The Frontline Reports column features short descriptions of novel approaches to mental health problems or creative applications of established concepts in different settings. Material submitted for the column should be 350 to 750 words long, with a maximum of three authors (one is preferred), and no references, tables, or figures. Send material to Francine Cournos, M.D., at the New York State Psychiatric Institute (fc15@columbia.edu) or Stephen M. Goldfinger, M.D., at SUNY Downstate Medical Center (steve007ny@aol.com).

Guided Peer Support Groups for Schizophrenia: A Nursing Intervention

Whereas peer support groups are frequently available for patients with all kinds of chronic diseases, they do not usually form part of the care program for people who have schizophrenia. Still, schizophrenia patients have a professed need to talk to each other in a group as peers and discuss daily life problems.

In the 1990s, we set up peer support groups for people with schizophrenia. These groups initially were guided by a nurse but with the idea that the participants would take over the guidance as soon as the group process had taken effect. However, in the absence of outside guidance, the groups tended to lose momentum. This development prompted us to create a "minimal guidance" group structure.

We developed our own manual—*How to Support Peer Groups for Schizophrenia*—because there was no methodology available. Furthermore, we did a pilot study, followed by a randomized controlled trial, to compare the effectiveness of peer support groups with groups receiving care as usual (article in press). Peer support groups should not be confused with self-help groups or self-help therapy in which the mental health professional has a more active role.

The aim of peer support groups for these patients is to share experiences with each other about how to cope with daily life after a psychotic episode. Our group involves 16 sessions of 90 minutes each, conducted once every two weeks. A group consists of about ten patients and one professional. The professional is preferably a nurse, as the intervention appeals most to people with a nursing background. The group sessions are offered as a service for both inpatients and outpatients.

The guided peer support group methodology acknowledges the problems that patients with schizophrenia encounter when they take part in a group session, which are associated with their cognitive and social disabilities. To this end, each session starts with asking the participants to form pairs, and this is followed by a plenary discussion. This procedure enables as many participants as possible to interact with each other, because people with schizophrenia often have difficulty talking in groups.

The presence of a nurse in the group is crucial. In all sessions, the nurse offers structure, continuity, and a sense of security, without actively interfering with the group process; the key point is to provide peer-to-peer interaction. Therefore, each nurse is trained in the guided peer support group methodology.

All sessions are structured in the same way. First, people are encouraged to work in pairs to exchange positive experiences from the previous two weeks (ten minutes). Next, all pairs share with the group the stories they just heard (ten minutes). Then the nurse initiates the general discussion by asking, "What have you just heard that could be of interest for the whole group?" Next, the participants choose the theme of the session (five minutes), briefly introduced by the nurse (two minutes). The themes should relate to the illness, for example: living with schizophrenia, telling others about your illness, or resuming your job. After a 15-minute break, they share their experiences about the theme in pairs (15 minutes), participants reconvene for the final plenary session (25 minutes). At the end, the nurse briefly summarizes the session (eight minutes).

Preliminary analysis of the data from five groups reveals that the participants and nurses evaluated the methodology positively. In their experience, the structure of the sessions supported the patients' participation in the group. Participants judged the presence of a nurse as meaningful and preferred this guidance above peer guidance. Also, they found the biweekly gathering to be convenient and the sessions of sufficient length. The intervention clearly met their expectations, and most of all, they felt supported by other participants. Nurses reported that the structure of the sessions provided participants the opportunity to tell their own story.

The manual sets out in detail the recruitment procedures and logistics and describes the protocol of each meeting. It is available for the cost of duplication and mailing through the first author.

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Supported Education for Adults With Psychiatric Disabilities

The Bridge Program is a supported education service for adults with psychiatric disabilities who wish to pursue postsecondary education or employment. Because the onset of psychiatric disability commonly occurs in late adolescence and early adulthood, many people with psychiatric disability have difficulty completing high school and entering postsecondary education or employment. Conse-

quently, many possess gaps in their basic educational knowledge and lack interpersonal skills needed to succeed in the student or worker role.

The Bridge Program consists of 12 classroom-lab modules, each lasting two hours. They include training programs, degrees, and work options; study skills; time management skills; effective reading skills; basic writing skills; basic computer skills; introduction to Internet skills; basic math skills; library resources; public speaking strategies; professional behaviors and social skills; and stress management tools. An hour of one-on-one mentoring follows each two-hour module. Mentors help participants to explore available educational and job training programs, complete application forms for specific schools or training, complete financial aid forms, study for the GED or school or job placement tests, and use customized compensatory strategies to enhance school and work performance. The program is held twice weekly over a six-week period. Participants who complete the program and become actively engaged in school or vocational pursuit are offered an additional six weeks of mentoring to facilitate a successful transition to the student or worker role.

To participate in the program, individuals must possess a tenth-grade reading and writing level and be fluent in English. Individuals having an active substance use disorder are ineligible to participate until they can demonstrate six consecutive months of sobriety.

The program was tested for effectiveness with 38 participants who were randomized to an experimental (21 participants) or control group (17 participants). The experimental group attended the 12-session Bridge Program and received treatment as usual at their mental health facilities. Control group participants received only treatment as usual at their mental health facilities during the six-week study. The Bridge Program was implemented in the occupational therapy program at Columbia University; both faculty and graduate-level occupational therapy students participated as instructors and mentors. Data were collected before and after the program, with follow-up at one month and six months.

Recruitment occurred at three outpatient mental health facilities in the New York metropolitan area. The participants, 22 men and 16 women, ranged in age from 19 to 55. Most participants were Hispanic (15 participants, or 39%), African American (14 participants, or 37%), or Caucasian (eight participants, or 21%). Psychiatric diagnoses included schizophrenia (16 participants, or 42%), schizoaffective disorder (11 participants, or 29%), bipolar disorder (six participants, or 16%), and depression (five participants, or 13%). The highest education level achieved for most participants was a high school diploma or GED (22 participants, or 58%). Eight participants (21%) completed some college. Another eight participants (21%) did not complete high school. No participants were currently employed.

Sixteen (76%) of the 21 experimental group participants completed the Bridge Program. At a six-month follow-up, ten of these 16 participants (63%) had enrolled in some form of educational program or job training, had obtained employment, or were in the process of applying to a specific program in the next year. Only one of 17 control group participants (6%) reported being involved in school or work; he was involved in school coursework.

The results suggest that the program helped participants to increase their skill level in basic academic areas, improve professional behaviors and social skills needed for school and work settings, and gain confidence to test their skills in the larger community. Factors that correlated with success in the program included adherence to a medication routine ($r=.70$, $p\leq.001$), possession of a stable residence ($r=.64$, $p<.001$), and motivation to attend the program regularly ($r=.84$, $p\leq.001$). Diagnosis, prior educational level, number of hospitalizations in the past five years, age of illness onset, and parental education level had no relationship to success in the program. Data collection at a one year follow-up is planned.

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