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The Communication Group: bringing group psychotherapy back to acute in-patient psychiatry

SUMMARY
People who are admitted to acute psychiatric wards need psychological as well as pharmacological treatments, but psychological care is not always available in the acute setting. Group psychotherapy can prove a practical and cost-effective answer to this unmet need in service provision. We describe a psychotherapeutic group that our team has implemented on our busy, inner-city, male-only acute ward, which has been running successfully for over 2 years and has since become an integral part of the acute care we provide to our in-patients. Group therapy can enhance individuals' adherence to treatment plans, reduce reliance on pharmacological approaches, pre-empt untoward serious incidents and potentially reduce patients' duration of stay. In addition to addressing the psychological needs of acutely unwell people, group therapy is beneficial to the clinical team by promoting a better work and therapeutic environment on the ward.

Following the advent of newer community services (Smith, 2003; Johnson *et al*, 2005), inner-city acute wards now operate under unremitting pressure, admitting for shorter lengths of stay patients who are increasingly unwell (Dratcu, 2006). Although medication is almost always the first line of treatment, psychotherapeutic interventions may be as important but are not always available. Group therapy can successfully address this need in service provision if tailored to this setting. We describe a psychotherapeutic group we have developed to suit the needs of the adults admitted to our busy, inner London, male-only acute ward.

Group psychotherapy, a neglected therapeutic tool

Psychological treatments should play a crucial part in mental healthcare but are not always accessible to those admitted to acute in-patient units, precisely where psychological approaches may be most needed (National Institute for Health and Clinical Excellence, 2005). As psychology services have never been available to our unit, a 18-bed acute ward that admits over 200 male patients a year and where bed occupancy consistently exceeds 100%, our pro-active occupational therapists have endeavoured to provide psychological input for our patients by offering a range of programmes, from community and educational groups to physical activities. With a view to promoting a better therapeutic milieu on the ward and further improving our standards of care, we thought we could use our own home-grown experience to implement a more formal model of psychological care that was compatible with both our setting and our resources. Group psychotherapy seemed a promising option.

Group psychotherapy in the acute setting has been virtually abandoned in recent years. Increased work pressure, changes in working practices and financial constraints may all be to blame. As a result, in-patient mental health teams may now be reluctant to implement a useful therapeutic activity with which they may no longer be familiar. Moreover, most models of out-patient group therapy currently on offer cater predominantly for people with neurotic or personality disorders who undergo lengthy selection procedures, and are therefore difficult to replicate in the acute setting. As is the case in our service, individuals who are admitted tend to be severely ill, typically suffering from psychotic or major affective disorders which are often complicated by substance misuse and an array of social and legal problems (Dratcu *et al*, 2003). Many are compulsorily admitted and may be seen as too unwell or unmotivated to engage in a therapeutic group. In search for a practical solution to our quest, we revisited different models of in-patient group therapy, including Yalom's (1983, 1985) and Kanas' (1996, 2000).

Planning group psychotherapy

Yalom's model

Models that are based on specific diagnostic categories (e.g. schizophrenia), such as Kanas' (1996), would be

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unlikely to cater for the clinical diversity of the individuals who are admitted to our unit and who otherwise could benefit from group therapy. In contrast, Yalom (1983, 1985) had previously designed a format of group therapy specifically for the acute in-patient setting that is largely unconcerned with diagnostic boundaries and that was commonly used in past years. Rather than aspiring to accomplish overly ambitious goals, the main purpose of Yalom's in-patient group is to facilitate interpersonal interactions among the patients themselves and between the patients and the clinical team, their families and their friends. It also aims at helping individuals to understand better their current difficulties, both inside and outside the hospital environment. This model prescribes group sessions 5 days a week, lasting 75 min and ideally involving six to eight patients each, that should be facilitated by doctors and nurses, and where each session is seen as a 'single entity'.

Yalom suggested six basic achievable goals for in-patient group therapy: engaging patients in the therapeutic process; demonstrating that talking helps; problem spotting; decreasing isolation; being helpful to others; and alleviating hospital-related anxiety. Facilitators must adopt a clearly pro-active role and ensure that the group feels safe and constructive. Unlike some forms of out-patient group therapy, in-patient group therapy should avoid or dispel conflict and tension, as on acute wards the aim to provide a containing environment takes precedence over the scope for confrontation or expression of anger.

Preparing the team

Yalom's model seemed to offer us some major advantages. First, its eclecticism appeared to suit the heterogeneous clientele that we see on our ward. Second, we could capitalise on the existing skills and motivation of our team to implement it, while the team could develop and practise new skills in the process. Third, relying on our own workforce to provide psychological care to our patients meant that there was no need to recruit external therapists who, at any rate, would be unfamiliar with the ward. Finally, expertise for supervision was available from another local service, which we could approach for this purpose.

The senior manager of our local group psychotherapy day service agreed to supervise a core team of six facilitators from our ward. Medical participation was seen as essential from the outset to consolidate the group and make it truly multidisciplinary, and also to demarcate its place in our clinical routine. In addition to the associate specialist, nurses, support workers and the occupational therapist, all of whom had some of experience of group work, volunteered to join the project.

In the course of several preparatory meetings between the supervisor and the facilitators, Yalom's model was discussed in the light of our circumstances, and adapted accordingly. Although we were unable to offer group sessions on a daily basis, we agreed that we could provide group psychotherapy sessions on a weekly basis. Once the group was established, two to three facilitators should participate in each therapy session, whereby one experienced facilitator would initially lead the group assisted by at least one inexperienced one. Thereafter, facilitators would change each week so that all could hone the relevant skills. We also agreed that supervision sessions, covering facilitation methods as well as organisational and practical matters, should henceforth continue regularly every 2 weeks and be attended by as many facilitators as possible. Finally, to effectively convey the purpose of the group to our patients, we decided to call it the Communication Group.

The group begins and evolves

After the team of facilitators felt ready to start, posters were displayed on the ward informing in-patients about the Communication Group, which would meet once a week. People were invited to join by members of the team or when seen during ward rounds. The need for screening procedures was reconsidered after individuals who at first were thought unsuitable to participate eventually proved able to contribute positively to the sessions. From then on patients were excluded only if they were felt unlikely to stay for the duration of the meetings or likely to pose a risk of harming themselves or others during or after the sessions. Most were invited to attend as soon as they had been admitted.

Two months after its launch, the Communication Group had established itself as a landmark in the ward's therapeutic programme. We had to expand our core team of facilitators to at least eight people to ensure that enough facilitators were available each week, which has been made possible by coordinating the group activities with the nursing shifts. The group has now been running successfully for 2 years, during which period it has held over 100 weekly sessions. Well over 200 different patients have participated on at least one occasion.

Group sessions

From the beginning, the Communication Group sessions have adhered to the same format and been held in a designated room on the ward itself, to attract and encourage participation. Each session lasts 50 min and starts with a clear statement by the main facilitator explaining its purpose, how long it will last and that participants do not have to talk if they do not wish to. Then all participants are invited to introduce themselves in turn. In the attempt to introduce 'here and now topics', the facilitators may ask individuals to briefly mention the reasons for which they think they have been admitted to hospital, unless patients spontaneously indicate other topics they may wish to address. During the last 5 min, all participants, including the facilitators, are invited to comment on the session and on what has been learned from it. At the end of each session, the facilitators meet for a further 15 min to discuss the proceedings. The progress of the group and of the facilitators is reviewed in supervision sessions every 2 weeks.

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The number of patients varies up to a limit of ten, averaging eight per session, and no two sessions have included exactly the same people. Most sessions run smoothly and almost spontaneously, when conversation usually flows easily and individuals respect each other's turn to speak. On some occasions, however, facilitators have to play a more active part and, at times, keep the group focused on 'here and now issues'. For example, skilled facilitation has prompted participants to confront major factors contributing to admission, such as alcohol and substance misuse, that otherwise would be unlikely to be fully addressed elsewhere. Of note, there has never been any aggressive or serious incident in the group and relatively few people have ever 'walked out' from the sessions, even though they are allowed to leave if they feel uncomfortable. Very rarely has someone been requested to leave for being disruptive to the activities.

Group psychotherapy: welcomed by patients, embraced by the clinical team

By offering our patients the opportunity to safely disclose and debate critical issues on a structured and regular basis, and our multidisciplinary team the opportunity to develop and practise newer therapeutic approaches at the workplace, the weekly group sessions have clearly fostered a therapeutic environment on the ward.

Audit is ongoing, but there are preliminary indications that the Communication Group has played a prominent part in improving people's satisfaction with hospital treatment and reducing the number of untoward serious incidents on the ward. It may have also contributed to both enhance patients' adherence to their treatment plans and reduce reliance on pharmacological treatments, particularly 'as required' prescriptions. To our multidisciplinary team, participating in the Communication Group has represented an educational experience that is unlikely to be available elsewhere. As the growing number of facilitators feel empowered to apply their newly acquired skills into other aspects of our clinical routine, the gains to the service have extended beyond the weekly sessions alone. Not only do facilitators feel more actively involved with patient care, and with the whole therapeutic process that defines hospital care, but their input is valued by the clinical team at large. This has promoted a sense of team identity and boosted morale which, in turn, has generated a better work environment, to the benefit of all.

Now that the group has consolidated, nursing students and trainee doctors are also encouraged to take part, thereby enriching their training with practical communication and psychological skills that they may use in a range of professional settings. The Communication Group has also attracted interest from other acute services, including requests from colleagues both within and outside our own Trust to attend as observers.

Psychological care on acute wards: group psychotherapy as the way forward?

The benefits to patients of psychological care on a structured and regular basis as part of hospital care was acknowledged in the best traditions of psychiatric hospitals of a not-so-distant past (Wing, 1990). No less should be expected from a modernised mental health service, but this is not usually on offer on today's acute wards. Current practice favours behavioural methods that focus primarily on the management of disturbed behaviour (National Institute for Health and Clinical Excellence, 2005), yet the psychological needs of acutely unwell people go far beyond those that can be met by de-escalation techniques and similar *ad hoc* strategies. If anything, the effectiveness of such approaches in preventing potentially violent situations serves as a clear reminder of the scope for psychological interventions in the acute setting, where the vast majority of individuals are not always agitated.

Implementing group psychotherapy in the acute setting involves some obvious challenges. The first is the task of motivating the team and attracting enough facilitators, as additional time and effort will be required, at least initially, from clinical teams already coping with heavy workloads. Second, it is crucial to negotiate high calibre supervision regularly as well as medical participation from the outset, yet qualified supervisors may not always be available. Third, any such project needs careful planning before it is launched. The Communication Group could start and evolve only after we adjusted an established model of group therapy to the constraints of our setting, with all the preparation this entails. Finally, it should be seen as a formal part of the ward's clinical routine, and one that requires commitment from the team in the long term so that it remains appealing and attractive to individuals who are admitted. From the patients' perspective, the motivation to attend is bound to be largely associated with the expectation that the sessions represent a positive and valuable experience. The group is always mentioned in the ward's daily planning meetings and our nurses personally invite individuals to attend on the morning prior to the sessions. Yet, perhaps a chief factor contributing to patients' continued attendance is that many of the ward staff are themselves the facilitators, including one of the senior psychiatrists.

By optimising existing resources and adapting Yalom's model to our acute setting, our team was able to introduce weekly group psychotherapy to our ward, thereby devising a practical and cost-effective way of providing psychological care to our patients as an integral part of their hospital care. Our experience has also shown that acutely admitted patients who are severely unwell, as is the case with our clientele, may all not only potentially engage with group therapy but also actually gain from it within the context of the six goals delineated by Yalom. In the group sessions, staff and patients talk openly about aspects of their treatment. Patients are encouraged to bring their concerns for discussion and explore the rationale for their treatment, and are also

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given the opportunity to question staff about this. The team, in turn, has benefited from a better and more rewarding work environment.

Formal scrutiny of this and other indices, such as the impact of the Communication Group on patients' duration of stay and satisfaction, still needs to be completed. Moreover, as individuals' participation is automatically terminated once they are discharged from the ward, the implications of this are unclear. Similar forms of psychological care are unlikely to be offered in the community to those who wish to continue attending the group. However, rather than being a shortcoming of the Communication Group, perhaps this should be seen as a reflection of shortcomings in the provision of psychological care to these people in the community. Whether group psychotherapy could fill in this gap in the community as well as in the in-patient setting is also a question that warrants further scrutiny.

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Declaration of interest

None.

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Road testing programme budgeting and marginal analysis: Norfolk Mental Health pilot project

AIMS AND METHOD
Programme budgeting and marginal analysis (PBMA) is a recognised tool for commissioning healthcare. The objectives of this project were to test the acceptability, data availability and practical value of PBMA within the sphere of mental health. The PBMA methodology was applied to the consideration of Norfolk Primary Care Trust's National Health Service expenditure on mental health for the fiscal year 2006/7.

RESULTS
The project successfully attracted the interest of, and contribution from, important stakeholders with the exception of general practitioners. The process led to the identification of areas for disinvestment, releasing funds to be made available for the development of new services, or enhancement of existing services.

CLINICAL IMPLICATIONS
Programme budgeting and marginal analysis is a useful structured tool for the commissioning of mental health services. It is essential, however, that psychiatrists fully engage with the process in order to have an influence over the future direction of mental health services.

Programme budgeting is a technique designed to identify how much money has been invested in major health programmes (Brambleby *et al*, 2007). Information concerning levels of investment in mental health and other healthcare areas can be found on the Department of Health website (www.dh.gov.uk/en/Managingyour organisation/Financeandplanning/Programmebudgeting/index.htm). Marginal analysis is an economic appraisal that evaluates incremental changes in costs and benefits when resources within a programme are increased, decreased or deployed in different ways (Brambleby *et al*, 2007).

The practical application of programme budgeting and marginal analysis (PBMA) has been described by Ruta *et al* (2005). The approach can be broken down into five essential steps. Steps 1 and 2 establish the total resources available and identify services on which these resources are currently spent. They allow for the relevant programme budget to be calculated. Step 3 involves identifying potential services as candidates for receiving

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