

# Voices of Youth and Families: Community Integration of Transition-Age Youth

## Introduction

This project addresses the priority of community integration (CI) for youth and families, as well as the key program themes of youth and family participation, stigma reduction, recovery, individualized planning, and successful transitions. The project is designed to gain understanding of community integration of youth as they transition from receiving services in the children's mental health system to the adult system from the perspectives of youth, young adults, and caregivers. RTC project staff will develop a participatory research team with youth and family research assistants and advisors and will conduct focus groups to gain understanding of CI. This participatory methodology will allow us to explore the relationship of CI to stigma, recovery, youth and family participation, and empowerment from the perspectives of youth and families.

Project Goal: To gain understanding of community integration from the perspectives of transition-age youth, young adults, and caregivers.

### Project Objectives:

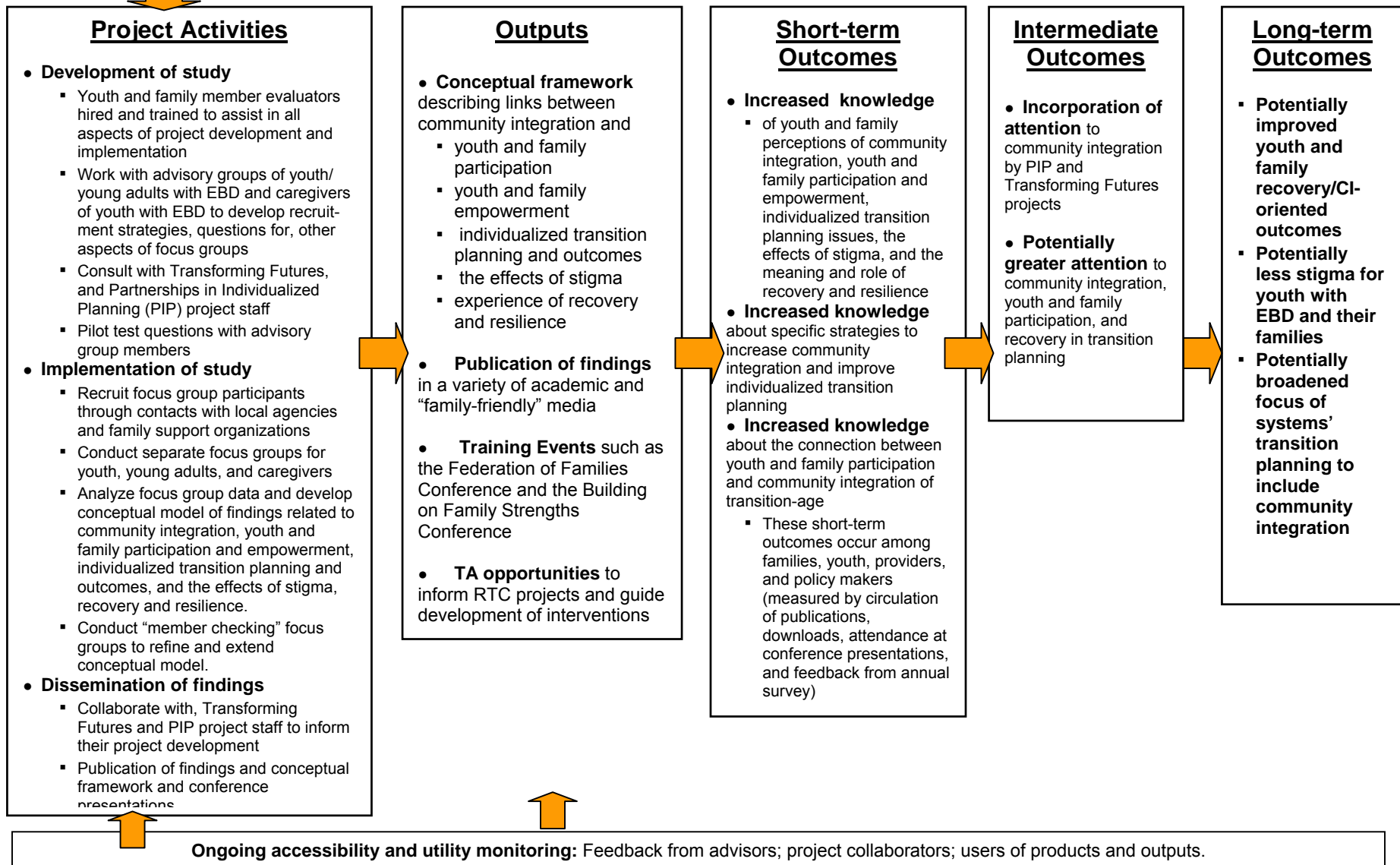
1. To gain youth, young adult, and family perspectives on the meaning of community integration (CI) for transition-age youth with emotional and behavioral disorders (EBD) across domains of living.
2. To gain youth, young adult, and family perspectives on social, psychological, cultural, and economic barriers to CI, including the effects of stigma.
3. To gain understanding of supports for CI, the relationship between resilience/recovery, empowerment and community integration.
4. To gain understanding of the roles of families in supporting transitions to adulthood for youth with EBD.
5. To inform RTC projects, especially the *Transforming Futures* and *Partnerships in Planning (PIP)* projects about youth, young adult, and family perspectives on CI and youth-adult transitions.

In the past, mental health professionals determined the outcomes that would guide their work with individuals. With the advent of a service delivery paradigm incorporating consumer and family participation and empowerment, there has been a shift to individualized or person-centered outcomes. This approach requires professionals to play two distinct roles: first, that of learner; second, that of facilitator (Gardner, 1999). Therefore learning must precede any decisions about what role the professional might play in the provision of supports and services. Project objectives are aimed at the first role: learning about the lived experience of youth and families in dealing with the challenges to achievement of optimal CI, and documenting approaches and supports that young adults and their families have used effectively to navigate the transition to young adulthood. This qualitative study of youth and family members perspectives will be conducted in the first year of the RTC and findings will assist in the development of the *Transforming Futures* and *Partnerships in Planning (PIP)* projects.

The project builds upon previous Center research on barriers to family participation in services (Kruzich, Jivanjee, Robinson, & Friesen, 2003), unique perspectives of African American families on participation in out of home mental health placements for their child, (Kruzich, Friesen, Williams-Murphy & Longley, 2002), development of a family empowerment measure (Koren, DeChillo, & Friesen, 1992)) and educational/individualized service planning (Friesen & Pullmann, 2002). In addition, theoretical and empirical literature on community integration of adults with serious mental illness and youth transitions to adulthood inform project design.

**Figure (R-1.1) Community Integration Logic Model**

**Inputs:** This project addresses the absolute priority for community integration (CI) as well as key program themes, including: participation, recovery, and stigma. This project builds on existing organizational capacity derived from previous studies of youth and family experiences of family participation in service and educational planning and ongoing work focused on youth transitions to adulthood.



## Literature Review

### **Communities and Community Integration**

As a central concept in NIDRR's Long Range Plan (1999), community integration (CI) refers to the extent to which individuals with disabilities participate fully in community life. The goals of CI are to optimize the ability of people with disabilities to fulfill activities of daily living (physical integration), to engage in social interactions with non-disabled community members (social integration), and to feel a sense of belonging in their communities (psychological integration) (Aubry & Myner, cited by Prince & Prince, 2002). CI includes both objective elements (e.g., activities outside the household, contact with neighbors and others) and subjective elements (e.g., feelings about the meaningfulness of social contacts, attitudes about one's sense of belonging, availability of help, feelings of influence, and emotional investment in the community and community members) (Aubry, 1996; Minnes et al., 2001; Prince & Prince, 2002). A major emphasis in CI is on individually experienced concepts like options, choice, control, empowerment, self-determination, independence, and participation (Lakin, Hayden & Abery, 1994; Nelson, Lord, & Ochocka, 2001; NIDRR 1999). While the integration of youth with serious mental, emotional, and behavioral disorders and their families in the community has not been an explicit focus of research to date, research findings on community integration of adults with serious mental illness and other populations with disabilities are relevant.

The earliest studies of community integration were based on samples of adults with serious mental illness who resided in community residential facilities. Segal and Aviram (1978) examined the influence of client, facility, and community characteristics on community integration of residents of board and care facilities. They found that community characteristics were the most important set of predictors; these characteristics included neighborhood response to clients, complaints to authorities, location of facility, and distance of facility from community resources. Important individual characteristics included whether the consumer had chosen the facility and clients' perception of sufficient spending money. A second study of adults residing in community-based facilities established that residents' levels of both community integration and self-sufficiency were strongly influenced by the degree to which the facility maintained an individualized approach to care. (Kruzich, 1985; Kruzich & Berg, 1985). Segal and Aviram's and Kruzich's studies also noted that age was related to significant differences in types and levels of community integration.

The 90's witnessed increased attention to client empowerment and growth in the importance of peer/consumer-focused and delivered services. Greater attention is now being paid to alternative models of care with some evidence that strengths-based models lead to significantly greater improvements in terms of symptoms and life satisfaction than traditional case management approaches (Barry, Zeber, Blow, & Valenstein, 2003). A second study used in-depth interviews with mental health consumers and focus group interviews with varied stakeholders to determine how three organizations' shift to a greater emphasis on empowerment, community integration and social justice influenced agency consumers (Nelson, Lord, & Ochocka, 2001). Increased participation and involvement in the community was a result noted by all stakeholder groups who identified three different aspects of community, the consumer/survivor community, human services, and the community-at-large. Findings indicated the greatest change in consumers' participation was in the community at large, with consumers more involved in leisure activities, churches, and with friends and families. A recent study by Hardiman and Segal (2003) underscores the potential roles of self-help agencies in supporting community integration among adult consumers with serious mental health issues. Using a social network analysis methodology, their results indicate that consumers involved in self-help agencies (SHAs) that extended control and decision making to consumers had higher self-esteem and were more likely to include fellow

SHA participants in their networks. These findings from community integration studies of adult with serious mental health problems sensitize us to a variety of individual, organizational and community factors that can inform our efforts with youth and their families.

Like others, youth and young adults with mental health needs belong to multiple communities of place, such as neighborhoods, school districts, and metropolitan areas, as well as multiple communities of identification and interest, and these may overlap. A youth's "personal community" denotes her/his membership in a mix of communities in which s/he engages in social interactions and gains goods and services to achieve social and economic well being (Fellin, 2001, p. 69). The effects of stigma and discrimination, in contrast, are segregation, social isolation, and limits on community participation (Mackelprang & Salsgiver, cited by Fellin, 2001; Prince & Prince, 2002).

CI is an implicit goal of community-based services for children and youth with mental health needs. At the service delivery level, a focus on CI requires a shift in planning toward individualized supports rather than "one size fits all" services, with choices available, and with the locus of control in the youth and family. In the future, "the effectiveness of service providers, researchers, policymakers, and advocates will increasingly be judged by their ability to assist [individuals with disabilities] to actually live the life-style they envision" (Lakin, Hayden & Abery, 1994, p.15).

### **Developmental Issues for Transition-Age Youth**

Developmentally, youth and young adults with serious emotional and behavioral disorders experience the same transitions as their non-disabled peers. According to Erik Erikson (1968), adolescents are in the stage of identity vs. diffusion, in which they develop a sense of their personal identity, emphasize peer group relationships, experiment with new roles and activities including high risk behaviors, and lay the foundation for transitioning into adulthood. From approximately age 18 to 25, the stage of emerging adulthood is characterized by exploration of possible life directions related to intimate relationships, employment, and beliefs about the world (Arnett, 2000). During this developmental stage, achievement of goals of social competence, academic achievement, and socially acceptable conduct is predictive of adult success (Roisman, Masten, Coatsworth, & Tellegen, 2004). For youth and young adults with disabilities, however, progress in these developmental stages and toward these developmental goals may be complicated by the presence of the disability. A disability may be a developmental risk factor, and its effects are related to the complex interplay of individual factors such as the visibility, level of severity, duration, and personal perceptions of the disability, with contextual factors, including social isolation, poverty, and family stress (Oschwald, 2001).

According to Gill (1997), the identity development of young people with disabilities has been impeded by community stigma and oppression, resulting in separation from the wider community. In response, youth and young adults have distanced from mainstream society to focus on group affiliation and personal integration. Achieving preferred levels of social integration includes four possible types of integration identified by young people with disabilities: coming to feel we belong (integrating into society, particularly with other young adults); coming home (integrating with the disability community); coming together (integrating sameness and differences); and coming out (integrating how we feel with how we present ourselves) (Gill, 1997).

## **Community Integration and Transition-Age Youth with EBD**

Prolonged use of restrictive residential and inpatient services is antithetical to CI; even in the shift to community-based services, however, the combined effects of stigma, poorly coordinated, developmentally inappropriate services, and weak transition planning efforts have constrained youth with EBD and their families from achieving their preferred levels of CI (Delman & Jones, 2002; Collins, 2001; Vander Stoep, Davis, & Collins, 2000; Federation of Families for Children's Mental Health, 2001). Furthermore, opportunities for this group of youth and young adults to participate optimally in community life are compromised by low employment rates, below average post-secondary educational achievement, above average involvement with juvenile justice, and ongoing difficulties managing thoughts, feelings and behaviors (Blackorby & Wagner, 1996; Davis & Vander Stoep, 1997). Thus, a distressing proportion of youth with EBD become "disconnected youth" (Levin-Epstein & Greenberg, 2003), who struggle on the margins of their communities, without work, without stable housing, without supportive relationships, and often in trouble with the law.

Recovery from early onset mental illness, described by a youth who consulted with us in developing this proposal as "feeling whole again," does occur. Young adults living with mental illness have recounted their own and their peers' journeys through adolescence and young adulthood, describing their successful search for meaning, vocation, and a sense of belonging (Farmer, 2002; Handler, 1998; Simon, 2002). Their stories highlight the value of appropriate diagnosis, sound information and treatment options, and unconditional support from caregivers, family members or service providers. Such autobiographical literature supports research and theory on the closely-related concept of resilience for adolescents and young adults with and without identified disabilities (Collins, 2001; Howard & Johnson, 2000; Werner & Smith, 2001), that posits the importance of unconditional acceptance by a caring adult and connection to positive community activities as two of several potential protective factors that can ameliorate risks. Research on developmental assets (Scales & Leffert, 1999), confirms the role of additional internal and external factors that promote recovery of adaptive developmental trajectories in the presence of risks, including EBD.

Families can be significant sources of support in transitions to recovery in adulthood (Hatter, Williford, & Dickens, 2000); at times, however, family members still report being ignored, blamed or otherwise discounted in planning and actions for their teen and young adult children's future (Federation of Families for Children's Mental Health, 2001; Friesen et al., 2001; Gordon et al., 2003). Moreover, balancing support for emerging independence with parental values, preferences and needs is challenging for many families; these challenges are compounded by the effects of stigma youth and families often associate with being labeled as mentally ill, along with systemic issues of adequate and relevant services (Davis & Butler, 2002).

Best practices in holistic, individualized supports and services for transition-age youth with EBD include the Transitional Community Treatment Team model (Bridgeo, 1997), and the Transition to Independence Process (TIP) (Clark, Deschenes, & Jones, 2000). Model youth transition programs like these share principles of person-centered planning, comprehensiveness, coordination, unconditional commitment, skill building, and being oriented toward individual and systemic outcomes. Research on school-to-work supports and services for youth with EBD (Benz, Lindstrom & Yovanoff, 2000; Bullis & Cheney, 1999; Carter & Wehby, 2003) reinforces the importance of these principles, finding, for example, that completion of self-determined transition goals was highly associated with improved graduation and employment outcomes, and that youth value personalized, persistent attention from helpers. Clark and Foster-Johnson (1996) offer a useful conceptualization of the life domains that

supports and services should span, and in which community integration takes place. Setting-based domains are employment, living situation, and educational/training opportunities; a fourth domain, community-life adjustment, incorporates the skills and activities that are relevant across all domains (for example, learning skills of emotional regulation affects a young person's ability to fit successfully into work and educational settings, and to live in a community setting). We propose to build on and extend the existing evidence-base on transition-age youth and their families; the following sections detail how we plan to do so.

### Hypotheses/Research Questions

This exploratory study is the first study explicitly designed to gain understanding of community integration of transition-age youth with emotional or behavioral disorders from the perspectives of youth and families themselves. For this exploratory, descriptive qualitative study, hypotheses are not appropriate, for our aim is development of a theory of community integration for this population of youth and their families.

Open-ended questions will elicit family and youth definitions of CI, the key elements of CI, their perspectives on optimal CI, and the factors that promote and impede optimal CI. The focus of questions will be on integration with both geographic and associational communities. Probes will explore participants' perspectives on stigma and resilience/recovery.

### Methods

#### **Design**

The project will use a focus group methodology to explore CI from the perspective of youth and young adults with mental health disabilities and their families. The goal will be to develop understanding of the phenomenon, and develop a conceptual framework to inform other proposed projects. Focus groups are an ideal research method for examining similar subjective experiences and to allow mutual shaping and extending of participants' ideas (Morgan 1988). Another strength is that individuals are likely to feel less vulnerable in a group than in a one-to-one interview and feel a greater degree of control, relative to individual interviewees, over how much they feel under pressure to contribute to the discussion (Farquhar, 1999). A limitation is that findings cannot be generalized. However, we believe that qualitative research using a focus group methodology will permit exploratory study and theory building.

Another limitation of focus groups is that the natural flow of conversation is altered. Some participants may dominate and "group think" may result in more consistency in responses than might be found in individual interviews. The facilitators actively seeking divergent experiences and points of view will address this issue. On the other hand, focus groups offer the opportunity for participants to hear the perspectives of other participants and thereby extend the complexity of their personal reflection and analysis (Morgan, 1988). A key assumption of the focus group literature is that individuals with common concerns and experiences will be more willing to share viewpoints and disclose personal information (Jarrett, 1993). We expect that youth and young adults will feel more comfortable discussing their experiences and perceptions with other young people than they might in individual interviews. In consultation with the project advisory committee, we will take into consideration youth diagnoses, age, ethnicity and gender to help ensure that focus group members perceive a commonality of concerns and experiences with other members of the group. Participants' comfort level will be

increased by focus groups being co-facilitated by a trained youth research assistant family research assistant

First, the team will undertake literature reviews on CI and the issues affecting youth with serious emotional disorders as they transition into adulthood. We have identified youth/young adults, caregivers, and professional experts on youth transitions who are willing to participate in project advisory groups. We will seek the input of the advisory groups about the optimal age range and mix of focus group participants, recruitment strategies, research questions, and appropriate language to explore domains of community integration.

Based on issues of concern identified in the literature and by the advisory groups, we will develop focus group questions. The project will use separate focus groups of youth, young adults, and caregivers to gain understanding of CI and to identify barriers and supports to preferred levels of CI. We are particularly interested in the effects of stigma and perceptions of resilience and recovery. Questions will also examine the choices and control available to youth, youth self-determination and empowerment, and the ways that families support youth transitions to adulthood. We will invite participants to attend “member checking” focus groups in which we will present preliminary findings and seek verification and extensions of findings.

### **Family and Youth Project Participation**

As mentioned above, we will form advisory groups of youth/young adults and family members who negotiated this transition in recent years or are currently engaged in the transition. In writing this proposal, we have consulted with three mothers of transition-aged young adults with EBD (Jennifer O'Connor, Kathy Larrabee, and Sandra Bumpus). Youth advisors have all had significant involvement with mental health services, and all are currently successfully negotiating the passage to adulthood; at present, they include Melanie Green, Heather Fay, Alex Kigerl, and Vito Spadavecchio. We plan to consult with members of these advisory groups in the planning phase of the project to gain their ideas about recruiting focus group participants and the appropriate focus and wording of questions. We will also seek their feedback on emergent findings during the course of the study, to ensure that findings make sense and are relevant to the lives of young people and their families. Near the conclusion we will gain advice about appropriate formats and media for dissemination of findings of the study to multiple audiences. Membership of the advisory groups will include representatives of culturally diverse youth and families.

We will hire a youth researcher and a family researcher who will be trained to participate in all project activities. The decision to recruit youth and family researchers is based on the assumption that this will improve the relevance of the study and the quality of findings; it is also based on the Center's values and commitment to system of care principles that call for consumer involvement in all aspects of research, evaluation and service delivery. There is evidence that collaboration with youth and families in research improves the quality of research because studies are more likely to answer questions of interest to them (Turnbull, Friesen, & Ramirez, 1998). Additionally, when family members act as data collectors, participant retention is increased and more complete and more accurate information gathered (Federation of Families, 2001; Osher & Telesford, 1996; Vander Stoep, Williams, Jones, Green, & Trupin, 1999). The youth and family co-researchers will be trained in focus group research methodology and their training will address the ethical aspects of research and issues related to confidentiality.

## **Collaborators and Advisors**

We will collaborate with local family support organizations, including the Oregon Family Support Network and the National Alliance for the Mentally Ill (Oregon Chapter) in recruiting focus group participants and arranging focus group logistics (see letters of support in proposal appendices). Staff of King County Mental Health, Chemical Abuse and Dependency Services Division's Health 'N Action! partnership and their partner organizations, United Voices, A Village Project, and SAFE-WA (Safety, Advocacy, Family, Empowerment for Washington) have also expressed willingness to assist us in recruiting focus group participants and arranging focus group meetings (see letter of support). In addition, Stephanie Lane, MSW, program manager at Children and Families in Common, at King County Mental Health, Chemical Abuse and Dependency Services Division has agreed to serve as a project advisor. She and another project advisor, MaryAnn Davis, a nationally-recognized expert from the University of Massachusetts Medical School in transition for youth with EBD, will advise this project and the *Partnerships in Planning* and *Transforming Futures* projects.

## **Cultural competence/ cultural issues**

We will attempt to enhance the cultural competence of the study using the following strategies recommended by Sobeck, Chapleski, and Fisher (2003): including diverse representatives of the community as members of the advisory group and ideally as research assistants; viewing all advisory group members and research team members as experts; collaborating with local families to develop questions suited to the cultural context; seeking review of questions for sensitivity; training a young adult and a family member to participate in data collection, analysis, and interpretation; and seeking verification of findings from research participants. Our sampling strategy will deliberately seek to over-represent culturally and socio-economically diverse youth and their families.

## **Sample**

We plan to conduct 6 focus groups of 5-8 parents/caregivers of youth aged 16-24, 2 focus groups of 5-8 youth aged 17-18, and 6 focus groups of young adults aged 19-24, for totals of 30-48 caregivers and 40-64 youth. These age groups represent both youth involved in high school transition planning and young adults who have graduated from high school and are employed and/or in postsecondary education.

We will recruit participants by placing announcements in local schools, colleges, youth employment centers, and mental health agencies that serve diverse communities. We will also recruit youth and families through contacts with local family support organizations, youth advocacy organizations, and community agencies that serve GLBTQ (gay, lesbian, bisexual, transsexual, and questioning) youth. We will sample youth of different socio-economic statuses, ethnicities and those living in different types of communities (urban, rural, suburban). An incentive for participation will be a \$30 gift certificate for both youth and caregivers (based on a 90-minute focus group agenda). In consultation with project youth and family advisors we will determine what group composition characteristics would provide opportunities for maximum comfort in expressing opinions and feelings. We will also offer opportunities for school-age youth and their caregivers to participate together, if they wish. We anticipate older youth and caregivers may prefer to attend separate focus group meetings, but will follow the advice of our advisory groups.

Potential participants will be informed of the purposes of the research, and assured that declining to participate in the study or to answer any question will have no effect on their services. Assurances

about participants' privacy will be provided and the limits on confidentiality related to the focus group methodology will be explained, so that participants are fully informed about their choice to disclose. Participants will be informed of the researchers' responsibility to report disclosures of harm to self or other. Application to the Portland State University Human Subjects Research Review Committee will incorporate a description of the family/youth participatory methodology.

## **Measurement**

Open-ended questions will be used to explore family and youth definitions of CI. We will invite participants' perspectives on optimal CI, the key elements of CI, and the factors that promote and impede optimal CI. The final wording of questions will be determined in consultation with our project advisors; focus of questions will be on integration with both geographic and associational communities in terms of:

- Meeting basic needs for shelter, employment and/or learning, and health and mental health care
- Gaining opportunities to participate in community life across the domains of school, employment, living situation, recreation, faith communities, and social relationships
- Having opportunities to fulfill social roles and achieving a sense of belonging
- Managing cultural barriers and using cultural supports to CI
- Having choices and sustaining self-determination and a sense of empowerment
- Family roles in supporting CI and independent living
- Useful information and resources (including web resources) for youth and families
- The effects of stigma on CI, and
- Associations between resilience/recovery and CI.

Demographic data on focus group participants will be collected in a survey mailed prior to the focus group. This will include age, gender, sexual orientation, race/ethnicity, residence situation, school/work/college status, mental diagnosis and severity of disabling condition (self-reported).

Furthermore, we will assess CI of youth and young adults in our sample using an existing brief measure developed to assess CI of individuals with brain injury, the Community Integration Measure (CIM) (McColl et al., 2001). The CIM focuses on personal attitudes, perceptions, and beliefs and conceptualizes CI as consisting of four dimensions: general integration, social support, occupation, and independent living. The CIM is reported to have acceptable psychometric properties (Minnes et al., 2003). Because of the centrality of self-determination control, and empowerment in conceptualizations of CI (Lakin, Hayden & Abery, 1994; Nelson, Lord, & Ochocka, 2001; NIDDR 1999), we will also use a measure of youth empowerment adapted from the Family Empowerment Scale (FES; Koren, DeChillo, & Friesen, 1992) by researchers at Oregon Health and Science University (Powers et al., 2001). Both the FES and its adaptation, known as the Youth Empowerment Scale (YES), are reported to have acceptable psychometric properties. A copy of the YES and the CIM are included in the proposal appendices.

## **Data Collection**

Youth and young adult focus groups and mixed caregiver-youth groups will be co-facilitated by a youth-researcher team and family focus groups by a family member-researcher team. Participants will receive a \$30 gift certificate for their time. Refreshments will be provided and youth and young adult participants will also be asked to complete brief measures of CI and youth empowerment prior to the start the focus group. The sites of focus groups will be to suit participants' convenience, i.e. some focus

groups will be arranged at community facilities, such as local libraries, while others will be at the research center. After an “ice-breaker” question, focus group participants will be guided through the open-ended questions and care will be taken to elicit the perspectives of all participants on each topic. Specific questions will be determined in consultation with advisory group members. Probes will be used to draw out and extend the detailed descriptions of experiences and perceptions.

After the focus group data has been analyzed, initial themes identified, and a preliminary model developed, participants will be invited to attend a second focus group for the purpose of member checking. At these meetings, preliminary findings of the study will be presented. Youth, young adults, and caregivers will be invited to comment on the conceptual model and to offer additional insights, which will be incorporated into the model.

## **Analysis**

Focus group data will be audiotaped, transcribed, and analyzed for themes and categories with the assistance of Nud\*ist qualitative analysis software (QSR, 2002). The youth and family research assistants will assist with analysis and interpretation of findings. A goal is to develop a conceptual model of youth and family experiences of CI. Analysis will be guided by a constructivist grounded theory approach (Rodwell, 1998) with the goal of gaining understanding of individuals’ constructions of their experiences.

Qualitative analysis will be guided by the purpose of the study and the questions asked. Through reading and re-reading, researchers “notice” instances of a response, develop a hunch, and examine other data for examples to confirm, disconfirm, or elaborate on the initial finding (Morse, 1994). In this inductive process, categories and themes “emerge” from the data through synthesis of data units. By fitting alternative explanations, an emerging theoretical model is developed which may be tested in other settings. “Thick” description of the context in the written report provides for recontextualization of findings in the setting.

To avoid acting on biases, such as tendencies to respond to first impressions and to ignore conflicting information, the research team will develop clear decision rules about what to include in a category and what to leave out. Independent coding by team members will be used to bring biases to light and to reach consensus. Final categories and codes will be achieved by negotiation between team members; where resolution cannot be reached, a third reader will assist in decision-making. Other strategies we will adopt to ensure trustworthiness of findings include: member checking (the process of verifying information with the person interviewed); peer debriefing (consultation with team members); documentation of all decision rules related to analysis, and use of an audit trail (a complete record of all raw data and interim data transformations for review by an independent person) (Lincoln & Guba, 1985). Participants’ ratings on the CIM and the YES will be aggregated and reported as descriptive data, along with the demographic information.

## **Results**

Results of this study will be in the form of a conceptual model, which will be used to generate hypotheses to guide the *Transforming Futures* and *PIP* studies. We will publish quantitative and qualitative findings in an academic journal, web-based, and “family-friendly” and “youth-friendly” formats.

## Training Activities

A proposal to present study findings at the Federation of Families for Children's Mental Health annual conference will be submitted and findings will also be presented at the RTC conference. We will invite our youth researcher and/or focus group participants to participate in these conference presentations. The research team will offer to give guest presentations in M.S.W. courses and a Ph.D. seminar based on the study findings. Additionally, the project Co-PIs, Pauline Jivanjee and Co-P.I, Jean Kruzich, will incorporate findings in courses they teach at Portland State University and University of Washington Graduate Schools of Social Work and will share project information with other instructors of social work practice courses at both schools.

## Dissemination

We will prepare a manuscript for publication in a practice journal for service providers and "family-friendly" and "youth-friendly" versions of our findings for inclusion in *Focal Point* and newsletters read by families and youth. A web page on the RTC web page will be developed to report project activities and provide regular updates. We will also facilitate a discussion on the "Forums" page in the RTC web page to share ideas and seek input from youth and families on the topics of CI and youth transitions. We will seek ideas from the advisory groups about pursuing funds for disseminating findings in alternative media and formats that are used by youth, such as local radio or public service announcements.

## Technical Assistance

Technical assistance will primarily take the form of guidance to project staff on the *Transforming Futures* and *PIP* projects. We will seek opportunities to inform local service providers whose focus includes CI of youth and families. Lyn Gordon, a member of the research team has opportunities to facilitate technical assistance activities at the Clark County Partnerships for Youth Transition project, where he serves as evaluation project manager.

**Table (R-1.1) Community Integration Timeline**

Tasks	RTC Year 1			RTC Year 2												
	2004			2005												
	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	
Collaborate with Transforming Futures and PIP project staff	█	█					█				█			█		█
Identify and convene youth and family advisory group members	█	█				█					█			█		
Prepare Human Subjects application	█	█														
Recruit and train youth and family member research assistants	█	█	█	█												
Identify sites for recruitment of participants		█	█	█												
Identify sites for focus groups		█	█	█												
Make arrangements for focus groups			█	█	█											
Conduct focus groups				█	█	█	█	█								
Analyze focus group data						█	█	█	█	█	█					
Share findings with Transforming Futures and PIP projects										█	█	█	█			
Prepare report of focus group findings											█	█	█			
Disseminate findings											█	█	█	█	█	█