of possible solutions; identifying best solution or combination of solutions; planning to implement the solutions; 8) effective communication skills (i.e., expressing unpleasant feelings, active listening, expressing positive feelings, making requests).

AIMS AND QUALITY OF CARE INDICATORS OF CBGI FOR INPATIENTS PSYCHIATRIC UNITS

The aims of the intervention are:

1) general: a) to build a therapeutic alliance with inpatients and their relatives; b) to improve inpatients commitment to treatment;

2) services: a) to create a positive setting where inpatients and staff work actively together to overcome dis-

ability and mental disorder, b) to improve collaboration among professionals;

3) inpatients: a) to give a dimensional view of disorders and to normalize their experience, b) to reduce the isolation of inpatients by sharing their experience of their disorders, c) to improve self-management of disorders, d) to increase inpatient self-efficacy and self-esteem.

Indicators of effectiveness of the intervention include: 1) frequency of aggressive and violent behaviours in the unit; 2) frequency of readmissions; 3) satisfaction of inpatients and relatives; 4) satisfaction of professionals.

Indicators related to performances of services: unit atmosphere, length of inpatient stay.

CBGI BRIEF HISTORY OF ITS ORIGIN AND DISSEMINATION FROM 2000 TO 2014

As above mentioned, in 2000, two psychologists of the San Filippo Neri psychiatric unit, in collaboration with the Italian National Institute of Health developed a group cognitive behavioural intervention to be integrated into the routine care for acute psychotic inpatients. It was mainly inspired by the Falloon's psycho-educational approach [17], a well-known cognitive-behavioural family intervention. Its basic components were: 1) information sessions about mental disorders, in which mental disorders were normalized and inpatients were considered experts of their own mental disorders; 2) identification of early signs of acute episodes and relapse prevention; 3) information on pharmacological treatment advantages and adverse effects; 4) definition of inpatient individual goals to be pursued during hospital stay and after discharge.

In this first experience, Bazzoni and colleagues asked some psychiatric inpatients admitted to the San Filippo Neri unit to collaborate in order to underline the issues that inpatients considered to be more relevant and useful to be implemented in the intervention sessions. Four themes were highlighted: *What occurred before the admission, Stress-vulnerability model, Medication, Discharge goals*. A preliminary 1-year follow-up study showed a lot of promising results (e.g., decline of revolving door admissions, decline of violent episodes and physical restraints) [7]. Moreover, patients' escapes from the ward almost disappeared and patients' opinion about the participation to the group was excellent [7]. Despite the fragmentary compliance of psychiatrists, the intervention was well accepted by psychologists and nurses, and, therefore, it was systematically introduced into routine care up to 2013. The intervention was interrupted later because the two psychologists who had conducted the groups moved towards other services.

As mentioned above, in 2001, three psychiatrists of the Campobasso MHD (Molise Region, South Italy) were trained in the application of the intervention by the San Filippo Neri staff. As a result, since 2001, not only has the GHPU of Campobasso implemented the intervention but it has also elaborated a new version, supplemented with additional topics and operative modules. It published a structured Manual for the implementation and evaluation of this new version [8]. In 2008, the same authors of the first edition elaborated the second

edition of the Manual in which other optional modules were added [19]. These authors conducted a number of training courses to facilitate the dissemination of the intervention throughout Italy. Currently, the Campobasso MHD is the department where the intervention has been applied longer.

In the Molise Region, in 2004, the intervention was also implemented in the GHPU of Termoli three times a week by a psychiatrist and two nurses. However, the adoption of the intervention was interrupted after three years because the trained psychiatrist who mainly conducted the group interventions transferred to another health service.

In 2004, some nurses of the Arezzo GHPU (Tuscany Region, North Italy) attended a training course conducted by the Campobasso staff and then implemented the intervention in routine practice. The main findings concerned the improvement of perception among nursing staff regarding the creation of a therapeutic alliance with inpatients, to the point that, since its introduction, the nurses mainly manage the inpatients with only a minimum engagement of psychiatrists [20]. In subsequent years, the intervention was also implemented in other GHPUs of the same Region (in Pontedera, Pistoia, and Siena) but only for a short period of time because, despite promising results, it was interrupted due to organizational difficulties (i.e., rapid staff turnover and consequent lack of continuity).

Also in 2004, the intervention was implemented in the Foggia GHPU (Puglia Region, South Italy), three times a week by a psychologist, a psychiatrist and two nurses. Also in this unit, the intervention produced a reduction in untoward events and an increase in staff and inpatient satisfaction [21]. Nonetheless, the adoption of the intervention was interrupted in 2015 and only recently restarted. The GCBI was also activated for a short period in the same Region in other GHPUs (in Galatina di Lecce and Bari, South Italy) but subsequently interrupted owing to organizational difficulties.

In the same year, the intervention was implemented in L'Aquila (Abruzzi Region, Central Italy) in the psychiatric day-hospital, two days a week. In this hospital, the intervention produced a reduction in episodes of violent or aggressive behaviours and improvements in the ward atmosphere [22]. Moreover, a study was conducted to specifically evaluate the improvement of inpatient insights into various aspects of their disorders and treatments [23]. Together with the head of the day hospital (a psychiatrist), the rehabilitation therapists who implemented the intervention elaborated two new modules, which concerned *Physical wellbeing* and *Coping with aggressive behaviour* (as optional Modules). The peculiarity of L'Aquila was that after an earthquake had occurred in 2009, which had partially destroyed the town, the treatment continued, in any case, on a daily basis in a big emergency tent for a long period of time. Unfortunately, after this latter valuable experience, which lasted around four years, in 2013 the treatment was interrupted owing to the retirement of the day hospital's head and the reassignment of the rehabilitation therapists to other patient services.

In 2004, the application of the intervention was also

started in Trento (Trentino Alto Adige Region; North Italy), thanks to the work of an educator and a psychologist. In this town, the treatment has been provided daily and almost continuously with good outcomes. In the opinion of the professionals involved, the approach used in the intervention gives a great impulse to transform the inpatient unit into a no-restraints-unit, which offers a range of psychotherapeutic and rehabilitation services, including physical activities such as massages and relaxing exercises.

From 2007 to 2009, Perugia (Umbria Region, Central Italy), with a psychologist, a psychiatrist and a nurse, Ostia (Lazio Region, Central Italy) with a psychiatrist and two nurses, Frattamaggiore (Campania Region, South Italy) with a psychiatrist and two nurses and Parma (Emilia Romagna Region, North Italy), with a psychiatrist and two nurses, implemented the intervention in their services for acute inpatients. According to the opinions of professionals involved, the outcomes were very promising, although no studies were conducted for documenting the improvements observed in these services. On the other hand, as a consequence of the implementation of the intervention, the professionals of Perugia elaborated new initiatives such as a program regarding how to reduce smoking to be included in the intervention. The professionals of Parma developed a program to improve physical wellbeing (most of this program was merged with the same initiative developed by L'Aquila and included in the current *Physical wellbeing* optional Module of the Manual). The approach was interrupted in all these units due to the expiration of the contract of the psychologist who mainly conducted the intervention in Parma, and organizational difficulties that occurred in Ostia, Frattamaggiore and Perugia.

In 2007, an experience started in the GHPUs of Saronno and Gallarate (Lombardy Region, North Italy), thanks to the work of a psychologist, a psychiatrist, three nurses and two volunteers. In 2008, also Busto Arsizio, a town of the same Region, started with a psychologist, a rehabilitation therapist, two nurses and two volunteers. In all these units, the intervention was implemented three times a week and currently remains operative. A similar intervention, with some changes, has been operating in a residential facility of Busto Arsizio since 2007.

Also in 2007, the GHPU of Desio, a town in the Lombardy Region, adopted the intervention. The most important outcomes consisted in better unit atmosphere and inpatient satisfaction. Also in Brescia, a bigger town of the same Region, the intervention was implemented in a private residential facility for two years by a consultant psychiatrist. However, as a result of the subsequent retirement of the consultant, the intervention is no longer applied in Desio and Brescia. In the same year of 2007, a GHPU of Milan (Lombardy Region) adopted the intervention in its routine, three times a week for many years, but it was recently suspended for the same reason as Desio and Brescia.

Since 2011, the CBGI has been implemented daily in Nocera Inferiore (Campania Region, South Italy). Due to a decrease in readmissions, the team decided to conduct a two-year study in order to evaluate inpatient

satisfaction by means of a self-filled questionnaire created ad hoc by the local staff. The satisfaction expressed by inpatients was very high; the most negative opinion concerned "feeling bored" during some recreational activities [24].

In 2012, the intervention was started in a residential facility located in Ferrara (Emilia Romagna Region, North Italy). This facility provides short to medium-term care for inpatients with acute and sub-acute psychiatric conditions. It is worth noting that until 2012, the facility's staff conducted a discussion group once a week as a sort of group talk therapy. However, this activity was judged to be "not interesting" by inpatients. As a consequence, the staff decided to adopt the GCBI once a week. Since 2015, the GCBI has run twice a week with high inpatient satisfaction, measured through the Ferrara Group Experiences Scale, an instrument for assessing five different dimensions of group experiences: 1) sharing of emotions and experiences, 2) cognitive improvement, 3) group learning, 4) difficulties in open expression and 5) relationships [25].

In 2014, the GCBI was applied in a GHPU of Modena (Emilia Romagna Region, North Italy) where a study was carried out over a period of six months. Despite the fact the findings were inconclusive regarding the effectiveness of the intervention in reducing relapses (possibly due to the short follow-up), they did, however, register positive inpatient feedback (i.e., inpatients found it useful, they were happy to attend the programme again in the future, and group topics were considered not difficult) [26].

In the same year, GCBI was also implemented in Verona (Veneto, North of Italy), three times a week by two physicians and two nurses.

Finally, the experience of the GCBI was also adopted in a residential facility of Fabriano (Marche Region, Central Italy) for discharged post-acute inpatients, but as reported by the head of this facility, the intervention was considered by inpatients to be unproductive and boring.

THE CURRENT EXPERIENCES OF CGBI IMPLEMENTATION

The GHPUs that started with the previous two editions of the CBGI Manual and which are still running with the help of the Manual in its third edition (2015) [9] are: Arezzo, Busto Arsizio, Campobasso, Ferrara, Foggia, Gallarate, Nocera Inferiore, Saronno, Verona and Trento.

Since 2017, other GHPUs have decided to implement the intervention. They include: Fano (Marche Region, Central Italy), Chioggia, Dolo, Mestre, Treviso, Venezia, (Veneto Region, North Italy), Ferrara, Imola (Emilia Romagna Region, North Italy) and Viterbo (Lazio Region, Central Italy). More recently, in 2018, also the GHPU of Brescia decided to run the approach with rehabilitation therapists as conductors.

On the 20th and 21th of October 2017, a National Meeting Conference was held in Campobasso, under the sponsorship of the local Medical Board, with all the heads (or their delegates) of GHPUs that adopted the CBGI, in order to discuss the CBGI's strengths, criti-

cisms and better outcomes. Below, we briefly describe the most important findings that the heads presented during this conference.

In the Arezzo and Campobasso units, the results of some outcome indicators from 2015 to 2017 were similar to those obtained in the first years in which the intervention and the Manual, in its I and II editions, were implemented, as documented by the CBGI effectiveness studies conducted in those units [10-13, 20]. As previously stated, the CBGI was pioneered in these units and therefore they boast the longest period of daily application. In the conference, these units were presented as the units in which the best outcomes had been registered, especially concerning the percentages of voluntary (12%, for both the units) and compulsory readmissions (0%), within the 2016 calendar year.

In the unit of Foggia, since the third edition of the Manual includes a basic Module entitled "dealing with the stigma", a study is ongoing in order to evaluate the relationship between the severity of psychopathological status, stigma and ability to cope. In the GHPU of Trento, professionals reported that the most attractive topic for inpatients was *awareness* and that the relevant Module has prompted inpatients to engage in a series of other daily group activities, e.g., activities concerning physical relaxation and *shiatsu*. Positive impact on quality of care process indicators and high levels of satisfaction were also registered in Saronno, Gallarate and Busto Arsizio regarding the application of the third edition of the Manual, although no overall differences between the first two editions and the third edition of the Manual emerged. The same trend was observed in Nocera Inferiore and Ferrara, especially concerning inpatient satisfaction.

Regarding the units where CBGI was more recently implemented, we would like to mention Fano even though, at present, the approach was interrupted.

As previously stated, the approach was also recently started in Mestre and Venezia with good results concerning unit atmosphere, inpatient satisfaction, motivation of professionals, number of restraints, number of readmissions. In the same period, the approach was also introduced in Viterbo (Lazio Region, Central Italy). The conductors were two rehabilitation therapists. The best results concerned the high level of effectiveness in improving patient insight, clinical stability, quality of life, and satisfaction in enhancing family members' ability to manage stress [27].

In Imola, the CBGI started in May 2017. The inpatients were more satisfied than some psychiatrists or nurses with the intervention. In the subsequent months, the improvement concerned especially unit atmosphere, where inpatients expressed greater satisfaction than staff, but there was also a considerable reduction in the number of restraints.

In Ferrara, the approach started in another unit in September 2017, the adoption of the programme being decided by the nursing staff. Since in that unit there was a high prevalence of inpatients with borderline personality disorders, the nursing staff suggested adding a new module called *emotion dis-regulation* developed on the basis of the "ABC model of Ellis" [28-30], which

appears to be working extremely well. Inpatients played an active part in this decision.

In the same period, the approach was started on a daily basis in Chioggia, Dolo, and Treviso showing comparable results to Imola. In Treviso, the staff decided to have a supplementary meeting, once a week in the afternoon, with a small group of inpatients, with planned discharge, and their relatives, to better discuss the topic *Early signs of relapse*.

Overall, in all inpatients units in which the intervention is operative, the following goals have been met: 1) satisfying inpatient participation in the group (more than 65%); 2) greater collaboration of inpatients and adherence to the treatment programs; 3) reduction in episodes of violent or aggressive behaviours; 4) reduction of inpatient isolation and better communication among inpatients and staff; 5) greater inpatient satisfaction regarding the care received. Inpatients who did not participate in the group intervention (about 1/3 of inpatients) were elderly inpatients with cognitive deficits or inpatients with moderate or severe intellectual disabilities or forensic psychiatric patients or with substance intoxication or bedridden by a physical disease, or inpatients who were not willing to be engaged in a group or believed that it had limited utility.

Finally, at the date of the conference, on the basis of a data overview regarding diffusion, the longest period of application is 16 years (1 GHPU), followed by 13 years (3 GHPU), 12 years (1 GHPU), 10 years (4 GHPU), 9 years (1 GHPU), 6 years (1 GHPU), 5 years (1 GHPU), 3 years (3 GHPU), 2 years (5 GHPU) and 1 year (15 GHPU). In the first period 2000-2005 the approach was applied by 12 GHPU, while in the second period 2006-2011 it was applied by 18 GHPU and the latter period by 23 GHPU (*Figure 1*).

A REVIEW OF THE CBGI EFFECTIVENESS STUDIES IN ITALY

In all the studies performed, the authors used a longitudinal pre-post evaluation study design with baseline data collected in the previous year that CBGI was introduced; that is, they compared data regarding specific processes or outcome indicators obtained before implementation and 12, 24, or 48 months after the implementation of CBGI.

A number of indicators were used to evaluate the CBGI effectiveness with a statistical significance ($p < 0.01$) (*Table 2*).

The size of the samples in all except one study [13] did not allow addressing issues related to inpatients' characteristics (e.g., symptoms, neurocognitive deficits, illness duration, social cognition and personality factors) that might play a role in outcome in CBGI and might be related with better outcomes. The 4-year follow-up study of Veltro and colleagues [13] only suggests that having a diagnosis of schizophrenia or bipolar disorder was significantly associated with reduction in readmissions compared to having a diagnosis of major depression or personality disorder. Consistently, recent research has suggested that having a diagnosis of bipolar disorder or being female significantly predicted attendance at group cognitive behaviour therapy for het-

Table 2

The indicators used in the studies evaluating the effectiveness of Cognitive Behavioural Group based Intervention (statistical significance: $p < 0.01$)

Proportion of voluntary readmissions [7, 10-13, 20];
Proportion of compulsory readmissions [7, 10-13, 20];
Proportion of inpatients escaping from the unit [7];
Proportion of restraints [7, 10];
Severity of psychiatric symptomatology and clinical stability [21, 27];
Number of violent and angry acts toward others inpatients and/or staff [7, 10, 20];
Level of insight and awareness of psychiatric conditions [23, 27];
Number of accidents which require insurance intervention for professionals [20];
Inpatient satisfaction concerning the group intervention [7, 21, 24];
Inpatient satisfaction with care provided [10-13, 20, 27];
Unit atmosphere [10-13, 20, 22, 23].

erogeneous acute psychiatric inpatients [31]. Another study which examined the effectiveness of group CBT for depressed inpatients, revealed that the only variable that was associated with differential outcomes was symptom severity such that the greatest change was observed in the inpatients who were most depressed [32].

As previously stated, since the recent introduction of the new edition of the Manual, we have no updated data and as a consequence, the findings are related to the first and the second editions of the Manual. Inpatient satisfaction and unit atmosphere were the most used indicators. Below, we give some more detailed information about the characteristics of tools utilized to evaluate these indicators.

A questionnaire included in the Manual evaluates inpatient satisfaction. The questionnaire derives from the Rome Opinion Questionnaire for psychiatric wards [33], a self-filled instrument with good psychometric characteristics. The questionnaire items regard opinions on: 1) suitability of care; 2) immediate availability of staff when needed; 3) staff kindness and politeness; 4) information received concerning health conditions; 5) psychosocial group activities. As an answer scale, the questionnaire used a Likert-type scale with five points (1-5), with higher numbers indicating greater satisfaction.

Unit atmosphere was assessed in all studies using a scale, developed ad hoc and included in the Manual, with good psychometric properties, as reported by Veltro *et al.* [11]. The scale is rated using a 5-point Likert scale three times a day by nurses, who assess effective communication among inpatients and professionals, presence/absence of aggressive/violent behaviour, presence/absence of bizarre behaviour and any other conditions related to relaxing/alarmed atmosphere. To facilitate the rating, items are coded both by numbers and colours: 1) *white*, if the atmosphere is excellent; 2) *green*, if the atmosphere is acceptable; 3) *yellow*, if there are one or more inpatients with disturbing behaviours that are not alarming; 4) *orange*, if there are one or more

inpatients with disturbing behaviours that require immediate interventions but coercion is not necessary; 5) *red*, if there are one or more inpatients with disturbing behaviours that require interventions with coercion and physical restraint.

CLINICAL AND CULTURAL CONSIDERATIONS

In Italy, the CBGI is the only manualized group intervention based on a psychosocial structured approach with explicit goals, developed ad hoc for psychiatric acute units. This approach was pioneered in some units but over the years other progressive acute units located in different geographical areas of Italy have emphasised its use and the importance of patients playing an active part in decision making. In fact, this approach above all: a) promotes the active involvement of patients in decisions regarding their individual objectives and care, resulting in greater control over their life situation and likely better functioning; b) contributes to the establishment of a therapeutic alliance among staff, which is the best predictor of good outcomes [34].

There is limited hard evidence that cognitive behavioural and psycho-educational interventions can play a significant role in inpatient care in Italy, perhaps because the attention and interest of research has focused on community services (i.e., community mental health centres, day-centres and residential facilities). In any case, psychosocial intervention during the acute treatment phase is typically uncommon in Italy [35], although service users should have priority access to these types of programmes [36] and many official governmental reports have underscored the need for the provision of a wide range of psychosocial programmes in the acute management of psychiatric inpatients [37]. Yet, some forms of psychosocial intervention (e.g. patient or family psycho-education, some rehabilitative interventions) have been available for only some patients in Italian facilities, including residential facilities [38]. Maybe this phenomenon reflects psychiatrists' more general difficulties in implementing psychosocial intervention programmes for severely ill patients [39] and in particular it might depend on the belief that psychosocial interventions are not beneficial over a short time span for severe acute inpatients. Similarly, few head psychiatrists have reported CBT being used on a regular basis [38]. However, there is a growing literature which suggests that CBT can be used during inpatient care [40, 41], and there is evidence that it can reduce both negative and positive symptoms, accelerate recovery, and decrease time to discharge [42].

In Italy, users tend to be critical of in-patient care [43] and acute wards tend to be seen as unattractive places to work compared with community settings. In fact, the findings of a survey on job satisfaction among mental health professionals showed that the percentage of satisfied staff members was much lower in hospital wards than in community-based services, such as outpatient clinics or residential facilities [44]. With mental health services often being subject to constant change (e.g., the recent closure of the Italian Forensic Psychiatric Hospitals), the acute ward is an often-neglected

area. Over the years, there has been increasing pressure on beds and problems with staff recruitment and retention. The short length of stay (an issue of particular relevance in Italy, where the length of stay in psychiatric hospital wards is only about 12 days) [45], associated with a shortage of inpatient beds, [46], professionals dissatisfaction, and other data point to an unsatisfactory situation, although many problems encountered in Italy can also be observed in most other European countries (e.g., lack of in-depth outcome evaluation, paucity of effective psychosocial interventions, defective patient connections with community services prior to discharge) [47]. As a result, there is a rapid staff turnover and a consequential lack of continuity, which can lead to custodial solutions prevailing over therapeutic values.

Since the Italian psychiatric reform of 1978 (the so-called “Law 180”) [48], acute psychiatric wards are often recognised as the settings in which quantitative and qualitative features of inpatient care remain largely unexplored and many problems still await appropriate solutions [49]. Reports of low staff morale and high levels of patient complaints suggest that acute psychiatric wards are not achieving their full therapeutic potential [43, 44]. Accordingly, acute wards have been described as places of physical restraints [50], locked-doors (49), and poly-pharmacy treatment [51] at the expense of psychological therapies [38]. In a few cases, they have

been even replaced with 24-hour mental health centres [52]. Nevertheless, for the care of the acutely mentally ill, as in all other areas of medical care, inpatient care represents an important treatment need and resource in psychiatry [53]. Acute psychiatry has the complex task of managing patients at the most critical stages of their lives [36, 38]. Therefore, it is probably time to review acute hospital services with the same determination with which community services were once promoted. Action is needed to introduce psychosocial treatment procedures of proven effectiveness given that findings of a previous national survey suggest that acute facilities are dominated by a strictly medical pharmacological approach [38]. Various factors most likely contribute to the fact that emphasis is placed on pharmacotherapy in psychiatric inpatient settings, for example (i) the fact that, upon admission, most patients are suffering from acute psychotic disorders that place clinicians under pressure to achieve rapid treatment effectiveness; (ii) a general lack of professional training in various types of psychosocial intervention; and (iii) the commonly held belief that psychosocial interventions should be conducted mainly by community-based services. With regard to the first point, medication can be more effective when administered in conjunction with appropriate psychosocial intervention [42]. The problem of insufficient staff training in various forms of psychosocial intervention, including CBT techniques, has also been



Figure 1
The spread of the Cognitive Behavioural Group based Intervention.

observed abroad [36]; the latter have been suggested as the standard for training staff that work in inpatient units [36]. Regarding the third point, it is questionable whether or not community-based services can offer a comprehensive range of psychosocial interventions. At the same time, however, these types of interventions are generally unavailable in GHPUs, where people are most ill, vulnerable, and in need of help. Service users in acute care should have priority access to various types of programmes [49]. Moreover, the event of inpatient admission provides an ideal opportunity to embark on compliance therapy [54] and to foster the necessary therapeutic alliance with the service, which will eventually be responsible for aftercare. Special reference is also needed for patients at their first-ever contact with the inpatient facility. These patients were found to constitute more than 40% of the total number of admitted patients [38] and it was likely that most of them were in the early phases of their disorder, a critical period for establishing an effective therapeutic alliance.

As previously stated, the CBGI approach may contribute to the establishment of a therapeutic alliance because it is underpinned by the collaboration between the patient and the professional. In Italy, to the best of our knowledge, no such structured group based interventions informed by a bio-psychosocial understanding of mental ill health have been put into action as part of hospital stay. Other group interventions are more frequently available. A national survey performed ten years ago showed that in our country unstructured and socializing group activities such as discussion groups or expressive activity groups (painting, newspaper reading, etc.) were available in about one out of three acute inpatient units [38]. Group dynamic psychotherapy was available in approximately one out of five units. However, group CBT and psycho-education were rarely provided [35, 38, 55, 56]. At present, there are no updated data available concerning the provision of psychological therapies and rehabilitative interventions for Italian inpatient wards.

CONCLUSIONS

The present article shows that CBGI is feasible, albeit mostly on a short or medium-term basis, even when it is implemented in units with standard personnel resources. From 2000 to 2017, interventions were set up in 35 out of 285 Italian GHPUs (12%) counted by the Sistema Informativo Salute Mentale (SISM; in English: Mental Health Information System; available at the following link: www.salute.gov.it/imgs/C_17_pubblicazioni_2731_allegato.pdf). There were 22 in Northern Italy, 7 in Central Italy and 6 in South Italy. The number of GHPUs, which apply the approach, has increased from 12 in the first period (2000-2005) to 32 in the recent years. However, only 9 GHPUs have applied it for a period of more than ten years while 23 GHPUs have applied CBGI for 3 years or fewer. Of these latter, 5 GHPUs have begun to apply it in the last two years, and 15 GHPUs in the last year.

The current level of CBGI spread is 6% (18 MHDs), a percentage which is consistent, though slightly lower, than that reported by Magliano *et al.* (8%; 23 MHDs)

in her article concerning community dissemination of any forms of structured psycho-educational intervention in Italy [57]. More recent data, derived from the 2016 national report of SISM, on the provision of various forms of psychosocial or rehabilitative interventions (i.e., individual or group-based basic skills intervention, individual or group-based psychotherapy, individual or group-based re-socializing intervention, individual or group-based expressive activity, individual or group-based informative and psycho-educative family intervention, family psychotherapy) in the community mental health centres (CMHCs), has shown that altogether these activities represent 17.8% of the total number of performances provided by all the Italian CMHCs. Of these, group-based or individual socializing activities represent 3.7%, family psychotherapy 0.1%, group or individual psychotherapy 3.8%, and informative family psycho-education 0.6% (www.salute.gov.it/imgs/C_17_pubblicazioni_2731_allegato.pdf).

Therefore, the 6% CBGI diffusion in settings for acute inpatients could be interpreted positively, especially considering that psychosocial rehabilitative interventions, including psycho-education, CBT and structured family therapy are not widely available even in the CMHCs in Italy. This is also consistent with an Italian survey conducted by the Italian Society of Psychiatric Epidemiology (in Italian: Società Italiana di Epidemiologia Psichiatrica; SIEP) in 2008, which had evidenced the discrepancy between the evidence-based NICE guidelines for schizophrenia and the usual practice of the Italian mental health services in order to promote the recovery of patients with schizophrenia [58]. This survey, conducted with the collaboration of 19 MHDs, showed in particular that less than 10% of psychiatrists in 41% of the CMHCs surveyed and less than 10% of psychologists in 64% of CMHCs were experienced in CBT. In 60% of CMHCs, no patients with schizophrenia received CBT and in the remaining 40% of CMHCs such therapy was available for only less than 10% of these patients. As regards family psycho-educational intervention, this was provided in less than 10% of cases by 45% of CMHCs and in more than 75% of cases by 12.5% of CMHCs. Therefore, consistently to the PROGRES-Acuti (PROGetto RESidenze per pazienti acuti; in English: Acute psychiatric in-patient facilities project) survey [35, 38, 56], the SIEP survey showed that mental health Italian services do not systematically adopt psychosocial interventions such as psycho-educational and CBT interventions, even though these interventions are the most accepted by users and professionals and many research studies recommend their use.

In our experience, the vast majority of professionals who were involved in GBGI affirmed that CBGI was useful and able to greatly improve the ward atmosphere and that it was highly appreciated by patients. At the same time, the CBGI sustainability revealed that some obstacles still persist at organisational and clinical levels. As a result, CBGI was interrupted in 17 GHPUs. In some cases, it was suspended due to the transfer of the head or the professionals who mainly conducted the intervention; in other cases the main motivation was *organizational difficulties*. The reasons behind these obstacles

are complex but, in the authors' opinion, they include the difficulty in finding time and space for psychotherapeutic work within the stressful ward environment [59], the different clinical orientation and risk management vision of some rehabilitation managers, the scarcity of mental health professionals who have had training in the CBT approach in psychosis, and the absence of a structured framework to guide rehabilitation practice.

This paper supports the idea that the discovery of a psychosocial culture in the acute unit is possible and advisable. The relevance of using psychosocial interventions such as CBGI has been discussed. There is particular evidence for the use of CBGI given that a number of studies attest that CBGI produces improved clinical outcomes, a reduction in untoward events and increased staff and inpatient satisfaction [7, 10-13, 20-24].

To the best of our knowledge, there are no other published analyses regarding the effectiveness of psychosocial interventions in acute psychiatric units in Italy, and, in general, there is limited research evaluating the effectiveness of psychosocial interventions for those receiving acute adult mental health inpatient care [60].

Acknowledgments

The National Meeting Conference held in Campobasso was supported by a grant of Azienda Sanitaria Regione Molise (ASReM). We are grateful to Debora Del Re for her valuable technical assistance.

Conflict of interest statement

There are no potential conflicts of interest or any fi-

nancial or personal relationships with other people or organizations that could inappropriately bias conduct and findings of this study.

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Received on 4 July 2018.

Accepted on 5 September 2018.

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