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# Clark/Floyd Crisis Intervention Team Capstone Project

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In 2019, I was invited to participate in the Dearborn CARE interprofessional team through professional relationships created as a substance abuse professional at Wooded Glen Recovery Center. The Dearborn CARE team meets quarterly at the Ivy Tech Campus in Lawrenceburg, IN to share ideas, evaluate interventions, and use our collective talents to address important substance abuse issues including barriers to transportation, stigma, screening, and establishing a local recovery hub where individuals would have access to support, treatment options, life skills, and social connectivity.

Over the last two and a half years we have worked to address needs in the community and have partnered with the Indiana University Center for Collaborative Systems Change to evaluate our efficacy (See Appendix A). Our interprofessional team has been able to decrease community stigma, increase transportation options, assist in creating the 1Voice Recovery Hub, and have implemented screening measures in areas including St. Elizabeth Dearborn Hospital and the Community Mental Health Center in Lawrenceburg, Indiana. Using our wide-ranging and collective skills, our interprofessional team has had a substantial impact on the substance use issues uncovered through community needs assessments, group member expertise, and surveys.

The purpose of this project is to utilize that experience to build a similar program in another local Indiana community. In May of 2022, the Clark/Floyd Systems of Care agency director invited me to join a new initiative that would become the Clark/Floyd Crisis Intervention Team, responsible for establishing a similar program in their community to the work ongoing with Dearborn CARE. Not only will I utilize my experience with the Dearborn

CARE team to spearhead this initiative, but I will also lean on my education from Eastern Kentucky University to apply interprofessional social work practice and behaviors to produce best outcomes for the community.

Bronstein (2003, as cited in Iachini et al., 2018) defines interdisciplinary collaboration as "an effective interpersonal process that facilitates the achievement of goals that cannot be reached when the individual professionals act on their own" (p. 4). As a social work professional, it is imperative that I work alongside professionals from other fields and disciplines to achieve best outcomes. These interprofessional disciplines can include but are not limited to medical professionals, education professionals, politicians, law enforcement, community leaders and stakeholders, and other clinicians.

Through my employment at Wooded Glen Recovery Center, I have had the opportunity to collaborate with local agencies and professionals to develop strong partnerships that reduce barriers to treatment and increase the likelihood an individual is able to access inpatient, medical detox, outpatient, and medically assisted substance abuse treatment. Due to the rapport and trust built through previous collaborations and having an understanding of the team make-up in Dearborn County, I am inviting many of these same professionals to join the Clark/Floyd Crisis Intervention Team.

One finding from the Dearborn CARE team's early experiences was that in the beginning, when the group was small, our short-term goals were broad and left us thin on team members who were assigned to each initiative which eventually caused some to experience burnout. According to Cox (2020), "it is increasingly understood that self-care among

practitioners is vital for sustaining high-quality services. When work-related stress is not managed effectively, it can pile up and, in some cases, lead to burnout, secondary traumatic stress, or vicarious trauma" (p 15). Working with the substance abuse population can be emotionally taxing and utilizing self-care techniques will be invaluable in producing effective collective action. Some of these self-care strategies include prioritizing time with family and friends, exercise, recreation, proper sleep and eating, and support from group members and supervisors, and self-care prioritization from team social work professionals.

The Clark/Floyd Crisis Intervention Team project is ongoing, in real time, and relies upon important evaluation measures from the work done by the interprofessional team at Dearborn CARE, evidence-based research, and community assessment through the University of Indiana. Substance abuse is one of the most pressing social issues facing our communities today and understanding how to best intervene requires collaborative group work where professionals can use their unique strengths, skills, and resources to promote positive, culturally competent outcomes. My passion for substance abuse recovery is strong and developed in part due to my personal battle with opioids, giving me unique insight and experience that combined with my social work education, allows me to be an effective change agent who understands the issue cannot be solved by social workers alone. The following paper will detail how the interprofessional collaboration at the Clark/Floyd County Crisis Intervention Team is developing to best address the community's needs.

## Evaluating Evidence for Individual and Collective Action

Alcohol and substance misuse is a complex, biopsychosocial issue that is devastating communities throughout the world. Adding to the complexity of substance misuse are unique cultural, environmental, social, and racial disparities that complicate assessment, intervention, evaluation, and service delivery, leaving oppressed community members underserved and vulnerable to cycles of disadvantage and professional distrust. Due to the complex nature of substance and alcohol misuse, intervention requires collaboration from professionals from an array of disciplines working together to provide insight, skills, experience, and resources aimed at recovery efforts.

According to the National Association of Social Workers (2018), "Social workers partner with individuals, groups, families, and communities to promote well-being and enact social change. The core values of social work include service, social justice, dignity and worth of a person, importance of human relationships, integrity, and competence. Social workers, advocate for people who are poor, vulnerable, or disenfranchised providing counseling and engaging in community organization, administration, policy advocacy, research, and education" (p. 1). In addition, the Academy of Social Work and Social Welfare (n.d., as cited in Iachini et al., 2018) states, "addressing these complex challenges facing our society cannot be achieved by social workers alone. There is a wide recognition that no single profession can effectively address any of these issues in isolation. Therefore, the social work profession is increasingly emphasizing interprofessional collaboration as best practice strategy for addressing these societal challenges" (p. 4).

The framework shaping and guiding the Clark/Floyd Crisis Intervention Team is Bronstein's (2003) Model for Interprofessional Collaboration. According to Petri (2010, as cited

in Iachini et al., 2018) “the MIC is the most extensively cited and studied model for interprofessional collaboration in social work and beyond” (p. 23). The MIC provides social workers and interprofessional team members a model of collaboration to better understand how their best skills, knowledge, and resources can be used to achieve positive outcomes.

Among the initial tasks of the Clark/Floyd Crisis Intervention Team was to identify potential community professionals for inclusion. This is an essential element to the success of the team. The team will use the loose blueprint of the Dearborn County CARE team to begin by addressing three issues that are appropriate for the initial size, funding, and professional resources of the team. All three levels of social work: micro, mezzo, and macro, will require social work competence and skills for the team to make an impact.

The founding members of the team are Troy Mansfield, social worker, Wooded Glen Recovery Center; S. Austin, peer support, TruHealing Riverbend Recovery Center, A. Carruthers, social worker, Clark/Floyd Systems of Care; K. Hodges, case manager, Floyd County Sheriff’s Department; and M. Bradford, RN, Baptist Floyd Hospital. This strong foundation brings expertise and experience from the medical, social work, treatment, and community criminal justice systems and were the members present for the inaugural meeting.

The community substance use issues will be identified by research through the Indiana University Applied Research and Education Center (2021) Priorities for Progress (See Appendix B) community assessment. The Clark/Floyd region is different from Dearborn community in that it is less rural (being just outside of Louisville, KY), less Republican (approaching nearly 75% in

Dearborn County, and about 56% in Floyd County), and less subject to issues such as lack of reliable internet access depending on where clients live in the area.

According to the United States Census Bureau (2022), Lawrenceburg, IN demographics include a 95.7% White population, 3.5% Black population, a medium household income of $26, 729, with 84% of the population having a high school diploma or more. In New Albany, IN, the largest of the cities in Clark and Floyd County has about 5 times the population of Lawrenceburg and about 85% White, 9% Black, a medium household income of $49, 415, and 87% with at least a high school diploma (United States Census Bureau, 2022). These differences are significant and will be important in developing team initiatives that are appropriate for the community.

Diverse populations in the region continue to experience the cycle of inequity and systemic discrimination. According to Indiana University Applied Research and Education Center (2021), “Poverty remains a concern and is not evenly distributed across the population. As the “Overview” indicates, people of color comprise a relatively small portion of the population in Clark and Floyd Counties (compared with state and national demographics). These groups, however, are overrepresented among the region’s poor” (p. 26).

The need for research and evidence-based assessment, intervention, and evaluation will be key in developing and maintaining the interprofessional team’s vision and goals. Working with the Dearborn CARE team for the last few years gave me an important opportunity to develop a professional relationship with the Indiana University Grand Challenge’s Program who

provide research, insight, and partnership in addressing issues relevant to the substance abuse crisis. According to Indiana University, (2022):

> The Responding to the Addictions Crisis Grand Challenges is IU's commitment to prevent and reduce substance use disorder in Indiana and beyond. Alongside community partners, we aim to combat this crisis with 30+ interdisciplinary research projects, statewide naloxone training and kit distribution, and community partnerships throughout the state.
>
> This ambitious program has three primary goals:

- Reduce the incidence of Substance Use Disorder,
- Decrease the number of overdose fatalities, and
- Reduce the number of babies born with Neonatal Abstinence Syndrome.

> Leveraging the strengths of IU's seven campuses, and with 160 community partnerships, this statewide initiative is one of the nation's largest and most comprehensive state-based responses to the substance use disorder crisis and the largest led by a university. The interdisciplinary team of researchers participating in this multifaceted effort is led by IU School of Nursing Dean Robin Newhouse (para. 4).

This research gives the team an evidence-based starting point that will guide team collaboration around developing high impact initiatives that will address community substance abuse issues.

Other professionals on the team use theory and evidence relative to their respective disciplines to identify areas of need. M. Bradford, RN with Baptist Floyd is focused on transportation to treatment barriers, disease prevention, and overdose deaths. Much of her input has been on the research promoting harm reduction. According to the Center for Disease Control National Harm Reduction Technical Assistance Center (2022), "offering harm reduction services is an effective approach for preventing overdose, the spread of infectious disease, and other harms resulting from drug use" (para. 3).

A. Carruthers, a Licensed Clinical Social Worker and founding team member is focused on research surrounding stigma, racial and cultural inequity, screening, and cultural

competence. According to the White House Executive Office of the President Office of National Drug Control Policy (2022), “It is estimated that in 2020, over 41 million Americans had a substance use disorder (SUD). Yet only 2.7 million received treatment” (para. 1). According to SAMHSA, of individuals who need treatment for illicit substance use disorders, Whites receive treatment 23.5% of the time, while Black and Hispanic individuals receive treatment 18.6% of 17.6% of the time, respectively” (p. 33). Understanding how the social determinants of health relate to inequity in substance use treatment and mental/behavioral health treatment will be essential to culturally competent assessment and intervention.

Floyd County Sheriff Office Case Manager K. Hodges is interested in eliminating criminal justice barriers, stigma, and access to treatment through a criminal justice lens. Indiana University (2022) research suggests:

> Societal barriers are often amplified by the incarceration cycle. Inmates with addiction in the criminal justice system need help the most, yet rarely receive treatment. Nationally, about 90 percent of inmates do not receive addiction treatment services, and three-quarters of individuals imprisoned for a drug-related offense are arrested for a new crime within five years of release.
>
> Prisoners are also as much as 129 times more likely to die of a drug overdose during the two weeks following release from prison than those in the general population. Hoosiers released from jail will likely return to drug use because their addiction hasn’t been adequately treated. After a period of not using drugs during incarceration, though, tolerance is lowered and risks for overdose increase (para. 6).

The Clark/Floyd Crisis Intervention team will collaborate with one another and recruit community stakeholders to address these important issues. Using data and professional experience to identify areas of need will inform evidence-based interventions and initiatives that will seek to reduce stigma, reduce overdose deaths, increase treatment referrals, increase evidence-based screening, focus on cultural, racial, and gender equity, and criminal justice policy changes. Alone, social work professionals A. Carruthers and I would not be able to adequately intervene in all these areas, however using interprofessional collaborative

frameworks including the MIC will empower the team to achieve together what they cannot alone.

## Exercising Social Work Values and Ethics

The impact on the clients and community will depend on the effective and collective teamwork of the interprofessional team. Building the interprofessional team is essential to identifying areas of need and implementing appropriate interventions. The Clark/Floyd Crisis Intervention Team founding members identified more potential professionals to invite to the project's initial team, understanding that over time new members will be welcomed depending on need and project growth. The inaugural meeting would result in the additions of K. Kavanaugh, Jeffersonville Police Department; B. Webster, Director Floyd County Department Child-Based Services; J. Barnett, The Breakaway Sober Living; M. Adams-Wolf Our Place Drug and Alcohol Education Center; P. Stucky, Scott Thrive, and D. Randelia; Floyd County Community Corrections.

Optimal team functioning requires understanding the importance of maintaining social work professional values and ethics with both clients and team members, while respecting and collaborating with professionals who adhere to other ethical standards. The National Association of Social Workers (2018, as cited in Iachini et al, 2018) states:

> Social workers who are members of an interdisciplinary team should participate in and contribute to decisions that affect the well-being of the clients by drawing on the perspectives, values, and experiences of the social work profession. Professional and ethical obligations of the interdisciplinary team as a whole and of its individual members should be clearly established (p. 281).

Iachini, et al. (2018) agrees, "establishing clarity about professional and ethical obligations of an interprofessional team is optimally achieved by increasing our

familiarity with the documented ethics and values of the professions with whom we regularly work" (p. 281). Establishing this clarity provides a framework for the group when conflicts arise due to conflicting standards, values, and interpretations. At times, due to the deeply held adherence of ethical standards, decision making can lead to division, group fracturing, and decreased group efficacy. Avoiding potential damage to professional relationships and collaboration requires the use of cultural humility. According to Iachini et al. (2018), "cultural humility supports an understanding, acceptance, and ability to openly discuss differing and similar ethical standards and values. Within cultural humility, we can attend to the possibility of our own centrism, as well as the strengths, reasoning, interpretation, influences, and limitations of all ethical codes" (p. 282).

Due to my experience working on the Dearborn CARE team, I had previously collaborated with professionals from disciplines similar to those making up the inaugural Clark/Floyd Crisis Intervention Team. These professionals, despite holding many of the important values required by the NASW (2018) Code of Ethics, are subject to the ethical frameworks of their professions. The experience from the Dearborn CARE team helped me to understand that respecting the ethical values and standards of the non-social work professionals is essential in establishing adherence to social work standards.

The Clark/Floyd Crisis Intervention team has several members with non-social work professional ethical codes. K., Chief of Police Jeffersonville, adheres to the Law Enforcement Code of Ethics (2017). The Law Enforcement Code of Ethics (2017) states, "Whatever I see or hear of a confidential nature or that is confided to me in my official

capacity will be kept ever secret unless revelation is necessary to the performance of my duty" (p. 2). This, for the purpose of the team, allows for interpretation that could be less restrictive than the ethics surrounding confidentiality required by social workers. Information learned through the team efforts could be legally harmful to clients and was clearly addressed in the early formation of the Dearborn CARE group. Open discussions about the issue, using social work communication skills including active listening, respect and unconditional positive regard, and reframing. According to Iachini et al. (2018), "Rapport is built by using interpersonal skills, such as empathetic listening, to enhance understanding and communication. Much like in clinical practice, establishing rapport helps individual's feel connected, supported, understood, safe, and forthcoming" (p. 224).

Similarly, K. Hodges of the Floyd County Sheriff Office and Daraias Randelia of Floyd Community Corrections are also subject to ethical requirements. The American Probation and Parole Association Code of Ethics (2022) states "I will uphold the law with dignity, displaying awareness of my responsibility to offenders while recognizing the right of the public to be safeguarded from criminal activity" (para. 2). Again, this leaves for open interpretation to criminal activity that could conflict with the confidentiality requirements of social workers.

M. Bradford, RN, Baptist Floyd RN, is governed by the American Nurses Association Code of Ethics (2015). The AMA Code of Ethics (2015) states "Individuals are interdependent members of their communities. Nurses recognize situations in which the right to self-determination may be weighed or limited by the rights, health, and

welfare of others, particularly in public health" (p. 19). Though, this is similar to the standards of social workers, interpretations could be dependent upon language including the 'welfare of others'. Each of these codes however also expresses the importance of working with other legal agencies to provide needed services.

According to Iachini et al. (2018), "Social workers view problems through a social justice lens, assessments using a strengths-based approach, and intervention through harm reduction. A probation officer or court administrator is trained through a criminology lens, through which trauma or victimization may not be as important to consider when thinking about sanctions to crime. Professionals with training in criminal justice are often required to use an abstinence-based approach" (p.81). This is one of the most common reasons for potential ethical conflict. For example, one initiative considers providing increased access to treatment options at the local hospital for clients presenting with substance misuse concerns.

Jane D., a 34-year-old female presents to Baptist Floyd Hospital following an overdose. Through screening efforts, it is determined the client would benefit from access to substance misuse treatment. The client is then referred to a local treatment facility through the Clark/Floyd Crisis Intervention Team collaborative and during assessment the client reveals she is on local probation and has began prostituting to support her habit. After her admission, the interprofessional team reviews caseload and probation officer are upset that he has been lied to by the client and has the authority to incarcerate her. Other team members believe this will be destructive to her therapeutic process.

To best serve the client and the interprofessional team, the team will apply an ethical decision-making model for guidance. According to Ling and Hauck (2016), "The ETHICS model is a theoretically grounded ethical decision-making model that draws from the latest relevant literature in ethics" (p. 3). This model provides a course of action for decision-making when no matter the course of action that is taken, some value will be compromised. This is even more common on interprofessional teams because they are a group of professionals subject to different standards and interpretations of ethics.

The first step in the ETHICS model is: E- Evaluate the dilemma. According to Corey et al. (2015, as cited in Ling & Hauck, 2016) "Once an ethical dilemma is identified and evaluated, it becomes clear that the rest of the ETHICS model is necessary to determine which course of action is most ethical" (p. 5). During the meeting the interprofessional team identifies that the treatment center, social workers, and medical team members believe that taking the client into custody will be harmful to the client's recovery process. However, the probation officer now knows the client has been using and involved in criminality and has been given treatment opportunities in the past. The officer believes and has the authority to take the client into custody. This clearly creates an ethical dilemma at the team level and constitutes next steps.

The second step in the ETHICS Model is: T- Think ahead. Ling and Hauck (2016) state that, "This involves evaluating each option independently to determine all foreseeable repercussions, both positive and negative…in essence, this process takes a utilitarian perspective to encourage seeking the greatest good for the most clients" (p.

5). The options evaluated are that the client is taken into custody and subjected to a probation violation, which could eventually lead to a treatment opportunity, or to allow the client to continue with her treatment, as recommended by clinical assessment. This part of the process for the interprofessional team requires respect, open dialogue, communication skills, and it is essential that team members feel safe providing their perspectives without fearing retribution (Iachini et al., 2018, p. 80).

Next, the ETHICS model suggests that the group: H- Help. According to Warburton (2013, as cited in Ling & Hauck, 2016) “In addition to thinking ahead to outcomes, it is important to receive help from consultants. This is supported by the moral relativism perspective, which encourages consultation regarding relevant industry standard practices” (p. 6). Individual team members should consult their supervisors and colleagues while the group can also consult similar groups with prior experience. This is helpful in considering personal biases and for strengthening the argument for the perspective they initially supported or suggested. According to Ling and Hauck (2016), “Drawing from the framework posited by Behnke (2014), questions for consultation can fall into one of four categories: legal, ethical, clinical, or risk management. Legal questions involve how laws and regulations may apply to a situation. Ethical questions relate to the interpretation of the ethics code. Clinical questions comprise how actions may affect the best interests of the client. Risk management questions are concerned with exposure to liability” (p. 6).

The ETHICS model then requires the group consider: I-Information. This part of the model requires the group to consider law, regulations, and literature relevant to the

ethical dilemma and applying to other steps. In the example above, information gathered from evidence-based sources about efficacy of treatment, issues when client leaves against clinical or medical advice, recidivism rates with and without treatment opportunities, and must consider the law and how it relates to HIPPA, probation violations, and other criminal activity. Then the information is applied to the options in an unbiased manner during open team communications (Ling & Hauck, 2016, p. 7).

Once information is gathered and evaluated, the next step is C: Calculate Risks. According to Alexander and Moore (2015, as cited in Ling & Hauck, 2016), "since all (counseling) practice involves risk, it is important to calculate how each option might impact a (professionals) exposure to liability and fulfillment of responsibility. This step is supported by the moral absolutism perspective, which encourages following rules and avoiding harm over the consequences of the action. This is a direct contrast and serves to balance out the utilitarianism perspective in the think ahead step" (p. 7). The team and individual team members must consider the potential for risk to one another and their various professions. The efficacy of the group depends on the trust of other members and being aware of risks involving professionals and their careers is an important way to establish this support.

Last, the ETHICS model suggests to: S: Select of Course of Action. According to Ling and Hauck (2016), "this decision should be in alignment with evidence gathered in previous steps" (p. 8). If the process has been followed, the decision will logically follow, and the ETHICS model preserves evidence for the decision and the process to make it. After considering all information, the probation officer agrees that the client will be

allowed to complete the program and remain in treatment. The potential harm of interrupting the recovery process outweighed the officer's obligation to uphold the probation agreement and his supervisor is supportive. This is an important decision because it provides the group with a framework that justifies decisions such as the example.

## Being Culturally Responsive

According to the National Association of Social Workers (2018) *Code of Ethics,* "Social workers should promote conditions that encourage respect for cultural and social diversity within the United States and globally. Social workers should promote policies and practices that demonstrate respect for difference, support the expansion of cultural knowledge and resources, advocate for programs and institutions that demonstrate cultural competence, and promote policies that safeguard the rights of and confirm equity and social justice for all people" (p. 6.04).

Social justice issues are at the heart of the social work profession. Social workers have a strong understanding of how factors including oppression, structural disadvantage, racism, and inequity are catalyst for cycles of criminal activity, poverty, substance misuse, and violence. Social workers also understand the inequities in service delivery that create barriers to important resources. Amplified over the last decade, social issues including political policy surrounding topics including abortion, voting rights, financial assistance, and gun violence have made for an increasingly divisive environment.

Throughout my work with the Dearborn CARE group, I began to understand that social issues were not always agreed upon by team members. Despite the focus of the team's work being grounded in social issues, some professionals were not always aligned with the social workers. During these times it was important for the social work leaders in the group to take on a role of educator and advocator, relying upon their experience, education, and communication skills to help the group understand how underlying social issues relate to the problems identified by the group.

This experience allowed me to take on a leadership role with the Clark/Floyd Crisis Intervention team. At the first meeting with the entire team present, group members began to brainstorm areas of concern based on their experience, education, and community data. During this discussion, A. Carruthers and I spoke from a social work, person-in-environment approach to some of the identified issues. One issue, community stigma was brought up to the group. During the discussion, some group members expressed that they felt there were times that individuals in the criminal justice system used substance misuse as an excuse to avoid consequences and that they see them relapse and return to criminal activity much of the time.

Other team members voiced having a negative opinion of medically assisted treatment, believing it to be simply a replacement for their drug of choice. Using evidence-based research, I was able to draw upon that according to SAMHSA (2022):

> MAT has proved to be clinically effective and to significantly reduce the need for inpatient detoxification services for these individuals. MAT provides a more comprehensive, individually tailored program of medication and behavioral therapy that address the needs of most patients.

> The ultimate goal of MAT is full recovery, including the ability to live a self-directed life. This treatment approach has been shown to:
>
> - Improve patient survival
> - Increase retention in treatment
> - Decrease illicit opiate use and other criminal activity among people with substance use disorders
> - Increase patients' ability to gain and maintain employment
> - Improve birth outcomes among women who have substance use disorders and are pregnant
>
> Research also shows that these medications and therapies can contribute to lowering a person's risk of contracting HIV or hepatitis C by reducing the potential for relapse (para. 2).

When addressing social issues, it is imperative social workers remember the importance of maintaining professional respect with team members who have altering viewpoints. It is also important that all team members be open-minded and willing to put personal biases aside to ensure the focus on client and community outcomes outweigh any personal beliefs about social issues. According to Bronstein, (2003), "personal characteristics relevant to interdisciplinary collaboration include the ways collaborators view each other as people, outside of their professional role. In studies Mattessich and Monsey (1992) reviewed relevant personal characteristics included trust, respect, understanding, and informal communication between collaborators" (p. 304).

It is also essential to effective collaboration that despite this respect for viewpoints, that social workers should also focus on dismantling systems of oppression, disadvantage, and inequities. According to Murray-Lichtman and Levine (2019), "social workers who are members of interdisciplinary teams can promote group cohesiveness. However, social work field educators must also equip their students with the knowledge and practice skills to guide their

interprofessional team in understanding the ways in which privilege, oppression, marginalization, and powerlessness contribute to social injustice" (para. 3).

One way I have effectively communicated with individuals who have not been exposed to the experience and education to help understand social injustice, has been by honestly and outwardly examining my own privilege. According to Cross et al. (1989, as cited in Iachini et al, 2019) "Professionals may work toward developing cultural competence in collaboration with colleagues and clients by ensuring differences are accepted, privilege is acknowledged, organizational policies match professional values, and cultural knowledge and resources are continually expanded" (p. 230). Acknowledging difference, understanding privilege through self-awareness, and communicating respectfully with team members provides an opportunity for advancing social justice through education and advocacy.

Understanding how housing discrimination, racism, and oppression have impacted underserved community groups is vital to assessing community issues and providing culturally competent interventions. With the Deaborn CARE team, one way that we were limited in our pursuit of social justice and being culturally responsive was that our interprofessional team had little diversity outside of political ideology, and some gender differences. Professionals in the Dearborn County, Indiana area live in an area that is heavily White, politically right, and few professionals with diverse race, ethnicity, and gender identity or expression work there. Of the group members all but three were White women, the other three were White men.

With the Clark/Floyd Crisis Intervention team, we have a greater focus and ability to ensure the team and the work of the team is focused cultural diversity. According to the Counsel on Social Work Education (2022):

> Social workers understand how racism and oppression shape human experience and how these two constructs influence practice. Social workers understand the pervasive impact of White supremacy. The dimensions of diversity, equity, and inclusion are understood as the intersectionality of multiple factors. Social workers understand the societal and historical roots of social and racial injustices and the forms and mechanisms of oppression and discrimination. Social workers demonstrate cultural humility and manage the influence of bias, power, privilege, and values in working with clients and constituencies, acknowledging them as experts of their own experiences (para. 11).

Understanding the impact of diverse inclusion on the interprofessional team was vital in forming the members. A. Carruthers is a Black female social worker who inherently understands the structural oppression and discrimination that exacerbates substance abuse and other social issues. K. Hodges openly identifies as LGBTQ and brings knowledge and experience on related issues to the group. K. Cavanaugh of the Jeffersonville Police Department is the first Black captain of the force, D. Randelia is from India, J. Barnett is also Black and brings unique perspective as someone who has insight on diversity issues in substance misuse, and I have unique perspective through my own active addition as a felon and someone who experienced substance misuse issues firsthand both in and out of the criminal justice system.

Intersectionality and diversity shape the human experience, identity development, and the worldview of clients and colleagues. This intersectionality could lead to oppression and discrimination, but also power and privilege. The Counsel on Social Work Education (2022) states:

> Social workers understand the societal and historical roots of social and racial injustices and the forms and mechanisms of oppression and discrimination. Social workers understand cultural humility and recognizes the extent to which a culture's structures and values, including social economic, political, racial, technological, and cultural exclusions, may create privilege and power resulting in systemic oppression. Social workers (a) demonstrate anti-racist and anti-oppressive social work practice at the individual, family, group, organizational, community, research, and policy levels and (b) demonstrate cultural humility by applying critical reflection, self-awareness, and self-regulation to manage the influence of bias, power, privilege, and values in working with clients and constituencies, acknowledging them as experts of their own lived experience (p. 9).

Ensuring these individuals were represented and respected as interprofessional team members was a first important step in creating a group that responds to injustice and inequity. It was also effective for me to share my story of privilege in my personal substance use recovery and how it increased my ability to recover from lighter sentencing at the criminal justice level, having a paid attorney, being White and socioeconomically in the middle to upper class, and access to treatment options unavailable to many community members.

Bringing together professionals from other disciplines and instilling social work values and ethics into the interprofessional team is a skill common to social workers. Understanding the environmental factors that shape the human experience and having the ability to practice humility and self-awareness allow for the communication within the team to feel safe and respectful. It is also important to respect the abilities of the professionals from other disciplines while using the wide range of social work skills that overlap some of these arenas. I have experience with the biology and medical components of substance misuse and how it relates to disease, I understand how medically assisted treatment medications work on the brain and body, and I have experience in clinical counseling. This allows me to be a leader on the team

and assist initiative leaders in assessments, interventions, and evaluations related to their professional expertise.

## Preparing, Engaging, and Assessing

Social work skills, understanding of the causes, and commitment to social justice initiatives are indispensable to the success of the group, however, they should all be grounded in theoretical framework that drives interprofessional collaboration. Without a model grounded in theory to guide collaboration, teams risk disorganization, poor communication, resentment, and fatigue. The Iachini et al. (2018) Model for Interdisciplinary Collaboration provides this framework and is supported by research. Bronstein (2003), "used four theoretical frameworks in the development of the model, including a multidisciplinary theory of collaboration, services integration- the program development model discussed most frequently in conjunction with collaboration- role theory, and ecological systems theory" (p. 299).

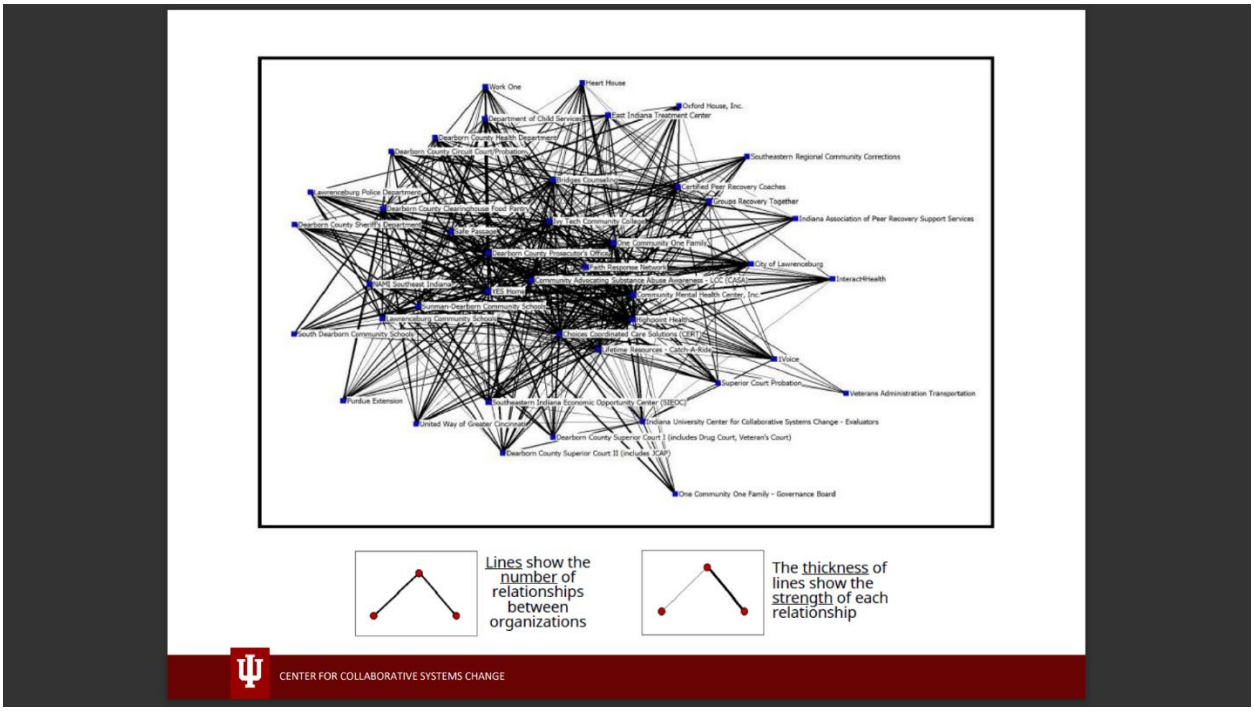
The Model for Interprofessional Collaboration framework is made up of five components that inform effective collaboration: interdependence, newly created professional activities, flexibility, collective ownership of goals, and reflection on process. These components provide social workers on interprofessional teams with guidance that creates optimal collaboration through utilizing the wide range of experience, skills, and education to provide interventions and positive outcomes social workers could not accomplish on their own.

According to Iachini et al. (2019), "social workers and other professionals with whom they collaborate practice *interdependence* when they rely on each other to accomplish their goals and tasks" (p. 25). Interdependence requires that professionals understand and respect

the expertise and roles of other group members and utilize those skills to deliver appropriate interventions. Interdependence can create connectivity that is valuable for team initiatives and goal attainment. The Indiana University Center for Collaborative Systems Change (see Appendix A) (2022) shows interdisciplinary connectivity achieved by the Dearborn CARE team (Fig. 1).

Figure 1

*Dearborn CARE Interdependence*




The Clark/Floyd Crisis Intervention Team will maximize the team efficacy by developing strong, professional relationships and being clear about roles and responsibilities. Bronstein (2003) states “characteristics of interdependence include formal and informal time spent together, oral and written communication among professional colleagues, and respect for colleagues’ professional opinions and inputs” (p. 299). Creating an e-mail chain for the group,

establishing regular group meetings, and participating in local related events were all introduced as ways to increase the relationships required for successful teamwork.

At the heart of the Dearborn CARE initiative and the newly created Clark/Floyd Crisis Intervention Team is addressing substance abuse issues through initiatives that require interprofessional collaboration. The second component of the Model of Interprofessional Collaboration is: *Newly Created Professional Activities*. Newly created professional activities are the collaborative acts, programs, and structures that can achieve more than if the same professionals acted alone (Bronstein, 2003, p. 300). Bronstein (2003) provides reference stating, "Kagan and Neville's (1993) application of systems theory to service integration emphasized how individual people and programs linked together have the opportunity to create that which they cannot create when acting independently" (p. 300).

Newly created professional activities for the Clark/Floyd Crisis Intervention Team initiative will create new systems, actions, and structures including screening and referral to treatment through overdoses and emergency room visits, partnering with local peer support network for improved transportation to resources, installing an Active Recovery program, activities to decrease community stigma, creating a grant application, and activities aimed at decreasing barriers to intervention for individuals in the criminal justice system.

*Flexibility* is the next component of the Model for Interprofessional Collaboration. According to Bronstein (2003), "Flexibility extends beyond interdependence and refers to the deliberate occurrence of role-blurring. Behavior that characterizes flexibility includes reaching productive compromises in the face of disagreement and alteration of role as professionals

respond creatively to what's called for. Flexibility is displayed by team members by probation and parole officers allowing compromise around giving probation and parolees opportunities for treatment that would normally result in incarceration. Flexibility is also utilized when social workers can detail the medical dangers of overdose when speaking to potential clients and constituents. Having a team that is adaptive and free from hierarchical structure allows for equal voice and group conscious.

The next component of the Model for Interprofessional Collaboration is: *Collective Ownership of Goals.* Collective ownership of goals refers to the shared responsibility of reaching goals, including joint design, definition, development, and achievement (Bronstein, 2003 p. 301). According to Bronstein (2003), "This includes a commitment to client-centered care whereby professionals from different disciplines and clients and their families are all active in the process of goal attainment. To engage in a collective ownership of goals, each professional must take responsibility for his or her part in success and failure and support constructive disagreement and deliberation among colleagues and clients" (p. 301).

Opey (2000, as cited in Iachini et al., 2019) states "To do this work most successfully, team members need to be able to disagree in efforts related to defining, executing, and assessing goals" (p. 26). Sharing ideas and voicing opposing viewpoints are both important parts of the collective ownership of goals component. Graham et al. (1999, as cited in Bronstein, 2003) states that "inclusion of the client and his or her family in goal setting and achievement as part of the definition of interdisciplinary collaboration attends to the importance of the clients voice in all aspects of service delivery" (p. 302).

Understanding the importance of inclusion of the client and community in assessment was evidenced by our reliance upon data collected from an interprofessional agency. By referencing the University of Indiana Southeast Applied Research and Education Center (2021) Priorities for Progress community needs assessment. This needs assessment provided important data and allowed us to quickly assess areas of need.

The University of Indiana Southeast Applied Research and Education Center (2021) Priorities for Progress needs assessment "report document contains triangulated findings from public data sources, community conversations, and surveys. These data present a snapshot of a moment in time. The data provide a shared reference for strategic planning, applying for particular grant monies, and setting a baseline against which to establish benchmarks and measure progress. The data represent a place to start community conversations, but they do not replace the need for ongoing opportunities to engage diverse actors in taking ownership in how this region will build on its assets, develop, and respond to the challenges it faces over time" p. 13).

Using our skills, experience, professional knowledge, and available data such as the evaluations on interventions from the Dearborn CARE group and the community needs assessment, the Clark/Floyd Crisis Intervention team was able to identify initiatives that were appropriate and necessary to overcoming some of the substance misuse issues facing the community.

Culturally competent engagement with both members of the interprofessional team and with the community is improved by our commitment to diversity. Modeling this

commitment has allowed the group to engage with one another and with the community in ways that we could not have achieved without diverse experience and input. Culturally diverse team members are experts of their own experience and relate to the clients in the same way. It is essential to practice cultural humility by engaging in open discussion, actively listening, and challenging professional competence, and growth. Understanding the impact of oppression, utilizing diversity on the interprofessional team, and then applying that knowledge and experience to promote social justice and equity is evidence of a profoundly culturally competent team and is prioritized by the Clark/Floyd Crisis Intervention Team.

The final component of the Model for Interprofessional Collaboration is: *Reflection on Process.* Bronstein (2003, as cited in Iachini et al., 2019) states that reflection on process "include 'collaborators' thinking and talking about their working relationship and process in incorporating feedback to strengthen collaborative relationships and effectiveness" (p. 178). Having regular evaluations akin to the collaboration modeled by the Dearborn CARE group includes quarterly meetings including ongoing evaluation and annual data reviews. Working with an interprofessional team requires not only client and community level assessment, but the ability to assess the team and how the team is functioning toward agreed upon goals.

## Setting Goals, Planning, and Contracting

The preparing, engaging, and assessing phase the Clark/Floyd Crisis Intervention Team, through both the community research data provided by the Indiana University Priorities for Progress and the team's professional experience provided a foundation for identifying

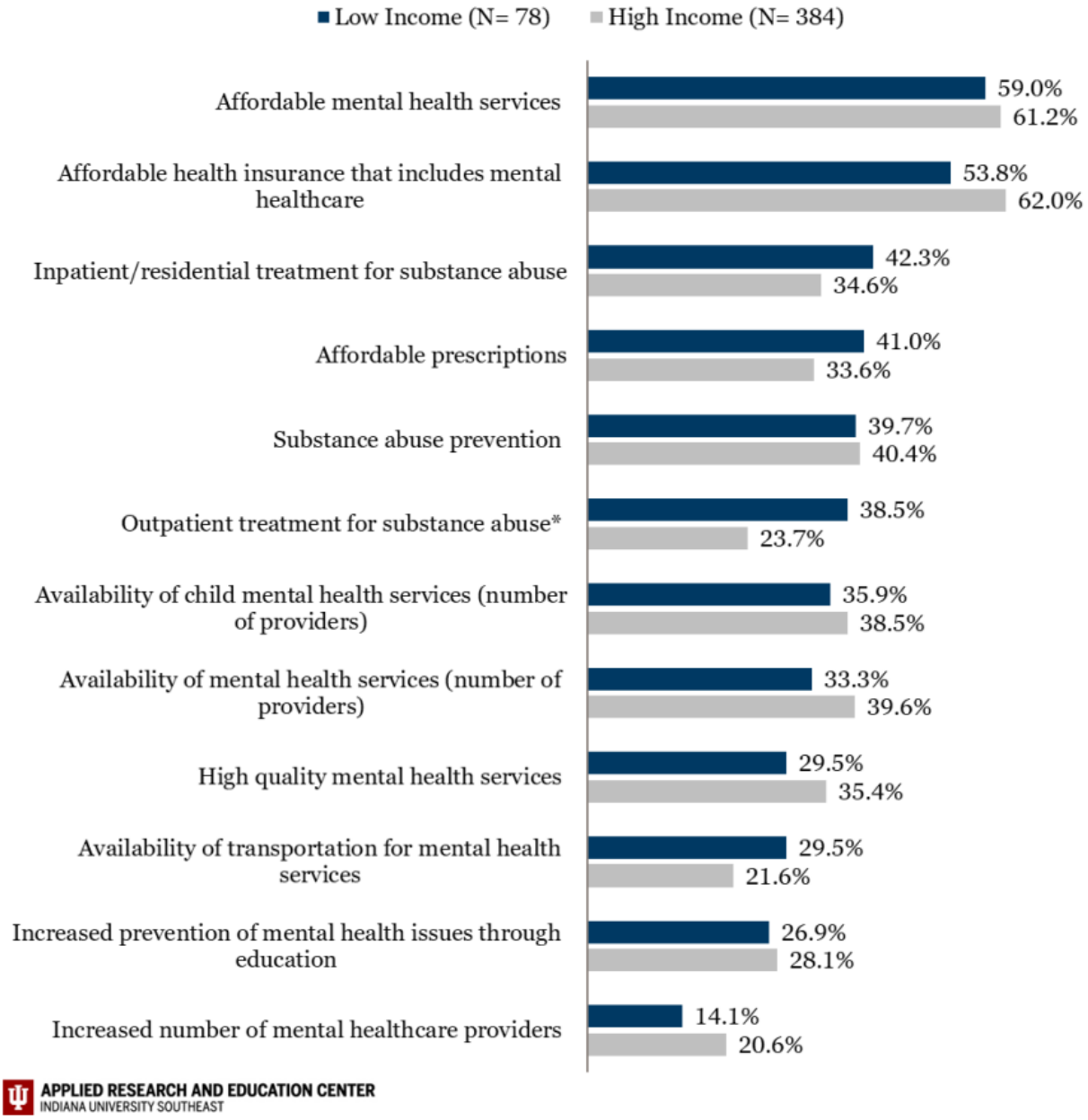
community substance use issues. Applying this assessment, and assessment of the interprofessional team itself provided data and logistical insight on how the team would choose initial goals.

In the goal setting process, it is vital that the interprofessional team incorporate the voice of the community in decision-making processes. Utilizing the data collected from the Indiana University Priorities for Progress community needs assessment, the Clark/Floyd Crisis Intervention team is given useful data on what the clients and community experience and prioritize. According to the Indiana University (2018) Priorities for Progress Survey, "Top priorities for mental health include concerns about affordability, access, and quality. Substance abuse prevention is the third most frequently selected priority. More than a third of respondents selected inpatient/ residential substance abuse treatment, and more than a quarter selected outpatient treatment as top priorities (p. 58) (Figure 2). Other strategies that ensure the diverse perspectives of the community are incorporated include prioritizing diversity on the interprofessional team and engaging diverse community leaders and stakeholders in ongoing assessment and intervention efforts.

Figure 2.

*Clark/Floyd Mental Health Priorities by Income*

*FIGURE 48: MENTAL HEALTH PRIORITIES BY INCOME*




The community needs assessment also shows that the community could benefit from a focus on school-based youth prevention programs, increased access to trauma-informed care, access to treatment, access to lifesaving Nalaxone, and harm reduction efforts aimed at combating disease and overdose deaths.

These assessments, community input, and professional experience were the foundation for the team goal setting, planning, and contracting. It is also important to take on educator roles to help interprofessional team members understand and remember the impact of social determinants of health to inform intervention planning. Sue (2016, as cited in Cox, 2019) "suggests the following guidelines for group discussions of culture and racial/ethnic differences: Understand your own racial and cultural identity, recognize and be open about your racial biases, encourage discussions about feelings, pay more attention to the process than to the content of race talk, and encourage and support people who are willing to take the risk of expressing themselves (p. 126).

The interprofessional team at Clark/Floyd Systems of Care identified three problems that would be addressed through collaborative goal setting. 1.) Inequity, both current and over time, has negatively impacted the community in areas including health and substance misuse. 2.) Treatment options are scarce and face barriers to access. 3.) There is a lack of childhood trauma and early intervention efforts necessary to meet the needs of the community.

The interprofessional team then met the following month to brainstorm goals and research to support the intervention. After some back and forth, disagree, and debate, the interprofessional team was able to develop three goals for the project. Effort was made to develop goals that were SMART (Specific, Measurable, Achievable, Relevant, and Timely).

Goal 1: Improve engagement and treatment outcomes for oppressed populations using culturally competent interventions within 24 months.

Objectives:

- Increase treatment and knowledge options for underserved, diverse populations within the community.

According to The African American Behavioral Health Center for Excellence (2022), "Black and African Americans who resided in non-metro areas were more likely to report accessibility barriers such as the lack of transportation, knowledge of where to go for care and the inconvenient location of providers compared to their peers in large urban areas. They were also more likely to believe that mental health treatment would not work. One possibility for this point of view is that accessibility barriers are preventing individuals from seeking care and therefore limiting opportunities to experience positive outcomes of care" (p. 4).

- Provide local systems of care with implicit bias training

The African American Behavioral Health Center for Excellence (2022) goes on to state, "a study found that implicit bias was significantly related to patient-provider interactions, outcomes, treatment decisions, and adherence" (p. 5).

- Advocate for implementation of legislative policy allowing Clark/Floyd Crisis Intervention Team members to address substance misuse and psychiatric emergencies to also enhance community to first responder stigma

Goal 2: Increase access to treatment for individuals in crisis within 12 months

Objectives:

- Apply for grant with National Council for Mental Wellbeing (See Appendix B) for harm reduction pilot program by December 23, 2022

Although the group has funding through the Clark/Floyd Systems of Care agency, ongoing efforts to raise funding will increase the team's ability to deliver ongoing services and develop new initiatives as the team will remain adaptable due to changes in research, culture, and environment.

- Establish peer led outreach team available Baptist Floyd Hospital to develop rapport and link clients to recovery resources following EMS intervention
- Develop program for harm reduction within Clark and Floyd County Jails including Naloxone distribution and in-house Medically Assisted Treatment

According to the National Council for Behavioral Health (2020), "A growing body of evidence demonstrates that MAT programs in correctional settings are effective in preventing overdose deaths. After expanding access to MAT statewide in its correctional system, the Rhode Island Department of Corrections experienced a reduction in post-correctional overdose deaths rates by 61% in the first year" (p. 9). This program would also align with reducing barriers to individuals who have previously been underserved by social determinants to health.

Goal 3: Increase access to mental health screening and intervention for community youth within 12 months

- Assist Lifesprings Integrated Health Systems with Youth and Adult SBIRT screening in schools, emergency rooms, and health department

According to SAMHSA (2022), "SBIRT is a comprehensive, integrated public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders" (para.

1). This screening will target resource scarce areas and culturally diverse areas where there have been gaps in resource allocation.

- Host mental health, medical, and substance use resource fair in identified communities with high diversity and scarce resources quarterly.

Encouraging providers throughout the area to provide information and resources to underserved parts of our population. Bringing in Care Management team members from Indiana Medicaid providers will also allow community members to access benefits they may otherwise not know were available.

- Increase access to trauma focused interventions in school systems through culturally competent and humble screening and referral

Trauma and substance misuse go hand in hand. Individuals in the Clark/Floyd County area have been impacted by oppression, divisiveness, the pandemic, and generational trauma that exacerbates mental health, substance misuse, and other social issues. These goals were developed through a clear understanding of the collaborative team mission and how we can utilize our inherent professional roles, skills, and resources to impact community level issues.

## Applying Practice Theories and Skills

In addition to understanding the components of the Model of Interprofessional Collaboration, Iachini et al. (2019) notes that “it is useful to know what influences interprofessional collaboration in practice. Variables which can strengthen or undermine

professional collaboration, include professional roles, structural characteristics, personal characteristics, and a history of collaboration" (p. 28).

Bronstein (2003) states that "a strong sense of *Professional Role* includes holding the values and ethics of the social work profession: an allegiance to the agency setting; an allegiance to the social work profession; respect for professional colleagues: an ecological, holistic view of practice consistent with the social work profession: and a perspective that is similar or complementary to collaborators' perspectives" (p. 302). Having clearly established roles allow the team to better understand the skills and expertise of each team member and how to best utilize them. It is also important that this ownership of professional role and knowing when it is best to lean on the expertise of other group members are both exercised in highly functional collaboration.

During the first meeting of the Clark/Floyd Crisis Intervention team, Ann Carruthers and I led a group activity where we went around the room to introduce ourselves to the group and detail our professional backgrounds and skills. This gives the group a better understanding of our interprofessional expertise and the opportunity to ask questions and discuss ways to best utilize our professional resources, knowledge, and skills.

*Structural Characteristics* are the next variable that can strengthen or weaken collaboration. According to Bronstein (2003), "structural characteristics relevant to interdisciplinary collaboration include a manageable caseload, and agency culture that supports interdisciplinary collaboration, administrative support, professional autonomy, and time and space for collaboration to occur" (p. 303). Drawing upon the commitment to self-care, social

workers on the Clark/Floyd Interprofessional Team led by A. Carruthers and I prioritized important structural issues. A. Carruthers and I engaged in open group communication about expectations, workload, time commitment and took into consideration that team members were volunteering time to the community effort. We also provide lunch from local restaurants at each meeting to encourage self-care and show appreciation leading to increased collaboration. We also have offered telehealth options for professionals to decrease time spent traveling and personal expenses.

*Personal Characteristics* also factor into the success of the interprofessional team. Working with professionals who we like, respect, and appreciate leads to a stronger sense of collective ownership and is optimal in the team setting. However, diverse teams will experience disagreement, tension, and altering perspectives. These conflicts are opportunities for professional growth and trust building. Implementing team building skills will promote relationship building important to effective function.

Communication using interpersonal communication skills, process techniques, and self-awareness has created a culture on the Clark/Floyd Crisis Intervention team that encourages the use of social work skills to communicate with team professionals. The team requires that members “show respect and unconditional positive regard. When collaborators appear open and warm, people are more likely to feel safe and supported” (Iachini et al., 2019, p. 225).

Lastly, *History of Collaboration* is a variable in interprofessional collaborations. According to Mellin and Weist (2011, as cited in Iachini et al., 2019), “research has shown that when professionals have positive prior experiences with collaboration, they are more likely to

have current positive collaborative experiences" (p. 29). To enhance the team's view on history of collaboration, I have shared the evaluations of the Dearborn CARE initiatives. Showing the group, the efficacy of collaboration develops a sense of trust and vision for the group by drawing upon evidence of positive outcomes. The Model for Interprofessional Collaboration enhances our collaborations and provides a framework that will help the Clark/Floyd Crisis Intervention team build on the Dearborn CARE efforts to utilize assessment, set goals, and evaluate our efforts.

There are many macro level policies that shape how the interprofessional team process with clients, the community, and one another. HIPPA, the Health Information Privacy Protection Act, requires client consent for sharing of private individual health information among agencies. This is important when working with agencies and clinicians at Lifespring Integrated Health and treatment centers. Though many of the team members are not in the medical or mental health profession, adherence to the protection of individual health information is a federal law and must be followed appropriately.

Another relevant policy initiative is the Model Expanded Access to Emergency Opioid Antagonists Act (2021). According to the Legislative Analysis and Public Policy Association, (2021), "The act gives legislators and policymakers the means to implement mechanisms that increase the ability of citizens in every state to access and use emergency opioid antagonist to save lives" (p. 4). Essentially, this policy will allow for expansion of Nalaxone state-wide, grant immunity to individuals administering opioid antagonist, and provide increased access to opioid antagonist in education institutions and correctional settings.

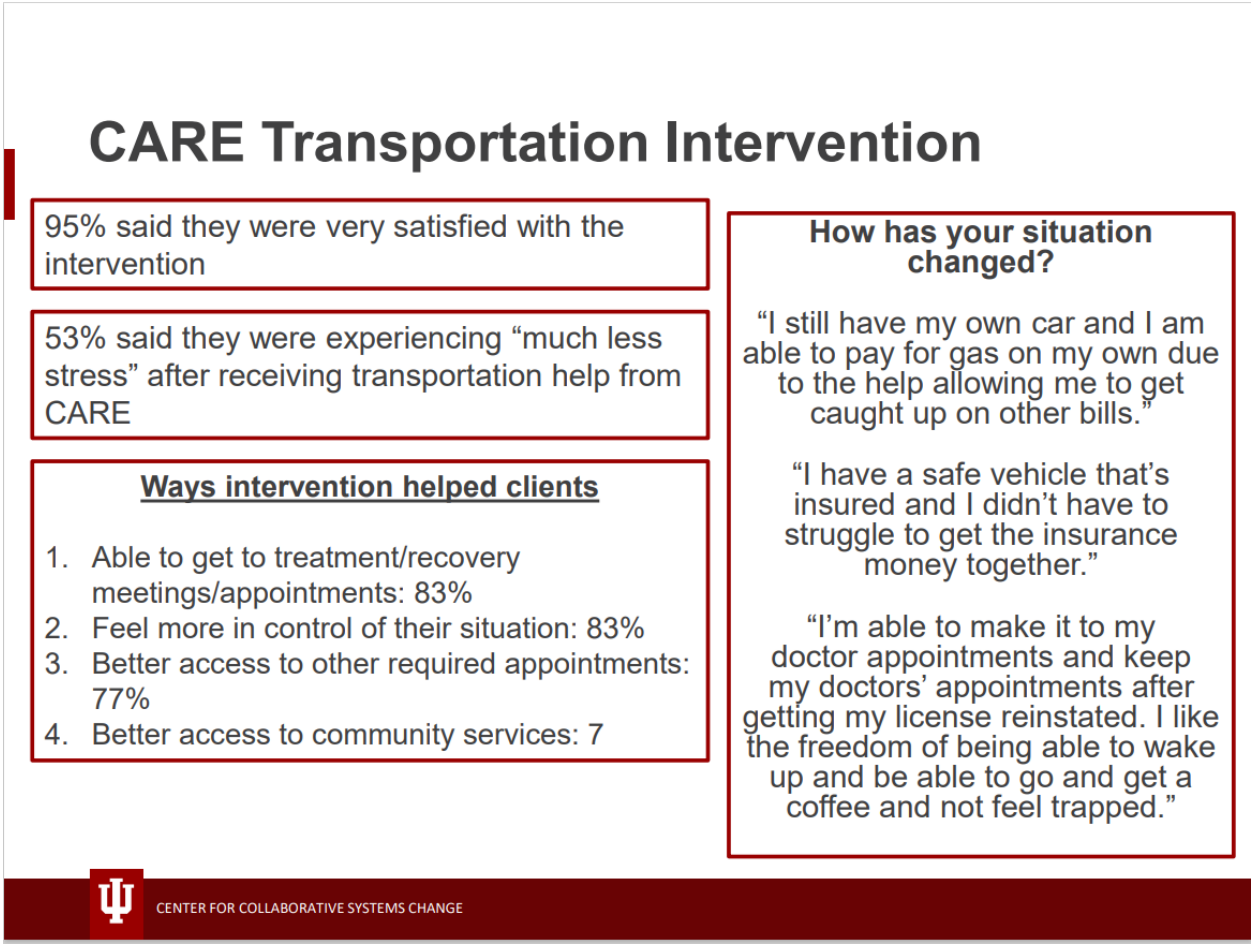
There are also several factors that influence policy for medication-based treatment in correctional facilities. According to O-Kelley-Bangsberg (2020), “across the country, correction institutions are implementing medication for opioid use disorder programs in jails and prisons to save lives and money. However, barriers to further expansion of MOUD programs persist, including stigma and immediate costs. In 2018, only 1% of jails and prisons in the United States offered medication to people with opioid use disorder” (para. 1). There are many ways to overcome this barrier including allowing Medicaid to remain active during incarceration or using opioid settlement or grant funds to kick off the program. Advocacy routes include how withholding the medication is a violation of the American Disabilities Act and could be considered in the court systems. As the interprofessional team grows, utilizing our range of skills and resources to advocate for macro level change will positively impact our clients and community.

## Evaluating, Ending, and Documenting

Evaluation is an essential practice that provides data and evidence supporting the efficacy of an intervention, or that an intervention may not be working. According to Cox (2020), “both process and outcome evaluations provide a wealth of information that may be used to recognize strengths and design needed improvements for service delivery programs” (p. 174). Micro level evaluations including client satisfaction surveys and exit interviews are qualitative evaluation types while quantitative data such as number of screened individuals entering treatment will also be used to measure efficacy. Below is an example (Figure 3).

Figure 3

*Dearborn CARE Group Transportation Evaluation Survey*




Preparing interprofessional team members for termination with clients and families will help them to cope with some of the emotional toll of working with the substance use population. According to Cox (2020), "if the ending occurred with poor outcomes, the social worker may experience feelings of guilt or anger. Supervision is an important vehicle for processing and resolving these commonly experienced emotional reactions" (p. 170). Similarly, social workers on the interprofessional team should prioritize self-care and healing for team members and themselves.

Evaluation is an ongoing process and includes evaluation of the interprofessional team. According to Iachini et al, (2019), “through a broad array if research studies, collaborators’ ability to discuss their own behaviors and interactions with each other correlates with strong collaborative relationships. Sometimes such conversations and reflections occur as regular parts of team meetings, and sometimes they occur spontaneously in team meetings or formal discussions” (p. 27). Though the Clark/Floyd Crisis Intervention Team is in the early stages of intervention, it is important social workers in the group provide respectful and timely feedback to professionals’ performances, recognize the impact of diversity and personal characteristics, share accountability, and recognize team strengths and weaknesses, including their own.

My experience with the Dearborn CARE group provided me with an understanding of the factors that shape interprofessional collaboration. Evaluation of the teams’ values, knowledge, skills, and cognitive processes are important in evaluating team functioning. Successful teams are also able to solve conflict in a professional manner and utilize social work communication skills to encourage positive feedback. The ability to accept feedback is also important, as social workers are looked at as leaders in interprofessional collaboration and should set an example for professional growth opportunities.

Structural characteristics such as regular, scheduled meetings and informal communication provides regular opportunity for collaborative evaluation. One way that I have effectively established a professional culture on the Clark/Floyd Crisis Intervention team is by practicing self-awareness. Along with understanding professional role and skill, Iachini et al. (2019) states, “cultural competency is a function of self-awareness, as practitioners use cross-

cultural knowledge, skills, and professional education to support and advocate for a diverse workforce" (p. 231).

Self-awareness also involves understanding privilege. Sharing with the team how my privilege allowed me distinct, unearned advantage during my substance misuse both active and in recovery provided me resources that enhanced my ability to recover. From having the ability to pay for a private lawyer, to light sentencing, to treatment opportunities given through private insurance and cash, I was given a much better opportunity to recover than individuals from oppressed populations. The intersectionality of being a middle-upper socioeconomic class, White, male has provided me privilege since birth. My awareness of this privilege and the journey I have taken to advocate for social justice and equity gives me insight on the issues our clients face, and encourages safe, honest, and supportive self-reflection for team members.

Despite their effective initiatives, I believe that the Dearborn CARE team misses opportunities to improve the quality of intervention and interprofessional collaboration through their lack of diversity. Diversity not only provides unique perspectives, ideas, and lived experience, but it promotes social justice and inclusion for community members. As social workers, promoting social change in practice and on interprofessional teams sets an example for other professionals that can lead to overcoming bias, discrimination, oppression, and exclusion.

The Clark/Floyd Crisis Intervention team, on the other hand, prioritizes diversity and social justice. An essential element of the evaluation of the group's efforts will depend on the partnership with and data provided by the Indiana University Southeast Priorities for progress

report. Indiana University Southeast (2021) states, “The data provide a shared reference for strategic planning, applying for particular grant monies, and setting a baseline against which to establish benchmarks and measure progress. The data represent a place to start community conversations, but they do not replace the need for ongoing opportunities to engage diverse actors in taking ownership in how this region will build on its assets, develop, and respond to the challenges it faces over time” (p. 13). The impact of our interventions and interprofessional collaborations will depend on our ability to have ongoing evaluation and assessment, and how we can be flexible and adapt to changes. I believe that our work is essential, and I am proud of our commitment and leadership in the community and hope that it can become a blueprint for community change across the world.

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# Appendix

## Appendix A.

7.27.21 CARE Quarterly Meeting Final Version.pdf

## Appendix B.

HR-PS-Pilots-RFA-FINAL_11.15.22.pdf

## Appendix C.

cfsi_PrioritiesForProgress_update_08-04 (1).pdf