The Future of Supported Employment

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Personal Introduction

Thank you very much, I appreciate the warm introduction. It's always a pleasure to be back in the country that my family comes from, like many Americans, and to see old friends here. I would also like to say from the beginning that I'm envious that you have such wonderful think tanks and policy centres as The Sainsbury Centre and I wish we had a comparable organisation in the United States.

In the interests of full disclosure I want to say from the beginning that I'm not a vocational specialist. I got into this field honestly in the sense that I come from a family that is riddled with mental illness, so at least three generations of people in my family have suffered from serious mental illness and I'm sure I was destined to do the work as a clinician and researcher that I've done for the last 35 years now. I really only began to get interested in vocational services because after about 15 or 20 years in the field I couldn't ignore any longer the fact that my patients were always saying they would like to go back to work and they wanted a meaningful role for themselves in life and I thought, well, of course you do. When I look at my family members that's what sustained them and helped them towards recovery over the years.

And so in about 1990 we launched a series of studies to try to figure out how to improve vocational outcomes. I was very fortunate from the beginning to meet two people who have become my closest colleagues over the years, Deborah Becker and Gary Bond who were already interested in vocational services and were kind enough to teach me what we knew about the field so far and have been kind enough to be on the journey with me for the last 15 or 20 years as we hopefully move this field forward a bit.

Lecture Introduction

So with that brief introduction let me launch into this. We have recognised in our country only recently I think that recovery is a goal that we would like to endorse for all people with mental illness, the President's New Freedom Commission Report is really the road map for mental health services in the United States and we're hoping that it will be the road map for funding in the near future too. So far we've had the road map as an unfunded mandate in the mental health system. It's nevertheless inspirational in many ways, not the least of which is its identification of work as a primary goal for people with mental illness and it's a key central feature of recovery.

Now what I'm going to try to do tonight, and I have to put on my glasses to make sure I know what I'm going to try to do, what I'm going to do is really just review briefly four areas and I'm going to go over these in the sort of sense of public interest rather than research details, although I'd be happy to send you papers or give you research details at other points. But what I'll do tonight is first talk about the current status of supported employment. Here I really should say from the beginning that as a researcher I'm convinced at this point that this is one of the only effective treatments and clearly

the most effective treatment that we have for serious mental illness, it's much more than a vocational endeavour. In following people for 30 years and then following patients who are in dozens and dozens of research studies that are sent around, it's totally clear to me at this point that there's nothing about medications or psychotherapies or rehabilitation programs or case management programs or any of the other things that we study that helps people to recover in the same way that supported employment does. That doesn't mean that we've had success with everybody and I'll try to give you a feeling for that, but it does mean that for a significant portion of people we've had tremendous success in the sense of helping them to get out of the mental patient role and recover meaningful lives.

It's also true that as we've had this kind of success, the limits of supported employment and who we can help and how much we can help them have become more and more clear. I think in the field now there are a variety of studies looking at amplifying the effects of supported employment and I'll describe briefly for you a number of them. And then finally I'll tell you about our own efforts and what we're modestly trying to do in order to push things ahead a bit faster. So those are the four topics.

Current status of supported employment

First - the current status of supported employment. I should also say from the beginning, I think it was clear from what Bob said, that my area is people with serious mental disorders, the 5% or so of the population who are disabled by their psychiatric illness, who are on psychiatric disability payments for years and years, and I don't claim to be an expert on employment services for people who have less serious mental disorders, but I'd be happy to try to entertain questions in those areas. OK, so we know a few things, the first is that supported employment is vastly superior to any of the other interventions that we've tried, and I've studied many of them, to help people achieve their vocational goals. We also know that a number of other benefits accrue to people, not by being in supported employment but by being in jobs. And so it's really the people who become consistent workers who benefit in so many other areas of their adjustment.

We also know, and I think this is an interesting point because I was very unsure of it at the beginning, you know all of the research studies, at least in the United States, go for a year or two years at the most because that's all we can ever get funding for, and the initial studies of supported employment showed that we were greatly successful at getting people in jobs for five or six months. But we didn't know if that really affected the trajectory of their employment or of their lives over time. We now know that if we can get people started in work it actually improves over time, and I'll show you some data on that and that's a consistent finding across the long-term studies.

And finally we know that supported employment at least compared to other mental health programs, is relatively simple and easy to implement, so that we've had great success implementing it in a variety of programs in different areas of the United States, different real world routine mental health programs and in fact in different programs around the world.

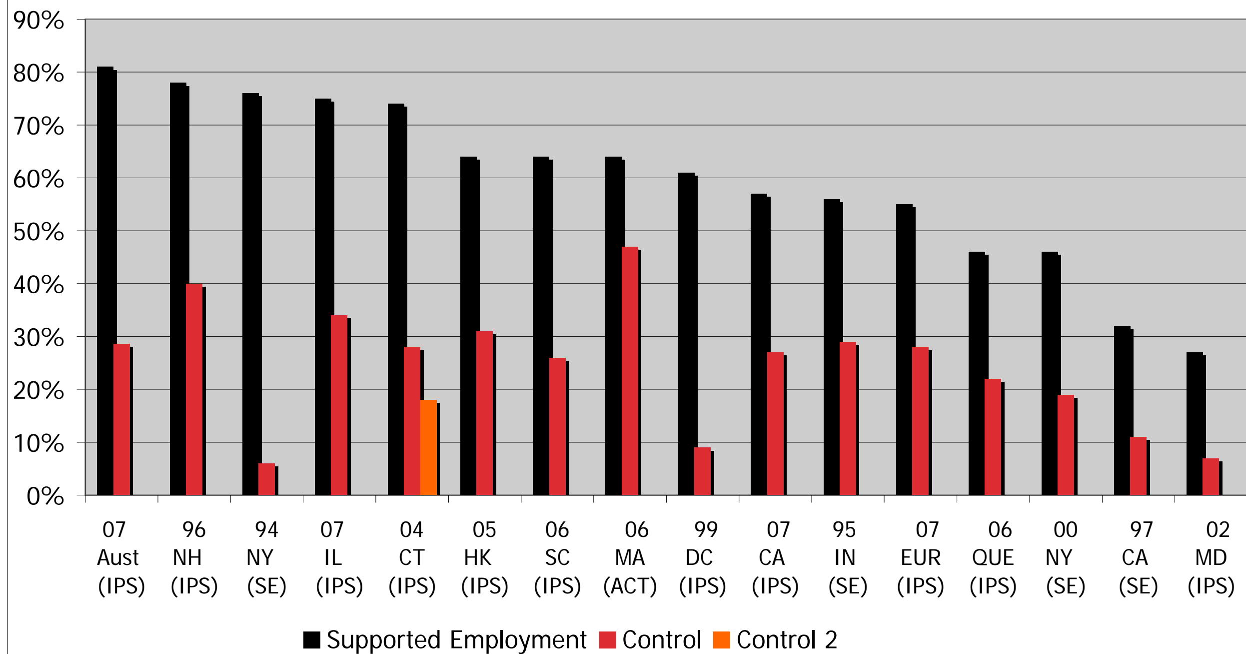
So as this work has gone on for the last 18 years now the model of effective services has become more and more clear. Deborah Becker and Gary Bond have in fact just revised the Supported Employment Fidelity Scale to reflect a lot of the findings as things have evolved over that time. But it still focuses on these main features:

- Since people want competitive jobs, we should try to help them from the beginning to get into competitive jobs.

- It's more efficient to use a team orientated approach so that mental health professionals and vocational professionals are working together.
- We should pay attention to the client. I hope client is a word that you use here in this country, I know that it varies in our country from state to state and time to time, but by client I mean patient or user of mental health services. Client choice is terribly important in terms of the timing of services and of going to work and the client usually has a much better sense of this than professionals do.
- We know that most people don't understand, at least in the United States, the complex structure of their health and disability benefits and so benefits counselling is an essential part of the model.
- We also know that all of the pre-vocational training that we used to do and that I was taught was terribly important when I first got into this field, is probably terribly ineffective and that starting with the rapid approach to searching for employment is much more effective.
- And we know that matching jobs carefully to the client's interests and skills is an important feature of the model and that people who are in jobs that match their interests are much more satisfied and stay in their jobs much longer.
- And finally we know that many people are going to require ongoing support as they develop not just their first jobs but try several jobs and develop careers over time.

So those are the essential features of the model as its evolved and the details of all of these are much better worked out than they were 15 years ago and we'd be happy to send you copies of the current Fidelity Scales and training manuals.

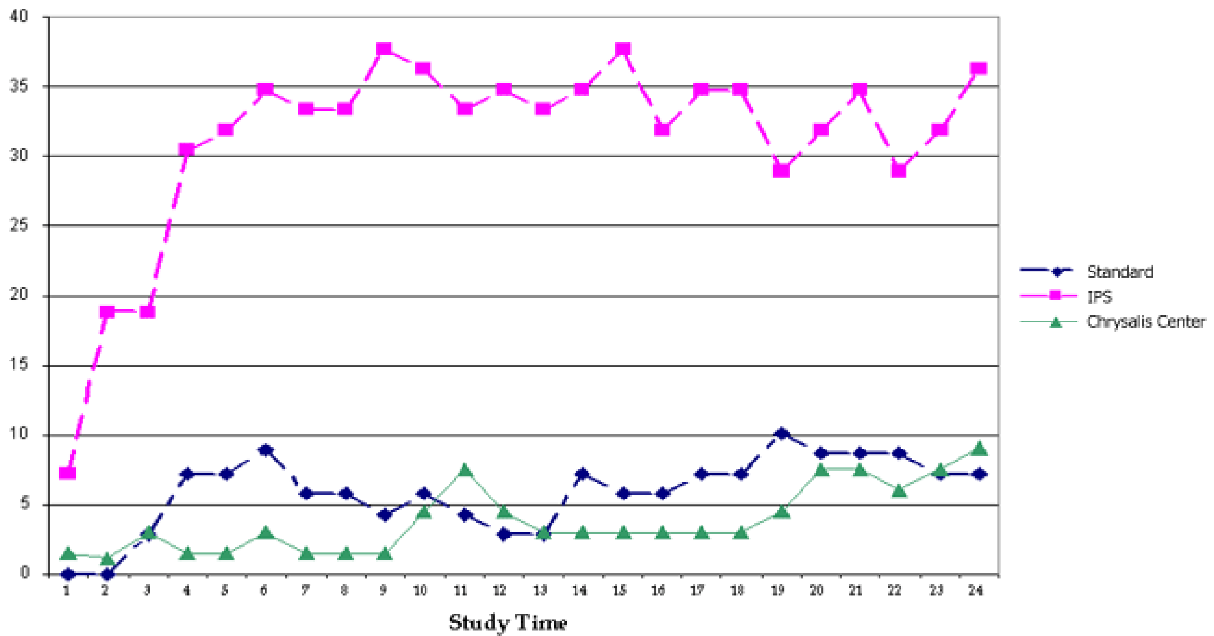
OK, the evidence base for this intervention is strong, probably stronger than anything else we do in mental health. You know when we do medication studies we tend to have to have hundreds of people in the studies because the effect size is so small that you really can easily miss it if you don't have overwhelming numbers. But that's not the case in supported employment, it's such a robust intervention that, as you can see in this slide, it's superior to everything else that it's been tested against, in every country that it's been tested, with every kind of client and mental health worker where it's been tested.



So there are 16 in this slide, there are now 18 randomised control trials looking at supported employment. It's better than all sorts of forms of psychiatric rehabilitation, clubhouse models, transitional employment programs, on and on and on, where we've had the opportunity to test it.

In the modal study, about two-thirds of the people are successful in getting into competitive jobs, the jobs usually begin a few hours a week, they typically, in the United States at least, build up to about 22 hours a week and that's because they're limited by the health insurance trap that exists for people who are on the Medicaid Insurance in our country. The typical first job lasts about five months and the typical client in these studies tries two or three or more jobs before they settle into a job that really becomes a long term career. So when we just follow people for a year it looks like they're brief jobs and when we follow people for 10 years it really looks like they settle into a job that they consider close to their heart, just the same that most of us do, and that is a career and part of their personal identity that they stay in for years.

Percentage competitively employed in 24 month period



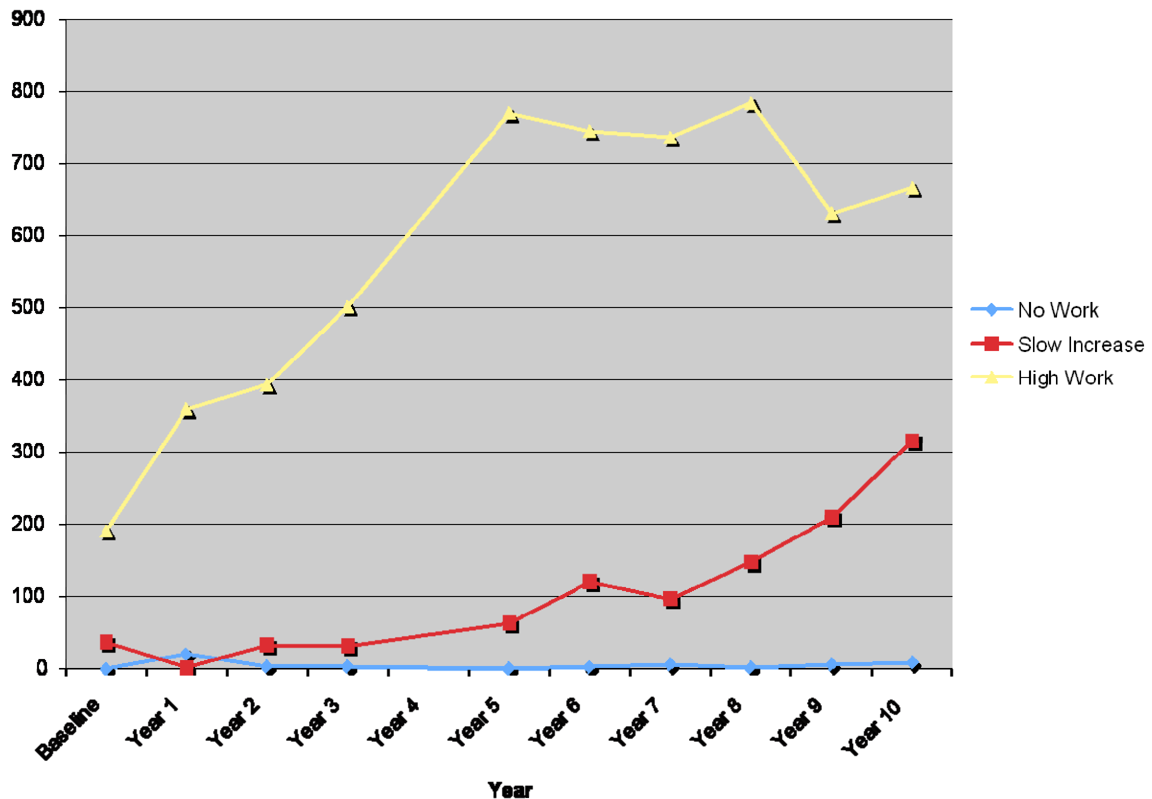
CT Supported Employment Study (Mueser, 2004)

This is a typical study, by Kim Mueser in our group did in Hertford, Connecticut, and we did the study there because we were able to have the kind of racial and ethnic diversity that we're interested in today in the United States, so it was a third Hispanic clients and a third African-American clients. And you can see that after the first two or three months of the study in any month about 35% of the people who are getting IPS supported employment were in a competitive job compared to clubhouse and the psychiatric rehabilitation programs where it was more like 5 or 10% of the people in any month were in competitive jobs.

Now Gary Bond has showed very clearly that it's not supported employment per se but being in a job that helps people to improve their self esteem and their lot in life in many ways in terms of how they learn to manage their mental illness in terms of how they think about quality and life satisfaction in their lives. And these gains accrue over time and the longer that people stay in competitive employment and it's very clear that the same gains do not accrue for people who stay in sheltered employment for similar amounts of time, even if they earn similar amounts of money. I sometimes hear professionals say, we might as well put people in the more sheltered kind of jobs where we can watch over them, particularly if we can pay them well, there's really no difference. But the clients somehow perceive a difference, they know that a real job is a real job and a sheltered job is not.

The long term outcomes which I told you I worried about for many years at the beginning are really pretty strong. We now have six long term studies and four of them that have followed people for at least ten years. Every one of these studies the outcomes improve over time rather than deteriorating over time. And again, that's different from anything else I've ever studied as a mental health intervention, in general we have to keep giving people medicines or keep giving them psychotherapy or keep giving them various kinds of supports or the effects erode rapidly. But that doesn't seem to be the case in supported employment. It looks more like if you launch people on a trajectory of working that natural forces take over and somehow they make connections in the community and they build their own strength and resilience and if you come back a few years later, even if they

haven't had a lot of services they're doing better rather than worse, that is working longer, working more hours.

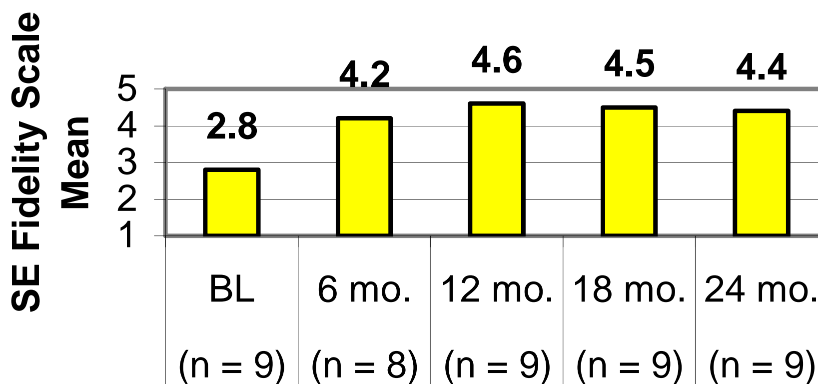


One of the really remarkable things that we've just learned, this analysis is not yet written up, but in one of our studies, and this is actually a study of dual diagnosis clients, patients who have serious mental illness and substance abuse problems, and we've been able to follow these people for 15 years prospectively, a large cohort of people. Because some of them were in centres that instituted supported employment at the beginning of the dual diagnosis study, the patients from those centres were highly likely to go to work and so we had a chance to look at them over time, and you can see in this slide that the yellow group are the patients with dual diagnosis and again these people were selected not because they were interested in work, but because they were so seriously disturbed, they were in and out of hospitals and jails at the time the study began. But nevertheless 1 in 4 of them, or 25% became good workers, and as you see they started slowly and really built up to their optimal or modal level of work after about five years and then they maintained that trajectory over time. There is also a group of people who, and these people again went to work because they happened to be in the two or three centres that were doing supported employment at that time, it's not that they were selected for tremendous vocational interests. Patients in the other centres, you can see there was another ¼ of the patients where supported employment came much later in time and they started working well out into the 7th or 8th year and then there's a big group of the patients that had never worked at all, at least in the first 10 years here.

One of the interesting things here is we have a detailed cost analysis of what it costs to take care of these people over time and the average client who goes to work costs the mental health system about $150,000 less than the average client who doesn't go to work. And I know from following these people carefully the reason for that. The people who don't go to work, 10 years later are still

living lives as though they are dependent, chronic mental patients. The people who have gone to work are living their lives pretty independently. A lot of them, some of the ones I take care of in fact, I see once a year for a medication check and they've pretty much moved out of the mental health system and they have their own apartment, their own car, they're living a totally different kind of life, and when I bring some of them to meetings or show their pictures, people will say, well those aren't like our patients, those people don't look really ill, but since I've known them back in the days when they were in and out of hospitals, I can promise you that they were very ill.

OK. Now I also mentioned that supported employment is relatively easy to implement, we just finished a long study called the National Evidence Based Practices Project in the US where we tried to implement several practices, the five mentioned here are: Supported Employment, Illness Management Recovery, Family Psycho-Education, Assertive Community Treatment and Integrated Dual Disorders Treatment, there was also a systematic medication management study at the same time. Anyway, we instituted these in routine programs all around the United States, some poor states, some rural states, some intercity urban areas, etc, etc, and the clinicians got a year of training to try to implement the model and then they were followed for another year after that. And one of the interesting findings was again that supported employment was relatively easy to implement.

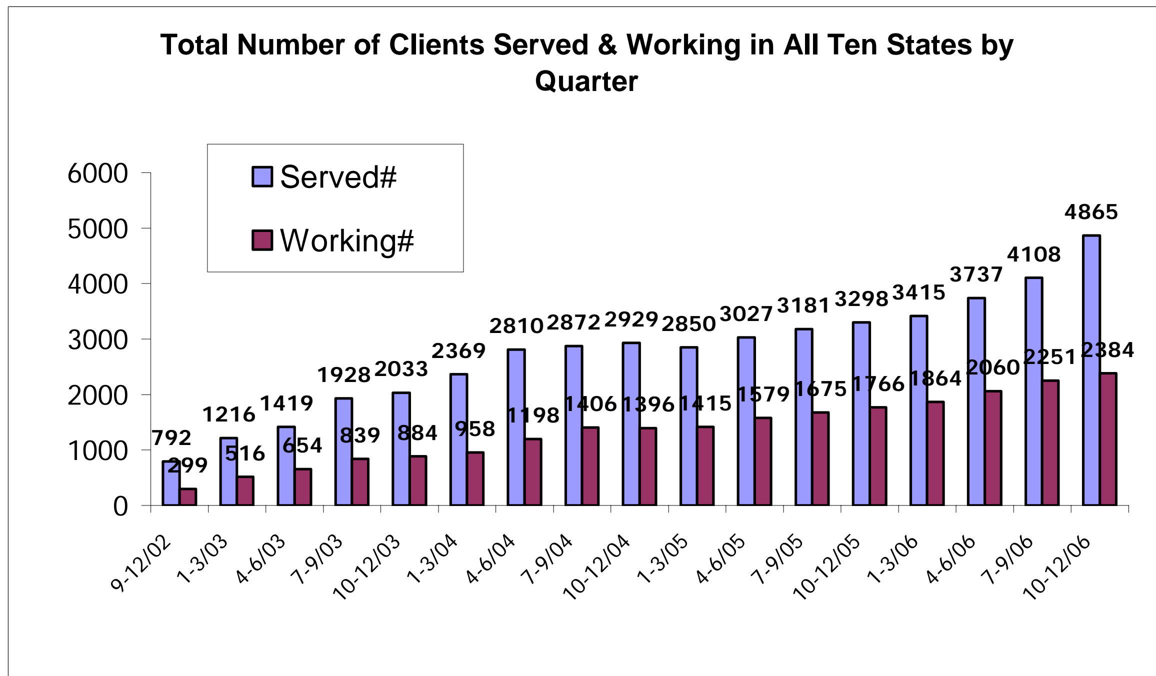


Over four on the Fidelity Scale means high fidelity implementation and you can see the average program was over four within six months and we were able to maintain that over time, even without the training experience. This was not true of the other interventions. It is very, very hard to get clinicians trained to do integrated dual disorders treatment, it's even harder to get them to do family psycho-education.

And our experience after the two years is also interesting. Supported employment seems to expand and expand in the states where it got started, in part because all the clients are interested in it and the clinicians like seeing their clients get better over a time, and that's not the experience we've had with some of the other interventions. We could barely get family psycho-education instituted and even the programs that we coerced into doing it dropped it immediately when the contract was over and they weren't forced to continue. But with supported employment the programs seem to be able to maintain themselves over time and it seems to spread in the region because once you've created interest people begin to have different expectations.

Another program that we've worked with is with the Johnson & Johnson Charitable Trust where we've helped them distribute grants to states, and these are small grants but they're used by the State Department of Mental Health and the State Department of Vocational Rehabilitation to

collaborate and start IPS supported employment programs. Usually they have a great deal of difficulty working with each other, the usual separation of systems according to finance and such, but a small amount of money from Johnson & Johnson was enough to induce them to work with each other. And then we allowed them to just pick programs out across their state and gradually start to help these programs implement supported employment, the money was really only enough to hire a trainer to help interested programs get started.



And the experience across all of this wide variety of places was striking, the number of people served has increased every year, this goes to the end of '06 but I now know that the data continues to go in the same trend through '07 and in any quarter about 50% of the people who are served are in competitive employment.

It varies a bit from program to program and something about the local economy effects how successful the programs are, and something about the level of fidelity to the IPS supported employment model effects how successful they are, and of course there are many, many of those correlational studies nowadays that show that fidelity really corresponds to good outcomes. Some 7,000 clients with serious mental illness have got into competitive employment through this Johnson & Johnson philanthropic program now.

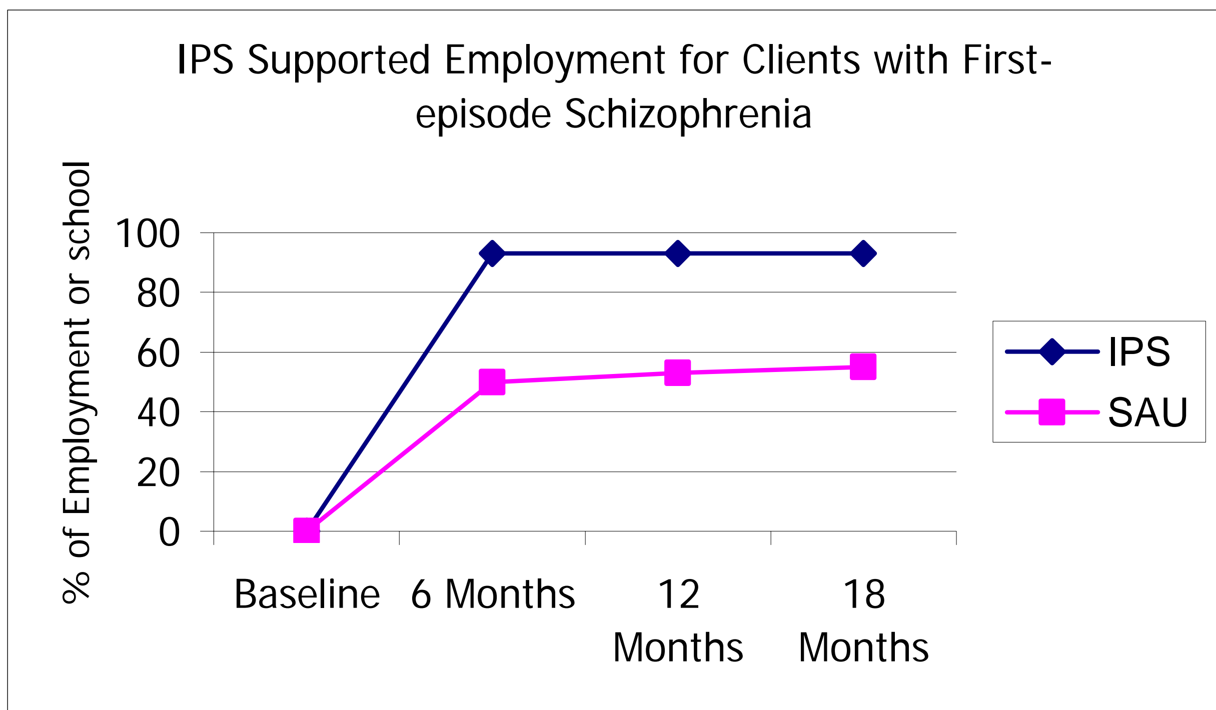
Limitations of Supported Employment

So now I want to move on and talk about the limitations of supported employment and there are really three issues here. One is that many clients don't express interest in supported employment and I don't know the exact number because it varies over time and across programs. Many of those who enter supported employment programs do not achieve consistent employment, they may have a few jobs but they don't become consistent workers, and then those who become consistent workers often don't work full time. And so much of the research today to amplify supported employment tries to address these three different groups of people. Now I'll first talk about the lack of interest, and here I think the issue really has more to do with the expectations that we as a society and we as a healthcare system have for people, rather than that they are inherently not interested in having a meaningful role in society. And it also has to do with the benefits trap that we set up for

people, which I know varies a lot from country to country, but in the US it's really extreme. People who work more than 25 hours a week are likely not only to lose their benefits payments but also their health insurance, so they can't pay for their medications or anything else, so it's really a terrible dilemma for them.

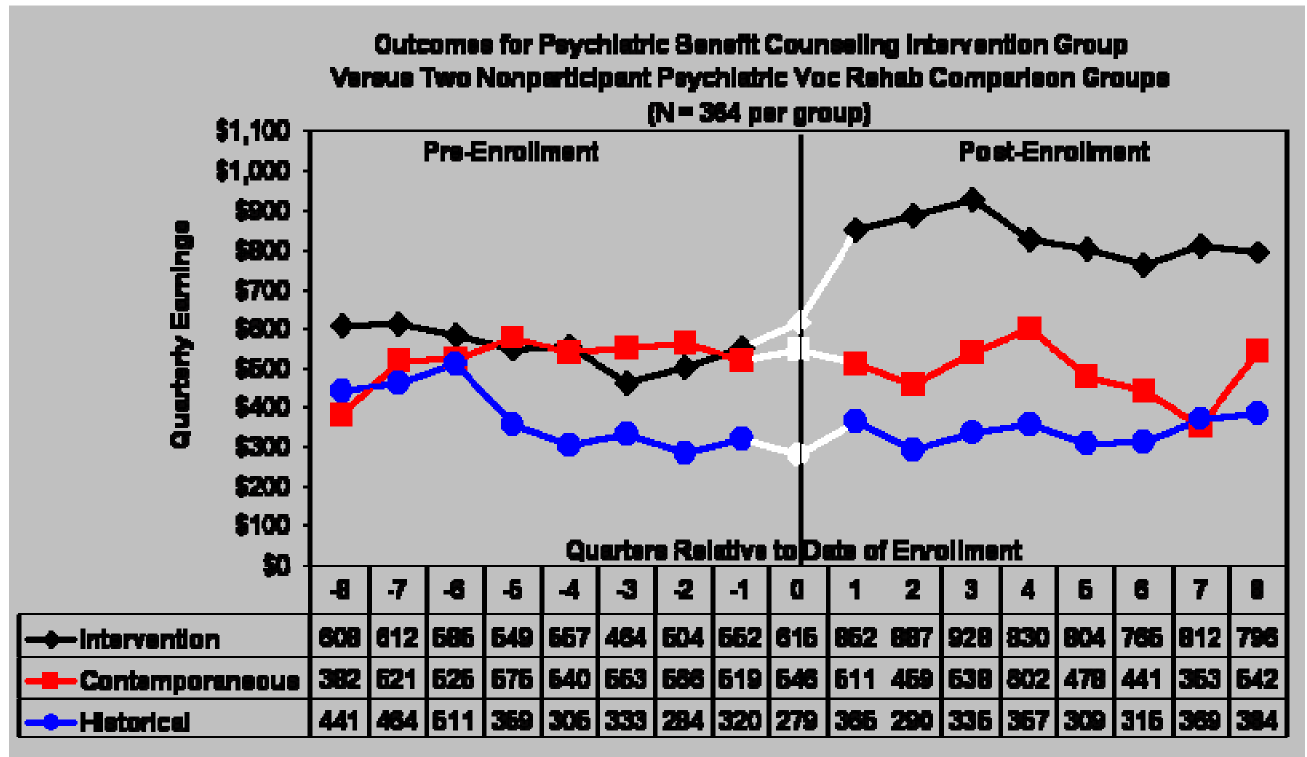
One of the reasons that I think the lack of interest is not inherent in the clients is when we follow, as we have in a number of studies, day treatment closures where day treatment programs get converted to support employment programs. What you find is that all of these people who haven't been working at the time of the closure, nearly all of them begin to develop interest in work as they see their colleagues going to work, so over time there are more and more people working. Here was a follow up of 8 to 12 years that Deborah Becker did, 71% of the people were working at follow up, 85% of them in competitive jobs and a large proportion of people had worked more than 50% of the ten years or so. So even though these were not people that expressed interest in employment, when the opportunity became greater more and more of them began to go to work. And also because of the benefits trap they nearly all stayed on benefits, because again, they couldn't afford to lose their health insurance in our country.

There's also the example of early intervention programs and the study that we know the best because we participated in it was by Keith Nectarline at UCLA. I know that you've had some very nice work done here in the UK by Miles Rinaldi and there are also some good studies in Australia now of this phenomenon.



In the studies from UCLA, we randomly assigned young people in their first episode of a schizophrenia illness to IPS supported education and employment versus the usual services, and you can see that over the course of 18 months about 90% of those in IPS were either going to school or working or doing both, and in fact about 65% of them were doing both, and that compared very favourably to the usual services. The only thing that was really interesting to us about this study is that these young clients who were going to school and working were much more likely to continue their treatment and not drop out of treatment.

There are other ways to think about motivation, I mentioned that benefits counselling is important, here's a study that Tim Tremblay and colleagues did across the state of Vermont. There was really no intervention except that one group of patients was given detailed benefits counselling over time about exactly what would happen to them if they went to work and they worked so many hours. You can see that the group in black, the benefits counselling group, worked many more hours and earned more money after the intervention, which is marked by the white lines in the middle.



	-8	-7	-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6	7	8
Intervention	608	612	586	549	557	464	504	552	616	852	887	928	830	804	765	812	796
Contemporaneous	382	521	526	575	540	553	566	519	546	511	459	538	602	478	441	353	542
Historical	441	464	511	359	306	333	284	320	279	365	290	336	357	309	316	369	384

There are studies now going on, Chuck Drebing in Boston is one of them, looking at motivational interviewing to try to help clients who are scared of going to work or ambivalent about going to work and enhance their motivation. These are not published yet that I'm aware of, but Chuck tells me the findings are very positive. Similarly with contingency management, Chuck Drebing has been using that to help people attend services, cut down on their substance abuse and go to work and he's finding good results with the contingency management approach. And finally social security administration is paying close attention to this at this point and we're really hopeful that when we get a new government in our country we'll also be able to do something in terms of health reform and disability reform, because we know very clearly that people get socialised into disability and that disability benefits themselves become a terrible trap that it's difficult for them to get out of.

So there are a number of policy changes being initiated and many of them follow the good advice of Carl Suter who is the National Director of Vocational Rehabilitation Agencies in the US. He says that people with disabilities need cash assistance for a time, they need health insurance and they need a job, they don't need to be assigned to a lifetime of unemployment and poverty, but that's what we gave most of them in the United States.

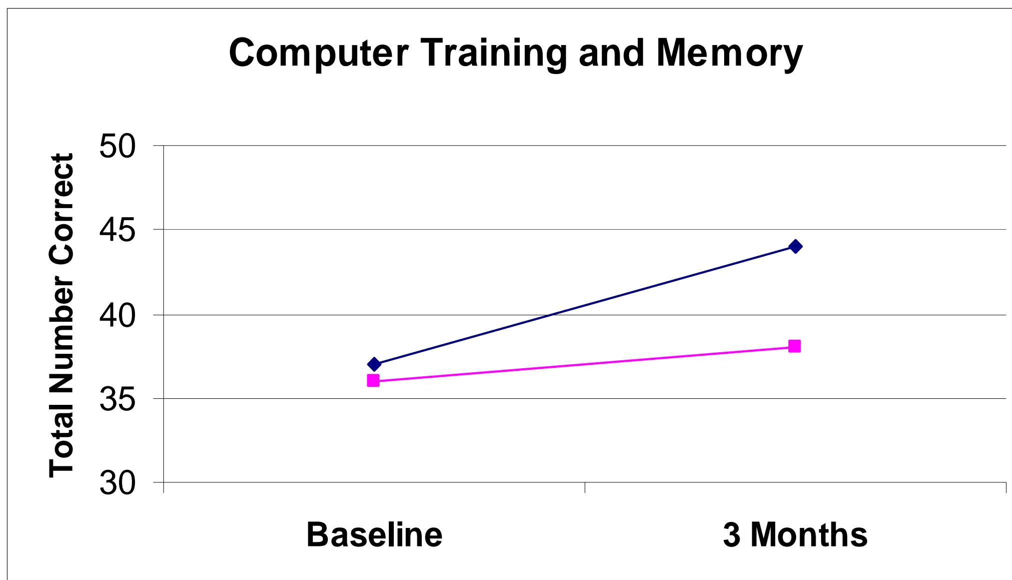
There are a number of initiatives to look at benefits changes, I'm not going to labour on them because I know the issues around disability regulations are very different in your country.

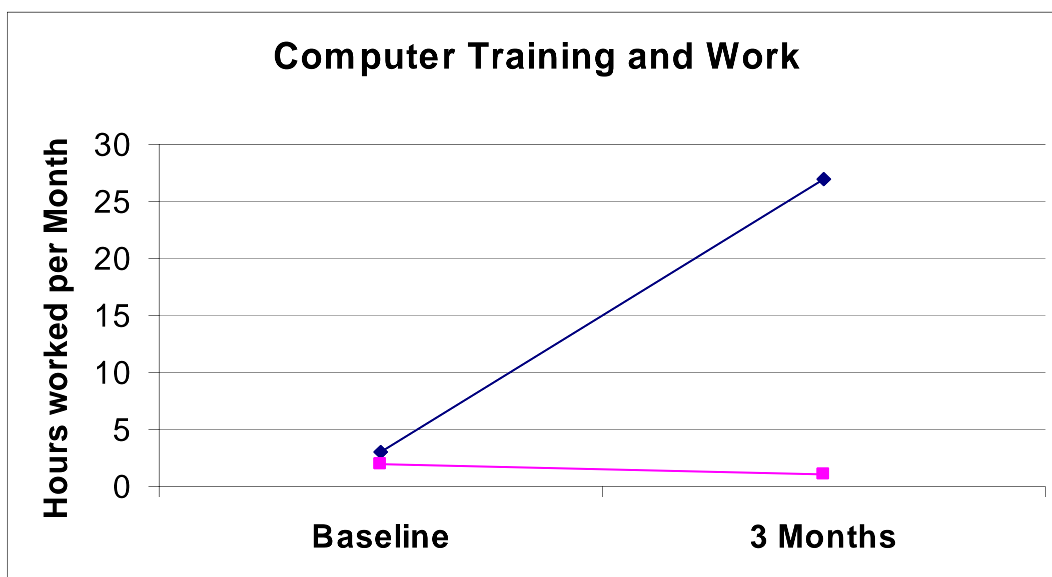
Research into improving supported employment

But I next want to talk briefly about the topic of inconsistent employment, the people who try employment but somehow don't stick with it or have difficulty maintaining jobs, sometimes get fired, sometimes lose jobs, walk off jobs without much success. And we know from a number of studies that this is a fairly large portion of people in supported employment, there are a number of efforts to look at assisting them and making sure that a higher proportion of people have successful outcomes. Some of these address symptom barriers related to medical as well as physical, mental health and substance abuse issues, and some of them involve just improving the basic model of supported employment. All of these I think have great promise.

We're currently involved in a large randomised controlled trial of 3,000 social security disability insurance beneficiaries across the United States and here the study assures that these people have good insurance so that they can get good vocational and mental health and physical health insurance and we're only three years I think into this study but we already have just tons and tons of anecdotal evidence from the various sites that we send to Social Security as client reports. There are a large number of people who, once they get systematic medication management and their symptoms are under better control are able to go to work, or once they get good medical care and their physical illnesses are under better control they're able to go to work. So we're very optimistic about the effects that we'll find in this study.

There's also a huge movement in the United States now to address the issue of cognition. As you probably all know cognitive deficits like memory and attention and problem solving ability are very common across all of the serious mental illnesses. People with schizophrenia on average are about two standard deviations below the population norms. And there's a lot of evidence that the cognitive problems rather than the psychiatric symptoms are the biggest barrier to being successful in competitive employment. And so there are a number of studies going on all across the US and I'm assuming here in the UK as well, trying to address this problem, and they do it in a variety of ways, one is just making sure that the vocational counsellors are more aware of these deficits, another is trying to be systematic about making sure that the client is helped to find a job where the deficits are not so much of a barrier, where there's a better match for the functional parts of their personality and workability. Another is to address the cognitive function problems directly with a variety of cognitive enhancement techniques like practising cognitive skills with computer games. And finally there are strategies that involve looking at compensatory mechanisms, these are the ones that work for me where I have everything written out in a schedule book and a couple of secretaries try to keep me going in the right direction all day long, and it turns out people with mental illness need just as much help as I do to try to keep focused on their job through the course of the day, and there are a number of very positive strategies that work for them. Susan McGurk in our group is one of the people involved in this field, but there are lots of other good people I know doing work here. Susan combines all of these techniques by the way and for the cognitive training part, she's really very clever at making sure the computerised tasks that people practice correspond to the job that they have, so that if they really are learning new skills or developing new neuronal connections they're related to the job that they're doing in hopes that it will translate to better work success.





Here's a typical finding, this is again one of Susan's studies, with a bit of computerised practice like this three days a week for an hour, people can learn to improve their memory or any of these other cognitive functions, and that's not surprising. What's surprising is that this group of patients increased their work hours so much. These were all people who were selected because they were failing severely in supported employment and you can see the increase in work is even much greater than the increase in computerised cognitive functioning and I think that's because she's addressing it with all these other aspects to the compensatory mechanisms in the job match and such.

There also is a big NIMH (National Institute of Mental Health) movement, there's developed medications that specifically target the cognitive deficits of serious mental illness and that's really in its infancy at this point and we have no idea whether that will affect people's actual functioning. I mean we do know that the new psychiatric medications of various kinds which promise to do this probably do not.

OK, there are a few other efforts to improve the supported employment model that I'll mention briefly. We know, for example, that the biggest portion of the variance here is explained by some employment counsellors as being much better at developing jobs that just match who a person is than other employment specialists. So when you read these research studies you always see the overall program results are average, but I can tell you, within every one of these studies that I've been involved in as a researcher, there is always one supported employment specialist who has 100% of their people working for the whole time of the study, and then there's another one on the same team who's got nobody working for most of the study, you know. And it's really clear, following them around, why that occurs. The people who are so successful at this job really are marvellous artists in many ways and they're able to figure out who somebody is and what kind of job they'll succeed in and then go out and talk an employer into hiring them to do just that job, and these kinds of job matches are exquisite and artistic and it's a brilliant thing. I mean I'm hopeful that Debbie and Gary and others will be able to figure out exactly what it is so that we can train more employment specialists to be in the 100% group, but it's a marvellous thing to see.

There are also a number of studies looking at a variety of mechanisms to support people in jobs and help them to make sure that they're successful doing their job. We know that the sort of group skills training approach (the UCLA modules) is not very effective in this regard because we've tried that in a couple of studies, but I think we're very hopeful that individualised approaches of other kinds will be more successful and there is at least one study by a fellow named Bob Kern at UCLA using Errorless learning with people, again, people who are having extreme difficulty with being successful in the workplace, showing that these people, through Errorless learning can learn to do their jobs quite well.

And finally, you know we're really very interested in the topic of helping people to develop meaningful careers over time rather than just short term jobs. Strikingly it looks like in the data many people do this on their own. They try a few jobs and they figure out which job is going to work for them and they stick in it for years, so we're trying to learn from their experience by studying them, figure out how we can use supported education in conjunction to help people move on to higher level jobs when they're ready to do that and get the disability policies changed so that they won't be encumbered by those things. Hopefully over time there'll be a real science to career counselling and helping people not just get into competitive employment but succeeding in long term jobs.

I also mentioned that one of the commonly sighted problems is that people stay in part time employment, 20/25 hours a week for years, but I know from interviewing many of these people and their employers that that has mostly to do with disability regulations. Many of these people want to work more hours and their employers want them to work more hours, but the regulations at this point won't allow them to do that. So we're helping the social security administration experiment with new techniques to get around that.

Our current project - the Thresholds-Dartmouth Center

OK. And finally, I just wanted to tell you briefly about one of our efforts to approach this problem now. There are so many promising interventions out there that I'm really reluctant to try our usual NIH (National Institutes of Health) simple, one step at a time approach because I think we're so excited that a third of the people are doing extremely well, we'd like to help all the others get into that group faster and faster and we really believe that that's possible by all of these amplification studies.

We're working In conjunction with an agency called the Thresholds Rehabilitation Agency in Chicago which is the largest psychiatric rehabilitation centre in the country. It serves about 6,000 clients with

serious mental illness every year. We're setting up a centre there where all clients come into a recovery centre first and part of the recovery centre experience is they get lots of education about supported employment and they are able to see as many personal testimonies from people who have been successful as they want to see. And they also then learn about all the studies that are possible that they can enter, so it's really a client choice kind of model based on equipoise randomisation procedures so that clients can enter one or more studies. We're hoping that this will be sufficiently attractive, that most people will want to enter studies and it will allow us to make progress at a much faster rate. And that as we learn more about what works for which kinds of people, we can also be simultaneously building that into the electronic decision support systems that we're building for clients and their families, as well as clinicians, so that everyone can know better up front what approach might work for them and what services they might need in order to be successful in this regard.

OK, so in conclusion I think that we have every right to be much more hopeful about all of this than we were in 1990 when Bond's Reviews of Literature showed that essentially nothing works for helping people with psychiatric disabilities get back to work. We have robust evidence now, certainly more robust than anything else we do in the mental health system, I believe, and we also have the promise of significantly improving where we are now in the next few years. I think all of the current research is very promising and there are great findings in a number of the areas that I've tried to survey for you.

Finally I want to thank all of my colleagues at Dartmouth who work in the Employment Psychiatric Disabilities & Employment area, especially Deborah Becker and Gary Bond whom I've mentioned several times have been sort of the leaders for many years, but also Greg McHugo and Haiyi Xie who are wonderful methodologists and statisticians who keep us all honest and make sure that our findings really are valid before they go to print.

I'll mention a couple of things, next month there will actually be an entire issue of the Psychiatric Rehabilitation Journal devoted to this topic - about 18 empirical articles and I hope you will all get a chance to read this because many of them are very exciting, I've just eluded to them in 30 seconds in this talk, but you can get the details of many of them in this issue.

And we also have available through our Centre an updated manual for practitioners who are interested in learning supported employment and we've printed this ourselves and are happy to make it available to people at our printing costs. I gave up on making money as an academic long ago, so we're happy to send you books and videos about supported employment, we have several 20 - 30 minute videos that are very inspiring for employers and family members and other people who are surprised to learn about some of the success in this area. Our assistant, Karen Dunn would be happy to send you articles, books, videos if you just email her and tell her what you're interested in.

OK, so that's my 45 minutes, I appreciate your attention very much, thank you.

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