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[Dave Glogoza] Hello everybody! Thanks for joining! Welcome to Collab chats, a podcast hosted by the Temple University Collaborative on Community Inclusion. The Collaborative is located in Philadelphia, Pennsylvania. We spent the last 15 years focused on full and meaningful community participation of individuals with serious mental illnesses.

The collaborative receives funding as a national rehabilitation research and training center from the National Institute on Disability, Independent Living and Rehabilitation Research. Dave Glogoza here, I will be your collab host today. I am joined by the founder and director of the Temple University Collaborative, Dr. Mark Salzer, Mark I believe you have some good news to share with all of our listeners?

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[Mark Salzer] Hey Dave, it's great to be here today and it's great to be here with everyone in podcast land. I do have some good news to share and you kind of talked a little bit about our funding being from the National Institute on Disability, Independent Living, and Rehabilitation Research, we actually got noticed earlier this summer that we've been refunded for another five years so we have a another set of research projects, training technical assistance and dissemination projects and I've got to tell you it's an honor to do this work and I promise everyone out there that we will continue to be as productive and impactful over the next five years as we've been over the last 15 years.

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[Dave] Perfect, this is great news. We're going to talk a little bit about that work. We will talk a little bit about the history, you know what is community inclusion? I know I for one had no idea of this concept, so we'll shine a little bit of light on that, talk a little bit about how the center came about, you know, what's intriguing about this area of research, and of course what the future holds.

Mark holds many titles along with being the founding director and principal investigator of the Temple University Collaborative on Community Inclusion, he is a professor in the College of Public Health at Temple University, he was also the founding chair of the department of rehabilitation sciences, he is a licensed psychologist, a consultant, an author, a mentor, a journal editor, and he serves on various committees both at Temple and in the mental health community. I have his CV here in front of me to prepare for this and I can tell you it is very long.

So before you know we get into anything of substance I guess for you know people who don't know what is community inclusion?

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[Mark] Well first of all I I don't know why you printed out that whole CV because it is pretty long but again I'm excited I'm fortunate to be able to do what I do and had a lot of fun doing it.

Community inclusion refers to the rights that people with disabilities have to live meaningful lives in the community like everyone else it refers to the opportunity to live work or school play, pray, date, have intimate relationships and generally participate in our communities like everyone else participates in the community.

It also means the community's fully welcome and embrace people who experience disabilities in the community. I've been excited to help increase awareness of this concept in mental health over the last 15 years or so.

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[Dave] So this is not necessarily very traditional of concept in terms of you know, mental health and research. Usually when somebody thinks of you know some of the schizophrenia you know they need medicine they need some kind of meds to fix their problem, so how does this differ from that how does this maybe even work with that what is what is it the basis of this as opposed to you know the traditional talk that we all always hear?

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[Mark] Right so I guess a traditional mental health approaches focus on disability focus on disorders, disease, symptoms, those kinds of things and what we really get to focus on is what people are able to do and the importance of doing those kinds of things in the community. So we get to focus on work, and why work is important to people's mental health and wellness, as well as physical health and cognitive health. We get to focus on the importance of education, and leisure, and recreation, and spirituality, and religion, and lots of different things like that, and why it's important in people's lives.

So we focus on participation as a medical necessity, the type factors that affect participation and people might be surprised that it goes beyond genetics, it goes beyond biology and diagnosis there are a lot of things outside of individuals and maybe the symptoms of mental health issues that they experience that affect their ability to participate in the community like everyone else. So those are the kinds of things that we do and why it's different.

We really get to focus on the capabilities of people with significant mental health issues who have traditionally, I guess, been viewed as not having much to contribute to society, or it's thought that they're not able to contribute or participate in society. Our work actually is demonstrated that people are able to do this and it's critically important for us to support people's inclusion and participation in the broader community.

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[Dave] So I guess for anybody sitting at home who, you know, has no idea about you know mental research or community inclusion research, or what you just said is the first time they heard anything about it: what would you say to people who you know- somebody has schizophrenia, they shouldn't have a job or they're not well enough to have a job? It's safe at home, it's safe in, you know, their program it might not be safe at a job or at school.

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[Mark] Well you said a lot of stuff there, I'll try to do my best to respond. I mean you use the term should or could, or shouldn't or couldn't, and one of the first things that's a foundation of our work is, we do here some of our colleagues who in the mental health community who think that people with significant mental health issues/with serious mental illnesses wouldn't work, wouldn't go to school, those kinds of things or they couldn't do this kind of stuff, or they shouldn't do this kind of stuff.

One of the types of research that we do is actually bring together the evidence, and generating some of the evidence indicating that people would, could, and should participate in all of these areas again: work, going to school, dating, parenting, leisure, and spirituality, religion, voting, volunteering, doing everything like everyone else.

You also talked about or mentioned some of the environmental factors that affect people with significant mental health issues just like environmental factors affect all of us and affects all of our lives as well as our health in in health care. We actually, in public health, we actually talk about social determinants of health. So things out in the environment that affect health beyond genetics or disease or biology, there are things outside of people.

In the disability community we have a particular framework for understanding the impact of environment and that's called the social model of disability. Pretty much everything we do at the Temple University collaborative on community inclusion is in some way consistent with the social model of disability. So, let me try to explain it in this way: the individual model of disability or the traditional model of disability views the disability as being inherent within the individual and what that means is somebody who's been diagnosed with schizophrenia, or bipolar disorder, major depression, because of that diagnosis, they are disabled. It's something within them within their biology or their genetics or their symptoms that explains why they're not working or going to school or dating or parenting or all of those things that we talk about. And from that perspective the way you reduce disability is by fixing the person. You give good medications or therapy or something else that targets their impairments and by doing that you reduce the disability.

That is a traditional perspective on disability and really a more modern perspective on disability is the social model of disability and it's actually something that's been around for really 40 years plus now. People started talking about this in the broader disability community

in the 1970s and this, the social model of disability views disability is resulting from a person environment fit and in this case it's a poor person environment fit, so there's something about the individual their uniqueness and abilities that are not overlapping or connecting with the environmental context. And that lack of connection is what causes the disability, is what causes unemployment and people not being successful in school, or dating challenges, or social relationship challenges or whatever area of participation that we're talking about. And that from a social model of disability perspective you can address the uniquenesses of the person, maybe symptoms and that might enhance someone's ability to participate to a certain extent but it won't lead to full participation.

The other way you could address it is by addressing the environmental barriers that limit people's participation. In mental health, well let me talk about the physical health context. In physical health context for a long time, people have identified environmental barriers, especially physical barriers, as limiting the participation of people who use wheelchairs for example and this is why we have curb cuts and ramps and things like this as an environmental barrier that enhances people's ability to get around in their communities and participate. People who have sensory impairments, people who have visual problems or auditory problems we have a Braille signage we have auditory communications so you're on an elevator and it announces what floor you're on, that's going to support somebody who has a visual impairment to be able to know what floor their on so they can participate. People who experience psychiatric disabilities, the major environmental barriers are poverty, access to transportation and other resources, and a major barrier outside of them is prejudice and discrimination. So our work is really about trying to enhance that person environment fit and understanding that the reason the people are not participating is not just because of symptoms and impairments related to a particular diagnosis, it has to do with a poor person environment fit.

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[Dave] So it's almost as a holistic approach as a whole as opposed to just looking at this one part of it?

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[Mark] I mean I think more holistic, more contextual. Also it's more strength based, so it identifies or recognizes that people are not just you know a bundle of symptoms or deficits, that people do have strengths and uniquenesses and we can create participation that really takes advantage of people's strengths and uniquenesses and capabilities and should be doing that and that really isn't an orientation that the broader disability is taken and the mental health disability or mental health community has been a little slower in adopting that framework and it's one of the things I'm most excited about with our Center is we've been able to introduce some of these concepts that again the broader disability community has been talking about for 40-plus years, and we've really been bringing in into the mental health community.

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[Dave] And so I know this isn't this doesn't just benefit, you know, people with serious mental illnesses or people with disabilities, this actually benefits society as a whole, it benefits all of us. Can you touch a little bit upon that?

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[Mark] Yeah, I mean first of all there's lots of research indicating that a society that is more inclusive and welcoming of difference are healthier societies, they're also economically stronger societies. There's something called the capabilities theory that has won a Nobel prize in economics and basically the idea is that cultures countries that promote the capable of all citizens are more economically strong than cultures that don't.

There's evidence, indications that employers that have a more diverse workforce are more productive and more creative and do better and there's a sense that really any kind of community or you know, educational communities, colleges and universities, religious communities, neighborhoods that are more diverse, are stronger and do better both from a mental health and wellness standpoint as well as an economic standpoint.

So we, diversity promoting diversity inclusion is a good thing. And that includes not only racial or ethnic diversity, gender diversity, and diversity in terms of people who experience different types of impairments including people who experience mental health issues in their lives.

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[Dave] So if I run an agency or I you know I am a policy maker what kind of things can be done to promote community inclusion? What can I do at my agency to say hey this this all sounds great, I heard Mark Salzer, I read, you know, all the documents over at [tucollaborative.org](http://tucollaborative.org) and heard him talk, what can I do, what is this first step?

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[Mark] well I'm glad you got the [tucollaborative.org](http://tucollaborative.org) plug-in there, and we would recommend that people go there and see all the documents we have and a lot of different areas. Boy there are a lot of things that agencies do. The first thing is actually recognize that a number of agencies are doing some great things. Some agencies and some communities counties or states do have employment programs, they do have housing programs, some, very few, but some have programs that support people's educational attainment, be it obtaining a GED or going back to college or these kinds of things. But the issue is, it's not enough. They're not, there's not enough funding for these programs, there's not enough attention to these types of programs, or there aren't enough referrals to these types of programs.

I do speak with employment and educational programs in particular and I know their agencies have tons of people who can work, who can go to school and they're not being referred to these types of programs. So, the first thing is again to recognize the good things that are happening but also understand that more can be done.

I would say one of the first steps might be to even get an understanding of the current extent to which people are participating in your agency or programs. We have developed something called the Temple University Community Participation Measure that is free for anybody to use. It asks individuals how many days last 30 days they participated in different areas, is this area important to you, and do you do it enough not enough or too much and we've worked with many agencies and programs around the world to gather information using this measure to get an understanding of you know to what degree are people that they're supporting in their agencies, to what degree are they doing what they want to do and this really raises awareness of the need in programs or agencies, so that's a first step.

A second step is to develop new initiatives to support people and participating in ways that they want to participate this doesn't always have to include or doesn't always require new money. I know that mental health systems nationally in states and counties are strapped for funds sometimes, but it's important for current funded programs to pay more attention to community inclusion and participation. This could be residential programs, case management programs, psychiatrists, outpatient therapists, any type of programs--psych rehab program, club houses, drop-in centers. Lots of different funded services that are out there can pay more attention to understanding what people with significant mental health issues want to do in their lives, and figure out how to support them in doing that. And again, a lot of the resources that we have on [tucollaborative.org](http://tucollaborative.org) really do just that. Help people, help providers as well as consumers, people with lived experience think about how to promote inclusion and participation.

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[Dave]So, this is about, you know, helping people get out in the community, but I guess that an important piece is, you know, to help people do the things they want to do. I guess that's an important step that possibly could easily be overlooked?

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[Mark] Yeah. I think it's sometimes overlooked because we--traditional perspectives about people with significant mental health issues is that they might not, or there's a belief that people with significant mental health issues don't make good choices in their lives, and that other people need to make those choices. And we actually have evidence that the promotion of self-determination and choice actually leads to better outcomes for people with significant mental health issues.

So, a community inclusion and community participation perspective means supporting people in doing the things that they want to do. That's critically important, and again I use the word self-determination, and promoting self-determination and choice as being key. There is some evidence suggesting that self-determination and choice, for example, will lead to enhanced service engagement. People will be more engaged in services, may be more likely to take medications, to meet with their case manager, to engage in certain therapies or treatments if they're doing that for reasons that they think will benefit them. So it's their choice, it's self-

determined. So, that is critically important to this, supporting people in doing what they want to do will keep people engaged, and it also will support people in doing the things in the community they want to do. Not everybody wants to go to work, but those people that want to go to work, we should be supporting them in doing that because work is associated with good outcomes. And again, that's the same for education, leisure/recreation, hanging out with friends, going to church synagogue or mosque-- self-determination is really a key part of promoting community inclusion and participation.

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[Dave] I guess I'm also thinking, so you know, if somebody initially did not want to, you know like you said, go to work or hang out with friends maybe a provider could get very discouraged and, say you know, this person doesn't want to do anything, but I guess I'm wondering if there's, you know, certain strategies or ways around that, or a persistence to kind of pass the initial not wanting to do anything because some people, you know, haven't been participating in the community for a long time, so to want to do it might not be the first thought that comes to their mind.

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[Mark] Right well, actually I'm, I'm thinking about a bunch of things as you, as you're talking. The first thing is self-determination and choice doesn't mean that everything is, everything is allowable. So sometimes I'll talk to people about self-determination and choice and they'll say, oh great so the person I'm working with, that they say that they want to go, you know, walk nude in the middle of a busy highway when it's minus 10 degrees outside, we should allow that to happen. Or somebody wants to jump off a building or otherwise hurt themselves or hurt somebody else, that's self-determination and choice. And promotion of self-determination and choice doesn't mean that everything goes, especially if somebody's a danger to themselves or others, that does not constitute self-determination and choice. Okay, that's the first thing.

The second thing is we, I am sensitive to conversations that our provider colleagues have with folks that they're working with, and sometimes individuals will say that they're not interested in doing anything, or you know they don't want to go back to work or maybe not now they're interested, but they don't want to do it now, and I would really encourage providers to dig in a little bit more into that to understand the reasons why people are not interested in participating. One reason for that is all of our research actually indicates that most people are interested in doing this kind of stuff, and most people find it important, just like most of us find participation as being important, but people with significant mental health issues sometimes say that they don't want to do things because a provider has told them that they can't do this, or a family member has told them they can't do this, or that it will be harmful to them. Or sometimes around employment, people fear losing benefits, especially social security entitlement benefits if they get jobs, and they might not be aware of the different incentives to work that they can actually make a certain amount of money even while maintaining their Social Security benefits.

So really what I would recommend to, to providers is to have fuller conversations with people to really understand why someone says that they might not want to do it or reasons why somebody might not pursue an activity even if they say they want to do it, because there are oftentimes these environmental factors that are keeping them from doing it. Again, one of the big factors is people have been told for 20 or 30 years that they shouldn't do this, that going to work will cause stress, stress will lead to an exacerbation of symptoms, exacerbation of symptoms will lead to crisis, and crisis will lead to hospitalization, which is why you shouldn't work, you shouldn't go to school, you shouldn't date, you shouldn't parent, because we don't want people to be hospitalized. and unfortunately what that does is limits people from benefiting physically, cognitively, emotionally, and from a wellness standpoint, from participating in all these areas like everyone benefits from these areas.

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[Dave] So you touched a little bit a couple of times upon, you know, different domains of participation. What exactly are these domains, how many are there, you know what do they consist of?

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[Mark] Right, so I-I don't often count them, but this would be, you know, typically it's employment, education, leisure/recreation, spirituality/religion, voting/volunteering. Really living, anything that anybody does, these are the community inclusion domains that we really focus on. And we do believe that it's important to focus on all of these domains. We talked earlier about some of the good things that are happening around the country and around the world in inclusion and participation, and employment and housing are two of these areas. There are resources, there are programs in these areas--there aren't enough, and people aren't referred enough--but these do exist. But one of our concerns, and one of the things that I think we are having the biggest impact on is raising awareness about the promotion of inclusion and participation in these other areas. Again, education, parenting, dating and intimate relationships, leisure and recreation, voting and volunteering, all of these other areas are just as important as employment and housing for people's physical, cognitive, and mental health and wellness.

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[Dave] So, right now you mentioned the Collaborative's, you know future funding, current funding, so what's going on at the center right now? What kind of research projects, what kind of training projects are going on?

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[Mark] We're in a great spot in that we're ending our current a five-year cycle of projects where we've done some innovative work on leisure and recreational intervention support, an education intervention, restorative justice: we're looking at reintegration for people with significant mental health issues who have been in the criminal justice system, we're looking at the importance of community inclusion and participation for people who have experienced

recent homelessness and are going into housing and the importance of inclusion participation for enhancing people's community tenure in housing. So we're doing a lot of exciting projects and finishing up our data collection and folks can be looking for some of our publications of these studies and some presentations on these things and that'll be happening really has been happening over the last five years and will be happening over the next couple of years.

In the next five-year cycle that starts in a couple of weeks here, September 30<sup>th</sup> we officially start our next five-year cycle of funding. The next five years we have some exciting research, we again try to do randomized control trials as much as possible, as well as looking at interventions, as well as raising awareness of factors that affect community inclusion and participation beyond diagnosis, beyond symptoms.

So in the next five years we're looking at studies of interventions looking at bike share programs as a strategy for increasing people's mobility in the community, looking at travel training programs and seeing how effective those are in enhancing community mobility and participation, we're looking at the extent to which coordinated specialty care programs for people experiencing a first episode of psychosis include community participation, and the reason we're doing that is community participation is viewed as not only important for participation of young people and it's that community participation of young people is not only important for their physical cognitive and mental health but we also believe that a focus on community participation will enhance their engagement in these types of programs so we're excited about that study. We're looking at community inclusion and participation in rural areas are there unique factors in rural areas, does participation look different or their different environmental barriers and characteristics? We're looking at the impact of a Photovoice based intervention for college students with mental health issues. We're doing all sorts of exciting research I get I can't even keep track of all of it we're doing so much.

From a training and technical assistance and dissemination standpoint, what you and I are doing right now with this podcast is an example of a new innovative strategy in that we're taking to get the word out about this type of research.

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[Dave] So backing off of that, so technology, and social trends are a huge factor, for example this podcast. There was a big kind of project that was recently concluded using GPS technology, can you talk a little bit about that?

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[Mark] Yep so I mentioned before the social model of disability and how important we think attending to environmental barriers, things outside of people with serious mental illnesses, how it's important for us to pay attention to this. Just like the other disability communities have done, physical, sensory, cognitive, intellectual, and developmental disability communities have all looked at environmental factors as it relates to in community participation: we need to do the same in mental health.

We have traditionally, and this is probably one of the areas where I think we've had some of our biggest impacts in the field over the last 15 years, we've been using GIS geographic information systems to understand where people with serious mental illnesses live in their communities and what kind of access to resources they have, what kinds of social factors they're affected by there that impact their lives based on where they live.

For example we know that people with serious mental illnesses live in some of the poorest communities, poorest neighborhoods and our communities, they're exposed to high levels of crime, they're exposed to high levels of unemployment, they're exposed to high levels of physical inadequacies, broken down you know housing, abandoned housing, broken windows, sidewalks and ill repair: so that's GIS.

You mentioned GPS, we're just finishing a study where we've been tracking people using Global Positioning Systems to understand how people with serious mental illnesses move around in their communities, to understand how much time people spend outside of their homes, you know how far they go away from their homes, what kind of neighborhoods they go into, and we're also using GPS to look at destinations: different places that people go to in the community. This is helping us understand, again, how to understand people's lives in the community as well as using possibly using GPS as an outcome measure.

So we might do a study, we actually are doing transportation studies with bike share and use of public transportation, and we'll look to see whether or not people are out of their house more using GPS after being trained and using public transportation or trained and using a bike share so that's some of the stuff we've been doing with GIS and GPS.

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[Dave] So it sounds like both the research and the dissemination of that research came a long way so I guess what I would be wondering is, you know, how did this start? So you got your degree in psychology, PhD in clinical psychology, at what point did this concept of community inclusion enter the fold here and how did we kind of get on this path?

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[Mark] Well I do like to say that I've had in some ways a pretty traditional training and pretty traditional work experiences. One thing I sometimes mention is my grandfather was psychiatrist, and my mother was psychiatric nurse, sometimes I jokingly talk about myself as having a royal lineage in psychiatry in the sense that my grandfather was co-credited with coining the term antidepressant.

So I've worked on pharmaceutical studies, I've worked on studies looking at biological factors associated with serious mental illnesses, so I've done that traditional stuff but I've also been I guess I would say that, I've been open to listening to people with serious mental illnesses and especially seeing people who have received a diagnosis of schizophrenia, bipolar disorder, major depression, other related diagnoses and seeing these individuals as people like everyone else. So I would say that that might be what got me in this direction of looking at

community inclusion and participation because what I constantly hear from people, and I've worked in inpatient settings for a couple of years, I've worked in outpatient settings, I've talked to lots of people, and I've listened to people say that inclusion and participation is important to them and that this is a primary concern in their lives and that participation would enhance their physical and mental health and wellness so I think that that's really what's influenced me and driven me to do work in this area.

I've had the good fortune of working with people in the consumer and peer movement for about thirty years now and part of that is, listening to what people want listening to what people say is, is beneficial to them there's a really actually somebody who I idolize who is a psychologist, but she's also somebody who has been diagnosed with schizophrenia. Her name is Pat Deegan and she talks about personal medicine and personal medicine are things other than medications that benefit people's physical and mental health and wellness and this concept really intrigues me because she'll talk about how you know work is personal medicine for people, going for a walk is personal medicine, going to school, really participation and inclusion hang out with friends is personal medicine, and really for us to understand that, this kind of stuff is also beneficial to people other than medications or therapies that's really central and that's what drives me as well in this work.

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[Dave] So as we mentioned so the center started in 2003, that's a long time ago, so what are the things, some of the things you were most proud of over the last 15 years that the center has been in existence?

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[Mark] Wow. There's a lot of things I've been really proud of. First of all I can't believe it's been 15 years. It's gone really fast and I guess that means that we've been having fun, and it also means that yeah... that I'm really proud of what we do. I think one of the things I'm most proud of is our inclusive approach at the center we actually intentionally call ourselves the Temple University Collaborative on Community Inclusion, because we've taken the notion of nothing about us-without us to heart, and everything we do and to that end.

Our Center has involved the full inclusion of people with lived experience in all areas of our work, our research, and our training, and our technical assistance, and our dissemination. People with lived experience have played major roles and not roles on advisory panels or simply on advisory panels or giving feedback, people have had major roles in all areas of our Center and that will continue over the next five years. We have some individuals with lived experience who are participating and will continue to participate and that's something that maybe first and foremost I'm most proud of. I think over the last 15 years we really have raised awareness about inclusion and participation in mental health and in the last couple of years that has been particularly evident in terms of our arguments and documents that we've been producing that have been well received making the case for the medical necessity of community inclusion and participation. We pulled together a document called "Well Together" where we make... We provide the conceptual and research evidence base behind

inclusion and participation as having physical cognitive and mental health and wellness benefits for people with serious mental illnesses, so I'm proud of that. I actually... Dave you know that I pulled together a nice little graph showing that that after 2003 when our Center was first funded that there's been an increase in the number of publication, peer-reviewed and scholarly publications using the term community inclusion and community integration for people with serious mental illnesses and while correlation does not equal causation I hope we had an impact there, so I'm proud of that.

I think as I mentioned before, I think we've had an impact on helping people understand the importance of environment and context on the lives of people with serious mental illnesses, again social model of disability is critical for this and I think we've had a big impact in that area as well. I am proud of our work and under studied areas or poorly understood areas that are critically important to people with serious mental illnesses. So these would be areas like dating, areas like parenting, areas like leisure, and recreation. Areas like spirituality and religion, and transportation, all of these are areas that people say are critically important in their lives and there's very little research that's been done to understand their importance or develop interventions to enhance people's abilities to participate in these areas So, I'm proud of that.

I'm proud of the new intervention approaches and models we've been using we've been using looking at social media and the internet and other types of technologies to promote community inclusion and participation, so I'm proud of that.

I think we've been at the forefront of promoting and trying to understand peer support interventions, and peer delivered interventions related to community inclusion and participation, so I'm proud of that. And finally I think we're doing kind of cool stuff and you're involved in some of that now in terms of translating our research and knowledge that's been generated from our Center and from our different studies into policy, program, and practice change. We've developed new products, we are using social media, we're doing podcasts, were doing lots of training and technical assistance around the world to get the word out. There's been some research suggesting that it typically takes 17 years for research to have an impact on practices or policies, or those kinds of things and we're trying to shorten that significantly by aggressively working to get the word out, so I'm really proud of all this stuff. It sounds like a lot, but I think... I just think it's been... It's been great and I'm excited about the next five years too.

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[Dave] So in kind of wrapping it up here I guess before we go. What is your favorite thing to do in the community?

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[Mark] Some of my favorite things to do in the community, I like hanging out my with my wife and my children, I like sporting events. I go to Temple football games and basketball games,

sometimes they're not always doing well, but I go anyway. I love going to plays, that's something I've been able to do the last couple years. That's been a change that I've made in my life recently. I like to go to the gym, the gym is not for everyone and I get that, but I really enjoy it. I like to work out, so those are things I like to do. I am... I don't like going to a lot of restaurants, I go out to eat too much because I travel a lot, so I'd like to cut back on that kind of stuff and I guess I'd say, I like my work I'm fortunate, I like what I do. I do work a lot and I have no complaints about it.

0:43:31.779

[Dave] Perfect, thanks Mark. Thank you Mark for taking the time to do this. For anybody listening, if you want to learn more, feel free to reach out to Mark, or the Collaborative at [tucollab@temple.edu](mailto:tucollab@temple.edu), that's [tucollab@temple.edu](mailto:tucollab@temple.edu), and also we can be reached at [tucollaborative.org](http://tucollaborative.org) and you can also reach us on Facebook, Twitter or Instagram @tucollab on Facebook or Twitter and at @tu\_collab on Instagram.

Thank you everybody for listening.

[Music]