2023 Minnesota SUD Summit Comment Summary

WHAT DID THEY SAY?

The following is an unedited summary of comments that attendees shared. Use the links below to go to each section.

Coordinated, Holistic, Integrated Continuum of Care Strengths

What is Minnesota's greatest achievement? What are we known for?

- 12 steps
- Recovery community
- Creativity
- Innovation - culture of developing new models.
- Land of 10,000 treatmemt centers
- MN Model
- Recovery capital
- Hazelden
- Behavioral Health Fund
- Early childhood services
- Variety of SUD providers
- Commitment to patient care by providing oversight and regulate treatment standards.
- 1115 SUD waiver
- Increased mobile crisis units.
- Mn offers various models of case management for mental health.
- Sober houses or aftercare programs

What does Minnesota do that is unique?

- Continuum of Care
- Early funding for SUD treatment
- Treatment court
- Funding in jails for SUD, drug courts
- Recovery schools and education
- Peer recovery support services in schools
- Culturally specific programs
- Client centered care
- Treatment Coordination (funded by MA, CCDFT)
- Plentiful payment sources and grants for community based program.
- MN insurance requires SUD and MH coverage
- Having a designated recovery/ SUD staff position in the state… governors office.

What does Minnesota do that others want to copy?

- Quality of treatment program
- Behavioral health funding
- State plans that cover SUD and MH
- DOT
- MARRCH
- Advocacy groups
- Legislation and government that supports SUD and MH =
- Passionate professionals
- Focus on patient care and patient's rights in delivering services.
- Licensing that uphold quality care

What key resources provide an advantage for individuals to connect with their communities?

- Transportation
- Peer recovery specialists
- Treatment services all over the state.
- Direct admit
- Case managers
- Cultural specific groups
- Online resources
- Grants
- Peer recovery specialists
- Conferences
- Harm reduction teams
- CEU's, education, cross training
- Free Marxian training and service
- Drop in/walk in centers
- Behavioral Health Center at 1800 chicago
- Person centered care and harm reduction/ all pathways

Can you think of the work of a particular provider, program, or service that you consider to be a success?

- 988
- MICD programs
- Peer support
- Behavioral Health Center at 1800 Chicago
- Treatment coordination
- Police embedded social workers
- Hazelden

- Recovery Community Organizations
- YourPath.
- Family Treatment
- Needle exchange.
- Healthcare for the Homeless
- Treatment courts
- Diversity in our treatment programs, not just one size fits all

Why does that provider, program, or service stand out to you?

- Multi-disciplinary team approach.
- Hazelden - holistic and collection leadership fighting the stigma, conducting studies, and providing education
- Easy access for individuals
- Services that are willing to try something new, break glass ceilings
- Meeting clients “where they are at”.
- Person centered care, harm reduction/ all pathways
- Commitment to quality
- A strong missional sense in all of their staff.

What 5-8 things would you consider Minnesota’s greatest strengths?

- Collaboration
- Funding recourses
- Vast recovery community
- Culturally specific treatment and programs
- Culture of innovation.
- Prominent community leaders being transparent about their personal recovery
- Support for harm reduction
- Diversity in our treatment programs, not just one size fits all mentality
- Better focus on adolescents
- Recognition of SUD as a treatable medical condition.
- Hosting conversations.
- Thinking of innovative ideas.
- Diverse levels of care available
- Funding grant opportunities for special projects or targeted areas of focus.
- DAANES
- We recognize culturally specific care is necessary.

Coordinated, Holistic, Integrated Continuum of Care Opportunities

What is the community asking for related to a Coordinated, Holistic, Integrated Continuum of Care?

- Transportation
- More access to care, working towards eliminating barriers to SUD TX
- Seemless handoffs
- Eliminate barriers to SUD TX
- Easy access to programs/providers of choice.
- Children's substance use treatment options.
- Non Emergency Transportation Options
- Collaboration between disciplines
- Individualized approach that takes into consideration demographics and personal development
- Workforce
- Integrated programs where multiple services available- SUD, therapy, psychiatry, MAT, etc
- Integration of Trauma Informmed Care with SUD
- Financial Incentives to provide case management and collaboration between providers.
- Treatment options for more complex medical needs and that are culturally affirming
- Streamlined process of finding resources, making referrals for care, closing the loop on referrals and tracking outcomes
- Less documentation requirements for a LADC so they can spend more time coordinating care.
- SUD programs removing barriers for admission/scheduling intakes.
- Use of peers that understand how to complete referral process

Do you see any alignment with strengths related to this topic and the identified community needs?

- Plenty of awareness
- Communication opportunities
- There has been an answer to having more diverse providers
- Openness of providers to work together
- Collaborative between service providers
- Yes, provider options are good but we still dont have enough
- Grassroots efforts that have provided a lot of education and resources to communities
- Increased access to services- virtual, removing Rule 25 process, in home.
- Insurance companies offering more accessible transportation support.
- Innovation is embraced
- Telehealth opportunities
- Online offerings are great, especially telehealth but some don't have access to internet or tech needed
- Civic and legislative engagement
- Co- responding
- Transportation to MAT programs can be challenging

- Grants for folks to go to school to become LADC due to workforce shortages.
- Co existing SDoH needs being addressed for whole health
- Research on psychedelics for mental health and SUD evidencing posiitive health outcomes
- Research on psychedelics and psilocybin.

What are key areas of untapped potential for the Coordinated, Holistic, Integrated Continuum of Care?

- Coordinated ongoing funding streams
- In home services.
- Implementation of case managers(social workers) that work in SUD and are funded with a focus on integrated care.
- Support at home
- Use of peers to coordinate treatment options and complete referrals
- Earlier intervention opportunities with providers outside of SUD treatment
- Social Determinate's of Health
- Programs embracing SUD care as a continuum rather than episode based, 28 day residential, 6 weeks outpatient.
- Get payer sources on board
- More early interventions of harm reduction; vending machines needle exchanges.
- Spiritual component
- Tools to coordinate health services and available social services and collect data from outcomes
- Research on psychedelics and psilocybin
- Schools, workplace, community readiness to understand continuum and intervene earlier
- Coordinating with criminal justice system to allow incarcerated individuals to access SUD and Mh support while in custody so they can access service upon release earlier.
- ED depts
- Alumni engagement and collaboration to help identify continuum outcomes and shortcomings

What community partnerships would lead to greater success?

- Law Enforcement
- Payers
- Emergency Departments
- Schools
- Partnering with jails so residents in custody are able to connect with providers earlier and easier.
- Recovery Community Org
- Faith communities
- Housing advocates
- Mental Health Programs

- Peer recovery supports accessible in restricted settings such as jails and hospitals.
- Culturally specific community based programs
- Counties
- Open the door to the community to actually see the core and care of your entity
- Alumni engagement and collaboration to highlight outcomes and shortcomings
- Community Action Programs
- Behavioral health walk in centers
- Multigenerational
- Tribes
- Residential programs accept folks on methadone and coordinate care with opioid treatment programs.
- Universities
- Engagement with active drug users
- Highschools
- The decision makers at the state
- CPS
- Partnerships with providers (understanding policies)
- Employers
- Partnering with programs that deliver or assist with MAT
- Partnering with industry and trade associations
- Unions

What changes do you expect to see over the next five years? Where could we make a difference?

- More detox facilities
- Offer access to care to anyone in MN
- Use all continuum to lower repeats
- Lift the ban on federal funding for harm reduction supplies
- Easy access to treatment
- Less stigma in the community
- Fund harm reduction at levels more in line with treatment programs (which are generally profitable)
- More in depth support after primary treatment
- Licensing devision to look into staff shortages - how to facilitate an increase in need and decrease in employees
- Documentation changes
- More harm reduction housing options
- Increase in education and prevention
- Universal code
- Less strict documentation requirements
- Increased access to treatment programs, particularly detox and withdrawal management
- Support and care for the SUD workforce

- Fewer deaths -more access to fentanyl testing, MAT and naloxone
- More access for children's mental health/SUD treatment
- Affordable housing
- Higher compensation / reimbursement rates
- More peer engagement
- Increase in experiential treatment
- More access, in greater MN
- Investment in recovery community and events
- More harm reduction funding
- Creative ways to fill workforce
- Increase in women specific programming
- More access to care for Native Community
- Improvements in rural areas
- Pathways for those in the beginning stages of recovery to giveback and join the workforce
- Increasing use of SBIRT

What are the top 3-5 opportunities to work on?

- Transportation
- Sustain and support the workforce
- Affordable housing
- Workforce supports and sustainability
- SOCIAL DETERMINATES
- Willingness to keep adjusting to new processes
- How to include or separate family
- Decrease overdose rate
- Spirituality
- Implementation of innovative ideas
- Expanding on what we have learned and executing on what works
- Expand PRSS capability.
- Family Peer Recovery Support Services
- Transitional housing/sober supportive housing expanded
- Perhaps certification and training for PRSS to manage and supervise sober homes

Coordinated, Holistic, Integrated Continuum of Care Aspirations

What is our community passionate about?

- Transitional Housing
- "providing full continuum of care
- transitional housing"

- Our community has had difficulty with unsupervised sober home environments that do not provide the sober environment that is intended.
- supporting clients where they are at.
- Sober living and extended living services
- Whole person care
- Integrated housing, supportive services, and community based care.
- Reducing stigma and educating others about SUD/ mental health
- Harm reduction
- Collaborate across the state level and throughout providers
- Sober homes offering transportation to treatment services for the residents
- Stakeholder involvement
- Mental health and resource support accessing harm reduction programs
- Involving more community members in the sobriety lifestyle.
- Opportunity to fill in pieces of the framework of the continuum of care
- Person centered care
- Building Recovery capital along full continuum of care. As early as prevention end and through to long term recovery end of continuum
- Providing a “seat at the table” for those who are currently struggling with their use, families and other supportive parties, community members, those in recovery, and providers of services.
- Address to overdoses and inform community of “bad batches” similar to other states.
- Trainings
- New approaches to interventions
- Training and networking
- Treatment and supportive services instead of criminal charges for all but violent drug offenses
- Adapting to clients ever-changing needs
- Culture and Inclusion.
- Individualized care, meeting individuals where they are at and identifying what their recovery journey looks like.
- Limiting insurance barriers for treatment
- Discontinue the practice of "Lifetime Maximums" for treatment services by private insurers and the VA.
- Streamlining referral process
- Alternatives to the “you are using and it is impacting your life so you need to go to residential treatment” approach and truly creating personalized and individualized care.
- Medicare and Tricare (Veterans Insurance) need to allow the same options in accessing SUD treatment programs as everyone else.
- Guaranteed open door
- Incorporate program outcomes
- A clearing house to access that information is an excellent idea. Even if it is simply an ability to connect with another providers EHR to get the background on previous treatments and what the patient has responded to in the past.
- More education about Direct Access

- Educate courts and community stakeholders about 1115 and direct access plans.
- Proactive instead of reactive
- Early intervention
- More SUD and MH support for youth
- More focus on youth supportive services. Lower age requirements for those programs as the ages are getting younger and younger for those on the streets, living with relatives, etc.
- Funding for coalitions
- New/more funding sources for school districts
- Opportunity to do a 10 year longitudinal study
- Keeping youth in their home and attending their school.
- Many schools have foundations now that can assist with funding sources. That may be an opportunity to spend time with your students, while the foundation works on funding sources for your program. This should be publicly funded.
- Referral clearinghouses
- In-home and family-focused services for youth (versus going to "treatment")
- Could the state build endowment funds that can be raided by the legislature to provide a long-term funding for adolescent education and prevention services in the school systems?
- Genetic testing
- Teach DBT and life skills as part of the core curriculum in schools. Give the kids the tools to avoid the problems in the first place. I wish the skills I have now were taught to me then.
- Wildly passionate about reducing the stigma! Especially in the school system
- Focus on holistic services for youth and families who are struggling instead of trying to focus on a "primary" mental health or substance use concern by pulling that youth out of their home, community and school.
- Home based care
- Wildly passionate about "treating" communities.
- Wildly passionate about using genetics and analytics to prevent and treat health issues
- Genetics testing to determine best route of mental health medications
- Education for families and children about behavioral issues, mental health, substance abuse, etc.
- Combined SUD and MH case managers

What should our future community look like?

- Stigma free!
- Open door transparency
- Total collaboration
- No insurance barriers
- A beautiful utopia of happy, healthy and sober families.
- Guaranteed access
- Restructure the system - needs to be simplified and unified
- More diverse perspectives shared and allowed at events like this

- Low threshold access to care regardless of insurance status
- Equal access to services for all, elimination of discrimination & racism in services
- Community organizations coming together Collectively, rather than selectively!
- More SUD and MH summits to connect and troubleshoot with professionals
- Limit excessive paperwork and over regulation
- Focused first on outcomes rather than compliance and utilization
- More awareness of available resources at an affordable cost
- Build a process that involves and supports family more
- Breakdown silos in healthcare- addiction medicine is healthcare - but it is treated as a separate system
- Allow SUD counselors to focus on supporting mental health, not chasing down and doing medical case management as we are now expected to do. We can support healthy choices and good medical care, but I never get to speak with a doctor.
- Remove individual billings codes - simplify billing process
- Youth are never labeled as “addicts”
- Payers being on board with providers' and clients' plans
- Uniform requirements between insurance providers to simplify funding and documentation
- Hospitals and clinics should be required to have all staff who interact with public, undergo diversity training. A lot of prejudices happening within those healthcare facilities towards addicts and towards People of Color.
- SUD and mental health coping skills as part of the core curriculum. We would not need insurance or diagnosis to educate adolescents about real life situations. The "just say no" message has never worked.
- A shared vision that is developed by involving the stakeholders who want to see and be part of positive change.
- Including preventive and physical health in behavioral health education
- SUD specific case management of some sort?
- Incentives for Providers to be waivered to prescribe MOUD (insurance or licensing fees)

What strategic initiative would support our aspirations?

- 1115 Waiver
- Education
- Standardized outcome measures - identify what is success
- Protected funds for treatment services through endowments or trust funds tha cannot be raided by the legislature
- Family based education and initiative
- SUD treatment and MOUD billable
- Promote and have accountability for cross state department and division coordination (DHS, MDH,DOJ)
- Treatment services in local jails
- Modifying case management - SUD and MH combined
- SUD specific case management of some sort?
- Less prescriptive treatment plan requirement by DHS

- Eliminate and simplify excess documentation requirements
- Increase Peer Recovery Support Services
- Increase cultural awareness
- Every SUD TX center is MAT friendly
- Incentives for providers to become waivered to prescribe MOUD (through insurance or licensing fee reductions)?
- Integrate SUD in child and family service continuum development and discussions
- Decreased administrative burden on counseling staff
- Reducing burden and creating efficiencies in state grants/contracts process as a main Goal/Mission from upper leadership.
- Medicaid coverage when incarcerated

Based on the passions and the needs of our community, what can we do to advance the strategic plan goals?

- Accountability
- Keep advocating
- More SUD Summits to connect with the recovery community
- Develop a plan
- Clear next steps
- Identifying potential SUD problems at medical appointments. SBIRT on all medical visits, similar to the PHQ and GAD.
- Ensure stakeholders are involved
- Identify decision-makers within stakeholder group
- Identify “owners”, stakeholders and others who will be involved and have accountability for the hosts/leads to create pathways for representation.
- Meet regularly with the new addiction and recovery director that Peggy Flanagan mentioned yesterday
- Promoting self-care for staff. Preventing compassion fatigue and burnout. So they are capable of helping our relatives/clients at their full potential.
- Make priorities and goals clear and simple
- Establish timelines
- Piggyback on the county/city opioid settlement groups to develop a shared vision.
- Be better partners to the Tribes and cultural organizations. Make room for flexible solutions.
- Promote livable wages for direct support professionals.
- Take an iterative approach and include continuous measurement.
- Create stable workforce by competitive pay and valuing those working closely with clients/their families (Case Managers, Practitioners, Peer/Family Peer Supports, etc.), not just M.D.s and those working in Executive Leadership roles.
- "Shared education and understanding of the key issues/challenges. Withholding knowledge is elitest and can rob
- communities of viable solutions."

What are the top 3-5 aspirations to focus on?

- Early education, prevention and coping in the school system for all students so no one is stigmatized.
- Guaranteed access (no insurance barriers and availability)
- Cultural and diverse options
- Social determinate of health - full continuums
- Stop penalizing programs and providers for oversights in charting. The current 100% compliance expectation of DHS is impossible to meet.
- Strategy/plan (stakeholders present, funding streamlined, etc.)
- Fund efforts through taxes on alcohol, tobacco, and potentially marijuana.
- Guaranteed access (**ensured availability)

Coordinated, Holistic, Integrated Continuum of Care Results

Considering the identified strengths, opportunities, and aspirations, how will we know we are on track in achieving our goals?

- Elevate issues of addiction to public crisis – state offers anyone access to treatment and handle billing on back side
- Track barriers to treatment
- MN Student Survey
- Track timeframe of client attempts to get into treatment vs when they admit
- Research why clients pick specific programs
- Decrease disparity numbers
- Review plan annually with the state to ensure progress
- Group of assigned peers (volunteers or employees) to work towards goals and keep plan moving
- various continuum of services
- Adequate reimbursement
- Model is healthcare based
- DHS regulations are less strict, clients have more choices and documentation is less overwhelming
- Federal, state, and local collaboration
- Uniform standards for healthcare (SUD/MH included)
- Better outcomes
- Staff retention
- Decrease in client AMA discharges

What results do we want to see?

- Prior to DHS submitting policy to the legislature to approve for BH policies, run it past a workgroup of providers/payors/community members.
- Legislatures being involved and informed by the recovery community

- Youth support*
- When compliance measures are too stringent, having a workgroup & DHS communicate concerns and preferred compliance measures/methods to CMS.
- SUD services connected - not a silo
- 1. Total days to access care 2. Total cost of care (TCOC) 3. client evaluation of services 4. mental health & sud stabilization 5. re-admittance rates to Inpatient/Emergency Room/Treatment

How might we track the impact or changes that have happened?

- Uniform services standards
- MN Student Survey

What are 3-5 indicators we would want to include on a scorecard?

- Average timeline from request for services and entering a program.
- Timeline for the entire process
- Track time from phone call to assessment, to admittance
- Uniform mental health survey to track improvement
- PHQ, GAD, SBIRT regularly in patent care at all points in the healthcare system
- Client progress focused SUD standardized assessment tool at standard interval
- Distances to nearest MAT provider, psychiatry, substance use services across the state of MN
- Client satisfaction data
- Exit surveys for clients - track how client felt about program, like, dislikes, etc.
- How easy was it for the patient to enter and participate in programming. What barriers existed (transportation, cultural appropriateness, cost/coverage, problems at intake process, etc.)?
- Dashboard/or portal that tracks initiatives, give updates on legislative requests, has calendar for input sessions, upcoming trainings, etc. so we can collectively be informed & participate.

What resources would we need to implement these measures?

- IT Support
- Allowing PRSS staff to complete surveys with patients as part of their scope, as well as completing up front paperwork needed by the organization prior to the assessment.
- Funding
- More people in the workforce
- Funding community members to get trained and certified in Peer Recovery.
- Advanced technology
- Organization from dedicated resources, inclusive of new voices in the SUD field
- Grants to help fund advanced technology

- If there is a delay in assessment or entering treatment, allow PRSS to bill for services to maintain motivation within the patient
- Legislation
- Time
- Community involvement
- Don't reinvent the wheel - tap into current resources. Complete assessments to ensure progress.
- Sustainable plan that supports changing priorities

Cultural Engagement and Responsiveness Strengths

What is Minnesota's greatest achievement? What are we known for?

- Minnesota Model
- People who are committed to helping others
- Great treatment centers
- The push toward increasing access.
- Nationally known for LGBTQ treatment
- Target.
- The "Land of 10,000 treatment centers"
- Music and music
- Recovery community
- Top healthcare
- Financial support
- Public funding for treatment
- Collaboration of providers
- Prince
- Humid summers, mosquitos
- The University of Minnesota, one of the top research Universities in the country
- Our Elders
- Pushing for better access, slow, however starting to happen a bit more.
- Many people move here from other parts of the country to gain access to treatment they wouldn't otherwise have
- Accessibility of treatment
- Co-Occurring sercises
- Known for Minnesota Nice and the 10,000 lakes. Greatest achievement for a place to live and work.
- Good treatment centers.
- Great parks
- AIM
- A GREAT Govenor
- fortune 500 companies; Target, Best Buy, Cargill, General Mills, 3M
- Strong service for the LGBTQI community

- The American Indian Movement, Prince, and The Mighty Ducks
- Grumpy Old Men
- Named one of the healthiest cities in America
- Top three state to raise a family in the nation
- Best Powwows!
- Communities coming together to find solutions to addiction. Finding faster responses to treatment
- Welcoming to immigrants and refugees
- Where everyone in recovery relocates to
- Progressive history
- the State of hockey
- The artist Prince
- Social safety net
- Snow
- Prince
- Giving everyone second or third chances
- Make SUD treatment highly accessible.
- Nothing is open past 10pm
- We celebrate our cultures
- Lutefisk
- Duck, duck GREY duck
- A lot of diverse restaurants
- Public funding
- Starting to involve more Tribal Communities to the table, again, slow process however it is happening.
- Easier Access to healthcare
- Treatment Coordination for providing resources in community
- The Behavioral Health Fund, though not specific to Cultural Engagement/Responsiveness, provides treatment services for persons even if not Medicaid enrolled, and for SUD services outside of what Medicaid will buy.
- Local RCOs

What does Minnesota do that is unique?

- Shovel snow ! :)
- Hotdish
- Uffta talk
- Tribal councils
- Peer recovery community groups
- We are willing to discuss disparities, we are not always good at engaging change however.
- We individualize care
- Diverse restaurants
- Outreach groups

- Have multiple languages in government application formats.
- Harm reduction integration
- First Hmong and Somali elected officials in nation
- Reaching out to Tribal services to allow for collaboration
- Traditional Healing is unique, I believe other state programs are Medicaid related
- Cultural Specific Treatment programs . Mashkawisen.
- Increase of diversification in programs and in increasing engagement and motiving BIPOC indiv. To become practitioners (licensed/certified/lived-experience.
- Outreach and services delivery
- Native American cultural integration. Like on-site ceremonies and language development
- First East African Recovery Community Organization in nation
- Traditional teachings and creating space for healing.
- Providing PRS to undocumented individuals
- Twin Cities Recovery Project - national leadein African American recovery community organizations, recovery support
- Programs that pay for recovery housing are rare in other parts of the country.
- Recognizing and talking about the value of cultural responsiveness in programs and service delivery.
- Harm reduction outreach and support at encampments
- Aaa
- Sober Squad indigenous recovery movement

What does Minnesota do that others want to copy?

- Wrap around services from start to finish
- State level leadership on homelessness
- Treatment options for co-occurring SUD and MH
- Culturally specific services
- Harm reduction outreach and support at encampments
- Easier access the SUD services. Easier access to culturally responsive treatment. Easier access to healthcare in general.
- Hazelden sites
- RCO, virtual harm reduction, outreach support
- Provide resources that are abundant in this state
- Seek and uplift community voice in problem solving. Willing to pilot, evaluate and improve service delivery.
- Sober Squad indigenous recovery movement
- Language specific information
- Healthcare designed for low-income families.
- Grant funding to help offset licensing costs for culturally diverse providers
- CEMIG program

- License
- Spanish AA meetings now avail on-site in areas that were previously not accessible
- DAANES system
- Culturally specific recovery coach training
- Competent providers or providers working toward cultural hulmility when working with BIPOC indiv.
- Homeless helping homeless
- Minnesota Care
- Provide funding for cultural programming for prevention, treatment and recovery

What key resources are available that provide an advantage for individuals to connect with their communities?

- Sober housing
- Traditional Healing, for Tribal Nations and Urban Indian Organizations
- Transportation
- Community resource centers
- Safe at home
- Queer specific treatment and recovery supports
- Culturally responsive recovery housing
- Tribal colleges
- Coordinated entry
- Culturally specific treatment centers
- Local RCOS
- Peer services
- Culturally specific programs
- Strong LGBT Housing programs for recovery
- Media Outlets (receiving information and staying connected)
- Communities of practice
- Authentic Recovery Community Organizations, grounded in local and/cultural communities
- Community co-occurring services, ARMHS/ACT, etc
- Sober squad and Red road recovery meetings. Wellbriety meetings.
- Interpreter availability
- Communication that is language specific
- Community centers
- Treatment Coordinators that provide community resources on individual basis
- Relationships
- American Indian organizations that provide access to their community members
- Culturally specific recovery meetings
- Recovery Meetings for addiction & mental health
- Native American - Powwows.

- Community clean ups.
- Niyyah Recovery Initiative, Twin Cities Recovery Project
- Native American non-profit agencies providing culturally responsive care.
- Prevention, education, funding
- School program
- CLUES
- School family programming
- Service trainings to help family & friends to have and use with Narcan
- Mutual aid groups and networks by and for communities in need
- Offering of opportunities to strength Community ties that are culturally sensitive and inclusive.
- Hmong American Partnership
- Cultural navigators
- Peer recovery specialists
- Recovery Corps service opportunities
- "Recovery corp navigators and Opioid housing navigators
- Pilot Project Healing House geared towards women coming from incarceration and supporting them while on their recovery"
- Ombishkaa Program in Bemidji, MN.

Maybe a focus on Minnesota is too broad, can you think of the work of a particular provider, program, or service that you consider to be a success?

- No votes for this session

Why does that provider, program, or service stand out to you?

- No votes for this session

What 5-8 things would you consider Minnesota's greatest strengths?

- No votes for this session

Cultural Engagement and Responsiveness Opportunities

- No data available

Cultural Engagement and Responsiveness Aspirations

What is our community passionate about?

- family, feedback, the communities that we are all apart of, treated with respect
- Take the time to respect one another

- providing hope
- Substance use disorder and mental health should work together as a team and collaborating
- Historical trauma
- murdered and missing indigenous people
- Climate change
- bullying at shelters and in schools
- sober housing
- Assessment/treatment and transportation
- Time for self care for people who work in the field
- too many natives in prisons and in jails. Change policies and laws.
- decriminalize drug use
- diversity in leadership
- prevention is equal to recovery
- socio economic factors playing a huge role in Substance use
- Come together
- homelessness-we should be marching in the street about that
- We have to get to the children who are in unsafe environments
- Focus on the children
- more services in the community
- Come together collectively
- Organized summits for people who are living outside
- Privacy and spiritual healing
- institutional bias that our people are faced with
- sense of belonging
- The children and the youth
- Positive program. The science of hope
- Pride hope and advocacy
- Native and African American children are falling through the cracks
- Give the young people a chance
- Help young people not have to incur the large educational debt
- Livable wages for LADC and peer recovery specialists

What should our future community look like?

- No votes for this session

What strategic initiative would support our aspirations?

- No votes for this session

Based on the passions and the needs of our community, what can we do to advance the (breakout topic's) strategic plan goals?

- No votes for this session

What are the top 3-5 aspirations to focus on?

- Cultural strategic plan/ really listen to community with community led solutions and accountability attached (cultural specific and language specific!)
- Funding and rates reform!
- Less paperwork required by law for addiction providers
- Housing! Sober housing that accepts non English speakers, housing for folks who use, more detox specifically opioid and for non english speakers
- Housing pipeline for with criminal records
- Professionals who reflect participants! Supporting their praticums and licensures
- allocating funding for communities of color
- A plan put in to action
- Be a voice for my community
- Dispelling the silos and and work together
- Face all of this together and put the differences aside
- Putting this in to action. Responsiveness," nothing about us without us"
- funding is not going to the right people-channel the funds to the right people
- Multi disciplinary collaboration-
- Rural Communities in need of resources-detox-and access to services. Language barriers
- Criminalization of houselessness-evictions of encampments move toward action steps
- Not a lot of funding centers for youth leading to problems
- Youth Funding to help students stay employed and safe.
- Youth needed direction and a space to be safe and have role models.
- passionate about freedom, autonomy, meeting people where they are at, family focused, community based and family oriented
- Unsheltered populations welcomed to the table
- Be solution orientated and patient
- Institutions better at serving the people
- More communication
- unsheltered people needing friends and support

- "Housing for all. Stop the sweeps!
- Decriminalization and releasing thise incarcerated for all drug charges!
- Debt free career paths for youth and maginalized people!"
- "anything about us without us is not us"
- Diversity in the workforce
- Access to care for all humans
- Access to housing
- Continue funding

Cultural Engagement and Responsiveness Results

Considering the identified strengths, opportunities, and aspirations, how will we know we are on track in achieving our goals?

- Receiving data from a survey that the government did
- looking at my process and seeing what small changes have been made
- Setting measurable goals
- hearing about less funerals especially on the reservations
- Checking on the progress of my goal setting
- Building and maintaining healthy relationships
- Building and tracking outcomes
- Less gun violence
- Honest conversations in the black community about heroin use
- Community being more open to harm reduction
- Making connections
- Inclusion, accountability and follow through,
- Continuing the conversation and follow through
- HIV is not a death sentence. People are paying attention
- stop losing people to gun violence
- Decrease in overdose
- Being able to get non English speaking folks into SUD and MH Services and then same amount of time and english speaking individual. Increase in diversity in the SUD field
- Increase revenue for non billable services for culturally specific programs.
- Normalizing help for SUD for the youth. All communities but especially the african american communities
- The red tape and length of time to access services is so slow
- People in this room also represented in the governmental agencies in the state of Minnesota
- Being given the statistics.
- Making practices billable
- Looking at the data of who is not passing the exams and why?
- Non English speaking folks who are unable to get in to programs
- folks with lived experience need to be in leadership. Credentials versus education.

Increase the life span for native americans.

- Seeing other who look like me sitting next to me
- More DHS state level representation at local sud gatherings that native american organizations are hosting.

What results do we want to see?

- No votes for this session

How might we track the impact or changes that have happened?

- how long until we are invited to the next meeting.
- See some action with what we will do
- Follow up resources with billable serives
- Access to anger management
- Everything that we have discussed sent to us on a form with concrete next steps
- Be invited to the table for next steps
- Bring representation in to the meetings that dont have access to the meetings
- Create a summit for people who use drugs, feed them and listen to them
- Go to encampments and bring these people to the summit
- turning the conversations in to outcomes

What are 3-5 indicators we would want to include on a scorecard?

- Speed of entrance into residential care for non-English speakers.
- Results or audits should be done by people using the services provided
- Open/equitable access to services
- Recovery sober supportive housing as well as treatment
- detoxification
- Harm reduction
- Diverse teams
- Recovery Prevention, Reentry, Supportive Services
- Seeing people who use drugs leading efforts and being invited and respected
- Seeing encampment sweeps END
- Seeing people housed and maintaining autonomy
- Lets no build walls but work together
- Seeing a significant increase in bipoc providers
- Seeing a significant decrease in racial disparities in health, recovery, and overdose deaths
- Decriminalization of drug use
- Culturally specific programs

What resources would we need to implement these measures?

- Making sure we are on track
- How do we get feedback from the community
- What partnerships can be created
- Funding and funders
- making it better for people wanting to enter the workforce
- Funding for research into efficacy of culturally-specific programming.
- Providing scholarships for conferences/CEUs and
- Actionable steps to move forward
- Increased grants. Sober living spaces opened immediately. The longer we wait, the more deaths we will see.
- Hear about next steps
- Funding
- DHS holding program's accountable
- Funding
- Understanding how implementation of rules really affects people directly
- State/Fed funds that are disbursed not have to be split between 6 tribes and or organizations. It doesn't work well from what I've heard these past two-days.
- Transportation that is safe to places like MAT clinics and not opting to go with lowest cost options is not person centered/safe
- transportation
- Medical rides
- Reimbursement for interpreter services
- Safe transportation
- Accountablity
- Speaking on data. We have to be very inclusive on relevant stakeholders, community champions who can bring the community recommendations on what measures are pivotal and community friendly

Education and Prevention Strengths

What is Minnesota's greatest achievement? What are we known for?

- Responses
- Tim Walz
- Comprehensive treatment
- Cold Weather
- LARGE AMOUNT OF TREATMENT CNETERS
- Treatment and Recovery related culture
- Genuine concern for the wellbeing of others
- Being leaders in health and education
- Large number of treatments centers

- Lots of treatment options
- Education and Compassion
- Mn nice
- Being a leader in the health industry
- MN Student Survey for 33 years! Great source of youth data
- We were using motivational interviewing as a technique/approach before other states
- Treatment funding available
- Passion and desire by MANY to come up with solutions
- https://mnprc.org/2021/05/24/reducing-youth-alcohol-use-through-positive-community-norms-in-minnesota/ Strongly supported grants from DHS BHD for community coalitions to create local level changes, able to create transformation lower youth use
- Working with Tribes
- "responsiveness by school
- Staff: MH services embedded in District"
- Many MN prevention coalitions have been able to successfully apply for and receive Drug Free Communities grants to further their substance use prevention work; still need more support for this
- Embedded MH services in schools
- Drug Overdose Dashboard: https://www.health.state.mn.us/communities/opioids/opioid-dashboard/index.html
- CLAS Standards & Promotion of Culturally Affirming Continuum of Care
- Treatment Programs for moms and their children
- Funds Regional Prevention Coordinators so everyone and every community can receive Prevention training and TA
- Embedded MH Services in schools
- Embedded MH services in schools
- Trauma informed treatment
- Indian Education programs in the schools.
- Multi-cultural services
- Mn model

What does Minnesota do that is unique?

- Collect and use data
- Fund services to address MH/SUD in schools
- The MN Prevention Resource Center, MN Regional Prevention Coordinators, and Substance Use MN website for county, regional, statewide data along with fact sheets and reports
- Always looking for solutions that include everyone
- response to "rural" SUD issues
- SUMN.org Data to support communities
- Background of Jeremy Drucker
- Lots of great programs but all need to work together

What does Minnesota do that others want to copy?

- The Minnesota Model of SUD
- Implement an SUD division in their local government
- Direct access funding for treatment
- Positive Community Norms---this would also be great statewide!
- Embedded MH services in schools
- Minnesota student survey
- Family Recovery Organization- Thrive
- LADC services in schools
- Funding of cohorts of prevention grantees at community level for multiple years (through fed block grant funds) support from multiple levels for training for strategies, creating locally driven strategic plans, evaluation
- MN Student Survey
- Direct and relatable education for students surrounding SUD
- www.sumn.org http://www.sumn.org/tools/ReadingRoom.aspx All of these reports and resources available to communities at no cost
- Coalition work for prevention AND recovery support in community
- Recognizing that MH and SU are very much integrated
- Focusing grant funds on culture- specific prevention in youth/school

What key resources are available for individuals to connect with their communities?

- Mental health
- County support
- SEL
- MN Regional Prevention Coordinators www.rpcmn.org
- Recovery agencies and services
- MN Prevention Resource Center www.mnprc.org
- School-based services
- Treatment Coordinators
- cultural centers
- churches
- https://searchinstitute.org/resources-hub
- LINK
- Collaborations with community organizations
- AA and NA
- Non Profit Educational Resources
- Mobile recovery response teams
- Free, community- based, positive activities for youth - with lots of opportunities to expand on this
- we have DECO teams that coordinate with law enforcement on calls
- Pathways to Wellness- care coordination throughout community

- Prevention specialists/health educators working on preventing youth initiation
- Local community resource centers
- Public Health Law Center for guidance on tobacco and cannabis policy
- Sober/recovery schools
- Law enforcement trained in mental health
- https://pttcnetwork.org/centers/content/great-lakes-pttc Prevention Technology Transfer Center
- Recent SBIRT launch to assist with getting people into treatment with fewer barriers
- ANSR-MN
- Peer recovery support specialists
- Recovery Community Organizations - RCO's
- Youth involvement in local/community boards
- Local and state wide collaborative meetings where networking and resource sharing happens
- county issued gas vouchers
- Collaborate with other state departments for trainings and resources: Responsible Beverage Server Training - training of trainers, suicide prevention resources and trainings, etc to address shared risk and protective factors for substance use.
- Family recovery groups
- Coalitions
- MN Prevention Alliance https://mnpreventionalliance.org/
- Comprehensive system of care
- Resources are there but they may not promote them well so no one knows they are there
- All recovery groups
- Community education in public schools

Can you think of a particular provider, program or service that you consider to be a success?

- Recovery Alliance Duluth
- Mounds View Schools-Chemical Health Preverion
- Beauterre was very helpful for my son
- Hazelden Betty Ford
- Thrive Family Recovery Resourced
- Rice County Chemical and Mental Health Coalition
- APEX at Rochester Public Schools
- Mn Prevention Coordinators
- Adult and teen challenge
- Change the Outcome
- Ely Prevention addiction & recovery Coalition
- Steve Rummler / hope network
- Sober schools-Insights/PEASE
- Project Turnabout and their continuum of care
- Minnesota Recovery connection

- Chemical Health Specialists in Faribault Public Schools
- Positive Community Norms grants - have greatly reduced youth substance use within the communities that received them
- Fairview Adolescent Programs
- Minnesota Regional Prevention Coordinators
- Pathways to Wellness-care coordination/care facilitators
- Community Coalitions, Responsible Beverage Server Training, Compliance Checks, Teen Intervene
- Know the Dangers.com
- Police providing mental health assistance
- Positive Community Norms grantees
- All schools that provide LADC support
- Positive Community Norms Framework
- Ely Community Resource (ecr) for students and families in the community for a multitude of supports before during and after school
- Anoka Hennepin school district
- Warmline and 988 services
- SHIP coordinators
- Reframe app on phone
- Schools that provide on campus mental health services
- Social Emotional curriculum in schools
- SHIP focus on mental well being
- 180 Degrees Programs
- My Life, My quit
- Recovery Community Organizations
- Harm Reduction Sisters
- Trauma informed training in schools
- Project Echo
- Mama Bears of Harm Reduction
- Treatment courts
- Make It Ok new focus on MH and SUD stigma
- Needle exchange programs
- Allina - Mental Health Consultants
- Narcan trainings
- Alina Change to Chill
- MAT in local Essentia clinic treated as healthcare
- Suboxone/Methadone
- Change the Outcome
- Fentanyl test strip availability
- Mat clinics
- Steve Euler HOPE Foundation
- Essentia Health- substance use disorder treatment-Brainerd MN

- MAT in jails
- Free naloxone pharmacies
- Narcan Access Points
- Narcan and harm reduction training by Steve Rummler
- https://www.health.state.mn.us/communities/opioids/mnresponse/town.html
- https://nopainmn.org/

Why does that provider, program or service stand out to you?

- Evidence based
- 1-1 attention
- Great follow up
- They are person first-whole family paths
- Best practices
- parents who have lived experience connecting with other parents
- Offered harm reduction
- Because they are constantly seeking change in SUD
- Prevention at it's core
- Relatability
- Brings together people at various touchpoints in a person's life, to provide wrap around services/interventions
- Offered family programming
- Many are using evaluation to guide programs
- Well trained professionals
- Ability to pivot for life saving effort disregarding stigmas
- Evidence-based and works toward preventing/reducing youth substance use initiation
- They disprove myths and stigma of SUD
- anyone can use it at any time, from any location, is they have a phone. plus extremely affordable, plus common sense approach
- MN Regional Prevention Coordinators bring immense knowledge and passion to primary prevention efforts statewide.
- someone took a risk/chance and went against being told no and created their own
- Uses CRAFT, ITC, latest research
- Invitation to change approach
- Primary prevention focus
- Comprehensive approach and willingness to work with prison and workhouse populations
- https://www.health.state.mn.us/communities/opioids/mnresponse/town.html
- Essentia Health provides comprehensive continuum of care that is person centered, strength based.
- LADC have the ability to support all levels of substance use

What five to eight things would you consider Minnesota's greatest strengths?

- Effort
- Passion for this work!
- Comprehensive system of care
- Collection and use of data and evidence-based methods
- An eagerness and yearning to adapt in order to help people
- building on what we know works
- Coalition building
- Internally known Healthcare systems like Mayo
- Infrastructure
- volunteerism.
- MSS Data
- Offering opportunity to have a voice
- We have a conprehensive Regional Prevention System on which to build and expand!
- Funding
- Minnesota's culture surrounding SUD and Treatment
- Providing licensed professionals in the school setting
- The diversity in the programs we have available, it's not one size fits all.
- National expertise HBF,Mayo, uofm
- MSS data drives services in schools and agencies
- Early childhood intervention programs (not SUD specific) and attempts to lift people out of poverty when possible- as we know, SUD concerns don't exist in a vacuum.
- Time Walz
- Connection & education opportunities through technical support
- Services that target parent-child relationships for adults in treatment - as a preventative measure to reduce ACEs and impact on kids
- "MN Student Survey data to drive youth work,
- MDH/DHS and RPCs to support communities,
- Family Services Collaboratives to bring together partners to focus on children and families
- Engaged Public Health
- Mental Health Services
- Strong schools"
- Trifecta in legislature
- Drug courts
- Primary prevention efforts
- A commitment from the Walz/Flanigan Administration
- Training and technical assistance for primary prevention
- A renewed focus on SUD system reform efforts is a strength.
- Very proud that the state has allowed these conversations in line with working towards the greater good.

- Innovation
- We are ahead of the game in education on primary prevention.
- Influx of people from all over who have come to Minnesota, found their recovery, and made this their home.

Education and Prevention Opportunities

What is the community asking for related to prevention and education?

- Quick, practical solutions
- They don't know-
- Culturally appropriate education, working on identifying ways to reduce stigma within specific cultural groups
- More support in the schools related to substance use
- More education for students and parents
- Realistic, not fear-based education about drug use
- Addressing the stigma
- Quick access to services
- Community based education - going to where people are to share info, not expecting families to come to us
- More adolescent support in schools
- Mental health supports
- Easy access to Narcan
- More MH/SUD support and services in school
- Help with their childs school attendance
- Increasing access to free, low cost activities for youth in rural areas
- How to get their child hep, i.e. assessments
- positive community norms Grant
- More access to children's mental health
- More state funding
- Education opportunities
- Continued funding for prevention
- More stigma free education for PARENTS
- Providers serving youth
- SEL being required in all schools, truly integrated into the curriculum
- SEL
- Sources for family support and evidenced-based approaches
- practical in service trainings for school staff
- Better options for treatment for folks on medical assistance
- access in rural areas
- Ability to provide services at schools or workplace
- Increase awareness of Resources in the Community for youth andvoarents

- diverse workforce to deliver culturally affirming and response prevention and education
- More school or community opportunities to educate parents about substance use
- Expandin on fmily treatment options, as addiction impacts everyone in the family and extended family.
- Safe and supportive housing for folks with SUD and mental health with homelessness
- Education for parents, about normal child development, causes for concern, how to talk to kids and address concerns before they escalate
- There is a serious lack of mental health counseling appt and counselors
- Family peers!
- More partners to help educate for youth regarding social emotional/coping skills.
- easy and seamless access to prevention in the community trusted spaces
- Its easier to raise healthy healthy informed children than it is to fix broken adults.
- Promotion and Support of Cultural Healers
- Reduce stigma so parents and the community want to engage
- A state wide campaign with one common message about prevention and education.
- Companion curriculum for parents when their children or adult children are receiving treatment services.
- Reduce the stigma of talking about problematic substance use
- Parent communication skills - Rob Turrisi, Penn State
- Resources to help parents start the conversations.
- Children and student intervention in high-risk families
- incorporate these discussions into things such as extra-curriculars (sports coaches, directors, youth group leaders, etc)- these are respected and influential individuals
- Partnership and collaboration with the medial community.
- Alternatives to suspension for students who have been identified by schools.

Do you see any alignment with strengths related to prevention and education and the identified community needs?

- More focus on trauma-informed schools
- Trying to implement SEL in schools more consistently
- Prevention and Recovery Coalition affiliated with behavioral Health network of organizations working closely with school, community and county
- Schools are investing in appropriate school based substance use disorder support
- "Coalitions and agencies have the desire to do
- Something but it feels so overwhelming"
- Facilitated mental health literacy curriculum in the school for grades 6-12 but only touched upon SUD
- Recovery Community Organizations
- There are increased supports in school today in comparison to just a few years ago.
- DHS BHD funds a prevention system (https://rpcmn.org/about.php) that helps support communities to address substance misuse prevention
- Grant funding to provide MH/SUD services in schools

- There needs to be an LADC in each school, just like we have school social workers or counselors.
- Schools are recognizing that MH and SUD often go hand in hand
- Coalitions are collaborating across communities to leverage resources and share knowledge. Coalitions are including partners from across the continuum of care to create solutions to meet community needs that wouldn't be possible without partnerships
- The MN Student Survey helps guide coalitions and schools to invest in areas of most need
- SUD concerns are becoming (somewhat) less stigmatized than they once were leading to opportunities.
- Lots of Schools have coordinated mental health services in school. There are less SUD services in schools
- Community based action, the forming of outreach related organizations that offer education
- MN Prevention Program Sharing Conference gives opportunities for people to connect, learn, and gain new ideas to implement in their communities to improve substance use prevention
- Resources are: youth, MH/SUD service providers, parents, front line staff
- Leverage resources: can be sharing training access with each other, developing social norms messaging / positive community norms messaging, sharing speakers, planning events together,
- Care facilitation warm hand off (sometimes within the same visit) for needs established outside of the healthcare visit
- Prevention efforts that include changing the narrative in how we engage with others in talking about substance use.
- One of the issues is referring someone but wait time for appts is verrryyy long
- Sporting events…

What are key areas of untapped potential?

- Smaller nonprofits doing good work
- Peer support within recovery
- Forward and progressive thinking
- Mandatory SEL for students and families
- Faith and spiritual mentoring resources
- Statewide prevention.Campaigns vs diff counties all doing their own thing
- Our youth
- Youth orgs that are already reaching kids
- Need harm reduction sites and housing
- Connecting colleges to their communities to share resources/expertise
- In school support
- incorporating extra-curricular leaders (coaches, directors, youth-group leaders) All influential and highly respected individuals
- Venues that already host families (sporting events, etc)
- A clear and unwavering focus on PRIMARY prevention
- Retro-fitting unused office space for treatment beds, shelters, syringe services, etc
- Several counties banding together and doing prevention campaign (Ie metro) around opioids and marijuana. There are too many disjointed responses and efforts
- Coaches, advisors - people who have influence

- Junior achievement programs and connections
- State funding for youth led primary prevention efforts
- Reliability
- Creating clear, financially and geographically accessible career paths for people to capitalize on their lives experience with addiction, trauma, mental illness, etc
- Money
- Relatability
- YOUTH INPUT! Lakeview Hospital in Stillwater has a Youth Advisory Board where you can run efforts/questions by them and get youth input
- Properly trained interns, student leaders, career pathways, etc.
- A intentional movement across the state that support Policies and laws that address youth access, density, flavor bands, social host ordinances, Responsible Beverage Server training,…..

What community partnerships would lead to greater success?

- Schools / Education / PTA
- Public health and schools
- local law enforcement
- Dept of education to embed in the curriculum
- Faith institutions
- Nothing about us without us! Need youth voice in everything we do
- Community Education programs
- Peer to peer and treatment centers
- Legislators and the people they serve
- Federal level policy partners
- Recreational organizations
- County partnerships
- Chamber of Commerce--partnering with businesses to learn about prevention/ ACEs/ diversity to increase engagement with the community
- Local businesses (employment opportunities)
- Stronger partnerships with local media, to help work messaging, sharing of info
- Local businesses who can host and support events
- Universities - students as volunteers/mentors and faculty/staff as subject matter experts
- Local businesses and cultural communities
- Partner with local Family Services Collaboratives and Children's Mental Health Collaboratives
- Taking a look at infrastructure already i place so not to recreate something already in existence

What changes do you expect to see over the next five years? Where could the make a difference?

- More - and more sustainable - prevention funding
- Primary prevention across the board, mandatory, in schools.
- MH/SUD providers and services in a majority of schools, greater funding

- Less stigma PLEASE
- Expansion of the Regional Prevention Coordinators from 7 to 14! At least!!
- Statewide anti stigma campaign around mental illness and SUD
- improvements in legislature
- less stigma around SUD
- Harm reduction services and housing
- Matching Community resources with immediate needs
- Behavioral Health to be implemented into the education of educators
- Inteoducing the Positive Community Norms campaign to the ENTIRE state! Make PCN a household term!
- More training and education for mental health professionals
- More investment in Youth Programs in prevention and Education
- Increase awareness of harm reduction strategies. Develop comprehensive harm reduction strategies statewide
- Collaboration between the new tiny homes development and homelessness caused by mental health and SUD
- Include all secondary grades in the MN Student Survey for a true accurate picture
- Naloxone in ALL schools.
- CIT Crisis Intervention police teams trained across the state
- Careful consideration of legal access to substances (and gambling)
- More family and friends being empowered and educated with evidence-based approaches
- More direct stigma reduction efforts
- Prevention infrastructure in the K-12 curriculum, and funding support for appropriate staffing.

What are the top 3-5 opportunities to work on?

- Prevention infrastructure in K-12 curriculum and funding for appropriate staffing.
- Early prevention curriculum that includes families. Incorporating the toyth in decision making.
- A system that works regardless of the substance causing the most uproar at the moment.
- Being proactive versus reactive in regard to driving prevention and education efforts.
- Culturally responsive efforts including literature.

Education and Prevention Aspirations

What is our community passionate about?

- Helping those who need/want it!
- Youth engagement
- Racial justice
- Educating and supporting families/friends of loved ones suffering from SUD/mental health/addictions
- A long history of SUD treatment provision
- Supporting the person in the way that fits their need
- Positive activities to get our youth engaged in.

- Culturally specific outreach, education and prevention efforts
- our youth!
- Prevention!
- Supporting adolescents
- Reducing the stigma of SUD & mental health
- Partnering with other providers, organizations and entities to address gaps
- Harm reduction
- How SUD affects MH in youth.
- Help individuals not start using damaging substances
- Addressing stigma and reducing related barriers to services, activities and other engagement
- Stigma reduction
- Supporting parents struggling with addiction
- Connection between SU and MH
- Reconnecting families
- Getting services our youth need into our schools.
- PRIMARY prevention not only overdose prevention
- "Drug free community. People living together in harmony.
- People living fulfilled lives."
- Passionate about youth voice
- Passionate in Providing a variety of ways for youth to gain, learn and practice coping skills and healthy social emotional skills.
- Creating healthy communities
- Passionate about supporting parents in their parenting journey.
- Delaying initiation of use
- Culturally relevant AND linguistically appropriate primary prevention programs/services/curriculum
- Culturally specific early education
- Desiring engagement with those that are not engaged and we need. (This includes many parents and people with lived experience that we need to hear from to find solutions for our communities.)
- Shared power and decision making with community
- Helping families learn communication and relationship tools as well as advocacy
- Cross generational culturally specific education and resources - informed by the community members, not dictated by organizations.
- Consistent connection, effective messaging and communication to our very different communities that reside together. Age appropriate education throughout lifespan.
- Empower families and our loved ones
- Changing societal norms around substance use.
- Youth led prevention iniiatives!
- Communities want money, but they arent awaren of what is avaialbe.

What should our future community look like?

- A greater focus on "living well"
- Earlier education for youth and their grown-ups about SUD/MH
- All people in power reflect actual population demographics
- Free of Substance Use Disorders, people helping people, looking out for others, being humble and kind. Going out of your way to help others and being open to new ways of doing things.
- We have learned how to love each other well! Truly see and hear each other! Be hospitable leaders from our families, RCOs, and governments.
- Making Positive Community Norms (PCN) a common household term in Minnesota!
- Income equalization
- Teaching adults to better communicate with youth, to equip them to have the "big/uncomfortable" conversations much earlier on. Sometimes adults try to approach these conversations when it's too late or they have less influence on a youth's life.
- Caring more about our whole community than about preserving our own organizations, the whole person rather than separate parts
- People get what they need when they need it
- https://mn.gov/dhs/people-we-serve/adults/health-care/alcohol-drugs-addictions/programs-and-services/positive-community-norms.jsp
- Stronger emphasis on SEL in all schools, at all grade levels - and partnering with folks who have the ability to do this if stretching educators even further isn't possible
- Equity in grant funding to ALL Minnesota communities!
- We need funding to put LADC's in the schools again same as the social workers. Youth need individual counseling support to address and teach substance use issues.
- Places where people have frequent intersections should have the basic knowledge to discuss, assess and refer for MH/SUD. I think of primary care, pre-natal care, pediatrics, school nurses, school attendance officers, child protection, etc.
- Recognizing the impact other industries (big pharma, tobacco, alcohol, etc.) have on our prevention efforts.
- This was mentioned yesterday, but employers need more resources to address SUD/MH in the workplace. Wouldn't it be great if people knew they would be supported by their employer vs. fearful of losing their job because of their disease state
- Family and peer recovery coaches an integral part of care continuum
- The majority of the opioid settlement dollars fund primary prevention
- Prevention should be a priority. We should also consider what can be done to engage people to gain skills that allow them to not only build skills, but also to benefit them personally (i.e. improved job placement) to benefit to our communities.
- Private insurance payers need to be at the table for some of these conversations, along with Medicaid and Medicare. What they cover and do not cover does not seem to support good care. Or perhaps they are mandated through regulatory efforts?
- Involve all local stakeholders in decisions regarding how local public health agencies direct their opioid settlement dollars
- Lobby for prevention funding in the current marijuana bill

What strategic initiative would support our aspirations?

- Sustainable state funding for broader prevention infrastructure in MN
- Develop replicable primary prevention programming in all K-12 schools
- Having the appropriate people at the table and hearing ALL voices.
- Having a director in the new office of addiction and recovery is a good start … with the advisory council of people with experience in the field
- Communite is basic languge grant reuqirments and opportunities. Grants are SO hard to obtain because of the language and detauls required.
- Companion education for families when schools provide education about MH/SUD in health class, etc.
- Education uses a systems framework called Multi-Tiers of Systems of Support [MTSS] - (prevention, early intervention and treatment) - we need to focus on funding each tier of support in schools and in the community
- Break down types of funded based on types of prevention. Primary prevention will increase resiliency and reduce SUD.
- All encompassing harm reduction models.
- harm reduction vending machines!
- Access to fentanyl test steips; access to narcan, etc
- Make MDE come to the table
- Parental support for Primary Prevention.
- Early Childhood education of parents. Talk Early Talk Often or Talk, They Hear You SAMSHA campaign.
- Bring MN Dept of Education, MN Dept of Health and MN Dept of Human Services together around what state agency does or funds what work and part of the overall continuum of services and support for SUD
- Stakeholder involvement with decisions on how to spend opioid settlement dollars awarded to local public health agencies and cities.
- Lobby for prevention dollars in the new marijuana legislation
- Approah the work with the mindset that ALL of our children are at risk. We need to reset the conversation to include the facts on mental health and SUD risks throught their lifetime.
- More substance use prevention funding, dollars allocated to primary prevention. We need to stop people from falling into the river! We cant keep pulling peope out, that is where the burnout happens.
- Mandatory requirement to include MDH and DHS Prevention stakeholders engaged before laws pass that allow substances to become legal recreationally
- Educate ourselves on the mandated prevention strategist role and funding of local public health departments
- Training on how to let the legislative leaders know what is needed. People are afraid of legislative processes and it seems to BIG

Based on the passions and the needs of our community, what can we do to advance the strategic plan goals?

- Continue the conversation and commit to ACTION!
- Exert influence on how DHS and local public health/cities decide to spend their opioid settlement dollars

- Partnering with MDE
- We are showing up for it, right her amd right now!
- Have all the appropriate people at the table
- Individuals and families are not eligible for settlement funds, despite experiencing extreme emotional trauma, financial loss, etc. Wild idea: what if settlement $ was awarded with the caveat that familie engage in education within the family unit?
- Keep this conversation going; continue relationship building with this group (all attendees of the summit) of invested individuals
- Funding for collaborations
- Engaging legislators from the community level.
- Using knowledge of ACEs and Trauma, review policies and practices currently in place to consider those initial, local changes needed to support clients being served or who may be served in the future.
- Collaboration with all levels of elected officials at state and local community levels including school boards.
- Agreed upon (by DHS, MDE, MDH) state-wide message on primary prevention or other health promotion.
- Funding that can be used in each and every community that support prevention coalition.
- Share what is going well, sharing the steps, challenges/what we'd do differently next time to really understand it's not an 'easy' process to make change.
- Families who have experienced a fatal (or non-fatal) OD should have access to a range of services, funded by settlement dollars, removing barriers of geography and money. Prioritize families with children.

What are the top 3-5 aspirations to focus on?

- Licensed Alcohol & Drug Counselor (LADC) in every school
- Required education that is age appropriate with companion parental guide both culturally and linguistically appropriate
- *Required 'primary prevention' education...
- Prevention that is targeted to the needs of the actual high risk population.
- Prevention / intervention
- Increased funding from the state and local levels to support sustainable primary prevention programming statewide.

Education and Prevention Results

Considering the identified strengths, opportunities, and aspirations, how will we know we are on track in achieving our goals?

- When the prevention literature, educational materials and programming are accessible in contexts and languages that are reflective of our communities
- know what the baseline is, evaluate continually as effort progresses, make corrections as needed

- Data will show lower use numbers and less mental health diagnoses
- Make sure there are checks and balances to assure that the mission is on track.
- When all of Minnesota is represented with equity in our service provision.
- Collaboration seen between and among all culture groups
- There will be less first episodes of substance use disorder treatment because rates are actually reducing.
- Greater numbers of families educated and directly supported
- When both process AND outcome measures improve
- When parents/caregivers and youth report back that they're having these tough conversations
- "Fewer overdoses
- When test strips and narcan are widely available, as much as fire extenguisers"
- when there is less stigma around conversations of SUD
- "Has anyone gone to a pharmacy and asked for narcan?
- What was your experience? Were you successful?
- Did you have to pay?
- Were you treated respectfully?"
- MSS data
- We have the opportunity to fund data collection measures to represent under representive cultural groups who we say we have no data on!
- Substance use rates decline, participation increases in efforts to engage the community
- When the prevention funding doesn't have restrictions that ultimately offer funding to the upper class whites whom aren't truly the ones at hishest risk.
- When overdoses decrease; when deaths decrease; when kids aren't taken out of homes by child protection because of drugs; when MN student survey results improve; when babies born with neonatal abstinence syndrome decreases
- All service providers educated in the latest evidence based approaches
- When community partnerships reflect community demographics
- When ED/hospital visits for overdoses decrease
- We allow for non traditional service provision in underserved diverse communities.
- In working with families across cultures, we find involved family members are 90% women. A measure to know if we are more on track is if more men are becoming involved in family recovery.
- Communities are engaged and active with education and prevention. Community organizations work together and share resources to better community members (schools/churches/government/non profit etc)
- When we go where to the places our SUD folks and families are already meeting.
- We HALT, and leave no community Hungry, Angry, Lonely or Tired!
- When parents/caregivers can speak to the SEL their children are getting
- When there are larger, societal conversations about positive community norms
- When there is statewide agreement on performance metrics we will monitor
- When ACE scores improve
- Ensuring internal systemic issues do not perpetuate racism.
- When all prevention materials are available in languages other than English

- When the majority of opioid settlement dollars received by counties/cities are used for primary prevention
- Data showing and available for equitable funding by cities, rural areas, and cultures
- We actually have the funding to meet the needs in both rural and urban communities.
- We have established a robust and flexible gran funding and proposal reviw system that includes payment to reviewers.
- When data is made available and accessible to local communities to inform all planning

What results do we want to see?

- MSS data that reflects decreased SUD/MH rates in youth
- Solid relationships of support!
- More education and funding for education and resources.
- Ability to intervene on the front end rather than the back end.
- Students, parents and teachers educated
- Minnesota as one of the healthiest and safest places in the US
- For all!
- Coverage and funding for mh/sud services that are meant to catch those before it gets to "disorder" level
- Upstream practices that are reaching all populations
- The narrative we hear from diverse communties changes, and we hear from them how things have changed.
- Racial and heath equity for all
- MSS that also increases protective factors
- Youth reporting that they feel heard, supported and understood by the grownups around them
- Reduce educational and health disparities
- A focus on social determinents of health so individuals do not fall to... addiction, poverty, homelessness, etc. We are social beings, how are we being socialized in the immediate family, the community?
- More options for people with out health insurance who don't qualify for MA, or other grants, that don't get insurance through work.
- Youth and adults making choices that promote a healthy life
- https://www.cdc.gov/healthyyouth/wscc/model.htm there people in Minnesota using this model

How might we track the impact or changes that have happened?

- Data entry, documentation, and statistics.
- Focus groups
- Conduct surveys and focus groups to collect qualitative data
- Graduation and attendance at schools, law enforcement and hospital/emergency room data, MSS data,
- Comprehensive data and evaluation component and utilization of results.

- Minnesota-wide data system provided to ALL communities to have input with no barriers developed by those we serve
- Incentivized surveys.
- collect both quantitative and qualitative data, conduct evaluations designed with community
- This goes back to collaborative relationships across sectors- build the relationships and hopefully easier tracking of impacts will come.
- Ensure "data reporters/report writers" are trained in culturally relevant data visualizations
- https://www.cdc.gov/healthyyouth/wscc/model.htm
- State agencies need to provide their data in accessible formats so we can do our own LOCAL analyses (not just written or pdf reports)
- Decreased recidivism of substance use in probation, drug court. Could be at multiple timeframes.

What are 3-5 indicators we would want to include on a scorecard?

- Decrease in reported use rates/MH concerns by youth in the MSS
- Fatal and nonfatal overdoses
- Decrease in need of SUD treatment
- Babies born with Neonatal Abstinence Syndrome
- Lower rates of children/early teens who have tried alcohol or drugs.
- Need to define: long term or short term indicators?
- Kids removed from home by child protection because of caregiver drug use
- We just talked about upsteam prevention....what are positive assests
- Decreased community underage substance use violations
- Decreased violations in the school setting.
- Decreases in law enforcement and/or hospital substance-related data
- https://www.rwjf.org/en/cultureofhealth/taking-action.html we need to think differently and probably need different data
- "1. Education
- 2. Funding
- 3. Reseach
- 4. Outcomes"
- Social determinants of health

What resources would we need to implement these measures?

- Funding
- Sustainable funding-we need the money to do anything
- Providers educated and trained to represent and serve all communities
- Infrastructure-a reformed sustainable system along the continuum of care.
- Workforce and funding
- people trained in program evaluation, data analysis and visualization
- Defined roles and funding streams

- https://www.wilder.org/wilder-research/research-topics/education-and-youth-development we need good information and tools
- ACEs/Trauma-informed staff from entry level through management/admin
- clearly defined roles-State vs local
- LADC's can provide support in all levels of MTSS
- A broader understanding of roles and responsibilities of local public health departments
- Community coalitions
- MDE at the table
- Access to and knowledge of grant availability offered by all sectors
- Possibly PTAs/PTOs with the schools to help make connections with families and youth
- https://www.samhsa.gov/resource/ebp/preventing-marijuana-use-among-youth

Funding and Workforce Strengths

What is Minnesota's greatest achievement? What are we known for?

- The MN model
- MN Model of Treatment
- Plethora of social services which are easy to access.
- Behavioral Health Fund - access for those who can't afford
- Surprisingly, Funding for treatment
- BHF
- Good healthcare options
- As a state, we were one of the first to charge pharmacy licensing fees which resulted in OERAC.
- Behavioral Health Funding
- We are known for Hazelden on a National Level
- DHS grants to help with workforce shortage.
- Very hands on approach to those struggling with severe MH or SUD (civil commitment). Quite paternalistic approach compared to many other states.
- Loan forgiveness
- Hundreds of treatment centers to choose from and several modalities
- Drug Court and Mental Health Court
- Research driven workforce development
- I think we have a much more collaborative approach to care and connection than other states. We are not fighting for clients- we are not patient brokering- we are working to get the client is in the most appropriate program
- High education requirements for licensing - maybe not good idea? Limits licensed workers in field and added cost.
- Offering clients many options for treatments services to meet them where they are at- with insurance to cover them and the post treatment services as well.
- A lot of programs paid for Practicums to help with access to education and equity for those looking to get into the feild

- What loan forgiveness? Been in field for 9 years and still paying loans. Not because of lack of trying. State needs to do more.
- I have worked in other states- where it felt money driven, competitive and "shady". I do not feel that in MN. We have MARATP, MARRCH, Compliance Collaboration and open discussions with DHS. I know that our family providers meet quarterly.

What does Minnesota do that is unique?

- Traditional Healing
- Certification AND Licensure - Unsure what benefit Certification has in the state of Minnesota but is needed when moving to other states - Ex: Iowa
- Fast Tracker website for locating programs in Minnesota

What does Minnesota do that others want to copy?

- It was already mentioned, but our levels of treatment that include high, medium, low and OP services.

What key resources are available that provide an advantage for individuals to connect with their communities?

- Many social workers, peer recovery specialists and other behavioral health staff roles.
- Very limited in rural mn. It varies per county/region
- Peer Recovery specialists, though still very limited outside metro.
- Connecting with the local SUD coalitions, networking meetings, connecting with HeadStart, CPS in a collaborative way, PO, Public Health Nurse Teams, ARHMS work, strong continuing care discharge plans, harm reduction services either onsite or referred
- Telehealth has been helpful

Can you think of the work of a particular provider, program, or service that you consider to be a success?

- Any program that survived and is still open after COVID
- Any program that offers access to all levels of care throughout their organization is helpful. Being able to step down from residential, to IOP with lodging, to Sober Living & outpatient.
- Ones that communicate communicate communicate, some forget that they can and should communicate with the PO the SW for the resources that may be back in their community. So those that do communicate a big THANK YOU
- Places that were able to accommodate people with higher acuity medical needs. The ones I referred to have since shut down so options are limited.
- Steve Rummler and their ability to get Naloxone and test strips and training to providers, consumers, community members.
- Many programs that make intakes and admissions easy are successful. We know that daily many are inundated with faxes and emails and are great at getting back to referents

- Programs that accept people with increased needs, medical, mental health, brain injury, language barrier, cultural,etc. Our clients' needs appear to be more complex especially since COVID and a program that is willing to work with them is SO helpful!
- Any program that takes Medicare.
- ditto on any program that is able to take Medicare, need more
- Programs that offer transportation from client homes to get to residential treatment.

Why does that provider, program, or service stand out to you?

- No votes for this session

What 5-8 things would you consider Minnesota's greatest strengths?

- "1. The people in general - strong work ethic,
- 2. Involvement in the lives of those with MH and SUD concerns and funding to support.
- 3. Supportive legislature."
- "1. Passionate Providers in the field
- 2. Helpful DHS Staff
- 3. Legislative Support
- 4. Positive relationships between providers"

Funding and Workforce Opportunities

What is the community asking for?

- More staff
- For funding we need more services covered by Medicare
- funding for more medically managed detox centers for greater mn
- Flexibility in statutes
- Medicare and Medicare replacement plans for covering Substance Use Outpatient services.
- More staff in Office of Indian Policy and more support for Tribes
- Having more staff that can focus on housing, mental health access, training opportunities for people coming home from incarceration. .
- adolescent services in greater mn
- need to work around and set aside previous felonies, charges, etc
- More culturally specific treatment options

Do you see any alignment with strengths related to the identified community needs?

- willingness is here!
- Licensing good. Create flexible opportunities for entry level professionals, and/or graduate certificates for professional's transitioning to this industry who already have another master's degree.
- Peer support pays more than treatment coordination, that should be re-evaluated.

- the funding for medicaid folks is there, but the bulk of people with SUD who don't seek treatment don't seek it at least in part because they have poor health insurance via their employer or MNSure and can't afford their out of pocket costs.

What are key areas of untapped potential?

- Schools
- Universal code for mental health
- Being able to provide services to people in jail or incarceration and receive payments. Difficult to get services to these individuals and get contracts for reimbursements.
- high school to career bridge programs- earn while you learn
- Provider-Payer
- university and colleges working with treatment providers

What community partnerships would lead to greater success?

- Flexibility in hiring in mental work force

What are the top 3-5 opportunities to work on?

- Flexibility in statutes
- Partnerships with schools
- Partnerships
- Rates that support quality services.
- Lessons restrictions on ladc's,
- Communication of higher ed opportunities
- Universal code for mental health
- multi-disciplinary reimbursement structure - OTs, MH, additional disciplines
- Communications, multi-modal
- large employer education on SUD and MH
- Client retention & satisfaction rates

Funding and Workforce Aspirations

What is our community passionate about?

- Collaboration to find innovative solutions in a multidisciplinary fashion
- Making a difference and helping people to stay alive
- Serving, saving lives, creating programs and services to assist client to live their best life.
- "Collaboration
- Inclusion -especially our consumers"
- Increase the number of people accessing treatment

- Services to people to reduce harm at all levels even if someone is not open to abstinence focused treatment
- Harm reduction and promoting all pathways
- Housing and work/volunteer (meaningful time use) as integral to their paths forward in ongoing recovery
- Reducing stigma
- Retaining our existing staff and their well-being
- Serving the underserved
- No barriers to access treatment/services. Seamless transitions to and from levels of care. Safe and stable housing in communities of a persons choosing. The window of opportunity for change is often so small, need to strike when the iron is hot!
- Collaborative approach from OIG/Licensing. Providers acting in good faith should be given support and TA. Referrals to SIRS, being talked down to, and being treated like a scheister isn't helpful.

What should our future community look like?

- Should reflect the identies of the people we serve and need our services
- SUD professional remain a viable specialty
- Being able to meet the needs of our community not what DHS check boxes say
- Create our own solutions for our community and population- flexibility for programs to do what is client centered for them
- Cross cultural equity in our workforce
- Expanded work force to press further in holistic treatment interventions which supports client centered needs
- We need stable funding sources for services so that people can maintain access and we can maintain the field - some services that an agency needs to provide to run aren't reimbursable (admin svcs/facilities/etc) and reimbursement rates are too low
- Figuring out a way for clients that have Medicare or Medicare replacement plans that don't meet income guidelines to not have to pay out of pocket for treatment
- A developed contiuum of care which would require providers to collaborate to ensure the clients are receiving appropriate level of care
- Not to diminish the need for a more diverse workforce, I believe it is to be aware of the facts so we have a realistic perspective. By all statistical measures, Minnesota is 81.4% Caucasian. There may be a metro bias that is affecting assumptions.

What strategic initiative would support our aspirations?

- Remove all regulations in 245G that do not fit with ASAM and are not safety related.
- Participate in the rate study questionnaire that will come out at the end of January. This is our chance to provide input.

- BHD needs to bang on the 'state substance abuse authority' statute in 254A. DHS administration and the gov's office must listen and prioritize SUD initiatives. Ensure that Jeremy Druckers role has teeth and power to effect the change that is needed
- Identify the actual cost of providing services and be able to pay that. This also for programs to use their revenue to support their communities without having to apply for grants or meet specific requirements and reporting. (1)
- Which allows for more time to implement and provider the service (2)
- Remove the co-occurring ratio- it is SO hard to find fully licensed providers and especailly board approved supervisors. I am one of like six supervisors in our county for mental health
- Share workforce. Allow treatment and medical staff to do residencies or short-term work at another 245g licensed program without having to redo background studies and be place on the roster. Promotes learning, collaboration and best practices.
- More communication between MDH and DHS - there should be no wrong door to get an answer on how to start or provide services.
- More communication between MDH and DHS - there should be no wrong door to get an answer on how to start or provide services. (I accidently put this in the chat)
- Identify things we can implement NOW. We have people dying NOW. 3-5 years we will have even less providers, organizations and more people dying.
- Clarity around housing regulations. Providing housing can be considered an inducement which is a violation of federal law. Counties have regulation over board and lodge. Housing supports are the same. Where do we find out the how?
- From the webex chat: Just a note for perspective. Not to diminish the need for a more diverse workforce, but all statisical measures, MN is 81.4% Caucasian

Based on the passions and the needs of our community, what can we do to advance the strategic plan goals?

- Hold the legislature and DHS accountable. We can't change anything without their help.
- 1115 discussions and initiatives have very positive. Continue these and give the suggestions actual implementation
- Social services in general is going to continue losing workforce unless pay can reflect more value (people can do easier jobs with much more pay) and offer more flexibility in our work
- Many of the goals require statute changes and provider participation in that process is needed.
- From: WebEx: Continue to voice our concerns and ideas to how we see things could be improved, but we have to have DHS support as we cant do it without them
- Allow programs the freedom think outside the box and to undertake creative approved pilot programs that may need flexibilty of regulations.
- From WebEx: Can we identify successful value based models nationally that we could adopt or modify?

What are the top 3-5 aspirations to focus on?

- Provider rate increase. Reduce paper work.
- Can we identify successful value based models nationally that we could adopt or modify?
- Rate structure and statute that includes additional services and professionals
- Less paperwork, rate increase that includes an annual increase based on inflation without having to ask, workflow chart for DHS and MDH that also includes what each person does and who their supervisor is
- From WebEx: Rate increase for services provided
- Funding source for our Medicare patients to access SUD. Lobby on a fed level but create a short term solution through the state- our baby boomers are going to need services NOW
- Engage with The Minnesota Association of Student Councils (MASC) and the Minnesota Association of Honor Societies (MAHS) are student leadership organizations.
- Communication building across the spectrum
- Tech training through DHS and ability to ask questions without feeling "in trouble".
- I have been asking for change for 7 years and still feel defeated more times than not- help navigating the system
- payment for transportation

Funding and Workforce Results

Considering the identified strengths, opportunities, and aspirations, how will we know we are on track in achieving our goals?

- Publishing and tracking workforce demographics based on location/county
- Staff turnover is another dimension that's important to keep track of
- Employees are staying (being retained) in their roles in treatment settings thanks to less burnout, paperwork, etc
- Workforce demographics based on Ethnicity to ensure all populations are served by chosen ethnic providers.
- Stated verbally already - Statute and reimbursement includes the added providers
- New license rate equals or exceeds attrition rate.
- Staff that move from another industry who move to behavioral healthcare.
- Working with legislators and lobbying, for licensing issues and DHS backgrounds.
- Are LADC's staying in the field? And if not where are they going?
- Staff retention

What results do we want to see?

- Satisfied employees, less vacancies, treatment completion rates improve
- equity in Greater Minnesota too
- Longitudinal studies with client outcomes at Year 1, Year 5, Year 10…

How might we track the impact or changes that have happened?

- Transparent information sharing by payers
- I know we've talked DAANES before, but it seems like if DHS put a lot of money and effort into it, it make sense to beef it up a bunch
- A clearinghouse for data sharing that could be accessed by all providers
- I agree w DAANES platform and use what is already established w data.
- Unemployment Insurance data could also be something to track - should be some good data on behavioral health workforce over time. Broad, but a helpful benchmark.
- ❤️❤️❤️❤️
- ❤️❤️❤️❤️❤️
- Job opening rate in programs and ancillary providers.

What are 3-5 indicators we would want to include on a scorecard?

- Job opening rate by program/provider.
- Staff to patient ratio
- Are LADC's staying in the field? And if not where are they going?

What resources would we need to implement these measures?

- MONEY!!
- Rate Increase
- Staff retention
- Pipeline of trained staff
- Data scientist dedicated in our division of DHS to spearhead this.
- Fee setting folks to collaborate with existing providers and ancillary providers who can join the SUD tax teams
- Not responding to the actual question but think we should all acknowledge what a great job Jason has done moderating this session over these two days!
- Jason rocks!!!
- Yes - Jason! What a fabulous job you and the crew there have done! THANK YOU
- Having spent a day in another room that was not as well moderated, yes Jason has been AWESOME!
- JASON!!!
- Jason is the best facilitator of a hybrid situation that I've experienced thus far. Awesome

Law and Policy Strengths

What is Minnesota's greatest achievement? What are we known for?

- Drug courts, or the movement in a direction of rehabilitation instead of punishment
- Disability advocates
- person centered care
- Treatment center
- The land of 10,000 Treatment centers
- Most Treatment Facilities.
- Active involvement in engaging treatment courts and peers
- Drug courts
- implementation of new services
- Starting the Dosage Program in MN
- We have some great schools, but we also have the largest disparities in outcomes for Native American and Hispanic children v white.
- Drug courts, treatment centers
- Medical Model
- Our greatest achievement is being a hub for recovery known throughout the nation.
- Compassionate social service networks
- Many treatment options
- Police brutality and the racial injustices in urban settings.
- Offering a lot of treatment opportunuties to clients in the legal system.
- medical model
- Nationwide health care services
- Substance Use Disorder Treatment
- Bring an early adopter for the CCBHC model
- PROGRAMS IN GENERAL
- Person centered care
- "We take care of ""our"" people here in Minnesota.
- Land of 10,000 treatment facilities"
- Treatment court's
- Data
- Implementation of treatment courts
- Full continuum of care
- Providing treatment and opportunities for treatment for those incarcerated.
- "Education
- Drug Courts
- Land of 10000 Lakes"
- Known for being extremely cold too!!
- Drug courts (Duluth model)

- Creativity for Services
- education
- social services
- Welfare Systems
- Treatmet courts
- treatment services
- Drug Courts as a collaboration with the courts and treatment
- Minnesota nice!
- Affordable treatment for those that need it most.
- Restorative courts and diversion
- Numerous treatment centers, Fortune 500 companies,
- Treatment Services
- Treatment for SUD
- Dual disorder treatment addressing trauma.
- Treatment courts, Vets court
- Land of 10,000 treatment programs
- We have funding for low income persons to access SUD treatment, This is something other states do not have.
- Police embeded and coresponder with police
- Dosage Supervision
- Funding for public assistance benefits.
- Access to social services
- Tribal led/run culturally specific treatment and programs
- Duluth Model; individual, former judge and local doctor created a drug court system to work with high level felony conviction to connect them with probation & resources, serves as 'last resort' but results in very high success rates.
- Multiple pathways
- Individualized levels of care are necessary - everyones journey is different and MN has various programs to accommodate to client specific care
- Multiple Pathways of Recovery; MRC offers 'All Recovery Meetings' for those that don't necessarily want AA/NA specific meetings.
- We have multiple programs that treat woman and children.
- Shifting towards more person centered
- Continuous care is acknowledged as vital to long term recovery
- We offer supports through recovery centers,case management,peer support, and telehealth services including online support groups.
- Pre treatmet beds

What does Minnesota do that is unique?

- Variety of modalities to address substance use and mental health disorders
- Client centered client driven approaches.
- Coming from WI, the different civil committments and competence processes
- Amount of treatment programs and detoxes
- Individual centered care and quick access to treatment.
- Availability of services to people who can't afford treatment
- Has the most treatment centers
- We have several throughout the state but the largest syringe exchange in North Minneapolis. Free and person centered.
- INSURANCE ACCESS
- A unique pot of funding that other states do not have.
- We have policy makers who are interested and engaged in making improvements to the behavioral health continuum of care
- State supervised, county administered human services.
- civil commitment
- Our states progressive approach to residential treatment
- Public Assistance Available to those that need it - compared to other states.
- Restorative court, diversion and felony restorative court, social services in the jails and workhouse, peer engagement and walk in support
- Direct Access
- Civil commitment and detox
- It is very easy to get public assistance
- resources
- Loads of Harm Reduction focused agencies/groups/philosophies
- Direct access
- "RE: Multiple pathways.
- RCOs, Treatment, Harm Reduction, Moderation Management, non-anonymous meetings, family support, justice-involved, families, veterans, mental health, peers, care coordinators, wellness pathways, fitness, options."
- We are working toward being more client-centered and giving care the client wants not just what we recommend. We are also moving more towards an interdisciplinary team working with the clients needs
- Offering of different programs. Abstinence, MAT
- Community is actual able to make contact with state staff for assistance.
- Direct access
- Options to reduce recidivism
- SBIRT
- Offering plethora of services in correctional settings
- We have a lot of treatment programs with different specialties.

- Creating a place for self directed are through direct access
- Very progressive in our approach to treatment - multiple tools and resources available to those that want support.
- Virtual support groups
- Expanding screening brief intervention and referrals to treatment (SBIRT) in 2023, a Medicaid benefit.
- Public assistance is better than surrounding states
- He are proactive to have SUD Summits like this!
- Quality training for LADC's, there are case load ratios and there are so many tx centers to chose from
- New Program - Dosage Supervision; utilizes behavioral modification (CBT, DBT, Motivational Interviewing) to identify triggers and establishes a plan for them to achieve success rather than punitive action.
- Narcan at release from state correctional facilities
- Dosage Supervision; working with drug court (Washington County started this in Nov 2020)
- MARRCH and state agency collaboration
- Produces an annual report on people being released to homelessness or near homelessness as mandated by the legislature.
- Virtual Meetings; specifically for out of state individuals who lack support in their own communities (LGBTQ community, rural areas, etc)
- willingness to work across agencies, with law enforcement and criminal justice system working with CBOs, RCOs, healthcare, behavioral health, social services, etc. to provide wrap around care for justice involved individuals
- Virtual meetings for people in rural areas or out of state.
- Co-Occurring Training for Mental Health Providers and Dual licensed providers
- More access to care for those in recovery and the LGBTQIA+ community.
- Im not entirely sure about other states, however we have multiple Specialty Courts, not only Drug Court but Mental Health Court, DWI Court, ETC.
- Medicaid covers a majority of treatment facilities which allows a significant amount of options for those in need of recovery services; they have the ability to choose what's a good fit for them.
- Treatment
- Destigmatize MAT and improve access for MAT.
- Direct Access
- Destigmatize MAT.
- Another Naloxone resource https://nextdistro.org/naloxone
- Additional community-based services: ARMHS, mental health TCM, in-home psychotherapy, and virtual diagnostic assessments.

What does Minnesota do that others want to copy?

- all of it hopefully!
- Drug Court
- Harm reduction services
- Access to services and variety of services.

- access
- Multiples kinds of court drug, VA, family etc
- Financial support to treatment
- Bring in external peer recovery specialists form RCOs into our jails
- Medicated Assisted Treatments
- POs, tx and drug court working together
- Our specialized funding stream. Multiple access points to treatment.
- My instructors at UW Madison say there are more incentives for treatment providers in MN
- MAT programming
- Address all co-occurring aspects of treatment
- Harm reduction
- Forensic Peer Recovery Services. Integrating Peer Support Services into state incarceration facilities.
- insurance for all
- Minnesota nice. We want to help everyone!
- Health services release planning - holistic/health related release support at correctional facilities
- Felony restorative court, diversion, social works in the jails and in work house to address sud and mental health needs with support to return to community
- Person centered approaches
- Co-ocurring
- State funding options for SUD services
- Work done with peers
- Release planning sud services for incarcerated individuals
- starting to integrate SUD/MH programming/funding into our jail systems
- OERAC
- Medication Assisted Treatment for individuals who are incarcerated with substance use disorder
- Social Workers in the jail , LADC/SUD services and mental health providers in jail
- Variety of treament options and a willngness of providers to give clients that are difficult a chance.
- Cultural programs
- Destigmatize MAT and improve access for MAT.
- OERAC; Opioid Epidemic Response Advisory Council
- We have better funding than some states.
- Many churches who talk about addiction in sermons
- Treatment in jails
- “Drug court” and mental health court programs
- Bring in external peer recovery specialists form RCOs into our jails
- Pregnant women and women with children treatment facilities
- Using other modalities such as acupuncture, Animal-Assisted Therapy, etc.
- Programs specifically for pregnant women
- Advocacy and Legislation advancing Substance Use + Mental Health Disorders
- We are starting to address aces in treatment.
- Counties are working on a no wrong door approach to services and supports

- Echo Programs; Trainings for providers - Native American specific programming
- MAT and MAT navigation programming in St Louis County jail
- Trauma informed care
- Understanding this is a family disease.
- I didn't answer it, but the use of accelerated resolution therapy in programs
- Trauma Informed Care = Person Centered Care; training for all staff to recognize individual experiences that they may have in their past
- Programs for mothers with children in their care
- Educating all staff on trauma and looking at various curriculums to use in programs in order to treat those with existing trauma in best ways possible.
- Identify SUD as a disease and mental health issue and removing the stigma
- Animal Therapy to support trauma informed care
- Commitments for CD
- National Leaders; Hazelden Betty Ford, Mayo, U of M, etc. We set the standard for incorporating a variety of models in the industry with leading providers.
- Recovery groups
- Progressive state - open to funding new ideas

What key resources are available that provide an advantage for individuals to connect with their communities?

- telehealth
- PRS staff FOR SURE!
- Peer support
- telehealth
- Findhelp.org
- FastTracker
- MARCH-Recovery Walk at the Capital
- Recovery community organizations
- Crisis Centers, warm lines
- Treatment coordinators: people who know what's out there locally
- 211
- Re-entry services within the jail
- Virtual options for meetings, medical, trainings, etc.
- Pathfinder
- Zoom meetings, telehealth, mobile assessments
- 2-1-1
- ONLINE MEETINGS
- Direct connection to peers and specialist in mental health and addiction
- 988
- Telehealth

- direct access they can go where they want to not a prescribed location
- SUD treatment coordination/case management provided either by counties or private treatment centers.
- RCOs
- Rcos
- Drop in support with no wrong door
- Support meetings
- Culturally-Specific, Person-Centered Care
- Minnesota recovery connection, recovery, community network, Alcoholics Anonymous resources, online narcotics, anonymous online.
- Virtual addiction clinics where patients can meet with LADC's and CRRS's. It's very beneficial for those in rural communities and those who have jobs or children and can't make it in a classic inpatient.
- Fast tracker
- Direct Access
- Certified Peer Recovery Specialists
- Jails and prisons have opened up various methods for inmates to contact family/supports as well as service providers. ie Jpay, texting, 800# access/toll free calls to providers etc
- SSPs and Harm reduction mobile pop-ups
- Online, on-demand assessments and access to services; peers who can walk with the person to navigate resources and remove barriers, help with access, and build recovery capital.
- Churches like Eagle Brook or Union Gospel that offer support
- assistance and knowledge within the county to refer and coordinate for those seeking help. Even though we are not able to complete Rule 25s individuals still come to us to get in the door
- 988
- Community outreach (encampments, warming hubs, etc) connecting the unconnected with recourses.
- Variety of Recovery Community Organizations and key advocacy movements
- Current support groups/meeting access, including cancellations and location changes
- Housing link
- The network of peer support groups, sober lodging, the large "recovery community". For example the MN Twins even have a special "recovery night" game.
- Community Health Workers, Case managers, Care coordinators
- Virtual
- Peer support. Warm handoff for individuals reentering from incarceration.
- Collaborative Care
- Support from medical providers in the community , outreach teams, and online options for care
- Non-"Anonymous" meetings
- fast tracker isn't a good tool
- Mobile Crisis Response Teams
- Fast Tracker; online resource for providers to update bed availability. However some barriers exist - information isn't always updated accurately.
- Emails from providers about openings

- 988- Access to crisis/mental health services
- Youth Shelter App
- BCR
- Recovery Community Organizations
- Alignment resources in areas where people are actually housed or attending. Schools, Housing complexes, Shelters, Transition services, easy google for MN Insurance companies and treatment centers and treatment centers
- direct acess
- The metro area has a substantial recovery community which appears to make it easier for people to get jobs due to less stigma.
- ER recognition of mh/sud needs
- Alternative response to 911
- sober living
- MASH
- Peer Support and Re-Entry Services for individuals who are incarcerated
- Case managers at counties collaberting with treament or families.
- County provider meetings
- Mobile MAT (YourPath)
- ARMS workers
- Behavioral Crisis Response (BCR); Alternative response in Minneapolis to 911 where social workers respond. Call 911 and you will get directly connected to them through dispatch. (some counties have adopted this, some have other similar programs)
- Ability to expand credentials for Certified Peer Support Specialists
- Brainerd Area has a very strong recovery community as well
- transitional sober living as a step-down from residential
- https://yourpathhealth.org/
- That is YourPath Health
- Crisis housing to people accessing residential treatment
- Your Path; online forum to submit request for assessment online /text message. Receive services within 24 hours. They also review assessments and connect to services.
- I work for YourPath, it is an incredible team that ensures clients get the care they need quickly helping then with what they need and what is helpful for their personal recovery.
- Growing Recovery Community in NE MN
- County Social Worker Navigators
- State starting to acknowledge and factor in the lack of resources in rural Mn. And distance between resources in rural Mn
- County Provider Meetings - a number of treatment providers from the area included - it's an opportunity to connect, share updates, status, etc for visibility of available local services. (includes law enforcement and other local officials)
- Pre-treatment beds, Brandy Brink, Mankato WECovery; Docs Recovery House
- Naloxone Access Points (NAP sites)

- Minnesota Recovery Connection
- Sober Living Houses
- ANY Recovery Community Organization
- Ability to request overdose prevention resources and receive them via mail anywhere in the state.
- "http://www.docsrecoveryhouse.org/
- https://beyondbrink.com/pre-treatment-housing"
- http://www.docsrecoveryhouse.org/
- "Beyond Brink
- https://beyondbrink.com/pre-treatment-housing"
- Pre-treatment beds; recovery center for those waiting to get into inpatient (release from jail, transition to sober housing, etc) - located in Mankato funded by GRH or self pay with funding options available for those who are unable to afford it.
- "Doc's Recovery House
- http://www.docsrecoveryhouse.org/"
- Pre treatment beds cont. - CPRS on staff to meet with individuals
- Leave Behind Program with Hennepin County EMS (leaving behind naloxone on 911 calls)
- MnPRA
- Fentynl strips, Naloxone, Steve Rummler
- Nalaxone/Narcan Access Points
- Test stips
- Clean exchanges, supplies, harm reduction
- SRHN request on their website and will send resources to anyone throughout the state for anyone who may not physically be able to go and access resources. https://steverummlerhopenetwork.org
- RAAN
- https://www.health.state.mn.us/people/syringe/ssp.html
- In N Out Syringe Exchange
- https://rainbowhealth.org/community-resources/syringe-exchange/
- RAAN - Rural Aids Action Network; HIV testing, needle exchange, fentanyl test strips (Mankato, Duluth)
- "https://southsideharmreduction.org/
- Southside Harm Reduction"
- The Pink Cloud, Pets!!
- Pink Cloud Foundation - funding for sober living, help keep pet while going to treatment, storage units, etc.
- https://pinkcloudfoundation.org
- NEXT Distro. https://nextdistro.org/minnesota
- "The P.A.R. Program is the Rochester
- Police Department’s effort to provide
- non-arrest pathways to treatment
- and recovery for individuals struggling
- with substance use disorder in our
- community. Drug addiction within our

- project turnabout has all levels of residential care as well as IP gambling program
- Providers offering treatment inside correctional facilities
- Twin Town and Douglas place taking sex offenders
- helping people get medical assistance or prepaid health plans to have insurance coverage to get medications

Maybe a focus on Minnesota is too broad, can you think of the work of a particular provider, program, or service that you consider to be a success?

- Recovery Alliance Duluth
- Nuway and offering to help pay clients sober housing
- Harm Reduction Sisters
- HCMC addiction medicine saved my life.
- Restorative courts
- Providers that welcome those with recent incarceration and significant criminal histories
- Several Providers in the state also offering gambling treatment
- MARATP. Minnesota alliance of rural addiction treatment providers.
- Alternative meeting like SMART Recovery and All Recovery Meetings for those who do not find NA beneficial.
- Harm reduction coalition
- They are pretty new- but YourPath. They are filling the gaps for people in recovery, especially those with OUD
- In n Out syringe exchange, we are the largest syringe exchange in the state. We offer supplies, works, wound care kits and resources in the community.
- Wellcome Manor and New Hope
- YourPath
- CCBHCs
- Project Turnabout- excellent work!
- Center for Alcohol and Drug treatment in Duluth. Have the withdrawal management/ detx and OTP programs
- Recovering Hope in Mora
- Reset jail program in Beltrami County
- Quick access to assessment and services at Nystrom
- YourPath, WECovery, MRC, Mission Restart, Pathfinder, Anchor Recovery, Reentry House (crisis beds) People Inc.
- Vinland National Center
- SOAR Career Services
- Treatment courts
- Providers that serve those with extensive criminal histories such as sex offenses, violent crime, arson charges
- "Steve Rummler Hope Network
- Pink Cloud Foundation

- RAAN
- Docs Recovery"
- Pine Manors in Nevis, MN - huge shoutout if you need a 28 day program
- Native American treatment at Fond Du Lac
- Incorporating Direct Access and ASAM criteria is helping clients get what they need quicker and removing some barriers. Education for providers and clinicians on ASAM is also going to help our clients be more successful.
- Wellcome Manor, Recovering Hope, programs for women and children
- Project Morning Star. Sober Living Homes in Worthington MN
- "Housing for Men and Children, with SUD treatment
- https://www.fellowshipsoberhouse.com/
- Fellowship Sober Housing/Program"
- Dakota county jail MOUD program. Suboxone induction in custody, Comp assessment, referral to Tx and community MOUD resources
- Olmsted County: Docs Recovery House; Recovery Is Happening; PAR (police assisted recovery); social workers embedded with law enforcement; Olmsted and Dodge county Drug Court
- Project Turnabout!
- Hennepin county jail and other jails that provide MAT
- ANY residential program that takes sex offenders: too few of them - we need MORE!
- Integrated access team and direct access support in jail
- MARATP, MAARCH, DHS working together in an open, honest, transparent manner
- Alina Virtual Addiction for those who cannot make it to a classic treatment. It's an amazing option for those in rural areas or those who have many responsibilities but are still seeking help for SUD. They meet with LADC's, have groups, and a CPRS.
- MnPRA - providing PRSS to the community including Hennepin county.
- https://www.health.state.mn.us/people/syringe/ssp.html
- Know the truth
- MAT Navigator and new Behavioral Health Jail Team in St Louis County Jail
- Christian Family Solutions high intensity dual disorder outpatient
- Beltrami County Reset Jail Program - short term case management, provide resources, keeps them on positive path while incarcerated (started a little over a year ago)
- Transition from jail to community
- Olmsted County Housing stability team; The Landing https://www.thelandingmn.org/
- the Police Co-responder model
- "Expanse MN,
- https://expansemn.com/"
- Anoka County Workhouse - Grant through state of MN. Program supports those with violent crimes/history use in order to prevent them from parole violations, return to custody, etc. Continue to follow up with services upon release.
- Drew Horowitz intervention services
- ARHM's workers that meet people in their homes for those with agoraphobia or intense social anxiety.

- Mayo Rochester Genrose mental health
- (Anoka County Jail) Criminal Justice Jail Calls - Peer to meet with them for 20 minutes a week using lived experience and provide resources
- Pen Pal letters for people in prison.
- ARMS Workers - meeting in the individuals homes
- Hennepin counties criminal justice and jail work
- Hennepin County - preparing to get peers in the jail
- Mobile assessments
- Crisis Services and having both peer recovery specialists and peer specialists in mental health settings.
- Peer Services and the broad range of specific advanced credentials that expand on professional development
- Anishinaabe Endaad - culturally specific service
- DART; diversion and recovery team. The behavioral health center at 1800 Chicago
- https://www.knowthetruthmn.org/
- Sober schools
- Telehealth Assessment
- Expanse MN. Very progressive organization supporting multiple pathways, including psychedelic support, therapy etc.
- Know the Truth; Prevention Presentations provided to Middle and High School students by young individuals in recovery who share their own personal stories. Also offering Youth Peer Support Services for 1:1/group support. www.knowthetruthmn.org
- Jail re-entry services state-wide.
- County pregnant using motgers case management services
- (MRC) Pen Pal letters - helps individuals find and access services while in prison, continued engagement upon release
- https://thephoenixspirit.com/resources-2/minnesota-recovery-high-schools/
- The Northeast Regional Corrections Center (NERCC)
- Sober Schools - PEASE Academy
- Pregnant using Mothers Case Management Services; working with peer support, mental health services, etc.
- Change in reporting laws for using g mothers receiving services has been a positive change
- Every county has to offer some sort of intervention or outreach to pregnant mothers that are using - can look different in every county
- Yellow Line - Blue Earth County
- WELLNESS IN THE WOODS. https://mnwitw.org/
- Virtual Peer Network, Wellness in the woods.
- Yellow Line - Officer Involved Care Coordinator Program through Blue Earth County. Street Level Referrals, pre booking/post jail resources, etc. Mankato Police Department, Blue Earth County Sheriffs Office - street outreach collaboration team
- Police embedded social workers
- "VPSN

- https://mnwitw.org/vpsn
- Virtual Peer Support Network"
- https://mnwitw.org/
- Wellness in the Woods; Virtual Peer Network - offering peer support line, trainings. Mental health, SUD resources
- All Peer Network, Peer support alliance
- Equitable access

Why does that provider, program, or service stand out to you?

- creativity, flexibility, person centered
- Person centered, MI approach
- harm reduction model
- Quick entry into services
- person centered
- Great communication.
- Equitable access
- reduces barriers to care
- Providing transportation.
- Person centered approach, collaboration with other providers
- Brings services to the person- not making a person search for services on their own
- Their counselors ACTUALLY send progress notes.
- Creating space for new thinking, new ways of doing things and looking at the holistic pic of the person and environment
- Outstate mn resource
- MARATP looks out for the needs and different challenges in rural Minnesota vs. the metro.
- They saw a need in the community and started a grass roots program to meet the needs.
- Resource Broker for anyone in need of help finding services.
- ditto the progress notes comment!
- "Wellness in the woods, remote services, and virtual support, SUD & Mental Health
- YourPath, for that on-demand, I need help now service
- Pretreatment beds, FOR SURE!
- Spaces for people to just get healthy, overcome crisis, so many good ones in MN"
- I work for In N Out, and strive to make participants comfortable and able to talk about their SUD- which helps us better help them get care/ know the current trends of drugs coming into the state.
- Telehealth because we don't have very many treatment programs in our rural area.
- Open to all Minnesotans; does not matter cultural background, socioeconomic status, criminal background, etc
- Virtual Addiction Clinics stands out as it’s a valuable to anyone and breaks down many barriers one may be facing to get treatment for their SUD.. it’s very flexible and can bend to meet anyone’s schedule.
- Progress note, returning phone calls

- Provide services for adolescents in rural MN
- Understanding the importance of drug court (rare)
- Programs that have been successful with us are ones that respond in a timely manner and do not send to someone else
- Preventative care
- Not just trying to fill a bed; but help the person.
- Collaberation with treatment courts and treatment coordinator.
- They work past the barriers of transportion and have thorough communication
- Follow-up with other providers and with clients
- Willing to collaborate; think outside the box to help people connect to resources and services.
- Ability to respond quickly, efficient and effective communication - not being passed through to others or given additional phone numbers to contact.
- Programs that start discharge planning the day a client arrives in treatment.
- Collaborative Care - Ensures No One Is Left Behind
- Virtual Addiction - breaks down barriers that someone might have to access treatment. Not a rigid structure and can fit individual needs.
- Same day assessments; transportation assistance
- Housing support
- Willing to break barriers and advance recovery advocacy
- They work well with treatment court
- MBH has 633 beds across the state of MN. Direct Access, provides a Comprehensive Assessment upon entry or via tele-health. Transportation is always available anywhere in Minnesota. One number to call our ACCESS Team 877-367-1715.
- Quickly adaptive to changes in the client and service environment
- Housing Support - having basic needs met so individuals can focus on treatment
- 1115 email response time, they are prompt
- Programs that actually send out discharge summaries!!!!
- T
- Support of MOUD/MAT
- "Reset Program - collaborations with community partners.
- Recidivism rate was reduced in 2022 with the help of this program and other partners."
- "Pathfinder - They connect our organization with our outreach and overdose teams, and MAT sites, and they help us prevent death and have services
- https://www.pfsbc.com/"
- Progress notes; difficult to get notes from providers without constant follow up. Barriers with Providers caring about client drug court needs/program.
- Programs that let you know client showed up
- Providers who are doing assessments and seek out collateral input.
- Programs needs to work with PT to get on medical assistance to ensure access to medication during and AFTER treatment
- Rural counties process MA/GA applications quickly

- Pathfinder - connect with LADC/CPRS and attend meetings for those in rural areas or those without transportation resources. Can 'check in' how they're feeling that day so providers have background on how they're doing that day.
- Providers that have workforce stability.
- Feels impossible for providers to do PO jobs while trying to help a client
- https://www.aadistrict1.org/
- Harm Reduction facility - doing best to help clients but very small step by step. Oftentimes being confronted by PO's that any ONE misstep will result in return to prison, in patient, etc. Even if showing big progress, not always a lot of flexibility
- Benefits
- opportunity for change
- Openness within this forum to be strengths based, we could all find something wrong in our system. These 2 days are to build on MN strengths which will inevitably bring up weaknesses and move them to strengths

What 5-8 things would you consider Minnesota's greatest strengths?

- Benefits
- Treatment Courts
- Services are accessible and often free.
- Medical Assistance/health care access
- Treatment courts
- Growing access to peer recovery support
- Access to state resources and benefits
- multi-disciplinary collaboration across professions
- There is movement in legislative support for sud needs
- access to treatment services
- creative programming; insurance access; major medical providers
- Availability of treatment programs/healthcare providers.
- Actively changing the system to fit needs
- Funding options for MN residents
- A lot of resources in the community for treatment and support at different stages of MH and SUD recovery
- Person centered
- Drug and Mental Health courts
- Jails being more open to MOUD and MAT
- treatment options, prevention efforts, person centered, wraparound supports,
- Willingness to collaborate
- Work with bail reform, warrant forgiveness and working with the bench on understanding sud and mental health
- "availability to be released from jail to go to treatment (sometimes many times)
- treatment programs within prison

- PO's who want to help client's succeed vs punitive reactions
- collaboration with multi-disciplinary teams"
- Continuing care, tx does not end after 28 day residential
- Person centered care, non-punitive options, MA., non-stigmatized MAT, peer recovery support, progressing our system to be health focused, not punitive measures.
- Our direct access policy for anyone to enter a recovery program
- "Expansive social services
- Drug Court/Diversion programs
- Numerous treatment programs/approaches
- Funding for low/no cost treatment
- Utilization of stages of change model"
- Having these continuous discussions for implementation - making effective treatment more available
- Staff that care for clients, drug court, OTP programs, direct access, harm reduction outreach and all the treatment centers to choose from
- LGBT programs/support for LGBTQIA community
- Multidisciplinary collaboration, insurance access, ongoing improvements
- Many treatment programs to choose from with different specialties
- Treatment courts, willingness to change and challenge the system to improve, open forums to discuss, dual disorder treatment, peer support and treatment coordination, rcos, sober housing
- Trauma centered care.
- Counties working with opioid settlement dollars to meet needs in their area.
- 1. Access to Care 2. Collaboration 3. Peer Recovery Support 4. Treatment Court
- ROSC
- sober supportive housing
- 5. person centered/client centered approach 6. multidisciplinary collaboration
- Consolidated funding
- Recovery Oriented System of Care - ROSC
- Data MN has a comprehensive data collection that is superior to other states.
- same day funding for people who meet eligibility-no other benefit program has this type of access.
- continue engagement with stakeholders
- 8. Evidence based practices and data collection
- DHS opioid dash board
- MDH - Opioid Overdose Dashboard https://www.health.state.mn.us/communities/opioids/opioid-dashboard/index.html
- MDH Naloxone Data too
- DAANES
- Data; trends, areas struggling, rise of certain additives

Law and Policy Opportunities

What is the community asking for related to this topic?

- Safe Youth Sites - Specifically for opioid use disorder to prevent overdoses
- Safe use sites.
- Equity
- "Peers
- They need to be able to work and make a liveable wage. They have to be able to work across multiple SILOS!"
- How will policy and treatment shift if/when cannabis is legalized?
- More options for adolescents
- Housing resources
- No legal action for transporting needles to exchange.
- Culturally specific programming
- Having the bench understand more about direct access and sud reform, how to support alternative ways to charge people
- More services and options for adolescents
- safe injection sites (aka overdose prevention sites); harm reduction vending machines
- Greater Minnesota needs to be factored in - accessibility to these sites (or other providers) in rural areas can be a barrier
- Housing
- More pre-treatment services.
- More drug courts. More transportation options. More public availability of Naloxone.
- More adolescent programs
- culture specific programs
- Warrant forgiveness and change to bail issues
- less transportation gaps
- Safe Use Sites; overdose reversal, monitoring - successful in NY City staffed 24-7
- For outpatient services, different times for groups because of varying work schedules and daycare needs
- Get rid of silos there is no shortage of people who need and want help. So if the large organizations would work together that would be good.
- Making it easier for people in recovery to get into the field - Streamline the background set-asides approval process.
- Better access to MAT
- Paperwork reduction
- More therapists to provide high intensity therapy.
- improved overdose response.
- Easy access to Naloxone
- Affordable and supportive housing

- I think there are lots of questions related to legalized marijuana and treatment
- Safe Use Sites; NY - 20% decrease in overdose rates
- More psychiatrist trained in addiction.
- More alternatives to traditional court process
- FAMILY SUPPORT
- Housing
- in more rural areas - increased access to MAT
- Re-Entry Services for individuals who are being released from incarceration
- Detox access in rural MN
- Better support for clients who relapse in sober living
- better communication with Judges, Corrections and the legal system. I think information isn't always communicated to those parties.
- Resources to help with program planning at a local level.
- Support around stable community resources that are open to active use while working through treatment and support or harm reduction
- Un-housed individuals and outeach/resources for these individuals
- Client wish to chooses the level of care. Not too many of our OTP clients want to go to IOP or residential programing. Some do not which to stop using but be safer, healthier and have some supports.
- Low threshold, easy to access, person-centered support to access resources and services
- Mental health supprt
- Low threshold housing; minimum rules about use, background history, allowed behaviors that would create a barrier to those who need housing.
- Sober Houses that are managed appropriately.
- Transportation
- Removing detox as an option for keeping commited cluents waiting for weeks or months for treatment. We need a better option.
- more harm reduction with housing and not kicking people out who do use but providing safe setting with increased resources to access for recovery /sobriety /treatment, etc
- Transportation, especially on rural areas
- Tenant rights within sober homes/recovery residences.
- More residential treatment centers in central and northern MN
- Changes in treatment courts on sanctions and advocating harm reduction
- LGBTQ Youth Resources
- Treatment and housing options for individuals with children
- Culturally specific programs
- School-linked SUD services.
- Get rid of the revolving door that treatment centers profit from use peers!
- Changing that all services have to be goal directed and that this can be about life style change and harm reduction
- Medicare coverage for more SUD services.

- Less prescriptive treatment plan inclusions by DHS. This creates coolie cutter treatment services and treatment planning.
- 100% emergency department participation in MAT bridging to an office provider
- DHS Legislation - pushing for less reviews, required hours, etc. for documentation. 1115 as it relates to the level of care needed per client
- Ability to stay with one provider the entire time, not switching from Residential, to IOP to step down, to nothing
- Immediate mental health support in jails, more comprehensive for people who know how to work the system
- MORE ACCESS
- Treatment providers that can support people with complex medical needs and detox that works with medical needs
- Access to withdrawal management in rural MN
- Increase reimbursement rates for SUD providers, in turn creates higher paying jobs
- A lot of our current laws don't allow someone who is a mental health therapist to complete some of the basic forms (expand licensing requirements for comp assessments, etc)
- Rate Reform
- Reimbursement rates for assessments need to be increased.
- Incentives for NPs, PAs, and MDs to become waivered (insurance or licensing fee reductions)
- Increased pay for LADC's. Offering incentives to students to enter the field.
- student loan forgiveness. making alternative therapies like equine and yoga reimbursable
- The shortage of LADC's could be addressed through allowing formerly rule 25 assessors with say 5+ years experience to do assessments again.
- Understanding of people who have Rule 20 charges and their integration into community programs. Many are denied as soon as they see they have Rule 20
- Incentives/requirements for health systems to have MAT/MOUD programs
- Filling educational, skill, and technology barriers instead of punishment. More people, more support, person center, better support in jails. More prevention and education
- Allow office-based MAT to be billable to the behavioral health fund
- Better access to Methadone in rural MN
- Reform the societal views on jail/prison system with a focus more on rehabilitation.
- Accommodating to client requests for lower levels of care (starting school, work schedule, etc)
- More collaboration LESS EGO
- Have a different internship threshold for an LADC who is just going to be doing assessments v. doing group's in a clinics or treatment setting.
- A review of culturally specific program and training.
- Medical marijuana vs recreational marijuana for clients; benefit to those who are looking for pain management for those using opioids for pain and became addicted
- Peers able to work across all settings
- Clients are reporting difficulties getting assessments done (long wait times) since the change to Rule 24. We need a solution to the loss of assessors when Rule 25 ended

- Psychiatrists and Primary Care Physicians trained in SUD
- There has been no detox in Brainerd for several years. Closest is in Nevis.
- Being assigned to a peer MONTHS before release to PREPARE for reentry
- Inform the bench/courts - lack of understanding in harm reduction acceptability. Should not be basing these success rates solely from UA's
- This community is asking for educating the bench and the stakeholders in the CJ system to see SUD for what it is and start utilizing treatment v. criminalizaiton.
- Review low level drug charges that are bringing individuals back into the revolving door of incarceration
- Allow insurance and the behavioral health fund to be billed in jail for MAT and treatment services
- Prevention services in schools to support cd and mental health. Helping support these kids so that they can graduate. Reducing may risjs for theur future
- Quick access to care, and multiple modalities for conducting assessments.
- Individualized care has improved but has a long way to go.
- Counties need to utilize veteran staff who formerly were able to do assessments. They now cannot do assessments and it is a huge waste of talent

Do you see any alignment with strengths related to (breakout topic) and the identified community needs?

- Not a ton
- collaboration and education
- More access to safer supplies and less charges for minor charges (carrying used needles, petty drug crimes, etc).
- Quick access to care and multiple avenues for assessments (in-person/virtual).
- Individualized care can be more specific and restorative than punitive.
- Would like to see less criminalization and more treatment availability; change frame of mindset for how we're dealing with SUD in criminal justice system. Can't 'jail' our way out of SUD or MH.
- Access for people with ID to SUD treatment
- Change qualifications that meet treatment court levels; still only high-risk and high-need individuals which are screening out a lot of individuals that need support
- there is more need /demand then there are providers and complexity of people seeking MH and SUD is intensifying as well .
- expand restorative practices- involve communities and informal supports
- Relapse is punished in the criminal Justice system when it is part of managing this disease (unless you are in a specialty court)
- DWI legislation as it relates to marijuana legalization
- More court orders for programs providing individual care and curriculums that gear there energy towards healing, mental health, ICWA, substance use, and trauma informed care.
- Other therapies included in drug court (yoga, equine, etc)
- Too much focus on completing a 30-60-90 day program as a checklist item without getting to the root cause

- SUD and Elementary Age; students kicked out of school at a young age, specifically students of color. We talk about barriers for adults but the criteria for receiving services in the school system is significant, which subsequently impacts adults
- Just because a drug court program is provided, it doesn't mean that it is able to meet the need of the individual (i.e. culturally specific)
- Allowing culturally specific programs to identify what 'culturally specific' means for their community. Also need to create a space for these smaller programs to get their foundation build/funded to meet the needs of their community
- The strength of viewing SUD on a continuum and that client's needs may change may be lesser or greater at various times in recovery is lost on the CJ system. Behavior is punished and treatment is postponed.
- How are your counties appropriating the monies coming from the opioid settlements?

What are key areas of untapped potential for the (breakout topic)?

- Start up costs
- We need more programming, it is related to client centered care, we can't force people into a box and call it client centered or culturally specific.
- Addressing Rule 20 so that someone treats to compency.
- Making sure the right people are around the table to have a fully integrated team of professions invested in these issues
- Consumers - talking to those using the services
- creating a process for external people to help support jails in getting clients assessments in a timely manner and helping them get into treatment/towards recovery
- counties employ many staff who were Rule 25 assessors who can no longer complete assessments. They have significant knowledge and expertise that should continue to be tapped into
- Mentors to help people start up program's.
- There needs to be input from rural areas as well as metro. Both need to be invited to the table because strengths, needs and resources are very different
- Understanding what client centered and trauma informed really mean - not just falling in line with the "buzz words"
- Diverse workplaces - focus on bringing those from culturally diverse groups to have a voice in these arenas to share their needs and provide insight/feedback on how to best overcome these barriers that exist
- I work in the CJ system and have yet to meet a client in need of treatment that doesn't have some form of trauma. Just as most treatment programs have moved to dual diagnosis treatment, it might be beneficial to add trauma informed care to SUD tx.
- Representatives from each community
- Collaboration
- Court/Criminal Justice - need for peers in the jail system to work with public defender offices, county attorneys, can bring perspectives and diversity to these teams

- We have so few culturally specific Latino programs clients with these needs are falling thru the cracks since few will take them with the language barrier
- More residential treatment facilities that can accommodate non English speaking individuals. So many roadblock, barriers and very few resources.
- Providing treatment to the family by offering services and resources in the home and to learn how to support them as a whole.
- Treatment services provided in criminal justice settings. Along with funding for these services.
- trust needs to grown between communities
- Collaboration
- Collaboration efforts; treatment records, privacy, need to know basis, etc. This takes time to establish streamlined processes and an understanding of each parties needs
- We all need to stop being protective of our company and remember that everyone in this field wants to work together versus this treatment versus that treatment... facilities and programs need to be open to working together
- Role for State Agencies, Role for Non-Profits, Role for those in the community = too often the change we are talking about isn't fully engaging others in the process and expanding the reach through strategy discussion and implementation
- Early intervention is crucial. For example, 1.7 million students are in schools with police but no counselors. Schools are that offer mental health services are grossly understaffed. Schools with police but no counselors. Some school social workers/c
- cont: workers/counselors report that they manage 600 students.
- Use of 'Core 4' - person centered thinking, motivational interviewing, positive behavior supports and trauma informed care
- Better collaboration: if referral sources get progress notes/treatment plan's promptly, they can be more proactive with the client going forward and can help with discharge planning
- Unopposed judges in elections; town hall/community inputs
- things just take forever to get implemented. we have great ideas but years to get those ideas going. disconnect b/t private and public sectors.
- Peer Recovery Support in the jails/prisons
- I would like to see OTP/methadone programs to separate to our own statutes. 245g is only retro fit to OTP. I know may disagree and the the approach to care is different in harm reduction and so should the guidelines. In this we could expand the work
- Create programs that provide social activities for at risk children with postive role model adults.
- Learn about what other's recovery looks like; providing individuals an opportunity to connect with those who may have a similar story
- Legislative change to allow social workers or MHPs who (formerly) could do Rule 25 to be able to do Comp assessments. This is a huge waste of talent and has resulted in more workforce challenges due to lack of assessors
- Restoration of voting rights for felons
- adolescence is a huge issue and resources very limited prior to age 18. addiction can be well established before they turn 18.

- Let therapists provide education about cd and mental health to students verses teacher's.
- Peers peers peers
- informal supports, restorative circles

What community partnerships would lead to greater success?

- Emergency departments
- Peers in the court system.
- allowing additional partnerships to help support in jails
- Emergency Departments working with external people to support the continuum of care
- Health System with Law Enforcement
- Collaboration and DHS providing education and support regarding direct access, harm reduction, person centered mindset, client choice, etc.
- Local emergency rooms actually listen to PWID when they are sick instead of just brushing them off as drug seeking when they need help.
- Mental Health and Drug Court a standard
- Harm reduction centers allowed to be safe used sites.
- Embedding social workers in public defender office, city, county attorney and district court to get up stream of people needing support
- Working with churches,counties, courts, and treatment centers, rcos to collaberate.
- Treatment centers tapping into local mental health providers, contract with them to come into the facilities
- Primary care clinics - especially in rural MN, this may be the only medical provider a person sees.
- Better connection and communication with the Bench
- health care providers; law enforcement; SUD agencies; schools; peers in recovery
- ED's to have education and readily available resources so post-overdose or SUD incident they can make an immediate appointment with an SUD or MH provider
- Partners with DHS, Healthcare, Law enforcement, and MDE. Alignment of resources
- We need more beds for inpatent mental health.
- Rural harm reduction partners
- One person to support them through all services. PEERS
- Participant denied care in ER for an infection because they were written off as 'drug seeking'
- Amy D- Policy. Make these things happen-
- Cycle through ER - lack of ability to get individuals care. Not using Trauma informed care in the ER
- Duluth - Recovery Oriented System of Care; ED is calling a CPRS to meet with an individual
- VA needs to be committed to caring for veterans and providing SUD treatment. We have had individuals told VA won't pay for anymore treatment, been too many times. Veterans usually have too high income to get help with treatment if the VA doesn't take
- Some type of educational funding opportunities/collaboration to assist underserved individuals pursuing careers in counseling or mental health clinicians. I often hear so many complaints about the shortage of mental health providers in the community

- i think ER's are afraid to admit because they've been forced to keep people for long periods of time that really should be in a facility but there's no room for them.
- There is great stigma that exists in healthcare. how do we overcome this?
- HRSA has several loan repayment programs for rural providers.
- Interpreting services and residential programs.
- Veterans that need treatment and are being told they've used up their allotment because it didn't work in the past
- Peers and the way they navigate systems with people provide hope-
- if legalization is passed-having a percentage of profits support recovery communities continuum of care.
- We need legislation that provides access to treatment and mental health services.
- Inequities - Tribes pay for an individuals treatment because they've used up their lifetime allotment
- One of the hardest things is getting people connected with CADI and compressive case management with their county. They get screened out as soon as they say they they were referred from a methadone clinic. We have many people who are growing old and
- and on MAT, people who are struggling with cognitive impairments due to overdoses/head injuries/tbi and who are on MAT because their medical needs are two high for any residential care.
- Transportation for a variety situations
- Collaboration between treatment centers and CPS agencies
- Peers break down barriers, they can collaborate with providers, and advocate, if providers allow it.
- Collaborating with treatment and the courts. The balance between safety for community and providing services to the client.
- Local government units working with healthcare systems/mental health providers to provide local education about use and its consequences. I found with adolescents that SCARY stories don't generally move the needle, but education worked better.
- Ability to have an affordable wage to keep people in a field where there is burnout, passion fatigue, etc. that cannot afford their OWN treatment when they're in need
- What is the role for faith based organizations ?
- Financial capacity of supervision; shortage of board approved supervisors - 2 years to get licensed, 2 years for certification = how are we going to support supervision of influx in staff in the field
- DSWAP - Diversity social work advancement program. Funding options provided for education, licensing, etc. Need more awareness for these programs
- Grant funding is a process with it's own barriers
- Grant funding is great but there has to be a way to sustain the program beyond the end of the grant
- A lot of work to be done with the legal system and those from culturally diverse communities
- Allow virtual supervision for rural professionals seeking licensure. Perhaps the state could provide funding to clinicians to become supervisors and subsidize their work as most new counselors have difficulty paying for supervision.
- 1115 Waiver; methadone will have to be a part of peoples treatment, but rural communities lack ability to get these things easily. Stigma associated with some of these resources.
- work closer with schools to identify kids with high ACEs scores and get them extra services early

- Faith Based organizations - they have their own audience of individuals that they're strongly connected to
- We have someone in Pine County willing to start a methadone clinic and they are having challenges getting thru the red tape to get started. This would be an amazing resource in our community.
- Our syringe exchange is loacted in a church building that lets us rent space. They are a huge help in North Minneapolis.
- The irony is that research has shown that MAT/MOUD programs not only reduce heroin use but overall involvement in crime
- Restorative Justice; how do we make people whole in the community and make recovery successful in all areas of life. Faith - beyond organized religion, but addressing the spiritual element of wellness
- Child care, and parent educators who can mentor parenting skills
- Working with landlords and management agencies to relax their prohibition on renting to people with felonies and /or drug crime convictions.
- Transportation barriers - specifically for individuals being released from custody who need to get to treatment, sober homes, etc.
- Meridian Can Have a Van waiting for anyone being release, pick them up and take them to any one of our 12 programs.
- How do we make sure that assistance programs are widely marketed and made available to all individuals
- There's no 1 place to find information on all available resources; which leads to a duplication of efforts
- MBH provides transportation anywhere in MINNESOTA to one of out treatment programs
- We need to have more adolescent programs in MN.

What changes do you expect to see over the next five years? Where could we make a difference?

- We will see changes with who is in office and their priorities
- Expansion of MOUD
- Current change is to look at reform and diversion
- Reduced sentencing for non violent drug crimes.
- Balancing patient choice with professional recommendations and probation deparments.
- Harm reduction acceptance
- Marijuana legalization will open up a whole new league of problems.
- Policy doesn't always have a lot of connection to criminal justice. Person centered approach in treatment courts and education needs to be talked about. What does the current and future treatment system look like?
- Marijuana will be legal and all of the justice system and child protection will need to completely overhauled
- We could make a difference not only imbedding Mental Health Professionals but substance use professionals in police departments.
- Change to charging and support from legislation on change to low level charges
- Friendly housing options for people with felonies and drug crime convictions.

- People experience life holistically - how do all of these provider and departments work together to provide holistic care?
- Fund treatment courts and make them available to anyone around the state
- Changing and supporting better education for the bench
- SUD is a brain disease and not a criminal condition
- Need to have more adolescent programs
- Access/enrollment to economic assistance prior to release from incarceration
- Change to policing in communities to look at diverting people to other option than the ER or jail
- Make an exception to 245G to allow those who had been working in the field for decades doing assessments....to be able to do assessments again.
- Trauma informed care
- ED's to be required to provide SBIRT or SUD assessment to person when they there for SUD related issue. Which means ED's need to employ LADCs and not just social workers
- Change is standards on paper work to show persons need for support and change to licensure dynamics for professionals
- MAT/MOUD availability in every community
- We need to provide client centered care. We also need to find a way to do it safely. Sometimes the least restrictive doesnt work. Then we try something different. Client safety has to be our first priority.
- Department of Education - partnerships available specifically for working with tribal schools to assist those individuals and families in accessing resources
- Change to diversion for Justice involved youth with engagement with the family/ support system
- SBIRT should be required for all medical appointments, just like the PHQ and GAD.
- Access to programs does not require a lot of paperwork and gets to the people that need it
- Allowing the former rule 25 assessors to again complete assessments. This is especially critical in non metro areas as there are not enough LADC's to fill the role.. Many decades of experience is being wasted.
- Clarification for what is Treatment Court - all encompassing term for drug court, veteran court, DW court, etc.
- Treatment courts need to open up to more individuals involved in the CJ system.
- Standardized screening for SUD at medical appointments that isn't just "do you use any drugs or alcohol?". Medical providers need more education on SUD so it isn't taboo to talk about
- restorative practices with courts/treatment
- System change

What are the top 3-5 opportunities to work on?

- Collaboration
- Early interventions
- 1. Outcome based performance. How fast people get to treatment & quality of treatment
- Education and collaboration with the courts.
- Expanded access in rural areas.
- Adolescent residential SUD/MH centers. There are 2-3 month waitlists right now and kids are dying.

- 2. Partnership & Collaboration - a lot of missed potential here.
- workforce solutions that actually work
- aligning the strategy & approaches payors, DHS, MDH, DOC etc to create sustainable change
- Mandates in schools for mental health and Cd services
- Funding and change in legislation on how and when communition can happen to support access and coordination of treatment
- sober housing continuum to reduce people having to move from place to place-est roots and stability
- System changes.
- Peer supports in schools
- Trauma informed education and training in all areas of work
- Peers connecting them to each person, doing virtual and text/email services and making it billable, putting peers everywhere
- Issues with Medicare covering treatment
- Education to the criminal justice system on person centered approaches
- Access to SUD treatment for people with ID.
- restorative practices= informal supports
- Peers, peers, peers!
- 24/7 MOUD availability in 100% of the state's emergency departments, jail, and prisons as well as the expansion of office-based and OTPs
- Education to justice partners on information about direct access and sud and mental health changes
- clear legislation about accessing funding.
- Sober Housing management by peer support specialists that are not current clients at the home.
- More cultural options for SUD residential treatment and interpreting services.
- adolescence education-early intervention
- Dialogue to understand where others are coming from, identifying gaps and educating decision makers accordingly
- Change to paperwork
- Have some of the 17 B $ surplus go to expanding adolescent programs, cultural options, education opportunities for psychiatry. Stop blaming certain entities and take action
- reducing overdoses
- harm reduction approaches
- Safe Use Sites
- Rate reform
- Permanent funding base for SUD services in MN (like exists for gambling) tax that goes directly to support the services
- Making legislation more clear for behavioral health fund.
- Partnerships and Connection to schools, (MDE DHS, DOC). Ultimately people incarcerated go back to schools and the community and need the resources at hand. Streamline and align resources in business and schools.
- Look at funding for the entire continuum of care
- State run treatment centers that do not require someone to be civilly commited.

- One of the major struggles with the justice system is working with multiple sides of the court that absolutely don't communicate. i.e. commitment court, criminal court, civil court, rule 20s. It is incredibly overwhelming to navigate.
- How individuals are treated when seeking care in ER/ED
- Civil Commitments need to be addressed.
- Use this discussion to work with council on advocacy and reform
- There's a wealth of knowledge being wanted with rule 25 assessors who aren't LADC's. Change 245G to allow that again
- Providing on the spot SUD services to those presenting in ED's and educating medical professionals that SUD is a disease and you treat the person, not the behaviors
- This would include connections to higher education, funding and creating opportunties for approved funding or loan fogivenss for hard to fill postitions.
- hold orders need to be revamped to be longer; this may reduce civil commitments if people on holds in hospital are given more time to clear from substance induced psychosis and once clear may be able to make better informed decisions about treatment
- Decrease stigma in the medical community.
- Putting money through evidenced based programs rather than 'how they've always done it'
- We have been having those meetings in Crow Wing County
- Opportunity to have informed discussions at the local level (county commissioners, county boards, etc) A lot of these individuals simply aren't close enough to the issue to fully understand - we can influence the narrative about the needs for SUD
- When funding trickels down to each county, it's not enough to get a comprhensive program together. If they went by region and the counties pooled there funds, they could possibly get something up and running.
- Most people served have a myriad of outside systems involved (hospital/medical needs, criminal justice, mental health, etc.) and these systems all have a different philosophy on how to treat a person.
- sometimes viewed as a 'county problem' to provide facilities and services; but no money to fund these initiatives
- Provide equal access to grants/funding to for-profit providers.
- I work for a small county and continue to do comprehensive assessments and there is no discussion to disban the unit.
- I would encourage everyone not in contact with their County Public Health to reach out and get involved with their Opioid Settlement Coalition.

Law and Policy Aspirations

What is our community passionate about?

- Help high risk clients, easy access for clients, filling the gaps in the treatment continuum.
- Helping people quickly and effectively
- saving lives - bringing families back together
- Warrant forgiveness and bail reform

- Grow harm reduction services in the rural and frontier part of the state.
- Housing Stabalization Services, Re-Entry Services, Set-Aside + Background Check Process Assistance
- Curbing gun violence and open-air drug dealing.
- Providing more community supports to help clients engage in the community they live.
- Sanctioning and funding long term supportive housing for SUD populations
- Peer Support, Public Education, Advocacy
- Keeping people alive
- widespread access and education about naloxone/Narcan, increase access to other harm reduction services in rural areas
- Raising up marginalized voices
- Working as a team with other providers instead of staying separate, we're all here to help not complete
- Continuation of services being provided and expansion where we're able
- Supporting people in the community and providing more local services
- Helping find resources for people in need, specific to what is tailored to each individual.
- peer supports and other informal supports
- Improve collaboration around positive drugs screens who are in the criminal justice system.
- Changes to laws and more supports in legislation on money to support diversion
- Filling gaps in treatment continuum: transitions from levels of care, transition from ED to residential/IOP
- Providing mental health individual therapy but also skills to help clients cope, but DBT skills that are highly effective.
- Lack of detox beds in MN; needing more crisis/stabilization on both CD and mental health
- timely access to beds
- Reducing barriers to living a successful life (former incarceration, housing status, etc.) including the stigma of SUD
- Other options for not jail, not ER, not detox but other supports
- Clients not being able to access care because having both CD and Mental Health needs
- Greater access to comp assessments to those in custody
- Helping people discover what resources are available to them. A lot of folks may not know what their options are.
- Better pay for providers and support for compassion fatigue
- A lot of changes in SUD, adding community education to aid families to navigate getting help
- Better access to assessments in jails to quicken ability to release people
- Getting judges to release people instead of making them wait for treatment
- person-centered care
- Struggling to get funding in our jail for assessments
- More in custody SUD treatment programs.
- Overcrowded jail systems while waiting for referrals to treatment
- Eliminating Rule 25 assessors should be revisted
- Access, prevention, peer recovery, and peer support, education, reducing stigma, LANGUAGE about us.

- Getting people into treatment ASAP in spite of court oblig. Treatment is held hostage in the CJ system. Fears that people will get a lesser sentence if they are allowed into treatment prior to sentencing, is an obstacle.
- Acquiring more treatment programs and supervised living situations that will accept individuals with mental illness, other health issues/ comorbidity, etc..- need more options/ resources for people with complex situations
- Rule 25 assessors went into jails and did assessments and got people to treatment timely. This process worked great in the rural areas. There are now more issues getting access.
- Psychedelic and psilocybin research and treatment; emerging evidenced based practices for SUD, trauma, and other mental health disorders. Use Oregon and Colorado as case expamples on access to this promising therapy.
- Recovery Oriented Systems of Care
- Backlog cause - some courts do not want clients in treatment prior to sentencing
- background checks to get into facilities (prison, jails, workhouse) can be significant
- Hennepin Co - aims for 10 day turnaround on in custody assessments
- How can we get assessments schedule for those upon release, regardless of how long they've been incarcerated
- Department of Corrects ASAM program; re-entry, getting them assessed and connected to a level of care
- We also have Health Services Release Planners
- Hazelden Curriculum for Re-Entry (in partnership with DOC)
- drug and homelessness decrim
- Forensic navigators into jails (100+) by July - need clarity around implementation
- The statues often are not in line with what is actually happening... this needs to change.
- Harm reduction across the state - improving transition into and out of jail/prison, access to naloxone, well funding mobile health (like healthcare for the homeless), syringe exchange, overdose prevention centers
- CPRS oftentimes have backgrounds that disqualify them from going into the facilities to meet with those in custody.
- State Competency Restoration Board
- Supportive housing for people who use drugs that is accessible to people who have active warrants
- More funding and services for people who are actively using and are not ready to stop
- many counties and Rule 25 assessors worked with clients to choose where they want to go for treatment. there could have been a middle ground
- Comp assessments - fully implemented in July (related to direct access) so that more people are able to do comp assessments within treatment settings. Federal Gov waive client choice for where they can access services
- Direct Access - barrier - often times treatment facilities/areas are still demanding a level of assessment from referring party
- At Meridian, we have clients that walk in and we will do a Comp Assessment. If they dont have insurance we will help them fill out the MNsure insurance and then back bill the county or state

- Allow dosing for methadone in jails or prison across the state.
- Yes, we need more family resources and adolescent resources
- Lack of resources for people with children; particularly men to be able to have their children with them while in treatment or sober houses
- Housing available for children to join parents somewhere along the continuum of care (as applicable)
- Drug Screens - stigma around this
- Reducing Stigma on what 'recovery' looks like - it looks different for everyone.
- Sending a lot of people to Prison that need help - Kelly Mitchel Robina Institute
- All jails/prisons dose for those that want MAT
- Kelly Mitchell, current Chair of MN Sentencing Guidelines https://robinainstitute.umn.edu/meet-team/kelly-lyn-mitchell
- Vivitrol and Suboxone are available at Dakota County jail
- Robina Institute https://robinainstitute.umn.edu/
- Some people are having to drive hours one way to just to access MAT services
- Satellite MAT for rural areas
- Licensing to report yo director of SUD. And to use basic concepts of being nice
- Better wages and more training for peers.
- Actionable steps
- More Peers!

What should our future community look like?

- Collaborative between jails, probation, Peers, and providers
- More inclusive about bringing those in the field with life experience (but have background challenges)
- more inclusive with those who have SUD and having them work in exchanges/harm reduction
- Decriminalized drugs and drug use
- better communication and logical realistic flows for clients
- Change to how we can share information so change at legislative level on exchange of info for court and treatment needs
- Fully embracing harm reduction and harm reduction services - they are an essential part of recovery. People can't recover if they are dead!
- Increase in true harm reduction and not polarizing harm reduction versus abstinence
- Overdose Prevention Centers
- Change of documentation to not make so intensive to get people’s needs met
- Linguistic and culturally affirming SUD prevention/education, asssessment, treatment, and long term care policy and programming.
- Supporting the Syringe exchanges and the work we do for the community.
- Support not punish
- Grandfather in non LADC's that were doing assessments previously as many have decades of experience that is being wasted. This is hurting rural communities.
- Addressing deep disparities in MN - Black, Indigenous, and people of color die from overdose, are homeless, are incarcerated, at much higher rates than white Minnesotans

- Better communication between treatment centers and referring agencies.
- Better communication with stake holders and less siloed information
- Funding for harm reduction services is greatly needed. Programs can't sustain under current levels and there is no way to expand what is available, particularly in greater MN
- Set Aside process - very overwhelming for those having to walk through that process after being in stable positions
- Reach out to legislation to share stories (especially with set aside processes, etc)
- Emily Baxter has done some great work and written a book, "We Are All Criminals" and the collateral consequences of even minor records, just as the speaker indicated.
- Collaborative Re-Entry Services that link individuals with justice-involvement with community resources + eliminate barriers
- More to harm reduction in the courts as a valid in showing people making progress and helping judges and lawyers understand how this ma look and that success can be seen differently
- Treatment centers need to allow clients to remain on prescribed medications while in treatment. Many don't allow medications that can be abused .
- Safe Dosing Sites - have led to less overdoses, and progressively gotten them off of the drugs. There is a continuum of harm reduction and MN isn't very progressive in that area.
- Strengths-Based, Person-Centered, Trauma-Informed Collaborative Care
- TRANSPORTATION to support getting to from jail treatment and other services and supports in urban, suburban and rural communities!!!
- I feel like regulators need to be more collaborative with the SUD community. Its time for us to look forward to auditors coming in, for support, and not being fearful of our compliance. Yes, compliance is important (it is the base of client care) and
- MAT should have it own statutes for MAT 245g is a different modality then harm reduction.
- Clients getting off MAT on their own and going into treatment without proper tapering
- Review of treatment court information and how to bring in restorative courts and diversion courts
- Transform the Punitive Approach
- Look at this as a disease: non-punitive approach, multiple paths, inclusive to everyone, etc
- Support for harm reduction - evidence based model meeting people where they're at
- Syringe exchanges
- I would say that at times we do punish people for their medical needs as they are treated differently, doctors will not support certian treatments, it is just something that is not talked about...
- Services, services, services. We have used a hammer for everything and went away from rehabilitation. Mental health on every corner.
- Educate community on what harm reduction is, it's purpose and what it looks like
- Concept of what abstinence based looks like - harm reduction / MAT should be viewed in that same way
- Syringe exchange - this is where those currently using may be most comfortable. From there, referrals to harm reduction can be provided
- A better understanding of the interconnected nature of SUD, homelessness, encampments, HIV, overdose, etc

- Funding is a main issue to all of the resources that are needed. Currently a federal band for purchasing any supplies
- Cannot sustain programs without funding
- Increased availability/access to clients
- The funding has to match the urgency of the war we're fighting

What strategic initiative would support our aspirations?

- Mn has the worst race rate disparities in overdose deaths
- Streamlining RFP funding process and Opiod Settlement money toward harm reduction programs and strategies.
- Fentynal has been in NON white communities for YEARS now.
- Billboards, Social media
- Allocate dedicated funding to support harm reduction programs - specifically program supplies.
- We have a surplus in the state - but need to allocate that money to more strategies
- In service with our judicial partnerships
- Rural communities lack funding and education for these programs all around (justice involved, MAT, exchange services)
- Overdose Prevention Centers
- Harm Reduction spaces by and for people who use drugs
- Allocate more resources to support better funding for not just programs but for pay to staff
- Mobile MAT
- Continue seeking funds to support naloxone purchasing for overdose prevention. That funding allows programs to provide needed services, especially those disproportionately impacted.
- Consistent funding for Naloxone and Naloxone hubs
- Rural communites stuggle with transporation and education.
- MARRCH had/has a harm reduction committee that brought lots of folks together from different areas to discuss harm reduction. We haven't met since pre-COVID
- Supporting some culturally competent providers with funding to expand services to be able to really work with the specific communities
- We need more LADC's. More funding for education and try to pay LADC's better
- Creating a data and method driven backbone to overdose response and prevention. Many of us are operating without clear feedback on the impact that we are having. Collective impact models exist and would be helpful
- Support that many licensed clinicians in various areas can support treatment needs
- Grant funding a lot of times is dedicated to staff time and supplies but doesn't leave room for much else
- Our Beds would be full yet you dont have the staff to help everyone
- We would serve so many more people if we could expand our hours
- Mobile healthcare in general
- awareness
- More holistic approach treating individuals, families, the community making it more the norm than the exception,

- Taxes from alcohol and cBD sales going to treatment and education needs
- Stopping and or improving encampment evictions - the way they are done now increases overdose risk, hiv transmission, and puts people back at 'square one'
- People need to know the stats so they can mobilize
- Housing, MAT, needle exchange, other services easily available on social media
- Look at different options for LADC's. Lots of wanted experience by changing to comp assessments. Allow hours/years of experience to count for something. Change the requirements for who can complete the comp assessment at the county level.
- Workforce issue--initiative increasing workforce diversity, reducing provider burnout, adding incentives for LADC and paraprofessionals.
- Example: Steves law came about because people were passionate and it resulted in true action, which furthermore resulted in funding to support the work
- Making methadone more accessible - precipitated withdrawal is especially tough with fentanyl use
- Legislate more funding for long-term housing supports for SUD and homeless populations, including sober housing
- The general public will only support initiatives if they are aware of the seriousness of this crisis in terms of deaths and the effects on our MN citizens. Tell the stories on social media
- Controversial but use of AI to narrow down the biggest opportunities

Based on the passions and the needs of our community, what can we do to advance the strategic plan goals?

- Be inclusive of people from diverse communities, especially those that are disproportionately impacted
- SUD Summit!!
- Lobby!
- Go in front of committees, meet with legislators, lobby, advocate for what you're passionate about
- Process/policy to address reaching out to the "functioning" addicts- reducing stigma/fear of accepting help, admitting, identifying. Being able to assist with reducing trauma within the home, which then allows future generations to heal, grow
- Process/policy to address reaching out to the "functioning" addicts- reducing stigma/fear of accepting help, admitting, identifying. Being able to assist with reducing trauma within the home, which then allows future generations to heal, grow.
- Partner with other like-minded organizations on shared agendas
- Take info from this and create workgroups to get into the logistics of how to move things forward what needs to be done
- Engagement with civic leaders across local and state government.
- Using data to arm us for lobbying
- continue conversations and keep pushing forward
- Use the new appointment for recovery person to support how to get in front of judiciary branches on what is happens and what could be happening
- There are communities that are not comfortable sharing data
- Involving media exposure to the strategic goals and planning implementation.

- Using personal stories and the voices of the underserved communities and getting them engaged/involved in the action

What are the top 3-5 aspirations to focus on?

- More LADCs
- Housing Access - sober housing option for those with children, specifically Men
- More LADCs
- Education across the board to provide people better understanding or what is going on sud folks understand well but others do not
- Reducing Stigma
- A pre-assessment process to screen out individuals who don't need a comp assessment. Could this free up LADC so they can focus on treatment?
- More education shared on exchanges and what we do
- Reassess who is allowed to complete the comprehensive assessments.
- Disparities among race and rural areas
- Barriers to background check issues, set asides
- Transform Punitive Approach to a Trauma-Informed, Strengths-Based Approach to Individuals with Justice-Involvement and SUD
- work on collaboration to support clients in jail or with criminal issues, allowing those clinicians to have support when back logged
- Harm Reduction & Overdose Prevention = taking a holistic wrap around approach, and finding funding to support all of this
- Alert the community on new drugs coming to the scene (some Narcan resistant)
- Treat substance use disorder as a disease. Stop punishing the staff for having a recurrence of their disease.
- Better communication about overdose spikes- prevention of overdose spikes
- 1. Access & collaboration of care 2. Removing Stigma 3. Removing punitive action for those seeking service as well as providing service
- Having recovery friendly workplaces
- Improving funding and services that harm reduction program are able to off
- Programs that will help pay for sober housing with those that don't accept GHR.....
- Overdose prevention centers / harm reduction spaces for people who use drugs
- Race-rate disparities
- Process for reinstating insurance for those released from custody after 30 days
- One of the biggest problems we have right now is that client are so much sicker now than ever. Unfortunatly many go ASA within a day or that day when they arrive
- Bring Tier II funding back

Law and Policy Results

Considering the identified strengths, opportunities, and aspirations, how will we know we are on track in achieving our goals?

- Hopefully we will see OD deaths decrease and accessibility to programs increase.
- Create centralized data base with the state to gather aggregate data from providers to show trends outside of just opioid use
- Less deaths and higher rates of recovery
- Overdose rates decreasing
- More adolescent programming, and school based services in rural areas
- less individuals in jails/prisons
- She a reduction in criminal charges for drug related crimes
- 100% Emergency departments and health systems offer MOUD
- more individuals receiving services
- Quicker admission to treatment, shorter waiting ti
- Show that recidivism rates for drug offenders have reduced
- See direct access be a standard of support that all providers support
- Increased funding toward overdose prevention
- more training for probation/parole officers
- See treatment courts use a harm reduction approach and review of sanctions
- More recovery housing
- Overdose prevention that focuses on those that are at highest risk of overdose - people who use drugs
- Treatment Courts
- Reduce barriers to countries in getting treatment court
- Increased funding and expansion of syringe service programs + harm reduction
- Not every county has a specified court (drug, dwi, veteran) due to funding needs. Opportunity for growth to establish them.
- reentry courts - sober homes, jobs, programming set up upon release
- Drug court is collaborative, requires training, education and checks a lot of the boxes for accessing additional resources - need for them to be statewide
- Harm reduction vending machines - in treatment programs (grant funded opportunities)

What results do we want to see?

- think Peer Recovery Specialist is a great thing for the recovering addict. Especially after leaving treatment/jails/prison... Having someone there to help you with re-entry into the world again sober etc...
- Decreased overdose rates
- More calibration with all harm reduction services from exchanges to treatment centers.
- Increased peer involvement in jails, courts and out reach programs

- We'd like to see our clients feel empowered and able to seek the help they need & then stay connected to help carry the message to those who still suffer.
- Forensic peer recovery specialists - increase by % throughout the state
- Reduced recidivism for people with crimes related to homelessness
- Increased accessibility, especially in rural areas
- Getting clients health-care so they can access mental health,medical, and cd services.
- Better access to restorative Justice
- More funding made available to support these initiatives
- Less restrictions on those who prescribe for MAT
- Free childcare for parents reduce barrier to treatment
- Easier access to health insurance .
- Provide transportation to support group meetings.
- More Peer Recovery Specialists , funding for new programs, housing, staffing.
- Housing - community partnerships to support housing access, less confusing to access, decreased barriers to access (due to background), more felony friendly housing
- We would like to see recovering addicts be more confident in themselves.... as a result to resourses offered.
- Less barriers to receive help.
- Increased investment in restorative justice
- Provide better financial support to veteran's in the legal system.
- Decriminalizing SUD (education to officers, community members, prevention education, ease of access to resources, etc)
- More funding to support all pathways to recovery
- Educating the criminal justice system (bench, probation) around more restorative approaches
- ISR reform; less restrictions upon released but increase as necessary. Use an incentive based mindset
- I think a better response around encampments is needed too. The current sweeps increase risk of overdose and puts people back at square one in whatever goals poeople may have
- Sustained funding
- Insurance Negotiations for SUD
- I would love to see and expansion of community resource for people with SUD/legal issues. Help them get education, work, housing without having to reach peek acuity to access services. We can provide all the tx we want but people need to have suppor
- Capacity Building - helping other agencies start sustainable and billable models
- grant opportunities for start up costs, supporting new programs become sustainable
- Forming our own entities that can financially support (holding companies) for these provider organizations for sustainability.
- Where do statutes lie - focused on professional regulation rather than patient safety and quality of care.
- more time into safety and quality than we are on re-regulating policies
- Reduction in the amount of paperwork
- All of the administrative tasks related to providing these services are causing burnout and decreasing the workforce overall.

- increase individuals in the profession
- We are not adequately paying individuals to support themselves and the work that they're doing (passion fatigue)
- The workforce was depleted significantly because of letters behind their name. There are many people with great life experience without the LADC behind their name. Let the assessors with experience get back to helping people.
- Why cant providers have dictation services. Medical model does this.
- Sustainable funding and increased workforce would both benefit from reviewing regulation
- Recognize professionals and let them fall under their own scope of practice
- Addiction field doesn't have a core. We need a centralized hub for the field as whole and what is encompasses. Be a leader to get the field more standardized.
- Seeing all CD and mental health professionals work together to support client care
- We are moving towards less residential. We need safe sober housing with peer supports. People are not succeded in theses enviroments because of use in the homes.
- Multidisciplinary team approach
- Our residents in our sober home that are also in drug court, seem to have a high success rate. I believe it is due to the connection with their PO's and Drug Court, all working together for the benefit of the client.
- Expanding mental health providers within the system is difficult because of cap - very difficult to find in the first place.
- Increase supervisors, LADC's, and those that specialize in co-occurring disorders
- Rank and File - ability to recruit and train individuals in urgent need
- Identifying more functional aspects of Bachelors/Master's programs instead of it being so clinical...so much of school is based on theory and "learning" rather than real world experience and multiple discipline experience....SUD, MH, end of life, etc
- Waivers and working with higher ed's and government officials to reduce tuition rates
- Care navigation/ case management available for justice involved individuals leaving incarceration. A go to person to for resources and referrals including behavioral health needs, healthcare, and social determinants of health needs.
- These are hard to fill positions therefore in education we have specific loan forgveness and programs as well as community experts limited licenses!
- In education there are limited licenses for hard to fill positions in math, and special education. Can we offer loan forgiveness and community expert positions for addiction and rehabilitation services. Work with higher ed's support reduced tuition
- Access to dual diagnosis care (mental health and substance use/ misuse) in jail and prison
- It can be difficult to maintain trust of client, collaborate with other agencies, and continue to do the work of each provider
- Adam Fairbanks Anishinaabe Endaad www.endaad.com
- Restorative Justice Circles for SUD

- St. Louis County jails / probation: frustration with the revolving door seeing the same individuals because they aren't able to access appropriate care or services. Would be helpful to have a Care Navigator or Caseworker that all PO's can go to
- Hard to sustain Care coordinator positions because there is no reimbursement.
- Payment Rate System evaluated and changed to meet the needs of the industry/providers
- Waiver that a social workers is automatically a treatment coordinator
- Pilot different models for peers and measure effectiveness and success rates
- Explore pilot programs - (using peers with criminal backgrounds who would otherwise face barriers)
- Accessible and quality treatment for all.
- Jails/Prisons with CPRS vs RCO/community peers who can continue to follow individuals beyond being tied to specific programming
- Recovery Alliance Duluth https://recoveryallianceduluth.org
- EMT protocols on incidents in the community involving drug psychosis and overdose. We need better access to holds on people who refuse help when they are obviously endangered. If conscious, you, they
- (Continued) can tell 911, EMTs they refuse help and possibly seek more drugs. the protocol is insufficient to help a person in distress.
- Clinical Care team in detox - case management team that connects them to resources on the front end. Could be available to anyone
- community members/information supports are so important. Professionals eventually go away
- Eliminate barriers involved in opening treatment programs .
- If you want to increase the number of LADC'S, let hours worked in a county agency doing assessments, doing treatment coordination, rtc. count for internship hours. They can then be allowed to complete assessments.

How might we track the impact or changes that have happened?

- Recidivism rates before and after implementation, length of time people are out of incarceration
- Treatment Episodes & Length
- OD rates, though hard to track once people leave incarceration
- lived experience; check-ins with community members and their perceptions of change
- Completion of treatment programs
- In the field - missing great measurement outcome tool
- use of ED and hospitalization rates before and after being part of a program
- How can we collect data from the communities that do not have the resources to track (qualitative/quantitative approach)
- Project achievements - (example: get an ID) and having a standardized list of goals for the individuals, and ensure they have support to achieve those goals
- community members/information supports are key and important. Professional supports go away when people are doing well
- Combination of wellness questionnaires and measurable tools for goal tracking
- PRAPARE is a common tool used for SDOH in the medical field

What are 3-5 indicators we would want to include on a scorecard?

- Recovery Capital is increased - having more support systems https://recoverycapital.io
- Laws/policies to increase workforce in the industry
- Retaining engaged patients, same with staff retention
- Increase LADC's
- Loved the idea of Recovery capital Index as the screening tool. That is potential measurement tool to look into. It is a wellness indicator that has been getting reliable results.
- More funding for SSP and safer supplies
- funding for an expansion of wrap around services, harm reduction, overdose prevention, and underserved areas
- I really feel that we need to bring the LADC license requirements back to an AA degree. This way we can reach a more diverse background and/or creating levels of LADCs. AA degree, BS/BA Degree and MA/MS LADC.
- Standard Indicators - are basic needs being met and are we seeing these indicators improve through their recovery
- PRAPARE Indicator screening tool
- Increasing services - decrease barriers to open additional programs and services
- Satellite offices to accommodate launching pilots without additional licensing
- If you want to increase the number of LADC'S, allow hours worked at a county agency doing assessments and treatment coordination count towards internship hours. Then they can do assessments for the counties.
- "https://recoverycapital.io/ ""The Recovery Capital Index® (RCI) provides a comprehensive picture of a person's whole wellbeing using an online, automated survey.
- indicator would be higher RCI over time"

What resources would we need to implement these measures?

- money
- Evaluation consultation
- Political buy in, Advocacy, Resources, Time
- Multidisciplinary work groups
- Evaluator for these initiatives
- Funding & Education
- A lot of universities have researchers that would be able to support this work and evaluation strategies
- Representatives from all different areas of the state
- Education curriculum needs to be updated for students
- how about broad spectrum student loan repayment for working in SUDS in the State for "x" number of years ???
- Partnering with school districts to provide education
- Bridging resources for students who are displaced due to SUD
- Working with legislators to write bills

- Governmental complexities that need to be overcome when it comes to evaluations. The political motivation/buy in to removing barriers to implement the measures
- collaborate with community cultural centers and churches as part of this work, to help plan and implement ideas.
- A lot of the smaller providers that are culturally specific are using all of their funding to provide care; we need more RFP's without so many check box requirements that they'll not be able to meet in companions to large organizations
- Need to be careful when writing bills to make them not SO specific that no one can access them; finding balance to allow the funds to be distributed appropriately
- expectations and reporting requirements also are a huge barrier to CBOs.
- Standard requirements waived if ability to show rational for doing such
- Different wants for thinking about background checks due to workforce issue. Many individuals that WANT to be in the field but can't because of their history. DHS waiver can take up to a year - revamp this process
- Submit appeals proactively with application for background study so that personal history and story can be considered when reviewing the process
- net study should mean that once approved to work in the field, should not need to process another background check as long as no additional arrests/convictions have happened