**Abstract**

**Background:** Adult mental healthinpatient units primarily provide a service for people deemed to be at significant risk to themselves or others, where treatment cannot be provided safely in the community. Whilst psychological interventions are indicated during episodes of acute mental distress, they often remain psychoeducational and skills based in nature. A common complaint remains amongst those admitted that there is a lack of psychological provision at a time of crisis when they most need to make sense of their difficulties **Aims:** This article reports on service user’s experiences of open group cognitive behavioural therapy where participants choose the therapeutic targets across acute inpatient units as part of routine care. **Method:** A totalof75 patients admitted to acute inpatient wards over a six month period accessed open group cognitive therapy as part of their care. Participants completed an evaluation questionnaire that measured their experiences of the group and the usefulness of them within an inpatient setting. **Results:** A total of 27 participants completed anonymous questionnaires (36%) and the results indicated that participants felt understood, respected and accepted within the group and felt that the group setting was helpful for sharing experiences. In addition, all participants reported that following the group they would be more likely to access psychological therapies in the future. **Conclusions:** Open group therapy where participants define the therapeutic targets each session is feasible and achievable on acute inpatient units and patients report finding this effective.It also appears that this format increases the likelihood of patients accessing further psychological therapies.

**Introduction**

Cognitive Behavioural Therapy (CBT) is an empirically validated form of psychotherapy, which has been shown to be effective in a wide range of psychiatric conditions (Beck & Weishaar, 2000). As such, CBT has continued to receive widespread support and has been successfully embedded into clinical services worldwide (Bieling & Kuyken, 2003; Clark, Beck and Alford, 1999). Traditionally CBT was designed and practiced in an individual format, however even the original treatment manual for depression developed by Beck made reference to the exploration of a group approach in order to treat more patients in a given time (Hollon & Shaw, 1979). Delivering group therapy can offer as much as 50% greater efficacy when compared to individual therapy (Beiling & Kuyken, 2003; Morrison, 2001). This in turn offers both financial and clinical time implications for services, where more than ever there remains an unmet psychological need with services often oversubscribed and with limited access to psychological therapies (RCPsych, 2008; NHS England, 2016).

The UK governments five year forward for mental health (NHS England, 2016) acknowledged the inequality that exists within the current mental health service. The rapid expansion of improving access to psychological therapies (IAPT) services in recent years has meant that nine out of ten adults with mental health problems are supported within primary care services with waiting times for accessing psychological services reduced to days. However for those who are supported by more specialist secondary and tertiary services, there remains long waiting times to access NICE recommended treatments, particularly psychological therapies (NHS England, 2016).

Admissions to inpatient units in the UK remain stable but it is reported that the severity of need and the number of people being detained under the mental health act continues to increase (NHS England, 2016). Inpatient admissions are costly to the NHS, highlighting a need to reduce bed occupancy days and improve rates of readmission and recovery. However, between 1998-2012 available inpatient beds reduced by 39%, resulting in a rise in the threshold for admission (Brooker, Ricketts, Bennet, Limme, 2007); but also shorter, repeated admissions for those with severe mental illness (SMI) and serious risk of harm to self or others. This has subsequently created changes for inpatient units and how services are delivered with the quality of care provided heavily criticised by service users and staff with many wards described as being over occupied, unsafe, un-therapeutic and not conducive to recovery (Greenwood, Key, Burns, Bristow & Sedgwick, 1999; Rose 2001; NHS England, 2016).

Current NICE guidance recommends patients have access to evidenced based interventions such as CBT to facilitate recovery, particularly for those diagnosed with SMI such as Schizophrenia (NICE, 2010), Personality Disorders (NICE, 2009), Bipolar disorder (NICE 2006) and complex trauma (NICE 2007), conditions which are common on acute inpatient units (British Psychological Society, 2012). Whilst evidence of the effectiveness of psychological intervention on acute inpatient units is limited, research has suggested that when CBT was offered to patients with a diagnosis of Schizophrenia during admission a 25-50% reduction in recovery time was observed (Drury, Birchwood, Cochrane & McMillan, 1996). Whilst historically group CBT has been delivered as a multiple session protocol, individuals in crisis often just want someone to talk to; someone to take their situation seriously and to help them to make sense of it (Vivyan 2013; Durrant, Clarke, Tolland & Wilson, 2007). Therefore, conventional methods of group CBT that rely on diagnostic specificity (e.g. depression or anxiety) with set numbers of sessions are not particularly well suited to the acute ward with varying presentations and unpredictable length of stays. With this in mind standalone sessions have become of increasing interest (Clarke & Wilson, 2009; Radcliffe, Hajek, Carson & Manor, 2010), with research so far demonstrating positive results when sessions have focused on a pre-set therapeutic target chosen by the therapist (e.g. anxiety, low mood, assertiveness). These groups included a range of cognitive techniques including psychoeducation, identifying and challenging thinking distortions and coping skills (Fell & Sams, 2004; Veltro et al., 2006; Durrant, Clarke, Tolland and Wilson, 2007).

Open group therapy provides a more flexible framework whereby members are free to join and leave as they wish and attendee’s define the therapeutic target at the start of each session, meaning there is no pre-set goal or psychoeducational structure. There is a gap in the current literature on running an open ongoing CBT group. Simon (1994) report finding the experience of facilitating an open CBT group for ‘non-psychotic’ inpatients stressful; in particular not knowing who would attend the group, who may have already left the unit and if the intervention could actually increase distress. However, Simon (1994) stated that the open group helped to promote patients problems solving skills and fostered personal responsibility. Raune & Daddi (2011) also reported that open CBT group therapy where participants chose the therapeutic target was acceptable and feasible within inpatient units. The standalone format that allows inpatients to choose the treatment target is rarely reported on in the literature and therefore remains empirically untested. The rationale for choosing the ‘standalone’ group format in this evaluation came from service user feedback after accessing CBT psychoeducational groups. Whilst patients attended the groups and engaged, it appeared to have little effectiveness outside of the group setting and patients reported being unable to apply the skills they have learned due to the acuity of their difficulties, highlighting more of a need to reflect and make sense of an experience and contain a crisis. Therefore, this paper aims to evaluate the feasibility and acceptability of Open CBT Groups on Adult Inpatient Units.

**Method**

**Participants**

A total of 75 patients attended groups over a six month period (Male 68%, Female 32%), which equated to 40.5% of all acute admissions during this period. All patients were adults with an age range of 21-71years (M=43.5), 92% of participants (n=69) were of White British origin. Of those that attended the group 30% attended on more than one occasion (n=23), with the average number of attendances per patient being 1.3 (SD=0.6). In addition, of those that attended the group 46% (n=35) also attended individual sessions with a clinical psychologist or psychotherapist, meaning that 54% (n=40) of participants would not have otherwise received any access to talking therapies during their acute admission if they had not attended the group. No further demographic information was collected.

**Ethics**

The evaluation was conducted as part of routine care and authors abided by the ethical principles of psychologists and the code of conduct as set out by the APA. The evaluation was conducted in accordance with local NHS trust policy.

**Therapist**

The group was facilitated by a qualified and accredited cognitive behavioural therapist and supported by another member of the multidisciplinary team, which included occupational therapists, associate practitioners and health care staff.

**Procedure**

CBT open group sessions were delivered as part of routine care on two acute treatment units, the first an adult 18 bedded all-male treatment unit and the latter a 15 bedded adult mixed sex assessment and treatment unit. The groups were open to all patients regardless of diagnosis and occurred once a week per unit for between 40-60 minutes.

The group format followed a standard CBT structure (Beiling, McCabe & Anthony, 2006; Vivyan 2013) and started with introductions, confidentiality and ground rules. Patients were briefly socialised to the model of CBT and an agenda was set as a group. This involved patients deciding on the problems that they would like to work on, or if no one offered this then a generalised topic that they wished to focus on. The group was very much focussed on the ‘here and now’ and the therapist utilised Socratic questioning techniques (Padesky, 1993) to inform a basic group formulation allowing group members to make their own links and think about how they may have responded in the situation. The therapist introduced some didactic psychoeducation and introduced cognitive change techniques, such as generating alternatives, weighing up the evidence and reviewing pros and cons, which were then implemented as a group. Patients were encouraged to discuss their own problems and any challenges or disagreements were discussed and actioned within the group. The final part of the session involved feedback and exercises to effectively close the session e.g. mindfulness and relaxation.

**Measures:**

A group evaluation questionnaire was developed to assess patient’s experiences of the open CBT format using a 5 point Likert scale (1= strongly disagree, 5= strongly agree). Participants were asked to indicate on the scale how strongly they agreed or disagreed that ‘I felt understood, respected and accepted in the group’; ‘I found the group useful for sharing experiences’; I have learnt something useful that will help me in the future’ and ‘I am more likely to engage in psychology sessions in the future’. Participants were also given the option to provide further comments. Data was also collected on themes chosen to discuss within the group and the attendance and re-attendance rates. The questionnaire was given out to participants immediately after the group, completion remained optional and confidential.

**Results**

Participants rated the group along a 5 point Likert scale with most scores indicating that participants either agreed or strongly agreed that ‘I felt understood, respected and/or accepted in the group’ (M=4.7, SD=.59), ‘I found the group helpful for sharing experiences’ (M= 4.5, SD=.73), ‘I felt that I have learnt something useful that will help me in the future’ (M=4.3 SD=.95) and ‘I am willing to engage in psychology sessions in the future’ (M=4.6, SD=.6).

*Fig 1: Graph showing participant responses.*

**Psychological themes**

The main psychological themes that were discussed within the group included feeling invalidated disempowered/vulnerable, paranoid and negative thinking; suicide and self-harm including addiction, relationships with staff and experiences of care, emotions as overwhelming and intolerable and coping strategies. The most commonly discussed themes were experiences of care and emotions as overwhelming and intolerable.

***Other feedback***

As part of the evaluation qualitative data was also obtained through an optional ‘additional comments box’ on the evaluation form. The feedback overall was positive, participants stated that “*The session was very helpful allowing me to express my thoughts and feelings without worrying about judgement”,* that ‘*The group really helps me open up’* with feedback further highlighting how the group format is helpful in developing awareness of difficulties e.g. *‘Sharing other peoples’ experiences has helped me identify negative behaviours that I also have’.* It was noted that the CBT group also helped people to re-familiarise themselves with CBT techniques for those that had engaged in therapy previously ‘*I found it useful to recap areas of CBT’.*

**Discussion**

The present article aimed to report on the usefulness, feasibility and patient experiences of an open CBT group format on acute inpatient units. Initial feedback indicated that the group was feasible, acceptable and that participants felt respected and understood. The groups had high levels of attendance with many individuals attending more than one session. Participants indicated that they felt that they had learnt something that would be useful for them in the future. Furthermore, attendees reported that they found the group format useful for sharing their experiences with qualitative feedback highlighting how the group ‘helped them to open up’ and share thoughts and feelings without fear of judgement’, indicating how the sharing of experiences helped to facilitate self-reflection. Interestingly in every session participants were able to choose something they wished to focus on and the recurrent themes such as experiences of care, relationships with staff, feeling vulnerable, disempowerment and invalidation were not topics previously incorporated into standalone psychoeducational sessions. This suggests that an open group format is more reflective of clinical need and offers a more dynamic approach that’s fits firstly with the CBT model and its emphasis on the ‘here and now’ but also with the acuity and unpredictability of the inpatient environment. The findings from the present study support previous research, which tested the feasibility, acceptability of a similar group CBT format and reported patient related effectiveness measured by participants ratings of enjoyment, usefulness, and likelihood of re-attendance (Raune & Daddi, 2011).

The implementation of psychological groups within an inpatient setting is not without its barriers, which within the current study centered on the inpatient environment. Whilst the service lends itself to a dynamic approach, the clinical unpredictability and heterogeneous population can result in disruption and difficulties in obtaining co facilitators from the multidisciplinary team; particularly at times when clinical activity is high. In addition the clinical acuity and unpredictability of the topics discussed would require a cognitive behavioral therapist that had a broad range of experiences within secondary services.

Finally it is useful to note that of those that attended the group 54% (N=40) would otherwise not had access to psychological intervention during their admission to a treatment unit. This supports the idea that group CBT intervention is one way of increasing access to psychological intervention at a time where there remains a lack of psychological provision within secondary services.

**Limitations & Future research**

This evaluation provides support for open group therapy where participants choose the therapeutic target each session. However, a limitation of the current study is the lack of pre and post empirically validated measures as participants views of the group do not provide evidence that participants went on to utilise CBT skills effectively outside of session, or that the group had any impact on validated measures of distress, symptom reduction or bed days. Therefore future research should focus on measuring clinical outcomes in comparison to a control group to assess the clinical effectiveness of the intervention. Furthermore, it is useful to note that those who experienced the group more positively may have been more likely to complete surveys. Future evaluations could consider strategies to engage all group participants.

Finally, Participants that attended the group reported being more likely to engage in 1:1 psychological intervention, therefore future research may consider any relationship between attendance at group sessions and future engagement in psychological interventions post discharge.

**Conclusion**

Implementing open group CBT therapy on acute adult inpatient units is feasible, acceptable and participants report finding it useful for reflecting on and expressing their thoughts and feelings. The current evaluation highlights how this method of service delivery provides a flexible way of delivering on NICE guidance and effectively meets the needs of the inpatient environment.

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