Substance Use Disorder (SUD) Community of Practice (CoP) Meeting

June 17, 2026

12:00 – 1:30 p.m. Hybrid

Brightwater Health

Meeting Summary

Background

On June 17, 2026, the Minnesota Substance Use Disorder (SUD) Community of Practice (CoP) convened in a hybrid format, with most participants attending virtually and a small group participating in person at Brightwater Health in Duluth. The meeting continued the CoP's Quarter 2 focus on Co-Occurring Disorders (COD), building on insights from prior sessions to identify system breakpoints and develop actionable recommendations across the continuum of care.

The session was designed to move from shared understanding to action, grounding discussion in real-world experiences and using a structured framework to generate recommendations across policy, communications and practice.

Attendance

Sixty-two (62) participants attended virtually. Six (6) guests joined the SDK team in person at Brightwater.

Meeting Objectives

- Identify the unique stages of treatment for individuals with COD
- Generate actionable recommendations to improve care across the COD continuum
- Share practical strategies and real-world approaches to strengthen care coordination, transitions and information sharing

Welcome and Opening (Stephanie Devitt, SDK Strategic Services)

Stephanie welcomed participants and reviewed the Shared Vision, Community Agreements, and expectations for participation in the CoP.

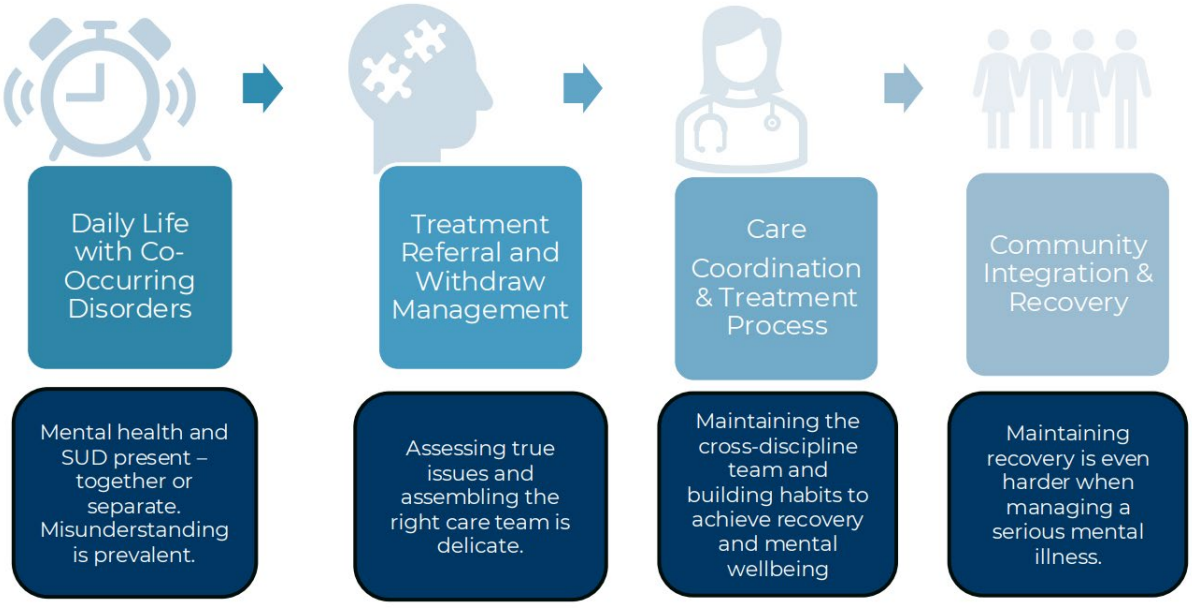
Brightwater Health and the CCBHC Model (Brad Hoder, Brightwater Health)

To ground the discussion in real-world practice, Brad Hoder from Brightwater Health provided an overview of Brightwater Health and the Certified Community Behavioral Health Clinic (CCBHC) framework. The presentation highlighted how the CCBHC model is designed to address fragmentation in behavioral health care by creating a coordinated, integrated system of services. The CCBHC model is designed to reduce referral barriers, improve communication between providers and ensure individuals receive the full range of services they need without being redirected across disconnected systems.

The presentation also acknowledged ongoing challenges, including workforce shortages, housing instability and system complexity, reinforcing that while integrated models improve access and coordination, community-level barriers remain significant.

Framing the Work: The COD Journey (SDK Strategic Services)

Following the site presentation, Stephanie provided an outline of the journey experienced by individuals living with COD. Drawing on Q2 feedback, Stephanie broke up the journey into four stages to illustrate where individuals encounter the greatest challenges and opportunities for intervention:



1. Daily Life with Co-Occurring Disorders
2. Treatment Referral & Withdrawal Management
3. Care Coordination & Treatment Process
4. Community Integration & Recovery

The COD journey framing reinforced several key insights:

- Individuals experience care as one continuous journey, not separate systems
- Breakpoints often occur at transitions between stages or systems
- Effective solutions require alignment across policy, communications and practice

Small Group Discussion Approach

Using the four-stage framework, participants were able to self-select into one of four breakout groups. Each group focused on a single stage and was asked to develop targeted recommendations across:

  - Policy (laws, regulations, funding structures)
  - Communications (information sharing, expectations, coordination)
  - Practice (day-to-day approaches to care and engagement)

This structure enabled participants to move beyond general discussion and generate concrete, stage-specific recommendations, grounded in both lived experience and system-level expertise. The following sections summarize participant feedback, key themes and recommendations across each stage of the COD journey.

Cross-Stage Themes (Consistent Across the COD Journey)

Participant feedback across all four stages of the COD journey revealed a set of consistent, system-wide challenges and opportunities, alongside targeted strategies that are unique to specific phases of care.

Across daily life, referral, treatment and recovery, participants consistently emphasized the need for system alignment, person-centered care and improved coordination.

1. Fragmentation and Siloed Systems Leads to Re-Traumatization

Across every stage of the COD journey, participants identified disconnected systems and inconsistent coordination as a primary barrier to effective COD care.

- Daily life: limited shared understanding of the interconnectedness of co-occurring disorders even prior to treatment

- Referral: silos between DHS, counties, corrections and providers leads to re-traumatization between stages as individuals have to reshare stories multiple times
- Ongoing care: “persistent siloing across providers, counties and systems”
- Recovery: “fragmented community systems and limited coordination”

Systems continue to operate in parallel rather than integrated pathways, leading to treatment failure for either mental health or SUD when re-traumatization occurs.

Quotes from across GroupMaps:

“Reducing silos within the system from Bench to treatment referral… the communication between all parties involved can be very difficult”

“Stop siloing services”

“Organizations operate independently without sharing updates or resources”

2. Need for Stronger Communication and Shared Infrastructure

Every stage of the COD journey highlighted the need to improve how information is shared, understood and acted upon.

Common recommendations included:

- Simplified and standardized release of information (ROI) processes
- Shared tools (e.g., databases, care plans, resource directories)
- Clear, consistent messaging across systems
- Stronger participant-facing communication

This appears as:

- Early-stage confusion about care roles and expectations
- Mid-stage breakdowns in referral and coordination
- Later-stage need for ongoing communication between community supports

Communication gaps are not isolated; they compound across the journey and significantly impact outcomes.

Quotes from across GroupMaps:

"Have the client sign a ROI so professionals can all communicate… we talk about it but nothing changes."

"Creating an easy access data base of programs and details of programs to make better more appropriate referrals."

"One location (website or database) for providers to access updates and real time openings for continuing care."

"A standard approved release of information (ROI) that could be used for multiple agencies"

3. Person-Centered, Individualized Care

Participants consistently emphasized moving away from system-driven and one-size-fits-all approaches.

This includes:

- Individualized treatment planning
- Respect for autonomy and participant choice
- Meeting people "where they are" across all stages
- Recognizing recovery as non-linear and long-term

Examples across stages:

- Daily life: "doing WITH someone vs FOR someone"
- Treatment: need for appropriate referral and placement
- Ongoing care: rejection of "one-size-fits-all" models
- Recovery: emphasis on client choice and person-centered care

Person-centered care must be embedded consistently across systems in order to accurately treat co-occurring disorders, not just within individual programs.

Quotes from across GroupMaps:

"Doing FOR someone vs doing WITH someone…"

"Not 'size' fits all. Start: individualizing treatment/care."

"One size fits all lens of treating co-occurring disorder"

4. Workforce, Lived Experience and Trust

Across all stages of the COD journey, participants emphasized the importance of:

- Lived experience in service delivery and policy-making
- Building trust through relationships and consistency
- Expanding workforce capacity and training

This shows up as:

- Early-stage need for culturally responsive and relatable providers
- Mid-stage navigation supported by trusted professionals
- Later-stage integration of peer supports and community-based roles

Trust and engagement are built through people, not systems, and require sustained investment in workforce and peer roles.

Quotes from across GroupMaps:

"Hire individuals with lived experiences to better connect with clients facing COD."

"People with lived experience being in the policy decisions (without being tokenized though)"

"Embed peers in hospitals, jails, shelters, and community orgs"

5. Structural Barriers: Housing, Transportation and Basic Needs

Participants consistently identified basic needs as foundational to COD recovery outcomes, especially beyond treatment.

- Housing instability appears as a large topic across stages involving active care and recovery
- Transportation barriers impact access across all stages
- Financial and funding limitations affect entry, engagement and continuity

Without addressing social determinants of mental health, even well-designed treatment systems struggle to achieve long-term impact.

Quotes from across GroupMaps:

"Have a focus on housing. Stop discharging back to the streets and stop the cycle."

“Stop making it so challenging to physically help people get to (transportation) to treatment.”

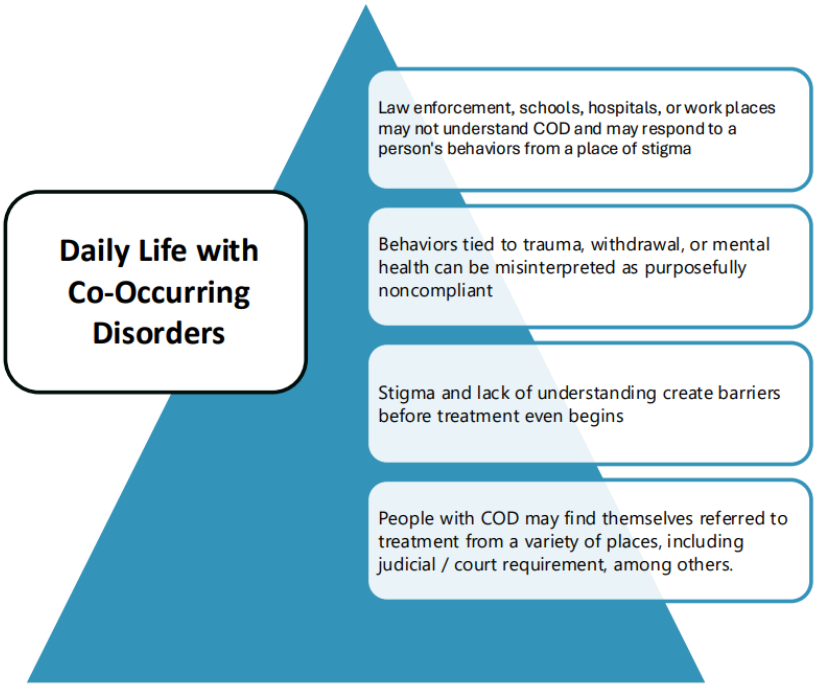
“Need for safe, accessible, and affordable housing”

“More housing with supports for people with no/low income…”

Stage-Specific (Unique or Concentrated) Strategies

While many themes were consistent, certain strategies were distinctly concentrated within specific stages of the COD journey.

Stage 1: Daily Life with COD (Pre-Treatment Focus)



Unique emphasis on prevention, education and early system interaction:

- Early mental health and COD education (youth, community-level)
- Reducing stigma of mental health and SUD across public systems (schools, employers, communities)
- Shifting from compliance to relationship-building at first contact
- Addressing documentation burden before treatment engagement

This is the only stage focused on pre-treatment system design, where engagement is first shaped.

Quotes from GroupMap:

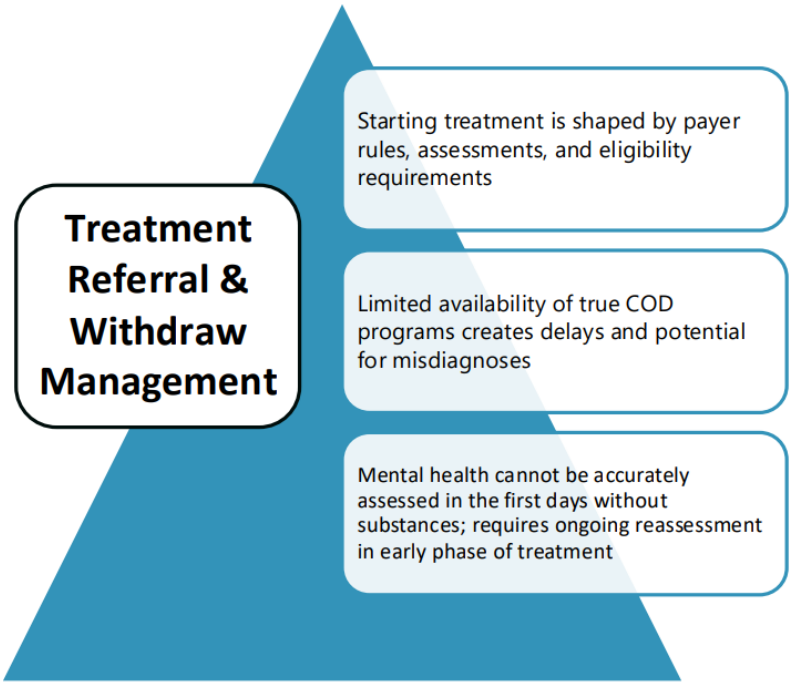
"There is stigma around COD especially in other communities, which leaves people feeling very alone."

"Create simpler participant-facing explanations of the care team and their roles. Participants often hear instructions but they don't know the why behind the coordination of care. We in the industry can often forget this is a complicated space to navigate starting this journey."

"Educate our communities and teach them skills around COD."

"Stop admitting the clients struggling with co-occurring issues into treatment centers that are not capable of providing co-occurring services"

Stage 2: Treatment Referral & Withdrawal Management



Unique emphasis on access, eligibility and system entry points:

- Standardizing referral processes and determination roles
- Addressing eligibility inconsistencies and exclusionary criteria
- Ensuring continuity of care across corrections and transitions
- Expanding access to withdrawal management and MOUD/MAT (especially in jails)

This stage is the primary "gateway into treatment," where policy and process barriers directly determine access.

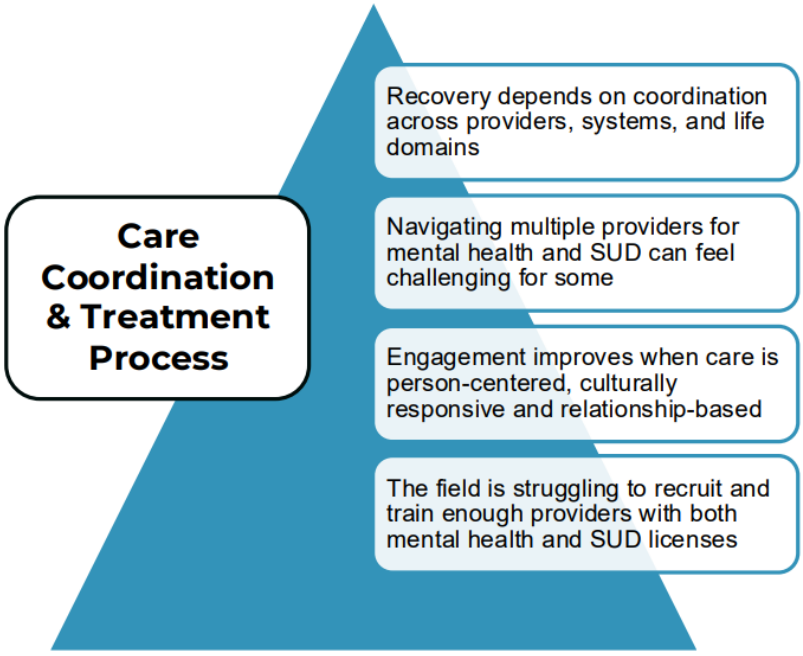
Quotes from GroupMap:

"Better access to DAs for incarcerated individuals; this would allow referrals to dual diagnosis programs like IRTS."

"Start better communication between DHS, counties, programs etc. So many do not understand clearly what is going on..."

"Better managed referral determination process. Who gets notified of determinations and who does the treatment coordination."

Stage 3: Care Coordination & Treatment Process



Unique emphasis on coordination timing and treatment structure:

- Starting coordination early in treatment, not at discharge
- Aligning levels of care and program structures (e.g., ASAM4, service hours)
- Increasing time for coordination and communication between providers
- Preventing cycling through treatment without progress

This stage focuses on how treatment is delivered and coordinated over time, rather than access or community supports.

Quotes from GroupMap:

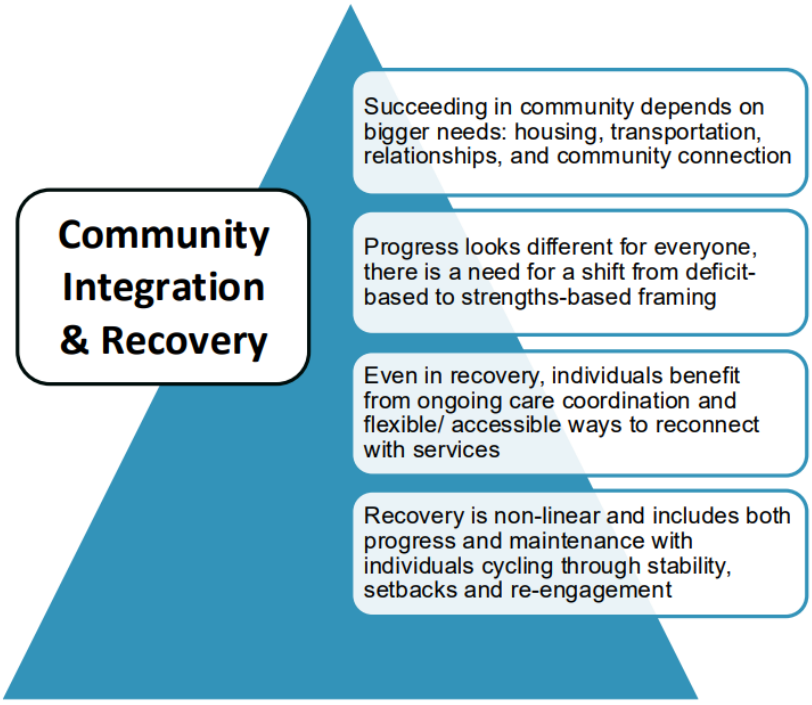
"Coordination with community partners at the beginning of treatment and not towards the end"

"Stop putting people right back into the same place they were before they entered treatment"

"Start seeing what patients need after discharging, such as insurance, housing, food, etc."

"Making clients aware of support systems available and let them decide what info can be shared"

Stage 4: Community Integration & Recovery



Unique emphasis on long-term stability and community-based systems:

- Housing as a primary determinant of recovery success
- Embedding peer support across community settings (shelters, hospitals, etc.)
- Expanding community-based recovery ecosystems

- Reducing criminalization and administrative barriers
- Sustaining recovery through ongoing, flexible supports

This stage extends beyond traditional treatment into long-term system design for recovery and stability.

Quotes from GroupMap:

"More housing with supports for people with no/low income that does not require a coordinated entry (CES) referral"

"People with lived experience being in the policy decisions (without being tokenized though)"

"Embed peers in hospitals, jails, shelters, and community orgs"

Overall Takeaways

Taken together, participant feedback highlights that improving outcomes for individuals with COD requires:

- System-wide alignment across policy, communications, and practice
- A shift from episodic treatment to continuous, coordinated care
- Investment in both clinical systems and community-based supports
- Recognition that each stage requires different—but connected—interventions

While each phase presents distinct challenges, success depends on how well

What's Ahead

In Quarter 3, the Community of Practice will shift focus to the intersection of corrections and the substance use disorder (SUD) ecosystem. This next phase of work will examine how justice involvement shapes pathways into and out of care, with particular attention to treatment access, housing stability, recovery supports, and long-term outcomes for individuals involved in the justice system.

- Next meeting: Wednesday, July 15, 2026 (12:00–1:30 p.m., virtual).
- Links to RSVP, a brief meeting evaluation survey, and the lived/living experience stipend request form were shared in the chat.
- Post-meeting materials (slides and GroupMap synthesis) will be distributed by the facilitation team.
- For questions, contact: SUD.CoP@SDKStrategicservices.com