Governor's Advisory Council on Opioids, Substance Use, and Addiction

Office of Addiction and Recovery

MINNESOTA
GOVERNOR'S ADVISORY COUNCIL ON
OPIOIDS, SUBSTANCE USE, AND ADDICTION

December 2, 2025

Agenda

- Welcome and roll call
- Council time with the Office of Addiction and Recovery
- Overview and discussion on Executive Order – Ending Crime and Disorder on America's Streets
  - Assistant Commissioner Teresa Steinmetz, Department of Human Services
  - Dr. KyleeAnn Stevens and Catherine Courcy, Direct Care and Treatment, along with Weston Merrick, Results First, MMB
  - Assistant Commissioner and Executive Director Cathy tenBroeke, Minnesota Council on Homelessness
- Council year end wrap-up and look ahead
- Debrief and adjourn

Council Charge

Purpose

- Advise the Governor's Subcabinet on Opioids, Substance Use, and Addiction on the purposes and duties described in Minnesota Statutes 4.046.
- Represent community leaders, individuals with direct experience with addiction (and recovery), individuals providing treatment services, and other relevant stakeholders.

Council duties

1

Advise the Subcabinet regarding implementation of its purpose, policy and strategy development, and public engagement.

2

Identify opportunities and barriers for the development and implementation of policies and strategies to expand access to effective services for people in Minnesota suffering from (experiencing) addiction (and recovery).

3

Examine what services and supports are needed in communities that are disproportionately impacted by the opioid epidemic.

4

Provide opportunities for Minnesotans who have directly experienced addiction (and recovery,) to address needs, challenges, and solutions.

Advisory council guiding principles

- **Center equity:** Acknowledge the disparities in Minnesota and the communities that are disproportionality impacted, including those based on race, geography, and economic status. The council agrees to support the Governor and Lieutenant Governor's commitment to diversity, inclusion, and equity as essential core values and top priorities to achieve better outcomes for all Minnesotans.
- **Acknowledge intersectionality:** Recognize the role of intersectionality and the need to address stigma and disparities to achieve outcomes for individuals and families impacted by substance use and addiction. This includes being geographically responsive and acknowledging the unique needs in urban and rural communities.
- **Take a systems level approach:** Acknowledge that solutions do not exist in isolation and that underlying structures and systems often prevent successful treatment and recovery outcomes, including workforce, housing, criminal justice, and financing challenges.
- **Create an inclusive process:** Engage and listen to the voices of people with lived experience to provide community and individual input into decisions that affect them.
- **Focus on results:** Identify opportunities for the development and implementation of policies and strategies that are transformative and lead to better outcomes for individuals and families.

Accomplishments

2024 Year-end report

- Welcomed new voices to the Council
- Statewide Goal for Substance Use Disorder in the One Minnesota Plan
- Minnesota's First Naloxone Saturation Strategy
- Advocated for Changes During the 2024 Legislative Session
- Workgroup Launched to Expand MOUD Access in Jails
- Centered Communities Disproportionately Impacted by Substance Use
- Guided Cannabis Legislation Implementation
- Expanded Access to Care Before Release
- Strengthened SUD Treatment Standards for Minnesotans who are incarcerated
- Developed the Council's 2025 Legislative Agenda

Procedures

Open meeting law requires public bodies to **record and maintain votes** of its members.

Formal votes will be held for meeting minutes and formal decisions made by the Advisory Council.

Virtual meetings require a vote by roll call and a quorum (simple majority) is required to vote.

Roll call and introductions

- Share your name and affiliation

Approval of meeting minutes

- Approval of October 2025 meeting minutes.

Council time with the Office of Addiction and Recovery

- Community engagement efforts
- Interagency State Substance Use Plan Report
- Substance Use Disorder Community of Practice
- Legislative update

State agency Legislative Proposal Process

Every year, executive agencies develop proposals for the Governor's consideration

Proposal development occurs throughout the year and can take 18 months or more

Bulk of proposal development work occurs between June – November for the upcoming legislative session

Proposal process and budget package varies based on multiple factors:

- Policy vs. budget year
- Budget forecast (surplus/deficit)
- Who's in Governor's office and legislature
- Priorities of Governor's office, state agency leadership, and other pressures impacting state programs and people receiving services
- Session starts February 17, 2026

Feedback interviews with Advisory Council members

- Feedback interviews were conducted in response to council member requests for additional communication with OAR.
- OAR also wanted council input to help shape our communication plan for 2026.
- Interviews were conducted with 9 out of 18 council members

Feedback interview questions

- What are some ways you think the council has done well in carrying out its duties and functions?
- As a council member, is there anything you would like to be able to do more of or do differently in the future?
- What is OAR doing well right now to support the Advisory Council in carrying out its duties and functions? Are there ways OAR can better support the Advisory Council in the future?
- Are there any updates or resources you would like OAR to share at the December Advisory Council meeting?

Feedback interview responses

What OAR Has Done Well

- OAR has been good at bringing together important skate holders and facilitating opportunities for the council to advise.
- The information and legislative support OAR provides to the council is valuable
- OAR represents the council and its priorities well to both the community and state leaders

Feedback interview responses (2)

What OAR Could Do to Improve

- More frequent communication with the council
- Provide additional ways for council members to coordinate efforts and opportunities with each other

Feedback interview responses (3)

The Council Environment

- The council does a good job of creating a welcoming environment for members to share their opinions.
- The council is made up of a broad range of people who bring valuable perspectives and have strong connections to the issues.
- Some interviewees expressed wanting additional representation on the council from certain groups.

Feedback interview responses (4)

The Council's Priorities

- The council has done well to identify high priority areas and gaps in services while remaining committed to representing communities disproportionately impacted by substance use disorders.
- At the same time, there remain issues important to council members that have not been focused on.

Feedback interview responses (5)

The Council's Accomplishments

- Interviewees were proud of the work they had done in the first two years of the council.
  - Access to MOUD in Jails
  - The 1115 Reentry Waiver
  - The 2023 Year-End Report

Feedback interview responses (6)

The Council's Future Work

- Becoming more involved in shaping the state's plans and legislative proposals.
- Becoming more educated on the legislative process and better equipped to create change.
- Focusing on tackling a specific issue through working towards actionable goals.
- Deciding how best to use council meeting time
- Changing the council's outreach to be more active and visible than what has been done previously.

Key takeaways and observations

- OAR should create new pathways for communication between itself and the council.
- There's a noticeable difference in perspectives between members that have been on the council for a long time and ones that recently joined.
- The variety of perspectives on the council is valuable but makes it more difficult to establish consensus.
- There remains a lack of consensus on what issues the council should focus on and how to tackle them.

Poll

- Do council members want to receive an email between meetings that includes OAR curated resources and information gathered from council members?
- How would council members prefer to share their thoughts and updates with OAR? Through bimonthly check ins, a short online form, or emails?

Reflections from the chair

Break

EO - “Ending Crime and Disorder on America’s Streets”

PRESIDENTIAL ACTIONS

ENDING CRIME AND DISORDER ON AMERICA’S STREETS

Executive Orders | July 24, 2025

By the authority vested in me as President by the Constitution and the laws of the United States of America, it is hereby ordered:

Section 1. Purpose and Policy. Endemic vagrancy, disorderly behavior, sudden confrontations, and violent attacks have made our cities unsafe. The number of individuals living on the streets in the United States on a single night during the last year of the previous administration — 274,224 — was the highest ever recorded. The overwhelming majority of these individuals are addicted to drugs, have a mental health condition, or both. Nearly two-thirds of homeless individuals report having regularly used hard drugs like methamphetamines, cocaine, or opioids in their lifetimes. An equally large share of homeless individuals reported suffering from mental health conditions. The Federal Government and the States have spent tens of billions of dollars on failed programs that address homelessness but not its root causes, leaving other citizens vulnerable to public safety threats.

Shifting homeless individuals into long-term institutional settings for humane treatment through the appropriate use of civil commitment will restore public order. Surrendering our cities and citizens to disorder and fear is neither compassionate to the homeless nor other citizens. My Administration will take a new approach focused on protecting public safety.

Sec. 2. Restoring Civil Commitment. (a) The Attorney General, in consultation with the Secretary of Health and Human Services, shall take appropriate action to:

(i) seek, in appropriate cases, the reversal of Federal or State judicial precedents and the termination of consent decrees that impede the United States’ policy of encouraging civil commitment of individuals with mental illness who pose risks to themselves or the public or are living on the streets and cannot care for themselves in appropriate facilities for appropriate periods of time; and

(ii) provide assistance to State and local governments, through technical guidance, grants, or other legally available means, for the identification, adoption, and implementation of maximally flexible civil commitment, institutional treatment, and “step-down” treatment standards that allow for the appropriate commitment and treatment of individuals with mental illness who pose a danger to others or are living on the streets and cannot care for themselves.

Harm Reduction

Assistant Commissioner, Teresa Steinmetz, DHS

- DHS core values
  - **Person-centered approaches** that respect individual choice and meet people where they are
  - **Multiple pathways to recovery** recognizing that many paths exist for people struggling with SUD
  - **Inherent dignity** of all people seeking support and care
  - **Harm reduction** as an important door to treatment and recovery

Federal policy shift

Housing First Model

Federal dollars prohibited from programs that prioritize providing permanent house to people experiencing homelessness

Harm Reduction Services

Federal funding restricted for programs offering safer use supplies such as sterile needles

Substance Abuse and Mental Health Services Administration

Will continue to support harm reduction programs such as naloxone distribution and drug checking kits for users but will no longer support programs that offer safer use supplies or services, such as sterile needles.

Minnesota’s strong harm reduction network

- Minnesota’s harm reduction efforts should continue with minimal interruptions thanks to strong investments over the years from the Minnesota Legislature.
- In May 2023, the Minnesota Legislature bolstered that network by approving funding for Safe Recovery Sites, harm reduction for culturally specific communities, and the Comprehensive Drug Overdose and Morbidity Prevention Act (MDH).

Safe Recovery Sites

- The primary function of these sites is to save lives through overdose and disease prevention
- The sites offer an array of supplies and services, including sterile syringe exchanges, Naloxone, street outreach, health and wellness services, education and referral services, Fentanyl test strips, access to sanitation and hygiene, and more
- Contracts are currently under development and sites will be announced soon

SAMHSA federal grant changes

Prohibited Grant Activities

- Pipes of safer smoking kits
- Syringes or needles for illicit drug injection
- Sterile water, saline, or ascorbic acid for drug use

Continued Grant Support

- Naloxone and nalmefene
- Substance test kits
- Medication lockboxes and disposal kits
- Wound care supplies
- HIV and hepatitis test kits
- Sharp disposal kits

Minnesota Impact:

Prohibited services are already solely funded by state dollars. Expect minimal impact on DHS-administered programs.

DHS remains concerned

- **Partner capacity:** Many harm reduction partners rely on federal funding. Reduced capacity means fewer people getting help to protect themselves and their communities.
- **Ongoing HIV outbreaks:** Two active HIV outbreaks in Minnesota disproportionately impacting people who inject drugs. Ensuring widespread sterile needle availability is key to reducing transmissions.
- **Lost connections:** If people stop coming into community spaces because sterile needles aren’t available, we lose an opportunity to connect them to services that could ultimately save their lives.

Minnesota's commitment

- **DHS remains committed to our partners and the people we serve**
  - Syringe service providers and Safe Recovery Sites **foster trusted, stabilizing relationships** — especially for marginalized communities and those experiencing homelessness
  - These sites **successfully engage people** not connected with community health programs or human service systems
  - Staff provide **education and referrals** to treatment, mental health services, housing, healthcare, and other critical supports

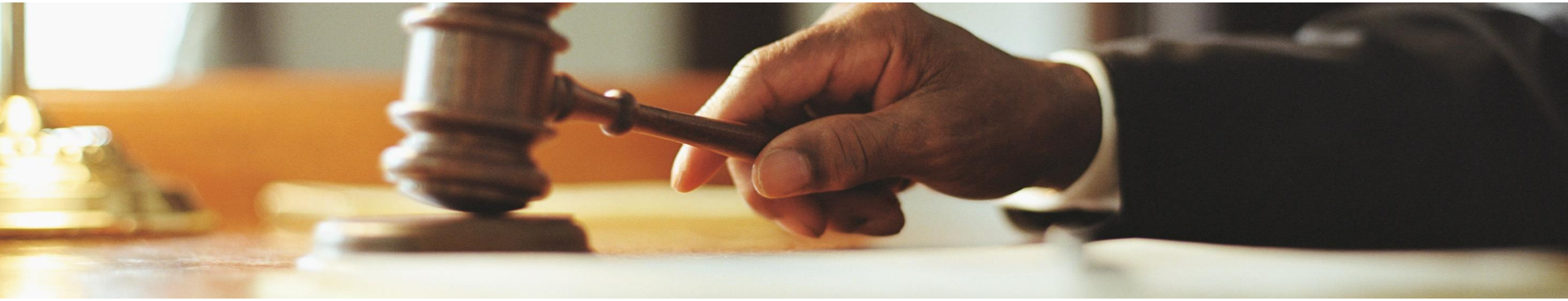
Moving forward

- **Awaiting federal guidance:** Executive orders are not law. We await additional guidance from federal government.
- **Lifting voices:** Continuing to center people with lived experience in our policy decisions.
- **Following federal law:** DHS will continue to follow federal law while planning for possible impacts.
- **Advocating for people:** Working with partners to advocate for person-centered policies that empower people.

Civil Commitment

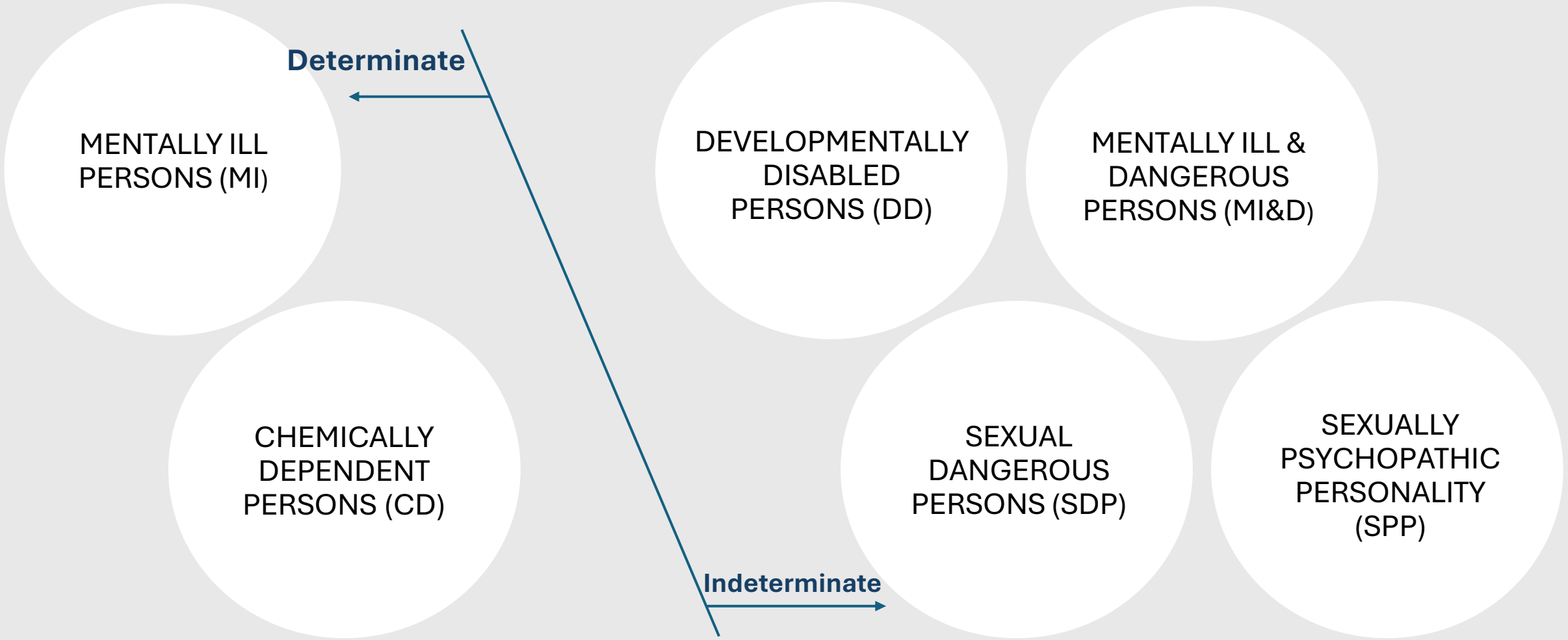
- Dr. KyleeAnn Stevens and Catherine Courcy, Direct Care and Treatment
- Weston Merrick, Principal Manager, Minnesota Management and Budget

DIRECT CARE AND TREATMENT



MI/CD Civil Commitment Overview

Civil Commitment Types



How a Commitment Starts

- Minnesota Statutes chapter 253B – the “Commitment Act”
- County-based “Pre-petition screening” (PPS) office reviews a case and makes a recommendation for or against commitment, and what type
- County attorney makes ultimate determination on pursuing a commitment in court by filing a commitment petition
- Before a commitment is ordered, a judge might issue an “Apprehend and Hold” order
- Before a commitment is ordered, a medical provider can issue an “Emergency Hold” order or a Peace Officer may issue a hold

How a Commitment Starts

- After the Petition, court appoints an independent examiner
- Hearing
- If court issues a commitment order, the order acts as legal authority for a treatment provider to **hold** and **treat** someone involuntarily
- Variation by county
- Can have any combination of commitments

Mentally Ill “MI” Commitment Standard

A "person who poses a risk of harm due to a mental illness" means any person who (1) has an organic disorder of the brain or a substantial psychiatric disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or to reason or understand, that is manifested by instances of grossly disturbed behavior or faulty perceptions and who, (2) due to this impairment, poses **a substantial likelihood** of physical harm to self or others as demonstrated by:

(1) a failure to obtain necessary food, clothing, shelter, or medical care as a result of impairment;

(2) an inability for reasons other than indigence to obtain necessary food, clothing, shelter, or medical care as a result of the impairment and it is more probable than not that the person will suffer substantial harm, significant psychiatric deterioration or debilitation, or serious illness, unless appropriate treatment and services are provided;

(3) a recent attempt or threat to physically harm self or others; **or**

(4) recent and volitional conduct involving significant damage to substantial property.

Chemically Dependent “CD” Commitment Standard

"Chemically dependent person" means any person:

(a) determined as being incapable of self-management or management of personal affairs by reason of the habitual and excessive use of alcohol, drugs, or other mind-altering substances; and

(b) whose recent conduct as a result of habitual and excessive use of alcohol, drugs, or other mind-altering substances poses a substantial likelihood of physical harm to self or others as demonstrated by

- (i) a recent attempt or threat to physically harm self or others,
- (ii) evidence of recent serious physical problems, or
- (iii) a failure to obtain necessary food, clothing, shelter, or medical care.

"Chemically dependent person" also means a pregnant woman who has engaged during the pregnancy in habitual or excessive use, for a nonmedical purpose, of any of the following substances or their derivatives: opium, cocaine, heroin, phencyclidine, methamphetamine, amphetamine, tetrahydrocannabinol, or alcohol.

MI, CD Commitments - Process

- If person meets the legal standard, the court issues an initial commitment order for no more than 6 months
- Once committed, person may obtain treatment at DCT or in the community
- Based on a treatment report at 6 months, court will “continue” the commitment for no more than 12 months, or it will expire
- When the commitment expires, the county will need to petition for “recommitment” if they want to continue to commit the person
- Treatment team or county responsible for providing treatment reports at statutorily-mandated deadlines to update the court on the person’s progress

Rights under commitment

- Attorney
- Limitation on use of restraints
- Right to mail
- Right to visitors and phone calls
- Right to give consent for medical treatment
- Proper care and treatment
- All commitment types eligible for Jarvis/SDM orders
- Care may be paid for by private insurance or the county

Discharge or Termination

- Person can petition the court to terminate commitment at any time
- Entity to which the person is committed can provisionally discharge the commitment when the person no longer needs care in the institutional setting
- DCT may do a “remote” provisional discharge when appropriate for people in the community
- “Stay of Commitment” option prior to admission to institutional setting

Other – Tribal Commitments

- Ordered under individual tribal commitment codes, not Minnesota Commitment Act
- DCT can recognize them and treat them as binding through the Minnesota Commitment Act 253B.212
- Red Lake and White Earth Nation can issue orders directly
- All other tribes must have their commitment orders recognized by a Minnesota district court
- Similar to Minnesota commitments although often they have no expiration date

7/24/25 Federal Executive Order

- Overall focus on “institutionalization”
- Direction to:
  - Seek … the reversal of Federal or State judicial *precedents* and the termination of *consent decrees* that impede the United States’ policy of encouraging civil commitment of individuals with mental illness who pose risks to themselves or the public *or are living on the streets and cannot care for themselves* in appropriate facilities for appropriate periods of time
- No “substantial likelihood of harm”
- No connection with mental illness or substance use
- Inconsistent with state statute standards

MANAGEMENT AND BUDGET

Competency & Commitment Descriptive Analysis

December 2, 2025

Project background: Competency & Commitment

- Project in response to limited information about:
  - Capacity and funding
  - Limited visibility into people's journeys through the commitment process
  - Limited understanding of peoples' interactions with other support systems (e.g., MHCP, AMHI)
  - Identifying roadblocks or critical paths in the system

Dataset	Type of data	Purpose
Courts	Competency and commitment hearings and judgments	Understand how people move through the court process; including variation by geography and demographics
MHCP claims data (MMIS)	Diagnosis, treatment/ services, demographics	Behavioral health services received before and after commitment case opened
AMHI-funded services (SSIS)	Treatment/services, demographics	Mental health services received before and after commitment case opened
DCT healthcare data*	Facilities, treatment	Extend journey maps beyond court judgment to look at journey inside DCT

Existing and Planned Data Integrations

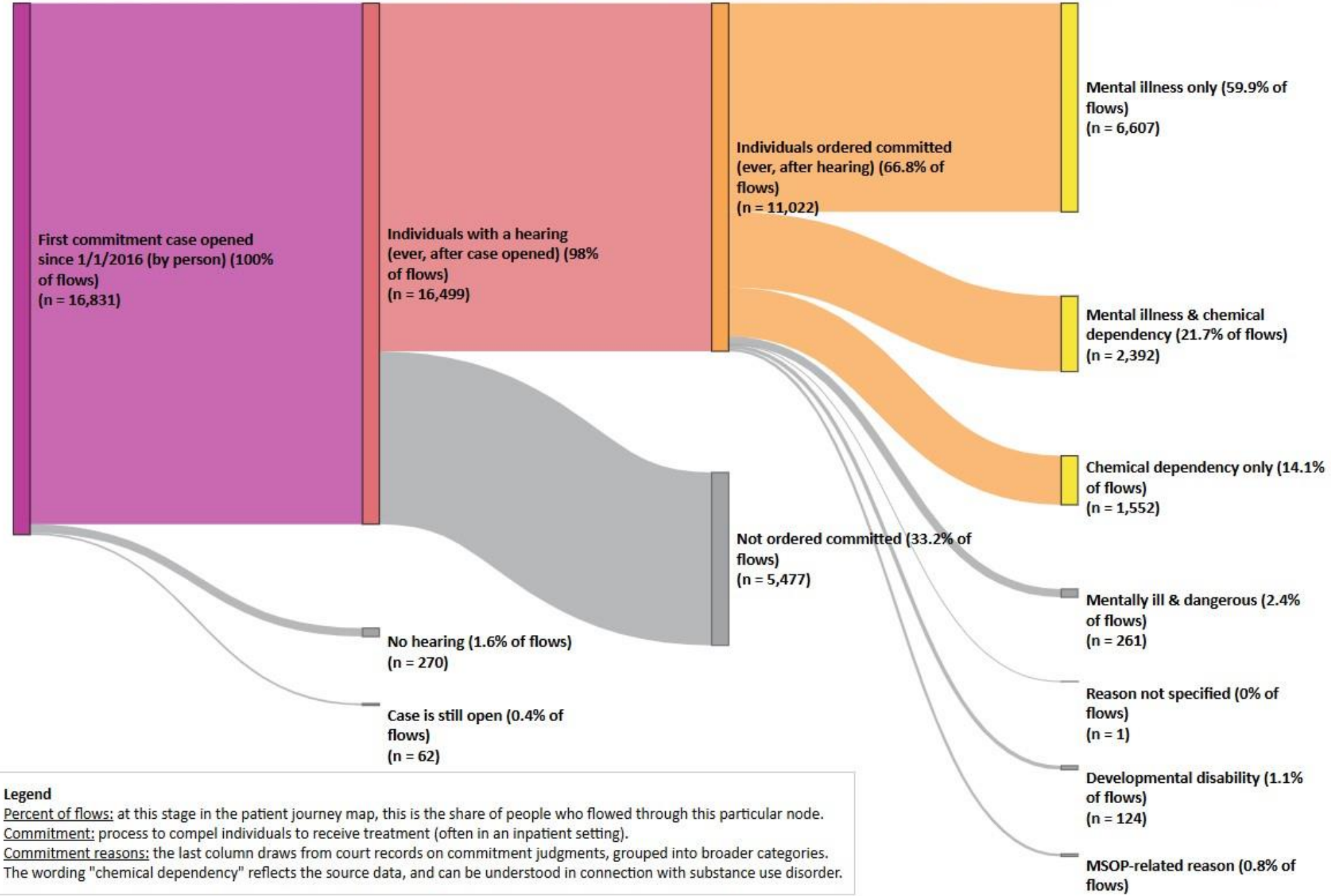
Pre-commitment	Commitment Proceedings	Commitment Care*	Post-commitment*
• MMIS • SSIS (AMHI)	• Courts Data	• DCT Data	• MMIS • SSIS (AMHI) • Recommitment (DCT)

- We are working to incorporate DCT data
- While we have MMIS/SSIS data for care, we do not currently know when treatments at DCT facilities begin and end
- Future analyses will offer a more complete journey, including through recommitment

Integrated

In process*

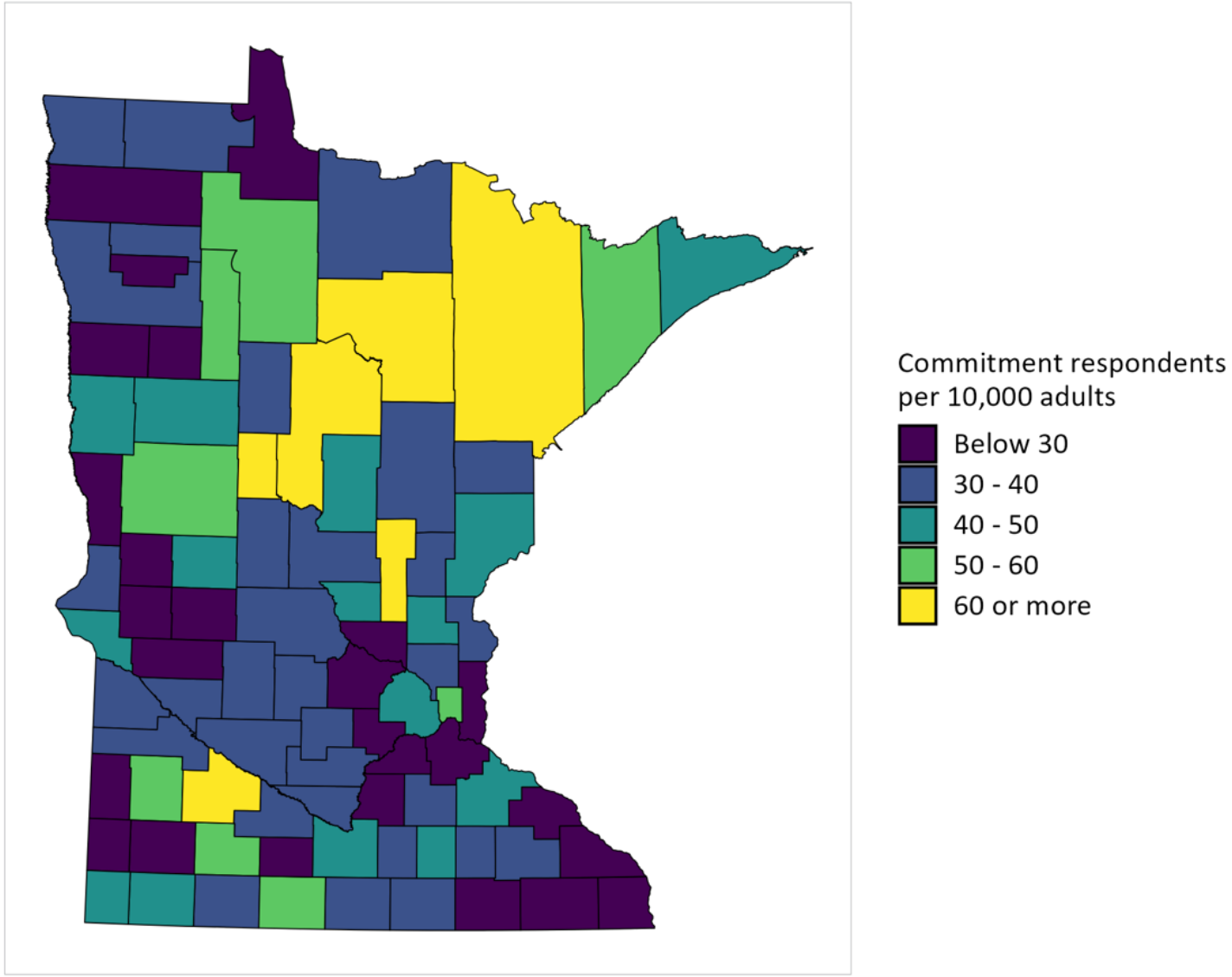
People with one or more commitment case that opened between 1/1/2016 and 12/13/2024, and data matched to MMIS and/or SSIS (n = 16,831)



Legend

Percent of flows: at this stage in the patient journey map, this is the share of people who flowed through this particular node.
Commitment: process to compel individuals to receive treatment (often in an inpatient setting).
Commitment reasons: the last column draws from court records on commitment judgments, grouped into broader categories. The wording "chemical dependency" reflects the source data, and can be understood in connection with substance use disorder.

Commitment respondents per 10,000 adults



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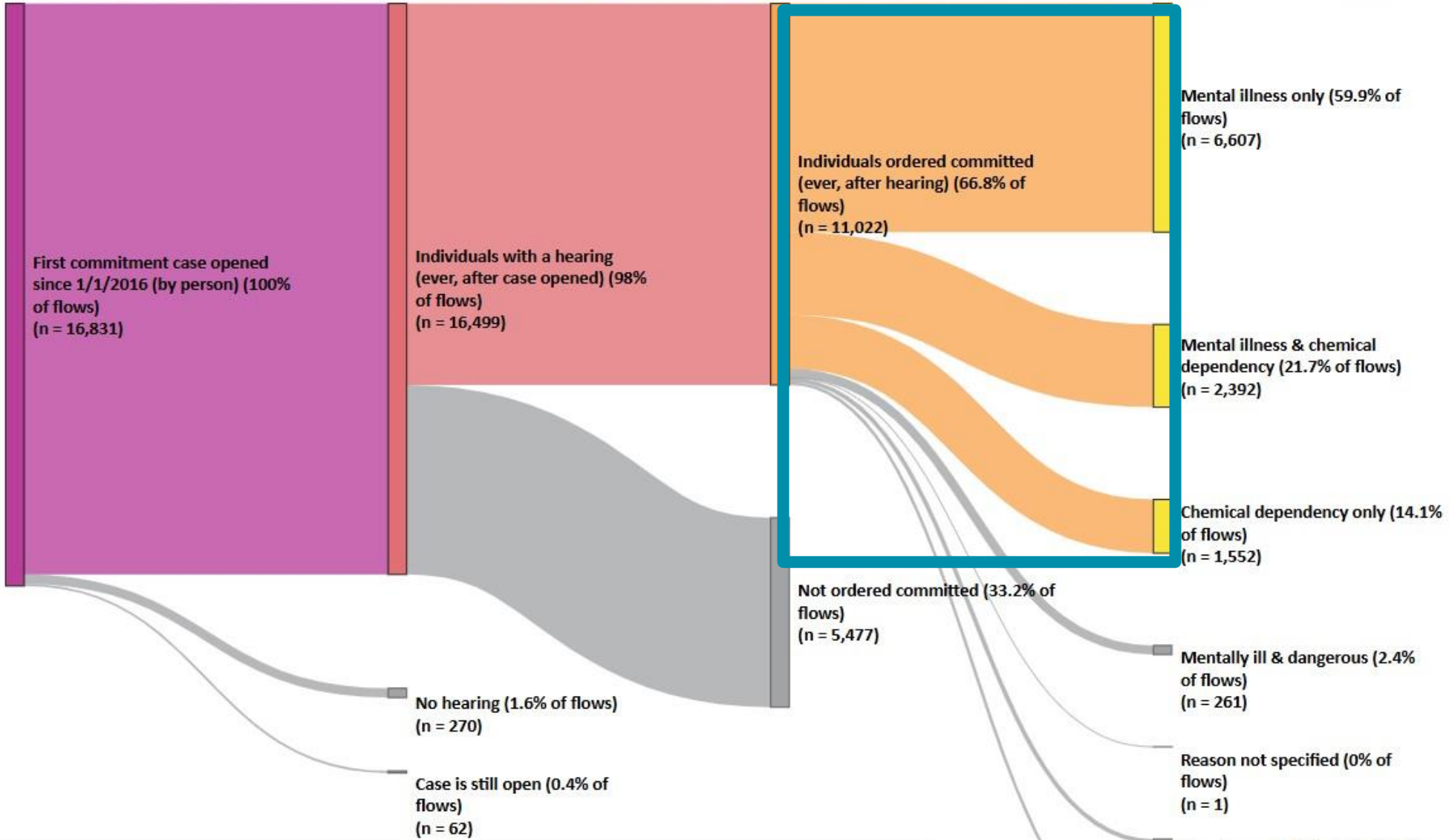

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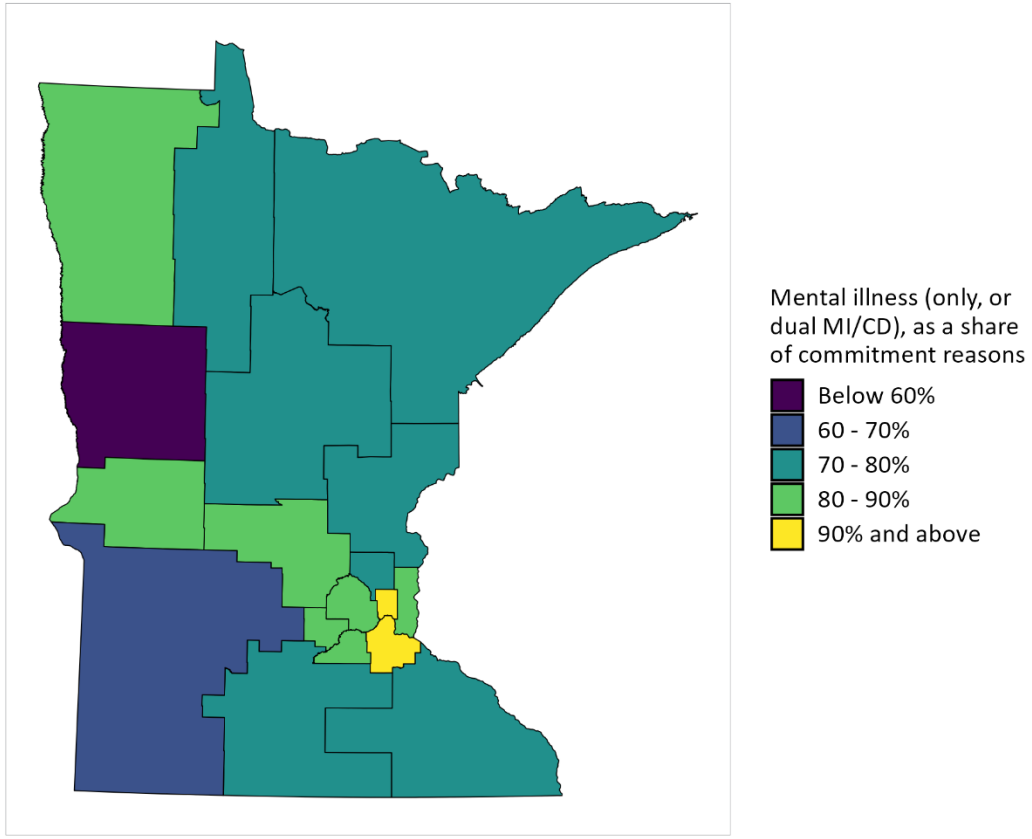
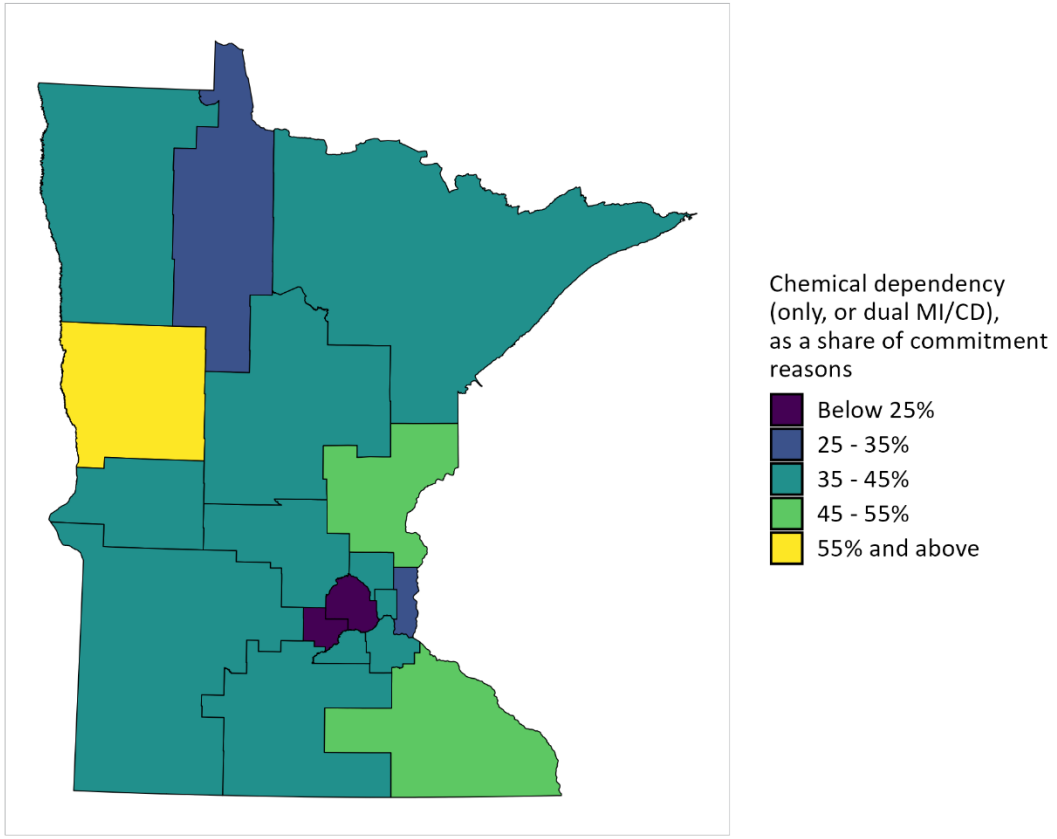
Commitment reasons: comparing MI and CD by AMHI region

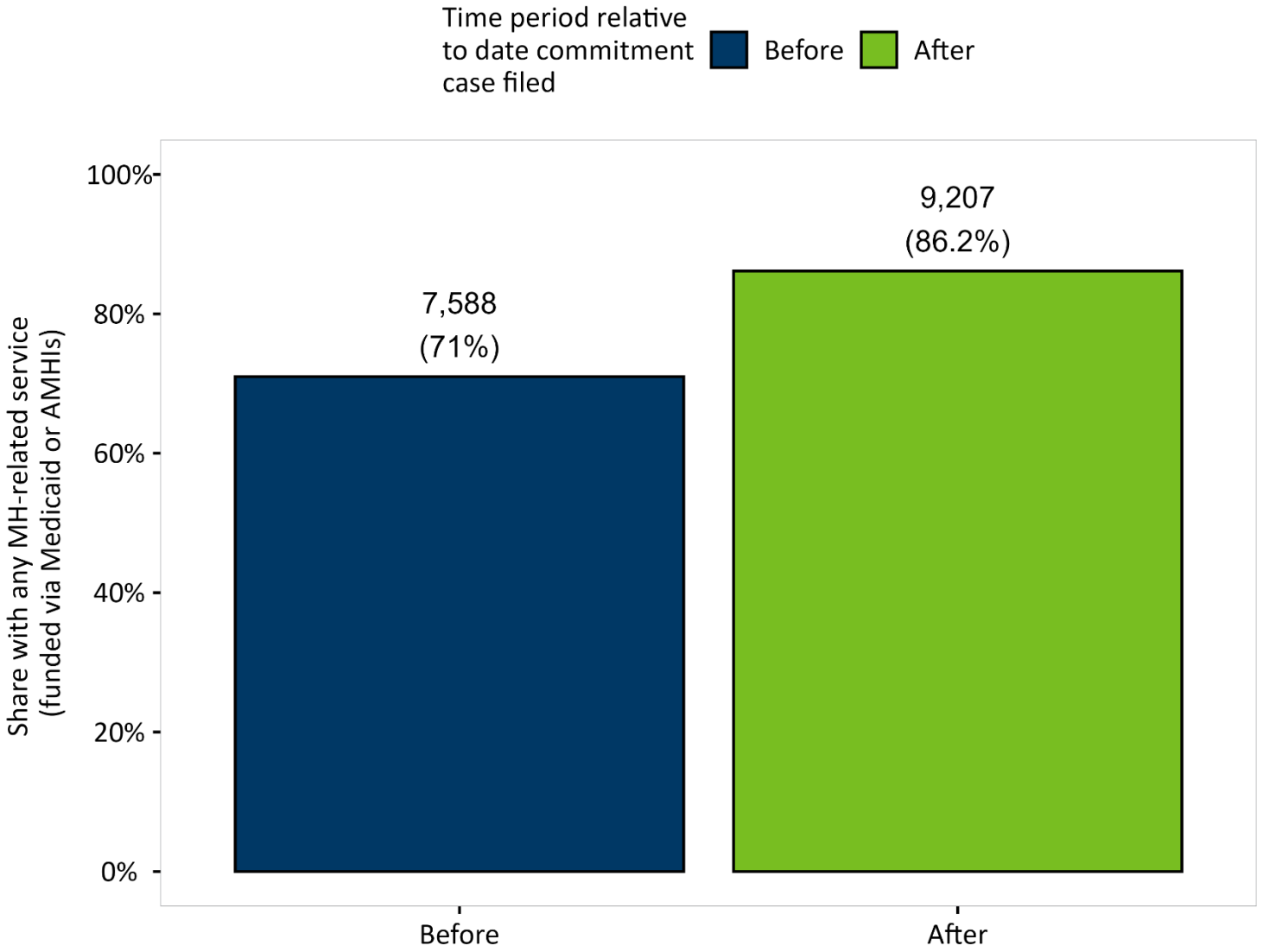
Mental illness



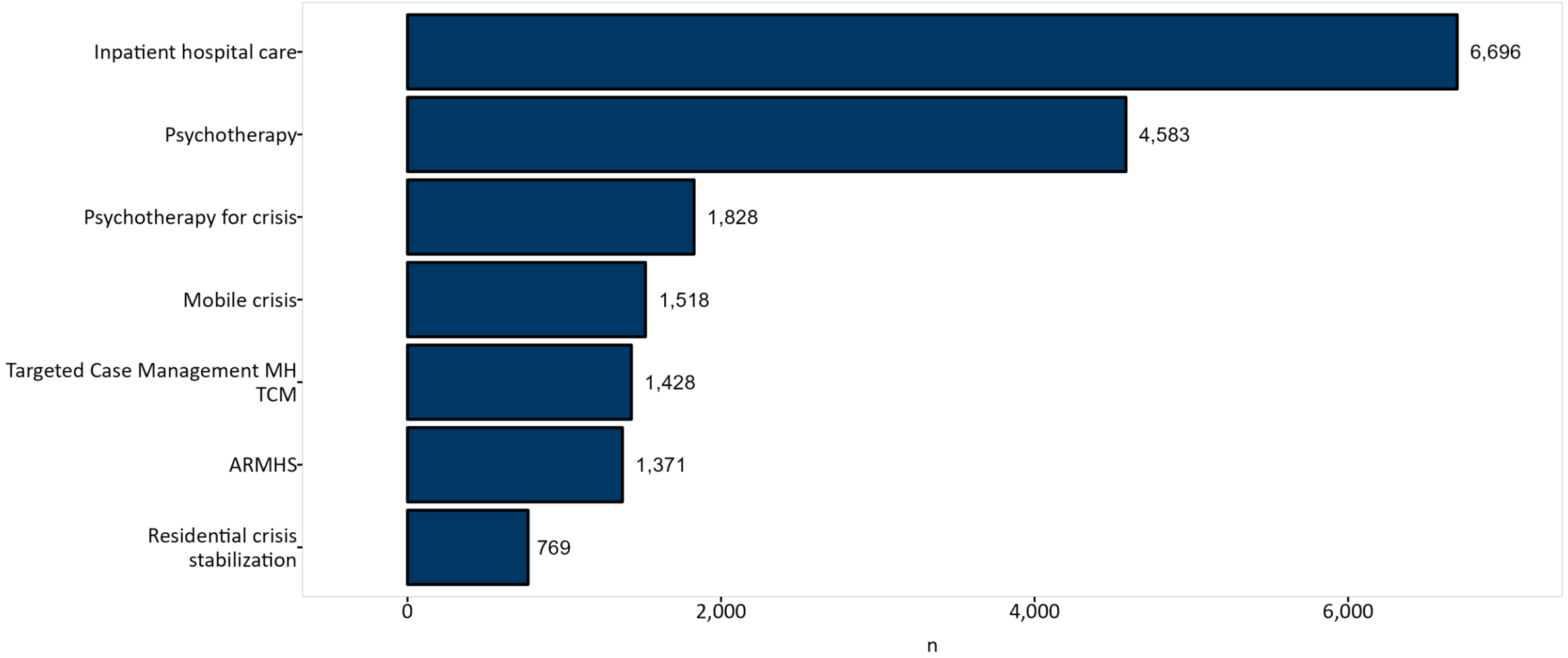
Chemical dependency



Received any mental health service (overall)



Most common types of MA services before commitment case opened



Additional analyses

- Variation by race/ethnicity, age, and gender (complete)
- SUD treatment before and after commitment case (in process)
- Linking DCT data to extend the journey beyond commitment judgment (in process)
- Complete full patient journey and examine trends, gaps, etc.
- Identify and study the impact of different models designed to prevent commitment and treat needs in community

Thank You!

Weston Merrick (Weston.Merrick@state.mn.us)

Housing First

Assistant Commissioner and Executive Director, Cathy tenBroeke, Minnesota Interagency Council on Homelessness

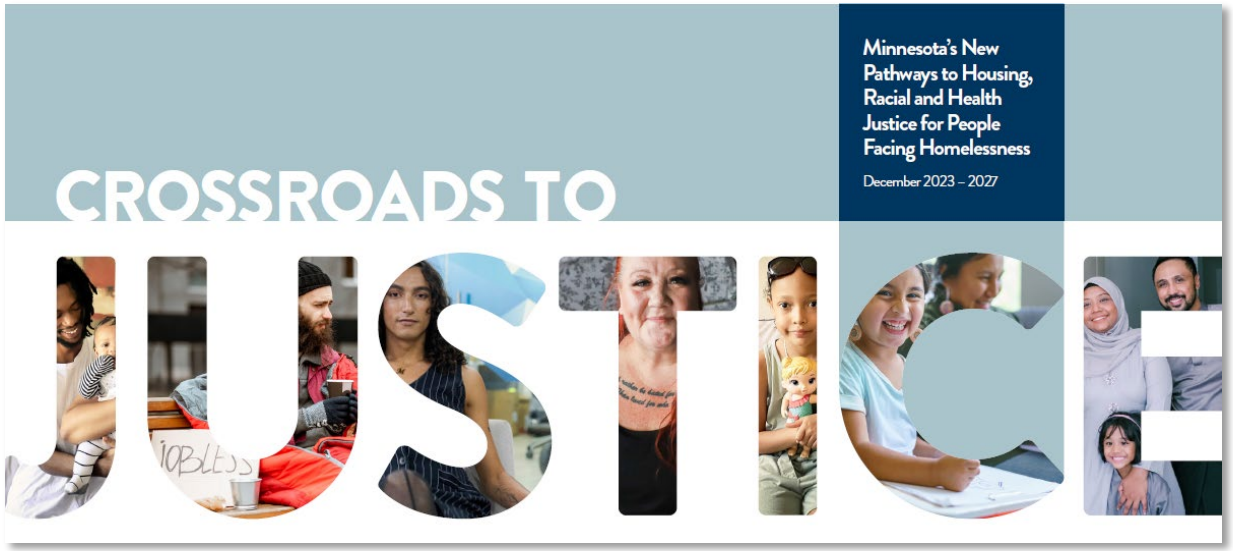
Minnesota Interagency Council on Homelessness

The Council is led by Lt. Governor Flanagan, Co-Chaired by Housing and Department of Human Services Commissioners, and includes Commissioners of these agencies:

- Department of Administration
- Department of Corrections
- Department of Children, Youth and Families
- Department of Education
- Department of Employment and Economic Development
- Department of Health
- Department of Human Services
- Department of Public Safety
- Department of Revenue
- Department of Transportation
- Department of Veterans Affairs
- Metropolitan Council
- Minnesota Housing
- Minnesota Management and Budget
- Office of Higher Education

Crossroads to Justice Plan

- On Jan 1, 2024, The Interagency Council on Homelessness began implementation of the Crossroads to Justice Strategic Plan.
- The plan was co-developed with 10 paid consultants with lived experience of homelessness. It is now being implemented with 14 implementation consultants with lived expertise.
- It focuses strategies and actions the state can take, in partnership with community, to achieve five bold results.



Learn more at
https://mich.mn.gov/crossroads-justice-strategic-plan

Results

1. Council agencies will collaborate and co-lead with impacted communities that have been historically oppressed and excluded including, but not limited to, Black, Brown and people of color, poor/low income, LGBTQIA2S+, people with disabilities, older adults, foreign-born, and people who have faced homelessness and Tribal Nations to implement the action plan on housing, racial and health justice.

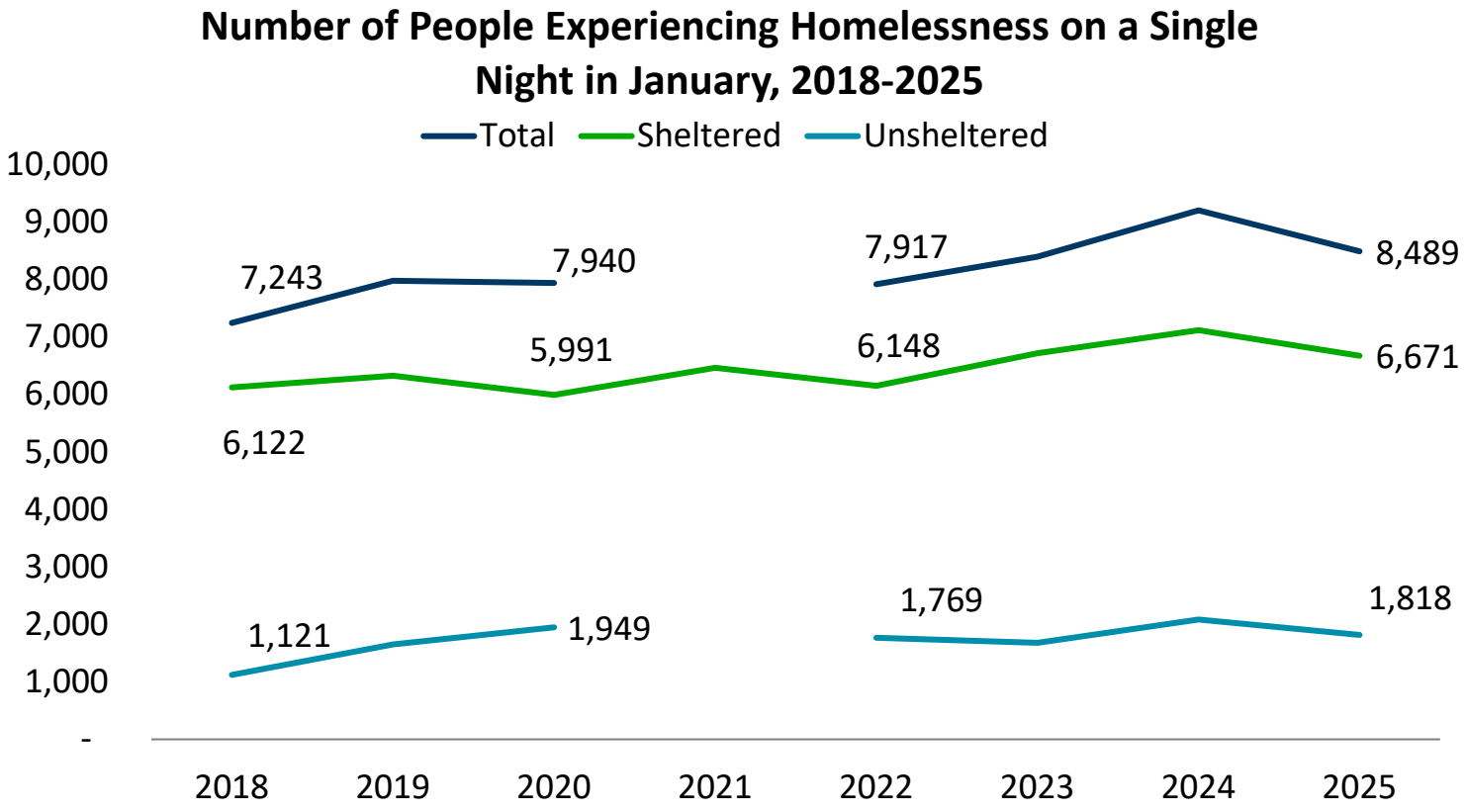
2. Homelessness is prevented whenever possible, and services and supports are provided to ensure no one returns to homelessness.

3. A robust crisis response geared towards housing outcomes supports people staying outside, in emergency shelters, and in community.

4. People facing homelessness have access to housing options that meet their needs and honors their choice.

5. Homelessness is treated as a crucial health and public health crisis wherever it occurs.

2025 Minnesota Point-in-Time (PIT) Count



2025 PIT Data

- 2025 count conducted on January 22, 2025
- An 8% decrease in the overall count of people from the peak (9,201) in 2024
- A decrease in both unsheltered (13%) and sheltered (6%) counts from 2024

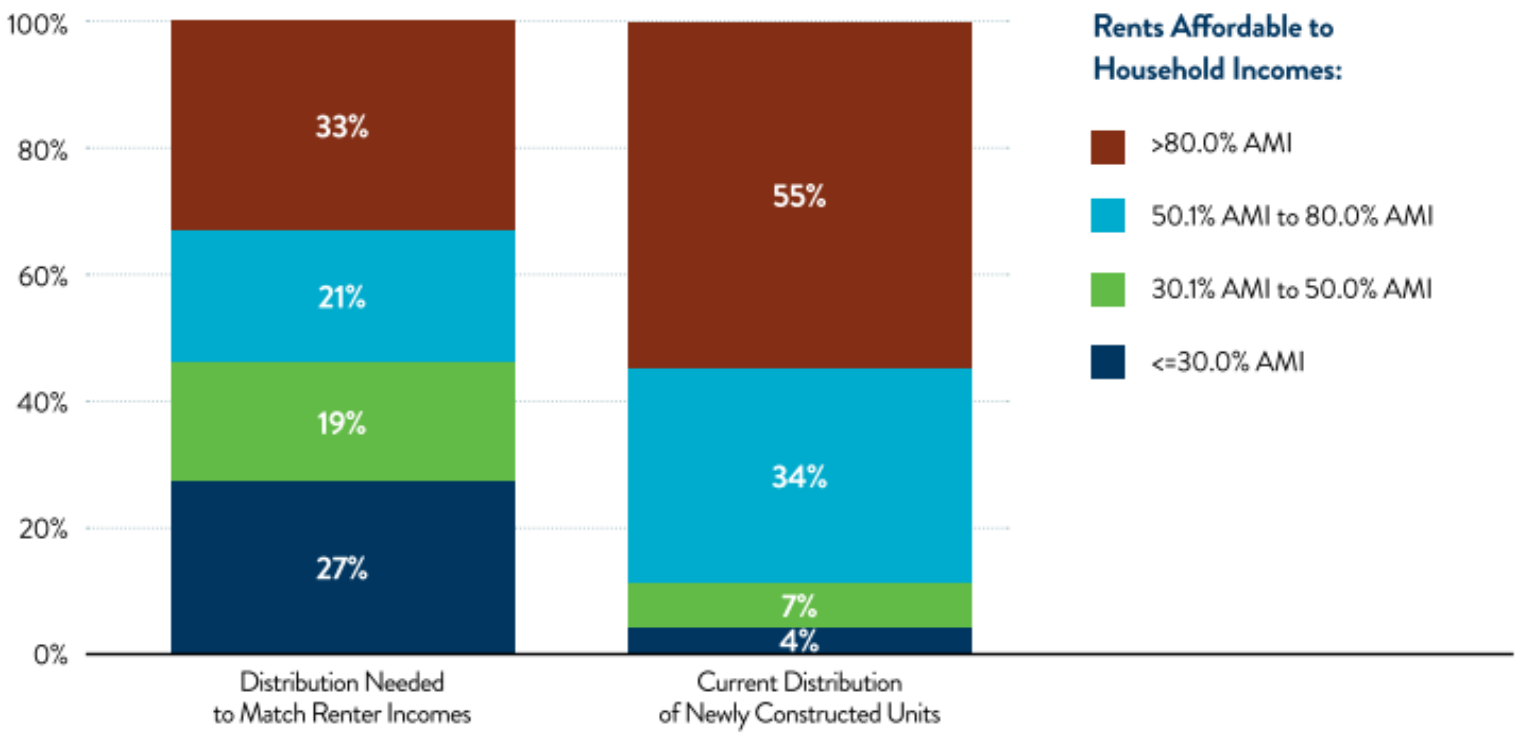
Source: HUD Point-in-Time Count, 2018 – 2025. 2025 data is considered preliminary and subject to change until published as part of the Annual Homeless Assessment Report to Congress in December. An unsheltered count was not conducted in 2021; data from that year is not comparable to other years.

Point-in-Time Count disparities increased in 2024

Race / Ethnicity	Proportion of the overall population of Minnesota	This group is ___ times more likely to experience homelessness	
		… compared to the overall population of Minnesota	… compared to the white population of Minnesota
American Indian	1%	13	32
Black / African American	6%	5	12
Latino	6%	4	9
Two or more races	5%	1 (about as likely)	3
Asian / Pacific Islander	1%	0 (less likely)	1 (about as likely)
white	76%	0 (less likely)	N/A

Source: Minnesota's Point-in-Time Count of persons in emergency shelter and transitional housing (sheltered locations), and unsheltered locations, 2024, and 2022 American Community Survey 1-year estimates. 2024 data is considered preliminary and subject to change until finalized and published by HUD in December 2024.

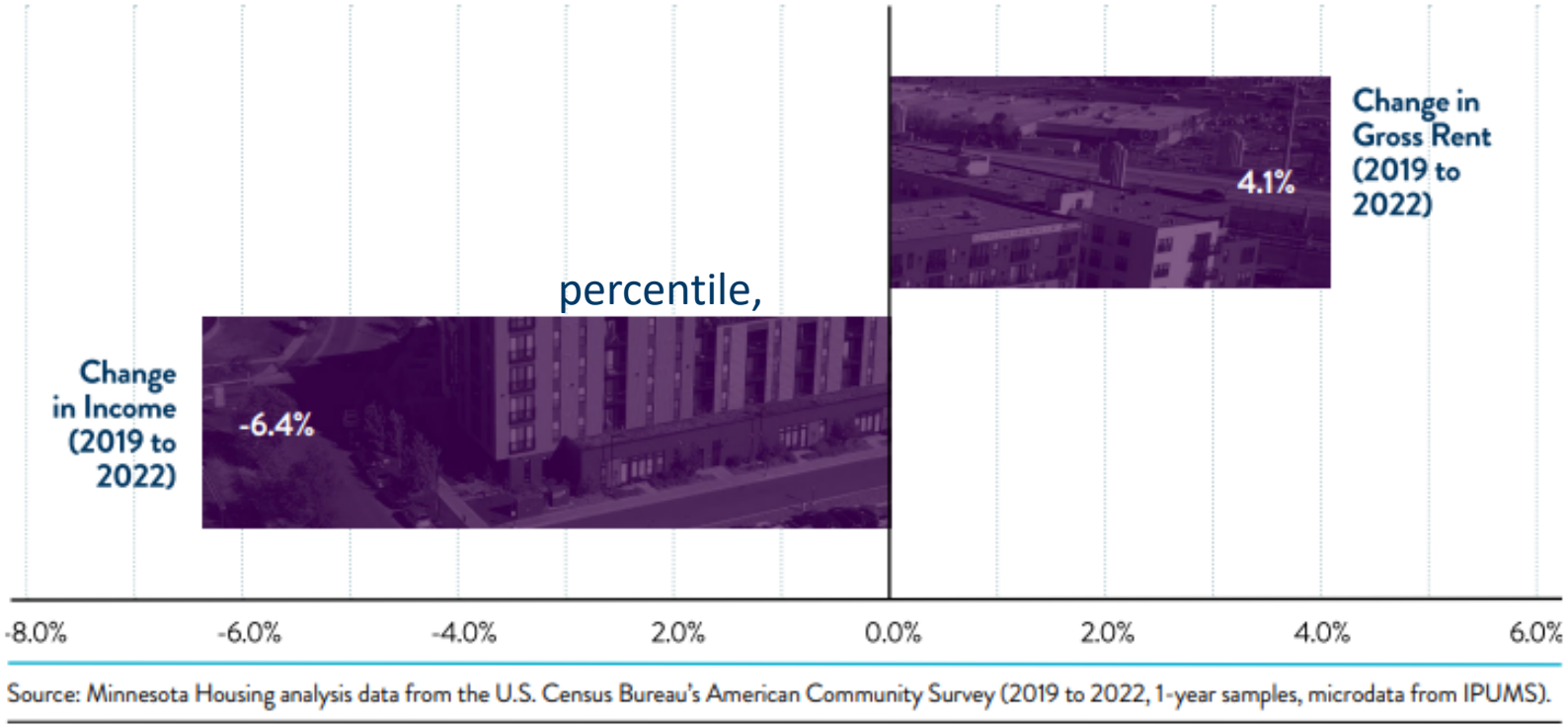
The lack of affordable housing is a key driver of homelessness.



Source: Minnesota Housing analysis based on data from the Met. Council (2022–2023 construction) and of HUD's 2017-2021 CHAS (Comprehensive Housing Affordability Strategy) data.

- This chart compares the share of new rental housing that is needed to match the incomes of renters across Minnesota with the share of new units produced.
- Only a small fraction of new rental housing is affordable to households with the lowest incomes.
- There is a large mismatch between the incomes of renters and the rents of newly constructed housing. For example, while 27% of renters have incomes at or below 30% AMI, only 4% of the newly constructed units have rents affordable at 30% of AMI

Housing has become less affordable for lower-income households.



Source: Minnesota Housing analysis data from the U.S. Census Bureau's American Community Survey (2019 to 2022, 1-year samples, microdata from IPUMS).

Between 2019 and 2022, the 25th percentile gross rent increased 4.1% from $778 to $810, and the 25th percentile renter income decreased 6.4% from $23,400 to $21,900. (All figures are adjusted for inflation to 2022 dollars.)

In recent years, rental housing has become less affordable for lower-income households because rents rose faster than inflation, but incomes did not keep pace with inflation.

MINNESOTA
INTERAGENCY COUNCIL
ON HOMELESSNESS

Federal Updates and Impacts

Executive Order on Homelessness

- Calls for the defunding of Housing First, despite the vast evidence that Housing First works to end homelessness.
- Imposes sobriety requirements on people who reside in federally funded housing and homelessness programs and calls for the defunding of harm reduction approaches.
- While defunding proven solutions, makes clear that resources should instead be directed to punitive approaches that do nothing to resolve homelessness.
- Takes away people's autonomy. If implemented, it will force people into institutional settings without their consent. It aims to undermine established legal protections for people with disabilities.
- Requires programs receiving federal funding to collect personal, health-related information from the people they serve and to share this data with law enforcement authorities and the government.
- Positions substance use disorders and mental health challenges as somehow criminal and recklessly implies we should fear our relatives facing unsheltered homelessness rather than stand in solidarity with them.

Housing First

- A philosophy / approach to end homelessness
- Premise: Start with housing as the foundation for success and then surround people with the services they need to be stably housed
- Housing First does not equal "housing only"
- It doesn't force or require people to do certain things in order to be "ready for housing"
- Proven, cost-effective, compassionate

Learn More about the Executive Order

- The National Alliance to End Homelessness (NAEH) developed a series of blogs covering the context and impacts of the executive order.
- You can find that ongoing series at https://endhomelessness.org/blog/
- Topics include:
  - What the Recent Executive Order Does – and Doesn't – Do
  - Understanding Trump's Executive Order on Homelessness: Attacks on Housing First
  - Understanding Trump's Executive Order on Homelessness: A Return to Forced Institutionalization
  - Understanding Trump's Executive Order on Homelessness: Rejecting Harm Reduction Services

Threats to Continuum of Care Funding

In Minnesota, **~$50 million in CoC funding annually** supports providers offering supportive services, transitional housing, rapid re-housing, and permanent housing for people experiencing homelessness.

~50% of Minnesota CoC dollars fund permanent supportive housing

- **At least 3,600 people** annually use permanent supportive housing funded by the CoC program

~30% of Minnesota CoC dollars fund rapid re-housing

- **At least 1,300 people** annually use rapid re-housing funded by the CoC program

Source: Minnesota Continuums of Care 2024 project awards and preliminary 2025 HUD Housing Inventory Count data

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Questions & Discussion

Break

Council worktime

- Letter to the Subcabinet
- Interagency State Substance Use Plan

Public comment opportunity

- Please submit public comments to officeofaddictionandrecovery.mmb@state.mn.us
- You are also welcome to contact Jeremy Drucker, Addiction and Recovery Director jeremy.drucker@state.mn.us

Debrief and adjourn

- Closing comments from the chair and vice-chair
- The next meeting is Tuesday, February 3, 11:00 a.m. – 3:00 p.m.
  - Virtual

Thank You!

https://mn.gov/mmb/oar/gacosua/

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