Listening Sessions for SUD Summit on Oct. 12, 2022

WHO ATTENDED?

Figure 1: Attendees by role (pie chart)

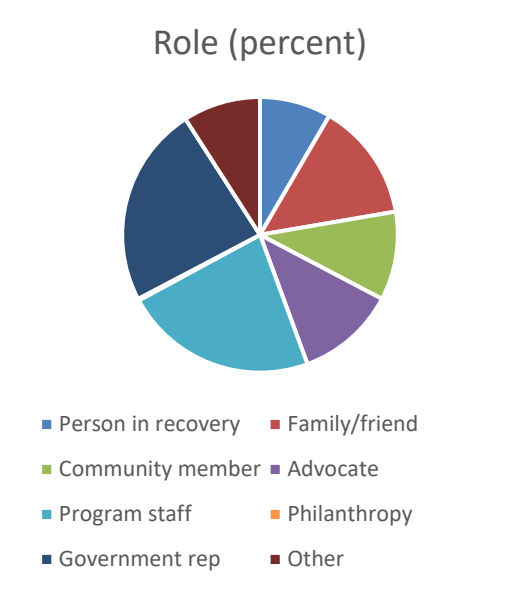

Table 1: Attendees by role (in text)

Attendee	Number	Percent
Person in recovery	39	8.4
Family or friend of someone confronting SUD	64	13.9
Concerned community member	48	10.4
Advocate	54	11.7
Program staff	105	22.7
Philanthropy	1	0.2
Government representative	109	23.6
Other	42	9.1
TOTAL	462	100

WHAT DID THEY SAY?

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

QUESTION 4

Responses to the question: "What are the most critical unmet needs to help Minnesotans confronting substance use disorder?" There were 201 responses.

- housing
- There are not enough beds MI/SUD and there are not enough long-term sober housing
- access to long term aftercare
- Access and ability to pay
- Housing
- Transportation
- Lack of housing
- Housing
- treatment for people with intellectual disability
- Lack of local treatment issues
- Lack of resources in rural areas.
- Housing
- financial barriers
- Access to testing, beds, transportation
- Staffing shortages
- Detox facilities and sober housing
- Supportive housing. Housing
- Lack of resources.
- Extended care residential programs.
- Transportation
- Easy access to assessments
- Safe use sites
- housing
- Non-AA based treatment
- understanding that there is MORE than one pathway to recovery
- Connecting to an assessor
- MAT in non-metro areas
- Access to detox & residential programs in rural area
- lack of LADCs
- Individuals being sent to prison for struggle with substance use
- Lack of Detox Beds. Not enough MI/CD facilities
- SDoH needs, limited beds, staff shortage
- Non-traditional forms of treatment
- Staff
- Housing
- Aftercare
- Ability to pay

QUESTION 4 RESPONSES (continued)

What are the most critical unmet needs to help Minnesotans confronting substance use disorder?

- I have no staff!
- Housing
- access
- transportation
- Mental health parity
- transportation
- Stigma and cost
- A chronic approach to a chronic disease
- Social Determinants of Health
- Legal bypass
- Detox services, access to services in rural MN. Inadequate ER staff trained
- lack of LADC's
- Data sharing
- Provider access, transportation issues, financial support
- MAT prescribersAccess to navigation services, support.
- supportive housing
- Not enough staff to provide services,
- Staff and counselor shortages
- Getting access to treatment, understand ing the process
- workforce
- limit resouces/ lack of sober housing and transportation to appointments
- Housing
- Resources in remote areas
- Sober housing
- Housing for felons who are addicted
- Housing
-
- Co-occurring mental health treatment
- Lack of prevention work.
- Lack of integration with mental health services and lack of housing and transportation.
- long term care, housing, pay, facilities
- Staff to help run the programs
- lack of housing or treatment not willing to take clients
- Funding and placement coordination
- Transportation
- Access to care in rural MN. Transportation, housing, lack of programs and services inside the county.
- Lack of beds
- Lack of access to treatment
- poorly paid for services
- Establish both adult and youth tobacco cessation programs in SUD programs. We know this reduces relapse rates by 25%
- Available services - TX providers refusing to accept court ordered clients
- ESL, Housing, still looking at episodic care vs. logitudinal care
- Lack of resources in rural counties
- Long term support. My patients can get support while pregnant but need more long term support, especially when they have a new baby
- Lack of preventative programs for adolescents; Lack of adolescent treatment centers; staffing shortages
- Transportation in Rural MN
- Housing, funding, bed availability - staffing shortages
- Not knowing what resources are out there
- LGBTQ cultural competency
- Recovery supports
- lack of resources in our area- transportation, providers, housing
- criminal backgrounds
- Housing, access, rates
- More peer services
- Lack of support and housing.
- We have to start the education a lot sooner. We are always trying to address the issue after it's happened- we have to have some focus on the front end
- Overcoming stigma related to SUD and treatment
- not enough resources in rural areas, limiting of LADCs in private practice

QUESTION 4 RESPONSES (continued)

What are the most critical unmet needs to help Minnesotans confronting substance use disorder?

- LACK OF BILINGUAL PROVIDERS
- SOBER HOUSING"
- Working together in healthcare system
- Housing supports
- Housing
- They don't know where to start navigating the system, housing, open spots for treatment residential or outpatient,
- Staffing shortages, sober housing
- lack of integration
- youth
- individualized services for individuals with IDD and SUD
- Staffing
- lack of integration with other services
- Simple road map to obtain a comp assessment
- Increased payment for treatment staffHow to get into treatment
- Funding
- detox beds
- Access to care and continuing care coordination/case management
- "Supportive resources
- Transportation"
- Funding for new innovative programs
- someone who will help access services and follow up
- treatment for people with intellectual disabilities
- Access and resources to support individuals living with SPMI
- Employment opportunities for those with felonies on record
- Not enough LADC's / staff
- HOUSING
- Support for family members
- Sober housing that is sober
- Lack of LADCs
- Worker shortages have decreased providers capacity
- Transportation for rural communities
- Not enough counselors for treatment providers. No moderate level care. No coordination for client's. Not recommending appropriate care.
- Programs won’t allow kids
- Lack of adolescent treatment
  Lack of continuum of care for substance use disordered treatment including treatment services in rural Minnesota.
- Workforce- Exams are preventing peers or LADCs that fit the cultural need of our community
- Veterans need special help that is not available eitherUniversal screening for SUD
- sober housing taken over by Housing first, d/c chronic pain patients opioid medications forcing them to go to the streets
- treatment options for people with a sexual offending crime
- lack of treatment to meet the person's needs, mental health, no interpreters, lack of aftercare resources
- Rural access
- Shortage of ladcs
- Lack of providers that accept suboxone
- cultural specific programs in rural Minnesota.
- Shotage of providers and state provided safety net services
- RCOs and lack of follow-up after completion of treatment.
- The fact that many people do not understand how to start the process and how they can access it
- Lack of Staff/LADC
- Very little funding for SUD treatment for those that are incarcerat

QUESTION 4 RESPONSES (continued)

What are the most critical unmet needs to help Minnesotans confronting substance use disorder?

- Microdose induction Suboxone
- treatment and aftercare in rural areas

staffing shortages

- Staff shortage
- Community awareness and support in rural communities.
- Lack of LADC's
- No LADCs
- Interested in providing K-12 education within communities based on their needs and values
- Lack of LADCs
- step down supports for medically and psychiatrically complex clients
- Mille Lacs County
- Lack of continued support after treatment services end
- transportation and lack of providers
- Lack of Culturally responsive recovery
- Access, Access for Medicare patients
- Consistency in access to treatment and provider staffing
- Lack of after care after residential treatment.
- Stigma
- Staff shortage
- Lack of funding
- Lack of LADCs
- Lack of aftercare / mentorship after treatment
- Reducing stigma
- Detox education
- Housing is huge, basic stuff such as food, clothing and transportation
- youth-led prevention activities
- Housing and income
- supportive community
- GPS to find services
- Stigma with MAT
- Long waiting list to get in
- Felony friendly housing and jobs
- Housing, transportation, long term step down options, recovery maintenance programs, non AA sober support meetings, harm reduction support meetings
- Waiting times
- Education in schools about SUD
- Staff cannot keep up with requirements
- transportation
- Need LADCs
- Lack of concurrent treatment for tobacco use disorder
- Lack of RCOs
- Lack of staff for 245g facilities
- 42CFR rules create barriers for integration
- Insurance reimbursement- pay us what we are worh
- Getting rid of the X Wiaver
- Prevention, workforce, hx trauma, cultural specific interventions.
- Mental health care access and the underlying unmet essential life resorces like economics housing etc
- Treatments are not operating with evidence based practices and there is a lack of services for co-occurring
- access to longer term treatments for people who do not do well in shorter programs or unsecure programs; lack of culturally appropriate resources, lack of housing
- Sober housing after care
- medicare not a payor
- internet access
- Lack of housing
- Need more harm reduction options
- lack of adolescent services
- Care coordination beyond treatment program
- Transportation issues
- staffing shortage professional and para professional
- Harm reduction friendly housing
- Social support
- Lack of understanding from family/friends knowing how to support.
- Payer issues for facilities

QUESTION 4 RESPONSES (continued)

What are the most critical unmet needs to help Minnesotans confronting substance use disorder?

- ACCESS FOR THOSE OVER BHF GUIDELINES AND ONLY HAVE MEDICARE INSURANCE
- PeerRecovery specialist that has your best interest, better communication between the person in recovery and the agency that is helping.
- Access to care
- Funding
- addiction prevention in the schools
- Transportation, insurance stands in the way of meds, peer support, jobs that pay livable wage once sober,
- Workforce is a HUGE issue
- Funding
- not addressing MH needs for SUD and homelessness taking a front seat
- Funding!
- "Culturally Responsive Care
- -Residential programs not taking non english speaking folks
- - Programs not providing culturally responsive care
- - Sober housing not accepting non english speaking folks"
- Poorly run facilities
- Respect and personal self worth driven by societies treatment of the individual.
- When someone comes to the point of indicating they need/want treatment, it seems the process to getting the assessment, insurance, funding, bed availability - they are over it and back in the cycle of abuse / use - often seeming defeated by system.
- "More peer programs and billing options for reimbursement."
- Transportation
- transportation
- More Recovery Community Organizations
- harm reduction program access
- Housing, access, mental health treatment
- Transportation and housing
- lack of access to mental health serviceCultural specific programs that meet 245G standards
- Housing (sober)
- Understanding the issues that affect marginal groups
- Prevention Prevention Prevention
- their families
- Understanding the cultural differences in recovery and providing those services
- older adult
- Cooccurring SUD and MH treatment services
- Resources
- Too much paperwork and not enough face to face time with clients due to checking boxes
- Lack of understanding that it is treatable chronic health condition
- Mental health access.
- Failure of state leadership and vision
- No funding, probation officers and court systems being flooded (the 'bigger fish' are violated but others are forgotten), access to treatment, MH issues - no facilities, no adolescent services for MH - leading to increased SUD
- Lack of Daycare
- Lack of integration with healthcare and MH care
- Poor pay for SUD Providers
- sober housing
- Lack of harm reduction
- all these issues having exposure to the public in general
- Helping people to reduce or limit use before it becomes chaotic use
- Lack of aftercare services and support for those coming back to rural communities after residential programming.
- Need dual peer support (sud and mental health)
- Stopping the undue shame/ degradation by law enforcement

QUESTION 4 RESPONSES (continued)

What are the most critical unmet needs to help Minnesotans confronting substance use disorder?

- Livable wage employment
- Assessors are now only short term.
- antiquated technology systems, poor integration
- Programing for limited cognitive abilities
- We're playing catch up…only treating high acuity cases and not focusing on prevention and education
- Emergency rooms not equipped to support treatment needs
- mental health, inefficient diagnosis, not understanding the relations between addiction and criminalgenic behavior, lack of long term support, housing access, lack of programing addressing victims of sexual violence. lack of ancillary services,
- People will be discharged from treatments way too easily for any hiccup that might come up
- Regulatory burden
- Lack of coverage for Medicare clients who are over tier.
- paperwork
- LADCs
- Residential treatment options where parents can bring kids
- access to health care
- Poor internet
- Unrealistic expectations and legislation
- limited resources, resources in remote areas, long term support, housing, treatment for co-occurring needs as well as other specialized populations (cognitive disabilities, culture specific)
- Lack of ADC 1 - through UMICAD
- Services for clients who are discharged from treatment centers but still want services
- We need ladcs at treatment programs
- Co-occurring treatment
- Funding for longer time in programs that appropriately treat underlying co-occurring issues prior to having to step down levels of care
- misdiagnosis for those specifically that have criminal behavior when they are discharged from jail
- Sober housing
- ZERO Medicare reimbursement
- Sex offender specific treatment
- Too much of alcohol in the culture
- overly complicated paperwork for counselors as well as new facilities getting licensed.
- Paperwork inconsistency between mental health professionals and LADC's
- paperwork
- Peer support
- MAT
- Not serving the whole person at once-people with MI are too MI for CD tx and CD is too much for MI facilities
- Treatment in corrections
- Whole person care
- harm reduction models
- peer support
- We need tier 2 back for people who are working but have no way to access SUD services.
- Structured housing
- harm reduction
- access to step down programing
- MI / CD facilities
- Re entry services
- culturally specific work force. criminal justice system barrier to people getting better.
- Peer recovery
- Support in community that's not NA
- Easier access
- Peer support services
- access to regular mental health visits while in residential treatment
- Medication and counseling and mentor combination
- Culturally Specific programing out of the metro and community support
- treatment, aftercare, detox - rural areas.
- RCOs and peer support
- Stigma
- Office based treatment within healthcare

QUESTION 4 RESPONSES (continued)

What are the most critical unmet needs to help Minnesotans confronting substance use disorder?

- Legislature forming treatment needs - reduce statues to help people in treatmenttoo much paper work verse working with clients
- Safe spaces for use
- MAT, harm reduction, Peer recovery
- SSP harm reduction
- long term services
- Pipeline to LADC
- Coordinated care
- Coocurring tx, mat, peers, long term, tx courts, harm reduction, housing, integrated care
- Sober housing with staff. Dbt/cbt trained counselors. Client centered diesnt mean not holding client accountability.
- Low threshold housing
- Team approach like one would find at Mayo
- Safe use spaces
- INSURANCE making LIMITS -- needing program design to foster recovery not money.
- Ccbhc
- Safe spaces to use
- addressing mental health and SUD issues prior to housing the homeless. Have to treat the SUD and MH to help homelessness
- CBT
- Less about faith and more about confronting life situations
- Consistent staffing at DHS and in behavioral health
- Drug/treatment courts
- Safe spaces to use
- prevention
- Make info available to public about how to access and pay for treatment
- detox facilities
- Focus on prevention programs
- Follow up after treatment completion
- presence in schools
- Early screening within healthcare
- Jail discharge planning.
- expand funding eligibility
- utilizing staff who were completed Rule 25
- Not only focus on the one who is experiencing SUD, but also help the family and their support system
- Require state to have pretreatment beds for comitted clients.
- Edication requirements gor all medical doctirs as tgey do nit understand or know how to treat withdrawal.
- Family support staff.
- listen to the experts in those communities
- Not only focus on SUD treatments but also focus on community trauma
- Better care to those incarcerated
- Better care to those incarcerated
- How to coordinate services with Justice involved clients
- Perinatal substance use disorders
- Access to detox services
- Quick response, when someone is ready for help, getting there that day.
- Not loosing public housing when seeking treatment
- Transportation or physical access to care
- Access to Care
- Short and long term supports.
- Where do I actually go to get help?
- "access to detox
- sober housing"
- "- Law enforcement stigma-reducation efforts
- - Community and primary-care opiate agonist treatment
- - Guidelines for methamphetamines use disorder."
- Lack of staff
- Lack of LADCs
- Family support for those in treatment
- "Withdrawal management, housing, access to MAT,
- child care, jobs"
- Specific SUD treatment for youth
- Quick access to treatment when needed due to lack of beds, lack of open treatment slots. Transportation issues. Housing issues.
- Recovery services that support a person after treatment for at least one year.
- provider shortage, access to detox, access to care
- LADC shortages
- Access to funds for treatment.
- residential centers that include families/children

QUESTION 4 RESPONSES (continued)

What are the most critical unmet needs to help Minnesotans confronting substance use disorder?

- access to stabilizing economic resources (i.e. SSI, SSDI)
- Access: money, insurance, cultural and religious barriers, criminal justice system barriers, language barriers, unawareness
- sober housing
- Lack of housing
- Co-occurring services across the State.
- More providers trained in cultural humility
- Workforce
- transportation
- Lack of Recovery support after treatment
- collaboration among service providers
- Rooted support with transition from treatment to everyday life
- Enough support and peers once a person is in recovery.
- Probation officers lacking knowledge and compassion of SUDS.
- Legal consequences
- Court appointed people that are forced to enter treatment can "spoil the waters" at treatment for folks who want it. Why do we do that?
- state funding for college students into LADC/mental health programs
- Access to mental health care systems and existing care structures to manage co-occurrinng systems. Addressing historical trauma of people of color, LGBTQ grougs, and trauma experienced by woman with SUD, and vetrans within treatment programming.
- Need more WM and detox locations in rural areas and solutions for lack of LADCs
- More time for counseling staff to counsel clients. Too much time spent documenting interactions, treatment plan reviews weekly take a significant amount of time.
- Support for family members of people in treatment/recovery.
- Continuum of care for SUD
- Access to harm reduction services
- Social determinants of health support to avoid recurrence of symptoms.
- sober housing
- Complexity of qualifying for treatment, insurance coverage of treatment and long term support.
- Care continuum, more peer support and resources for folks outside of healthcare (housing, jobs, food, healthcare)
- Accountability from governmental positions, friend had court ordered treatment and PO never did routine drug testing
- How can we organize Imam training to help understand the disease? Would they be open to this truly?
- Permanent funding for traditional healing grants and other culturally appropriate services.
- Understanding tribal entities, and their differences
- Teaching about treaties
- education
- How each recovery journey is unique. Not a cookie cutter type of approach.
- SUD treatment for those who are incarcerated to reduce recidivism
- Appropriate funding for recovery supportive services
- Harm reduction and meeting then where they are at with no judgement
- Harm reduction and meeting then where they are at with no judgement
- Workforce, too much regulation, too many barriers, lack of housing, programs paying for housing and others not, transportation, TOO MUCH PAPERWORK, no support

QUESTION 4 RESPONSES (continued)

"What are the most critical unmet needs to help Minnesotans confronting substance use disorder?"

- access to MOUD, Housing, peer recovery support, harm reduction, navigating those who were incarcerated to find housing, MOUD, and assist in peer recovery. Working with EDs and training physicians on how to help patients with addiction.
- Stigma
- Rural access
- no time limits with treatment episodes
- Reduced pressure to push people through treatment fast. Many people needs several weeks to months simply to physically prepare to engage in treatment.
- Medical care for those in treatment
- Peer recovery standards must be stood up better. And pay them better
- Trauma-informed care
- Services for pregnant people living with SUD.
- Specialty courts that support sobriety
- Safe use sites
- Lack of LADC's. Poor funding reimbursement for SUD services
- programs being identified as substance use agencies vs. treatment
- more school-based supports for middle school through college aged kids
- Reducing barriers to access detox, treatment, sober housing, long-term services.
- workforce development; specifically advanced practice RN
- How do we talk about relapse in this space?
- unmet critical emergency response services. (Need Addiction ER programs with immediate placement)
- Funding of the SUD detox, w/m, and treatment is insufficient to allow for immediate access any day of the week any time of day. There is a narrow window of when someone may be ready to access treatment.
- Majority focused on abstinence being the only acceptable outcome. Instead focus on harm reduction approaches which is more client driven
- Research-based treatment as healthcare (not as criminality)
- transportation issues, stigma,
- Families too busy, tired or frustarted
- We need a broad public awareness campaign that is consistent and sustained and focused for the community(ies) across the state.
- Specialty Courts
- Emergency Rooms providing harm reduction, trauma informed care.
- Users scared of criminal charges and stigma
- Access to harm reduction services
- Recovery Residences
- Direct access
- Treatment
- Client-centered care, harm reduction therapy, no limits on treatment and services
- Consistently supportive drug court.
- Recovery Residence support.
- "peer support services
- mental health and behavioral health"
- Outreach programs, decriminalization, safe use sites reducing stigma science based approach to recovery.
- reduce impact of felony impact on worforce employment
- Emergency Rooms being trained in warm hand-offs to chemical health organizations/workers
- Same-day opiate agonist treatment
- integration of statewide response coalitions gathering data to increase quick response
- increase statewide recruitment efforts for providers
- fund sud treatment for inmates
- Funding for high-qualify early childhood education and public schools.
- Funding SUD treatment for incarcerated individuals

QUESTION 5 RESPONSES

The following are an unedited summary of comments attendees replied with when asked “What responses to substance use disorder work well and should be expanded?” There were 125 responses:

- MAT Therapy
- Housing
- Prevention work
- MOUD (MAT)
- Harm Reduction
- Access to Harm Reduction services
- Harm Reduction
- Longer treatment programs
- support groups, family support, individual support
- Unconditional support
- MAT
- culturally specific care and services.
- Harm reduction
- SBIRT and primary care
- cultural
- Harm Reduction
- Same day assessments
- treatment courts
- Medication for Opioid Use Disorder
- Treatment care coordination
- harm reduction
- Asking the person what THEY need. Walking along side them.
- MAT and harm reduction
- Prevention work
- Client choice
-
- person-centered - harm reduction
- Dual MH/CD treatment
- Harm reduction
- PEER RECOVERY SPECIALIST
- Culturally specific treatment programs (LGBTQ, cultural and racial groups)
- Detox. Residential Outpatient WITH transitional LT housing
- Recovery Engaged Communities
- Harm reduction
- Integrated Treatment
- MOUD/MAT
- Access to smoking supplies instead of only syringes
- Long term treatment options
- MAT/MOUD
- More funding for treatment
- Housing with treatment inhouse
- Overdose Prevention Centers
- "Harm reduction
- MAT"
- Variety of treatment modules
- family support
- MAT
- Peer Recovery specialist engagement
- accountability and ongoing support
- RCOs
- Treating substance use with mental health support/treatment.
- Peer Recovery Services
- New programs are not a solution because we have no one to run them
- Continuum of care
- MAT and harm reduction
- Peer recovery support
- individual services vs group
- Harm reduction, long term support
- MAT
- MAT
- having a full and comprehensive spectrum of services available
- K-12 education
- Syringe Service Programs
- HARM REDUCTION
- Co-occurring MI and CD supports

QUESTION 5 (continued)

What responses to substance use disorder work well and should be expanded?

- statutes to validate the needs of culturally specific care and services
- Cultural specific services led by people impacted
- expand types of providers (ie. like MHP In mental health)
- Peer Recovery
- Policy change to reduce barriers
- MI / CD facilities
- Care Coordination
- Longer tx programs
- Treatment Court
- MAT and harm reduction
- Warm handoff from corrections to services/MAT
- Co-Occurring Services
- Longer inpatient episodes to treat underlying issues, build secure relationships etc.
- harm reduction
- Coexisting disorder treatment
- Peer Recovery
- Rewards/ incentive based treatment plans
- IOP with wrap around supports; housing + services
- Financial support, peer support
- Longer term , MAT, Access to mental health services
- Following recommendations of assessment
- Telehealth, Harm reduction
- Listening to clients!
- Community integration
- Harm reduction
- Addiction Medicine training
- treatment programs, harm reduction, recovery specialist
-
- harm reduction, longer treatment programs, not getting kicked out the first time a client uses when in a treatment program, peer recovery specialists
- MAT, DBT, CBT- Co-Occurring Disorder Treatment, Using Person First Language and Services
- MAT induction in corrections
- Do not assume AA is for all
- Peer support services
- Client created plans
- integrated medical access systems (epic)
- Smoking supplies (not just syringes)
- Evidenced based practices in treatment
- Supportive and transitional housing.
- Stop allowing corrections/probation to “force” treatment. Clearly this does not work
- Explanation of service options
- Family programming
- Aftercare follow-up/collaboration with PO's, SW's and family
- Peer recovery
- MAT
- Long-term care
- Housing
- Won't deny based on criminal background"
- Motivational interviewing
- integration of care and services
- Culturally specific and wrap around services, connection to larger community of support
- Paying reimbursement rates that cover the services
- Ssps

Peer Recovery Services

QUESTION 5 (continued)

What responses to substance use disorder work well and should be expanded?

- "1. Tobacco cessation programs. 2. Integrative therapies to deal with underlying stress. 3. Culturally sensitive programs. 4. Staff education and their wellbeing"
- Peer recovery
- Faith based recovery programs
- Safe injection sites
- Local treatment options close to families
- Detailed Explanation of services offered
- Access to other services and mental health services in addition to substance specific recovery
- Treatment coordination
- Facilities that can accommodate co-existing medical + SUD needs outside of hospital setting.
- HOUSING, TRANSITIONAL SERVICES AFTER TREATMENT HAS BEEN COMPLETED TO PREVENT RELAPSE.
- Trauma Informed Care
- Serving mental health, substance use and any other life issues ALL AT ONCE
- Peer recovery
- Faith based recovery programs
- Longer term programs
- Payers willing to pay for services
- continuing care, most programs only want to do the high intensity services
- Treatment Court
- logitundial care
- Safer smoking supplies
- Individualized outpatient treatment
- Rules implemented so people don't get d/c from treatment so easily
- Voice for the person in recovery when in a halfway house
- "Whole family support, Peer Support.
- Meeting the person where they are at."
- Strengths based, attachment/relational repair, finding purpose and meaning rather than just a job
- Aftercare post incarceration
- Payors beginning to not require auth for IOP/OP
- SMART Recovery model
- Educating Medical Professionals
- Linkage to care staff
- Family treatment they are closing and not financially viable
- Justice system catch up with SUD Field
- SBIRT-Screening, Brief Intervention, Referral to Treatment
- Individualized care encompassing the physical, mental, emotional, and cultural needs of the individual, along with basics of food, housing, etc.
- We need housing for clients who are waiting to get into treatment
- lowering the LADC credentials below a bachelors degree. 2 year ladc licensing and possible 2 years specialization.
- Structured housing
- Housing First
- Giving free or low-cost housing as part of IOP or aftercare
- SUPPORTIVE SOBER HOUSING
- Use of the “ never use alone” phone number
- MAT support
- LADCs in primary health care

QUESTION 5 (continued)

What responses to substance use disorder work well and should be expanded?

- More billboard/marketing campaigns to educate on narcan, fentanyl, HIV, etc
- SMART recovery
- sober housing that is truly sober environment to support those in recovery
- Treatment courts and programs similar to that. Alternatives to Incarceration programs that provide ongoing support and accountability
- Contingency management
- Tobacco treatment integration
- Legal strategies to assist people with felonies or other justice involved individuals to get housing, workUpdate to ASAM criteria to align with the 115 waiver
- the ability for SUD Providers to be paid appropriately
- Get rid of background checks
- Parody for insurance co's
- Truly all pathways to recovery including abstinence and MAT listening to our clients needs and goals.
- MAT, housing, peer recovery specialist, long-term treatment options (with step down), MI/CD
- holding the person accountable
- HARM REDUCTION!!
- Peer Recovery
- Early intervention, walk in detox centers, peer recovery
- Utilize more Peer recovery specialist
- Housing with Cog behavioral element
- Communication with all of the parties involved!
- Peer specialists
- Second harm reduction!!!
- Co-occurring tx
- wraparound services
- MICD, peer recovery, family programs for moms with children
- Safe use sites
- Opioid treatment programs (OTPs)
- Agree, harm reduction.
- Ditto on harm reduction!!
- Specialty Courts
- Also forensic specialist if working with justice involved
- Harm reduction, Peer recovery, immediate access to services.
- MI/CD programming
- More data on racial disparities
- Syringe exchange
- Supporting new research on psylocibin and integrated therapies to treat SUD
- Also data on perinatal substance use
- Family programs where children can be with parent receiving tx
- cultural programs and models
- Non punitive response to lapses when on probation
- Housing for families with treatment and support.
- Direct access
- Ambulances and police officers carrying narcan
- Safe injection sites
- partnerships with DCFS and treatment centers
- Recovery Residences
- Map of providers
- Data! That dashboard is great
- Public/private School training that shares drug prevention
- Treatment works.
- Prevention efforts in schools
- Listening like this to be informed by those impacted

QUESTION 5 (continued)

What responses to substance use disorder work well and should be expanded?

- Medication Assisted Treatment
- Reduce stigma
- Networking and working together
- Wrap around services, moud in criminal justice setting
- DHS Reduce paperwork instead of increasing it
- Listen to people from those communities
- Community Education of what helps people in recovery Housing first model
- Peer support
- CCBHC Model
- Yes, a focus on the continuum of care
- Peer recovery specialist
-
- Treatment coordination services
- longer treatment programs.
- Recovery support
- ongoing case management
- recovery support in the community
- integration of services with SUD, CPS, Probation, etc."
- Treatment for parents with childrenPerson Centered Services
- harm reduction and sober housing options
- Skipping the Rule 25 for MA client's and having them go directly to a provider.
- Long term programming and support
- flexibility in the definition of paraprofessionals
- Longer inpatient treatment, holistic care dual diagnosis programsadditional fund for providers to support longevity and decrease the impact provider organization. often the cost of services is lower than the cost of the services that actually work and create change. (reimbursement rates are too low)
- Truly honoring all pathways to recovery.
- 24/7 access
- Allow primary care providers to have more tools for screening, prevention, education, access to resources for treatment.
- Needed, tx and prevention services for people with intellectual and developmental disabilities, specifically those residing in group homes, as well as education and support for their staff.
- I agree with everything that has been said. I would like to see more case managers to help
- Allow payment for services in primary care not just through behavioral health centers
- community support
- Post treatment support for person with SUDS and family/friemds
- drug court
- Include them in the planning process.
- Include those who actually need the care to share their input
- Include the extreme mental health crisis which is co-occurring
- Equal representation from all groups.

QUESTION 6 RESPONSES

The following are an unedited summary of comments attendees replied with when asked "What are the greatest opportunities to more effectively confront substance use disorder in Minnesota?" There were 131 responses

- Overdose Prevention Centers
- Treatment programs
- Preventative measures with YOUTH
- Education and prevention
- Decriminalizing substances
- Getting out into the community
- pre-treatment beds
- prevention intervention with youth
- Prevention
- More detoxes
- Education within high schools
- Peer to peer support
- Schools, church
- Better prevention programs in schools
- in jail programs
- peer community outreach
- Mental health Centers, overdose centers, education in community
- Prevention for youth, especially multigeneration trauma/SUD
- Prevention for youth
- Restructuring DHS
- Harm reduction models
- Serve individuals residing in remote communities
- decriminalization
- Telehealth
- Reduce the stigma
- housing and transportation needs met in the rural areas
- less regulations from DHS
- Peer recovery support
- Work with counties to inform decisions regarding opioid settlement dollars
- Education to reduce stigma
- Detox centers
- Prevention programs, youth prevention, more LADC presence in schools
- Increase support to encampments instead of bulldozing communities
- Build out more providers
- Primary Care settings
- Housing first models
- Make it more desirable to join and remain in the field as an LADC.
- Community housing programs/ Income based highrises
- Education
- Multiple touch points- not focusing on one area. Yes opiates are the hot topic but alcohol and meth are still the leading admission to resident
- Education and treatment within schools
- Integrated services- holistic approach
- Temporary housing for those waiting to get into residential treatment
- Community Education to reduce stigma. More harm reduction.
- Alternatives to incarceration
- Schools-being open and honest about substance use and just teach abstinence
- Improve reimbursement rates to increase staff and have more qualified staff.
- Fund new innovative programs!
- more community engagement
- treatment and prevention measure for youth.
-
-

QUESTION 6 (continued)

What are the greatest opportunities to more effectively confront substance use disorder in Minnesota?

- increasing access for free harm reduction tools
- Youth prevention
- Education on the prevalence of OD.
- Increase rural access
- Increase in fudung from the Block Grants
- Education to parents
- Not let go of all the staff (non LADC) that were doing Rule 25/ to begin with, grandfather them in
- Drug testing for safer supply
- De stigmatization
- RCO's
- Government and Human Services collaboration and trust in providers
- Get faith communities involved in prevention
- decriminalizing substances and educationsafe injection sites. education. community.
- Virtual treatment
- "More Detox
- More Treatment Beds"
- Treatment centers need updated programming and evidence based practices
- more harm reduction options / programs
- Prevention and education.
- Harm reduction education
- Correction programs
- expanding definition of providers to allow practitioner level staff alongside LADC to allow more staff to enter the field (like mental health)
- remove barriers for people in recovery to provide services
- increase incentives to train future SUD provider professionals
- Community centers
- supportive beds for those waiting on commitment hearings vs waiting in a hospital/detox
- Person centered access to treatment
- Educate community with sustance, harm reduction, prevention and treatment of all ages
- Engage churches
- Communication that help is available for low income
- Funding for activities to prevent youth substance use
- expand care continuum
- we could create more culturally diverse programs; look at overdose prevention, increase access to Narcan for staff working with people who have substance abuse disorders, more treatment beds, more teaching of coping skills for hard emotions
- Getting Medicare to reimburse SUD Providers
- COMMUNITY INVOLVEMENT
- allow MA/PMAP to continue when in jail
- Educating communities about SUD-reducing the myth it is a moral failure
- help chronic pain patients and providers be treated and treat accordingly and not just what to insurance and the CDC suggest
- More treatment facilities for MI/CD
- Decriminalize SUD
- Make getting into programs easier. There always seem to be hoops to jump through, and client's that don't appear perfect on paper often get denied.
- Stop using faith based treatment and shame
- reduce stigma public service announcements

QUESTION 6 (continued)

What are the greatest opportunities to more effectively confront substance use disorder in Minnesota?

- step down treatment programs, working within the community, working within the family, housing, wrap around services
- create wide spread public awareness campaign support by the state so it does not come from organizations.
- Drug Court
- more treatment beds for our civilly committed clients
- Stop d/c individuals from treatment because tx center can't handle mental health, adverse behaviors, relapse, etc
- Address the criminal justice system.
- Prevention
- More trauma informed care during incarceration.
- Legalization of cannabis and utilization as MEDICINE
- Education within the incarceration
- Overdose prevention centers, less regulatory requirements, increase rates to improve access.
- Support for families of those with addiction.

Breaking cyclical trauma.

- Broaden income limits for Behavioral Health fund
- treatment in the jails
- Reduce legislation that leads to unreasonable demands on an already stretched thin workforcePlanned housing with supportive programming and FUN
- Use ASAM or other national model - not state stautes to guide services for SUD
- LADCs
- Prevention efforts, address trauma, Social emotional learning in education, coordinated care upon jail/prison release, ccbhc to allow outreach and engagement.
- recovery support in the jails
- Allowing housing support services to stay active while people attend treatment so they can keep stable housing
- Increase family involvement in treatment
- Pairing education and resources frequently and creatively, continuing to gather data around what works/helps people
- education programs in jails that do not require treatment
- more adolescent services
- Better collaboration across service providers to achieve greater outcomes and sustainability, more prevention programs
- no wrong door
- Reduce the paperwork required by 245G
- Take another look at the requirements for doing assessments. Not necessarily being an LADC
- PREVENTION YOUTH INFORMATION AND MENTAL HEALTH SCREENING ALONG WITH SUD
- More education/resources in Adult Protection Investigation's approach
- Sober Supportive Housing before Housing First programs
- Increasing incentives and support for providers who enter the mental and substance health fields

QUESTION 6 (continued)

What are the greatest opportunities to more effectively confront substance use disorder in Minnesota?

- Course model treatment - people choose their education path for their addiction
- State investment in greater mn community programs where the market and lack of density can't support profitable models
- address stigma, educate about harm reduction
- Get more education in our schools for children - get SWAT teams and law enforcement, first responders, nurses, ED physicians to share stories. More community education opportunities, mental health care in our jails -
- Meaningful involvement from PWUD
- Advocate to elimate federdal ban on purchase of smoking supplies
- Peer support specialists
- make it more acceptable to learn emotional health skills and to learn conflict resolution and coping skills, create more supports for young people
- Raise MCT/UMICAD standards to meet DHS requirements
- Look to the Regional Prevention Coordinator model and increase across the state
- The SUD treatment system is way behind the times-need updated strategies to help people
- Training professionals on trauma and more overall education and support to all professionals working with these individuals as well as more flexible funding.
- "Programs that take non-English speaking folks
- Reimburse interpretive services
- Shift the certification exams to expand diversity in LADCs and Peer Recovery"
- Less barriers and more funding for peer support
- atment and services to MFIB recipients that can be qualified in the same way as job search requirements..
- Visible and engaging recovery events for social supports/relationship building in recovery
- Increase treatment funding. To help LADC retention and recruitment.
- allow previous R25 assessors to help with assessments
- Assessment services and intervention at hospitals/ER
- Better coordination across both public and private sectors. Partner with governmental services, schools, faith and health care services
- community support for recovery
- Get faith and Jesus out of treatment who don't want it
- state provided data systems.
- More silos working together - not dupliicting efforts
- Prevention and education, more Certified Prevention Professionals.
- More non-Christian-based recovery support services
- Barrier free Counseling available at syringe exchanges
- Peer support in hospitals

QUESTION 6 (continued)

What are the greatest opportunities to more effectively confront substance use disorder in Minnesota?

- Incentives for LADCs to enter field and to continue working in the field
- Access to Medicaid in jail/prison for continuity of access to meds for those discharging
- Give inmates all medications ordered - don't keep sleep, anxiety and other medications from them during their incarceration - they decompensate and often use whatever they can get to 'treat' their MH when released
- rural sober housing
- Educate family and friends on addiction as a disease
- Dual diagnosis programs
- Reduce treatment coordinator requirements to assist/work alongside LADC
- Engagement centers
- Support for individuals leaving treatment to build community, supports, stable housing, wrap around services
- Raise the price of alcohol
- listen to rural providers - they are saying they cannot make it work without the counties doing R25 assessments
- I second getting Medicare to pay for more treatment programs
- have one Rule 24 eligibility form, versus everyone county still doing it a little different
- Appropriate rates to help cover costs of infrastructure
- Leverage churches and charities in advocacy and outreach
- More medically based programs for those with severe medical issues who also need treatment services. They often cannot get in to any programs, when they need that support in order to stop, and therefore improve the health issues happening.
- Our MDH partners would agree; PREVENTION! We have several prevention models that could be expanded statewide.
- Leverage bipartisan support
- Simplify Eligibility for Programs and Required Paperwork for Providers to get funding.
- Getting Medicare and Ben trans Tri-care to cover treatment services remove the restrictions
- More dual diagnosis beds
- expand MAT programs in rural area, and central Minnesota
- access for medically complicated clients
- Treatment for people with DD or ID...NO treatment anywhere in MN for them!
- True co-occurring treatment centers-that are skilled in mental health AND SUD
- increase training and understanding on delivery of evidence-based treatment
- Felony friendly environment
- recovery support in jails.
- Give 245g facilities more room to work with clients - not guided by legislature, have DHS Deptment a licensing guide not punish
- Long term recovery support

QUESTION 6 (continued)

What are the greatest opportunities to more effectively confront substance use disorder in Minnesota?

- Make it easier to qualify for payment
- Support family to family opportunity
- child care for people in need
- increased funding to public health for prevention
- SUD providers in private practice
- Job fairs for addiction jobs
- easier way to get people on MA
- SUD PHP programs
- Rural services
- more loan forgiveness for ladc educations
- Get DHS to trust providers - listen to facilities not just talk about it etc OD issues
- more culturally, language, etc specific programs. OT referrals, voc rehab, at all levels of care, including jail.
- Cover treatment for all
- Funding treatment during incarceration.
- include prevention support and education through employee assistance programs.
- License and tax the new THC products
- The SUD and Mental Health systems should combine to become a true behavioral health response-from DHS down to counties, to providers-no more silos
- Intentionally build longer term relationships in step down programs. Go after healing underlying issues. Change narratives from what's not working to bring hope for healing (rather than chronic treating or rehab episodes)
- Grandfather R25 assessors with 5+ years experience doing assessments
- Felon friendly housing and employment resources for those in early recovery
- Tri-care cover treatment outside of VA
- VERY limited adolescent beds
- Churches, charities, schools
- DHS needs to do program audits and look at program content
- innovation treatment options - for various settings where help is needed. Current system does not foster innovation in helping
- Removing unpaid internships, allow LADCs to bill for SSD
- More consistency in licensors/auditors
- Retain, and hire folks from those communities
- Allow for profit facilities to access grants. For profits are willing to provide no reimbursable programs but don't have access to grants. For profit vs non profit is a tax designation not a morale failing.
- Long-Term Recovery, Reducing Stigma, and Reducing generational addiction cycles.
- We should have narcan in all AED kits across the state.
- Opioid settlement dollars
- Meeting ppl where they are at
- IOP with housing
- Stop the drugs at the border
- Again SUD as healthcare rather than criminality
- Family treatment services, better relationships with CPS
- Narcan
- Recovery is possible! WE do recover

QUESTION 6 (continued)

What are the greatest opportunities to more effectively confront substance use disorder in Minnesota?

- funding for perinatal addiction; funding for workforce development; funding for more residential treatment centers that include pregnant people and families
- Homeless intervention services provide an opportunity to intervene.
- Rehabilitation over incarceration
- We have to be able to build relationships with folks, treatment is more successful
- Recovery support after tx
- Reduce stigma
- Celebrate people in recovery
- Engagement with active drug users. Parntership with law enforcement and skill training for public safety.
- Evidence Based Home visiting
- Be able to get narcan w easier access - e.g. in gas stations
- Policy makers need to listen and respond to what providers are asking for. We're in the trenches doing the work, we know what we're talking about.
- Partnerships-integrated systems
- Family support
- Stigma stigma
- Funding needle exchange programs, staffing with BIPOC counselors and LADC
- Education, culturally specific programs, gaining buying from clients who are justice involved rather than forcing them
- Overall education and awareness on information.
- Funding for people to go to school to become LADC's
- Implement evidence based prevention strategies and upstream approach's.
- Helping the unsheltered community
- Open discussions to educate on substance use to reduce discrimination
- The housing support program should open honor SUD as the condition that makes them eligible for the program and allow for housing settings that are recovery supportive.
- Trauma informed care
- Acceptance of harm reduction as a valid approach to treat
- There isn't one way to come to recovery, recognize the different opportunities people have and that they have a choice.
- services in jails, treatment and social workers.
- Legislation and policies that help individuals
- Lifeline opportunities, hotline for people wanting treatment staffed with peer recovery specialists
- Legilastion that reduces the paperwork load to focus more on client care
- Provide hope for a better life on the other side e.g. affordable housing, connection to careers, education etc.
- Agressive outstreet outreach, realizing the repality that people will use regardless of law, homeless services need to be expanded. Meeting active users and providing help regardless of current use. People cannot be forced to quit.
-

QUESTION 6 (continued)

What are the greatest opportunities to more effectively confront substance use disorder in Minnesota?

- We need more data informed decisions and do not have sufficient information to do so.
- Increased rates and more flexible regulations to reduce
- Consistency between counties on how address treatment and program closures and increase providers through the state
- Identify SUD as a chronic disease that requires a long term focus
  DWI ed for justice involved people
- Communication with treatment providers,
- access to affordable housing
- Education, education, education in the schools, community, law enforcement, probation, courts, etc… therapists, doctors, probation, etc…
- Collaboration

QUESTION 7

Responses to the question: “What needs to be done to address the disproportionate SUD problems in both the American Indian and African American/Black communities?” There were 114 responses.

- Be more welcoming
- More community outreach
- Outreach
- Education and outreach
- Listen to those specific communities. They know best
- Go to where the clients are - not wait for them to come to use.
- geographically targeted harm reduction programs
- More culturally specific programs!
- Cultural specific treatments and sober support meetings, outreach, education
- Cultural specific staffing.
- Input from the community instead of white folks always making the rules
- More culturally specific workforce - recruit, help mentor
- Give incentives and support for more providers of color in the mental health field
- Safe housing community options
- More representation in health care
- outreach and listening
- More counselors that match the population
- representation
- Pay Black and Indigenous people to lead AND be on the front lines
- Historical trauma recovery work
- More Bipoc providers
- Culturally specific programs
- more resources
- Youth education
- More bipoc staff
- Provide incentives to get more bipoc professionals
- increase incentives for those communities to fully fund education for LADC's
- Empowerment
- Too many large so called non profit centers with amazing services but only for those who can pay
- "Cultural Responsive Support Groups/Professionals
- Advocating needs of services"

QUESTION 7 (continued)

"What needs to be done to address the disproportionate SUD problems in both the American Indian and African American/Black communities?"

- allow cultural traditions to be incorporated into the treatment model
- Don't force white norms on populations and utilize cultural specific treatments.
- state funding and support as a prioritization. funding should not be a barrier to care or services.
- education and outreach, more cultural support
- Have people from those communities in the roles of treatment providers
- Culturally specific sober housing
- Culturally specific training for providers
- More education for professionals to be able to best help and support those communities, if culturally specific programs are not available in the rural community.
- Meet peoples material needs!
- Establishing more partnership and relationship with those communities
- Give the communities HOPE
- Culturally specific programing. LEARNING from the client. LISTENING to the client.
- More options and resources for all in communities
- Understanding where the help is coming from
- Listen to the community and use their ideas
- more culturally appropriate resources, more diverse providers
- Integration with cultural places of worship and gatheo
- more bipoc providers
- Greater opportunities and funding to support African American/Black and AI people to enter the SUD treatment and prevention field.
- include communities
- Scholarships for POC to enter grad school and eventually go on to treat/open programs
- more state/federal funding
- Culturally specific tx, need more native american counselors
- Grants for BIOPOC members to go to school and get LADC
- Reach into these communities to develop appropriate curriculum
- Partnerships and support to serve these communities
- Culturally sensitive treatment programs who understand how to connect with similar lived experiences.
- Recruit from these groups; provide incentives
- support leadership development.
- Listen to what they say they need and then deliver
- We need to also address the South East Asian community.
- Representation
- Hire and retain folks from these communities
- Youth programs/ go into schools
- Focus on the culture aspects - I would say that's more the issue of the disparity vs. a race specific disparity
- Go to community - current rules do not foster innovative solutions for these popluations
- Counties working together
- Raise the price of alcohol

QUESTION 7 (continued)

"What needs to be done to address the disproportionate SUD problems in both the American Indian and African American/Black communities?"

- Seek input from those currently working in these communities
- More resources for culturally specific treatment.
- Encourage more specific programs. Create task force so population can encourage communitues to become educated to be ladcs
- allow for professionals certified in various fields to be billable providers (not just LADC's)
- Culturally appropriate staff, then pay them appropriately and resource them appropriately
- Youth and teen prevention models, community based
- Reduce stigma with MAT
- We have some examples of provider from cultural communities working specifically with youth in their communities. We can expand on these models!
- Improve rates and less restrictions on LADC licensing to allow for
- "Grants/scholarships to pay for services for
- Low income people"
- historical trauma trainings
- Decriminalize substances
  improved expansion of cultural programming and LADCs
- culturally specific programming; access to services; long-term
- support, education, wrap around care
- Listening to what the community thinks would work best, training and education for providers to incorporate those best practices and working together
- Paid practicums for BIPOC studying to become LADC
- Increased opportunities for training about needs of POC in SUD settings.
- More resources! Listen to needs of the community.
- Help current cultural programs be environments that are safe and consistent and have BBHT licensed staff
- more resources for rural tribes/tribal agencies/ lack staff to complete the numerous assessments requested
- More culturally specific programs in rural areas
- Funding support for BIPOC providers to enter the field
- Address systemic and institutional racism issues
- accept suggestions for what's needed instead of having to validate the recommendations.
- listen to the experts in those communitites.
- Focus on overall health of the community- food, employment opportunities, and wages should be fair to foster health and wellbeing.
- Reduce stigma it only adds to prejudice and discrimination they face
- Recognize the cultural providers as persons to provide services
- Outreach to BIPOC community to enter SUD and MH field.
- Value lived experience as a professional qualification

QUESTION 7 (continued)

"What needs to be done to address the disproportionate SUD problems in both the American Indian and African American/Black communities?"

- more resources
- Again housing always housing
- Culturally responsive harm reduction treatment
- Help with basic needs that are necessary to support recovery especially housing Normalize recovery across cultures through outreach and education
- More education on what is specific cultural trainingAllow for other licensed staff to complete R25s and SUD assessments not just LADCs AND shorter certificate program for licensed providers to learn assessments
- meet folks where they are at, basic needs, recruit/support BIPOC students/prof in SUD
- Train staff to be relational - listen, learn, respond and build trust over time. Need more time in programming and more funding to build relationships well
- representation in decision-making conversations and on state boards
- support a state coalition/board specifically tasked with focusing on this community.
- Use tax dollars on alcohol & tobacco to help funding for these populations to gain a greater access - guided by community leaders not politicians
- DHS could grant fund a student intern ongoing.
- meeting people where they are physically at-outreach-mobile assessments
- Recovery education for families, spiritual leaders, community leaders, etc
- funding for rural SUD programs
- give the support needed to improve impacting factors.
- Transportation and housing
- Stop assuming that what works for whites will work for them.
- Increase the state rates so we can pay the people who provide SUD services
- tax alcohol sales
- Include elders in community planning
- Increasing rates
- Don't discriminate against court ordered individuals
- Ways to engage community that breaks down stigma...what are simple ways to do so not just theory.
- Slow down drug trafficking across across our state and nation.
- Culturally sensitive and appropriate providers
- More BIPOC providers, recruitment efforts
- Culturally specific programming
- Language translators
- Hiring more BIPOC in State and providers
- Identify structural barriers and eliminate them.
- Funding for programs in areas that are not served
- Policies policies policies
- Imam training
- Peer support specialists
- upstream mentorship for AI and AA/Black high school students to attend college for healthcare fields; scholarships for nurses, LADCs, etc

QUESTION 7 (continued)

"What needs to be done to address the disproportionate SUD problems in both the American Indian and African American/Black communities?"

- Addressing structural racism
- Betterhousing
- Historical trauma
- More culturally appropriate programs, addressing the trauma
- integration of trauma-informed care across all licensed programs
- Bringing treatment to the client to ease access of care
- Jobs; reducing trauma, housing
- Making existing appropriations easier to access - i.e. simplify grants processes.
- Providing more co-occurring treatment to address directly the trauma of racism
- Need to address economic disparities (historical) that have contributed to the SUD disparities.
- Quality childcare and preschool
- Stop the flow of illegal drugs harder into these communities.
- Improve access to funding for community organizations
- Transportation/access to Tx
- Long term services that support families
- LPracticing Deep Listening to all. Practice Curiousity. Display Humility
- Disproportionate SUD problems in LGBTQ as well.
- Informing communities especially immigrant communities of what services and support are available. Communities often don't know there's help out there!
- Look at cultural differences and work within their culture/community
- Housing and jobs
- collaborations building relationships with community providers
- Funding scholarships for LADC programs
- allow tribes to act as sovereign nations
- Intervening prior to SUD, strength build in children when school absences are increasing
- Consider practices that may not be "evidence-based" yet because research hasn't been conducted.
- Getting more funding and resources to rural communities.
- Culturally sensitive outreach, working to fight poverty among these groups, eliminating discrimination towards addicts and people of color. Funding for housing and meeting basic needs, economic disparities need to be eliminated. Science based.
- Education in the schools and in the community. Peer recovery support.
- Policies and legislative solutions by DHS based upon listening sessions feedback and is working in other states.
- More funding for those organizations already in community on the ground doing this work.
- More in-depth cultural education
- Listen to people from those communities who are doing this work.
- Community coalitions for recovery
- More funding to specific programs and more funding for training for culturally specific CEU's
-

QUESTION 8 RESPONSES

The following are an unedited summary of comments attendees replied with when asked “What content should a summit aimed at creating a shared, statewide vision and strategic plan on SUD include?” There were 129 responses.

- share proven models - what has worked in other communities
- Measured action items
- Stop treating Mental Healt and SUD separately-we need a behavioral health response
- "Access to services.
- Intervention strategies"
- Growing the workforce
- information and data specific to rural central MN
- Harm reduction
- Culture and recovery! Community and recovery!
- How to fix the severe lack of staff.
- open ended discussion so people can identify models and needs that are not evidence based.
- Trainings and FREE CEUs
- see what other things are working in other states.
- treatment for people with SUD and intellectual disabilities
- Follow up events or meetings, not just one event
- ways to re-involve rule 25 assessor's involvement
- Workforce development ideas
- Prevention work with youth
- Coordination of services with other agencies
- Providers new ideas! What can we do different
- Identify what works
- Diverse voices - include people with SUD and their experiences with our systems
- information on current programs that are culturally appropriate, information on dual diagnosis programs
- how do counties provide care coordination
- Addressing the source of cultural trauma
- Community and housing resources.
- Measurable goals
- I would like to see legislative updates align with 245G across all statutes.
- Cultural considerations learning sessions
- Goals to expand treatment services
- "Action
- I did not find value in the childrens summit"
- Interactive exercises that allow providers and key stakeholders to collaborate real time
- Share ideas and resources with other participants here. Chatting
- Discussion on safer injection sites
- CEU's
- Evidence based resources and best practices
- Content that addresses the needs of rural Minnesota, not just what works for the metro
- Cultural variety on treatment of SUD
- Awareness of existing support groups
- some type of accountability to see things moving along
- Information on prevention and work being done with youth

QUESTION 8 (continued)

"What content should a summit aimed at creating a shared, statewide vision and strategic plan on SUD include?"

- How to integrate between MH and SUD services, as well as programs and counties. Some counties are still providing comprehensive assessments, and care coordination services.
- Plan to secure long-term funding from the state
- Overdose Prevention Centers save lives
- Having input into the identified vision prior to, and then having the summit really be about action planning.
- Building the capacity and access for rural communities
- Treating withdrawal for new drugs.
- How to access funding and work with other agencies doing the work to create real programming that works
- Workforce to reach out to high school counsleors to recruit new students
- Federal funding models for sud treatment in jail
- Learn about resources available to us as providers
- Reducing Stigma, Person First Language- Including MI treatment/services, Cultural/Gender Responsive- Trainings/Skills-
- Severe lack of staff and removing insurance/financial barriers
- Targeted comparisons to other states and what may be working elsewhere.
- staff shortages
- Meaningful input on actual changes that will be implemented after the summit
- Culturally inclusive and immerse experiences and education
- Treat SUD and Mental Health together always.
- Integrated SUD treatment within healthcare
- Information on the benefits of microdose induction of suboxone
- Number of facilities and programs vs number of staff available
- How can we strengthen our unified voice to advocate for legislative action to support culturally responsive and affordable SUD treatment and prevention services?
- Actually use the suggestions made
- how counties and providers can work together to provide BHF funding
- How all the groups, collaboratives, etc. can come together to solve issues. Stop the siloing! How can we all work together?
- Statewide approach, not just metro or greater-mn specific
- Cd county case management
- Shared innovative models that have worked in other states and identify what DHS is willing to do different.
- MEDICARE REIMBURSEMENT
- BIPOC TRAINING OPPORTUNITIES FOR STAFF, PROVIDERS
- Increasing rates

QUESTION 8 (continued)

"What content should a summit aimed at creating a shared, statewide vision and strategic plan on SUD include?"

- multiple learning opportunities - based on the current needs of your own community
- integration across DHS/MDH prevention and recovery
- you cannot treat SUD without treating MH. You cannot combat homelessness without treating SUD and MH. They are married, so to speak.
- Training community members, treatment clinicians, POs, law enforcement, etc. etc.. about peer recovery services (staying in your lane)
- Dual diagnosis tx
- Share successful community activities or events that promote normalization of substance free events in the greater community
- People in recovery sharing what was helpful in tx process
- Lists of treatments and what they offer
- Treatment options, Navigating systems, Funding Sources- how to apply for help for those who cannot afford treatment.
- Specific Rural and Frontier solutions
- Providers getting paid for providing services in jails.
- Getting everyone on the same page in regards to Direct access. Everyone is being told different things, and those in rural areas are greatly impacted by the drastic decrease in accessibility to assessments since Rule 25 went away.
- ASAM criteria training
- How to pilot ideas without so much red tape
- Space for community outreach and input on change, suggestions, resources
- Data base to store and distribute comprehensive assessments immediately to expidite admission to tx.
- How do we better utilize the resources we currently have
- Share resources
- information that considers and includes rural minnesota
- Relax paperwork standards to REALLY allow us to individualize treatment plans
- Influential people who are in recovery as a cheerleader for sobriety
- pregnant and using women
- equitable treatment barriers and ideas for solutions
- Something's not working. Fill the gap in the recovery landscape, don't create more of the same. Go after healing underlying issues, building relationships in longer programs rather than paying for revolving door shorter programs.
- "We have models to look to:
- Hennepin Health/HCMC
- The Certified Community Behavioral Health Clinic's (CCBHC) and all 245G licensed"
- Recruit our legislators to attend!
- New training for counties and pd.
- Integration with Primary Care
-

QUESTION 8 (continued)

"What content should a summit aimed at creating a shared, statewide vision and strategic plan on SUD include?"

- Mental health and substance use disorder together- ways counties can work together- resources that can be obtained quickly
- Treatment centers need updated practices and policies-and committment to assist people with complex issues
- Much of this is not new to any of us. HOW DO WE TAKE ACTION? HOW DO WE GET FUNDING? Without funding, policy makers behind these needs etc - it seems like just great discussion.
- At least one debate between advocates of contentious issues in SUD.
- Integration of services to care for the whole person
- Ways to educate and involve the general community in finding a solution that reduces stigma
- Develop system for legislative to exit current model of care dictated by the state
- Invitation to state senators and reps to attend and talk with front line workers
- Innovative programs/services that are working in other states.
- Trauma informed strategies for SUD programs
- Evidenced based treatment
- grant writing
- Success Stories: Share what has worked
- Value based care
- Culture training Non Native Counselor
- Evidenced based treatment interventions
- Specific sector learnings - government, health care, mental health, etc.
- A dry networking opportunity that is fun. Model the way
- Grant writing
- reducing stigma
- Funding for prevention programs, materials, and translation services.
- Raising medicaid rates, allow LADC to bill for social security, work towards reducing redundant documentation, increase availability of EBT materials
- How do we support people when they leave treatment-if they have no support, housing, etc-how can we expect them to stay sober??
- More opportunities to share ideas. Report out on findings and share actional steps
- Information how DHS is integrating multiple initiatives (Direct Access, 1115, SUD CoP, now SUD Summit) and not just creating more meetings and more paperwork for providers.
- Implications of synthetics; Delta 8
- Continued skill building in motivational interviewing and trauma informed language when communicating with clients

QUESTION 8 (continued)

"What content should a summit aimed at creating a shared, statewide vision and strategic plan on SUD include?"

- How can we expand SUD prevention and treatment services within local communities. Cultivate SUD services as part of fostering communities of belonging. Normalize treatment and integrate into routine health care.
- Changing legislation to be clear about determing funding to make sure we follow federal block fund
- Reduce current silos of care to truely have integrated healthcare
- getting input from people who are hurting
- Networking with agencies, county and schools and creating programming for schools and communities together.
- Less talk and more ACTION!
- Highlight a payor that is leading the way in covering and investing in SUD (is that UCare, BCBS who?)
- Equal/Equitable representation.
- Reduce the number of required statements in treatment plans so the plans aren't all about compliance rather than treatment.
- Identify policy changes that promote access, workforce and funding across cultures and geography of the state and align legislative proposals with all entities to advocate or lobby for approval.
- Collaboration with rural jails and ER's- all are serving those with SUD
- Statewide trainings on dhs for case managers.
- invite federal and local politicians
- normalize MAT, psychedelic treatments
- Streamline the documentation overlap between professionals working in a co-occurring program-
- Update on Medicare's plan for addressing SUD
- A framework for how to access and leverage the network of resources and providers for better communication and collaboration
- Resources that can be used later - having files/presentations shared virtually so that it can be shared to those who were unable to attend as well/can be used when needed
- Our service delivery system is flawed and siloed and needs a complete overhaul to treat people with SUD and other co occurring issues
- Legislative Action: How can I advocate for change?
- Ongoing funding support for MAT and for people early in recovery that may be ineligible for current funding but can't afford to pay for services.
- Training on ASAM and how to utilize ASAM criteria
- Explore innovative and alternative strategies to address SUD that is more responsive to the diverse needs of communities.

QUESTION 8 (continued)

"What content should a summit aimed at creating a shared, statewide vision and strategic plan on SUD include?"

- Focus on getting information from DHS directly to clinicians, just just the program directors who may/may not pass that information on to their teams.
- We are missing several levels of care
- Long-term recovery options
- Training on application of ASAM criteria and how these evidence based criteria differ from MN Matrix.
- Summit should be free so that workers can come without having to pay or have programs pay.
- take into account neuroscience and how long it takes to change the brain - let that guide length of programming
- Consistency between MDH, DHS, BBHT
- We need a transitional level of care for people entering and leaving treatment
- Consistency between MDH, DHS, BBHT
- We aren't talking about how address the dealers. Why do they sell? What aren't they getting that they sell drugs?
- mentor programs
- Increase the DHS rates. Has not been increase since 2017!!!
- Look at how to get educated people who are invested in this work - and align pay to very challenging and difficult work that is being done
- Must have follow up and follow through on recommendations by DHS. We need increased rates to support changes without extensive regulatory requirements
- Harm reduction accepted and helping keep people safe who do want to use substances
- Stop approving IOP programs. They are a dime a dozen and do not provide individualized care
- The comment was supposed to be that the CCBHC's are all 245G licensed
- panels for those in recovery share what worked for them
- "Educational Scholarships
- Scholarships for people in recovery"
- Education for the legislators on SUD and recovery as well as what their changes are doing to bog down the system
- Examples of what other programs are doing from Intake to Discharge.
- Funding for innovative pilot programs. Look for better solutions
- Better community engagement in state agency (DHS MDH DOC DPS EDU DEED) in developing federal grant applications and RFP
- DHS is forcing providers to use ASAM criteria with no training
- Direct access hasn't solved anything

QUESTION 8 (continued)

"What content should a summit aimed at creating a shared, statewide vision and strategic plan on SUD include?"

- Assurance that DHS will actually listen to the people on the front line and act accordingly.
- Where to get more $$ for Harm Reduction programs- the way funding is put out now makes agencies compete against each other instead of working together
- Plain language standards
- MN has the longest lengths of stay for treatment programs in the country without any positive results
- How to encourage positive parenting and family healing with someone new to recovery
- Where are all the inpatient programs for children?
- provider training on medical necessity for insurance reimbursement
- How to coordinate probation-treatment-assessments-placements-ongoing support
- Getting better participation and coordination with insurance
- reducing repetitive treatment episodes
- focus on healing
- Paperwork reduction
- Capping the group limit at 10 clients instead of 16
- Increase rates.
- Increased rates for SUD services: treatment, care coordination, peer support
- Allow county social workers that were formerly Rule 25 assessors complete Comprehensive Assessments
- Funding for treatment while people are incarcerated.
- Housing
- Educational support for LADC's who want to become licensed mental health providers (LPC or MSW)
- All of these ideas relate to dollars and then individuals to work on distributing those funds. We need staff at DHS.
- Comprehensive Assessments are essentially Rule 25's so there's no reason a R25 assessor can't do it-doesn't need to be an LADC
- Stop treating SUD and Mental Health separately in separate divisions-there should be a combined behavioral health approach
- Expand treatment courts and other Alternatives to Incarceration programs.
- Considering more access/resources for co-existing disorders treatment/programing and services appropriate for individuals with lower cognitive abilities.
- Simplification on paperwork and charting
- Mandating that all treatment providers are co-occurring with mental health professionals and practitioners are on staff providing full behavioral health responses
-

QUESTION 8 (continued)

"What content should a summit aimed at creating a shared, statewide vision and strategic plan on SUD include?"

- Support and funding for peer support specialists
- Treatment centers manditated to provide transportation
- Licensed Social workers should be able to do Comp assessments- LADC is a similar license to LSW
- We need to get away from SUD and MH being separate and we need to integrate ALL of it
- Mandates so individuals don't get discharged from treatment so easily
- Co-Collaboration with Community Resources to ensure Holistic Approach to Care :)
- Paperwork reduction
- Emergency Room commitment to offering same-day opiate agonist treatment
- Harm reduction training
- Addressing workforce shortages and increasing demands on SUD providers , demands which are driving people out of the field
- Cover the spectrum (primary prevention, early intervention, treatment, and recovery).
- Having policy makes and legislators there!
- An initiative like zero overdoses
- Include voices of people in recovery, those from communities disproportionately impacted by addiction, and work on real solutions.
- Including SUD services in primary care
- Networking and connecting
- Putting all of this into action
- Data session
- Sessions on Evidence based programming here and across the country
- The "how."
- development of an ongoing SU response strategic plan,
- How are we going to make these changes
- Agree that legislators need to be there
- Showing what other States have done well.
- Developing a full, inclusive range of services to meet varied needs of ALL Minnesotans experiencing SUD. Include supports to family members.
- Best evidence based clinical practices and public health interventions strategies.
- Moving - national speakers to inspire and show what works elsewhere
- Collaborating with the legal system
- Stories of families in recovery
- Burnout prevention (paperwork reduction is necessary, smaller case loads which requires higher reimbursement rate for services)
- See all the answers from previous slides :-)
- Support and advocacy for LADCs and SUD staff
- Grants available for rural communities need for technology advancement o case management an dprogramming.

QUESTION 8 (continued)

"What content should a summit aimed at creating a shared, statewide vision and strategic plan on SUD include?"

- Evidence based solutions effective in rural and frontier communities.
- Bring a legislative committee hearing to the summit
- Medicaid billing, financial aspects of clinic setup
- Meeting DHS leaders and understanding their roles
- learning about what's working around the state, harm reduction programs, direct access from the jail, treatment courts
- How to include and get family engaged in treatment and change behavior
- Partnering with probation and treatment … is there evidence based approach to align and that is consistent throughout state
- Mental Health and MOUD, peer recovery, harm reduction, opioid settlement dollars, rural workforce development.
- reduce barriers to professionals and para professionals becoming involved in state wide response.
- Ways to reduce administrative responsibility that increases quality care
- Paradigm shift, recognize self-determination of drug users and variations of recovery.
- Data and stories from successful programs
- Changing statutes around prenatal substance use so no longer by itself defined as child neglect
- Law enforcement + harm reduction reconciliation
- Report on where $ has been spent and program outcomes
- Rehabilitation over incarceration
- How we as providers can help reduce stigma/discrimination
- How to transition to a more restorative versus punitive recovery
- Strategic planning—identifying quick hits and a building plan forward
- How can we reduce stigma in healthcare professions
- Listen to people in active addiction and recovery and take them seriously. Again, providing basic needs. Outreach teams, increase number of counselors and assure they are well compensated for their work. Peer recovery, employing former addicts.
- Communication plans, how to have consistent messages across the state
- Sharing information and resources for LADCs to start their own private practice
- Stories of lived experience

QUESTION 8 (continued)

"What content should a summit aimed at creating a shared, statewide vision and strategic plan on SUD include?"

- Bringing law-enforcement, courts, providers, and government together for specific conversations around services and supports for those who are chemically dependent.
- Involve MARRCH more they are right on the money with SUD provider needs
- DHS must following thru on things they are not completing IE waivers, proper funding and not to penalize providers for insignificant items
- Hold a session like this at the summit where participants can provide input.
- People with involvment in the system know best how to meet addicts where they are. Police should be trained to approach addicts with the goal of diversion as opposed to incarceration. That would go far in bringing addicts out of the shadows.
- Increase availability to MAT. Funding for housing and employment support. More mental health availability.
- develop ongoing media coverage.
- Billing- incentivize big healthcare systems to invest in addiction treatment
- Rate enhancements
- Removing structural barriers to folks wanting to be on Suboxone and live a normal life
- Education on SUD,; treatment providers being consistent in how they communicate with all of the parties involved with a persons treatment, ensuring funding is there so everyone has the opportunity for the type of treatment they need/want, ROI's
- So much of these changes cannot be brought about by engagement with law enforcement. We need to align our goals.

QUESTION 9 RESPONSES

The following are an unedited summary of comments attendees replied with when asked “What legislative proposals or ideas do you hope will be considered related to substance use disorder?” There were 102 responses.

- State Funded Tuition reimbursement for LADC's
- Decriminalize substances
- Paperwork reduction for LADC's
- Paperwork reduction
- Have the legislature demand all insurance to to provide treatment
- Money for aftercare housing
- Decriminalize SUD
- Paperwork reduction efforts
- Less paperwork
- more money given to SUD
- More funding for testing and treatment
- Access to services without insurance
- Safe Use sites
- Increased reimbursement for LADC providers, daily rate for residential programs, and increased access to harm reduction
- Reimbursement for interpreters
- now that recreational gummies are legal, end the farce of "medical marijuana"
- more funding for chemical health treatment, money for sober housing
- Papaerwork reduction
- Paperwork reduction
- Safer injection sites, police not charging people for having Naloxone, police not taking unused doses of Naloxone
- Increased reimbursement rates
- funding, more drug court, access to services
- Student loan forgiveness programs
- increased funding
- Education/ prevention
- Funding for contingency management
- Recognizing Native American Practitioners as person to provide services
- funding help for those with medicare
- Grandfathering R25 assessors with 5+ year's experience in to be able to do assessments
- to make it part of 245I- universal standards to help create a consistent approach across the board.
- easier access to services
- contunuation of telehealth services
- Allowing for less treatment hours for holidays
- Housing
- Improving treatment services, more detox beds / facilities.
- elimination of the x-waiver for prescribing buprenorphine
- streamlined and simplified expectations for LADC documentation
- Access to nicotine treatment
- More guidelines about RCOs and peer recovery services!
- Increase rates for culturally specific care
- Student Loan forgiveness for LADC

QUESTION 9 (continued)

"What legislative proposals or ideas do you hope will be considered related to substance use disorder?"

- We have many people who were trained and completed excelled Rule 25. They have an expertise that is not being fully utilized.
- Use previous Rule 25 providers to conduct assessments
- Stronger parity in payment. State funding for hospitalization for clients with SPMI&D.
- End ban on purchase of safer smoking supplies with federal dollars!
- Increased funding and resources for rural communities
- College tuition reimbursement for those in the substance use disorder and mental health field
- Better supports and more attention paid to whats needed for the success of Group homes
- Make it easier for private LADCs to be vendors for insurance
- Funding for prevention work at counties and community level.
- Increase salaries for LADC
- Change that the legistlative proposals not guidance on how to run a client, it is so precriptive
- Teaching that the use of medical marijuana is a harm reduction method
- More benefits for LADC's
- Student loan forgiveness
- Technological investments
- Expanding who can get reimbursed for tobacco treatment services and eliminating barriers to FDA approved cessation drugs
- incentive for LADCs to remain the field
- Prevention dollars towards education and healthcare access
- Fund prevention activities that don't require competitive grants
- More harm reduction treatment services and facilities
- Medicare -increased funding and coverage for SUD
- Paperwork reduction, pathways to recovery's bill, overdose prevention centers, increased rates for all SUD programs
- Broaden ability to assess and treat beyond LADCs
- Jail treatment
- make DHS Licensing a helpful vs punitive agency
- Medicare coverage for elderly clients needing SUDS tx
- Stop demonizing managed use
- explore the way detox facilities are funded
- qualifying treatment as a rational to receive support for child care.
- Grandfather opportunities for other professions such as social workers to increase worker pool
- funding for sober supportive housing with recovery accountability built in
- Simplify billing for Peer Recovery Services

QUESTION 9 (continued)

"What legislative proposals or ideas do you hope will be considered related to substance use disorder?"

- Simplifying regulations and using pain language, mandating technical assistance support for licensing regulations for license holders
- Funding for transportation.
- Eliminate "paraphernalia" as a chargeable offense for drugs
- Allow purchase of safer smoking supplies with federal dollars!
- Medicare paying for MH/SUD providers (LADC, LPCC). Medicare paying for SUD treatment outside of hospital settings.
- Raise the DHS rates! Has not been increase since 2017!!
- Allowing syringes and smoking supplies to be able to be purchased by SSPs through grant fundings
- Expansion of services for adolescents supported with specific funding
- INCREASE STATE FUNDING FOR HOUSING SUPPORT AND GENERAL ASSISTANCE
- state investment in integrated technology systems
- Revaluation of TPR expectations (unrealistic expectations for paperwork)
- lower cost or offer reimbursement for LADCs to maintain their license.
- Creating digital means to complete paperwork.
- Tuition reimbursement for MH/SUD providers.
- Making direct access rules very clear to ensure we all do it the same. Calculsting income, identifying populations as eligible in jaul,iv users, non citizens,homeless. Make it a finacial program only.
- Insurance reimbursement of detox services
- Stop legistative from being authority on ho wto run SUD program / facilitySecond on the jail treatment Increase salary for cd professionals and benefits to avoid burnout
- RCO licensure opportunities (alternative)
- Behavior health providers have smoke free campuses
- Increase reimbursement rates for peer recovery services.
- Funding to pay for current LADCs to get Masters in MH and get finally licensed
- More emergency bed availability
- Reduce prescriptive nature of 245G licensing rules
- Supportive housing and other recovery services in rural areas
- Funding for transportation, housing, etc. Those social determinants of health that cost money but often don't get specific funding.
- Decrease requirements for treatment coordinator, including but not limited to 25 assessors
- Mandate telehealth coverage for payors

QUESTION 9 (continued)

"What legislative proposals or ideas do you hope will be considered related to substance use disorder?"

- Incentivize innovative programs. Use budget surplus toward funding something more effective.
- Medicare paying for more treatment programs.
- Capping group size to 10 clients instead of 16
- Housing and mental health funding rather than continued cuts
- Free treatment for veterans.
- Allow MDH to purchase Naloxone
- Increase the number of billable units per day for peer recovery services.
- more culturally specific mental health provider support, recruitment and retention
- Second on the TPR problems
- Funding for detox services
- Rate increases
- Easier access for education and training of culturally specifc practioners. Increase the numbers who can help address the issues
- modify paperwork deadlines.
- Paperwork reduction- tax alcohol and gummies-specific rural needs assessments for the extreme transportation issues which increase costs for rural SUD Providers. Many health insurances will not provide medical rides due to distance to closest SUD
- More investigation of Portugal's decriminalization peogram
- Paperwork reduction to be consistent with mental health
- Adding positions at DHS to assist in the distribution of these funds.
- Licensing transform to a application assistance agency
- Funding, reduce regulatory over reach, direct access to peers without having to be enrolled in tx. Reduce criminal penalties for sud, workforce, allow Mental Health Professionals to do comp assess and diagnose it is their scope of practice.
- Decriminalizing substance-related crimes
- medicare reimbursement
- allow for sabbaticals in the ladc field to decrease burnout.
- Unrealistic expectation paper work for treatment centers, always talk about client centered, but then DHS says providers can't do this or that without more paperwork REDUCE PAPER WORK
- Raise the tax on alcohol and/or the license to sell
- decriminalization of use
- minimal level of support for all programs (annual microgrant)
- Funding for prevention and awareness communication tools that have translated variations and available in both print and digital that can be ordered for community use, similar to the 988 communication SAMHSA tools.
- using money from legalization to build better programs; safety; etc

QUESTION 9 (continued)

"What legislative proposals or ideas do you hope will be considered related to substance use disorder?"

- State to negotiate cost of Naloxone- all harm reduction agencies to receive this negotiated price
- Reduction in violation penalizations for relapses/continued use
- Tuition support for new LADCs
- Funding for ongoing training for LADCs
- Licence and tax THC edibles and beverages and dedicate funds to treatment
- reduce administrative burdens
- Tuition reimbursement for rural providers
- Review ancillary services such as Medical Rides - not getting clients to where the client needs to access services
- Restructure a DOC facility into a locked co-occurring program for offenders
- more funding to development more specialty courts
- Address Insurance companies that refuse to provide rides to treatment as it is either too far to the SUD facility or they won't travel to evening program
- Follow suit with Portugal decriminalization and turn money towards treatment
- Loan forgiveness opportunities
- Resume 25% of LADC time must be aimed at paperwork and non client care
- Allow education by non ladcs in programs.
- Transportation and medicare
- 35% rate increase on all services and codes included in the Medical Assistance Outpatient & Behavioral Health Rates Study, including an annual inflation adjustor. This increase will sunset with the effective/ implementation date of the new rate metho
- Reduced case load #s for LADCs
- overhall of 245G to simplify and reduce administrative burdens contained
- So open to any resources anyone has to offer supports in this area.
- There's a need for more state hospital beds for MI/CD. We're seeing more significant mental health issues with those using meth in our area.
- We need effective prevention for youth
- elimnate use of DAANES. not useful for the client or provider - never get any info back. why do we do this?
- echo the need for DHS licensing to be less punitive and more supportive
- .
- We need to address social determinants of health and protective factors and not just treatment and emergency response
- More specific funding for k-12 education
- Less paperwork demands (loosen deadlines for certain documents)
- Paperwork/Administrative simplification

QUESTION 9 (continued)

"What legislative proposals or ideas do you hope will be considered related to substance use disorder?"

- Increase of funding for schools for mental and behavioral health
- Narcan available in schools and businesses
- Fund training for providers on treatment and management of sud, perinatal substance use
- Direct appropriations for RCOs!
- Reimbursement for SBIRT and treatment. Reimbursement for perinatal addiction outside of global package
- Increase funds for SUD services!!!
- Legalize safe use sites
- Increase in mobile crisis services
- reduction/update/revie w program licensure statues.
- loan repayment programs for providers
- Better system for medication delivery and coverage/MAT and Mental Health
- Legislation on MN Sober Homes standards will be in the next session via DHS Task Group and stakeholders.
- Funding for community organizations, especially those in Native and Black/AA communities.
- Legislated consistent response to outline a consistent response ordered from the bench
- Decriminalization, diversion as opposed to criminal charges for active addicts. Focus on prosecution of dealers instead of simple users.
- The previous slides should be analyzed for current authority of what we can do without legislative action. Then develop a bill that is inclusive of the previously listed items.
- Public Awareness/Anti-stigma campaign.
- Must improve reimbursements especially in rural areas in the desert
- Fine-tuning data privacy so systems can work better together and support those in recovery
- Expand restorative court interventions
- Funding SUD treatment for incarcerated individuals
- More funding for sober housing- long term vs. transitional housing
- change in background requirements to increase workforce
- Housing first approaches — including stability for existing housing while one seeks housing
- The impact of SUD on children and adverse childhood experiences is significant contributing to declining workforce
- Require and fund moud in criminal justice setting
- Serious attention is needed for SUD. As MDH already noted, deaths are at an all time high and climbing. Providers are burning out. We're nearing a crisis of a breakdown in the SUD system (ie programs closing their doors).
- increasing MAT services in jail/prisons
- Mental health and MOUD opportunities for communities.
- Train and support docs and nurses

QUESTION 9 (continued)

"What legislative proposals or ideas do you hope will be considered related to substance use disorder?"

- Giving mandated reporters discretion about reporting substance use during pregnancy to child welfare if no other safety concerns for infant
- Expansion of Detox Centers statewide
- Dedicated committee and funding to support SUD. All goods related to a potential SUD should be taxed e.g. alcohol to support SUD funding.
- change in daily/unit reimbursement limits for PRS services.
- Tribal jails lack appropriate medical and sud treatment options.
- Hold healthcare providers accountable to contributing to SUD
- State resources where counties don't have the resources
- Increased rates and real solutions for lack of LADCs
- I just want to say thank you for this opportunity!
- Outreach, outrepach, outreach!!! I echo the sentiment about backround checks for employment, addicts charged with nonviolent drug crimes find huge barriers to improving their standing in the community.

QUESTION 10 RESPONSES

The following are an unedited summary of comments attendees replied with when asked "What other feedback would you like to share?" There were 72 responses.

- perinatal drug use/overdose is a leading cause of maternal mortality nationwide and is just being recognized. More funding to prevent this is needed. Disproportionately impacts BIPOC communities.
- Agree that it's time for action.
- Allow AA/NA meetings in jails and prisons again (post covid)
- The summit must be eye opening! Authentic speakers, comfortable setting, tours available
- If we are not part of the solution we are part of the problem.
- new measurable data collection tool/s, specific to SU response efforts.
- DHS needs to better collaborate internally across all divisions as we try to improve systems. To support adults, families and children
- Action Action Action! Let's make all this happen!
- Support to end the ban on using federal funds to purchase syringe supplies
- Recognize that DHS has a huge undertaking to drive the policy. Execution is not always perfect; but, believe the intent is good and seeks to make progress.
-

QUESTION 10 (continued)

"What other feedback would you like to share?"

- Thanks for this opportunity! It's appreciated DHS wants to hear from community
- Tribes have a unique status within the state and counties. We need to be at tables/meetings for all discussions that impact services for tribal agencies. Know the differences between tribes and adapt to them.
- We need a state wide approach — there is so much variability amount counties
- Jails need to provide more tools for treatment if incarcerated folks want it.
- Get the Governor on board with this summit.
- Repercussions from daily life of what people may miss during treatment for why people might not go to treatment or seek it (such as can't miss work,, single parent, etc.)
- How can we be more proactive in addressing sex addiction/pornography within the treatment process for SUD. It is a barrier and very disturbing.
- We really need solutions and follow through. ACTION Action. Action.
- lack of SUD Treatment options for sex offenders
- Acceptance of harm reduction as more effective approach for some individuals
- Research programs implemented. Look at what other societies are doing to reduce overdose deaths. Offer support regardless of whether people are in active addiction. Ultimatums do not work for addicts.
- After working in a few different SUD treatment facilities I've come across unethical practices and overworking of staff. It creates a very unhealthy work culture which spills over to client care. This needs to change for SUD staff retention.
- When dealing with addicts you are working against long established habits that have hijacked parts of the brain responsible for seeking food, water, basic needs...these drives are strong and not well understood.
- It would be great for probation, law enforcement, county attorneys, Judges, etc… to job shadow at a treatment facility to be educated to what treatment is like. I think it would be great for a treatment provider to job shadow with those mentioned
- I hope that the summit is a hybrid model - virtual with an emphasis on in-person
- discussion and dialogue are great, but there needs to be action.
- Nothing else... I feel like the summit was a success- a lot of info to process
- DHS really needs to consider changing their practice during site visits to be less punitive and more supportive.
- Networking with plans of action based on what's working

QUESTION 10 (continued)

"What other feedback would you like to share?"

- Metro and rural MN are different- remember that!
- DHS has too many simultaneously occurring initiatives (Direct Access, 1115, SUD Community of Planning, SUD Summit)… every week it's a new project creating more complexity for providers.
- 245G has created so much oversight that DHS is micromanaging LADCs
- We have these meetings often; those of us actually doing the work share our concerns but NOTHING CHANGES
- Recovery continues long after inpatient treatment. Address the need for these support groups
- Allow participation from other advocacy groups, besides just MARRCH.
- this field needs to be responsive to population needs - DHS , MDH, BBHT cannot move as fast as needs change
- more collaborative efforts with faith based entities
- Prioritize prevention and upstream approaches
- Minnesota needs to catch up with other states and have commercial tobacco free grounds policies at all treatment sites.
- We need a strong DHS that can lead us into the future
- Make sure NAADAC is invited
- We need to focus on less silos-99% of people we treat have multiple issues-mental health and SUD, housing, etc. Treatment centers need to be able to treat both MI and SUD-DHS, counties, etc need to have a whole person approach
- table options for organizations to share work that they are doing and sharing resources
- concerned we have lack of latino services in MN for SUD and MH. Are there programs that have Latino MH programs
- We need DHS to partner with providers and be future focused, not reactive
- We could be funding ADC interns at the CARE programs, offering scholarships specifically to individuals from cultural communities. We could be taking immediate action in linking state agencies in regard to the education and workforce needs.
- Faith based models need to be less shaming and exclusive to one faith and include the use of all faiths
- DHS licesning mico-managing 245g facilities & Staff - not helping and guiding care
- Look at the overlap between regulatory and compliance issues when many agencies provide more than only SUD.
- DOJ needs to be present
- How does research fit into solutions?
- The Minnesota Chapter of NAADAC (MNAP) is the sole federal connection to SUD funding through the block grants and Medicare reform
-

QUESTION 10 (continued)

"What other feedback would you like to share?"

- Need to find ways to coordinate services with justice involved individuals- probation, treatment, counselors, sober communities
- Strengthen the continuum of care with better coordination between treatment and recovery with prevention across the age span.
- stop changing the process and plans. tings change every 3-5 years. we are not able to maintain efficacy and the retraining impacts staff.
- substance use education across all entities; ages; cultures in all languages
- partner for IV DU substance abuse facility in MN for 6 week IV Abx where folks can get SUD services while on IV abx instead of sitting in hospital .
- can we get on the same page for providers, clients and dhs(county offices on ga/grh benefits application and process). this meaning that communication is across the board.
- do NOT decriminalize substances, harm reduction needs to have limitations and accountability, more funding for SUD and less to homeless outreach
- Focus on ALL PATHWAYS to recovery and not on bashing pathways you don't agree with. Including abstinence and faith based as well as MAT and Safe Injection Sites.
- Re-evaluate comprehensive assessment/Rule 25 change and who can perform the assessments.
- Input from all areas of the state needs to be considered. Rural care and services is so much different than metro.
- we have to address the impact of poverty.
- Cd commitmrnts sit in detox. Repel the rule and make pre treatment beds funded for them.
- DHS licensing could add 245G application ssistance to the mission
- Less punitive responses to SUD issues/problems I love this can we get to the point where SUD is responsive without the "punitive" aspect that would be great
- I am frustrated by all the groups, collaboratives, Community of Procatce etc who are all working on the same thing. How do I know who to work with? Who will make a difference? Limited time and $ so I want to put my energy and efforts to best efforts!
- Too much change
- Value based care needs to be discussed and considered by all
- better marketing for SUD access; education; reduction; support; services; etc
- Need to bring young people to the table.
- LISTEN TO THE PEOPLE WHO ARE PROVIDING CARE
- Our current statistics are proof something's not working. Innovation that aligns with research from neuroscience along with current success stories can guide where money would be best spent going forward.

QUESTION 10 (continued)

"What other feedback would you like to share?"

- The switch to 1115 in upcoming years may unfortunately make it impossible for facilities to keep up. Too many are already struggling and shutting down.
- While we are all talking about it - people are dying! This is an epidemic - lets start treating it as such!!
- LISTEN TO THE PEOPLE WHO ARE PROVIDING CARE
- Training on ASAM
- We had a staff that had done Rule 25 and case management for people with SUD for 30 years that is no longer qualified to do the job- makes no sense
- Find pathways to serve individuals that are in need of residential care that don't speak English.
- Action items on a specific timeline should be the main goal for any solutions going forward to keep DHS accountable for the decisions made in regards to SUD.
- There needs to be followup after the summit
- I was in a DHS led paperwork reduction group 5 years ago... Still no movement
- Stop legalizing substances. Decriminalization is NOT the answer, it's creating more problems.
- How will we know if direct access is working or not working?
- state-wide leaders need to be there and be engaged
- Do NOT decriminalize. Need to limit/control access, not increase access and availability.
- address Medicare to see the need pay for SUD treatment outpatient vs only hospital SUD Programs or meeting with their Primary Provider (who has minimal training for SUD)
- Provide more education on SUDS for SW and child protection departments - often who think force will get people sober and don't like client choice or client centered approaches.
- three is need to be two definittions in statute- culturally responsive and Culturally specific (clarification-culturally specific programs are the lead content experts that culturally responsive service and programs can learn from))
- reduction in treatment episodes for people who don't want to stop using
- We need centralized intake across programs for referrals
- direct access is not working in rural MN! So sad how DHS has failed so many
- Probation is about accountability an sentence alternative. It may include treatment.
- Reduce unreasonable documentation requirements
- Direct Access is only direct access for some people. Programs still have discretion which leaves a lot of people not served or waiting for care.
- What happened to Walz's Recovery iniatives
- Let's work together and not blame

QUESTION 10 (continued)

"What other feedback would you like to share?"

- Address direct access concerns regarding downward departure choice from professional recommendations.. If that is allowed, why can't previous assessor continue to provide that service?
- Direct access is not good. Providers dont want you to go to any program but theres.
- Direct access has been a failure in rural MN. Putting so much pressure on programs that are already understaffed.
- disproportionate reimbursement rates for higher levels of care incentivize program based (predetermined lengths of stay) programming rather than individualized, stage-matched, and evidence based care matching
- SUD is losing good providers to MH due to the 245G oversight, paperwork needs and poor pay. We are dually training staff as LADC and LPCC or LicSW and losing them. This cannot continue
- faster turnaround with info from DHS
- Statewide resource map and initative map with priority focus areas to coordinate and organize the large amount of work.
- If you are going to allow services like traditional healing, recovery services through Shamans, etc. you need to allow Christian based services as well. Let the person decide if a Christian based service works for them they should have access to it.
- CD assessments dont really follow clients. They have to have a new assessments every time. Redundant!
- thank you for asking and putting this together!
- We seem to go in circles with paperwork reduction, we have been talking about this for over a decade and yet, we have more paperwork now than 5 years ago. Direct Access is great and creating more work.
- Prioritize equitable access and exchange of information, not just those who are already at the table
- Thank you for this forum! Would really like to see collaboration with other states about what is working well, ideas for simplifying regulations, etc.
- Please consider discussion regarding "holding spots" for individuals waiting for CARE when ordered to CD Civil Commitments. We've identified them as I'm most need, but can't access level of care immediately

QUESTIONS?

- If you have questions or need more information on XYZ, contact ABC