LIFESKILLS CENTER FOR CHILD WELFARE EDUCATION AND RESEARCH

Evaluation Services for the KJCMH 2023 Mental Health Summit

Final External Report

October 22nd, 2023

To:

Kentucky Judicial Commission for Mental Health

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Overall Summary

This report contains survey results completed by attendees of the Mental Health Summit hosted by the Kentucky Judicial Commission on Mental Health (KJCMH) at the Galt House Hotel in Louisville, Kentucky from May 31-June 2, 2023.

Evaluation services were provided by the Western Kentucky LifeSkills Center for Child Welfare Education and Research (LCCWEAR). This evaluation's overall goals were 1) Evaluation of Concurrent and Plenary Sessions from the Mental Health Summit and 2) Evaluation of the Overall Summit Participation Survey. This summary provides overall highlights of the full report that maps onto these goals.

Goal 1: Evaluation of Concurrent and Plenary Sessions from the Mental Health Summit

Concurrent Sessions

Sixty individual Concurrent sessions were offered during the entire 2.5-day Mental Health Summit. Logistically, these sixty individual sessions were offered during five separate time slots. A total of 12 individual sessions were offered concurrently during each time slot. Therefore, participants could select one of twelve Concurrent sessions to attend during each of the five time slots. See scheduling format below:

- Concurrent Sessions 1 (May 31st, 2023 – 10:45am – 12:00pm)
- Concurrent Sessions 2 (May 31st, 2023 – 1:45pm – 3:00pm)
- Concurrent Sessions 3 (May 31st, 2023 – 3:15pm – 4:30pm)
- Concurrent Sessions 4 (June 1st, 2023 – 10:30am – 11:45am)
- Concurrent Sessions 5 (June 2nd, 2023 – 2:00pm – 3:15pm)

After each Concurrent session, the attendees were asked to complete Concurrent session surveys by scanning the provided QR codes. The surveys contained five questions focused on the overall effectiveness of the presenter and six questions designed to capture perceptions about the overall effectiveness of the presentation on a 5-point Likert scale ranging from (1) strongly disagree to (5) strongly agree. In addition, open-ended questions asked session attendees to share candid feedback about their biggest takeaway from the session, avenues for implementation, and related barriers. In this summary, data pertaining to the presenter's overall effectiveness will not be examined.

It is expected that participants will attend sessions and decline to participate in the related surveys. Therefore, the following results are not intended to reflect actual “attendance” but to reflect the quantity of surveys completed per 1) Concurrent session time slot as a whole and by 2) individual session.

Related to survey completion by Concurrent session time slot, Concurrent Session 2 received the most responses (*n* =242 responses) and Concurrent Session 5 received the fewest responses (*n* =167 responses). While there was variance as it pertains to the quantity of qualitative responses by attendees (biggest takeaway from session, implementation, and barriers), every session did have some indication of ways to implement the material and/or barriers.

Related to survey completion by individual session, the individual sessions that received the most responses were Concurrent Session 1, Session B (The Judge as a Change Agent: Developing an Effective Local Criminal Justice/Mental Health Community, *n* = 40 responses) and Concurrent Session 2, Session D (The Fundamentals of Assisted Outpatient Treatment (AOT) and Kentucky's Expansion of Tim's Law, *n* = 40 responses). The individual session that received the fewest responses was Concurrent Session 4, Session J (988 Suicide and Crisis Lifeline: Transforming Crisis Response in Kentucky, *n* = 3 responses) as well as Concurrent Session 5, Session J (Aging with Serious Mental Illness, *n* = 3 responses).

In addition to examining the quantity of responses, this report will examine the attendee's perception of the presentation's overall effectiveness.

On the Concurrent session survey, a total of six positively framed Likert Style items (e.g., 1= strongly disagree to 5= strongly agree) were used to collect participant perception about the overall effectiveness of the presentation. Examples of these individual items include the following: "*The session increased my knowledge"* and "*I plan to implement what I learned in the session*." For comparative purposes, the research team created a variable to reflect the mean value across all six of these items for the purpose of summarizing Concurrent session data. Table 1 lists each Concurrent session in alphabetical order by session title.

Table 1: Individual Sessions: Overall Effectiveness of the Presentation by Alphabetical Order

	N	Mean	Std. Deviation
988 Suicide and Crisis Lifeline: Transforming Crisis Response in Kentucky	3	5.0	0.0
Adolescent Substance Use Trends and Prevention Strategies	7	4.4	0.4
Aging with Serious Mental Illness	3	4.5	0.7
Alternatives to Guardianship Using Supported Decision-Making	9	4.4	0.8
An Alternative First Responder Model	9	4.5	0.7
An Introduction to Trauma-Informed Care for Professionals Working with Justice-Involved Individuals	11	4.6	0.5
Any Positive Change: Harm Reduction in Public Health	16	4.4	0.7
Autism 101: How to Support Individuals with Autism	4	4.2	1.0
Breaking Down Barriers: Reentry and Recovery Housing in Kentucky	33	4.8	0.6
Breaking Down Silos: Identifying Links Between Interpersonal Violence, Animal Violence, and Substance Misuse	24	4.3	0.6
Bureau of Justice Assistance Visioning Session (Nunn)	19	4.0	0.9
California Ca1AIM 1115 Demonstration: Justice-Involved Reentry Initiative	8	4.6	0.5

Carrying Care: Enhancing Staff Well-Being and Resilience	24	4.8	0.3
Carrying Care: Enhancing Staff Well-Being and Resilience	23	4.6	0.4
Child Fatality and Near Fatality Review Panel	16	4.4	0.7
Combating Behavioral Health Issues for Kentucky Veterans	13	4.5	0.6
Crisis Intervention Team (CIT) and the E-Crisis Report: Using Data to Drive Decisions	20	4.4	0.7
Exploring the Prism: When Intellectual Disability, Mental Health, and the Judicial System Intersect	27	4.3	0.8
From Chaos to Collaboration: How Teamwork Saved My Life	7	5.0	0.0
From Chaos to Collaboration: How Teamwork Saved My Life	20	4.3	0.8
iHOPE: First Episode Psychosis	15	4.6	0.5
Just and Well: Rethinking Competency to Stand Trial	19	4.3	1.2
Kentucky Incentives for Prevention: An Overview of Youth Mental Health Trends, Risks, and Protective Factors	7	4.9	0.2
Kentucky Medicaid Behavioral Health Initiatives	10	4.3	0.8
Kentucky Office of Vocational Rehabilitation: An Overview of Consumer Services	7	4.5	0.9
Kentucky Opioid Response Effort: State Services Across the Sequential Intercept Model	14	4.7	0.5
Kentucky State Police Crime Victim and Community Resource Services	31	4.3	0.6
Kentucky's Opioid Epidemic: KYOAAC's Strategy	10	4.4	0.8
Kentucky's System of Care: Supporting the Behavioral Health of Children, Youth, and Families	18	3.8	0.7
Legal Implications of Sexting and Screen Addiction	27	4.6	0.5
Medicaid 101	13	4.4	0.7
Mental Health Challenges in the Judicial System: Judge's Role in Treatment Success	16	4.3	0.7
Non-Opioid Pain Management	12	4.4	0.5

Opioid/Stimulant Use: Effective Interventions for the Dually Diagnosed	8	4.7	0.5
Overview of Available Intellectual and Developmental Disability Services in Kentucky	9	3.9	0.7
Panel: Current Kentucky Initiatives	21	4.7	0.7
Panel: Diverting the Justice System: Identifying Strategies to Overcome Challenges of Placement, Services, and Funding for Individuals with Serious Mental Illness	30	4.4	0.7
Panel: Kentucky's Crisis Response Alternatives	18	4.5	0.8
Panel: Recovery Advocacy	12	4.8	0.4
Panel: Youth Voice Colloquia: Youth Perspectives on Improving Mental Health in the Courts	22	4.7	0.5
Person-Centered Justice	11	4.0	0.8
Primer of the DSM-V and Mental Illness Diagnoses	17	4.2	1.0
Recovery Ecosystems: What are They and How Can you Build One in Your Community	20	4.5	0.7
Recovery-Oriented System of Care and Mental Health Diversion	27	4.6	0.8
Review of Kentucky's Involuntary 202A and 202B	17	4.3	0.7
Review of KRS 504 and KRS202C	25	4.5	0.7
Right to Mental Health Treatment for Trafficking Survivors and Culturally Specific Approaches	5	4.0	0.5
Serving Youth with High Acuity Needs: System of Care Challenges and Opportunities	13	4.5	0.5
Social Determinants of Mental Health	31	4.5	0.7
Social Determinants of Mental Health	17	4.2	0.9
Strategies for De-escalation of Agitated Behaviors	25	4.4	0.9
Student Mental Health Initiative	22	4.6	0.4
The Fundamentals of Assisted Outpatient Treatment (AOT) and Kentucky's Expansion of Tim's Law	40	4.5	0.6
The Judge as a Change Agent: Developing an Effective Local Criminal Justice/Mental Health Community	40	4.6	0.6

Transforming Families: Implementing Family Recovery Courts	14	4.1	1.1
Trauma-Informed Practices in Schools	13	4.4	0.7
Understanding Race-Based Trauma	26	4.8	0.4
Unshame KY	27	4.4	0.6
Upstream: Strengthening Children and Families through Prevention and Intervention Strategies	5	4.0	0.5
Youth and Suicide	29	4.6	0.4

Sessions that seemed to be ranked the highest was because of the level of relevant knowledge shared that helped provide a clearer understanding of available Mental Health Court programs, wellness strategies to support staff mental health, and increased awareness of racial trauma. In sum, the bulk of these individual sessions were rated as agree/strongly agree regarding "overall effectiveness of the presentation."

Concurrent Sessions Summary. When examined collectively, 58/60 (96.7%) of the individual sessions averaged at least a 4.0 mean average on the positively framed 5-point Likert options as it pertains to participant perceptions of the "Overall Effectiveness of the Presentation." It is clear that the participants viewed the Concurrent Sessions as effective.

Plenary Sessions

Seven Plenary sessions were offered during the 2.5-day Mental Health Summit. Logistically, these seven sessions happened during dedicated time slots where participants could have theoretically attended all the Plenary sessions. See scheduling format below:

- Plenary Session 1 (May 31st, 2023 – 9:15am – 10:30am)
- Plenary Session 2 (May 31st, 2023 – 12:15pm – 1:30pm)
- Plenary Session 3 (June 1st, 2023 – 8:45am – 10:00am)
- Plenary Session 4 (June 1st, 2023 – 12:00pm – 1:30pm)
- Plenary Session 5 (June 1st, 2023 – 3:30pm – 5:00pm)
- Plenary Session 6 (June 2nd, 2023 – 8:45am – 10:00am)
- Plenary Session 7 (June 2nd, 2023 – 10:30am – 12:00pm)

Like the Concurrent Sessions, Plenary session attendees were asked to complete Plenary session surveys by scanning provided QR codes after attending each session. The Plenary survey asked five questions about the presenter's overall effectiveness and six questions about the presentation's effectiveness on a 5-point Likert scale ranging from (1) strongly disagree to (5) strongly agree. In addition, open-ended questions asked session attendees to share candid feedback about their biggest takeaway from the session, avenues for implementation, and related barriers. In this summary, only data pertaining to the overall effectiveness of the presentation will be examined.

Related to survey completion by Plenary session, Plenary Session 3 (Prevent the Trauma: Diverting from the System) received the most responses (*n* = 176 responses) and Plenary Session 7 (Local Action Planning, Day 3) received the fewest responses (*n* = 18 responses). While there was variance as it pertains to the quantity of qualitative responses by attendees

(biggest takeaway from session, implementation, and barriers), every session did have some indication of ways to implement the material and/or barriers.

Plenary Session 1. Out of 168 responses from Plenary Session 1 (Judicial Leadership: Ending the Criminalization of Mental Illness), the means for the six items that measured "overall effectiveness of the presentation" ranged from 4.2 to 4.6. Therefore, the overall effectiveness of this Plenary session was rated as agree/strongly agree on average.

Plenary Session 2. Out of 104 responses from Plenary Session 2 (Leading Change in Your Community: The Path Forward Utilizing the Sequential Intercept Model), the means for the six items that measured "overall effectiveness of the presentation" ranged from 4.0 to 4.2. Therefore, the "overall effectiveness of the presentation" was rated as agree on average.

Plenary Session 3. Out of 176 responses from Plenary Session 3 (Prevent the Trauma: Diverting from the System)**,** the means for the six items that measured "overall effectiveness of the presentation" ranged from 4.5 to 4.6. Therefore, the "overall effectiveness of the presentation" was rated as strongly agree on average.

Plenary Session 4. Out of 94 responses from Plenary Session 4 (The Least of Us: True Tales of America and Hope in the Time of Fentanyl and Meth), the means for the six items that measured "overall effectiveness of the presentation" ranged from 4.3 to 4.5. Therefore, the "overall effectiveness of the presentation" was rated as agree/strongly agree on average.

Plenary Session 5. Out of 35 responses for Plenary Session 5 (Local Action Planning, Day 2), the means for the six items that measured "overall effectiveness of the presentation" also ranged from 4.3 to 4.4. Therefore, the "overall effectiveness of the presentation" was rated as agree on average.

Plenary Session 6. Out of the 62 responses for Plenary Session 6 (Early Intervention, Deflection, and Diversion), the means for the six items that measured "overall effectiveness of the presentation" ranged from 4.5 to 4.7. Therefore, the "overall effectiveness of the presentation" was rated as strongly agree on average.

Plenary Session 7. Out of the 18 responses for Plenary Session 7 (Local Action Planning, Day 3), the means for the six items that measured "overall effectiveness of the presentation" ranged from 4.3 to 4.4. Therefore, the "overall effectiveness of the presentation" was rated as agree on average.

In addition to examining the quantity of responses and the range of individual items' mean values by Plenary session, this report will also examine the attendee's perceptions of the presentation's overall effectiveness.

Using the same approach as the Concurrent Session surveys, the research team created a new variable to summarize data related to the Plenary Sessions. Specifically, the new variable was created to reflect the mean average of the six positively framed Likert Style items (e.g., 1= strongly disagree to 5= strongly agree) that were used to collect participant perception about the overall effectiveness of the presentation. Examples of these individual items include the following: "*The Plenary increased my knowledge"* and "*I plan to implement what I learned from the Plenary*." For comparative purposes, the research team created a table to reflect the mean value across all six of these items. Table 2 lists each Plenary session in alphabetical order by session title.

Table 2: Plenary Sessions: Overall Effectiveness of the Presentation by Alphabetical Order

	N	MEAN	Std. Deviation
Early Intervention, Deflection, and Diversion	62	4.5	0.7
Judicial Leadership: Ending the Criminalization of Mental Illness	164	4.5	0.6
Leading Change in Your Community: The Path Forward Utilizing the Sequential Intercept Model	102	4.1	0.8
Local Action Planning, Day 2	32	4.3	0.8
Local Action Planning, Day 3	18	4.3	0.8
Prevent the Trauma: Diverting From the System	173	4.6	0.7
The Least of Us: True Tales of America and Hope in the Time of Fentanyl and Meth	93	4.4	0.9

Plenary Sessions Summary. When examined collectively, 7/7 (100.0%) of the Plenary Sessions averaged at least a 4.0 mean on the positively framed 5-point Likert options as it pertains to participant perceptions of the "Overall Effectiveness of the Presentation." It is clear that the participants viewed the Plenary Sessions as effective.

Goal 1 Conclusion. Goal 1 was to Evaluate the Concurrent and Plenary Sessions from the Mental Health Summit. Data from the evaluation provides clear evidence that the participants viewed the Concurrent Sessions and the Plenary Sessions as effective. In a separate report, participants also provided qualitative feedback related to takeaways, feedback, and suggestions for implementation from these sessions.

Goal 2: Evaluation of the Overall Summit Participation Survey

Description of the Overall Mental Health Summit Survey Report

Participants of the Mental Health Summit were sent a link to an electronic Qualtrics survey after attending the Kentucky Judicial Commission's Mental Health Summit (5/31-6/2/23) at the Galt House in Louisville, KY. The survey collected both quantitative and qualitative data as it was administered from 6/5/2023 through 6/16/23. A total of 1,168 individuals registered to attend the Mental Health Summit. Of those individuals 1,054 participants received the first email and a one-time reminder to participate in the survey, resulting in an overall participation rate of 35.1% (*n* = 370).

The overall summit participation survey was designed to capture participant feedback across the following domains:

1. Demographics
2. Knowledge
3. Overall summit experience
4. Attitudes and beliefs
5. Willingness/intent/capacity
6. Readiness to change

7. Barriers
8. Suggestions

Demographics. There were 370 participants who completed the Overall Mental Health Summit survey, which was administered from June 5, 2023, through June 16, 2023. Participant ages ranged from 22 to 86, with the average being 46.5 (SD = 11.4). Most participants identified as non-Hispanic (*n* = 353, 95.7%), White (*n* = 323, 87.5%) and female (*n* = 284, 77.2%). Many participants reported having some level of college degree (*n* = 326, 88.1%). Participants were asked how long they had worked in the field and how long they had been employed in their current position. Respondents indicated they had worked between 1 year and 54 years in the field, with the average being 15.0 years (SD = 10.5). Respondents indicated they had been employed in their current position between 0 years and 54 years, with the average being 5.9 years (SD = 6.6). Respondents who reported 0 years had been employed in their current position for less than 6 months.

Knowledge. There were two groups of knowledge questions. The first set of knowledge items provided respondents with a list of 35 topics (e.g., importance of strengthening community response; person-centered justice; sequential intercept model; peer support services) and asked them to rate their knowledge of each on a scale of 1 (Not at all Knowledgeable) to 5 (Extremely Knowledgeable) *after* attending the Mental Health Summit. The three areas identified as least knowledgeable were as follows: (a) Adolescent specific services (M = 3.0, SD = 1.2); (b) Assisted outpatient treatment – Tim's Law (M = 3.1, SD = 1.2); and (c) Adult guardianship (M = 3.1, SD = 1.2). The three areas identified as most knowledgeable were as follows: (a) importance of strengthening community response (M = 4.2, SD 0.9); (b) substance use disorders (M = 4.1, SD = 0.9); and (c) importance of incorporating the voice of peers/individuals with lived experience (M = 4.0, SD = 1.1).

The second set of knowledge items focused on participant perception of knowledge gained and how that knowledge will enhance their professional work. Specifically, there were two items (e.g., *I gained new knowledge by attending the Mental Health Summit*; *The knowledge I gained from this event will enhance my professional work*) participants were asked to rate on a scale of 1 (strongly disagree) to 5 (strongly agree). A majority (*n* = 352, 95.7%) of participants either agreed or strongly agreed that they gained new knowledge by attending the Summit (M = 4.5, SD = 0.7). Similarly, a majority (*n* = 343, 92.9%) either agreed or strongly agreed that the knowledge they gained would enhance their professional work (M = 4.5, SD = 0.8).

Overall Summit Experience. Overall summit experience was assessed using both a single item (i.e., *Overall, I was satisfied with the Mental Health Summit*) and a series of eight items (e.g., *I had an opportunity to connect with others*; *I would recommend this event to my colleagues*; *Attending this event was a valuable use of my time*). For the single item, participants were asked to rate on a scale of 1 (not at all satisfied) to 10 (extremely satisfied) their overall level of satisfaction with the Mental Health Summit. On the series of eight items, participants were asked to rate each item on a scale of 1 (strongly disagree) to 5 (strongly agree). For overall satisfaction, scores ranged from 2-10, with the average being 8.8 (SD = 1.5). Overall, a majority (*n* = 236, 66.5%) rated the Summit as a 9 or higher. Overall, most participants agreed or strongly agreed with each item.

Using an open-text response option, participants contributed qualitative feedback to the following prompt "*Please List One Takeaway from the Summit that will Improve the Work You Are Currently Doing*." The majority of participants reported an educational theme (*n* = 113 out of 332 responses).

Attitudes and Beliefs. Attitudes and beliefs were assessed using 11 items. Participants were asked to rate each item on a scale of 1 (strongly disagree) to 5 (strongly agree). Mean scores ranged from 4.5 – 4.8 across all items, indicating favorable attitudes and beliefs towards individuals experiencing mental illness, substance use, and intellectual and/or developmental disabilities. The item with the lowest score, on average, was related to whether these individuals should be involved in the decision making process (M = 4.5, SD = 0.7) with 1.2 % (*n* = 4) either strongly disagreeing or somewhat disagreeing with the statement, "*Individuals who are experiencing mental illness, substance use, and intellectual and/or developmental disabilities should be involved in decision making regarding services that meet their needs*." The second lowest scoring item, on average, was "*Decriminalization of mental illness, substance use, and intellectual and/or developmental disabilities promotes positive outcomes within the community*" (M = 4.6, SD = 0.7), with 1.7% (*n* = 6) either strongly or somewhat disagreeing with this statement.

Willingness, Intent, & Capacity. Willingness, intent, and capacity were assessed using seven items. Participants were asked to rate each item on a scale of 1 (strongly disagree) to 5 (strongly agree). Mean scores ranged from 3.8 – 4.6. The two highest scoring items were as follows: (a) *It will be worthwhile for me to apply what I learned* (M = 4.6, SD = 0.6); and (b) *I am planning to incorporate knowledge from this Summit into my professional practice* (M = 4.6, SD = 0.6). The three lowest scoring items were: (a) *I have the resources needed to change my approach when working with individuals experiencing mental illness, substance use, and intellectual and/or developmental disabilities* (M = 3.8, SD = 0.9); and (b) *I am planning to change my approach when working with individuals experiencing mental illness, substance use, and intellectual and/or developmental disabilities* (M = 4.0, SD = 0.9); and (c) *I have the support needed to change my approach when working with individuals experiencing mental illness, substance use, and intellectual and/or developmental disabilities* (M = 4.0, SD = 0.9). Overall, it appears that individuals are planning to incorporate what they learned; however, they may lack the capacity (e.g., resources, support) to carry this out.

Readiness to Change. There were two items used to assess participants' readiness to change. The first item was related to participants' approach in working with individuals experiencing mental illness, substance use, and intellectual and/or developmental disabilities; the second item was related to utilizing the skills participants gained through participation in the Summit. Participants were asked to rate each item on a scale of 0 (Uninterested/Unwilling to Change) to 4 (Already Implementing and Maintaining). Each one of these items included a follow-up item, "*Using the scale above, what would it take for you to move up at least one level (e.g., if at 'considering making a change' what would it take for you to move to 'preparing to make a change')?*" As it related to participants' approach to working individuals experiencing mental illness, substance use, and intellectual and/or developmental disabilities, participants scored an average of 3.3 (SD = 0.9). With respect to utilizing the skills gained through participation in the Summit, participants scored an average of 3.2 (SD = 0.9).

Using an open-text response option, participants contributed qualitative feedback to the following prompt "What would it take for you to move up at least one level [your approach in working with individuals experiencing mental illness, substance use, and intellectual and/or developmental disabilities]?" Results revealed that most participants reported a tangible theme, which included resources/services, staffing/support, and education/awareness subthemes (*n* = 89 out of 203 responses).

Using an open-text response option, participants contributed qualitative feedback to the following prompt "What would it take for you to move up at least one level [utilizing the skills you have gained through participation at the summit]?" Results reveal that most participants

reported a tangible theme, which included education/awareness, language/attitude, and collaboration/communication subthemes. (*n* = 65 out of 147 responses).

Using an open-text response option, participants contributed qualitative feedback to the following prompt "In what specific ways will you implement what you learned at the summit?" Results reveal that the majority of participants reported either tangible (*n* = 138 out of 299 responses, e.g., education/awareness, resources/services, client care/referrals, and language attitude subthemes) or systematic themes (*n* = 132 out of 299 responses, e.g., collaboration/communication, implementation, development, and advocacy subthemes).

Barriers. There were two open-text response options where participants contributed qualitative feedback related to their perceptions of potential barriers associated with implementation after attending the Summit.

Using an open-text response option, participants contributed qualitative feedback to the following prompt "list any barriers you anticipate facing in implementing what you learned from this summit." Results suggest that most participants reported either tangible (*n* = 120 out of 333 responses, e.g., access/resources, appropriate staffing, adequate time, transportation, additional education, and specific services) or systematic themes (*n* = 117 out of 333 responses, e.g., proper funding, collaboration/communication, structural changes, policy changes, political reasons).

Using an open-text response option, participants contributed qualitative feedback to the following prompt "What changes would need to occur in order for you to implement this new knowledge?" Results suggest that the majority of participants reported a tangible theme (*n* = 132 out of 260 responses, e.g., resources/services, staffing/support, education/awareness, and updated materials).

Suggestions. At the conclusion of the Overall Survey, participants were provided four open-text response options to provide qualitative feedback to describe what they felt was most beneficial at the Summit, provide suggestions for improvement, offer topics for future Plenary/Concurrent sessions, and provide other comments or feedback.

Using an open-text response option, participants contributed qualitative feedback to the following prompt "list any aspects of the mental health summit that you found to be most beneficial." Data suggest that the majority of responses fell into the "specific" theme (*n* = 120 out of 298 responses). This theme contained subthemes pertaining to MH/SUD, Presenters, Discussion/Learning, Court/Legislation, Breakout Sessions, and Additional.

Using an open-text response option, participants contributed qualitative feedback to the following prompt "list any aspects of the mental health summit that need improvement." Out of 228 responses, the theme with the most responses were time/scheduling (*n* = 62).

Using an open-text response option, participants contributed qualitative feedback to the following prompt "what topics would you suggest for future Plenary and/or Concurrent sessions?" Data suggests that out of the 209 responses, the majority fell into the systematic theme *(n* = 104, e.g., youth/at-risk populations, court/legislation, behavioral/medical, cultural competence, collaboration/communication, and lived experience).

Using an open-text response option, participants contributed qualitative feedback to the following prompt "*What Other Comments/Feedback Would You Like to Share?*" Out of the 185 responses, 128 fell into the specific theme that consisted of organization/management, future, suggestions, learning and additional sub-themes.

Goal 2 Conclusion. Based on the data from the Overall Mental Health Summit Survey, it seems as though participants reported favorable attitudes and beliefs towards individuals experiencing mental illness, substance use, and intellectual and/or developmental disabilities. Individuals are planning to incorporate what they learned; however, may lack the capacity (e.g.,

resources, support) to carry that out. As it related to participants' approach to working individuals experiencing mental illness, substance use, and intellectual and/or developmental disabilities, participants were willing to change and to use skills gained from participating in the Summit. However, many reported various tangible barriers to being able to implement things learned from the Summit. There was also positive feedback provided about the Summit itself and suggestions to improve future Summits.

Overall Conclusion

In sum, goal 1 (Concurrent and Plenary session findings) and goal 2 (Measures of the Outcomes of Summit Attendance) were achieved, and it seems as though the Mental Health Summit was successful regarding getting information out to the participants and the participants reported that the summit presentations were effective. Hopefully, the Mental Health Summit is a catalyst for reflection, learning, implementation, and change.