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TRACY PAKORNSAWAT >> Welcome... everybody, my name is Tracy Pakornsawat and... I apologize for the brief start -- delay in our start today. Had to knock out a few technical glitches here. For those of you who don't know me, I'm the Professional Development Coordinator with the Money Follows the Person demonstration project with the North Carolina Department of Health and Human Services. I'm the one who schedules and puts on these monthly webinars. Thank you for joining us today. We have a pretty large crowd. So... I'm glad that everybody is finding this an interesting topic.

I wanted to cover a few brief housekeeping issues. First... everybody is on a global mute, so... if you have any questions, if you could enter them in the questions box and then we will address them as it's appropriate or at the end. I also wanted to let everyone know that the PowerPoint will be sent to everybody as a PDF at the conclusion of today's webinar.

And so... with that -- I'd like to go ahead and introduce our presenter for today. We are pleased to have Mark Salzer with Temple University. He's the professor and former founding chair of the Department of Rehabilitation Services at Temple and is principle investigator. I'll let Mark do a little more introduction and turn it over to him.

MARK SALZER   >> Mark: Thank you very much, Tracy. It's great to be with everybody this afternoon. I hope everybody's doing well. We got a little bit of snow up here in Philadelphia, Pennsylvania last night and this morning, and... we're getting a little more this evening. So... wish me luck in getting home.

It's a pleasure to be able to talk with you about community inclusion and some of the efforts my center has been involved with over the last couple years in Money Follows the Person initiatives, especially related to self-directed care. The objectives of this webinar are for me to introduce you to the concept of community inclusion and community inclusion, especially as a medical necessity for people who experience disabilities. My work is primarily with people with psychiatric disabilities or serious mental illnesses, people diagnosed with schizophrenia, bipolar disorder and major depression and... my work is all about trying to support people to lead successful and fulfilling lives in the communities.

After talking about community inclusion as a medical necessity and giving you some background in that area, I'll share fundamentals and a couple quick implications of these different fundamentals for the types of supports that all of you are offering people that you're working with and then I'll end the presentation by briefly discussing a self-directed care project that we've done here in Pennsylvania and especially focus on the types of things, goods, resources, services that people with serious mental illnesses requested in order to support their successful living in the community.

The idea here is to give you some ideas of the types of things that enhance successful transitions to the community and positive lives in the community.

So... unfortunately, I can't see your faces, I can't see if yours heads are nodding or in agreement and understanding that this is a good direction to go in or if your heads are on the table, but that's okay, I'll assume all this makes sense to you.

I will probably end around 12:45 or 12:50 and that'll give us plenty of time for questions and comments as well. So... please send them along to, to Tracy, when those come up. I want to make sure you know I have no financial interest or conflicts to disclose. I'm not selling anything. Here I describe some of my salary support from different grants and projects over the last year. I want to acknowledge my funder, the national institute on disability independent living, they've funded a research and training center that I direct here at Temple University. On community inclusion and participation of adults with serious mental illnesses.

The first thing I want to clarify when we talk about community participation, I'm actually referring to all of these domains. I'm referring to employment or work for people who experience disabilities and psychiatric disabilities in particular. Talking about going to school. College or university or trade school. Obviously, we're talking about housing, dating, marriage, intimate relationships, parenting, leisure, recreation, spirituality, religion, civic engagement and friendships and social relationships.

You'll hear me talk about why it's important for us to focus on all of these areas and the reason for that is that we oftentimes focus on housing and employment for people who experience disabilities or are transitioning to the community and really, all of these areas are important in all of our lives, including the lives of people with serious mental illnesses and other disabilities... it's critical for us to focus on all these areas.

When I refer to community inclusion -- I actually like to use this graphic. And actually, I know that you recently had a presentation about self-determination and person-centered care. I notice they use this exact same thing.

So... some of you probably already participated in that, but just for those who did not, I wanted to remind you that inclusion, which is over here on the far left-hand side of this slide, refers to, well, the way to look at this is the circle represents participation in a particular domain, like work... going to school, going to a church, and you see all the green dots are participating and the non-green dots are outside or not participating in this area. That represents exclusion.

Segregation is presented by the middle circle. Here, we have, the green dots are participating in work and school, going to a gym, a community-based gym, going to a church, synagogue, mosque, going

to a community center, and here you have the non-green dots are also participating, maybe in work, but... participating in different types of settings.

And... in employment, for example, we'd think of sheltered workshops as an example. The non-green dots are participating, but they're not participating with everybody else. Obviously, institutionalization, for example, would be an example of segregation as well.

Integration is the circle to the far right. Here, you've got the green dots that are in the circle, participating in some way. The non-green dots are also participating in that same setting -- there's something unique about their participation. This might have to do with accommodations, for example. Different types of work schedules, maybe different hours of jobs or being able to work at home more often or something different about their participation, even though they're participating in the community. Integration is certainly a very good thing. And... that's what we definitely want to promote. But... really, the goal that we're looking for, in our center, and I think probably all of you is we want to promote inclusion. And... really, the difference between inclusion and participation is it goes beyond integration, which talks about the opportunity to participate like everybody else, with... for example, accommodation -- inclusion goes beyond that and talks about those settings, like the work setting or school setting or church... or other place of worship, that those settings, not only say, oh... yeah, we'll accommodate you, or we'll make some changes so you can participate, they actually say, we want you here. We welcome you here in our setting, it's important for you to be here. So... that's really what inclusion is all about, and... that's really the goal, but... the overarching goal is to increase participation for people with serious mental illnesses and... who experience other disabilities in the community.

When I first started doing this work, I used to start talking about or I think it was enough for us to talk about community integration and inclusion as a right.

This is a right, based on the Americans with Disabilities Act that was signed into law in 1990 and it is a right based on the Supreme Court Olmstead decision. People who can live in the community with the proper support is a form of discrimination, prohibited by the ADA. Our colleagues and policymakers and everybody would say... well... of course, let's really emphasize this and unfortunately, I found that that wasn't the case. Just talking about it as a right, wasn't enough to really capture people's attention.

I, then, started thinking about moving into community integration and inclusion as a right, but the resulting participation, the increased participation in employment and... education, and... leisure and recreation and going to places of worship and intimacy, marriage, parenting. I started looking at literature that indicated that not only are these rights, but the participation that results from the opportunity to participate in the community is a medical necessity. In the sense that it promotes physical, cognitive and mental health and wellness for everyone. Including people with disabilities and including people who experience serious mental illnesses.

What you see here is a document we developed in 2016. For an agency-based in Australia. The document is called Well Together. They came to us because there were some major changes going on in Australia. To their Medicaid programs and Medicaid, they use the same term for Medicaid -- like we do. As well as... their disability insurance scheme, like their Social Security services and entitlements. They were interested in maintaining the focus on community inclusion and participation and seeking the evidence for not only why is it important, but... what are the fundamentals for making it happen?

So... this document is available online. You can Google Well Together and my last name, Salzer, and it shows up pretty quickly. It's a little thick. We have to have references, they wanted evidence... and theories... so we provided them with evidence and theories... and really... this, the argument that we laid out for community participation as a medical necessity has really grabbed a number of funders and policymakers and providers to really understand that participation isn't just a side activity or ancillary activity and the types of services that we offer people. This is fundamental to people's physical, cognitive and mental health.

Part of this argument is based on something called the International Classification of Functioning, Disability and Health. I won't go into a lot of detail on this, but by the way, this is a framework that's not a mental health framework, per se. Some of the things this framework talks about, first of all, it talks about health, it's consisting of three different domains or areas... the first is body function and structure. This is probably how we traditionally think about health. Body functions and structures would refer to problems with kidneys, liver, heart, lungs... as well as in mental health, for example... we talk about issues in somebody's brain, for example and the symptoms associated with this particular health condition, either a disease or a disorder of some kind. That's the traditional view of health, but the ICF, this is developed by the World Health Organization, also says that activity is an aspect of health. Activity refers to the execution of a specific task or action, usually in Health Care... we think of this in terms of activities of daily living or instrumental activity... daily activities, grooming, bathing, budgeting... all the things that all of us do that help us live... being able to shop... these really discrete tasks or actions. These are important to health, according to the World Health Organization.

And finally... they, for the first time -- talked about participation as an important aspect of health and health functioning as well. Participation refers to involvement in a social situation. Usually we'll say meaningful social situation or meaningful social role. This means participation, in, for example, work, going to school, dating, parenting, intimate relationships, voting, volunteering, leisure recreation, church, synagogue, mosques, all of those things we talked about before in terms of community participation and according to this framework... participation is an aspect of health. If you don't have participation, you don't have full health.

The traditional perspective is that first we need to take care of body, function and structure issues. As a focus on health. And... then, once we do that, we need to take care of activities of daily living. Once somebody dresses appropriately and bathes and maybe social interaction skills or social skills... when those two areas are taken care of -- then we can get to participation. This is the traditional view on participation and... when we pay attention to it, the problem with that is oftentimes for many individuals, especially people who experience chronic conditions or episodic conditions, is the body, function and structural issues aren't fully addressed or able to be cured, for example or the ADLs might not be exactly right and we never get to participation. We don't focus, focus enough on employment or going to school or dating or any of these kinds of things.

The ICF doesn't go uni-directionally, it doesn't go one way -- they also point out and again... use examples from breast cancer, hypertension, diabetes, that participation, even while people are still experiencing body function and structural issues, that participation actually enhances ADL and enhances body function and structure. That's exactly what we see for many populations, and we also see that for people who experience serious mental illnesses or psychiatric disabilities, as well as people with intellectual and developmental disabilities, older adults, that participation is basically good for people.

For of those you who work in the context of individuals with serious mental illnesses, sometimes when we talk about community inclusion and participation as being important and being a medical necessity... they'll say, well... Mark, the people that I work with are really ill. They're very impaired... they don't want to do these kinds of things. They're happy sitting around their residential programs or maybe their institutions or hospitals and they don't want to do anything.

Or they'll say, Mark, the people I work with are so impaired, they couldn't do these kinds of things. Or they'll say, Mark, the people I work with are so impaired, they shouldn't do these things. They shouldn't go to work, they shouldn't go to school... they shouldn't date, they shouldn't have custody of their children -- they shouldn't go to church and we call this the wouldn't, couldn't, shouldn't, when, in fact, the evidence for people with serious mental illnesses and people who experience other disabilities as well, the evidence is that people with significant mental health issues want to participate, like everyone else.

And we see that employment, a good place to live and intimate relationship are the top three things people with serious mental illness want in their lives, like people who experience physical impairments, cognitive impairments, developmental disabilities and sensory impairments. These are the top three things anybody wants in their lives. People with serious mental illnesses are no different than anybody else. We have interventions that have demonstrated that people with serious mental illnesses can participate like everyone else, especially with the proper supports and interventions.

Things like supported employment programs, housing programs, education and socialization programs, that with the proper supports in the community... that people are able to participate.

And lastly, we know there's ample evidence that participation is good for everyone, including people with serious mental illnesses. The traditional argument is things like work causes stress, stress leads to an exacerbation of symptoms and exacerbation of symptoms leads to crisis, crisis leads to hospitalization, therefore we shouldn't support people around work and the evidence, again, indicates that work actually has positive benefits for people, both in physical health, cognitive health and mental health and wellness.

Something I'll mention very briefly, related to this argument, especially the should part of the argument is that there's a lot of concern about people who experience psychotic disorders and especially schizophrenia. The traditional belief is that these cognitive impairments, executive functioning impairments, problem-solving, memory impairments... that these, somehow, are solely a result of the disease process associated with schizophrenia, for example. And in fact... we have some evidence to suggest that maybe some of the cognitive issues that people with schizophrenia and other conditions experience is not just due to, maybe, a disease process, but it's also associated with lack of participation.

Some of the evidence is in three areas. One is physical activity. Basically... people who are engaged in sedentary behavior experience more cognitive issues and there are lots of biological explanations for this. One has to do with something called neurotrophic factor signaling. The more physically active we are, the -- it sets off these neurotrophic factors signaling processes that basically make us sharper and perform better on cognitive tasks.

We know that people who experience a serious mental illness as well as people who experience other impairments are much more sedentary or engaged in more sedentary behavior than the general population. People with serious mental illness spend 70 to 90% of their time lying down and that's bad for their brain, like it's bad for all of our brain. The lack of social interaction has been associated with cognitive problems. Most of this research comes from the older adult area. The more socially isolated people are, that's also associated with cognitive decline.

And the last thing is unemployment and the resulting depression is, and resulting poverty, is associated with cognitive issues as well. And the theory here is that multitasking -- trying to do a lot of different things at once creates more problems as cognitive tasks get more difficult and the experience of poverty is like multitasking all the time.

So... this is all related to the argument that community inclusion and resulting participation is a medical necessity. These aren't things that we focus on after we take care of everything else to all the other types of treatment or interventions we're doing with people. These are likely primary things we should be focused on.

So... what are some of the fundamentals for promoting community inclusion and participation? And again... these fundamentals are articulated in much more detail in that Well Together document that hopefully, while I'm talking, you're Googling right now and downloading. That will really give you more of the information that I'll be able to cover this afternoon.

The first three fundamentals have to do with our knowledge and beliefs. The first fundamentals, the community inclusion is important. Recognizing that community inclusion is important... and again, we make the argument that it's a medical necessity, hopefully, even in my short introduction to this area, you're convinced that this is important and critical thing to apply, to focus on in the work you're doing. Fundamental number two is community inclusion applies to everyone.

The reason that we started looking at this one is some of our colleagues, when we talked about inclusion and participation for people with serious mental illnesses, they would say that, that you know... maybe some of the people that they work with could do this kind of stuff, but... other people cannot. And... the same arguments have been made for people who have experienced other types of impairments or disabilities.

Again... physical disabilities, sensory disabilities, even older adults as well. There used to be a view that people couldn't, couldn't do these kinds of things. And... in fact, the evidence suggests that not only can most people with serious mental illnesses do better or engage in these things, these areas, these domains of participation... but people can be very successful in work and going to school and dating and parenting, especially with the proper supports.

So... that's the first thing. The second thing is, we can't really predict who is able to participate and who cannot participate. So... the notion of readiness hasn't been firmly established as something we're able to do in predicting who can do what in all of these areas of community participation. Evidence suggests the best predictor of participation or somebody's ability to participate is motivation or the person saying they want to go to work, they want to go to school, they want to do these things, so... fundamental number two is really to understand that community inclusion applies to everyone. Maybe the participation will be different, this is something that we spend some time talking with people

a lot about, is maybe somebody won't work 40 hours a week -- maybe they'll work 20 hours or 10 hours or 5 hours and maybe the participation will look different than other people, but still, people can participate in some way and our job is to support them as much as we can, because that participation is critically important.

Fundamental number three... is that community inclusion requires seeing the person, not the patient. The bottom line here is that our perspective about the people we work with influences the outcomes for those people. Either through our lack of efforts or not really focusing on those areas or maybe we community something to the people we work with that suggests we don't think they're able to do these things and... the individuals we support internalize that and... don't even pursue that at the end of the day.

This is related to something called the Pygmalion effect. This refers to research that's been done in elementary schools, primarily. It's basically looked at teacher expectations about students. And that if teachers have negative expectations about certain students, those students won't do well in the -- in that particular class. Or in that particular educational institution, so... the idea here is that, is that our perceptions about the people we work with and their capabilities of doing or engaging in these different areas of participation will have an impact on the success of people in these different areas.

Some different implications for this and I'm going to move on quickly, actually to make sure I cover everything, but the basic implications of all of these is to make sure that we're aware of the importance of inclusion and... we're sharing that with our colleagues and everyone else and also, making sure that, that we are addressing our own attitudes and beliefs about the people that we work with as well. And really challenge our perspectives about how we're seeing other people.

In the case of individuals with serious mental illnesses, for example, there's evidence that Health Care professionals and mental Health Care professionals have similar attitudes and beliefs about people with serious mental illnesses, as the general population. And the bottom line, about that, is that that means they have the same negative attitudes and beliefs about people with serious mental illnesses.

Self-determination and dignity of risk are critical. I recognize that a couple months ago, you had a nice lunch and learn about self-determination, so I won't cover this in too much detail. But... the idea is that promoting community inclusion and participation means promoting opportunities for people to make decisions that affect their lives. The concept of dignity of risk, extends that to a certain extent and says that people should have the opportunities to make choices that affect their lives, even if it could or does turn out to be a mistake and this allows people to learn from their mistakes, just like everyone else. And... at least in the area of psychiatric disabilities, this is something that people have a lot of concerns about, promoting dignity at risk and... it turns out that it's something critically important for us to pay attention to. Some of the evidence in this area suggests that interventions that involve opportunity for self-determination and dignity of risk are effective, with people with serious mental illnesses and people who experience other disabilities as well and... so... it's important for us to be using these types of interventions and promote, again, self-determination and dignity of risk as much as possible.

Our center has developed called managing risk. The reason we developed this is, I will occasionally give a presentation on dignity of risk and one of our colleagues might say you know... Mark, the people I work with, they're so impaired, does this mean that if somebody wants to, you know... take

off all their clothes in the middle of winter and walk down I-40 naked, is that what dignity of risk is all about? I say of course not. That's not what dignity of risk is about. We're not talking about choices that people make that could lead to death of themselves or somebody else. We're talking about all those other things that fall well short of that and sometimes we overemphasize the potential risk or potential harm from those risks and we don't do anything to ameliorate the chances that those risks might occur or... what we can do to support the person if something doesn't work and how do we support people? And this managing risk document was developed to help providers think through risk a little more strategically.

Fundamental number five refers to multiple domains of mainstream life being sought. I referred to this at the beginning of the presentation when I talked about community participation and the multiple domains of community participation and the fact that we need to look beyond housing and employment when we're supporting people who experience disability, including serious mental illnesses and... the data that's behind this, as we know, that all areas of participation, again... work, school, dating, parenting, leisure, recreation, going to church, voting, volunteering, other aspects of being a citizen that all of these have positive cognitive, physical, and mental health benefits and that people want to participate in these areas.

So... it's important for us to focus on all of these areas and not just be satisfied with focusing, simply on housing and employment and all of these areas of participation also enhance success in the other areas as well.

Our center has developed a number of documents to help think through how we support people in these areas -- I'm mentioning just a couple of them here. And... again, Tracy mentioned that you'll be able to receive the PowerPoint, so you'll be able to see these titles. These are all free and... things that you can download from the internet. Here are resources pertaining to supporting people in connecting to religious congregations and also developing what we call welcoming faith communities. This is an area that I'm spending a little more time in, because... it's so critically important in the lives of people with mental illnesses, just like it is for most Americans. 80% of Americans say they're very or extremely religious or spiritual and about the same percentage of people with serious mental illnesses say that as well.

So... faith is critically important and something we can pay attention to and it's good for people's health. Intimacy and sexuality, a couple other documents we've developed that you can utilize and parenting, an area our center has spent a lot of time on and something that's critically important in the lives of people with mental health issues, just like it is for other people who experience impairments that limit participation.

Fundamental number six, seek participation that's more like everyone else. The reason we talk about this is sometimes I'll present -- I'll talk about inclusion and participation and the importance of, for example, leisure and recreation, somebody might say to me... oh... my agency or my program already does a great job in that area. Wednesday afternoon is movie night, Thursday morning we do bingo and... they're talking about participation that is done at their institution, that maybe, the staff came up with, and... it doesn't promote interaction with other people, so... we started talking about participation on three different dimensions.

The first is, where does the participation take place? If it takes place at the institution or agency, versus in the community, participation that takes place in the community is participation more like everyone else. Watching a movie in a program or agency is not participation like everyone else. Watching a movie at a movie theater, out in the community, which is how I watch movies, that is participation more like everyone else.

The second dimension is, to what extent did staff direct or develop the participation that ended up happening, versus person direction of the participation and the last dimension is to what extent does the participation promote separation or segregation from other people? Versus association or opportunities to interact with other people, including people who don't necessarily experience an impairment or a disability.

So... I mentioned before, sheltered workshops are an example of participation, but... it's probably more at the separation end of this dimension and we can think about it as more institution or agency-based participation as well. The goal is association and community-based participation.

The main point here is to keep this, these dimensions in mind. When we think about community inclusion and participation and we want to seek participation that is more like everyone else. Fundamental number seven. I'm going to spend very little time on. This fundamental, basically point out that we have a number of effective strategies for supporting people with serious mental illnesses and other disabilities to live successfully in the community and to participate in all of these areas. These are really described in the Well Together document.

The main area I'd like to point you in the direction of, it's important for us to pay attention to the importance of natural supports in the lives of people who experience disabilities and including serious mental illnesses, natural supports... refer to unpaid support. These are family, friends, neighbors, clergy, coworkers, supervisors, other people in, in an individual's life who can or often do support community inclusion and participation for people we're working with and it's critically important, as we develop support plans to support inclusion and participation, that we attend to the role that natural supports can pay in people's lives. Paid providers can only do so much in people's lives and we only have a finite number of resources. It's important for us to support people who experience disabilities in identifying and developing natural supporters in their lives and then utilizing those natural supports, to support them in living their lives.

Fundamental number eight... providing support to family and other natural supports... promotes community integration. This basically refers to one important source of natural supports. That's family members.

Some of the research indicates that people who experience disabilities, that their family members aren't participating in the community like everyone else, either, just like... they're not participating as much as and family members can be a very important source of natural supports for people. Trying to enhance whole families in areas, we developed a number of tool kits and strategies you might find useful for supporting families and their loved ones in participating more in the community like everyone else.

I'm going to end with fundamentals nine through eleven and basically do this faster than I've ever done in my life, but... fundamentals nine through eleven have to do with the importance of

environmental barriers in limiting community inclusion and participation that people with serious mental illnesses and other disabilities experience. This is based on the notion of social model of disabilities and that disability or the lack of participation, results from a poor person environment fit.

Basically, the idea, is that the disability is not something that's inherent within an individual or inherent with a particular diagnosis or disorder... like schizophrenia. That disability or lack of participation actually occurs as a result of a poor fit between a person's uniqueness and their unique skills and capabilities and... the environment. What those environmental barriers might be... are things like prejudice and discrimination, access to resources, transportation issues, poverty in general, all of those are limiting the inclusion and participation of people with serious mental illnesses and other disabilities and... we need to pay a lot of attention to those environmental barriers and trying to overcome those environmental barriers.

The same notion was put into play, for example with people who experience physical impairments and... curb cuts and ramps -- were an example of an environmental change that removed those barriers and increased opportunities for people with physical impairment to move around and participate in their community. There's evidence in this direction that maybe 50% of the reason that people with serious mental illnesses are not participating in the community and all of those areas that I mentioned before. It's because of environmental barriers. Especially prejudice and discrimination, but poverty and access to resources are other major factors. Clearly, we need to do something to remove those barriers. We need to do more on prejudice and discrimination, our current efforts to reduce stigma, both in ourselves as Health Care professionals and in the general community hasn't been very successful, so... we need to address those kinds of factors. We need to be thinking about poverty and transportation and access to resources as being important and try to remove those barriers when we're supporting people with serious mental illnesses.

I wanted to end this webinar by talking about a specific money follows the person initiative that we implemented here in Pennsylvania. The reason I want to just show this to you is that it will hopefully give you some ideas about the types of supports and resources that, at least people with serious mental illnesses thought. In order to lead good lives and enhance their treatment and community inclusion and participation outcomes.

We call this the CRIF Demonstration Project and here are our partners who are involved in this project. We recruited people at the highest percentiles in terms of service utilization in mental health services in Delaware County, Pennsylvania and provided them with opportunities to direct their care, to make decisions about what types of mental, traditional mental health treatment services they wanted to receive, how often did they want to meet with psychiatrists or case managers or out-patient therapists or psychiatric rehabilitation services and it also gave them an opportunity to purchase non-traditional services that they could make an argument would enhance their mental health and wellness. CRIF constants for the Consumer Recovery Investment Fund. These are referred to as freedom funds. Those are the funds that people could use to, again, purchase goods or resources that they said would enhance their lives and ability to live successfully in the community.

We documented the types of things that people asked for. We referred to them as Asks and we categorized the types of Asks using that international classification of health, disability and functioning I mentioned before. These are the general domains that the Asks were in, but I really wanted to show you these kinds of specific asks and categories, the general Asks were related to, in some cases, handling

depression and anxiety, money to pay for driving lessons, pay a past-due electric bill, phone bill, groceries, entertainment, clothes, domestic life, getting money for bedding and utility bills, moving expenses that were connected to these, either to maintain their dwelling and furnishing or to do these other things. There were self-care-related Asks, memberships to a gym, buying nutritious food, getting money from Boston Market, Colonial Kitchen and restaurants to help with eating, access to those resources were a challenge to them.

Some other Asks related to mobility, education, jobs, taking computer classes, paying for GED classes, books, a laptop to be able to do school work and then there were Asks related to community, social and Civic Life as well.

This is a study we published a couple years ago... and I'd be happy to send you this article. The bottom line is the opportunity for self-direction and self-determination, the types of goods and resources that someone could ask for to enhance their mental health and wellness, we have evidence that it's promoted this promoted.

We've got a lot of findings in this area about how these were beneficial. So... again, you can send me a request... for -- this is the study -- Snethen et al., you can just send me an e-mail.

I know I went through this very fast. Making the argument for community inclusion and participation as a medical necessity, doing a good enough job with the fundamentals takes a long time, talking about this one type of intervention can take time. My goal was to give you an introduction and give you access to resources.

Again... I'm available to speak with anybody or to... you know, interact over e-mail or those kinds of things or... I'm available to you right now for your questions and comments. Thank you very much.

>> Mark, thank you so much. Finally, my technology is working again, so I can talk from my phone. This is an improvement, already, today. Thank you so much for the presentation and I know you had a lot to cover in a very short period of time on that. And I wanted to reiterate to everybody that has joined us today... the document you mention on the Well Together really is a great resource to take a deeper dive into these different fundamentals and I will go ahead and add a link to that when I send out the PowerPoint.

So... everybody can find that. I do have two questions that have come in so far... and the first one is when you were talking about fundamental number four... there was an acronym of WRAP on the slide, what does that stand for?
>> Yes... thank you for asking about that. I wish I could have gone through those in a little more detail. That is Wellness Recovery Action Plan. That was developed by Maryellen Copeland and the Copeland Center based in Vermont. These are plans that have primarily been used with people who experience significant mental health issues, to support them in identifying things that trigger mental health issues or stress issues or... maybe symptoms as well as strategies for addressing those issues when they do arise. It really helps people figure out what, what makes them not well... and what are the -- what are the things they do that help make them well?

And... this is a self-determination type of strategy because... the person really, the person is really driving the development of this. This is what they've identified as, as making -- as triggers for their

mental health issues and what they've I had as things that help them cope or deal with those issues and enhance their wellness.

>> Great... thank you. The next question is... we expect a lot out of our direct support professionals... and when they come to this work, they usually have very little experience or training or even professional support about community inclusion, but we're asking them to serve the function. How do you suggest we go about implementing your fundamentals when the workforce is not really prepared or trained to do so?

>> Yes... I think that's a great question. That's one of the hardest things we do with our center -- one of the first things we do is to help a person, a less-skilled person from an education standpoint or a more-skilled person, maybe somebody with a graduate degree, but we help everyone try to connect with the concept of community inclusion, themselves, by looking at their own lives and... looking at what their own participation is. What are things they'd like to do that they're not doing as much as they'd like to do. What facilitates they're doing things they want to do and what gets in the way of not doing things they want to do. Direct support, staff, professionals, really connect to community inclusion, participation personally, because... quite frankly, we all... we all... are involved in community participation and... all of these same factors are the same for us, as they are for the people that we're supporting and to really reflect on it, and maybe make some of the things that we do unconsciously, make it more conscious and explicit and then use those strategies, use those thought processes that we use in our own lives to support somebody else... so... that's the first thing we do. To just help people connect to it and... the process is really -- is that straightforward.

The second thing that we encourage is, is for people to work in teams. And... to really use that brainstorming, that understanding of different community resources that they might know about that might be helpful to somebody, to think about barriers that people might experience and how you can overcome these barriers. So... we really promote, and encourage, a lot of team work in promoting inclusion and participation. There's no one size fits all strategy. We talk about technical assistance and reflection, technical assistance either with us or reflection within the program or agency, especially supervisor skills and make sure that supervisors have developed strategies and skills in this particular area and... that the supervisors actually spend time with supervisees around these kinds of issues. Somebody's not just out there on their own trying their best. This is hard stuff that really takes, it takes feedback -- it takes reflection and time, just like our lives are complicated, that people, whose lives we support are also complicated and... getting feedback and support is really critically important.

>> Thank you very much. The next question was related to the demonstration project you talked about and... are there any outcome measures that have come out of that project?

>> So... we have used different outcome measures and I'd be happy to share those with people. The outcomes that we found were mostly qualitative outcomes. We actually didn't see a lot of -- I wasn't able to talk a lot about this... we certainly saw examples of people benefiting from this opportunity, especially related to self-determination and choice, but... we didn't see changes on some of our quantitative measures. In terms of -- we didn't see any bad things, we didn't see people get worse in any areas, but we didn't see positive changes we were hoping for. One of the things we found is that it was difficult for people to think outside the box or to think about non-traditional goods and services that might enhance their mental health and wellness. This is something that's been found in other self-directed care interventions as well. People who have been so engrained in the system and so...

used to other people telling them what to do or what they need... that when you say, okay... now you have the opportunity to self-direct and make decisions, people have problems, it seems, thinking about what these, you know... what these alternative goods and services, things that would enhance their lives might be. So... yeah... we didn't find the outcomes we were looking for... because it took some people a long time to start self-directing or... once they started self-directing and using these freedom funds, they didn't use what we think were enough of those funds to make much of a difference in their lives.

So... hopefully that answered the question. I'm happy to talk to somebody if they want to contact me.

>> Okay... great, I can always pull that information for you. At this time, I would say that we're pushing right at 1:00, so... I want to be respectful of everybody's time here. And... Mark, thank you so much for your presentation today. I know this was a fast-run together.

[Captioner has a hard stop at 1:00 p.m. ET].

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