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Psychoeducational group for acute psychiatric care. The Italian experience and suggestions for future needs

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Abstract

Introduction. The implementation of an innovative psychoeducational group intervention in Italian general hospital psychiatric units started in the years 2000-2001 in two Italian regions. The aim of this contribution is to describe the intervention method and the experience of its application, its spread, the results of evaluation studies and its evolution.

Method. The methodology is qualitative/quantitative. The qualitative approach concerns the description of the prevalent clusters of topics in the most used intervention modules. The quantitative approach concerns the analysis of indicators used in the evaluation studies carried out since 2000-2001.

Results. Over time, three topics of the intervention have remained constant: "What happened before the crisis"; "Stress-vulnerability-coping model"; "Psychotropic drugs: shared decisions". Other topics have been introduced based on the patients' preferences: "Psychophysical well-being", "Awareness", "Emotions-thoughts-behaviors connection", "Problem-solving" and "Stigma". The intervention has been applied over time in 15% of Italian psychiatric wards with positive results (main result: decrease in readmissions and restraints).

Discussion. Two main topics are discussed: a) the advantages and obstacles in applying the intervention; b) the need for addressing also the issues of substance dependence and antisocial personality.

Key words
- psychiatric hospital
- psychoeducation
- group intervention

INTRODUCTION

Services for acute psychiatric care are of a great importance for patients and their relatives, and use a significant budget of resources allocated to mental health all over the world. Despite that, for the most traditional service of the system of acute care, the psychiatric ward, according to Johnson *et al*. [1], a little attention has been paid to the explicit definition and discussion of its role and of its function. The same thing happened in Italy during the psychiatric care revolution, whereas we would have expected a greater integration, as well as a clearer definition of the role and of the function of the psychiatric ward allocated in General Hospital in the healthcare community. The conclusion of De Girolamo *et al*. [2] on a nationwide survey of acute inpatient services 20 years after the law 180/78 that changed psychiatric care was really dramatic. In fact, they stated that "*despite the importance, of acute in-patient care, its quantitative and qualitative features remain largely unexplored and many problems still await appropriate solutions and this holds true in Italy as elsewhere*". According to Thornicroft and Tansella [3] admissions to the ward were always judged as a failure of care, rather than a complementary pathway of care; at the same time the ward in itself has not been considered as an integrated clinical service playing a crucial role within a balanced mental health system. The Cognitive-Behavioural Group Intervention (CBGI) that we present here was conceived at the end of the 90s with the awareness of these critical issues and of some of the followings, as reported by Bazzoni *et al*. [4]. These issues have changed little in Italy and in the international context as recently elicited [1]: a) little at-

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tention has been given to the negative patient experiences as well as the feeling of emptiness and boredom during the day and to the trauma experienced due to hospitalization and to the separation from their environment; b) despair and depression arising from the forced cohabitation and from seeing other unwell patients without understanding their conditions, and stigmatization [5]; c) no interventions designed to reduce conflict and use of restrictive practices; d) no shared decision-making about drugs and plan of care after two days of admission; e) no structured psychosocial approach with the emphasis on the stressors related to the crisis. Moreover, two other aspects were considered lacking, although valuable for inpatients: giving as soon as possible a personalized meaning to the hospitalization as well as understanding what had happened before the crisis. These two aspects emerged forcefully in the various focus groups that two psychologists held with the inpatients at San Filippo Neri Hospital in Rome in 1998 [4]. In fact, for several weeks during the daily meetings, the two topics were the most prevalent and discussed; two other prevalent topics were the need of obtaining more information about psychopharmacotherapy and what to do to avoid relapses. In this respect, the professionals proposed among other domains of interest for interventions the topic of early warning signs that was also quite appreciated by patients. A first draft of the manual contained four topics, each of them daily used during the week, that were labelled as: "What occured before the crisis", "Stress-vulnerability", "Psychotropic drugs" and "Early warning signs". Although the developed group intervention described in three editions of a manual for professionals [5-7] had a psychoeducational matrix focusing on the communication of key-information with strategies belonging to cognitive-behavioural therapy it differs completely from traditional psychoeducation mostly based on the "diagnosis". It differs also from other group approaches generally based on the free discussion. In fact, this intervention has been conceived specifically for the acute psychiatric unit, starting each Monday of the week, with asking to each patient in the group "what had occurred in terms of mental and behavioral problems in the last days before admission" in order to obtain a list of "symptoms" to be written on the board visible to all inpatients. In this way, patients were encouraged to confront each other and to know some aspects of the condition of the others. We would like to underline that these two aspects are considered of great importance by experts [8, 9] as well as the collaborative approach that is receiving more and more attention [10-14]. Finally, it is important to pinpoint that this intervention emphasizes the true nature of psychoeducation, i.e., to extract (etimologically "*e*-ducĕre") the personalized information from the patient that is necessary for the therapeutic action, rather than to input information (to teach, etimologically "insĭgnare", just the opposite of "*e*-ducĕre"). The aim of this paper is to describe in detail the characteristic of the approach used in that group intervention and its evolution based on the preferences of patients and professionals, its spread, the results obtained in several studies, and the advantages and barriers of its implementation.

METHOD

Firstly, we briefly describe the main characteristics of the intervention. Secondly, the topics with the key-questions of some of them, and their evolution are summarised in four parts: the first concerns the years in which the manual had not yet been published, while the other three correspond to the three editions of the manual. Thirdly, the overview of the CBGI spread is summarised in accordance with periods which coincide with the three editions of the manual: 2004-2008; 2009-2014; 2015-2025 [5-7]. Data of the spread are in charge to the teams of Campobasso and Arezzo, accredited for the training of the professionals. In fact, it is possible to implement the CBGI in the wards only by an intensive training of the professionals, invited in turn to give routinely information about the activities/suspension of the intervention and eventually the reasons why the group is interrupted. For this paper we use also data obtained by a previous cross-national survey conducted in 2017 [15]. We would like to specify that data obtained by an *ad hoc* questionnaire regarding specific process or outcome indicators (see the list after in the Results section) filled by the centers for the survey in 2017 showed reproducibility when compared with data in charge to the team of Campobasso and Arezzo [15]. That means this data collected yearly are reliable and useful here as an update.

Main characteristics of the intervention

All admitted patients can participate to the daily meeting, which lasted 1 hour and 45 minutes with a break of 15 minutes. The suggested starting time for group meetings is 9.00 am, from Monday to Friday, every week, in order to dedicate some hours in the afternoon to the exercises assigned at the conclusion of the morning sessions. In fact, every session is structured in the following way: 1) presentation of the unit of work, 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 for the afternoon. These exercises are mainly personal-goal oriented and they are performed by inpatients with the help of the nursing staff in the afternoon. Solutions to the practical exercises of each session are reviewed in the next day session. Sessions follow a didactic treatment guideline presented in the manual for professionals. All rules and strategies are used in a flexible way. The main strategies are: a) encouraging direct communication and dialogue among inpatients rather than professionals giving information and advice to inpatients; b) Socratic questioning [16]; c) helping inpatients make connections between their thoughts, emotions and behaviors; d) normalizing symptoms; e) modelling and role-playing; f) positive reinforcement and constructive feed-back; g) structured problem solving; h) effective communication skills (i.e., expressing unpleasant feelings, active listening, expressing pleasant feelings, making requests). A well-trained professional (called the "conductor") with the assistance of another well-trained professional (the "co-conductor"), conduct the group sessions. The conductor's role

is mainly to ask the key-questions written in the manual for each topic and to stimulate a brief confrontation among patients, who are also invited to help some of them not yet "ready" to answer. It is possible to go to the next question only if answers are provided by patients and an agreement among them is reached; the role of co-conductor is to write the answers on the blackboards and to supervise the session.

Topics of the intervention and their evolution mainly based on the needs of patients

From 1999 until 2000 the intervention was applied only in the Ward of San Filippo Neri General Hospital of Rome by the two psychologists that conducted the focus groups in the previous year, with assistance of nurses. The topics were four as listed in the introduction. Generally, the topic of "psychotropic drugs" lasted more than one day. At that time, the topics were well detailed in an unpublished manual. The key-questions for each topic to be asked to each patient were the followings, in the order here illustrated:

- Topic 1. A) "How did you feel and behave before hospitalization?"; B) "What factors may have triggered the crisis?"; C) "What do these factors produce within us?", with the scope to obtain words like discomfort, tension, anger, irritation, depression, but above all the term "stress" or "distress" that is the "magic" word for the next question; D) "How can we define stress?" with the scope to share the following simple definition as an imbalanced condition that occurs between our coping skills and the problematic situations or stressful events that generate discomfort/distress within us;
- Topic 2. A) "What are the signs of stress?"; B) "Does everyone get stressed"; C) "Why do some people have a crisis when faced with the same stressful event, while others do not?" in order to introduce the concept of vulnerability and to the discuss in detail the scheme of diathesis-stress theory; D) "What does this excessive vulnerability depend on?" in order to discuss and to list the main causes such as biological vulnerability, personal characteristics and the use of ineffective strategies or difficulties in dealing with stressful situations;
- Topic 3. A) "What does psychotropic drug mean?"; B) "How do psychotropic drugs work?"; C) after that the co-conductor writes four categories of psychotropic drugs (antipsychotics, anti-anxiety, antidepressants, mood stabilizers) on the blackboard, the conductor asks each patient "What psychotropic drugs are you taking? What are they for? In which category would you put the drugs?". At the end of each answer the co-conductor fills them in the category; D) at this point, each patient is asked to prescribe the therapy himself and other patients are asked to rate the therapy indicated on its appropriateness and correctness about category and dosage. E) "How long should the therapy last?"; F) "What is the risk to suspend the therapy?"; G) "Why are drugs sometimes stopped?" in order to obtain a long list of reasons why the drugs were stopped; E) in accordance with the previous answer is asked "What can be done to counteract the reason for stopping medications?";
- Topic 4. A) "What are the early signs of crisis?"; B) "When you are under stress, do you notice some personal behavioral changes and if so, which ones?" in order to obtain a list of these changes; C) "Do you think it's easy to notice these behavioral changes right away, when we start to feel bad?" in order to obtain an obvious "no" as a reply; D) "Who could help us to recognize these signs?" in order to prompt collaboration with a key-person that could help them; E) "What can we do to cope with these signs?" in order to obtain a list of coping strategies; F) "Why is it important to recognize these signs and to cope with them?" in order to stress the importance to prevent relapses.

From 2001 to 2003 the intervention was applied also in the Ward of Campobasso by psychiatrists (mainly conductors) and nurses (mainly co-conductors). The interest in the approach was so high that many professionals participated to better understand the "health information needs" of inpatients during the several meetings. In the end, on the basis of the requests of inpatients, the following new topics were elaborated: alcohol, hallucinations, anxiety and fear, delusion and psychotic thinking, sadness and joy, anger, secondary advantages, suicide ideation, compulsory treatment. These topics were called "Optional" because addressed at discretion of the healthcare team based on the prevalent needs of hospitalized patients (for instance, if in a day there were more than 5 people admitted for alcohol problems or intensive anger). The original four topics were called "Basic". The first edition of the manual [5] was published in 2003; at the same time the Italian National Institute of Health (Istituto Superiore di Sanità, ISS), Rome, Italy on the basis of the first evaluative study [4] and of some outcome data of the Ward of Campobasso, decided to promote a national training for this approach and to collaborate to relevant future research projects.

From 2004 to 2008 in several centers that applied the intervention, professionals paid particular attention towards new needs of patients and were proposed other topics that were experimentally tested in these centers. One of them was considered as a "Basic topic" called "Personal goals and plan to achieve them". The main key-questions of the fifth basic topic are:

A) "I would like to list the symptoms present at the admission and those still present";

B) "I would like to know when you expect to be discharged on the basis of the symptoms still present";

C) "What pleasant goal do you think is possible to define and achieve in the following three months and what kind of goal is important to prevent a crisis?".

In addition to this, two optional topics were elaborated: "Physical well-being: diet and physical activity" and "Understanding and managing emotions". As a consequence, a new edition of the manual was considered useful and published in 2008 [6].

From 2009 to 2015 new needs emerged from patients and professionals. Patients admitted to different wards often liked to talk about the prejudice related to the mental illness. This topic was considered of great importance by professionals and it was particularly tested in the Ward of the Department of Mental Health of

Ferrara. Other three new topics were proposed; one of them, "Managing aggression", was proposed by professionals of the Institute of Psychiatry – University of L'Aquila to be addressed daily if there were in the ward at least two patients with this kind of problematic behavior. This topic, highly structured, is characterized by 5 psycho-educational sessions of 30-40 minutes to be held one every afternoon. The other two topics, "Awareness" and "Problem solving", were proposed by nurses of Acute Psychiatric Unit Care of the Department of Mental Health of Arezzo, to the patients subsequently hospitalized during a period of one year, who shared them with great interest.

As a consequence, a new and latest edition of the manual, updated both in structure and content, was published in 2015 [7]. The theme of prejudice gave origin to the topic "Stigma" considered as a "Basic topic" while the previous basic topics "Early warning signs" and "Personal goals and plan to achieve them" were considered optional. However, in this last manual there is an explicit recommendation for professionals to use the topic "Personal goals and plan to achieve them" as fundamental if there were 3-4 patients ready to be discharged in a few days. In fact, the name of the topic has been changed in "Discharge: individual goals at discharge". The "Managing aggression" topic is considered as "accessory" because is only treated with some patients in the afternoon and the other two topics, "Awareness" and "Problem solving", were considered "experimental" with the recommendation to further observe their usefulness.

From 2016 to 2025 the two centers responsible for the training of this approach (Campobasso and Arezzo) received many feedbacks and proposals by professionals of several wards applying the intervention to include new topics in the manual. The needs of professionals concerned the addition above all of "comorbidity" with personality disorders, the strategies to cope with antisocial personality disorder and problems with immigrants because of the significant prevalence of this kind of admissions.

Spread of the intervention

From 2004 to 2008, also as a consequence of national training, the intervention was applied in 8 centers in Northern, 8 in Central and 6 in Southern Italy. Three evaluative studies were conducted and published with good results and outcomes [17-19].

From 2009 to 2014 the intervention was interrupted or suspended for a long period of time (>1 year) in 3 wards in Northern, 3 in Central and 4 in the Southern Italy. On the other hand, it was introduced in other 2 wards in the North and 1 in the South of our nation. Other evaluative studies were conducted, discussed at congresses or published [20-24].

From 2015 to 2025 the intervention was interrupted or suspended for a long period of time (>1 year) in 4 wards in Northern, 2 in Central and 1 in Southern Italy. It was introduced in 12 wards in Northern, 3 in Central and 2 in Southern Italy. Several evaluative studies were conducted and published that demonstrate good results and outcomes [15, 25-29].

Finally, the CBGI has been introduced in 42 wards (22 in Northern, 11 in Central, and 9 in Southern Italy). However, it has been interrupted in 17 wards (7 in the North, 5 in the Center and 5 in the South). Thus, we can estimate that the intervention has been applied in 25 wards (15 in the North of Italy, 6 in the Center and 4 in the South).

As for the directors of the Mental Health Departments in which the intervention was implemented, 40% of them had a Cognitive Behavioral Therapy (CBT) and/or psychoeducational background; however, it should be added that 88% shared the Evidence Based Mental Health (EBMH) approach.

RESULTS

In this section, we present the results related to some indicators of the evaluation studies carried out by the several centers that applied the intervention, published in the journals or printed in the congress books where the CBGI has been discussed. We emphasize that in all the studies performed, except three [17, 25, 26] with a controlled non randomized trial, the study design was longitudinal pre-post evaluation with baseline data collected in the year before the introduction of the CBGI intervention; specifically, the authors compared data regarding specific processes or outcome indicators obtained before implementation and 12, 24, or 48 months after the implementation of CBGI. The indicators used in the studies were the following (*Table 1*): proportion of voluntary readmissions [4, 17, 19, 20]; proportion of compulsory readmissions [4, 18-20, 27]; time to relapse [25]; proportion of inpatients escaping from the unit [4]; proportion of restraints [4, 27]; number of violent and angry acts toward other inpatients and/or staff [4, 17, 27]; severity of psychiatric symptomatology [17, 28]; level of insight and awareness of psychiatric conditions [21]; level of specific competences acquired about the Behavioural Cognitive Group Intervention (BCGI) basic topics [28]; inpatient satisfaction [4, 17-19, 25, 26]; ward atmosphere [4, 18-22, 28]; cost and income. The indicators of psychopathology, aggressiveness, level of insight, satisfaction and ward atmosphere were measured by reliable tools, different among the various studies, the psychometric properties of which were reported in each paper by reference. Last but not least is the "Costs and income" assessed in terms of economic value based on the Diagnosis Related Groups (DRG) system, used as indicators of efficiency in Italy [19]. The main statistical measure used was the proportion, calculated as percentage of specific events which occurred (i.e., percentage of voluntary readmissions was calculate as the number of voluntary readmissions to the total number of admissions).

Indicators

The indicators area:

- reduction in percentage of voluntary readmissions was found statistically significant ($p<0.01$) in 3 out of 4 studies [4, 18, 19], but we pinpoint that the study by Travi *et al.* [20] did not show statistical significance; the minimum, -4.7%, at one year follow-up was ob-

served in Bazzoni *et al*. [4], the maximum -11% in Veltro *et al*. [19] where the indicator was measured also at 4 year follow-up with a reduction of 13%;
- reduction in percentage of compulsory readmissions was found statistically significant (p<0.01) in 3 out of 5 studies [4, 18, 19]; the reduction was quite similar: 45% [18] *vs* -47% [4]. However, the reduction was also observed in the other two studies as well as the comparison of the duration in days with the Compulsory treatment that decreased from 58 to 16 in the study by Bellini *et al*. [27];
- reduction in time to relapse [25] was found not statistically significant (hazard ratio 0.59, 95% CI: 0.13-2.75) in cases (exposed to psychoeducation) compared to controls (not exposed);
- reduction in percentage of inpatients escaping from the unit was found statistically significant (p=0.002) in the first and unique study that measured it [4] with a reduction from 12 (2.4%) to 1 (0.2%);
- reduction in percentage of restraints was found statistically significant (p=0.02) in the study by Bazzoni *et al*. [4] with a reduction from 12 (2.3%) to 2 (0.4%). This percentage decreased also in the other two studies by Veltro *et al*. [18] from 5 (the year before) to 1 in the following first and second year and by Bellini *et al*. [27] from 21 (six months before) to 1 in the following six months. They also conducted a controlled study and observed 6 restraints with a total of 66.7 hours of containment in the CBGI group *vs* 12 with a total of 386.1 hours in the control group;
- reduction in number of violent and angry acts toward other inpatients and/or staff was reported by Bazzoni *et al*. [4] with 211 violent episodes (41.5% - CI 37.2 - 46.0) in the previous year before CBGI implementation, and 121 (24.7% - CI 20.9 - 28.8; p<0.001) in the following year. They specified also the number of aggressive acts patient-to-patient (110 before *vs* 73 after) and patient-to-staff (101 *vs* 48). In the study by Travi *et al*. [20], the number of violent acts decreased from 13 to 4, 1, 0 in the last three years of follow-up. Massaro *et al*. [17] observed 22% aggressive acts in the experimental group (BCGI) against 77% in the

Table 1
Indicator, measure collected, and difference between, before and after the implementation of CBGI (D), with the Authors of the cited studies

Indicator	Measure collected	D	Authors
Voluntary readmission	Percentage	-3.03	Travi *et al*. [20]
	Percentage	-4.7	Bazzoni *et al*. [4]
	Percentage	-11	Veltro *et al*. [18]
	Percentage	-13	Veltro *et al*. [19]
Compulsory readmission	Percentage	-45	Veltro *et al*. [18]
	Percentage	-48	Veltro *et al*. [19]
	Percentage	-48	Bazzoni *et al*. [4]
	Absolute value	-42	Bellini *et al*. [27]
Time to relapse	Hazard ratio	0.59	Mattei *et al*. [25]
Escaping from the unit	Percentage	-2.2	Bazzoni *et al*. [4]
Patients with restraints	Percentage	-1.9	Bazzoni *et al*. [4]
	Percentage	-6.1	Veltro *et al*. [18]
	Absolute value	-6	Bellini *et al*. [27]
Violent acts	Percentage	-16.8	Bazzoni *et al*. [4]
	Percentage	-55	Massaro *et al*. [17]
	Absolute value	-13	Travi *et al*. [20]
Psychiatric symptomatology	Average (SD) at BPRS	-10.82 (12.7)	Massaro *et al*. [17]
Satisfaction for the care	Percentage	73%	Bazzoni *et al*. [4]
	Average (SD): rating 1-5	4.6 (0.8)	Veltro *et al*. [18]
	Average (SD): rating 1-5	4.4 (0.8)	Veltro *et al*. [19]
	Average (SD): rating 1-5	3.3 (0.9)	Tarallo *et al*. [26]
Ward atmosphere	Percentage	+38	Bazzoni *et al*. [4]
	Average (SD): rating 1-4	+1 (0.8)	Veltro *et al*. [18]
	Average (SD): rating 1-5	+1.5 (0.5)	Veltro *et al*. [19]
Cost and income	Diagnosis related group (DRG value expressed in euro)	+€ 360 (in four years)	Veltro *et al*. [19]

CBGI: Cognitive-Behavior Group Intervention; SD: standard deviation; BPRS: Brief Psychiatric Rating Scale.

control group; also the average of aggressiveness was statistically significant (p<0.0001);

- decrease in severity of psychiatric symptomatology in the pre-post (admission *vs* discharge) study conducted by Massaro *et al*. [17] was found statistically significant by comparison in the group that received BCGI (p<0.001) but not in the control group (p=0.054). Instead, in the study by Zucca *et al*. [28] there were no differences on the Brief Psychiatric Rating Scale among patients that received the CBGI and patients that did not participate to the group. However, the authors wrote that four months after discharge there were no readmissions for the patients involved in CBGI, while among patients that did not partecipate to the group 13 readmissions (19,7%) with 4 compulsory treatments were observed;
- improved levels of insight and awareness of psychiatric conditions, measured by the Insight scale, was found improved as declared by Adami *et al*. [21] at the "II Conferenza Tematica Nazionale" congress, although they did not report data in the abstract-book;
- improved levels of specific CBGI basic topics competences for all four topics at p<0.005 statistic significance and especially for the psychotropic drugs topic [28];
- high Inpatient satisfaction was found in every study. In Bazzoni *et al*. [4] satisfaction was 73% for the care, 81% for the staff and 91% for group usefulness. In Veltro *et al*. [18] at two-year follow-up the average (code 1 to 5) was 4.6 (p<0.01) for "care received", 4.7 (<0.01) for "availability of professionals when needed by patients", 4.7 (p<0.001) for "helpfulness of professionals", 4.6 (p<0.001) for "information received" and 4.6 (p<0.01) for "activities in the afternoon". These results were quite similar and statistically significant (p<0.001) at 4-year follow-up [17]. In the study by Massaro [17], the difference of satisfaction was found statistically significant between patients that participated to the CBGI and patients that did not participate (p<0.001); the difference was explained by sex (significant for male, but not for female). Mattei *et al*. [25] reported only a qualitative description given by patients at discharge of the CBGI as "useful", that they would "attend it in the future again", and that the "group topics were not difficult", but did not show data. In Tarallo *et al*. [26] the satisfaction for CBGI was found, in all the items of the questionnaire they used, higher and statistically significant (p<0.01) compared to that observed in a sample of control treated by another group intervention;
- improvement in ward atmosphere was found +38% since the first study [4]. In the study by Veltro *et al*. [18] the difference between year baseline and all subsequent 4-year follow-up was statistically significant (F=115.7; df=4; p<0.001). In Travi *et al*. [20] nurses rated over a period of three years the ward atmosphere as good/very good 83% of time. The ward atmosphere was found improved as declared by Adami *et al*. [21] and by Dosa and Cavicchio [22] at the same congress although they did not show data on the abstract-book. Zucca *et al*. [28] reported that 87.5% of patients rated the ward atmosphere "excellent" or "good" after the CBGI implementation;
- "Costs and income". The economic mean value of DRG increased from € 2,450 in 2001, to € 2,514 in 2002, € 2,540 in 2003, € 2,606 in 2004, and to € 2,810 in 2005 [19].

Finally, we have also to pinpoint the participation of about 80% of inpatients to the group as described by Gigantesco *et al*. [15] and reported by the teams of Campobasso and Arezzo.

DISCUSSION

The National Institute for Health and Care Excellence (NICE) guidelines [30, 31] recommend structured psychological therapies during the acute phase of many severe mental health problems and, at the same time, emphasize the need to improve psycho-social culture of care in wards [15, 32, 33]. Nevertheless, the current approach remains dominated by psychiatrists through the traditional ward round model, similar to the surgery unit, and by the use of psychotropic drugs only. This is probably due to many factors. First of all, many studies that investigate the effectiveness of non-pharmacological approaches to managing acute illness are not reported in the scoping or systematic reviews [34]. We regret to have to point out that the studies selected ranged from 16 to 29, with great difference in interventions; very few compared with a very large number of psychiatric wards in the world! This could also be due to, on one hand, dearth of funding for this kind of research; on the contrary, there are many studies about the psychotropic drugs efficacy often supported by pharmaceutical companies. On the other hand, the evaluation of non-pharmacological approaches in psychiatric ward is problematic for many reasons, including both difficulties to carry out a randomized control study (RCT) and to check for many different variables. In fact, in the review of Wood *et al*., [35] about the individual or group CBT for inpatients the risk of bias for the randomization was assessed for 18 trials out of 23 papers reported. Furthermore, blinding of participants and research staff is the linchpin for this study design, but impossible to ensure within trials of psychological interventions in the ward as participants and therapists know what therapy is being delivered. As a consequence, the same review [35] estimated that "all RCTs had at least one area at high risk of bias, and seventeen RCTs had at least two". This narrow focus of studies could therefore underestimate the interest for non-pharmacological approaches, their spread and also their good impact on the care in the ward. Bearing this in mind, we have to be optimistic looking to the literature on non-pharmacological interventions for psychosis adapted to inpatient settings, which is greater than reported in the review of efficacy. It is slowly increasing in recent years but a great transformation in acute settings has not yet been created [35]. Another problem concerns the nature of non-pharmacological interventions since most of them are structured on the basis of specific diagnoses like bipolar or schizophrenia disorders, and therefore difficult to organize in the first phase of admission. For instance, the study of Chen *et al*., [36]

on the bipolar disorder well underline this aspect: "Participants were referred to the program when their clinical symptoms were alleviated, as defined by Young Mania Rating Scale (YMRS) score of less than 8, and during their discharge period"; too late in our opinion considering that the length of admissions are decreasing all over the world and in the USA it is actually estimated less than 10 days [37]. We should also consider that for the spectrum of schizophrenia the lack of insight about symptoms and judgment at admission is too compromised in 70% of patients and show improvement after days of treatment [38]. This problem emerged more clearly for people at the first episode [39]. In fact, 40% of them declared that in the acute phase, after they have been admitted to a psychiatric hospital, they did not remember much of the conversations about the diagnosis. The phrase of a patient that could be considered as an epigraph in this qualitative research is "I think they have told me before, but I was psychotic at that time. I just don't have a clear memory of it". Finally, it is time to consider that during the crisis period the biomedical narrative is misleading because of the lack of insight; furthermore, it could have a counterproductive effect of reducing the person's locus of control and sense of empowerment with its message that the disease is responsible for their experiences [39]. These considerations are confirmed by an interesting survey made by Phillips [40]. He found a high satisfaction of inpatients for the psychoeducational group characterized by "safety planning, coping with stress, positive self-talk, relapse prevention, spirituality, and creative expression". In some way, these results are similar to those found by Morgan *et al*. [41] that "supports research which suggests that psychological interventions can help people make sense of a crisis and lead to changes at an interpersonal and intrapersonal level". Our approach appears much pertinent with the previous statements since it stimulates the participation asking inpatients "what occurred before the admission?". In this way patients talk about their feelings, their experienced state of mind, their behaviour and their life events. In the second day, dealing with the impact of stress factors, their personal way of reacting to them and their personal vulnerability, seems as a "second episode" of their tale. That means "normalizing the crisis", reinforced by all participants regardless of diagnosis, and also prompting a "meaning of what happened" giving them a sense of reality. We emphasize that "to find a meaning" is encouraged by authors of recovery process [42, 43] since 1993 [44] and it is described as one of the best key-factors in the scoping-review of recovery [45]. The way the topic of psychotropic drug is performed in our CBGI is also attractive for patients because of the collaborative approach based on a pair-to-pair learning, very similar to shared-decision-making approach [45]. Finally, this is the very nature of psychoeducation by asking and actively listening to patients' opinion rather than telling them information, that is psycho-didactics. All these factors probably improve adherence and awareness about the stress-vulnerability model as observed by professionals and reported by Adami *et al*. [21]. The attractiveness of the group is confirmed by the data of participation around 80% reported in the results paragraph. Many evaluative studies showed the effectiveness of our approach about the voluntary and compulsory readmissions as well as of the reduction of aggressive acts and of seclusion. We are aware that other specific effective strategies are available to reduce aggressions, conflicts and seclusion [46] but we believe that it could be easier to apply them, and probably in a more effective way, in a good "ward atmosphere" [47]; however, we need more research [48]. Since these practices concern a team-level intervention to avoid or mitigate potential conflicts resulting from patients-patients and staff-patients interactions, the need to improve engagement of patients and the culture of care on wards has also been emphasized [48, 49, 32]. Again, CBGI demonstrated good results on ward atmosphere in all studies that assessed it [4, 19-22, 28]. In many studies considering satisfaction about CBGI, it was found very high [14] and statistically significant [4, 17-19, 26]. Patient satisfaction has a very long tradition of interest in mental health [50, 51], also for inpatients [52-54] and it has been closely linked to ward atmosphere [47, 48], considered as correlated with "global functioning at discharge, improvement during treatment, and positive interactions with staff" [52]. To date, as we have shown, the CBGI seems to be effective to meet many needs of inpatients, and to contribute to a good quality of care on the basis of pertinent indicators. Considering the data collected by the teams of Campobasso and Arezzo, new needs of users and professionals have to be considered and addressed. Three of them are pressing and require immediate responses. One is the problem of addiction because of its prevalence and "comorbidity" above all with personality disorders. That means a new optional topic should be elaborated and studied. To our knowledge, nurses and technicians of rehabilitation of the team of Psychiatric Ward of University of Brescia are working on it [55]. The key-questions of addiction as elaborated by this team are: A) "When is addiction a problem?"; B) "What are the negative effects caused by a substance?". The answers are categorized in "physical", "mental" and "social"; C) "What does craving mean?"; D) What strategies can be implemented to cope with addiction?". The answers were useful to personalize the care plan and to be used by professionals of community mental health center after the discharge. They found preliminary good results by the process evaluation and thus they are currently considering to carry on a trial. Another need regards people with antisocial behaviour and with measure of legal restriction, who are being more and more frequently admitted to psychiatric wards, especially in Italy after the closure of forensic psychiatric hospital. We propose to integrate effective strategies as Safewards [56] or Six Core Strategies [57] with the Accessory Topic "to manage aggression" of CBGI. Something similar for the patients with antisocial personality disorders or with a high prevalence of violent/aggressive behaviours was made by the team of Department of Mental Health of the fifth area of Rome that manage three Residences for the Execution of Security Measures. They use [29] some topics of the CBGI, optimal strate-

gies to deal with violent behaviour [58] and some topics regarding literacy emotion of another effective intervention called InteGRO [59, 60]. The last need regards immigrants. In this case we believe that the problem is linked to the scarce presence of cultural mediators in the ward; a more structured presence of mediators would probably improve the feeling of participation and integration with other inpatients. The presence of different operators and professionals is one of the current debates [61] since the psychiatric ward is actually dominated by the presence of nurses and psychiatrists. A critical point is the continuous delivering of CBGI that by our qualitative survey and by the survey of Gigantesco *et al*. [15], it is applied in many wards two/three times per week or interrupted sometimes for months/years or permanently.

We think that the most important issue for CBGI and for other structured psychosocial interventions for inpatients concerns the barriers to delivering them extensively as described by Evlat *et al*. [33] and summarized in hospital environments and multidisciplinary staff factors. In our country, based on our large experience and by our surveys three factors appear prevalent: the role of ward's director, the organizational problems and the predominant *medical*/pharmacological approach. We observed that in many Italian psychiatric wards the CBGI was interrupted in conjunction with the turnover of the unit's director on the basis of his personal training, often different from cognitive-behavioural therapy or psychoeducation. As this is the only approach investigated for process, outcome and cost indicators in Italy, that means we are very far from applying Evidence Based Mental Health (EBMH). We suggest then that "formal" guidelines for professional accreditation should be adopted to introduce routinely these interventions linked to the budget system. The second problem frequently outlined by many staffs concerns the difficulties to implement the group because of lack of professionals in the wards. We believe that this problem is strictly linked to the third one, because often the director wants to maintain the traditional ward round model. The CBGI as proposed by the authors is not compatible with the traditional medical model, as it offers a much better opportunity; that is to see the interactions among patients for a long period of time and in this way to collect psychopathological observations in a more effective and efficient way. The third problem is the lack of training for psychiatrists/nurses in psychoeducational interventions, in psychological therapies as well as in approaches of *salutogenesis*. We believe it is time to give more importance to *salutogenesis* also for inpatients because it is promising for recovery [60]. Consequently, we are convinced according to McAllister *et al*. [32] and Weich *et al*. [62] that the care for inpatients can improve by listening to the patients' voice as well as by group interventions based on the transdiagnostic approach [37] like the CBGI.

CONCLUSION

This paper gives a large view about the nature, the spread, the results observed in many studies of the CBGI of Vendittelli *et al*. [7], about the importance of psychosocial interventions for inpatients and of the impact of these interventions on the ward atmosphere and on the users' satisfaction. We are aware that there are no RCT of the CBGI, that most studies have a follow-up with an internal control study design, some with a group of comparison and some are without a control group; these factors limit the interpretation and the generalizability of the results. Nevertheless, there are few studies about the psychosocial interventions as complained by Hawes *et al*. [37]. At the same time, there are many obstacles that limit the spread of CBGI, often interrupted for a short/long period of time or permanently, as well as other psychosocial interventions. Many of these factors are due to the hospital environments, to the organizational problems or to the staff; in our opinion the responsibility of the consultant as well as the lack of the explicit definition of role and the function of psychiatric ward are prevalent. On the other hand, the CBGI has received great interest in Italy and in the international literature as also demonstrated in the recent "call for action" of Hawes *et al*. [37], where two papers [18, 19] about this intervention were cited twice. Undoubtedly, in Italy the CBGI has been widely applied, the request for training is constant as well as for support to activate it, and many studies have been conducted even if not RCT. We can pinpoint that there is abundance of literature on CBGI effectiveness, characterized by several study designs and indicators, by several authors (mostly not involved in the elaboration of the intervention) and in different places of Italy. As we wrote in the discussion paragraph, we have many doubts about the feasibility of RCT to evaluate the effectiveness of ward group approaches. However, the CBGI contrasts the medical model and creates a psychosocial culture in the ward [15], consistent with the same model used in the mental health community centres all over the world. Finally, the CBGI is also "clinically" more accurate because of the transdiagnostic approach, based on a dimensional model and focused on the clinical as well as life variables.

Authors' contributions

FV: conceptualization, data curation, formal analysis, methodology, writing – original draft, writing – review and editing; GL: methodology, supervision, writing – review and editing; US: data curation, writing – review and editing; LZ: supervision, writing – review and editing; GA: methodology, supervision, writing – review and editing.

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