National Center on Advancing
Person-Centered Practices and Systems

Webinar Transcript:
"Co-Producing Recovery and Resiliency in Indiana Using Recovery Data"

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SPEAKERS
Tina Skeel, Jay Chaudhary, Bevin Croft, Amy Brinkley, Becca Sigafus, Wendy Harrold, Ari Nassiri, Sarah Gunther

Bevin Croft 00:15
Hello everyone, welcome we will get started in just a moment

Bevin Croft 00:48
Hello, good afternoon to all welcome. My name is Bevin Croft, I am a white woman with blond hair, and I'm in my home office chest, pink walls, and other brightly colored art in it. I co-direct the National Center on Advancing Person-Centered Practices and Systems at the Human Services Research Institute. And it is my pleasure to welcome you to our November webinar, co-producing Recovery and Resiliency in Indiana using recovery data. Next slide, please. We're very glad to be hosting this webinar in partnership with our friends at the National Association of State Mental Health Program Directors. They introduced us to Amy Brinkley and her wonderful colleagues who will be sharing their story with you today. NCAPPS is a Federal Center, and we receive funding from the administration for community living and the Centers for Medicare and Medicaid Services. We have webinars just like this every month on a range of different topics, and you are more than welcome to check them out on our websites.

Bevin Croft 01:32
Next slide please. Our goal as a center is to promote systems change that makes person centered principles not just an aspiration, but a reality in the lives of people across the lifespan. And we do that in a range of ways by providing webinars like this publicly available resources and also targeted technical assistance and learning collaboratives. Next slide, please.

Bevin Croft 02:40
A few logistics before we get started. This is a webinar platform, so everyone is muted. You are however more than welcome to engage with us through the chat function. Chat is open to all you can say hello. If you would like to just chat with the presenters, you will want to select hosts and panelists. But if you'd like to chat with everyone, just be sure to select everyone and feel free to engage and say hello. This webinar is being live captioned in English and in Spanish. To access the English captions, just hover down to the bottom of your screen and push the button that says live transcript. To access the Spanish captions, there is a link in chat that you can click and that will open up in a separate

window. We will have just one poll in a moment and also some evaluation questions at the end. So please do prepare to interact with us as well. Next slide please. And you're more than welcome at any time to reach out to us our email addresses and at NCAPPS@hsri.org. We will also let you know when this webinar recording along with a PDF of the slides, plain language summary. And any other materials are available in about two weeks. And those will be on our website and cavs.acl.gov. So next slide please. What we'd like to do next is just see who's here. I see we have folks from all across the country. We'd like you to just note here how you self-identify. This is a check all that apply poll. There are eight total options and if you self-identify in a different role, please enter it into chat. The roles are a person with a disability or a person who uses long term services and supports a family member or loved one of someone with a disability or someone who uses long term services and supports an advocate or self-advocate, a peer specialist or peer mentor, social worker, counselor or care manager or research or analyst, a community or faith-based service provider organization, or a government employee. And I will give everyone another 10 seconds or so to, to let us know who you are. Please take the time to do that if you're if you're able.

Bevin Croft 05:26
Oh, good. David Miller, federal advocate, and our wonderful colleague at NASHPID is here with us. Good to see you, David. Okay. So, let's go ahead and close the poll and share the results, Elayne.

Bevin Croft 05:56
I don't know folks are seeing the results. I don't see them quite yet. Can we display the results?

Bevin Croft 06:08
Well, what I will say is, oh, here we go, oh, well, I can see the results. And I'll tell you that what I'm seeing is that we have 56% of you who responded, self-identify as government employees. And that's the largest, I guess plurality, but we have a great spread across all of the other categories. People with disabilities, family members, self-advocates, peer specialists, welcome social workers, providers, and even a couple of researchers so fantastic to see you all. Alright, we can stop sharing here and I'm noticing on chat, we may have an issue with Spanish captioning. Please hold tight with that. And we will do our best to get that up as soon as possible. And thanks for letting us know. Okay, next slide, please.

Bevin Croft 07:10
All right, so it's time for me to introduce you to our speakers. We have an illustrious panel. And at the head is Amy Brinkley who is the director of recovery support services for the Indiana Division of mental health and addiction. Amy's work focuses on quality peer recovery and recovery support services. And she's excited to be part of Indiana's team, advancing recovery support services and setting the bar nationally for the collection of recovery data. So, after any present a bit about her experiences, she's going to hand it over to a panel of folks who are going to provide some reflections based on their experiences. And those folks are Becca Sigafus, Sarah Gunther, and Tina Skeel. So, Becca is the Chief Executive Officer of essential virtual solutions and has more than 35 years' experience in direct service management and operations in both private and not-for-profit business sectors surrounding

mental health and managed care. Sarah Gunther is a person in recovery with mental health challenges and substance use disorder, she uses her lived experience in her role as executive director of key consumer organization, a consumer run organization in Indiana that provides empowerment and support through its peer services, and mental health warmline. And Tina Skeel is the director of Indiana Works at Aspire Indiana Health Inc, she has devoted the last 30 plus years of her life to removing barriers to employment for people with disabilities. After we hear from Becca, Sarah, and Tina, we'll hear from a couple of folks who will provide a little more of an overview of the data portion of this initiative. And that'll be Ari Nassiri, who's the director of behavioral health integration for the Indiana Division of mental health and addiction, and his responsibilities focused on progressing the level of data integration across behavioral health. And we'll also hear from Wendy Harrold, who's the executive director of data strategy for the Indiana DMHA Division of mental health and addiction. And she oversees certification and licensure, quality improvement, data, and performance measurement. And to kick us off, we will hear a bit from Jay Chaudhary, who is the director of the Indiana Division of mental health and addiction. Jay, welcome.

Jay Chaudhary 09:44
Good afternoon. Thank you for having me. I'm super excited to be here. Jay Chaudhry I am I'm male. I have I'm of Indian origin of glasses and I'm speaking in front of a background that says Be well Indiana audit I'm in my late 30s, I have a very round face. So hopefully that will paint the picture. So I am, I'm thrilled to be here today to just kick off and highlight the work of the folks on the panel. I am as always just in complete all that I get to work with and in some cases supervise the folks on this panel who are doing amazing things and state of Indiana. And I just was tasked with kind of setting the stage and giving you all the backdrop and the kind of core principles that directs our work in the state of Indiana. And so, figure the next slide.

Jay Chaudhary 10:48
Great, and we'll go and go one more. So, this is where we're part of the Indiana Family and Social Services Administration, which is the Health and Human Services arm of Indiana. And one more slide, thank you. So, at DMHA Our vision is an unyielding focus on promoting and supporting the mental health and wellness of the people of Indiana and we adopted this vision about a year ago. And, you know, the key there for us is unyielding. You know, there's a lot of noise in this job, and in this role at the state. And so, you know, we our goal, and our aim and our north star, is to cut through it and do what's best for the for the folks that we serve. And that's not always, not always the case. It's somewhat aspirational. But that's our goal. And our mission is to champion mental health promotion, and substance use disorder prevention, treatment and recovery systems that are high quality, seamlessly integrated and accessible to the people and communities of Indiana. The inclusion of recovery in our mission was very intentional, and really has been, I think, both driven by and a driving force of the work that you're going to hear about today. Next slide.

Jay Chaudhary 12:04
So, I just wanted to highlight a few kinds of key concepts that that to me, you know, to me, you know, drive my approach to this work, and I, you know, hopefully have is filtered down somewhat to DMHA as a whole, and our recovery work in particular. So, you know, one of the things you know, we've done is we've we I tried to take a page from the recovery community, as many of you are familiar with, with the Serenity Prayer. And so, you know, a lot of times in the role of overseeing an entire state and overseeing, you know, a system that serves hundreds of 1000s of Hoosiers every single day, it can be overwhelming, and you can really focus on, you can really get frustrated, and overwhelmed by all the different things that you that you have. And so, one of the things that we've really tried to do, and hopefully with some degree of success is take what we call this serenity approach to this, which is, you know, focus on what we can control. You know, and so it doesn't always again, it's aspirational, isn't always doesn't always work. And then in particular, with recovery, we're always mindful, I saw this phrase, you know, just a few months ago, and I just was so I thought this was just perfect. And I think it's something that we always have to remember. And I think a lot of times in the role of the state mental health or addiction authority, or whoever or your government, or we get really fixated on, on the use of the use of the substance, right. And we forget about the reasons, and I think that, you know, regardless of what those reasons are, it's a very person-centered personal thing, I think we always have to remember that people use drugs for a reason. And it's not about you know, the substance or the use or the illegality or whatever about it's, you know, I think that those reasons are really important, whether those reasons are our trauma, or, you know, on, you know, untreated mental illness, or, you know, just difficulties in life. And I think that, you know, we need to remember that in our particular position. The third thing is this idea that, you know, recovery is easier when life is right. And so, our, our, our job and part of our job, we see it very much part of our job is not only, you know, making access to treatment easier, but helping folks, you know, make their life easier, whether that's through access to the childcare, transportation, or housing or, or peer supports or other sorts of things. Because, you know, we know that, you know, recovery is the part of this journey, you know, that takes place in your life and recovery is easier when life is. And then finally, you know, we truly, truly believe in the power of lived experience. 100% are our core. And so, you know, one of the phrases that's been done about it and kind of what we want to get to is, you know, there's a peer for that, you know, no matter no matter who you are, what you are, what you're going through you We believe in the power of connection through lived experience to get you to where you hope to be. So those are the concepts underpinning our work. And you will hear much more about that work in detail from our amazing staff. So, thank you for having me, and I appreciate the opportunity.

Amy Brinkley 15:20
Thank you, Jay. Good afternoon, everybody. My name is Amy Brinkley, and I am a 41-year-old white slash Native American female with brown curly hair. That pulled up in a ponytail today and I'm sitting in front of a bookcase. So, if we can go to the next slide. So, my title is director of recovery support services, and I have been with the Indiana Division of mental health and addiction for four and a half years. In this current role I was just recently promoted. So that's rather new. In my time at DMHA, one of the first things that stood out to me was the silos. We had a number of advisory councils that under a JD use that term underpinned and so now I'm leaning into that, but we had a number of advisory

councils that would advise the division on various topics related to recovery, sports service needs that weren't necessarily working together always. So systematically over the last few years, we have begun to intentionally de/silo, those efforts by intentional collaboration. Next slide. So, the two main advisory councils that we're going to talk about today are the Indiana recovery Council and the recovery support workgroup. The Indiana recovery Council is our consumer advisory board that consists of 16 people with direct lived experience in mental health and substance use disorders. The council acts in in an advisory capacity to DMHA and is essentially our voice for people across the state with mental health and substance use disorders. Next slide.

Amy Brinkley 17:12
So, the next Advisory Council we're going to talk about is the recovery support workgroup. So, the recovery support workgroup is comprised of more than a dozen state agencies, community statewide stakeholders and more than 51% of people with lived experience. So, the recovery support workgroup uses recovery data to validate the lived experience feedback from the Indiana recovery Council and helps to inform DMHA By making recommendations for funding policy and programs related to recovery support services. Next slide. So, we've tried to summarize the work holistically into three steps. So, step one, the Indian recovery Council, our consumer advisory board identifies lived experience gaps and needs across the state for mental health and substance use disorder related needs. Step two, the recovery support workgroup provides data informed recommendations at the division to address the lived experience gaps identified by the Indiana recovery council. So, step three DMHA, the division of mental health and addiction us would then review and accept or reject those recommendations based on based off of the available data. Next slide.

Amy Brinkley 18:34
So, in 2012, the recovery support workgroup conducted a statewide gap analysis that identified the top five supports missing as being personal support networks, peer support services, hobbies and interest prevention and wellness and safe and affordable housing. The city agencies and our recovery support worker have also identified the employment is interesting, intrinsically essential throughout each of these priorities. So, we have an employment subgroup as well to focus in on those needs. In 2020, we contracted with essential virtual solutions, and began to just do a review of our membership across the recovery support workgroup because we want to make sure that we maintain that 50% of people with lived experience being represented. We also began to standardize our process for goals and objectives and identify outcomes that each of the subgroups wanted to work on throughout the next year to two years, we began to create templates for our data reports. We wanted to measure outcomes, and we added a data group to kind of help us coordinate these efforts across each of the subgroups. So, the gaps identified on the left of the screen personal support networks, peer support services, hobbies and interests, prevention, wellness, safe and affordable housing, employment, those are all into individual subgroups made up of state agencies and people with direct lived experience focusing in on those areas. In addition to that we created, we began to standardize our forms. So, we created charters for each of the subgroups. We create a dataset brief for each of the site or for each of our data sets. And then we created a data request form for the subgroups to request data. And our vendor created a

process flowchart. So, Becca, I know that you're here. So, I'm going to go ahead and put you on the spot just for a moment. Is there anything you would like to share on this specific process?

Becca Sigafus 20:42
Absolutely. Thank you, Amy. Hi, this is Becca, I am a 60-year-old white female with brown hair that has natural gray highlights in hazel eyes. I am in my home office with a bookcase behind me. I have on an ivory sweater, and I'm wearing glasses. I really was honored when Amy approached me about the opportunity to work with them and the members of this recovery support workgroup. The original members of the workgroup were the subject matter experts on key areas and were very willing to be direct and honest on what they perceived as barriers, really moving the process forward, as well as what they would like to see the RSW achieve in the future. It was clear that some members were feeling somewhat stuck, and maybe a bit frustrated at that time. So, we really took a step back reviewed, considered and respected the previous efforts and work while creating and developing a customized process that builds upon the original foundation. In essence, we spent considerable time and efforts conducting gap analysis back in 2012 that they did that identified significant gaps, issues and access to personal support networks, the peer support services, the hobbies and interest, the prevention and wellness, the safe, affordable housing. And along with those areas, as Amy shared employment supports were noted as being a thread throughout each area and was formally included in our development process. For me really getting to know the DMHA team and our SW members was the most first important first step that allowed us to create and develop a more formal process to ensure that their expertise and opinions were not only heard, but truly considered and acted upon. Once we identified our overall mission, we were off and running. Thanks, Amy.

Amy Brinkley 22:44
This is Amy again. So next slide, please. So, there's no doubt that without Becca support as our vendor, our contractor, our quality improvement specialists, we would not be where we're at. And so, we've been very lucky to have her. So, we're also going to take a moment here to call on the panelists. So, we're going to go in order. We have Tina Skeel, Sarah Gunther, and then Becca Sigafus. So, we've asked them to just share their role and perspective throughout the process. Some of our panelists have been part of the recovery support workgroup before we made these changes in the last two years, and some are kind of new. So, I think that their perspectives are very valuable. So first up, we have Tina.

Tina Skeel 23:36
Thank you so very much. I am very honored to have the opportunity to come and share my experience with the recovery support workgroup. It's been a process and I think they've already heard some of the kind of waxing and waning of how this actually went about. I want to first but start out by saying my name is Tina Skeel. I'm the director of a Social Security work incentive planning and assistance project that is housed through Indiana Health. I also am very active in our Indian APSE chapter as far as public policy, and a lot of the conversations around recovery supports are near and dear to my heart. I'm a shorter statured dark blonde or at least that's the color I'm going to call it right now. dark blonde hair white female, and I am coming to you from my home office, wearing a blue dress with a white cardigan.

And hopefully you may get to enjoy some of the art behind me as well. So, let's talk a little bit about my role. I'm going to kind of take the first question just kind of wind them all together. My role with RSW was very focused on residential and vocational services because employments programming had been my background for many, many years. And we know that is such an essential part of recovery services. I was one of the first members are the RSW in 2012. So, I really got to watch things as we kind of developed various levels. One of the things that the director of the Division of mental health did was really allow us to have ownership of this group. In the very beginning that first gap analysis in the initial work that we did, most of us were volunteers, with just a few staff from the Division of mental health. And so, we were charged with a lot of responsibility as work group to data mine to analyze and then we did write ups and created products. For the general public, we even presented throughout the state of Indiana, on our effort, so many kudos because I think that really allowed us to, to really buy into this process. And I think it's really one of the reasons why we stay together. It's been exciting in sometimes scary to see how things have changed. As Amy mentioned, there was a time where there was about a year or so, where we weren't sure exactly where we were heading. And I just want to thank Jay and Amy for taking the bull by the horns and allowing us to move forward. Because if you have a good foundation, keep building. So. All right, I'm going to pass it back over to Sarah, if you want to turn on your camera.

Sarah Gunther 27:01
Hello, my name is Sarah Gunther. I'm the Executive Director of key consumer organization. I am a 40-year-old white woman with short dark hair and glasses and I'm wearing a grey sweater. Um, I am on the hobbies and interests subgroup as well as on the peer support subgroup for the RSW. And I did indeed feel part of the decision-making process moving from a more informal to a more formal way of doing with the RSW. And it was very nice. I started in 2019. So, I started right at the beginning of this more structured program. And it was great to see it come together, it was great to see everyone work together to try to become more and more data driven in our recommendations. And I believe Becca, did you have anything else to say?

Becca Sigafus 28:00
Hi, yes, this is Becca. And my role on the RSW is to assist that facilitating the overall change process. When I started approximately a year and a half ago, we continue to work on tweaking areas as we encounter, you know, issues on along the way and continue to do this in the future. Really, at this time. I feel like I am now taking a more supportive role in the process. It's been a wonderful experience for me to work with so many amazing and dedicated people. Amy has been a very strong leader, advocate, networker, and chairperson for the RSW. And we have some very strong chairpersons and members of our subgroups. And as you heard from, from actually Tina, I've known Tina for a while. They're here today. She's been involved really since its inception. So, they're just exceptional people. And I'm very proud and honored to work to work with them. Thank you.

Amy Brinkley 29:10
This is Amy again. Thank you, Becca, Tina, and Sarah. We're going to hear from them again here shortly. Can we go to the next slide, please?

Amy Brinkley 29:19
So, one of the things that we did with our survey back in 2020, is we asked our members to help us identify a mission statement. And so, the mission statement that was born out of that survey is this our mission is to recommend and promote identified needed supports and resources for individuals in wellness and recovery from mental health and substance use disorders. I'm not going to read the entire list on the right side of your screen. But I will say that our stakeholders consists of 27, 26 or 27 statewide stakeholders state agencies and are represented by more than 50% of people with direct lived experience. So, we've definitely grown significantly in the last few years. But I think it's been a very positive change. Next slide, please.

Amy Brinkley 30:18
So, a couple of the data sets that we're going to talk through today are on your screen. So, the first one that we're going to dive into is the lived experience feedback survey. The second one is the consumer satisfaction surveys. The third one is our assessment data cans and answer. The fourth one is our social determinants of health data. The fifth one is our recovery data platform. And one of the things I like to mention on this slide is that we also have a data software system that we call the management performance hub, which is which was actually born out of a Governor's Executive Order that created a warehouse across state agency data collection. So, we have not begun to fully use that to our advantage for this specific purpose yet, but we do know that that's available. And if we want to move into using that more, we will know in the near future, the next slide. So, the first dataset we're going to talk about is the lived experience survey. This was a survey that was completed by the Indiana recovery council. So, it's a consumer driven survey, the idea being that we bucketed gaps and needs into themes based off of Samsung's dimensions of recovery. So, within each of the questions that were asked, there were 19 total, we always left one open ended response for people to add in their own words, in their own voice. An answer to your question, so we wanted to very much keep this qualitative and quantitative in nature. At the end of the survey, what we did is we took all of the open-ended responses, and we color coded them by dimension. So, for example, our state agencies that work in housing could go to the bottom and look at the color code that matches home and identify exactly what consumers are saying about housing across the state. The next thing that we're going to be doing is hosting statewide listening sessions, that we're hoping to do that this next state fiscal year, to further fill in needs, as identified in the survey. One of the other benefits of the survey is that we were able to identify recovery and wellness needs by demographics. So, no different than prevention or treatment. We know that recovery support service needs are different by demographic. So, age, race, location, length of time in recovery, and wellness, those things matter. And we'll tell the story on what the needs our next slide. So, this was a first-time survey last year, there were 19, total recoveries centered and demographic questions. This survey was open for approximately four weeks. The survey was sent out six months into the pandemic, we had 199 people across the state respond with mental health and substance use lived experience. That breakdown resulted in 20% of the respondents had mental health lived experience. 50% of the respondents had co-occurring lived experience 18% had substance use disorder only lived experience. And about 11% of the respondents were family members. Next slide.

Amy Brinkley 33:52
There we go. So, one of the very first questions on the survey, we're not I'm not going to share the comprehensive survey with you guys because we have a number of other data that we want to look at. But here's a couple things. So, the very first question on the survey was based off of SAMHSA's dimensions of recovery, what is missing in your daily recovery, your wellness journey. And so, on the front end, it would appear that purpose was identified as being the primary missing dimension across the state for people with lived experience. But when we but when we started to filter it out by demographics, we began to see some very clear disparities. For example, people, Black and African American folks identified housing or home as missing a missing component to their recovery journey, almost double to those white income Caucasians respondents. So, the disparities began to become very clear. Another one was barriers to treatment and recovery support services. So, the other one we noted too, was transportation. So Black and African Americans identify transportation As a barrier at 50%, compared to white and Caucasian is at 31%. So, by adding those demographic questions, we were able to start digging into the weeds on what the recovery support service needs were by demographics. And to see the disparities. Next slide. So next we're going to talk about our consumers consumer satisfaction surveys. So, Ari Nazeri, one of our colleagues is going to share here. Go ahead Ari.

Ari Nassirri 35:33
Thanks, Amy. My name is Ari Nassirri, and although I'm pretty washed out by the light, Middle Eastern man, black hair, and I'm wearing a blue shirt that looks pretty white, and in front of a forest background. I'm the director of behavioral health integration here at DMHA. Now, the consumer satisfaction surveys that we send out are sent out to our certified community mental health centers. Here in Indiana, they're sent out to all of them under the Mental Health Statistics improvement. The missive and the Youth Services survey for families that USF their standardized surveys that get about 8000 responses annually. And these are given to consumers at the CMHC s. And the CMHC. themselves do distribute and collect these surveys. They're open-ended questions that we then take and look at and see for our purposes, what buckets they fall into, and which subgroups can utilize the questions best to answer some of the questions. But since they are distributed and collected through the CMHC, we are aware that they tend to skew pretty positive. So that is one thing that we take a look at, as well. And I'm going to go to the next slide and hand it off to Wendy Harold. Wendy?

Wendy Harrold 36:59
Hi, I'm Wendy. I'm a white woman with long brown hair and glasses. I'm going to talk to you about the assessment data that we collect. We have two assessments, the CANS, and the ANSA. That the can stands for Child and Adolescent Needs and Strengths. And ANSA stands for adult needs and strengths assessments. We chose these assessments in 2007, and 2008. Because they were holistic assessment tools, and they had a focus on strengths. So not just looking at a client's needs but focusing on what can be used with the client strengths. The data from these assessments can inform treatment planning, they can monitor progress, evaluate services, and they're used in decision support. They have a simple Zero to Three rating scale, which I'll show you in a second. The main categories are life functioning, behavioral health needs, risk behaviors, and strengths. Provider staff complete a

CANS and ANSA, which whoever's age appropriate with individuals at admission, every six months, and a discharge. These are copyrighted tools. And so, I've given you the link if you're interested in finding out more. Next slide, please.

Wendy Harrold 38:23
So, as I mentioned, it's a zero to three rating system, zero would mean that there's no need and the particular item, one would mean that it was a historical need, or there may be something there but it's not anything that we need to act upon. And then twos or threes are actionable needs. So, when I talk about items later on, talking about these two levels, the actionable needs, I need to deal with it immediately. Three, there's something dangerous about it, or very urgent, or to I need to have it in the actual the treatment plan. It's something that we need to address. Next slide, please. So, strengths are very similar rating system. So, zero, and one, we don't have to do anything with these. These are strengths that are present. And we can put them and work with the clients in putting them in their treatment plans and utilizing them twos and threes in our strengths that they don't yet have but we can build them. And so later on in slides, I'll be talking about building strengths. Next slide.

Wendy Harrold 39:35
So, in this project, we took the answer items and selected and group them according to this Samson's dimensions on recovery. So, this these aren't all the answer items, but these are the ones that we felt fit into these categories. So, in health we have medical physical involvement in recovery, self-care, sleep, and medication involvement for home we have independent living skills, community violence, residential stability. In community, we have community connections, family functioning, social connectedness, transportation, traditions and rituals, social functioning, family strengths, natural supports cultural identity. And for purpose. We have employment, volunteering, optimism, resourcefulness, job history, educational talents, and interests, spiritual and religious, recreational and resiliency. Next slide, please.

Wendy Harrold 40:40
So, this is an example of one of the reports that we created for this project. So, we created a report for each of the dimensions. So, you can see all of the items on the blue bar represents time one, and how many people had that as an actual need or buildable strength. And time two represents the person's assessment in state fiscal year 2021. This data is specifically for those that have substance use disorder in our system. And the percentage, if it's positive, it means it's trending the right way. So, the first two, you'll notice it's going down, those are to our needs. So, you want to have needs be reduced over time. And then the ones that go above and they're positive, it means that their strengths, and you would want to see the strengths built. So, the two things that that the subgroups can discover from this is one at, at the initial assessment, what are the highest needs, or strengths that need to be built, so we can come up with strategies and ways to address that. And then all of these are trending in the right direction for purpose, that's not the case for all of the dimensions. So, they can look at the things that are trending in the wrong direction. So over time, people are actually getting worse or more people are identified with a particular need, so they can help dress that next slide. So just that overview is not enough. So, there's a couple different strategies, we also have to look a little bit deeper the data. So,

the first thing is we can look at an individual item and see what's happening with that over time. So, I'll show an example of that report in a second. We can also look at actionable needs for an item by county. So, we have a report that we can run that shows how many actionable needs for a particular item. And we can rank them to see which counties have a more significant issue with this particular item. And then we're also looking at strategies to link this data with other data like chronic health conditions and Medicaid data to get a better idea on what's happening with the consumers. Next slide.

Wendy Harrold 43:08
So, this is an example of looking deeper at one specific item. So, this is the employment item. The first blue bar shows the initial 41% of clients with substance use disorder rated had actionable had an actual need of employment, then the next bar shows that continuing means that of those 60% continue to have that need on that second assessment. Clinical progress means 47% of those 41% went down and went from a three to a two newly identified means that there wasn't an actual need there. On the second time there was they identified employment as an issue. And then we're sending is going from a two to a three. So, by looking at this data, we can see a little bit more about what's going on with this specific item we can look at those. We can look at the actual people look at their demographics, look what counties providers are serving them. There's a lot of different ways that we can look at this data. Next slide.

Wendy Harrold 44:24
So, we wanted to give you an idea of looking at all of those recovery items that I read out. If you sort them by most common, either actionable need or need buildable strength. This is what came to the top. So, for those with serious mental illness, sleep, social functioning, resourcefulness, family functioning, and recreational were the type [of] top items. I'll mention that the list for those with serious mental illness and those with substance use disorder is different I'll show you that in just a second. But I mentioned that because resourcefulness was an issue, buildable strength that was needed, both for serious mental illness and substance use disorder. Next slide. So, resourcefulness, as I mentioned, it's the top one for substance use disorder, clients, optimism, legal family strengths and resiliency. So, this just gives you a kind of an idea of what we can do with it. Um, the next slide, and thank you so much.

Wendy Harrold 45:35
Oh, I'm sorry, this slide is mine. Um, so the next things that we're going to do is we're meeting with each of the subgroups and sharing this data and deciding what additional analysis they want. And then we're also looking at research of what recovery supports have had positive results. Thank you. Next slide.

Ari Nassiri 46:02
Thanks, Wendy, this is Ari again. Now, what we did next, as we were getting together and talking during the RSW meetings in 2018, we heard that FSSA, our mother agency, the Family and Social Services Administration here in Indianapolis, had been working on creating a social determinants of health survey and actually done so and that this survey was pulled from FSA, his own data, and they

created themselves and what they did is they asked everyone that was applying for any kind of public assistance through FSA online to fill out a 10 question survey. And it was presented every Hoosier and it was stated that explicitly that participation in the survey did not impact eligibility for services in any way, shape, or form. And these 10 questions, were then cross walked. For our purposes, we took a look at these questions, and we crosswalk them with ICD codes, to connect them with folks that had previously been engaged with Medicaid and had identified diagnosis of either SMI or SUD or both, or neither. And then we also took a look at how those matched up with social determinants of health. So go forward. Next slide, please.

Ari Nassiri 47:30
So, the original FSSA social determinants of health questions, there was 10 of them, and those questions were first, not enough money for food in the last 12 months. Second, utilities shut off in the last 12 months. Third, fear of not having stable housing in the next two months. Four, problems getting childcare, five cost preventing seeing the doctor in the last 12 months six transportation preventing seeing a doctor in the last 12 months. Seven, need of help reading or understanding hospital materials. Eight, fear of being hurt in the home. Nine, actively seeking work in the last four weeks, or 10 not engaging in regular exercise. And for our purposes, what we did is we took a look at surveys and other information that we had and realize that of these questions two utilities being shut off in the last 12 months three fear of not having stable housing, five and six which were costs and transportation respectively, preventing seeing a doctor in the last 12 months. Eight, fear of being hurt in the home. Nine actively seeking work in the last four weeks and 10, not engaging rower exercise lined up with a lot of what we're seeing from surveys of our consumers. Next slide, please.

Ari Nassiri 49:00
So, this is a still picture of what we ended up creating. And what you'll see here and doesn't exactly show it because it's still picture and, and this is a Tableau dashboard. So, what this actually allows us to do, and what you'll see on the dashboard is there are several different sections. One is a map of the state of Indiana split up by counties. And currently it has all of them colored the same way. But when you drag your pointer, your computer pointer over these counties, it'll let you know what the numbers of those assessments were for those responses. And then on top of it, it'll simultaneously change. So, if you were to click a specific county such as Benton County, all of the other pieces of the dashboard would filter only for Benton County. And the other pieces of the dashboard are the number of assessments that were completed. The percent of respondents the values of how many people oaks responded to the 10 questions, and then demographic breakdowns of the folks that responded to the survey. I'm going to wait for a second. And those demographics are age, education, ethnicity, gender, and marital status. And this is the FSA agency one. So next slide please.

Ari Nassiri 50:29
What we ended up doing is creating the mix. And so, we took all that SEL H data that had been accumulated and matching it against folks that had SMI, Sud, both co-occurring or neither. And then we created our own dashboard from that mix. And then we provided it to our subgroups, so that they can

take a look at how the social determinants of health are effective across Indiana, different counties, as well as by a couple different demographics, which were gender, race, and age group. And it allows us to filter out for the specific groups whether they have either diagnosis as well as the years which they responded. And next slide, please.

Amy Brinkley 51:18
Thank you, Ari, this is Amy again. So, in case you aren't noticing, there is a theme. Essentially what the recovery support Workgroup has done is we have taken existing data, and just begun to categorize it within Samson's dimensions every. And the last data set that we're going to talk about today is the recovery data platform. So, we have contracted with Faces and Voices of Recovery, a national organization that goes by favor, and we are contracting with them to get the recovery data platform. We are providing this resource to all of our peers within our regional recovery hubs, or our recovery community organizations. So currently, we have 21 plus, and growing recovery community organizations across the state, providing mental health and substance use disorder, peer support. And the recovery data platform provides a way to capture what favor calls recovery vital signs. So, when we go to see a primary care physician or a general practitioner, typically what happens is you would have your vital signs checked. So, the idea here is that if you're going to see a peer or a recovery coach that you would have your recovery vital signs checked on a regular basis. And what that involves is three different scales that are self-reported. It's the brief addiction recovery capital scale 10, which is 1010 questions, the engagement scale, which is 10 questions, and the lifestyle scale, which is also 10 questions. And our peers have been ones administering these scales and monitoring the recovery vital signs, and the RDP or recovery that a platform launched in 2020 and are today our recovery vital signs are still not captured consistently. So, we do have some room to grow in this area. Next slide. So, this is a cloud-based platform for our recovery community organizations to use. It allows our peer run organizations to capture things such as General interactions, intakes referrals, it includes a way for our peers to do rap or recovery management plans create smart goals, and action plans. The recovery vital signs, like I said in the last slide are three, three different scales. The idea being that the brief additional recovery capital scale would be done once a month or BI monthly to monitor recovery capital. And the engagement scale would be completed once a week. The engagement scale is three scales in one. So, it's the outcome rating scale, the relationship rating scale, and the cravings rating scale. And then we have the lifestyle scale. We initially piloted this recovery data platform with our mental health organizations as well to see how well it would work in a mental health setting. And it works probably not as seamlessly as the addiction recovery community organizations. But there is there is flexibility to use mental health peer supports and create your own scales and outcome ratings within the RDP. Next slide. So, this is just a breakdown of the questions so Recovery of vital signs, the lifestyle scale is one that we've encouraged our recovery community organizations to capture. One of the benefits of the lifestyle scale is capturing general social determinants of health-related data. But what we really wanted to know was whether folks coming to recovery community organizations had insurance. And so, if they do, then the idea being that the peer would connect them with the appropriate treatment and resources, because our recovery community organizations are primarily supported by block grant. The next one is the bar pen, which is 10 questions that are, I would say, a shorter version of the addiction recovery capital scale. So, it's one question from each of the 10 domains within the addiction recovery capital

scale. So, it's just a way to measure recovery capital ongoing, and the peers are the ones administering the scales. And these are self-reported in nature. So, the recovery themselves would be the ones entering the responses. Next slide.

Amy Brinkley 56:14
So, the engagement scale, is a sliding scale, and is the three scales in one. This is the outcome rating scale, the cravings rating scale, and the relationships rating scale. And the idea here being that with the outcome rating scale, it's just a general check in, [with] you know, our folks. So, for example, thinking back over the last seven days, how things been going in your relationships? Are you connected to other people? You know, are you staying plugged in? The next question, how have things been going for you socially? So how do you how connected do you feel? Or are you doing things? And then right how things are in your life overall? So just general check ins? The cravings rating scale is self-explanatory. So, what is your craving level? Ben, during the last seven days? How do you rate your cravings in the last 24 hours? The relationship rating scale is primarily going to be used during supervision. So, it's a way to capture how folks are engaging with their peer, and whether they're feeling connected to the person providing direct peer support. So, if I'm a supervisor, if I'm a peer supervisor, and I noticed that one of my peers have 10, people who are not writing them, well, as far as connecting, then maybe that's a supervision issue that I need to have a conversation with my peer about, versus if I noticed that the peer has one person out of 10, who are not connecting, well, maybe that recovery just isn't connecting to this specific peer and might do better with another person. So, it's a way to really monitor the engagement between the recovery and the peers. Next slide. One of the biggest, this is an example of the scales that are presented through the report. So, when we pull reports, we can pull this on the individual basis, we can pull this on the agency, agency wide basis, or we could look at the state. So, one of the biggest selling points for us was the preventative analytic component. So, the idea being that just with the engagement scale, if we're capturing this data over time, it tells a story. So, if the outcome if the outcome rating scale is extremely low, well, let me back up. So let me give an example. So, if I'm working with somebody who's had three relapses in the past 12 months, and I'm capturing their recovery, vital signs as I'm supposed to be, then I will have a record of what their vital signs were prior to a relapse, the idea being that hopefully, I can get in front of number four. So, if they're not feeling connected, if their outcome rating scale goes down, and their cravings rating scale rises, we should be monitoring that and tracking that. So, there's a preventative analytic component to this, which was a huge selling point for us. Because our recovery community organizations are not quite capturing the information consistently yet. We've not been able to use that to its full capacity. So, we'll get there. Next slide.

Amy Brinkley 59:23
So today, as of July, July 29 of 2021, we had 21. Actually, today we have 21 organizations using the recovery data platform. We've issued more than 100 licenses to peers across the state. We've captured 1200 recovery vital signs. We had 2200 individual participants entered into the recovery data platform, with 1800 of them engaged in July of this year. In June of this year, just one-month 2072 People were served through direct peer support. One 1557 People were served through group peer support. And then today, this is from April of last year to date, as of July, we had served 17,920 people through direct

peer support. And 16,340 people through group support with about 5600 referrals being made through our recovery community organizations. And, you know, two years ago, none of this would have been possible because we had one recovery community center that we were funding. And today we have 21. So, this is a way for our, our newly formed recovery community organizations to capture data. Next slide.

Amy Brinkley 1:00:43
So, these, so everything that we've talked about are the different data sets that we have identified could be used for recovery support, analysis. And so, the idea being that we take this data, and we present it to our recovery support workgroup members, and they make recommendations for blocker and spending, policy programming to the Division of mental health and addiction. So that's, that's all the data that we're going to talk about right now. But let's take a break and pull back Pam, Sarah, and Becca, you guys don't have to reintroduce yourselves per se. But maybe just go in that same order. And just take a couple minutes here and share your reflections on this process. As we've tried to coordinate these, this data, just share kind of your experience from your perspective, as we've evolved. Tina?

Tina Skeel 1:01:41
Thank you, I just have to say, the way I feel about this is we have come a long way, a really long way. From the days where we were laying all kinds of data surveys out on the table and trying to correlate them in, it's not been the smoothest ride, you know, we've heard we've had kind of some ups and downs. One of the biggest challenges we had really had to do with staff turnover, particularly in the division and with the stakeholders that were on the subgroup. Because as you bring in someone new into the group, things change that form storm, norming preform all kinds of change. So, we had kind of a rocky road once we lost our first champion of this process. But I want to leave you with three main points. And the first point is about getting a champion, this was an enormous project, I feel that we're finally at preforming stage. But it was a lot of work in having those champions, I mentioned, Amy, but when you look at organizational change, it really comes from the top leadership. And if we have not had good direction, and support from Jay in his team, I'm not sure that we would have made it this far. So, finding that champion and making sure that it's supported all the way through the organization itself. The second thing that I think was kind of a learning moment for us was that you really don't need to reinvent the wheel. We created all these different surveys in you've heard already talked about hate social determinants of health, or the state already had data points. And all these different agencies had data points is just going out there and finding them. So, know that if you have a good foundation, that you can build something really, really great, and you don't need to go out and spend a lot of time creating fancy surveys, my guess is in your state, there's probably a wealth of data, most states have data warehouses. And if you can get access to that, that can make life a lot easier. The second thing, really, is to make sure that or the third thing is to make sure that the voices of those that you're serving are at the table. And we found it vital to have those folks adding their comments along the process. There's an adage I've heard many, many times, and I think it really stands true, which is nothing about us without us. And so, I just want to share that with you all. Sarah, you ready to go?

Sarah Gunther 1:04:47
Yes, this is Sarah. And I just wanted to also just reiterate what Tina had said about having people with lived experience at the table and having a prominent seat at the table because it's so important. You don't want to Get lost in so much data that you forget that we're dealing with people, we're dealing with people's lives. And it's so important that we are providing support to them so that they can live their lives in a self-directed and in whatever way, you know, is best for them that they determine. So, I think it's very important, as Tina said that people with lived experience, both substance use and mental health lived experience are at the table and have a prominent voice. Becca, did you have anything?

Becca Sigafus 1:05:32
Hi, Sarah, thank you. And Tina, thanks a lot. I'm just going to echo with both with both Sarah and Tina said, also, this kind of just adding a couple of things that really accessing the data, to identify the gaps and issues has been an area of focus for the recovery support workgroup. The data that Amy Wendy and Ari had shared, they really has been recently completed and, and or initiating. And we're working toward that ability to have the data accessible for the subgroup review, as needed. So that's it that's really kind of continues to be in process. We've also been identifying available data sources and completing a data resource catalog. And that's been helpful for the process as well as Tina shared, it's just where is the data. So really, we're kind of trying to find that, and define really good, reliable information and data. Also, just, frankly, on my end, is having a team of individuals at the state in the community, who are just passionate about what they believe, dedicated, and have that expertise needed to see this succeed has been extremely important to the success of, of our process today. And, again, true in an actual collaboration between individuals with lived experience, the state and community agencies is a must, I'm just going to suggest you start there. It really, it must be real, not just having someone sit in on a meeting, or on a board or a committee to say that they are participating. It has to be an equitable partnership of collaboration. And this takes real time and effort. But I think in the end, it really pays off for success. And, again, it's been an evolving, amazing process. And I've been just honored to be a part of it. Thank you.

Amy Brinkley 1:07:45
Thank you, Becca, this is Amy again. So, one of the things I want to say before we move on to the next slide, is that some of the unique things that we're seeing unfolding within the workgroups is the de siloing of state agencies. And so, we have people with direct lived experience within each of the subgroups talking about real life situations, and needs that can be easily addressed, whether through funding or policy change. And by having the word proofs, you know, coming together, and the state agencies being there, and people with direct lived experience. There's also people on the table who can just with a snap of a finger, make that change, if it's just a policy change. We've seen things happen where they just say, Okay, let's, let's fix that. And it's a done situation, by just creating a safe space to have conversations to have targeted effort and focus in these areas, has really been amazing to watch. Conversations unfold relationships happening, we've had some new funding, for example, our peer subgroup identified housing as a large need for people with mental health, you know, concerns and so we had the housing group on the calls, and we were able to create a new funding stream to train peers on how to become housing navigators to address the need. So, we recognize that housing

system is extremely comprehensive, and folks don't really know where to go, or how to access the type of housing supports that they need. So, let's train people with less trained peers with direct lived experience to address that need and become housing navigators. So, it's just been really an awesome experience to watch state agencies participation and collaboration, relationships unfolding. So next slide.

Amy Brinkley 1:09:47
So next steps for us. We are going to continue to standardize and visualize our recovery data collection. We are working on creating some recovery dashboards and continuing to do some resource mapping. We are also working on funding some research efforts to capture the return on investment for individuals and communities when the dimensions recovery elements are available. So, when we make resources available to meet the need, what is what are the outcomes when we focus in on doing that, so let's do it, let's focus in on the ROI. We also want to continue to solidify the lived experience feedback loop and amplify consumer voice and choice to drive division of mental health and addiction decisions programming and funding initiatives. For too long, we've gone from the top down. And in this process, or really starting from the bottom up, and identifying what the needs are looking at existing datasets and categorize categorizing it by recovery dimensions, and then making recommendations with the right people at the table who can make the change that's needed.

Amy Brinkley 1:10:58
And that's really where we're at some really innovative things we've seen come out of this is the lived experience survey that was completed by the Indiana recovery Council last year was used in the addiction treatment strategic planning. So, they looked at the feedback and said, Okay, based off of what folks are saying with substance use disorders, which direction do we need to go? Where do we need to focus our efforts, the Indiana recovery Council lived experience survey also made space for folks to continue to get engaged or stay engaged. And so, we were able to create new focus groups based off of people who responded to that survey, and we access FSSA. So family, social services, administration and DMHA, we're able to access people who we previously did not have access to, to be part of our focus groups. So, we're not tapping the same five people to get the feedback that we need for the state. We're more branching out. And we're hoping that the listening sessions will continue to help us get new voices to the table. And that's, that's where we're at. I just want to take a moment and say thank you to David Miller with David Miller with NASHPID for, for introducing us to Bevin and for this great opportunity to present to you guys on the work that we're doing. We're happy to answer any questions. And we just want to say thank you guys for attending, and hope everybody had a great holiday.

Bevin Croft 1:12:23
Hey, this is Bevin. Thank you so much, Amy, and, and team for all of this information. It is really exciting to see the ways that people's lived experience and system folks are partnering. And systems folks with lived experience are all partnering together to use data. We've had some really excellent questions come through in the Q&A pod and in chat. So, I think we'll have plenty to take us to the end of the hour. A few questions. Maybe I'll just start with some quick ones. One is, is the IRC the Indiana Recovery

Council and the is it the RSW? Now I don't have the acronym top of mind. Maybe you can tell me but anyway, are either of those two the IRC or the RSW accepting new members currently?

Amy Brinkley 1:13:24
Yes, both. This is Amy. So yes, both are accepting new members. So, the Indiana recovery Council is striving for equal participation from both mental health and substance use disorder. people with lived experience. And so, we're really trying to identify more people with mental health lived experience right now. So, we're accepting applications for sure. Now for your recovery.

Bevin Croft 1:13:52
Oh, no. But my follow up question will be how can people get in touch with you if they are in Indiana and are interested in taking part?

Amy Brinkley 1:13:59
Okay, I can add a link, a quick Google search to DMHA Indiana Recovery Council, which should bring it right to the top. So, the other thing with the recovery support workgroup are chair people of the subgroups are really the gatekeepers for participate participation in those Workgroup settings. But anybody's welcome to attend the quarterly meetings. And there's a website for that too, it's DMHA's Recovery Support Workgroup.

Bevin Croft 1:14:27
Awesome. And we can when we post the recording, we can post those links as well for folks. Great, so kind of continuing on the theme of the council and rotation on the council. Can you share just a bit about you mentioned me that I'm on the recovery Council there's current maybe underrepresentation for folks with lived experience and significant mental health issues. Do you have a rough breakdown of sort of when you say lived experience? How many folks are identifying as mental health substance use both, and then family or natural supports?

Amy Brinkley 1:15:13
For the Indiana Recovery Council, it's a little bit more gray, we just generally know that the conversation typically veers off into the substance use disorder realm more so than the mental health. So, we know holistically, just looking at the members that mostly we have people with addiction, lived experience or substance use lived experience, compared to mental health. Now, with the recovery support workgroup, we actually have a survey that captures that and has people self-identify, we've not done that with any new curriculum. So, although they do identify within their application, I just don't have the breakdown off the top of my head.

Bevin Croft 1:15:51
Great. Great. Okay. Sounds good. Let's see. And then what are their questions sort of related to the council? And then we can move on to some other groupings of questions. And that's has, and, you know, in some of the slides that were presented, there's some language that's more clinical based. And

has there been any discussion on the council about the clinical vocabulary and some of the in some of the survey tools?

Bevin Croft 1:16:25
And Amy, you don't have to be the only one to answer to if other folks would like to chime in, please do feel free to come off mute.

Wendy Harrold 1:16:32
That's what I was waiting for.

Wendy Harrold 1:16:36
So, the CANS and ANSA is really a discussion. It's not, you know, a survey. So, I don't know if they're talking about that. So that's not a clinical sort of thing. It's actually it's used to buy child welfare, mostly, but not clinical in nature. I don't know if that answers their question.

Bevin Croft 1:16:59
It sounds like maybe there hasn't come up yet on the council. And I do wonder, just extemporize in here that it may be if there were more folks, you know, who've got experience in the mental health advocacy realm who are on the council, they may react to some of the some of the terminology and some of those assessments. So yeah, something to flag or to think about. Alright, let's see. We had a couple of questions around screening for traumatic brain injury or TBI, or if data are or if data about traumatic brain injury are identified or used. And thank you for answering in chat. The cans and answer don't screen for TBI, traumatic brain injury. But there are some other information, wondering if there have been any discussions or any uses of the data to specifically look at, you know, the behavioral health related needs or the recovery outcomes for people who do screen positive for traumatic brain injury.

Wendy Harrold 1:18:08
We haven't specifically looked at some of these items with the other data that we collect. So that's definitely something on our radar. But we are rather new to looking at the assessment data. So, we haven't done that yet.

Bevin Croft 1:18:23
Cool. Thanks. Thank you, Wendy. And yeah, some of these, I feel like these Q&A processes come up with a lot of good ideas for the future. And I know when you have such rich data, there are sort of endless ways to use it. So, a recommendation there to perhaps explore the needs of folks with traumatic brain injury. Okay, let's see. Um, you know, what, another while, while we're on the topic of the cans, can you share just a bit more about whether the CANS assessment is used in place of, or go side by side with any sort of plan authorizing services? So how does the sort of assessment data work with the service authorization data for the for the, I think this question was specific to the cancer answer, but maybe any of these data? How might they be used into a in a service planning function?

Wendy Harrold 1:19:28
I'm in our state, I'm not exactly sure if there so the CANS and ANSA data can inform what needs to be on the treatment plan. So, they say actionable needs and buildable strengths should be on the treatment plan. Um, the in our state, it's also utilized for decision support for a Medicaid rehabilitation option. And so, people, the consumers can get a package of services depending on how The whole assessment is what the recommendation of the whole assessment is. So, I don't know if that was where he was going or if that answered his question.

Bevin Croft 1:20:14
So, it sounds like then these data are used for to inform service decisions, as well as for the purposes that you've been describing. Yeah. Awesome. Thanks, Wendy. Okay, I want to ask about some issues around sort of representation and ensuring, you know, that the folks who respond to the survey are, racially, ethnically, linguistically diverse. So, we had a question come in that asked, if there are any languages besides English that the survey is offered in and? And Amy, you were able to quickly answer that question, thank you and say no, not currently, but that that's something that y'all are going to consider in the future, which feels really important. I'm wondering if you can, if you can say a bit about how these data might be used to inform any efforts at the DMHA to promote equity, you know, to work toward equity. You know, in terms of race, ethnicity, culture.

Amy Brinkley 1:21:20
This is a me so, so yes, so last year was the first year that that survey was administered electronically. In years past, it's been a paper survey only. And to my knowledge, it's only been offered in English as well. But last year, we made it more comprehensive. We included Samsung's dimensions of recovery, and made it available electronically, it was six months into the pandemic. So, everybody was really online at that time. So, this next year, we've contracted with a vendor to standardize the survey. And so that conversation about translating it into other languages is definitely on the table. So, it hasn't come up yet. So, I'm so happy that it came up, so that we can bring the conversation to the vendor. But as far as how we've been using it internally, we like the addition team specifically was meeting to do their strategic planning for the next. I think Becca knows, I think, a two year or five-year planning strategic plan for the whole education team, across the division, and they use that lived experience and equity is being addressed across our division in every team. So, the lived experience is definitely being utilized, quite honestly, much higher than my expectations. We've presented it to each of our advisory councils, we've presented it to our, our staff, and it's on it's on the website. So, we're getting it out there. It's being used. But we are still kind of early because that survey only went out last year. So, any concrete changes or outcomes from that are yet to be seen.

Bevin Croft 1:23:09
Great. Great. Thank you, Amy, it's cool to hear about the journey you folks are on and you know, really seems like you have a lot of a lot of power and opportunity with the data that you're collecting to really to do some do some awesome work in the in the equity space. So that's, that's really exciting, and really exciting to hear that you'll be looking at translation as well. Um, let's see, I believe, folks are more

than welcome to add questions into chat. One additional question, do you look at a monthly civil commitment data? By County? Is that is that data, a data point that you're looking at?

Amy Brinkley 1:23:09
This is Amy. Sorry. I feel like I'm doing a lot of talking. So I apologize. So we have no, I have not seen it. Um, to my knowledge, none of the subgroups are looking at that. But what I will say is that our division director, Jay, who was on the call earlier, used to be the director for legal services. And so he they're working on some civil Wait, it's competency restoration projects. So I don't know if that data is out there. Wendy, do you want to weigh in? Have you seen that data at all?

Wendy Harrold 1:23:46
So, we've not been looking at data? No.

Amy Brinkley 1:23:49
I haven't seen any. But I can't help but wonder if we can't access that though. We'll look into it.

Bevin Croft 1:24:49
Alright, I believe that we have gotten through the questions. Which is good because we're just at the end of The hour, just a couple of things to wrap up. One, I saw that backup, but the URL for the recovery supports workgroup into chat. So, if you are a Hoosier, and you're interested in in, you know, perhaps learning more or seeing if you can get engaged, you could check out that link. And then for the Indiana recovery Council, you can also Google Indiana recovery council to get that link, and we'll include those when we post the resources for this webinar. I want to really just think, to think certainly, Amy, for your incredible, incredible leadership of this initiative and the way that you were able to bring together this impressive panel of folks. Thanks to Jay for the support from the very top for this initiative, I think it's really remarkable to have to have that kind of support and buy in from from a director. And thank you to Becca, Sarah, Tina, Ari, and Wendy for sharing all of your wisdom and knowledge. And finally, just a note to say that we were really excited to partner with the National Association of State Mental Health Program Directors for this webinar. And caps is a center that is available as a resource to any human service agency, whether they are serving people with intellectual developmental disabilities, brain injury, mental health or substance use concerns, older adults, physical disabilities, any humans. We are, we are here as a resource. So really excited to be able to sort of elevate and focus on the specific work that is happening in Indiana around mental health and substance use recovery. A recovery-oriented system is a person-centered system and vice versa. So, we use different words sometimes, but I believe that the values and the approaches are quite, quite compatible. So, thank you to David Miller, for your leadership in this area. And if we could just pull up one final slide, we'd love to hear what everyone thought of this webinar. We use your responses to improve our webinars month over month. So please just take a quick moment. To respond to the questions, you'll want to scroll down there are six questions in total. And if you could just take a quick moment to respond to them before you log off. That would be great. So, thanks, everyone, and have a wonderful evening or afternoon depending on where you are in the country. Take care, and we'll see you next month.