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An examination of the community participation interests of young adults with serious mental illnesses

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Abstract

Participation in various aspects of community life (e.g., education, employment) plays a critical role in fostering young adult development and health. To support behavioral health services in addressing a broader array of meaningful community participation areas, the current study examined the participation interests of young adults with serious mental illnesses via a literature review and focus groups interviews. Literature review results revealed a range of community participation areas of interest to these individuals, including employment, education, religion and spirituality, social networking (e.g., using social media), volunteering activities, socializing, and civic and artistic participation (e.g., attending a political event, playing music). Focus group participants named many of these same areas, but also mentioned unique areas of participation that have not been the focus of previous research (i.e., playing games, sports, exploration of other communities (e.g., traveling), hanging out, and nature-based participation). Implications for future research and behavioral health practice are discussed.

Keywords

transition aged youth; first-episode psychosis; social engagement; employment; focus groups

Introduction

The transition from adolescence to adulthood is a pivotal developmental period during which individuals experiment with activities in a variety of life domains, including intimate relationships, community contributions, as well as educational and vocational pursuits.[1,2] Community participation, the self-determined actions that people take to engage in personally meaningful roles in their communities,[3] therefore plays a critical role during this period of development. Community participation provides opportunities for young adults to explore and negotiate their emergent identities, which organize and shape goal-directed

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actions, thought, and behaviors,[4,5] and promote motivated action and decision-making.[6] Additionally, participation in meaningful and interest-based activities in the community has been shown to support the development of competence and perceived self-efficacy in various life roles.[7,8] While young adulthood is often associated with newfound autonomy and behavioral independence, the choices made during this developmental period can have lasting effects on long-term development;[9] thus, it is important to develop a more in-depth understanding of the ways in which young adults participate in their communities.

The period between adolescence and adulthood also coincides with the onset of most serious mental illnesses.[10] This is especially problematic because mental health-related challenges can interrupt or delay the pursuit of community participation interests and goals. For example, the development of a serious mental illness during this time may prolong the attainment of educational achievements needed for competitive employment.[11,12] As this transitional period is characterized by key developmental milestones, young adults with serious mental illnesses who do not receive treatment designed to minimize illness-related disruptions are at greater risk for health problems and poorer functional outcomes as they age.[13,14] These findings support the notion that services focused on promoting community living and participation are a medical necessity[15] for this population. The idea that community participation is a medical necessity is further supported by the World Health Organization's International Classification of Functioning, Disability, and Health (ICF) framework,[16] which identifies "involvement in a life situation" as a key determinant of health, and outlines a number of different areas of participation that have positive health benefits (e.g., community life, recreation and leisure, political life and citizenship).

Behavioral health service systems have historically lacked the capacity to support young people with the transition to adulthood, particularly with preparation for participation in adult roles in the community.[17] This gap, combined with a growing recognition of the importance of early intervention of serious mental illness,[18] led the National Institute of Mental Health to fund the seminal Recovery After an Initial Schizophrenia Episode (RAISE) Early Treatment Program study, which compared a model of treatment for early psychosis, called Coordinated Specialty Care (CSC), to usual services. CSC programs are designed to provide developmentally appropriate care, in part by targeting work- and school-related participation.[19] The RAISE study, conducted across 34 sites in the United States, found that those who participated in CSC had better clinical outcomes and greater involvement in education and employment activities than those in the usual care condition.[20] These findings encouraged Congress to increase the availability of CSC programs nationally by allocating 10 percent of Mental Health Block Grant monies to support their implementation.[21] This expanding model of care evinces the value of promoting educational and occupational participation among youth affected by psychosis, which will hopefully lead to the development of supports for other forms of community participation and for other young adult populations.

While work and school participation are especially important areas of focus, a deeper understanding of the participation interests of young adults with serious mental illnesses is necessary in order for CSC and other service models to address a broader array of meaningful community participation areas. The purpose of this study was therefore to

examine the participation interests of young adults with psychotic and affective disorders by conducting a literature review and focus groups interviews with a group of young adults in two separate community behavioral health settings. Both broad areas of participation (e.g., occupational participation) and specific activities (e.g., competitive employment) of interest to young people were assessed, and findings from the literature and focus groups were compared to each other.

Methods

Literature review

Procedure—The fourth author (JS) conducted multiple literature searches up to December 2018 using PsycINFO, Web of Science, and Google Scholar. Search terms included keywords such as “young adults,” “serious mental illness,” “employment,” and “social engagement.” Articles were included in the review if they were peer-reviewed, written in English, and included quantitative or qualitative data pertaining to the community participation activities and/or preferences of young people with serious mental illnesses. All article types (e.g., original research, reviews or meta-analyses) and study designs (e.g., randomized controlled trial, quasi-experimental, naturalistic) were eligible for inclusion. The first author (ECT) reviewed all titles and abstracts and made the final determination about which articles to include in the literature review.

Results—As shown in Table 1, 10 studies were included in the literature review.[14,22–30] Seven were quantitative studies and three were qualitative studies. Five studies had a sample size less than 100 participants. In the quantitative studies, sample sizes ranged from 17 to 207 participants, whereas the qualitative studies ranged from 55 to 100 participants. Participants were diagnosed with schizophrenia, bipolar disorder, and major depression, and some were experiencing first episode or early psychosis. Most participants were between the ages of 18–30 years.

Community participation was assessed using a variety of instruments and other sources of data, including the Temple University Community Participation Measure,[31] Social Network Use Questionnaire,[29] Organizationally Mediated Empowerment Scale,[32] Goal Attainment section of the Wisconsin Quality of Life-Client Questionnaire,[33] the Social Behaviour Schedule[34] and study-specific questionnaires or interviews.[22,25,27,28] Based on these sources of data, a number of participation areas and activities were identified, including employment (50% of studies), education (60% of studies), religion and spirituality (60% of studies), social networking (e.g., using social media) (30% of studies), volunteering activities (30% of studies), socializing (in the community vs. online) (20% of studies), and civic and artistic participation (e.g., going to a political event, playing music) (civic participation: 20% of studies; artistic participation: 40% of studies). These findings support the notion that young people with serious mental illnesses are interested, and engage, in a diverse array of community activities and pursuits.

Some studies compared the community participation of young adults with those of older individuals. Kaplan and colleagues[14] found that emerging adults were more likely to be students and to spend time with friends, while older adults were more likely to be parents

and to engage in self-help and spiritual activities. Shimitras et al.[30] reported that younger individuals were more likely to engage in social activities, while those older reported more time in passive leisure (e.g., watching television). Finally, Thomas and colleagues[24] demonstrated that young adults were more likely to participate in and value employment and education activities compared to older adults. These studies suggest that working, going to school, and socializing may be particularly important areas of community participation for young adults.

Of import, some of the included studies shed light on the relationship between community participation and other outcomes. Kaplan et al.[14] demonstrated that greater community participation, particularly in the areas of volunteering, going to school, being a member of a group, civic participation, socializing, and exercising spirituality, was associated with higher perceived recovery. Social networking provided opportunities for developing or maintaining friendships, accessing resources to reach personal goals, and disclosing mental health issues.[26,27,29] Qualitative studies indicated that young adults perceived spirituality to be related to their mental health,[25] and that being involved in various community-based activities (e.g., going to school, working, volunteering) facilitated their having a sense of personal achievement, fulfillment, and connection to others.[28]

Focus groups

Participants—Focus group participants were recruited between October, 2017 and July, 2018 from two behavioral health programs within a large northeastern city that serve youth and young adults with serious mental illnesses. One was a CSC program, while the other was a residential program for young adult men at risk for homelessness. Individuals were eligible if they were between the ages of 18 and 26 years; were able to speak and understand English; had a psychotic or affective disorder diagnosis [as documented in medical records or according to a diagnostic screener[35]]; and were able to provide informed consent as assessed by research staff. Individuals were excluded if they had a legal guardian, or had a documented co-occurring neurological impairment, intellectual disability, or significant communication-related disorder that would likely impact the ability to provide informed consent or participate in the data collection procedures. Participants were recruited through study flyers, site presentations, and provision of information about the study by program staff; research staff then screened interested individuals in order to determine eligibility. Those who were determined to be eligible were invited to attend the focus group at the program from which they were receiving behavioral health services. At the beginning of the focus group, research staff provided a review of the study and obtained written informed consent from each participant prior to implementation of any study procedures. All procedures were approved by the Institutional Review Board of the researchers' academic institution and the local municipality.

A total of 25 individuals were determined to be eligible for the study, of whom 11 participated (6 from the CSC site and 5 from the residential program). Reasons for non-participation included: individual was not able to be re-contacted after screening (n=7), individual did not show up for the focus group as planned (n=4), individual changed mind about being in study (n = 2), and individual left the behavioral health agency (n=1).

Procedure—Focus groups were conducted to elicit a broad range of community participation areas and activities considered to be important to young people. The group discussions were expected to generate a greater diversity of ideas than what could be gleaned from a quantitative survey, and in a quicker and more efficient way than individual qualitative interviews. Focus groups are also used as a tool to empower marginalized populations,[36] and we hoped that they would inspire young people with serious mental illnesses to explore, and consequently engage in, areas of community participation that they identified as important. The first author (ECT) facilitated both focus groups using an interview guide that centered on identifying young adults' community participation interests. The interview guide was informed by participation domains as identified by the ICF,[16] but also included questions that enabled community participation areas to arise spontaneously (e.g., *"What recreation activities are important to you?"* and *"What other community activities are important to you?"*). Participants were asked to name and describe community-based activities that they considered to be important. Participants also completed a self-report demographics questionnaire. Focus groups lasted two hours, were audio-recorded, and were professionally transcribed verbatim.

Data analysis—An integrated approach was used that enabled both inductive (i.e., data-driven) coding of participants' responses as well as a deductive (i.e., theory-driven) framework to organize codes.[37] Specifically, the first and fourth authors (ECT and JS) independently coded community participation areas and specific activities within the focus group transcripts using content analysis.[38] Differences in coding were discussed to build consensus, which was achieved by either creating new codes or collapsing existing ones. For example, "going to a movie theater," and "going to a drive-in" were eventually collapsed into a single code, "watching movies (movie theater, drive-in)." Then, the authors categorized participation areas and their associated activities according to the participation domains identified by the ICF.[16] This final step was also achieved through a process of discussion and consensus building. Data analysis was facilitated using NVivo 12 Plus.

Results—Table 2 presents demographic and clinical characteristics of focus group participants. As shown, the majority of individuals were African American, male, and single. Slightly under half of participants had some post-secondary education and were students at the time of the study. Although more than half of participants had earned income from employment during the previous year and about a third were working for pay at the time of the study, the majority were receiving social welfare benefits. Over half of participants were diagnosed with schizophrenia; a smaller percentage was diagnosed with affective disorders. Most participants had received behavioral health treatment for the first time within the past few years, and many had been hospitalized for psychiatric reasons within the past 6 months. No participant endorsed experiencing physical disabilities (i.e., blindness, deafness) or significant mobility issues that would limit their participation in the community.

As shown in Table 3, participants identified a total of 16 community participation areas and 58 specific activities that were important to them. Community participation areas were highly overlapping between the two focus groups; more variability was observed regarding specific activities. Most of these participation areas and activities were able to be categorized

according to the ICF. ICF domains represented by the data included Arts and Culture, Education, Non-Remunerative Employment, Organized Religion, Play, Political Life and Citizenship, Socializing, Spirituality, Sports, and Work and Employment. Arts and Culture had two components: Artistic Participation (e.g., making music, painting) and Artistic Appreciation (e.g., listening to music, going to poetry slams). Within the Education domain, participants expressed interest in attending classes at an educational institution and taking classes online. Non-Remunerative Employment included activities, like volunteering, for which participants did not get paid. Organized Religion was characterized by participation in formal religious communities, such as going to temple or participating in Bible studies. Play was comprised of activities that involved games, such as cards, board games, or billiards, or going to places where games could be played, such as an arcade. Political Life and Citizenship included activities such as voting. Socializing included Going to Social Events, such as cookouts or parties. Spirituality was exercised through activities such as yoga or meditation. Sports was further divided into Sports Participation (e.g., biking, basketball) vs. Sports Appreciation (e.g., watching sports). Finally, Work and Employment was characterized by occupational activities for which individuals were being paid, and preparing for such occupational activities (e.g., working on a resume).

A minority of codes did not fit within the ICF framework and were consequently listed without an ICF heading. These included Exploration of Other Communities (e.g., traveling), Hanging Out (e.g., window shopping), Nature-Based Participation (e.g., camping), and Virtual Participation (e.g., online video games, participating in social media).

Discussion

This study facilitates a comprehensive understanding of the range of community participation areas that are important to young adults with serious mental illnesses. To the authors' knowledge, it is the first to synthesize findings in this important area. The use of both a literature review and focus group methodology supports the validity and breadth of the results, as evidenced by convergent findings across methods and the unique contributions of focus group participants. As such, the present study helps to fill a critical knowledge gap and has important implications for the field of behavioral health.

Several important insights may be gained from the literature review results. First, the included studies reported a range of community participation areas of interest to young adults with serious mental illnesses, including employment, education, religion and spirituality, social networking, volunteering, socializing, and civic and artistic participation. Second, the diversity of instruments and tools used to assess community participation suggest that an important step in expanding research in this area is the determination of consensus measures that could be used in future studies. In light of the breadth of the findings, measures that evaluate a range of participation areas, such as the Temple University Community Participation Measure,[31] might be prioritized for this purpose. Finally, most studies included relatively small sample sizes and were quantitative in nature; these findings also suggest opportunities for future research. For example, larger quantitative studies might be designed to address questions about the extent to which young adults are participating in

areas of interest to them, while additional qualitative research might be conducted to better understand facilitators and barriers of their participation.

Focus group findings are similarly elucidative. Participants identified community participation areas that echoed literature review findings, including artistic participation, education, volunteering, religion and spirituality, civic participation, going to social events, employment, and virtual participation (including social networking). However, these participants also mentioned unique areas of participation that have not been the focus of previous research (i.e., playing games, sports, exploration of other communities, hanging out, and nature-based participation). Some areas of participation also fall outside of the ICF framework.[16] For example, while its 2012 update acknowledges that one may *communicate* through "telephones, computer, and other electronic devices," the ICF does not recognize engagement in virtual activities (e.g., participation in social media, online gaming) as a form of community, social, or recreational participation, as was suggested by the focus groups. The unique contributions of focus group participants, who described making use of emerging technologies and social trends to support their participation, suggest exciting new directions for the study and classification of community participation among individuals with and without mental illnesses.

While the extent to which focus group participants were participating in the areas mentioned as important to them was not assessed, an examination of the demographic and clinical characteristics of these participants suggests that they may experience significant challenges to their participation. Fewer than half of participants were working for pay or in school at the time of the study, a large majority appeared to have limited finances (as evidenced by the fact that most were receiving social welfare benefits), and many had recently been hospitalized for mental health reasons. These issues demonstrate a negative relationship with community participation in other research involving individuals with serious mental illnesses.[39,40] Yet, it may be considered encouraging that even in the face of these potential challenges, participants enthusiastically identified a range of participation areas that were important to them.

A few limitations to this study merit discussion. First, although the literature search was comprehensive and spanned several relevant databases, systematic review methodology was not used, and it is possible that pertinent papers were consequently missed. Second, the number of focus group participants was relatively small and many individuals who were determined to be eligible did not participate. This meant that we were not able to compare community participation interests across sub-groups of participants based on demographic or clinical characteristics. Further, characteristics of the study sample may limit the representativeness and generalizability of results. Participants were from an urban setting, were predominantly African American, male, and from low income backgrounds, were actively engaged in behavioral health services, and did not have legal guardians nor certain comorbid conditions (e.g., intellectual disabilities). The fact that focus group results largely converge with literature review findings increases confidence that these findings apply to broad range of young adults with serious mental illnesses; however, it is encouraged that further research be conducted to explore the degree to which these preliminary findings apply to other populations of young adults.

Implications for Behavioral Health

The findings reported here have several practical applications for behavioral health services. First, the critical importance of community participation during the transition between adolescence and adulthood, combined with the range of participation areas identified in this paper, indicates that programs serving young adults should make assessment and support of community participation a routine part of practice. Assessment of participation interests may be accomplished through the use of formal measures[31] or more naturally, such as via routine goal-setting conversations. As both personal challenges (e.g., psychiatric symptoms) and environmental factors (e.g., stigma and discrimination, poverty) impact the community participation of individuals with serious mental illnesses, efforts to promote participation should focus not only on supporting young adults with their participation goals, but on reducing environmental barriers.[41] For example, behavioral health providers and other supporters can assist young people with identifying and prioritizing personally meaningful areas of community participation and connecting them to community-based resources to pursue them, while simultaneously striving to develop welcoming and inclusive communities outside of the behavioral health system.[41] These efforts may also lead to future research opportunities; for example, interventions and approaches to minimize the impact of reported barriers to community participation, such as low socioeconomic status, might be evaluated. Further, future research might elucidate the characteristics of welcoming communities and their impact on community participation.

Second, this study provides evidence supporting CSC services in targeting work and school-related participation, but suggests that CSC and other models of care should also address other areas of community participation that are important to young adults. Given the overlap between literature review and focus group results, additional areas of participation that may be especially important to focus on include artistic participation, volunteering, religion and spirituality, civic participation, socializing, and virtual participation. It may be particularly beneficial for behavioral health workers to establish partnerships with programs, venues, and other resources in the community that could support young people with engaging in these areas. Further, the same principles underlying evidence-based support technologies for employment and education, such as those pertaining to the Individual Placement and Support model,[42] may be applied to facilitate participation in other areas. In particular, a focus on individuals' preferences for participation, rapid placement in community-based activities, and follow along supports may be used to promote personally meaningful and sustained participation in a variety of important domains.

Finally, these findings provide insights into how to make behavioral health services for young adults more engaging in order to facilitate longer-term retention in care. While young adults with serious mental illnesses represent a particularly difficult to engage population,[43] research has demonstrated that a focus on life goals is considered to be an engagement facilitator by participants of CSC.[44] Thus, offering support with community participation in areas that are personally important to young people is expected to increase their engagement. Additionally, delivering or supplementing behavioral health services in formats or in the context of activities that are of interest to young people (e.g., online or via apps; through games, sports, or art) may increase engagement, and has been demonstrated to be feasible

within CSC.[45,46] Such youth-oriented, interest-based practices have the potential to significantly improve the participation of young adults with serious mental illnesses within and outside of the behavioral health system, thereby facilitating health and wellness.

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Table 1

Literature Review Results

Article	Type of Study	Total N*	Description of Sample	Sources of Data	Participation Area(s)/ Activities Studied	Conclusions
Abdel-Baki, Lal, Charron, Stip, & Kara, 2017	Quantitative	56	**Inclusion/Exclusion criteria**: Individuals were diagnosed with first episode/early psychosis. **Age range**: 18–29.	A self-administered survey was used to collect information on the use of technological tools.	Social networking, discussion groups, gaming	Technology use and social networking were associated with helping youth with first episode early psychosis to stay in communication with friends as well as facilitating participation in group discussions.
Gowen, Deschaine, Gruttadara, & Markey, 2012	Quantitative	207	**Inclusion/Exclusion criteria:** Participants included individuals with/ without mental illness. **Age range**: 18–24.	An online survey administered by the National Alliance on Mental Illness collected fixed-choice response data on several categories including social networking habits and preferred features and functions of social networking sites.	Social networking, discussion groups	The researchers found differences in the use of social networking in young adults with/without mental illness. More specifically, young adults with mental illness on social networking sites were more likely to participate in discussion groups and comment on a blog, whereas young adults without a mental illness were more likely to plan social activities.
Gürbüz, Demir, Özcan, Kadak, & Poyraz, 2017	Quantitative	108	**Inclusion criteria:** The sample included 53 adolescents diagnosed with depressive disorder and 55 adolescents without depression. **Exclusion criteria**: Individuals with intellectual disability or psychotic disorders. **Age range: 13–18**. The mean age by study group was 15.29 ± 1.32 years (patients with mental illness) and 15.23± 1.25 years (control group).	The Social Network Use Questionnaire is a measure used to describe the frequency, duration, and purpose of Internet use on social networking sites.	Social networking, sharing photographs, online chatting	One of the main findings from the study was that adolescents with depression spend more time on social networking sites than adolescents without depression.
Iyer, Mangala. Anitha, Thara, & Malla, 2011	Quantitative	68	**Inclusion criteria**: Considered to be experiencing first episode psychosis, had a schizophrenia spectrum disorder, had not previously received antipsychotic medication for more than 30 days, and were able to provide informed consent. **Exclusion criteria**: History of organic mental disorders and primary diagnosis of mood disorder or substance-induced psychosis. **Age range:** The mean age was 28.79 ± 9.86 years.	Goal Attainment Section of the Wisconsin Quality of Life-Client Questionnaire was a measure used to assess goals of patients, which related to areas of participation (e.g. employment, school, religion).	Employment, school, religion	Researchers found that patients diagnosed with first episode/early psychosis were able to clearly identify goals which focused mostly on areas of participation pertaining to employment and school.
Jivanjee, Kruzich, & Gordon, 2008	Qualitative	59	**Inclusion/Exclusion criteria**: Participants had a wide of mental health diagnoses, including anxiety disorders, depression, bipolar disorder, and schizophrenia.	Information was collected from participants via focus groups related to supports and barriers surrounding community integration.	Going to school, working, volunteer activities, reading, art, playing music, reading the Bible	This study indicates that community integration plays a significant role in the lives of young people, as it relates to their desire for making social connection with others with similar interests, personal autonomy to make their own

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			Age range: 15–28 with a mean age of 19.5 ± 2.45 years.			choices, and utilizing their individual talents and interests to achieve goals.
Kaplan, Salzer, & Brusilovskiy, 2012	Quantitative	233	**Inclusion/Exclusion criteria:** Axis I or II diagnosis, ability to give informed consent, actively involved in mental health treatment over the last 12 months, and primary diagnosis of serious mental illness. **Age range**: 18–30.	Yes-no, dichotomous variables were used to assess the following areas of participation: volunteering, employment, and education. Organizationally Mediated Empowerment Scale (Segal, Silverman, & Temkin, 1995) was used to measure civic engagement. Social Inclusion measure from Lehman's Quality of Life Interview assessed two items: 1) spending time with a friend and 2) spending time with a significant other.	Employment, school, civic engagement, engagement in religious/ spiritual activities, volunteering, friendships (e.g. spending time with friends)	These findings suggest that emerging adults are more likely to be students and spend time with friends, whereas mature adults are more involved in parenting, self-help, and spiritual activities.
Oxhandler, Narendorf, & Moffatt, 2018	Qualitative	55	**Inclusion/Exclusion criteria**: Presenting diagnosis of bipolar disorder, major depressive disorder, or schizophrenia spectrum disorder, were determined by unit psychiatrist to be stable enough to provide consent. **Age range**: 18–25	Information was collected from participants about mental health service use, religious identification, and religious practice via individual interviews.	Praying, reading the Bible, receiving support from their religious/ spiritual community.	Facilitators (e.g. prayer, reading the Bible) and barriers (e.g. negative experiences with church) related to religion and spirituality were some of the areas that played a role in the mental health of young adults with serious mental illness.
Ramsay et al., 2011	Qualitative	100	**Inclusion criteria**: Hospitalized for a first episode of a non-affective psychotic disorder and provided written informed consent. **Exclusion criteria**: Intellectual disability, significant medical condition, previous hospitalization for psychosis within 3 months, or unable to provide informed consent. **Age range**: 24.3± 5.1 years.	Information was collected from participants about life and treatment goals via individual interviews.	Art and music, employment, education, spirituality	The life goals of individuals with first episode/early psychosis related to employment, education, relationships, housing and health.
Shimitras, Fossey, & Harvey, 2003	Quantitative	17	**Inclusion/Exclusion criteria:** Adults diagnosed with schizophrenia or related non-affective psychosis. **Age range**: 18–24.	Detailed sociodemographic data, clinical questionnaires, symptom rating, and time budget data were used to collect information from participants about areas of community participation. Participants' case notes were reviewed, a key informant interview was conducted, and the Social Behavior Schedule was administered.	Active leisure (e.g. sports, arts,), passive leisure (e.g. reading, watching television, listening to music), education, purchasing goods and services (e.g. window shopping)	Adults with schizophrenia participated more in passive leisure activities (e.g. reading) compared to active leisure or productive occupations (employment or education activities).
Thomas, Snethen, & Salzer, 2017	Quantitative	105	**Inclusion/Exclusion criteria**: All participants provided informed consent. Individuals had a primary schizophrenia-spectrum or major affective disorder diagnosis. **Age range:** 18–30	The Temple University Community Participation Measure, which is a measure of independent participation in community-based areas, was used.	Volunteer activities, going a park, going to a barbershop, restaurant/ coffee shop, theater, health/exercise club (e.g. pool), community fair, place of worship	Differences in community participation were observed between young adults, middle-aged adults, and older adults. Young adults and middle-aged adults participated in employment and educational activities, whereas older adults participated in organizational,

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					(church, synagogue), museum, working for pay, going to school, zoo, watch and/or participate in a sports event, gym, movies, block party, earn a degree or certificate, political event, entertain family or friends in your home, visit library	civic, and religious activities. Working and training activities were more important to young adults compared middle-aged or older adults.

* N of participants who were considered to be young adults within each study.

Table 2

Demographic and Clinical Characteristics of Focus Group Participants (N=11)

Variable	*N (%)*	*M*	*SD*
Gender			
Men	8 (73)		
Women	3 (27)		
Race/Ethnicity[a]			
Black	8 (73)		
White	3 (27)		
Latino	1 (9)		
Other	1 (9)		
Education (years)			
<12	3 (27)		
12 or GED	3 (27)		
12+	5 (46)		
Marital Status			
Single	10 (91)		
Significant Other but Not Married	1 (9)		
Age (years)	11	21.82	3.16
Sources of financial support (past 12 months)[a]			
Employment	6 (55)		
Social Welfare Benefits (SSI/SSDI, food stamps, unemployment compensation)	10 (91)		
Family Contributions	1 (9)		
Vocational Program	1 (9)		
Occupational Status[a]			
Currently Working for Pay	4 (36)		
Currently a Student	5 (45)		
Diagnosis			
Schizophrenia	6 (55)		
Bipolar Disorder	2 (18)		
Major Depressive Disorder	2 (18)		
Unknown	1 (9)		
Age at First Mental Health Treatment	9	18.89	5.42
Number of Psychiatric Hospitalizations			
Lifetime	8	1.88	1.64
Past 6 Months	9	1.22	.83

[a]Categories are not mutually exclusive.

Table 3

Focus Group Results

ICF Domain	Community Participation Area	Specific Activities
Arts and Culture	Artistic Participation *	Making music
		Writing
		Drawing
		Painting
Arts and Culture	Artistic Appreciation *	Listening to music
		Reading
		Poetry slams
		Art shows
		Going to a museum
		Going to a library
		Watching movies (movie theater, drive-in)
		Watching soap operas
Education	School *	Going to school to earn a degree or professional certificate
		Taking classes online
Non-Remunerative Employment	Community Outreach *	Volunteering
Organized Religion	Religion and Spirituality *	Going to a place of worship (e.g., temple, church)
		Going to Bible studies
Play	Playing Games	Playing (card/board/billiards) games
		Going to an arcade
		Going to a casino
		Going to an amusement park
Political Life and Citizenship	Civic Participation *	Going to a march, run, or demonstration
		Voting
Socializing	Going to Social Events *	Cookouts/barbeques
		Going to parties
		Going to restaurants or bars
Spirituality	Religion and Spirituality *	Meditating (for spiritual reasons)
		Yoga (for spiritual reasons)
		Praying
		Reading religious texts
Sports	Sports Participation	Going to the gym
		Biking
		Basketball
		Football
		Walking or running
		Martial arts

ICF Domain	Community Participation Area	Specific Activities
		Going to a shooting range
		Exercising
		Swimming
		Bowling
		Skating
		Lasertag
		Paintball
Sports	Sports Appreciation	Watching sports (at sporting event or with others at home)
		Fantasy Football
Work and Employment	Work *	Working
		Working on a resume
	Exploration of Other Communities	Traveling
	Hanging Out	Window shopping (and other related activities such as going to the mall, hanging out with friends)
	Nature-Based Participation	Going to a park
		Camping
		Spending time in nature
	Virtual Participation *	Online video games
		Reading (celebrity) news online / searching for information online
		Emailing for social reasons
		Taking/posting pictures
		Social media (e.g., Facebook, Twitter, Instagram)
		Online forums

* Indicates findings consistent with literature review.