MINNESOTA
OFFICE OF ADDICTION
AND RECOVERY

INTERAGENCY STATE
SUBSTANCE USE PLAN REPORT

DECEMBER 2025

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INTRODUCTION

Substance use disorder (SUD), and substance misuse affect nearly every Minnesotan in one way or another. SUD is a chronic health care issue, and understanding of it has evolved greatly over time.

Once considered simply a moral failing or self-control issue, SUD is now widely recognized as a complex, treatable disease that alters the brain and makes stopping substance use difficult. Whether experienced directly, observed in a neighbor or loved one, or felt through broader consequences, the effects of SUD extend beyond the individual and reverberate throughout Minnesota's communities.

Estimates show that between 450,000 and 500,000 Minnesotans are directly affected by SUD[1], and many more are indirectly affected. This disease hurts individuals, destroys families, and harms communities. In addition to the emotional and social impact, SUD and substance misuse have a tremendous financial impact as well. A 2023 study from the Minnesota Department of Health found that excessive drinking alone cost Minnesota nearly $8 billion dollars in health care, productivity, and other societal costs.[2]

Fortunately, with better understanding of SUD as a disease an increasing number of treatments and therapies are being discovered that can help people achieve and sustain recovery. A recent Substance Abuse and Mental Health Services Administration (SAMHSA) survey on drug use and health reported that over 73% of people (over 23 million) who identified as having an SUD at some point in their lives considered themselves in recovery.[3] Proven treatments like cognitive behavioral treatment, medications for opioid use disorder (MOUD), peer support, and group treatment have shown great effectiveness in helping people find recovery and achieve happy, self-directed, and purpose-filled lives.

The State of Minnesota, in partnership with federal, county, local, and Tribal governments, plays a significant role in addressing SUD, both as a matter of supply and demand. On the supply side, the Department of Public Safety works with local law enforcement to reduce the flow of drugs into Minnesota and take illicit substances off the street. On the demand side, numerous state agencies work across prevention, harm reduction, treatment, and recovery to reduce the number of people experiencing SUD, assist those who are, and support individuals in recovery.

In 2022 Governor Tim Walz and the legislature created the Subcabinet on Opioids, Substance Use, and Addiction (subcabinet) to improve outcomes for Minnesotans experiencing SUD, their families, and their communities.[4] A gubernatorially appointed Addiction and Recovery Director position was also created to chair the Subcabinet and assist in leading a Governor's Advisory Council on Opioids, Substance Use, and Addiction. Further, the authorizing legislative language called for the director to bring forward a proposal for a permanent Office of Addiction and Recovery (OAR), which was done in the 2023 legislation and now resides at Minnesota Management Budget. OAR is an office of four full-time employees (FTEs), led by the director, that staffs the subcabinet and Governor's Advisory Council.

A key driver in the creation of the subcabinet and the OAR was the need to break down silos between state agencies to better coordinate and align the work across the multiple state agencies involved in addressing SUD.

An early observation was that there were many good plans across state government agencies focused on substance use or incorporating substance use within important goals and priorities, but there was no overarching state plan that brought them all together. To better align goals and priorities and ensure state resources were being deployed in a coordinated manner to achieve the best outcomes for Minnesotans there was consensus among the subcabinet that developing an enterprise-wide plan to guide budget and policy decisions would be beneficial.

In 2025, the legislature provided statutory authority to the subcabinet to develop and publish an interagency state substance use plan. State law requires the subcabinet to:

"develop and publish a comprehensive substance use and addiction plan for the state. The plan must establish goals and priorities for a comprehensive continuum of care for substance misuse and substance use disorder for Minnesota. All state agencies' operating programs related to substance use prevention, harm reduction, treatment, or recovery or that are administering state or federal funds for those programs shall set program goals and priorities in accordance with the state plan. Each state agency shall submit its relevant plans and budgets to the subcabinet for review upon request."

In developing the interagency state plan, it is neither feasible nor desirable to simply start from scratch. The State operates within numerous statutory requirements, legal and financial commitments, and long-standing directives that shape the approach to addressing SUD. These frameworks have emerged over many years of community, provider, and legislative engagement, providing both the contours and foundation for the SUD system that has been collectively envisioned.

Similarly, the many state plans, task force reports, and advisory councils that have provided recommendations and feedback have involved extensive community engagement to inform their work, and they continue to play a critical role.

To this end the subcabinet is approaching the development of the interagency substance use plan in phases. Phase one, memorialized in this report, is a review of the current state of the SUD system in Minnesota, with the goal of establishing the foundational understanding necessary for strategic alignment. Phase two of the interagency plan will use a collective impact model through the subcabinet to transform descriptive understanding into strategic action identifying priorities, goals, shared metrics and accountability structures.

Included in this report are:

- Key SUD prevalence data.
- Roles and responsibilities of subcabinet state agencies as they relate to SUD.
- SUD financial funds and the results of the state's first SUD fiscal map of all state spending across the continuum of care.
- Analysis of state commitments made through state statute, other state plans, and community and partner reports and a description of the SUD system as it is currently constructed.

Of the many plans and reports reviewed and incorporated into this document, some to highlight include:

- The One Minnesota Plan
- Substance Use Disorder System Reform Report and Recommendations
- Minnesota Naloxone Saturation Strategy
- 2023 American Indian SUD Summit Report
- Minnesota Interagency Council on Homelessness Crossroads to Justice Plan
- Opioid Epidemic Response Advisory Council 2025 Legislative Report
- 2024 Comprehensive Overdose and Morbidity Prevention Act Legislative Report
- The Department of Human Services' 1993-99 study "The Challenges and Benefits of Chemical Dependency Treatment"
- Minnesota's Model of Care for Substance Use Disorder Legislative Report
- Interim evaluation report: Minnesota SUD System Reform Section 1115 demonstration project evaluation
- 2024 Statewide Health Assessment
- 2023 Governor's Advisory Council on Opioids, Substance Use, and Addiction Report

Analysis of these and other reports were supplemented by additional review of state agencies' current goals and priorities as they relate to SUD. It is important to note that many of these goals and priorities are outlined by state statutory commitments or federal grant guidelines (i.e. federal funding streams that outline how those dollars need to be spent).

Key Findings

Main takeaways from this review and analysis include the following observations:

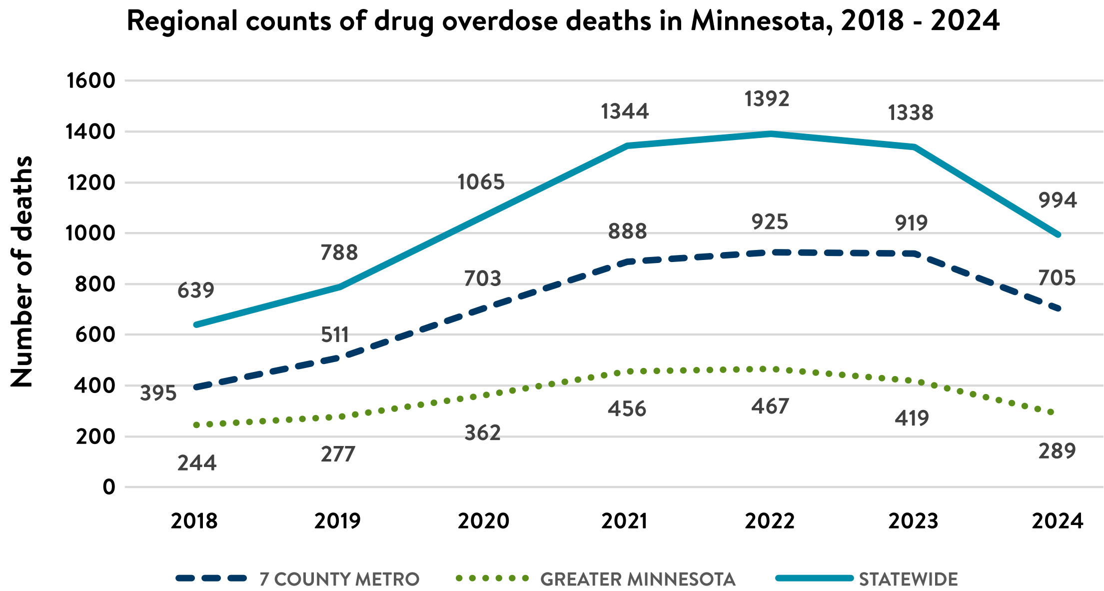
- Minnesota has a continuum of care—it is fragmented in places and there are gaps in service, but the underlying framework exists. Care coordination, linkages to care, and increased organizational coordination are critical to an individual's ability to navigate the system.
- Minnesota has made significant investments aligned with national best practices and evidence-based responses to address SUD and substance misuse.
- Ensuring adequate ongoing funding for each continuum component will continue to be a challenge—enhanced coordination and alignment between state agencies and partners will be key to meeting future needs.
- Every state agency plays a unique and important role in supporting individuals across the continuum.
- There is significant alignment in state agency goals and priorities in key issue areas such as:
  - Naloxone distribution
  - Justice-involved treatment and recovery pathways
  - Culturally responsive services such as traditional healing
  - Addressing the interaction between SUD and maternal and child health.
  - Integration of behavioral health into school-based settings
  - Strategies focused on addressing unsheltered homelessness
  - A focus on data and quality infrastructure.
  - Expanding access to medications for opioid use disorder
- Minnesota has a robust community and public engagement framework, but ongoing engagement is critical to meeting the needs of community.
- Ensuring Minnesota has an array of services and supports that meet an individual's unique needs no matter where they are in their recovery journey is critical.

As we look to phase two of the interagency state substance use plan process, the State will be sharing this report with stakeholders and partners to engage in feedback in the development of subsequent iterations of the plan.

OVERVIEW OF KEY PREVALENCE AND DEMOGRAPHIC STATS

The State of Minnesota maintains key demographics on substance use disorder outcomes within data systems across many state agencies. These systems provide valuable sightlines into how public health initiatives and state resources are impacting Minnesotans and informing responses to substance use and misuse across the state. Key to the Walz Administration's One Minnesota Plan is a goal to reduce the impact of the opioid crisis on Minnesotans, their families, and their communities. Within that broader goal is a measurable goal of reducing opioid deaths by 5% by 2027.[5] This goal has been reached as of 2025, and an update is underway.

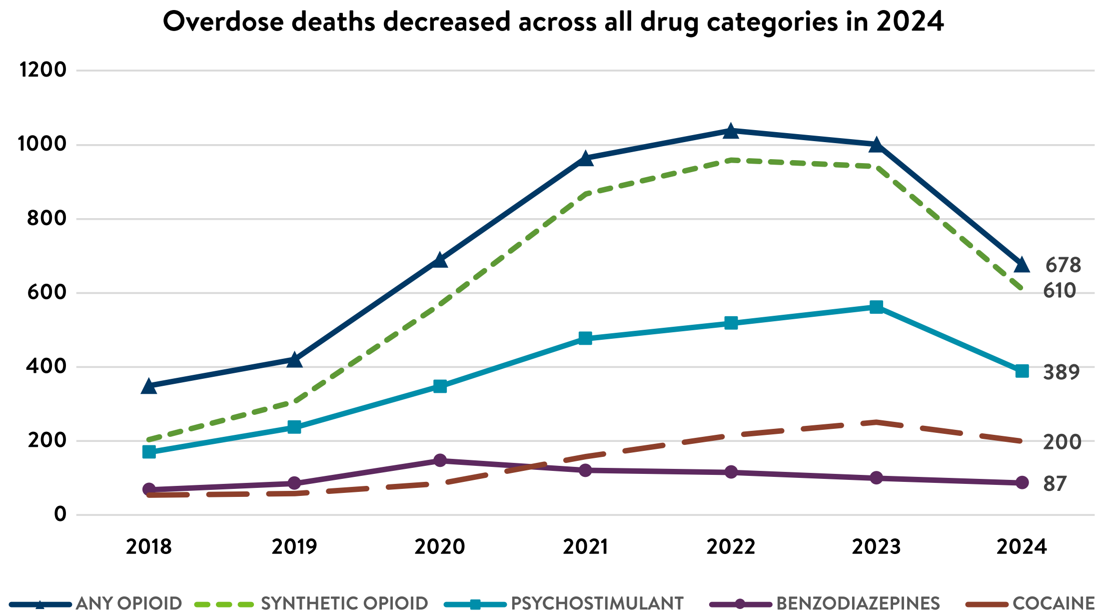
Figure 1. Notable decreases in overdose deaths across Minnesota in 2024[6]



Source: Minnesota death certificates, Minnesota Department of Health, 2018-2024

Figure 1 presents regional drug overdose death trends across Minnesota from 2018 through 2024. The data reveals a significant statewide decrease of 26% in overdose deaths between 2023 and 2024, with both the seven-county Metro area and Greater Minnesota experiencing substantial declines of 23% and 31% respectively.[6] This represents meaningful progress towards the One Minnesota Plan's measurable goal with two consecutive years of decreased overdose deaths across the state.

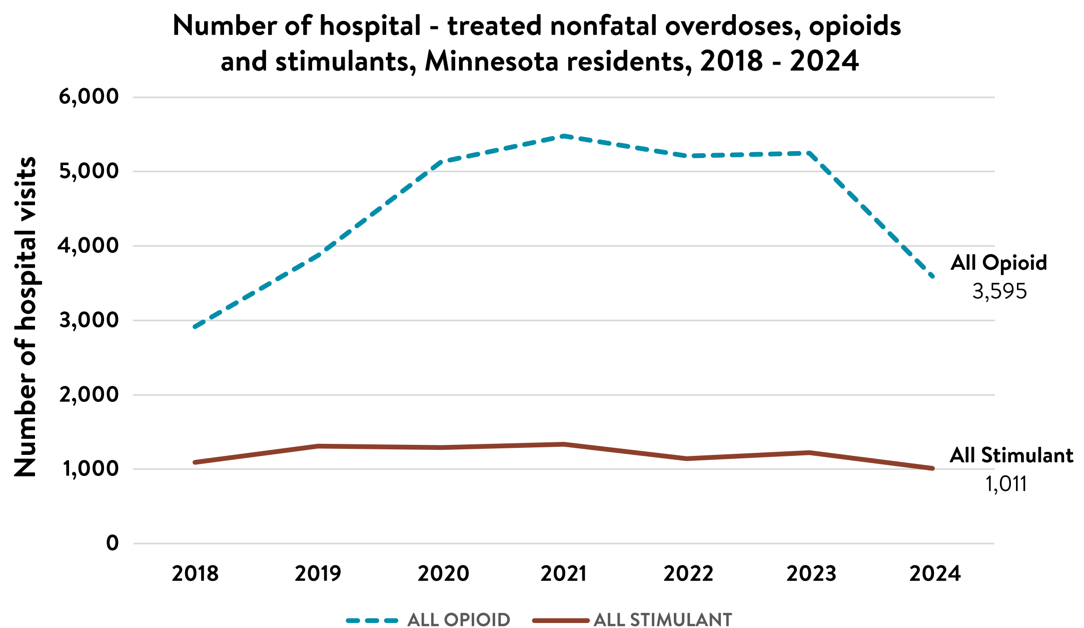
Figure 2. Decreases across all drug categories in 2024[6]



Source: Minnesota death certificates, Injury Prevention and Mental Health Division, Minnesota Department of Health, 2018-2024. NOTE: Drug categories are non-exclusive

Figure 2 demonstrates that this overall decline reflected broad reductions across multiple substances. Deaths involving opioids, including fentanyl, decreased by approximately one-third. The data also reveals reductions in stimulant-related deaths, primarily methamphetamine, showing the first decline in a decade, with cocaine-involved deaths experiencing their first decrease in five years. These downward trends across diverse drug categories indicate positive results in Minnesota's comprehensive approach to addressing SUD.

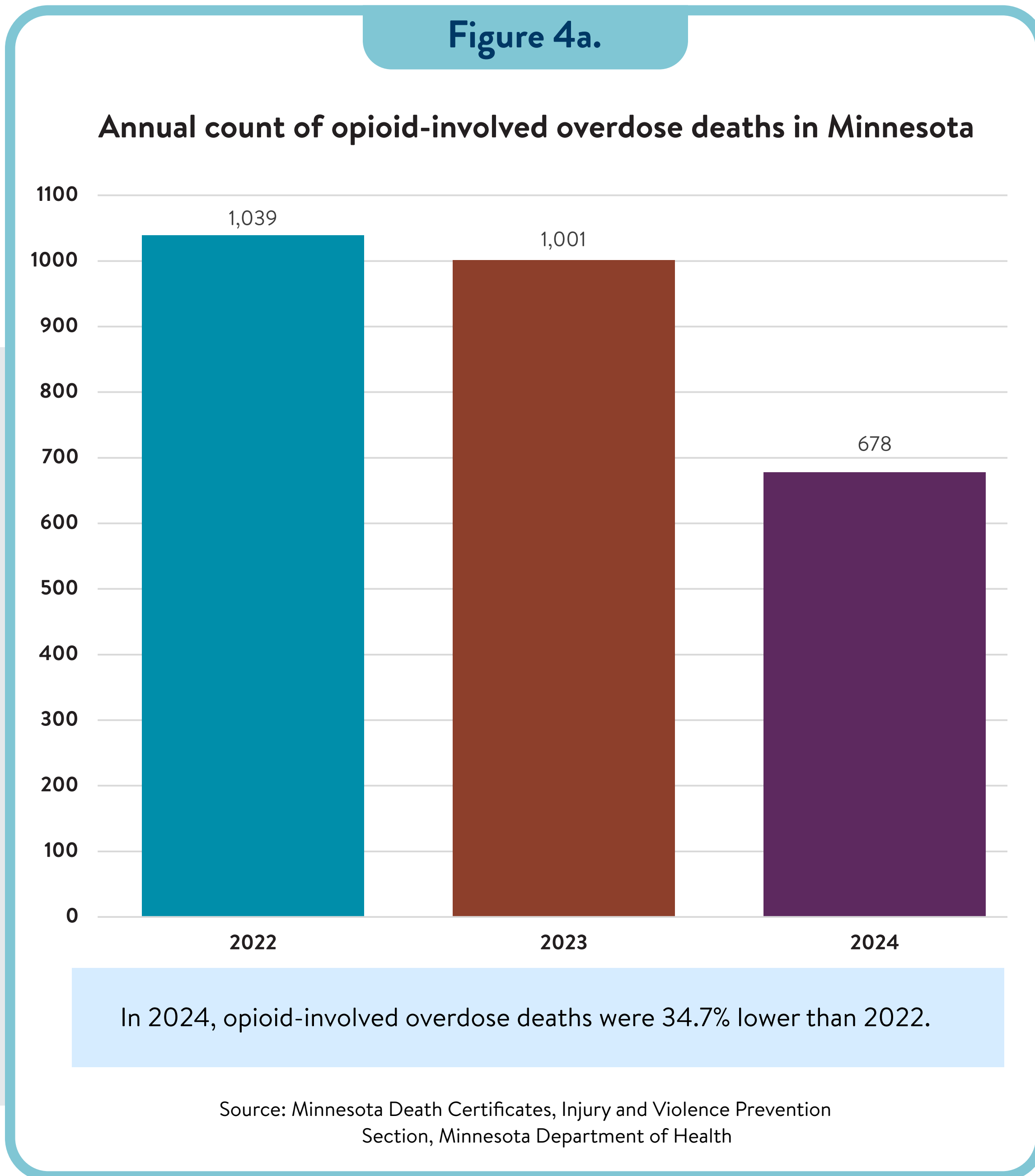
Figure 3. Nonfatal opioid and stimulant overdoses treated in Minnesota hospitals declined from 2023-2024[6]



Source: Minnesota Hospital Discharge Data, Injury Prevention and Mental Health Division, Minnesota Department of Health, 2018-2024. NOTE: Includes nonfatal overdoses of unintentional/undetermined intent among all patients treated in Minnesota hospitals (excludes federally funded facilities). Drug categories are non-exclusive and based on ICD-10-CM discharge diagnosis codes.

Figure 3 reinforces the general overdose reduction trends in figures 1 and 2 by tracking nonfatal overdoses treated in Minnesota hospitals. The parallel reductions in both fatal and nonfatal overdoses across multiple substance categories suggest that Minnesota is showing progress in reducing overdose harms at multiple intervention points throughout the continuum of care.

Figure 4a.– 4c. Opioid-involved overdose deaths, yearly comparison



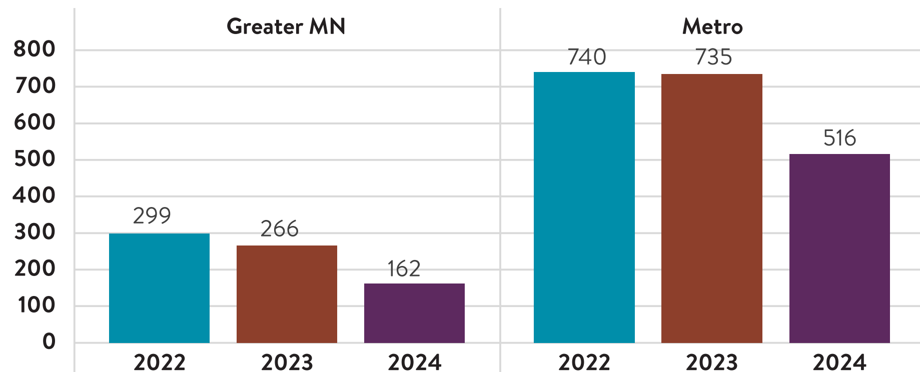
In 2024, opioid-involved overdose deaths were 34.7% lower than 2022.

Source: Minnesota Death Certificates, Injury and Violence Prevention Section, Minnesota Department of Health

Figures 4a. - 4c. illustrate opioid-involved overdose deaths across Minnesota from 2022 to 2024, revealing meaningful declines across all examined populations and geographic regions. While Greater Minnesota experienced steeper reductions than the metropolitan area, both regions demonstrated substantial improvement. Similarly, when examined by race and ethnicity, all populations showed significant decreases, with American Indian communities experiencing the steepest decline at 41.7%, followed by white Minnesotans at 35.8% and Black Minnesotans at 28.5%.

Figure 4b. and 4c.

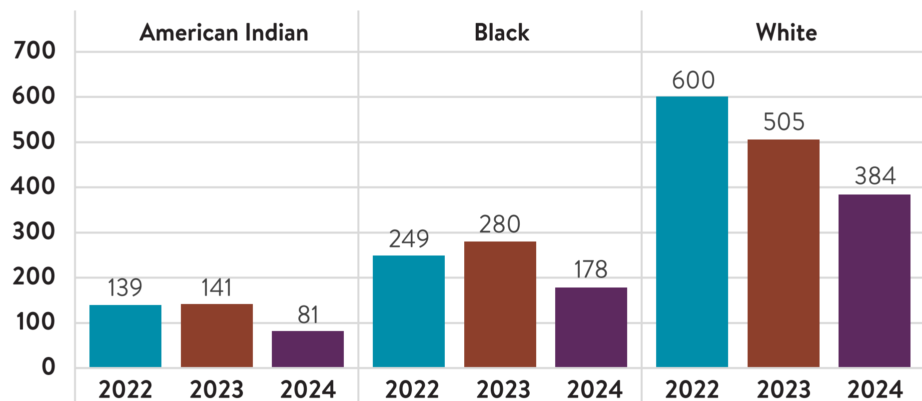
Regional count of opioid-involved overdose deaths in Minnesota



Overdose deaths decreased in Greater MN by 46% from 2022 to 2024.
The Metro area saw a much smaller decrease of 30% during that time.

Source: Minnesota Death Certificates, Injury and Violence Prevention Section, Minnesota Department of Health

Race count of opioid-involved overdose deaths in Minnesota



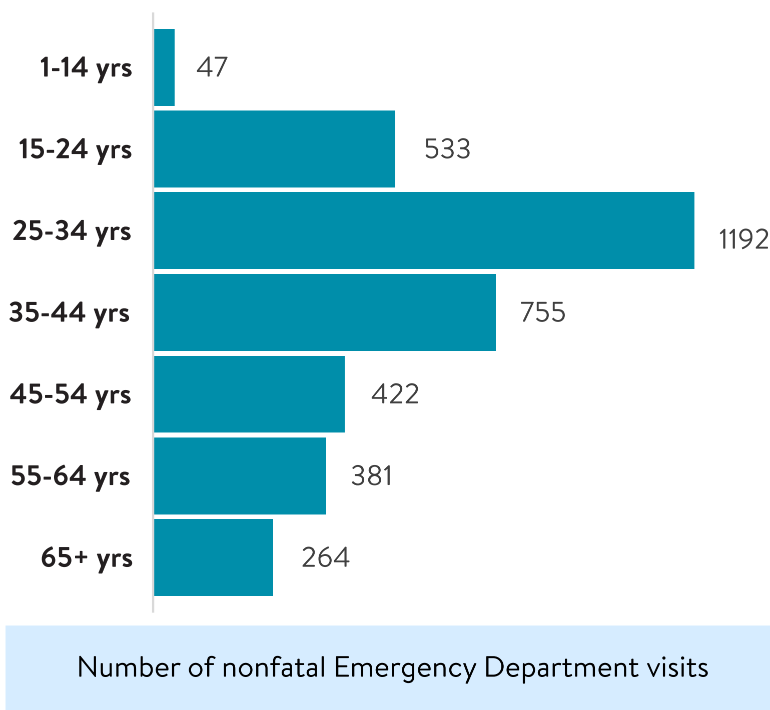
American Indians had the greatest decrease from 2022 to 2024 at 41.7%, compared to Whites and Blacks decreasing by 35.8% and 28.5% respectively.

Source: Minnesota Death Certificates, Injury and Violence Prevention Section, Minnesota Department of Health

These improvements are particularly significant given that from 2010 to 2019, American Indian mortality rates from drug overdoses nearly tripled, leaving American Indian Minnesotans seven times as likely to die of a drug overdose as white Minnesotans, while African American Minnesotans were two times as likely to die of a drug overdose as white Minnesotans.[7] The disproportionate impact on American Indian communities reflects a concerning national pattern, as these populations have experienced the highest overdose death rates of any racial or ethnic group in the country stemming from health inequities that include unequal access to culturally relevant treatment, treatment biases, and the ongoing effects of historical trauma.[(8)(9)] While the current trend toward improvement is encouraging, there is continued need for culturally responsive prevention, harm reduction, treatment and recovery support resources to be directed at populations disproportionately impacted by SUD.

Figure 5a. and 5b. Number of nonfatal Emergency Department visits

In 2024, 25–34-year-old Minnesotans had the greatest number of nonfatal hospital visits for opioid-involved overdoses.

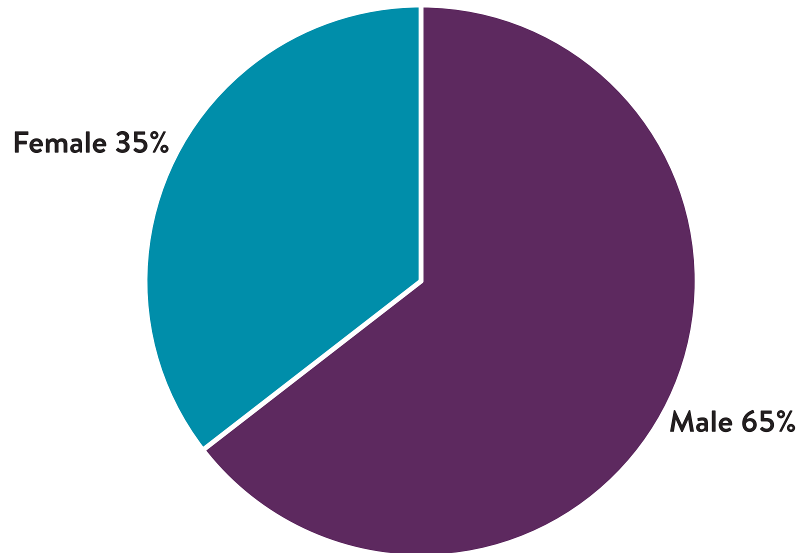


Source: Minnesota Department of Health, Minnesota hospital discharge data

While fatal overdose data shows significant declines, nonfatal overdose data, figures 5a. and 5b., provides additional insight into intervention needs and demographic patterns. The age distribution reveals that young adults aged 25 to 34 experienced the highest rates of emergency department visits for opioid-involved overdoses, with concerning numbers also appearing among adolescents and young adults aged 15 to 24. The data reveal that opioid exposure affects Minnesotans across the entire age spectrum, including children and adolescents requiring emergency medical attention. Additionally, gender patterns show that male patients accounted for nearly two-thirds of hospital visits for opioid-involved overdoses, mirroring disparities observed in fatal overdose data.

Figure 5b.

In 2024, hospital visits for nonfatal opioid-involved overdoses were highest among male patients in Minnesota.



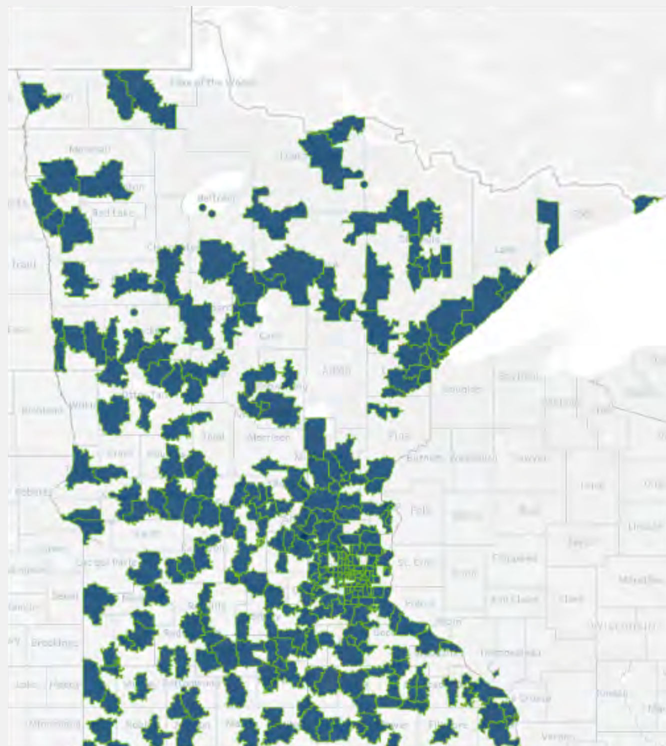
Source: Minnesota Department of Health, Minnesota hospital discharge data

The prevalence of nonfatal overdoses requiring emergency intervention, even as fatal deaths decline, illustrates that emergency medical services and hospital systems represent vital intervention points in Minnesota's continuum of care. These nonfatal events offer crucial opportunities for individuals who survive an overdose and face elevated risk for subsequent events to receive immediate care coordination and linkages to care and other recovery support services. These data are key to informing where other harm reduction activities such as naloxone distribution could be targeted.

Minnesota's naloxone distribution infrastructure represents a critical component of the state's harm reduction strategy. An important piece of naloxone distribution is the state's Naloxone Portal. The Portal, created in 2023, operates through a tiered eligibility framework designed to prioritize access for populations at greatest risk, ensuring that naloxone reaches both frontline harm reduction settings and broader community touchpoints.

The geographic distribution data in figure 6 reveals significant statewide reach. The substantial volume of naloxone kits distributed through this centralized infrastructure (totaling over 177,000 two-dose boxes) suggests meaningful saturation of this overdose reversal medication throughout Minnesota communities through more than 900 organizations from diverse sectors. This widespread distribution aligns with evidence-based harm reduction principles emphasizing that naloxone access must extend beyond clinical settings to reach the community locations where overdoses occur and that community distribution programs significantly increase naloxone availability in high-risk populations.[(10)(11)] The portal infrastructure addresses several barriers that historically limited naloxone access, including cost, awareness, and geographic availability. The portal centralizes procurement while maintaining community-based distribution. By maintaining broad eligibility criteria, the state has created a model that balances oversight with accessibility.[12] The relationship between expanded naloxone access and declining overdose deaths, while not definitively causal, suggests that this medication is reaching individuals who need it. Each naloxone reversal represents not only a potential life saved in the immediate moment but also a potential opportunity for treatment engagement or linkages to recovery support services.

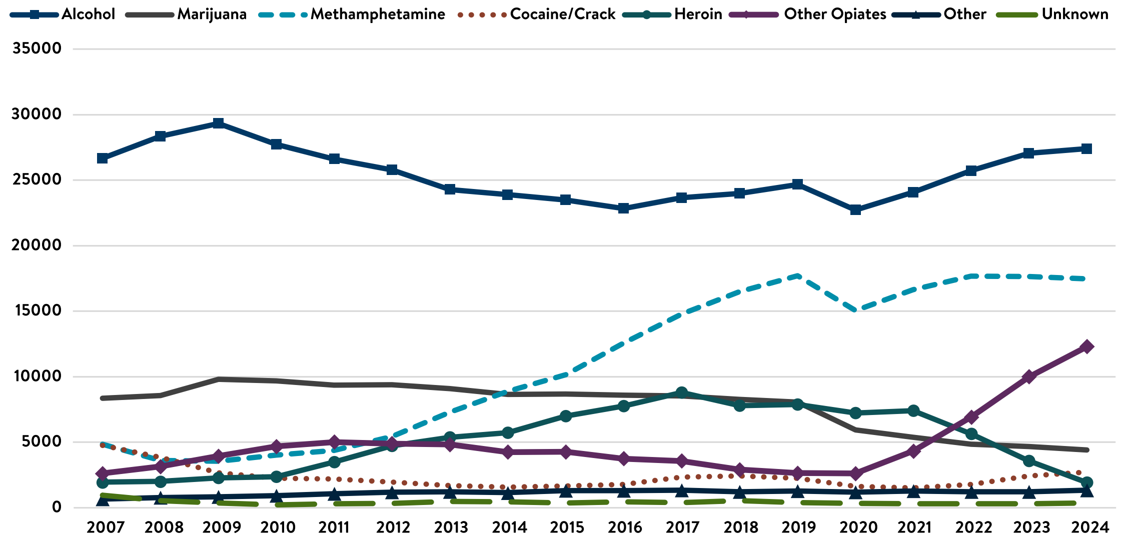
Figure 6. Zip codes ordering Naloxone through the state portal



Source: Minnesota Naloxone Portal September 2023 - November 2025

Expanding naloxone access and harm reduction interventions has shown improvements in preventing overdose deaths; however individuals experiencing SUD also require access to evidence-based treatment services that support long-term recovery. Understanding patterns in treatment admissions can provide additional insight into which substances are driving demand for services and how treatment needs continue to evolve.

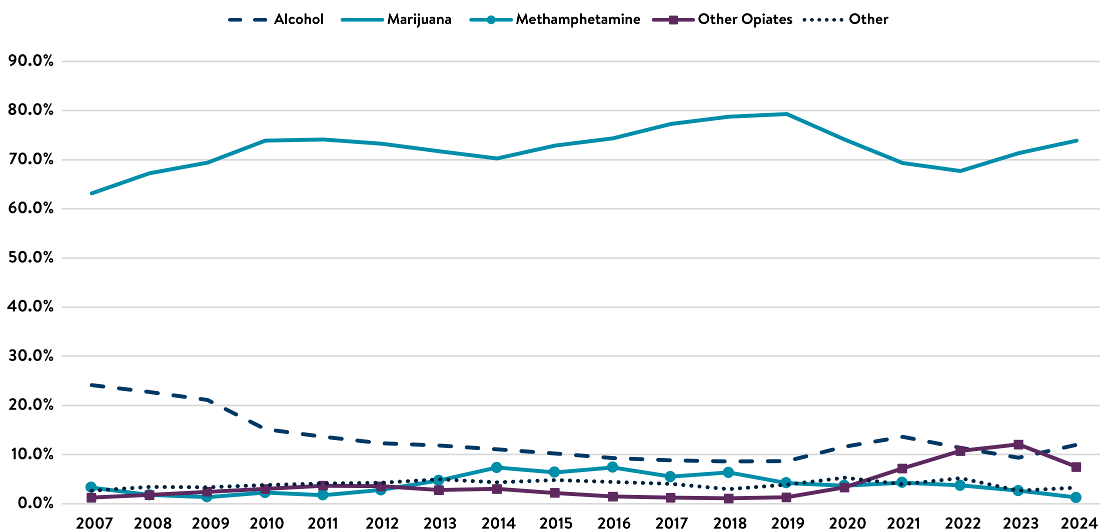
Figure 7. Primary substance at admissions to SUD treatment for adults CY 2007- CY2024



Source: Drug and Alcohol Abuse Normative Evaluation System (DAANES)

While focus over the last several years has rightly been on opioids due to the significant number of opioid-related deaths, the primary substance at admission for SUD treatment for adults remains alchohol. The Minnesota Department of Health (MDH) estimates excessive drinking alone costs Minnesotans nearly $8 billion a year. Additionally, according to MDH Minnesota had one of the highest binge drinking rates in the nation in 2023, with 17% of adults reporting binge drinking, and there were an estimated 2,844 alcohol-related deaths each year between 2020 and 2021, compared to 2,151 alcohol-related deaths each year during 2015 to 2019. Overall, MDH estimates fully alcohol-attributable deaths increased by 223% between 2000 and 2023. Among illicit drug use the primary substance at admission is methamphetamine.

Figure 8. Primary substance at admissions for SUD treatment for adolescents CY 2007 – CY 2024

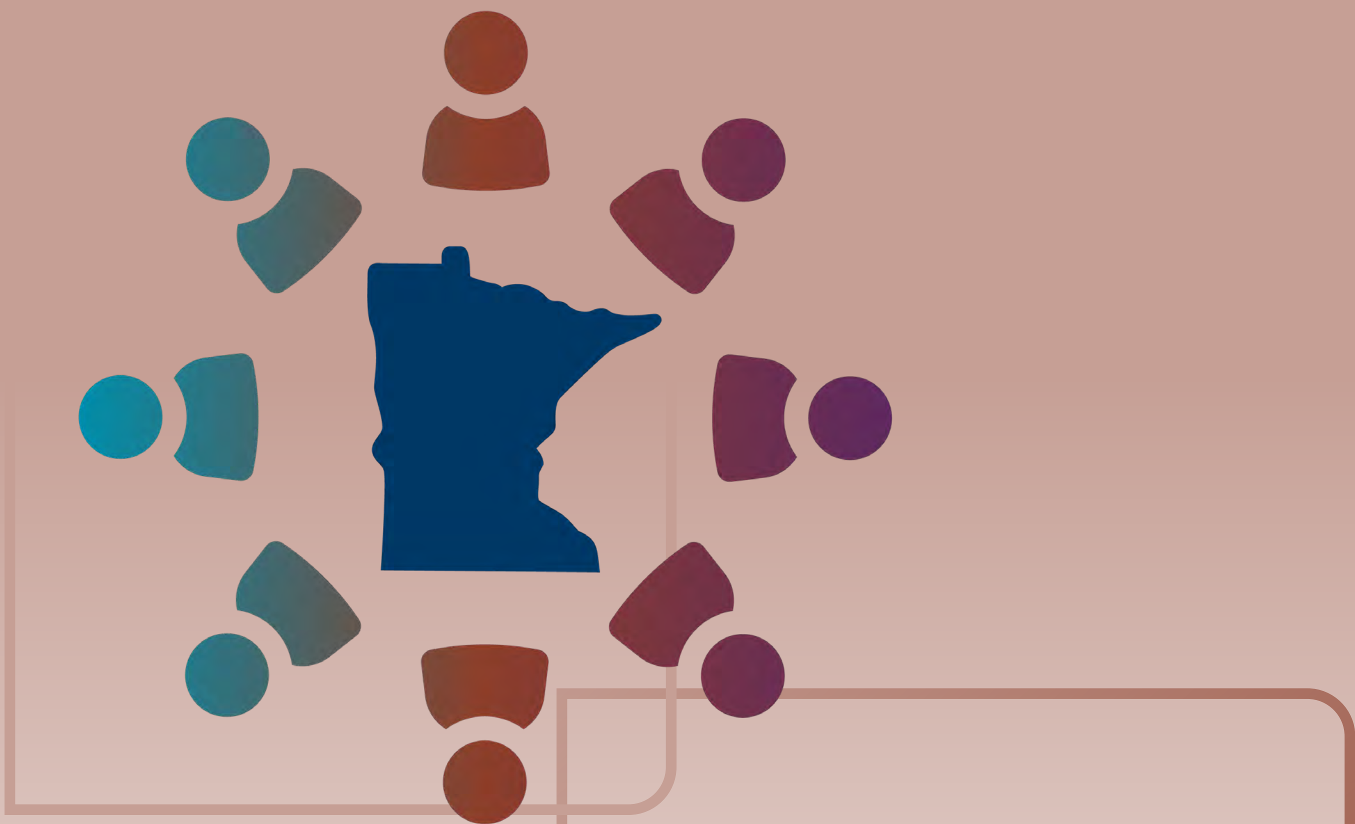


Source: Drug and Alcohol Abuse Normative Evaluation System (DAANES)

For nearly 20 years cannabis has been and remains the primary substance at admission for treatment for Minnesota youth. Amidst the legalization of adult-use cannabis, this trend emphasizes the importance of continuing to fund SUD prevention activities for young people and adolescents. The legislation legalizing adult-use cannabis also funded important youth prevention activities as well as local and Tribal public health grants for youth SUD prevention. As the state continues to develop a cannabis market, ensuring these prevention activities continue to be funded will be critical to ensuring youth are equipped to make healthy life decisions.

SUMMARY

Minnesota's SUD demographic patterns and encouraging trends documented in Minnesota's recent overdose data reflect years of sustained investment in evidence-based interventions across the SUD continuum of care and where additional focus must be targeted and maintained. The data also represents an opportunity to build upon demonstrated successes by creating a unified strategic framework that ensures all state agencies operating programs related to substance use have a foundation for aligning efforts toward shared objectives. While continuing to focus on illicit-drug mortality is imperative, it is equally important to continue to monitor and implement prevention, treatment, and recovery strategies for other substances of problematic use and misuse such as alcohol and cannabis.



AGENCY ROLES AND RESPONSIBILITIES

Minnesota's state agencies touch nearly every aspect of the SUD continuum of care. Effectively addressing substance use requires coordinated efforts among multiple state agencies, each contributing distinct yet interconnected capabilities and responsibilities. Understanding how subcabinet agencies function within the broader substance misuse and substance use disorder response system clarifies their distinct contributions. Together, these descriptions begin to illustrate how different agencies intersect and complement one another in responding to and addressing substance use.

Department of Human Services

As Minnesota's Single State Agency (SSA) for SUD and the State Medicaid Authority, the Department of Human Services (DHS) administers statewide policies and funding for SUD prevention, harm reduction, treatment, and recovery services.

The Health Care Administration (HCA) manages Medical Assistance (Medicaid) and MinnesotaCare, programs that provide health care coverage to one in four Minnesotans.[13] The HCA oversees managed care organizations (MCOs) that pay for the delivery of SUD services, manages provider eligibility and compliance, and maintains federal relations with the Centers for Medicare and Medicaid Services (CMS).

The Behavioral Health Administration (BHA) within DHS manages critical funding streams, including the Substance Abuse and Mental Health Services Administration's (SAMHSA) Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUPTRSBG), the State Opioid Response (SOR) grant, opioid settlement funds, the Behavioral Health Fund, and Medical Assistance programs (Medicaid). BHA develops evidence-based and person-centered policies to create accessible, high-quality SUD services, and in collaboration with HCA develops, implements, and maintains Section 1115 Medicaid waivers that expand coverage and services for individuals with SUDs through innovative care delivery models. The BHA has also implemented a Direct Access to care model, whereby individuals may go directly to a provider of choice for a comprehensive assessment and, if eligible for benefits, have an immediate intake across an array of American Society of Addiction Medicine (ASAM) levels of care. DHS's broad scope of funding and services has been critical to the development of a full continuum of care from primary prevention and early intervention, through withdrawal management, residential and outpatient treatment, to recovery support services.

Beyond funding and policy development, DHS licenses and certifies providers, establishes evidence-based standards of care, and conducts compliance monitoring to ensure health, safety, and treatment quality. The department collects and reports data on outcomes and populations served while providing technical assistance and training to strengthen local service delivery. BHA collaborates across multiple state agencies and sectors, including criminal justice, education, child welfare, housing, and health systems, to develop integrated responses to substance misuse, use, and co-occurring disorders while partnering with counties, Tribal Nations, and community providers statewide.

Department of Health

As Minnesota's state public health authority, the Minnesota Department of Health (MDH) addresses SUD through prevention, harm reduction, recovery support, linkages to care, and the intersection of SUD with broader public health and wellness priorities. The department leverages state and federal grant funding, technical assistance, and epidemiological surveillance to support communities across the continuum of care.

Central to MDH's SUD work is the Health Improvement Bureau, which employs a public health approach using data and research to identify risk and protective factors that influence substance use patterns. The bureau operates critical surveillance and response systems, including the overdose alert system, the Minnesota Drug Overdose and Substance Use Surveillance Activity (MNDOSA) system. Through participation in the High Intensity Drug Trafficking Areas (HIDTA) program, MDH links state-level data to local response efforts. MDH develops prevention and response strategies grounded in community needs while supported by state expertise.

MDH works with a variety of partners to influence systems changes that enhance the quality of SUD services, providing consultation and technical assistance for community-based organizations and providers working in prevention, harm reduction, treatment, and recovery supports. The department conducts studies, collects and analyzes health and vital records data, and establishes health standards for the protection of public health, including disease reporting requirements and regulation of health facilities providing addiction services. MDH also conducts awareness, and education programs and disseminates information about substance use prevention, harm reduction, and available treatment resources.

Department of Public Safety

As the State of Minnesota's primary law enforcement and public safety agency, the Department of Public Safety (DPS) addresses SUD primarily through investigation and enforcement activities and crime intervention, while also supporting prevention efforts and targeted support for disproportionately impacted populations. The department leverages state and federal funding, including opioid settlement resources, to reduce SUD-related crime and enhance community safety.

DPS operates through several key divisions, including the Bureau of Criminal Apprehension (BCA), Office of Justice Programs (OJP), Alcohol and Gambling Enforcement (AGE), and Office of Traffic Safety (OTS). These divisions employ law enforcement strategies and community-based interventions to conduct investigations, support prevention initiatives, facilitate care coordination and linkages to care, provide residential treatment services, and implement workforce development programs.

Through OJP-administered grant programs, DPS serves specific populations including children and families, justice-involved individuals, and urban Native and Tribal Nation communities. The department connects law enforcement expertise to broader public health and treatment efforts, coordinating with state agencies and other partners across criminal justice, public health, treatment providers, and community-based organizations to support integrated responses to substance use and misuse.

Office of Cannabis Management

The Minnesota Office of Cannabis Management (OCM) is a state regulatory agency responsible for overseeing Minnesota's legal cannabis programs. Established following the legalization of adult-use cannabis in Minnesota in 2023, OCM regulates both the medical cannabis program (which has operated since 2014) and the newer adult-use cannabis market, including the hemp-derived industry. The agency handles licensing for cannabis businesses, including cultivators, manufacturers, retailers, and testing facilities, while also developing and enforcing safety standards, product regulations, and compliance requirements. OCM works to ensure public health and safety, promote social equity in the cannabis industry, and provide education to consumers and businesses about responsible cannabis use and regulatory requirements. An example of this work includes CanRenew community restoration grants that support eligible organizations that make investments in communities disproportionately affected by the enforcement of cannabis laws.

Department of Corrections

The Minnesota Department of Corrections (DOC) is responsible for the individuals committed to the commissioner of corrections by the courts. The individuals committed to the department can be incarcerated in Minnesota's correctional facilities or be under supervision in the community. With a focus on public safety, DOC prioritizes strategies that hold people accountable while providing the tools they need to succeed as they transition back to communities.

DOC operates a continuum of SUD treatment using a therapeutic community model with over 1,000 treatment beds across multiple correctional facilities statewide. The DOC provides a continuum of SUD services including residential, intensive outpatient and extended outpatient levels of care. Substance use disorder treatment promotes physical, mental and emotional well-being, all essential in assisting those who are incarcerated with transformative change, including recidivism reduction. Treatment is available at every custody level except maximum security, serving both adult male and female populations.

In addition to providing treatment services for incarcerated persons, DOC provides targeted release planning services for individuals with specific treatment needs, including SUD, opioid use disorder, and co-occurring disorders. Specialized release planners coordinate continuity of care by connecting individuals to community-based treatment providers, arranging for MOUD when appropriate, and facilitating comprehensive assessments to assist in identifying appropriate community-based treatment needs. Release planning also addresses practical reentry barriers, including health insurance enrollment, Social Security disability applications, housing, employment, education, transportation, and connection to recovery supports such as recovery community organizations.

Direct Care and Treatment

Direct Care and Treatment (DCT) serves a specialized and critical function within Minnesota's SUD continuum of care by providing secure, inpatient treatment services to some of the state's most vulnerable populations. Operating under statutory authority encompassing multiple chapters of Minnesota law, including those addressing SUD and civil commitment, DCT fulfills a legislatively mandated role that other agencies and providers do not duplicate.

DCT operates the Community Addiction Recovery Enterprise (CARE) program, which provides locked, residential SUD treatment at three facilities statewide: Anoka, Carlton, and Fergus Falls. Unlike community-based treatment programs, CARE facilities offer locked settings designed for committed individuals who require structured, intensive intervention. Average lengths of stay are approximately 90 days, reflecting the complexity of client needs and the comprehensive nature of treatment provided.

DCT's treatment services primarily reach individuals who have been civilly committed by courts as chemically dependent or mentally ill/chemically dependent, who often have complex medical, psychiatric, and substance use treatment needs, and a history of multiple previous treatment stays in other settings. This subset of the committed population is one that often cannot be effectively served in less restrictive community settings. DCT specializes in treating individuals with high acuity co-occurring mental illness and SUD, a particularly challenging population requiring integrated clinical expertise. Forensic Services Licensed Alcohol and Drug Counselor (LADC) staff provide specialized SUD care for patients committed as Mentally Ill and Dangerous, delivering comprehensive services from initial diagnostic assessment through individualized co-occurring disorder treatment tailored to each patient's cognitive functioning and stage of change. Forensic Services LADC staff also serve as expert consultants to treatment teams on SUD matters, participating in aftercare planning and engaging in clinical oversight activities, including treatment plan reviews, Special Review Board hearings, and Forensic Review Panel proceedings to ensure appropriate integration of substance use considerations throughout forensic treatment and discharge planning.

Admission to CARE facilities operates through a controlled referral process typically originating from county social service agencies, courts, community hospitals, and mental health providers. This approach ensures that DCT's specialized resources are appropriately matched to individuals requiring locked treatment while maintaining connections with the broader continuum of care. The agency operates in coordination with DHS, counties, and other vendors, positioning DCT as an integrated component of Minnesota's broader behavioral health system.

Department of Children, Youth, and Families

In 2024, the Department of Children, Youth, and Families (DCYF) was officially established as a cabinet-level agency to unify programs and services for children, youth, and families that were previously dispersed across multiple state agencies and departments.[14] DCYF collaborates with other state and local agencies to address the critical intersection of SUD with child welfare and family services. Families affected by SUD historically faced significant barriers navigating multiple agencies for interconnected services, with this navigation burden falling disproportionately on already underserved families.

DCYF facilitates and supports local agency operation of prevention and recovery-related programs specifically targeted at children and families, and pregnant and postpartum persons affected by SUD. Services encompass support for affected families, child protection services with SUD considerations, and prenatal substance exposure response programs. These integrated approaches aim to remove access barriers to early intervention services, coordinate child protection with recovery supports, and deliver wraparound services with trauma-informed care across all programs.

DCYF works on multi-state, multi-jurisdiction projects including Expanding Evidence on Replicable Recovery and Reunification Interventions for Families that is supporting the development of a parent mentor program focused on caregivers who are struggling with substance use or misuse.

In addition, DCYF oversees the Child Protection Opioid allocation, which is distributed to counties and Tribal Nations participating in the American Indian Child Welfare Initiative. Funds are used locally to support training, staffing, and programming serving children and families affected by addiction.

Department of Education

The Minnesota Department of Education (MDE) addresses SUD within the context of ensuring safe learning environments that support students' academic achievement and the development of essential life skills. The department's approach centers on universal prevention education and evidence-based interventions for students experiencing substance use. MDE's work focuses on building educational systems and educator capacity to identify and respond to student substance use.

MDE establishes prevention programs through health education standards that incorporate substance use and cannabis-specific education for students. The department develops training, technical assistance, and guidance for school staff on recognizing substance use indicators, implements referral pathways in schools, and creates best practice interventions for students using substances. Recovery support efforts include funding for recovery school personnel and defining the role of substance use specialists within student support systems. MDE's approach seeks to engage students during formative developmental stages, foster safe school environments, reduce stigma around seeking help through accessible school-based resources, and establish coordinated response protocols, including standardized procedures for suspected overdose situations.

Minnesota Interagency Council on Homelessness

The Minnesota Interagency Council on Homelessness (MICH) is a cabinet-level body established in Minnesota Statutes[15] and led by Lt. Governor Peggy Flanagan. It is comprised of the commissioners of 14 state agencies and the chair of the Metropolitan Council. The council is co-chaired by the commissioners of the Department of Human Services and Minnesota Housing. Governor Walz and Lieutenant Governor Flanagan tasked the Minnesota Interagency Council on Homelessness with developing a strategic plan focused on justice and seeking a housing, racial, and health justice approach for people facing homelessness in Minnesota to guide the work of state government on this issue.

The Crossroads to Justice: Minnesota's New Pathways to Housing, Racial and Health Justice for People Facing Homelessness[16] report outlines the results and strategies that MICH seeks to achieve in addressing housing, racial, and health justice. Through this strategic plan, MICH seeks to expand access to harm reduction and treatment services for individuals experiencing homelessness and SUD by integrating harm reduction resources into shelter, outreach, respite, and housing programs and creating linkages to other care providers using low-threshold, community-based approaches that meet people where they are.

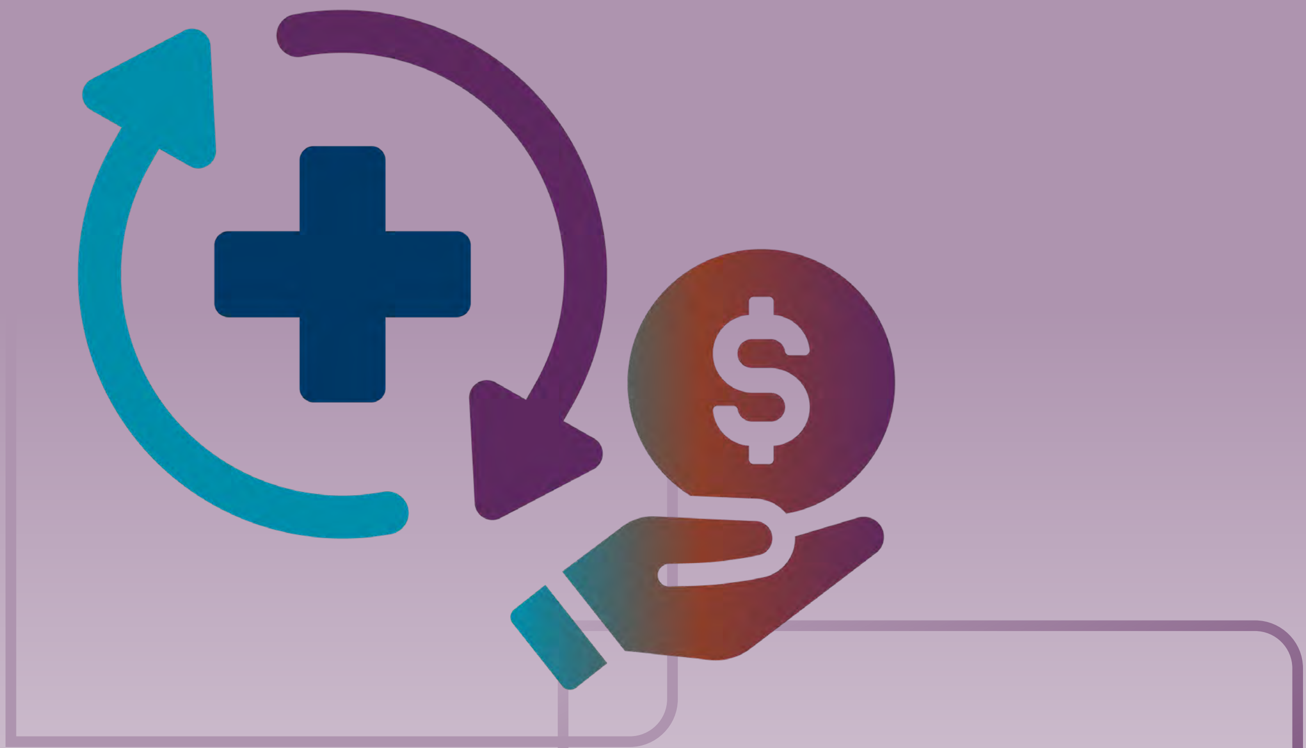
Department of Commerce

The Minnesota Department of Commerce (COMM) enforces state and federal mental health parity laws, which require insurance coverage for mental health and SUD care to be equivalent to coverage for other medical care.[17] Parity laws ensure that health plans do not impose higher out-of-pocket costs, stricter visit limits, or more restrictive prior authorization requirements for mental health and SUD services compared to physical health care. This protection helps Minnesotans access the mental health and SUD care they need without facing discriminatory insurance barriers.

Commerce reviews annual submissions from mental health insurers to ensure compliance with parity requirements and produces an annual Mental Health Parity Report with MDH on parity law compliance, oversight, and enforcement.[18] The department takes multiple enforcement actions to ensure insurers follow parity laws, including reviewing consumer and provider complaints, providing education to help identify non-compliance, monitoring insurance companies, and imposing fines when necessary. Consumers whose mental health or SUD claims are denied can appeal to their insurance carrier and, if still denied, file an external review to challenge the decision.

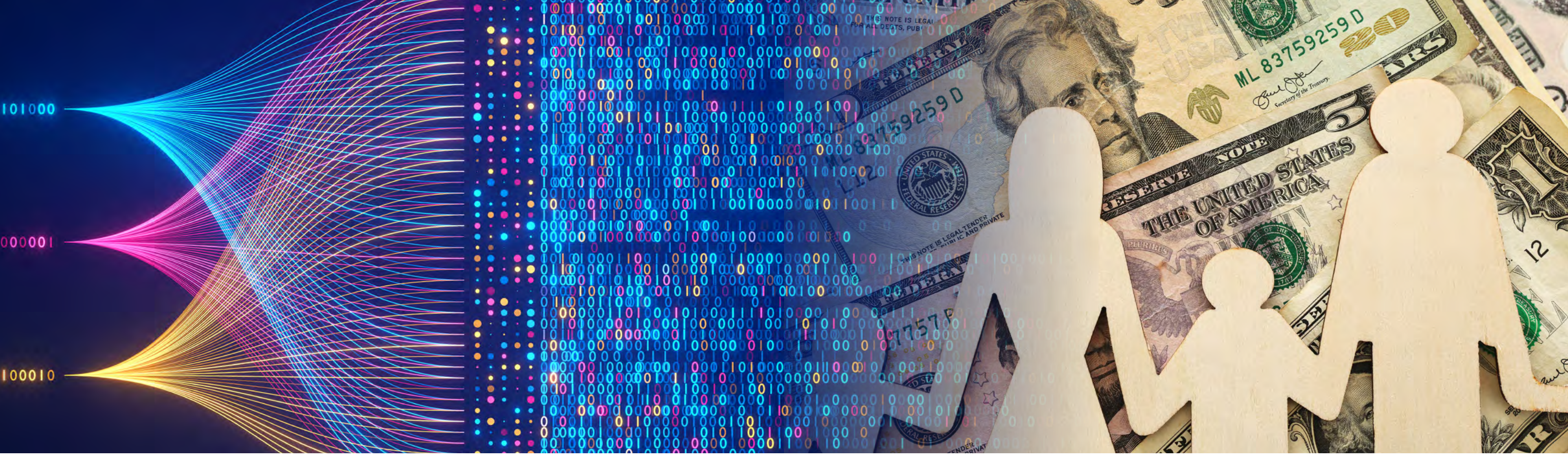
Minnesota Management and Budget

Housed within Minnesota Management and Budget (MMB) is the Policy and Planning division, where many of the interagency functions of the executive branch are housed, including the Office of Addiction and Recovery (OAR), the Children's Cabinet, and the Long-Range Planning team (LRP). OAR is charged with developing and publishing this plan for the state, staffing the subcabinet on Opioids, Substance Use, and Addiction to coordinate established goals and priorities across the SUD continuum of care. The director of the OAR chairs the subcabinet. MMB also houses the Results Management team, which conducts analysis and research that helps state and local partners make informed decisions, including around the use of opioid settlement dollars.



SUD FINANCING IN MINNESOTA

This section outlines the primary funding streams supporting substance use disorder prevention, treatment, harm reduction, and recovery in Minnesota, followed by a detailed breakdown of how these resources are distributed and administered.



Minnesota funds its substance misuse and SUD services and supports through many different state, federal, and settlement funding streams. At a high level, there are four major categories of SUD financing:

Medicaid - Medicaid is a joint state and federal program and is the backbone of SUD response. Medicaid pays for roughly half of all SUD treatment in the state and is the largest single payer of behavioral health services. Medicaid primarily funds treatment, care coordination and case management services, and some recovery supports. As an entitlement program with forecasted budgeting, Medicaid operates on the principle that eligible individuals who need covered services receive them, ensuring a safety net for Minnesotans regardless of fluctuations in demand.

Behavioral Health Fund - The Behavioral Health Fund is a Minnesota specific program that covers behavioral health costs (primarily treatment) for individuals who are eligible for but not enrolled in Medicaid. It also pays for some additional recovery services, such as housing. The Behavioral Health Fund is jointly funded by state, federal, and county contributions.

State and federal Grants - This is a broad category that includes specific state appropriations and federal grants from SAMHSA, the Centers for Disease Control and Prevention (CDC), and other federal sources. Unlike Medicaid, these are capped dollar amounts that often go to community-based organizations and are the primary source of funding for prevention and harm reduction, and some recovery supports.

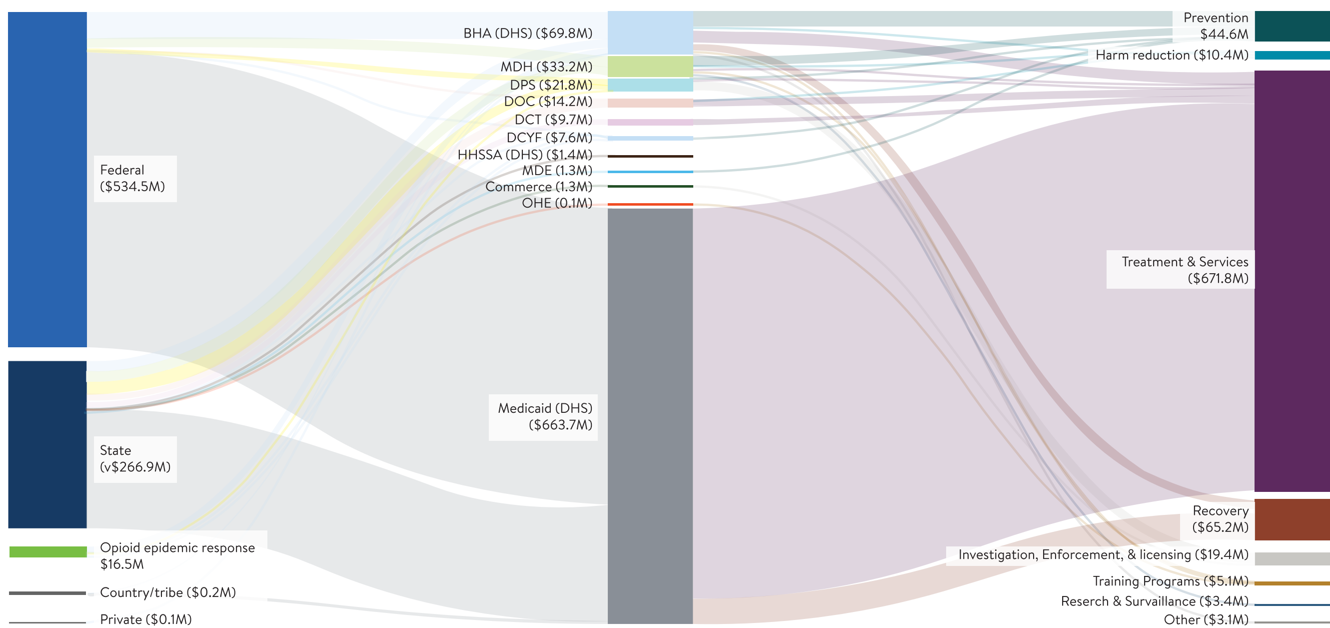
Opioid Settlement Funds - Opioid settlement funds often show up in the community as grant funding. Twenty-five percent of settlement dollars go to the state and 75% percent to counties and cities with populations over 30,000.

In 2025, OAR undertook a fiscal mapping exercise to better understand sources and uses of substance misuse and SUD funding across state government. This first fiscal map considered funding source (federal, state, or other), which state agency administers the funding stream, and which part of the continuum of care the funding supports (prevention, harm reduction, treatment and services, and recovery). The fiscal mapping output and analysis are a crucial foundational step in establishing a statewide SUD plan.[19] The information gleaned is also valuable as a point-in-time benchmark in light of forthcoming Medicaid cuts and potential reductions in other SUD funding streams. The analysis provides baseline information about where federal funding reductions are most likely to impact the continuum of care.

Key findings from the fiscal mapping exercise include:

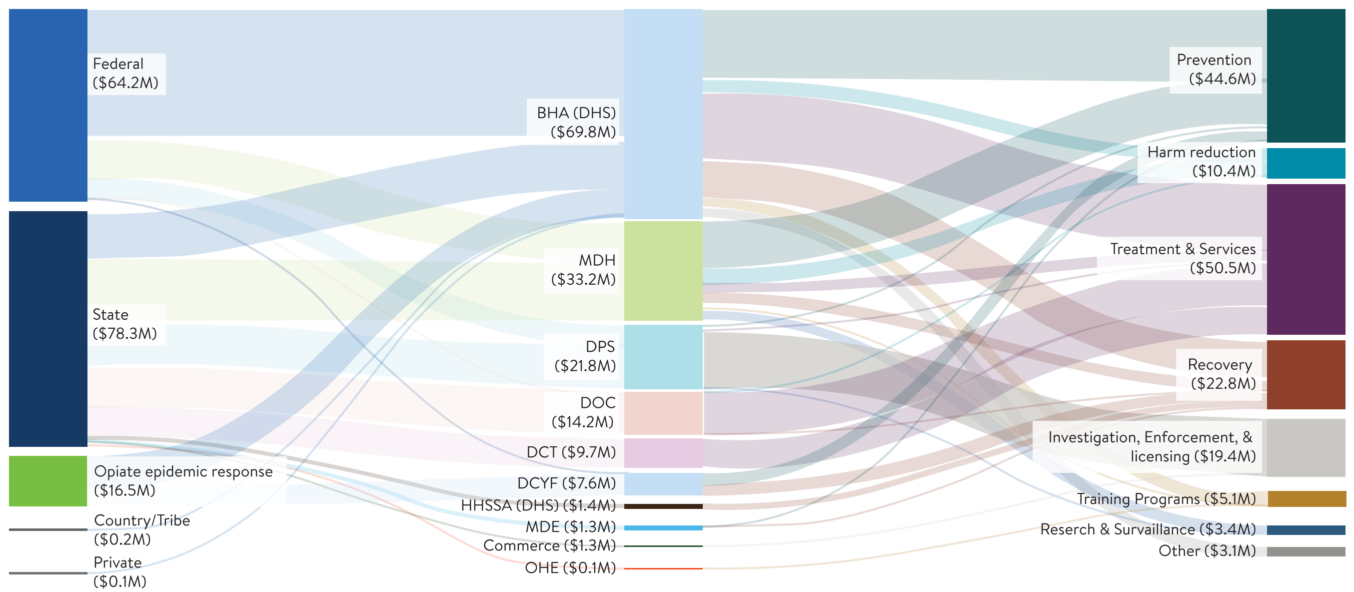
- Federal funding sources provided 65% of funding in Fiscal Year 2024, primarily driven by federal Medicaid funding. State funding sources accounted for roughly 32% of funding, with the remaining 3% a combination of opiate epidemic response funds, county or Tribal dollars, and private grants. See figure 9.
- Approximately $672 million in SUD funding was spent on treatment and recovery services across 110 different Medicaid billing codes. The treatment and services component of the continuum of care receives the greatest share (82%) of funding.
- Approximately $160 million funded 123 grant programs and directly related services. See figure 10.
- Each agency plays an important role across Minnesota's SUD continuum of care. In total, nine state agencies administered roughly $823 million in SUD funding. See figure 11.
- Ninety-five percent of SUD-related funding is administered by grantees or providers vs. state agencies.
- Agencies reported that federal or state law restricted how almost 80% of SUD funding may be deployed, which may limit the degree to which Minnesota can redeploy funding to support a future statewide SUD plan and/or to compensate for federal funding reductions.
- Categories of end use across the continuum of care comprise many, varied subcategories. For treatment and services, subcategories included outpatient/community-based care, residential care, other hospital inpatient, emergency services, and care coordination/case management. Outpatient/community-based care makes up the majority of treatment and services funding, driven primarily by Medicaid (96%). See figure 12.

Figure 9. $823 million of SUD related funding captured in SFY 24 across nine agencies



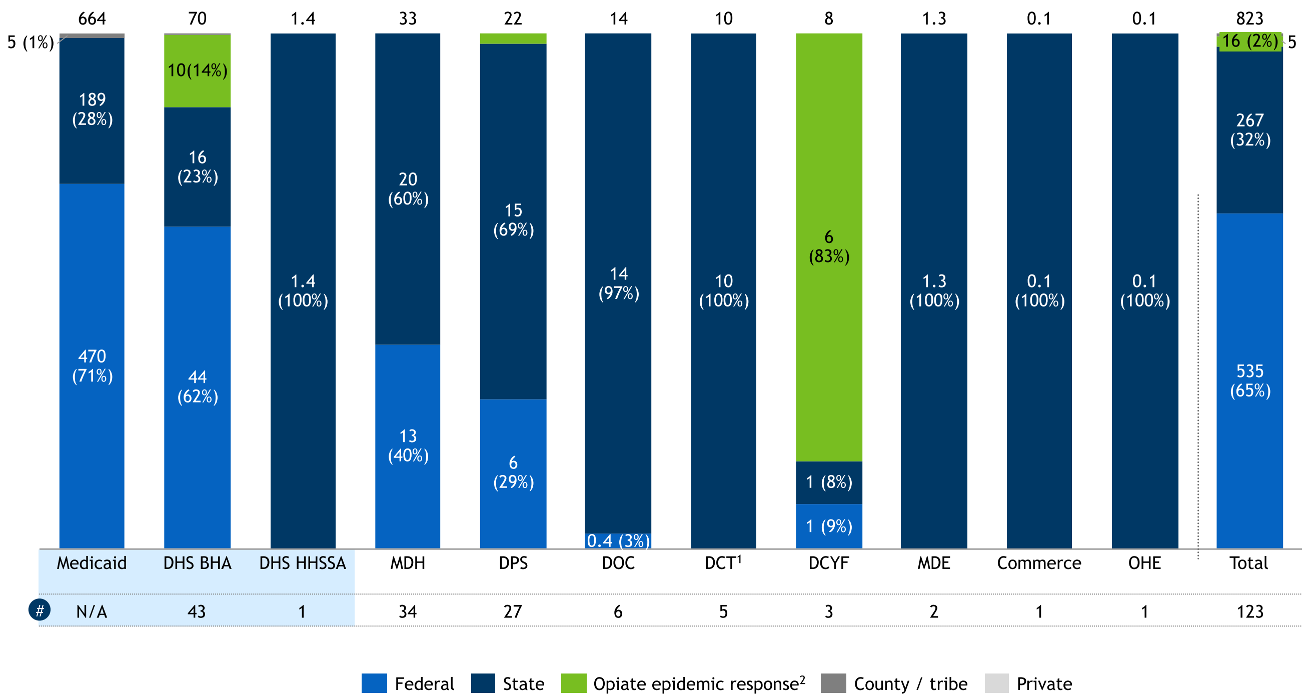
Note: For all funding except Medicaid, reflects SUD-related dollars budgeted in state fiscal year 2024. Medicaid funding reflects fee for service reimbursements and MCO capitation payments for SUD in SFY24. Excludes administrative activities given varying approaches to tracking. DCT budget excludes dollars returned to general fund across payers (e.g., Medicaid) which are captured separately as part of Medicaid funding. 'Opiate epidemic response' funding source includes MN share of opioid settlement funds and revenue raised through licensing fees for manufacturers of opioid-controlled substances. Source: Agency data requests.

Figure 10. Excluding Medicaid, $160 million of SUD related funding is comprised of grants and other directly administered activities across agencies



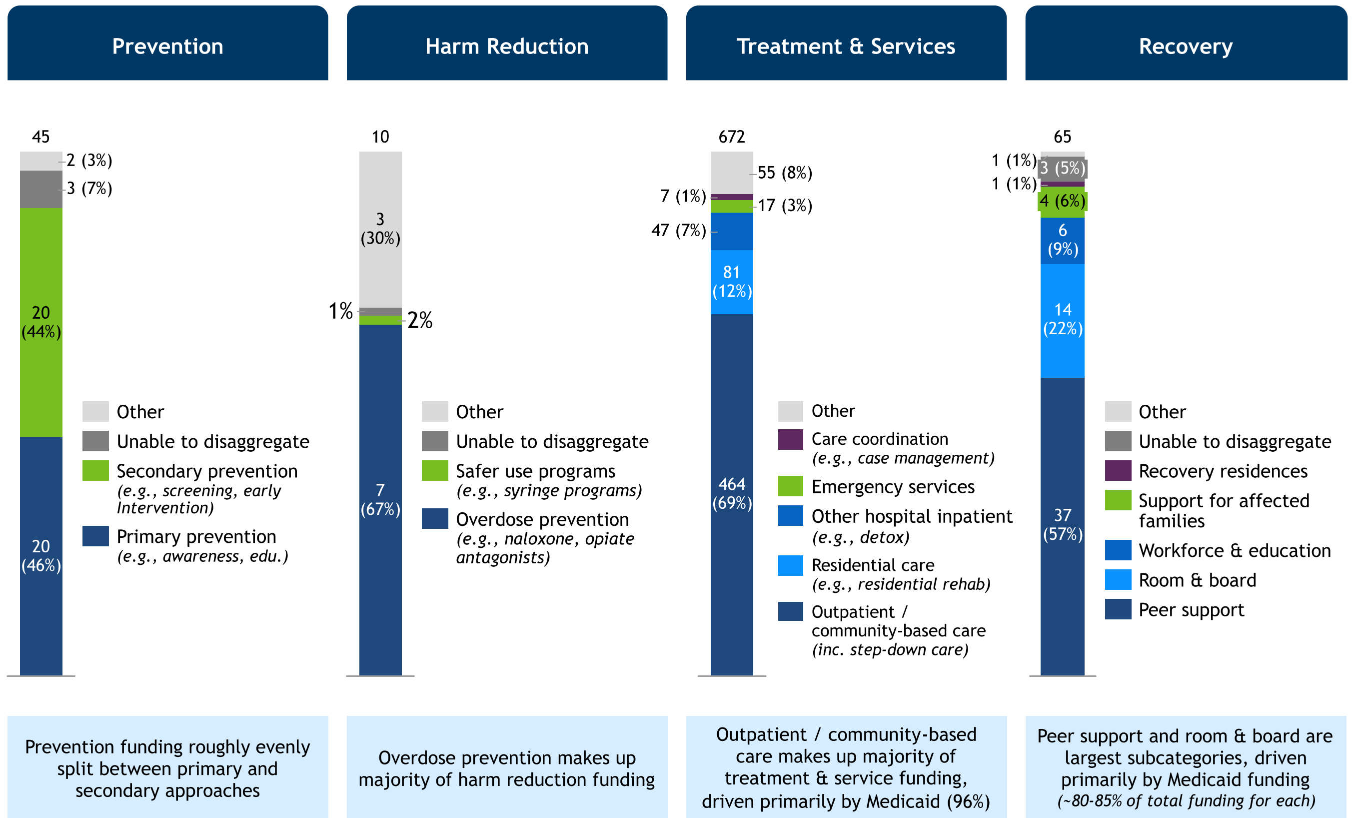
Note: For all funding except Medicaid, reflects SUD-related dollars budgeted in state fiscal year 2024. DCT budget excludes dollars returned to general fund across payers (e.g., Medicaid) which will be captured separately as part of Medicaid funding. Excludes administrative activities given varying approaches to tracking. 'Opiate epidemic response' funding source includes MN share of opioid settlement funds and revenue raised through licensing fees for manufacturers of opioid-controlled substances. Source: Agency data requests.

Figure 11. MN SUD related funding by agency, number of activities, and source (SFY 24, $M)

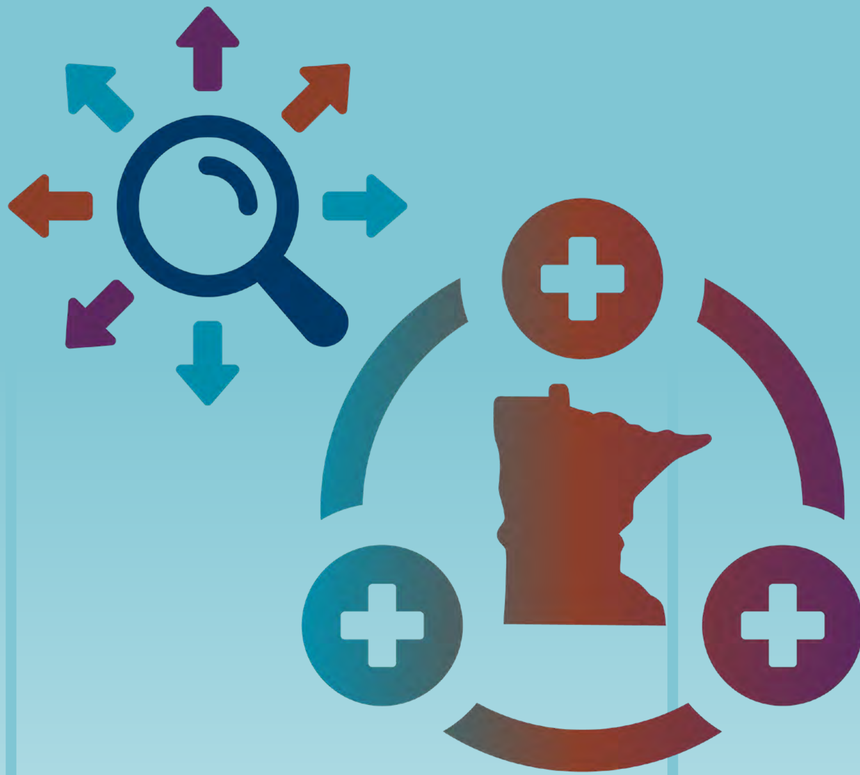


Note: For all funding except Medicaid, reflects SUD-related dollars budgeted in state fiscal year 2024. Medicaid funding reflects FFS reimbursements and MCO capitation payments for SUD in SFY24. Excludes administrative activities given varying approaches to tracking. 1. Excludes Medicaid dollars returned to general fund which are captured in the Medicaid category. 2. Includes local and private sources. 3. Includes MN share of opioid settlement funds and revenue raised through licensing fees for manufacturers of opioid-controlled substances. Source: Agency data requests.

Figure 12. Categories of end use across the continuum are comprised of many, varied subcategories (SFY 24, $M)



Note: For all funding except Medicaid, reflects SUD-related dollars budgeted in state fiscal year 2024. Medicaid funding reflects FFS reimbursements and MCO capitation payments for SUD in SFY24; distribution across categories and subcategories of end use reflect actual claims across billing codes in SFY24. Excludes administrative activities given varying approaches to tracking. 1. Represents ~25% (~$3M) of federal State Opioid Response (SOR) funding from SAMHSA. 2. Excludes Medicaid dollars returned to general fund which are captured in the Medicaid category. Source: Agency data requests.



MINNESOTA'S SUD CONTINUUM OF CARE

Introduction

SUD treatment has developed significantly over time. From the Minnesota Model created in the mid-twentieth century to the current system of services and supports, how people think about and treat substance use has changed considerably. One of the most notable changes is the shift toward person-centered models of care that focus on meeting individuals where they are in their personal recovery journeys. Implementing this shift in approach required SUD systems to adopt a longitudinal approach to care similar to those that address chronic diseases in place of episodic models.

Minnesota has been moving toward a SUD treatment system aligned with a chronic disease model for nearly two decades. The Department of Human Services' 1993-99 study "The Challenges and Benefits of Chemical Dependency Treatment" recommended creating a SUD continuum of care consistent with chronic disease management.[20] In 2013, Minnesota's Model of Care for SUD Legislative Report (DHS-6708) recommended updating Minnesota's treatment system from an acute episodic model to a chronic, longitudinal model of health care.[21] In 2016, the Minnesota Legislature directed the Department of Human Services to design and develop a robust continuum of care to effectively treat the physical, behavioral, and mental dimensions of SUD.[22]

Figure 13. Visual Representation of Minnesota's SUD Continuum of Care

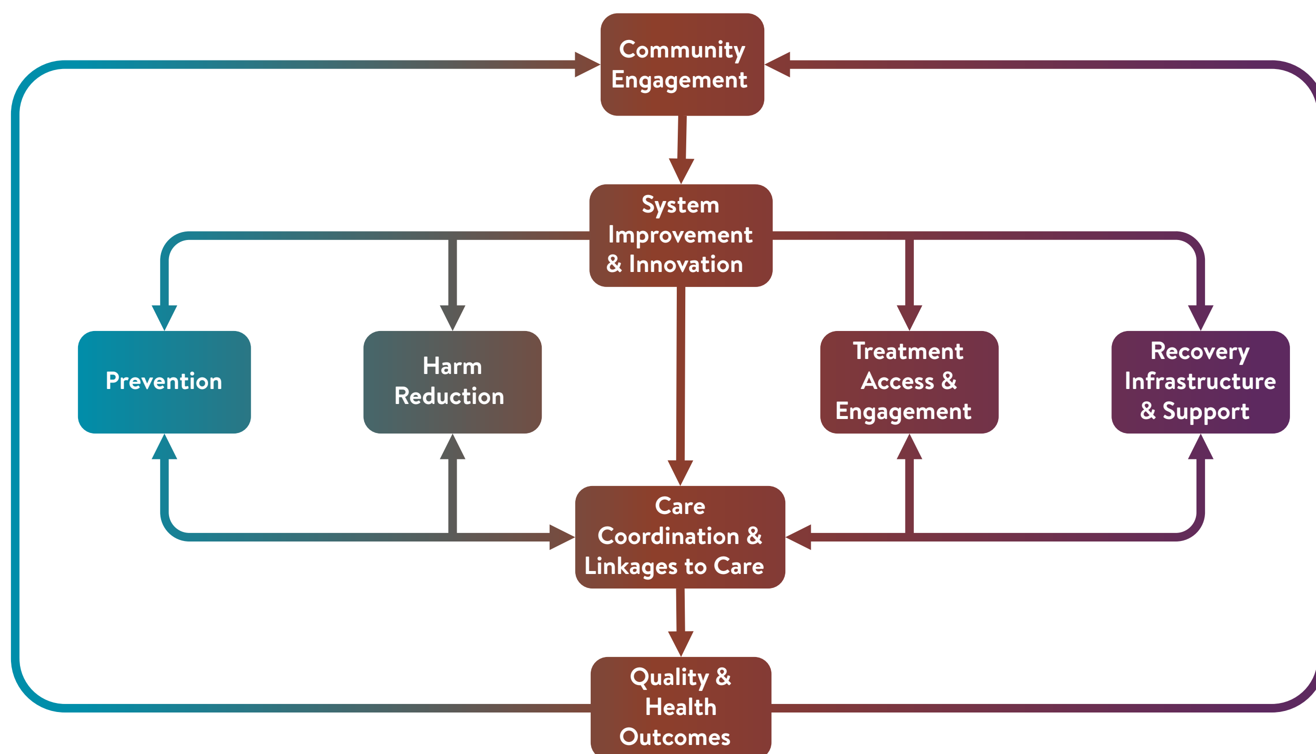


Figure 13 is a visual representation of Minnesota's SUD continuum of care and is a conceptual framework representing existing commitments within state and federal laws. While SUD continuums of care can be visualized in multiple ways, this continuum visual depicts eight interconnected components (Community Engagement, System Improvement and Innovation, Prevention, Harm Reduction, Treatment Access and Engagement, Recovery Infrastructure and Support, Care Coordination and Linkages to Care, and Quality and Health Outcomes) that together are intended to create a comprehensive system for addressing SUD in Minnesota.

This conceptual framework synthesizes how existing statutory requirements, Medicaid waiver goals, task force recommendations, and strategic initiatives work together and is designed to reflect a continuous improvement process rather than a static state. This intentional, continuous improvement structure recognizes that effective SUD response requires the ability to initiate interventions at multiple entry points while maintaining connections across all components through care coordination and linkages to care. Effectiveness is measured through quality and health outcomes monitoring alongside consistent community engagement. This continuous feedback loop ensures that programs and services achieve intended outcomes for intended recipients.

Quality and health outcomes monitoring requires system improvements and innovations that create data infrastructures necessary to track whether interventions work, for whom, and under what circumstances. Community engagement creates ongoing opportunities to understand whether services respond to actual community needs and are culturally appropriate. Together, these cross-cutting components enable the continuum to adapt based on evidence and community input rather than operating from static, top-down planning.

The continuum components detailed here highlight both the statutory requirements that establish Minnesota's commitments, research supporting the importance of each component, and the alignment across multiple initiatives that demonstrate how these commitments work together to create an integrated system. Each state agency conducting SUD-related work contributes to this continuum, often across multiple components. This framework supports the subcabinet's mandate to break down silos and develop coordinated interagency strategies that ensure all Minnesotans can access the services they need when they need them.

Responses Within and Across the Continuum

Many of the subcabinet agencies have complementary roles in addressing SUD across the entire continuum. Innovative initiatives such as DHS' 1115 Medicaid waivers in coordination with activities authorized by the Comprehensive Drug Overdose and Morbidity Prevention Act (COMPA) and overseen by the MDH fund supports and services across multiple components of the continuum.

For example, harm reduction efforts of several agencies are focused on administering programs that advance overdose prevention, safer use initiatives through syringe services programs, and naloxone distribution. These activities, along with surveillance systems like MNDOSA, provide real-time data that informs where services are most urgently needed.

A coordinated approach to care coordination and linkages to care supports a "no wrong door" system that significantly increases treatment access and engagement. A comprehensive evidence-based Medicaid benefit set overseen by DHS spans the full continuum of treatment services while MDH activities strengthen and build connection points between public health and clinical treatment systems. These coordinated efforts not only increase access to care, they also aim to prevent the initiation of substance use and misuse whenever possible. Coordinated reentry planners at DOC connect people to services upon reentry to the community. School-linked services within MDE offer opportunities to strengthen referral pathways across the entire continuum.

Recovery infrastructure and supports have been strengthened as a result of several agencies' commitment to developing peer recovery supports. By aligning strengths in coverage provision and community-based service delivery, agencies increase the likelihood that individuals will initiate treatment when ready and increase the probability that they will remain engaged across the continuum of care.

Throughout the continuum components and woven into the fabric of the state's approach to addressing substance use is a focus on ensuring services and supports are truly person-centered, including services that are culturally responsive and address the needs of the whole person. When services are attentive to the totality of an individual's identity (economic, cultural, ethnic, geographic, gender, etc.), then better outcomes will result, and people will move more quickly toward their potential, resulting in decreased governmental costs and increased productivity.

Many SUD services and supports are used across the multiple components of the continuum of care. For example, peer support specialists are important to treatment, recovery, and linkages to care. Similarly, MOUD are interventions that can and should be deployed within the harm reduction, treatment, and recovery components. Housing also plays an integral role in supporting individuals throughout the continuum.

Housing as Foundation: A Cross-Continuum Imperative

The intersection of housing and SUD recognizes that housing is more than shelter; it is a foundation for healthy living, preventing substance use, accessing treatment, and reintegrating into community. The urgency of this connection is evident in Minnesota's mortality data, where substance use deaths occur at rates ten times higher among people experiencing homelessness compared to housed residents.[23] Success in addressing SUD requires coordinated investment across all components of the continuum, with housing stability serving as the continuous thread that increases the effectiveness of prevention, harm reduction, treatment, and recovery interventions.

Integrating housing considerations throughout all continuum components creates coordinated responses that address the relationship between housing instability and SUD while reducing the disproportionate mortality burden borne by individuals experiencing homelessness.

A Continuum of Care

A continuum of care recognizes that effective SUD treatment is not a single intervention but rather a coordinated system featuring successful transfers across an array of services, similar treatment philosophy across services, and efficient transfer of client records.[24] SAMHSA emphasizes that the continuum features multiple entry opportunities into SUD care, which makes it important for service providers to grasp the interconnections between their programs and those operated by other entities across the broader behavioral health infrastructure.[24] Clinicians are encouraged to "envision admitting the client into the continuum through their program rather than admitting the client to their program," which prompts early focus on treatment planning for transitions and helps clinicians "look ahead to the next step in a client's treatment."[24]

Recognizing SUD as a chronic, relapsing condition means the continuum must provide "ongoing, less intensive, and tapered contact with treatment systems, much as with other chronic health conditions."[24] While not every client needs every service, the continuum must ensure availability of comprehensive services — medical, psychiatric, MAT, family therapy, employment counseling, housing support, peer support, and community resource connections that holistically address individuals' complex needs across housing, employment, legal, and family domains.[24]

SUD systems also require infrastructure and support mechanisms that span across and throughout the foundational continuum categories of prevention, harm reduction, treatment access and engagement, and recovery infrastructure and support. Within Minnesota's continuum of care, these additional components of infrastructure are also established through existing commitments and directives in state and federal laws and include community engagement, system improvement and innovation, care coordination and linkages to care, and quality and health outcomes. Surveillance and enforcement activities also play a critical role in supporting the continuum of care.

Community Engagement

Community engagement is effective at improving both behavioral health and general well-being in communities and is a cross-cutting component that provides a framework for designing, implementing, and maintaining all parts of the continuum in ways that respond to community needs and fit diverse cultures.[25] When people with lived experience participate in policy discussions, the resulting services and interventions better align with what people need, producing more responsive policies and better outcomes.[26]

Community engagement requirements are woven throughout state law, particularly as it relates to SUD. For instance, the subcabinet must develop and implement a framework to ensure meaningful public engagement is conducted by the subcabinet's agencies and boards.[27] Without community engagement, evidence-based interventions may fail to reach those who need them most, may not be culturally appropriate, or may not address the specific barriers faced by disproportionately impacted communities. Establishing community engagement as a distinct component of Minnesota's SUD continuum supports state agencies in breaking down silos within state government around addiction, treatment, prevention, and recovery through engagement with external partners who serve as bridges between government systems and affected communities.[28] This creates a sustainable infrastructure for developing solutions with Tribal Nations urban Indians, individuals with lived experience, communities of color, and other key partners.

Every state agency within the subcabinet is committed to taking time to create, strengthen, and sustain long-term relationships in community to foster meaningful dialogue with people with lived experience. This includes working closely with individuals and community partners to identify needs, concerns, ideas, and solutions in multiple ways, both formal and informal, including through task forces, community grant reviewers, advisory councils, communities of practice, community-hosted listening sessions and engagement events, roundtable discussions, and other activities.

Community Engagement: Building Minnesota's SUD Response Through Lived Experience and Partnership

State agencies employ diverse strategies to center the voices of individuals, providers, community partners, Tribal Nations, and urban Indian communities in program design, policy development, and service delivery—ranging from gathering input to full co-creation. Examples of community and public engagement activities include:

- Opioid Epidemic Response Advisory Council
- American Indian Advisory Council
- Governor's Advisory Council on Opioids, Substance Use, and Addiction 2024 Year End Report
- Crossroads to Justice Strategic Plan - Minnesota Interagency Council on Homelessness
- Reentry Services Working Group
- Substance Use Disorder Community of Practice - Minnesota Department of Human Services
- Overdose Outreach and Engagement - Minnesota Department of Health
- African American Health State Advisory Council - Minnesota Department of Health

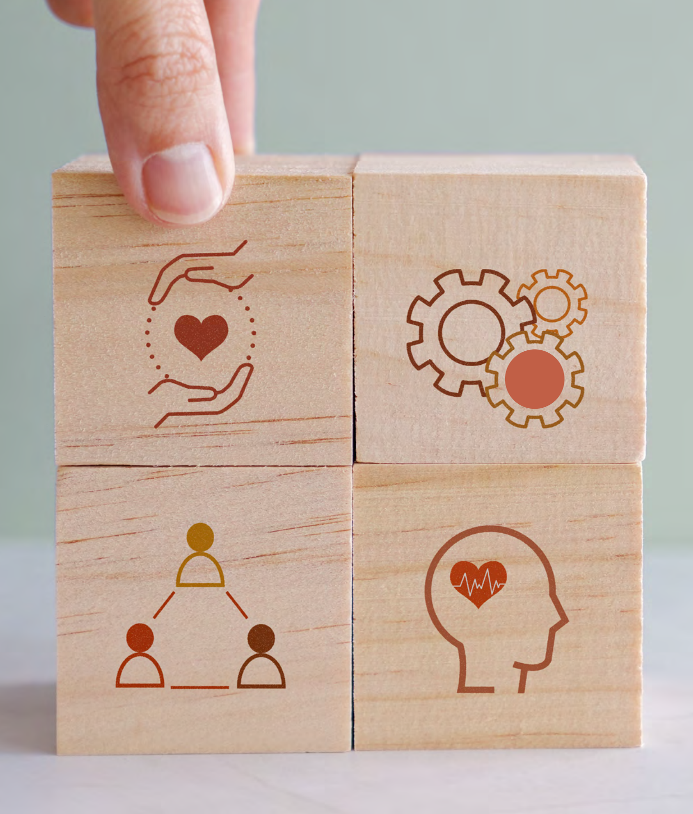
Statutory requirements of the Comprehensive Drug Overdose and Morbidity Prevention Act (COMPA) and the Opioid Epidemic Response Advisory Council (OERAC) reinforce the importance of community engagement through the establishment of collaborative partnerships with Tribal Nations, requirements for culturally specific interventions, culturally and linguistically appropriate services targeting historically underserved communities, and community-based organizations.[29][30][31] In addition to these statutory requirements, the 1115 SUD System Reform waiver's emphasis on evidence-based services with a holistic treatment approach requires community-responsive design through community engagement to develop culturally responsive services.[32]

The recognition of community engagement as a distinct, cross-cutting component reflects both statutory mandates and evidence-based best practices. Community engagement creates the foundational infrastructure necessary for ensuring all components of the continuum are culturally appropriate, responsive to actual community needs, accessible, and informed by the expertise of individuals with lived experience. This creates ongoing feedback loops that allow the continuum of care to continuously adapt based on community input.

System Improvement and Innovation

Effective system improvement requires identifying challenges that create silos and collaborative development of solutions, strategic deployment of resources, and sustained commitment to building an infrastructure that allows for measuring whether reforms achieve their intended outcomes. This component of the continuum is defined as systemic and practice reforms that develop a robust continuum of care by coordinating and consolidating funding streams to maximize efficiency, increasing the use of quality and outcome measures to inform benefit design and payment models, breaking down silos within state government around addiction, treatment, prevention, and recovery, and identifying innovative services and strategies for effective treatment and support, particularly for those disproportionately impacted by substance use and addiction.

Minnesota's system improvement and innovation efforts recognize that fragmented funding streams, siloed agency operations, and gaps in service delivery create barriers to accessible, effective treatment and support. Addressing these systemic challenges requires deliberate coordination across state agencies, strategic use of quality and outcome measures, and sustained focus on developing new services that respond to the evolving needs of disproportionately impacted communities.[33][34] Disconnected funding sources also create an administrative burden for providers, create gaps in service availability, and prevent efficient coordination and linkages to care that an effective continuum of care provides. By coordinating funding streams, the state can reduce duplicative processes, direct resources toward service gaps, ensure that payment models support appropriate care delivery and increase access to care, especially for individuals experiencing homelessness, justice system involvement, and other high-needs populations.[35]



Ideally, quality and outcome measures inform system improvements, providing the data infrastructure necessary to inform benefit design, guide payment model development, and track Minnesota's progress toward measurable goals. This emphasis on measurement extends beyond simple data collection to encompass systematic use of outcomes to identify what works, for whom, and under what circumstances, which is essential information for directing state investments toward effective interventions. More information on the development of quality and health outcome initiatives is detailed in the quality and health outcomes section of the report.

In support of system improvements, the subcabinet is charged with identifying innovative services and strategies for effective treatment and support, particularly those directed at serving communities disproportionately impacted by substance use and addiction. This focus on innovation acknowledges that effective responses require more than scaling existing services. New approaches must address emerging trends in drug supply, respond to community-specific needs, integrate lessons from implementation research, and develop services responsive to the chronic nature of SUDs.

System improvement and innovation are also monitored through the 1115 SUD System Reform waiver goals, which provide monitoring and evaluation of standardized national milestones that can serve as a guide for system improvement efforts.[32] Implementing nationally recognized standards like ASAM as a component of the waiver's milestones supports additional system improvements such as the Department of Commerce's oversight of state and federal parity laws. Standardized utilization reviews required as a waiver milestone in conjunction with the Department of Commerce's oversight ensures that insurance coverage for SUD treatment meets the same standards as coverage for other medical conditions, removing financial barriers to care and supporting equitable access across the continuum.

There are many instances of system improvement and innovation work across state agencies, including new legislation passed in 2025 requiring all state agencies operating programs related to substance use prevention, harm reduction, treatment, or recovery to set their program goals and priorities in accordance with the interagency state plan developed by the subcabinet.[34] This requirement operationalizes system improvement and innovation by supporting individual agency decisions aligned with coordinated statewide strategy rather than operating in isolation.

Prevention

Prevention activities are a fundamental component of the continuum and work to educate and support individuals and communities to prevent the use and misuse of drugs and the development of SUDs, focusing on reducing risk factors and strengthening protective factors related to substance use.[36] Comprehensive prevention strategies reduce the incidence of SUDs by addressing underlying factors that lead to substance use and misuse, decreasing stigma, promoting public awareness and education about substance-related risks, and fostering understanding of addiction as a treatable chronic disease with multiple recovery pathways.[28]

Culturally specific interventions represent an essential component of effective prevention. State agencies such as the MDH administer prevention funding focused on addressing risk and protective factors in specific communities. For example, COMPA requires implementing culturally specific interventions and prevention programs with populations and community groups that experience the greatest rates of SUD and/or overdose.[37] Prevention and education also challenge stigma by promoting an accurate understanding of addiction as a chronic disease, ensuring public awareness campaigns and prevention programs accurately represent the nature of addiction and recovery.[28] Similarly, addressing SUD prevention among pregnant individuals through multitiered approaches that promote medication-assisted treatment options and collaboration with interdisciplinary teams creates critical intervention points that protect both maternal and infant health.[37] These approaches help reduce barriers to seeking help early and promote community environments that support rather than shame individuals struggling with substance use.

Key system improvement and innovation initiatives:

Minnesota's SUD System Reform

1115 Substance Use Disorder (SUD) System Reform Demonstration

Minnesota Reentry Waiver Application

Comprehensive Drug Overdose and Morbidity Prevention Act (COMPA)

Statewide K–12 Academic Standards in Health

Opioid Epidemic Response Advisory Council (OERAC)

Minnesota Rehabilitation and Reinvestment Act

Minnesota Statewide Health Assessment

Task Force on Pregnancy Health and Substance Use Disorders

Task Force on Holistic and Effective Responses to Illicit Drug Use

Family Centered Care for Pregnant Individuals with Substance Use Disorders

COMPA mandate to design a system to assess, address, and prevent the impacts of drug overdose and morbidity on those who are pregnant, their infants, and children and respond to drug overdose and morbidity in pregnant individuals through multitiered approaches that promote medication-assisted treatment options and collaboration with organizations focusing on quality improvement initiatives creates critical intervention points that protect both maternal and infant health.[37] This requirement reflects recognition that pregnant individuals with SUDs face unique medical considerations requiring specialized approaches that balance maternal autonomy, fetal development, and family preservation.

Minnesota's approach to prenatal substance exposure reflects a fundamental shift from punitive interventions to family-centered support. A Task Force on Pregnancy Health and Substance Use Disorders convened by MDH put forward recommendations for comprehensive protocols emphasizing person-centered, culturally responsive, and trauma-informed care that recognizes substance use disorder as a family disease requiring holistic treatment rather than criminal or child welfare intervention. These recommendations establish a new paradigm for supporting pregnant individuals and families affected by substance use disorders while protecting both maternal autonomy and infant health.[(5)(38)]

1. Reform punitive laws
2. Implement universal screening
3. Limit toxicology testing
4. Establish early family care plans
5. Create a separate notification system
6. Support ongoing implementation

An interagency workgroup with collaboration from the National Center on Substance Abuse and Child Welfare[39] has launched to explore implementation of the recommendations of the task force.

Prevention programming can also occur in many different settings, including schools. The Department of Human Services has administered school-based prevention programming, and currently, the Minnesota Department of Education is developing statewide health standards that include substance use education and prevention.[40]

Minnesota's Prevention Landscape: Building Community Capacity

Minnesota's prevention infrastructure combines federal block grants, state initiatives, and community-driven programming to reduce the risk of developing SUD through sustained investment across local public health departments, schools, Tribal Nations, and community-based organizations. Examples of significant prevention initiatives include:

Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant
Federal regulations require that at least 20 percent of block grant funding be dedicated specifically to primary prevention activities.

Communities that Care Grants
Communities that Care Grants support evidence-based prevention frameworks that support local communities to assess their specific needs and implement proven strategies tailored to their unique circumstances.

Substance Use Prevention, Education, and Recovery (SUPER) Focus Grants
SUPER Focus Grants extend prevention capacity across Minnesota's diverse geography.

Local and Tribal Public Health grants
Local and Tribal Public Health SUD prevention grants create dedicated funding streams that support prevention infrastructure within county public health departments and Tribal Nations.

Comprehensive Drug Overdose and Morbidity Prevention Act (COMPA)
Provides funding for culturally specific overdose prevention programs.

Opioid Epidemic Response Advisory Council (OERAC)
OERAC directs focused funding toward public education and awareness campaigns for both adults and youth.

Minnesota's Family First Prevention Services Act (FFPSA) Title IV-E Five-year Prevention Plan
FFPSA brings additional federal resources to support prevention services for families affected by substance use disorders.

Statewide Health Standards (MDE)
MDE's statewide health standards integrate substance use prevention into K-12 curricula.

OERAC also has a specific focus on prevention, including public education and awareness for adults and youth, prescriber education, and development and sustainability of opioid overdose prevention and education programs, ensuring that prevention and education remain prioritized in Minnesota's efforts to address the opioid addiction and overdose epidemic.[31]

Prevention is a foundational component within the SUD continuum that reduces demand for treatment services by preventing use, thus avoiding potential SUDs, while also creating community environments that support individuals in recovery by reducing stigma and promoting accurate understanding of addiction as a treatable chronic condition. This makes prevention a component of the continuum that influences system utilization and outcomes across all other components of the continuum.

Harm Reduction

Harm reduction is an essential component of Minnesota's SUD continuum, which acknowledges that individuals need access to services that reduce the negative health, social, and economic consequences of substance use for themselves, their families, and their communities, and create critical connections to individuals that can form the foundation for a recovery journey. Harm reduction practices in Minnesota seek to minimize substance use-related harms through integrated overdose prevention and response activities, naloxone distribution, syringe service programs, housing supports, and comprehensive healthcare that addresses both addiction and physical health needs. Harm reduction services function as both standalone interventions that save lives and as a critical linkage to care that connects individuals to treatment when they become ready.

Harm Reduction in MN: Meeting People Where They Are

Minnesota's harm reduction approach recognizes that saving lives and connecting people to care requires removing barriers and providing immediate support that meets people where they are and creates onramps to recovery. Examples of harm reduction initiatives and agency work include:

Naloxone Saturation Strategy
Minnesota's Naloxone Saturation Strategy ensures overdose reversal medication reaches communities statewide through widespread distribution.

Fentanyl Test Strips for Public Health
Fentanyl test strips empower individuals to detect fentanyl contamination in drug supplies before use.

Syringe Services Program
Syringe Services Programs provide sterile injection equipment, wound care, infectious disease testing, naloxone, peer support, and treatment linkages without requiring identification, housing, or abstinence. Evidence shows these programs reduce HIV and hepatitis C transmission without increasing drug use, protecting public and individual health.[41]

Safe Recovery Sites
Safe Recovery Sites are brick and mortar locations that provide a continuum of harm reduction services.

Harm Reduction, Health, and Housing Hubs Grant
Harm Reduction, Health, and Housing Hubs deliver integrated housing, harm reduction, and health services to people experiencing homelessness.

Harm Reduction and Culturally Specific Grants:
Grant funding specifically for Tribal Nations and culturally specific organizations to address opioid epidemic impacts through harm reduction supplies, organizational capacity building, culturally specific service expansion, and opiate antagonist training.

Drug Checking:
Legislation provided funding to DHS to implement community drug checking programs that allow individuals to bring substances to designated sites for rapid preliminary analysis and comprehensive laboratory testing.

Minnesota's statutory framework explicitly recognizes harm reduction as a core continuum component through multiple commitments. COMPA establishes comprehensive activities to advance access to evidence-based non-narcotic pain management services and enhance overdose prevention and supportive services for people experiencing homelessness, including emergency housing subsidies and syringe services programs serving people experiencing homelessness.[37] These requirements acknowledge that individuals experiencing homelessness face disproportionate overdose risks and require targeted interventions that address the intersection of housing instability and substance use. By including the director of the Interagency Council on Homelessness on the subcabinet, state statute ensures that harm reduction services addressing housing instability receive strategic attention, recognizing that effective harm reduction cannot be siloed from broader housing and homeless response systems.[42]

The cyclical relationship between housing instability and SUD creates a self-reinforcing pattern. Individuals experiencing homelessness face SUD death rates 10 times higher than the general population, while those with SUD are simultaneously more likely to experience housing instability.[23] Systemic barriers further complicate this cycle: discrimination in housing access, inadequate coordination between housing and healthcare systems, insufficient availability of supportive services that address both conditions simultaneously, and persistent gaps in affordable housing supply that prevent individuals from accessing the stable housing foundation necessary for effective engagement with treatment and sustained recovery.[43] Emergency and short-term housing subsidies immediately reduce risk by removing individuals from environments where overdose risks are highest, while simultaneously creating stability that makes treatment initiation and retention more achievable.

Crossroads to Justice: Minnesota's New Pathways to Housing, Racial and Health Justice for People Facing Homelessness[16]

Minnesota's interagency approach to homelessness recognizes that housing instability represents not merely a shelter crisis but also a fundamental health and racial justice issue requiring comprehensive, trauma-informed responses. The Crossroads to Justice strategic plan was developed through collaborative leadership from compensated justice and implementation consultants, all of whom bring lived experience of homelessness and represent diverse backgrounds and regions across Minnesota, Lieutenant Governor Peggy Flanagan, commissioners from 14 state agencies, and the Metropolitan Council Chair. This strategic plan recognizes that all people's physical, mental, spiritual, and environmental health needs must be met by integrated public systems, including healthcare, public health, and public safety.

The plan commits to creating a more comprehensive, trauma-informed, and culturally responsive continuum of care for people facing homelessness and expanding harm reduction services through multiple interconnected strategies that collectively address the overdose crisis among people experiencing homelessness through coordinated pathways that meet people where they are.

The 1115 SUD System Reform waiver goals reinforce the essential role harm reduction plays within the continuum of care by recognizing that effective interventions must address the medical complexities facing individuals with SUDs. Harm reduction services contribute directly to multiple waiver goals by integrating substance use care with treatment for infectious diseases, chronic conditions, and acute health needs, thereby reducing barriers created by siloed care delivery systems. Naloxone distribution programs, overdose prevention education, and enhanced access to evidence-based treatment intercept overdose events before they become fatal, create repeated opportunities for individuals to access treatment services, and reduce overdose mortality rates, demonstrating harm reduction's evidence-based effectiveness in preventing the most severe consequences of SUD while simultaneously supporting pathways toward treatment engagement and improved health outcomes across the continuum.

The importance of harm reduction within Minnesota's comprehensive continuum reflects both public health evidence and statutory commitments. The evidence demonstrates that harm reduction services reduce overdose deaths, decrease transmission of infectious diseases, increase access to treatment, and improve health outcomes without increasing substance use.[41] Minnesota's statutes ensure that harm reduction receives both policy attention and resource allocation necessary for effective implementation. The subcabinet's coordination role ensures that harm reduction services align with prevention, treatment, and recovery components across the continuum rather than operating as disconnected interventions. This comprehensive approach ensures that Minnesota's continuum of care offers multiple entry points, flexible services that meet individuals where they are, and coordinated interventions that reduce harms while supporting pathways toward recovery when individuals become ready to pursue treatment.

Understanding ASAM: Minnesota's Framework for SUD Treatment

The ASAM Criteria are the most widely used evidence-based standards for patient placement, continued service, and transitions of patients with addictive, substance-related, and co-occurring conditions.[44] The ASAM Criteria are a standardized, multidimensional framework used to assess individuals with substance use and co-occurring disorders and match them to appropriate levels of care. The ASAM 3rd Edition Criteria use six assessment dimensions to determine an individual's treatment needs: 1) acute intoxication and withdrawal potential, 2) biomedical conditions, 3) emotional and behavioral conditions, 4) readiness to change, 5) relapse potential, and 6) recovery environment.[45] These dimensions guide clinical recommendations for treatment services ranging from early intervention through medically managed intensive inpatient levels of care.

In December 2023, ASAM released its 4th Edition manual, a comprehensive set of guidelines that use a holistic, person-centered approach to developing treatment plans for patients with addiction and co-occurring conditions.[46] DHS has begun work developing 4th Edition standards through a Design and Subject Matter Expert Workgroup in preparation for the implementation of these new standards in Minnesota.[47]

Treatment Access and Engagement

An effective SUD treatment system must identify individuals with substance use and misuse, ensure timely access and initiation into treatment, increase engagement and retention, and expand access to evidence-based, culturally responsive services focused on holistic care. Geographic isolation, workforce shortages, insurance coverage limitations, cultural and linguistic barriers, transportation difficulties, and stigma create obstacles that prevent individuals from entering treatment when they need it most.[35][48] Minnesota's approach to treatment access and engagement recognizes that removing these barriers requires coordinated action across state agencies to identify gaps in service, develop recommendations to overcome these barriers, and create pathways that support multiple entry points into care.[28]

Minnesota's SUD System Reform initiative included the development of a direct access to treatment process where clients may present directly to service providers of their choice for an assessment and intake to treatment, reducing administrative barriers that historically delayed treatment entry.[49] These reform efforts also extends identification strategies beyond traditional SUD treatment facilities into healthcare, social service, and carceral systems where individuals already engage with services, creating multiple intervention opportunities, while enhanced clinical guidelines and decision-making tools strengthen treatment quality and consistency across providers.

1115 SUD System Reform Demonstration Waiver

Minnesota's 1115 SUD System Reform Demonstration waiver[50] is a federal-state partnership with the CMS to transform how Medicaid beneficiaries access SUD treatment. While the waiver advances two primary objectives: implementing the ASAM criteria for evidence-based patient assessment, placement and treatment, and extending Medical Assistance Medicaid coverage to residential treatment facilities with more than 16 beds, known as institutions for mental disease (IMDs), it also serves as the backbone and North Star of the state's approach to SUD treatment and recovery.

Seven Goals Guide Minnesota's System Reform Initiative

Minnesota's SUD waiver establishes seven interconnected goals that drive system improvements:

- Increased rates of identification, initiation, and engagement in SUD treatment
- Increased adherence to and retention in treatment
- Fewer preventable readmissions to the same or higher level of care
- Improved access to care for physical health conditions among Medicaid beneficiaries
- Reduced opioid-related overdoses and deaths
- Expanded access to evidence-based services using a holistic treatment approach
- Reduced preventable or inappropriate emergency department and inpatient utilization

These goals align with federally required milestones that create a structured framework for system reform.[51]

Requirements of the waiver are to:

- Ensure access to critical levels of care
- Implement widespread use of evidence-based patient placement criteria like ASAM
- Establish nationally recognized provider standards
- Build sufficient provider capacity, including MOUD
- Develop comprehensive prevention and treatment strategies to address opioid abuse and opioid use disorder; and
- Improve care coordination and transitions across levels of care

The waiver also requires the development of health information technology infrastructure focused on expanded use of prescription drug monitoring programs (PDMP), as well as implementing a utilization management process to ensure individuals are receiving services at the right level of care at the right time.[50] Together, these milestones provide a framework for building, monitoring, and evaluating the state's integrated and evidence-based continuum of care.

Progress and Provider Experience

The July 2024 Interim Evaluation Report by NORC at the University of Chicago documented meaningful progress toward the waiver's goals despite complications related to implementation during the COVID-19 pandemic. The number of Medicaid beneficiaries with a new SUD diagnosis increased from 49,600 in calendar year 2017 to 53,644 in calendar year 2022, suggesting improved identification of individuals needing treatment.[32] Rates of treatment initiation within 14 days of diagnosis remained relatively stable between the three-year baseline and three-year demonstration periods, while the proportion of beneficiaries with opioid use disorder initiating MOUD increased by nearly 13 % (5.8 percentage points), reflecting strengthened access to evidence-based pharmacotherapy.[32] Provider experience reinforced these findings. Fifty-four percent of survey respondents rated the waiver "effective" or "very effective" in directing patients to the most appropriate level of care through improved assessment processes.[32]

According to Minnesota's Licensing Information Lookup website, Minnesota has over 400 licensed SUD treatment providers across the state; however, DOC is the largest provider of SUD treatment services in the state. The DOC's 2024 Performance Report identified that DOC provided SUD assessments to approximately 81 percent of incarcerated persons, demonstrating the agency's commitment to addressing the intersection of criminal justice involvement and SUD treatment.[52] The DOC provides a continuum of treatment and recovery services across nine facilities with 1,066 beds, using a therapeutic community model that takes advantage of the stable, abstinent environment prisons provide to deliver programming tailored to high-risk, high-need incarcerated persons.[53]

This prison-based treatment infrastructure creates essential entry points into evidence-based care for justice-involved populations. Peer recovery support services in conjunction with release planning services ensure continuity of care by connecting individuals to community-based treatment and MOUD programs upon reentry. The department's coordinated continuum of care approach supports individuals as they initiate and maintain engagement with treatment services from incarceration through the critical transition to community reintegration.

Justice-Involved Treatment Pathways

Minnesota's approach to addressing SUD among justice-involved populations emphasizes coordinated services spanning screening at justice system entry, treatment and peer recovery services within correctional settings, reentry planning, and community-based services supporting reintegration.[54] While national standards for organizing substance use disorder treatment in correctional settings do not currently exist, the ASAM is developing dedicated criteria for justice-involved individuals, establishing comprehensive frameworks for screening, assessment, and determining appropriate care levels.[55] Minnesota strategically invests in system improvements, recognizing that treating addiction in correctional settings advances rehabilitation and recidivism reduction goals while preventing overdose deaths during incarceration and the critical reentry period, when individuals face dramatically elevated risks.[56][57]

Treatment access and engagement as a distinct component within the continuum reflects understanding that barriers to accessing and remaining in treatment are not only excessive administrative barriers but also fundamental obstacles to entering into and maintaining recovery.[35] Addressing these barriers through coordinated state agency action, direct access processes, culturally responsive service development, evidence-based clinical practices, and recognition of multiple recovery pathways creates the infrastructure necessary to ensure Minnesotans can access and maintain engagement with treatment services when they need them.

Key Initiatives

1115 Reentry Waiver: Provides Medicaid-covered services in select facilities within 90 days of release, including case management, MOUD, mental health services, and prescription drug coverage.[57]

Minnesota Rehabilitation and Reinvestment Act (MRRA): Incentivizes participation in evidence-based programming through earned benefits, including early release and shortened supervision, shifting from punishment-based to achievement-based motivation.[58]

MOUD in Jails Workgroup: Developed comprehensive recommendations for expanding medications for opioid use disorder access in Minnesota jails, focusing on model standards, statewide electronic health records, and local implementation support.[59]

Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSUP) grants: Support planning and enhancement of treatment services for individuals with substance use disorders in criminal justice contact, including expanding MOUD access and strengthening correctional-community connections.[60]

Behavioral Health Fund (BHF) Utilization in Jails: Enables incarcerated individuals to access SUD services when Medicaid coverage is unavailable during incarceration.[61]

MN DOC – Harm Reduction Kits: DOC works hard to address the opioid epidemic and the impacts on those that are incarcerated by distributing harm reduction kits at release. These kits include naloxone, fentanyl test strips, education materials on overdose prevention, and a letter of support.[62]

Recovery Infrastructure and Support

Reinforcing the recognition of SUD as a chronic, relapsing condition, Minnesota has made extensive commitments to building recovery infrastructure that is "ongoing, less intensive, and tapered contact with treatment systems, much as with other chronic health conditions."[24] A key concept in helping people achieve and maintain momentum in their recovery is what is known as recovery capital.[63][64] Recovery capital refers to supports such as housing, employment, education, healthy social support networks, and other aspects of a healthy, self-directed life with meaning and purpose. Recovery infrastructure and support include numerous services and supports that also appear in other components of the continuum, such as access to MOUD. Notably, peer support specialists, who support individuals' recovery journeys throughout the continuum, are a primary source of recovery support.

Minnesota's Recovery Friendly Workplace Initiatives

Minnesota is a national leader in recognizing that supportive workplaces play a vital role in sustaining recovery from SUD. Recovery Friendly Workplaces (RFW) adopt policies that expand employment opportunities for individuals in recovery, facilitate access to treatment and support services, reduce workplace substance use risks, and create cultures where employees feel safe seeking help for SUD.[65] Evidence demonstrates that RFW initiatives produce tangible benefits for employers and employees, as workers in recovery from SUD average nearly 10% fewer days of unscheduled leave and demonstrate turnover rates 12% lower than overall workforce averages, creating substantial cost savings for employers while supporting recovery outcomes.[63]

Governor Tim Walz demonstrated state government's commitment to leading by example when he signed Executive Order 24-11 in October 2024, directing the State of Minnesota to become an RFW.[66] This executive action directs state agencies to facilitate conversations about SUDs, reduce the risk of SUD through education, strengthen staff training, and coordinate with health agencies to promote supportive workplace environments. The state is also in the process of developing a statewide RFW for non-state employers.

Peer Recovery Services: Integrating Lived Experience

Peer Recovery Support (PRS) specialists have demonstrated effectiveness in supporting recovery across multiple components that align with Minnesota's continuum framework. Research shows that PRS services improve relationships with providers and social supports, reduce rates of relapse, increase satisfaction with overall treatment, and increase treatment retention.[67] By helping individuals navigate complex systems, peer specialists facilitate connections across the continuum by linking people to essential community resources including housing, employment supports, and social services. The evidence demonstrates that PRS contributes to building recovery capital through improvements in self-efficacy, confidence, and social support networks, all of which represent critical internal and external resources necessary for sustained recovery.[68]

Since establishing its first Recovery Community Organization in 2010, Minnesota has built substantial PRS infrastructure. The state's 2022 evaluation of Medicaid-reimbursable services identified that individuals receiving PRS achieved significantly higher rates of outpatient treatment completion and medical office visits compared to matched comparison groups.[69] However, the evaluation emphasized that realizing the service's full potential requires continued investment in training and supervision funding, standardized curriculum development, and expanded provider capacity to support this statewide system.[69] Both the 2024 and 2025 legislative sessions included statutory updates that added further clarification of service standards, certification requirements, and vendor training in alignment with these recommendations.[(70)(71)]

Minnesota's commitment to the implementation of peer recovery services increases the availability of low-intensity community-based entry points across the continuum of care for individuals at multiple stages of their recovery journey and leverages the expertise of lived experience.

As part of meeting the required milestones of the state's 1115 SUD System Reform waiver, Minnesota adopted the ASAM Criteria's Third Edition framework into law in 2023,[72] and DHS has begun work developing Fourth Edition standards through a Design and Subject Matter Expert Workgroup.[73] The Fourth Edition framework now incorporates recovery residences with outpatient services as the optimal treatment approach for some individuals based on an assessment of their needs.[74] This expansion acknowledges recovery residences as vital components in many people's paths to sustained recovery.[74]

The recovery residence certification process, in coordination with Minnesota's implementation of the ASAM Criteria Fourth Edition framework, will enable the state to address gaps in recovery housing infrastructure through a coordinated strategy: systematic data collection via a Sober Home Scan to understand current capacity and needs, and developing standards and clinical integration protocols while establishing quality benchmarks.[75][76]

Another key part of this reform includes connecting individuals with housing support dollars to help them pay for housing within certified recovery residences.

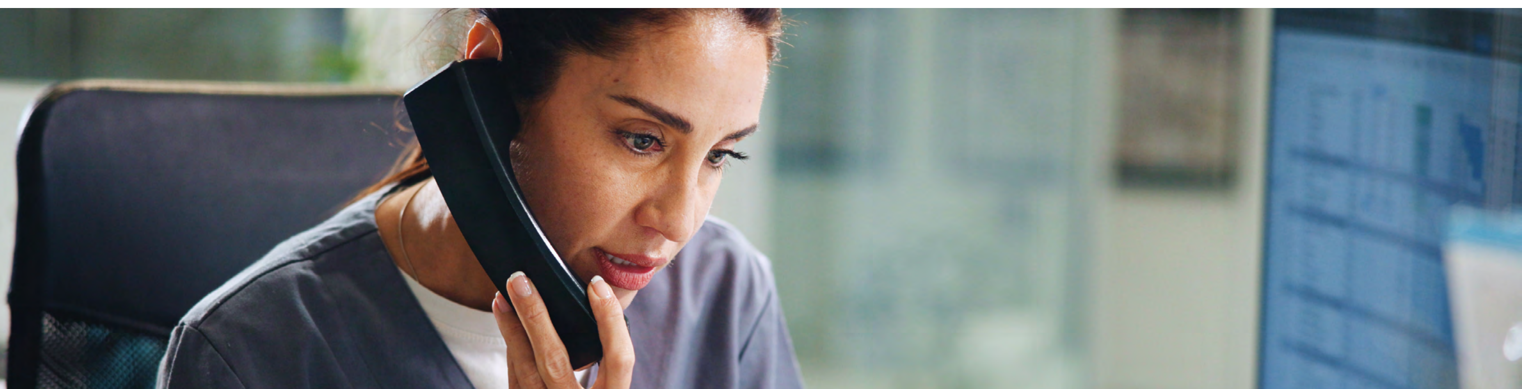
Recovery Residences as Essential Infrastructure

Recovery housing serves as non-medical settings designed to support recovery from SUD, providing a substance-free living environment commonly used to help individuals transition from highly structured residential treatment programs back into their day-to-day lives and is a critical infrastructure within comprehensive SUD treatment systems.

Due to the grassroots nature of how the recovery housing field has developed, various models of recovery residences have been created by members of local communities with the goal of providing those in early stages of recovery a supportive living environment. With such grassroots, decentralized efforts came a lack of uniformity in how sober homes operated. In the 2023 legislative session, DHS began reforming recovery housing through the creation of a renters' bill of rights.[75] Successive legislative sessions brought additional reforms as DHS addressed program integrity concerns through anti-kickback legislation, and in 2025, legislation was passed directing DHS to implement requirements for certifying recovery residences.[76][77]

Individuals experiencing homelessness face compounded challenges due to a lack of stable housing, competing survival needs, trauma exposure, and systemic barriers. Recovery infrastructure responsive to this population includes low-barrier access not requiring identification or stable housing as prerequisites, integrated services addressing both substance use and housing instability simultaneously, and coordinated approaches between homeless services and treatment systems.[(34)(37)]

Expanding recovery infrastructure and supports reflects recognition that system gaps prevent individuals from accessing needed care and contribute to poor outcomes when recovery supports are inadequate, especially within populations disproportionately impacted by SUDs. Minnesota has made substantial investments in building recovery infrastructure and developing support networks that enhance recovery capital for individuals pursuing long-term recovery, creating the potential for reducing disparities in access to ongoing recovery supports across diverse populations.



Care Coordination and Linkages to Care

Care coordination and linkages to care serve as a supporting component of Minnesota's continuum of care, connecting individuals to appropriate services across multiple care systems. Effective coordination requires linkages between SUD treatment and primary care, long-term care, mental health services, and social services such as housing, employment, and transportation ensuring that individuals receive integrated care that addresses addiction alongside co-occurring physical and mental health conditions as well as connecting individuals to resources that help build recovery capital. Without effective care coordination, individuals navigate disconnected systems independently, leading to gaps in care, duplicated services, preventable emergency department visits, and readmissions to higher levels of care.[32]

Minnesota's statutory framework recognizes care coordination as essential infrastructure rather than an optional enhancement, emphasizing the need to break down silos and ensure coordinated responses across agencies.[28] This coordination extends beyond clinical service delivery ensuring that SUD treatment integrates appropriately with other health care and social service delivery systems. These models employ treatment coordinators, case managers, navigators, and peer support specialists who help individuals navigate complex systems. Healthcare integration connects SUD treatment with broader medical care, addressing substance use alongside infectious diseases, chronic conditions, and acute health needs and attempts to bridge systems that have historically operated in isolation.

Supporting Care Coordination and Linkages to Care

State agencies operationalize care coordination through diverse programs addressing specific gaps and strengthening SUD system connections. Key initiatives include:

SUD System Reform Statute: Directs comprehensive SUD treatment system reforms recognizing SUD as a chronic condition requiring care coordination models linking individuals to appropriate providers throughout recovery.[33]

1115 SUD System Reform Waiver: Ensures access to critical care levels, implements ASAM evidence-based patient placement criteria, builds provider capacity including MOUD, develops comprehensive prevention and treatment strategies, and improves care coordination across levels of care.[50]

Treatment Coordination Standards: Establishes treatment coordination as reimbursable service connecting clients with providers, social services, community resources, and self-help networks while facilitating transitions between care levels.[80]

Certified Community Behavioral Health Clinics (CCBHCs): Comprehensive community clinics integrating mental health and SUD treatment with primary care screening, crisis intervention, case management, and peer support for underserved populations.[81]

Behavioral Health Home (BHH): Provides care coordination for Medical Assistance recipients through multidisciplinary teams integrating primary care, behavioral health, and SUD treatment, delivering six core services through person-centered approaches.[82]

Using Navigators to Support Linkage to SUD Care and Harm Reduction Services: Establishes navigators in syringe services programs and culturally specific organizations to connect people who use drugs to services to reduce overdose risk using harm reduction strategies.[83]

The Integrated Health Partnerships (IHP): Creates financial links between care coordination quality and provider payment through population-based payments for smaller organizations and shared savings for larger systems accepting financial risk.[84]

School-based integration provides particularly critical care coordination for youth through Minnesota statute-authorized grant funding that supports comprehensive behavioral health services within school settings, enabling schools to identify and treat SUD across the continuum of prevention, harm reduction, treatment and recovery while simultaneously building school capacity and supporting families in accessing needed services.[85] The framework recognizes that effective student mental health support requires integrated approaches that address student needs, family engagement, staff development, and the infrastructure necessary for accessible service delivery in schools. Child welfare integration through the DCYF coordinates child protection with recovery supports and trauma-informed wraparound services, ensuring treatment engagement receives support rather than a punitive response while maintaining appropriate child safety measures.[(38)(86)]

Housing coordination through initiatives like Crossroads to Justice integrates treatment services into shelter and housing programs, recognizing that addressing housing and treatment simultaneously removes primary barriers to sustained recovery.[16]

The DOC centers care coordination through specialized release planning beginning well before individuals leave incarceration. Release planners connect individuals to community-based treatment providers, arrange MOUD, facilitate comprehensive assessments, and address practical reentry barriers including health insurance, housing, employment, transportation, and connections to recovery community organizations. This approach recognizes successful reentry requires coordinating all supports in parallel rather than expecting individuals to independently navigate systems sequentially.[(53)(57)]

Peer support remains proven yet underused in many care coordination efforts.[87] Peer recovery specialists provide invaluable mentorship, help alleviate fear and uncertainty that accompany reaching out for support, and offer localized knowledge of community-based resources such as mutual help meetings and recovery community centers that formal treatment providers may not track systematically.[87] This practical knowledge proves particularly valuable during care coordination because peers provide information based on recent personal experience about which community resources actually prove helpful, which serve specific populations effectively, and which practical strategies help overcome common barriers.

Minnesota's 1115 SUD System Reform waiver establishes outcome measures that directly assess whether care coordination achieves its intended purpose within the continuum. The waiver tracks preventable readmissions to the same or higher levels of care, measuring whether coordination successfully supported individuals receiving the appropriate services at appropriate intensity rather than cycling unnecessarily between treatment levels due to poorly managed transitions.[32] This metric captures care coordination's fundamental role in matching individuals to services that meet their assessed needs while supporting continuity as those needs change over time.

The waiver also monitors preventable or medically inappropriate emergency department and inpatient utilization, reflecting coordination's critical function in connecting individuals to community-based continuum services before crises necessitate acute care interventions.[32] When coordination works effectively, individuals access appropriate outpatient services, harm reduction supports, and recovery resources that address emerging needs before they escalate to emergencies requiring higher-acuity care. These measurement systems create accountability structures so that care coordination improvements can be documented, evaluated, and refined based on evidence of what works within Minnesota's SUD continuum of care.

This measurement approach and broad coordination across systems and agencies allows for a shift of focus from volume-based metrics to value-based metrics, creating accountability for outcomes rather than just activities and ensuring coordination efforts advance the continuum's fundamental goal of supporting sustained recovery.

Quality and Health Outcomes

Effective SUD systems require implementing evidence-based practices and measuring whether these practices produce desired outcomes. Enhanced clinical practices and promotion of clinical guidelines strengthen treatment quality and consistency across providers and support individuals in receiving interventions matched to their assessed needs.[33] Quality improvement initiatives create structured processes for identifying gaps between current practice and evidence-based standards, implementing changes to close those gaps and measuring whether changes produce improved outcomes.

Quality Measures: Assessing Service Delivery Excellence

Quality measures evaluate the processes and structures that enable effective care delivery. Minnesota's 1115 SUD System Reform waiver establishes critical quality benchmarks including tracking preventable readmissions to the same or higher level of care, measuring whether care coordination functions effectively in matching individuals to appropriate service intensity.[32] The waiver also monitors reduced preventable or medically inappropriate emergency department and inpatient utilization, which assesses whether improved access to continuum services successfully diverts individuals from higher acuity care before crises necessitate acute interventions.

The state's emphasis on enhanced clinical practices and promotion of clinical guidelines strengthens treatment quality and consistency across providers, ensuring individuals receive interventions matched to their assessed needs. Minnesota's adoption of the ASAM Criteria provides standardized assessment protocols that promote quality-driven care across all treatment settings, and federal and state requirements for utilization reviews of publicly funded placements promotes alignment with evidence-based service delivery.[(50)(88)]

The Integrated Health Partnerships program demonstrates how quality measurement can be directly linked to payment structures, creating financial incentives that make coordinated care economically viable for providers and payers. The program's quality measurement across five domains (Quality Core Set, Care for Children and Adolescents, Quality Improvement, Closing Gaps, and Equitable Care) requires measurable progress closing gaps across all racial and ethnic groups, embedding health equity accountability directly into quality assessment frameworks.[84]

This measurement focus extends beyond individual program evaluation to encompass system-level tracking of whether coordinated reforms across state agencies achieve intended population health outcomes. Increasing the use of quality and outcome measures to inform benefit design and payment models creates feedback loops where measurement results inform resource allocation and service design decisions.[33]

Health Outcomes: Measuring Population-Level Impact

Health outcomes track the ultimate impact of coordinated interventions on individuals and communities. Minnesota's primary population health outcome measure is the reduction in opioid overdose-related deaths, which has seen a significant reduction in the past two years.[89] However, preliminary data from 2025 show the potential for an increase compared to 2024.[89]

Treatment utilization rates demonstrate system effectiveness in engaging individuals with care and supporting sustained recovery. The number of Medicaid recipients receiving medications for opioid use disorder increased from 13,331 in 2016 to 24,264 in 2021, reflecting expanded access to evidence-based pharmacological interventions.[32][90] However, treatment completion rates revealed that only 29 percent of discharges completed opioid use disorder treatment in 2021, highlighting persistent challenges in retention that require continued focus on care coordination and recovery support infrastructure.[90]

Multigenerational health statistics track broader impacts on families and communities. Neonatal Abstinence Syndrome diagnoses have varied between 344 and 444 cases annually since 2016, requiring continued monitoring and intervention development.[90] Rates of children entering out-of-home placement due to caregiver drug use, particularly the substantially elevated rates among American Indian children, underscore the importance of family-centered treatment approaches and prevention strategies that address intergenerational trauma.[90]

The Walz-Flanagan One Minnesota Plan, the State of Minnesota's strategic plan, establishes measurable goals across the state's most critical policy priorities, including an SUD goal of reducing the impact of the opioid crisis on Minnesotans, their families, and their communities.[5] The plan sets a clear and measurable statewide target of reducing opioid deaths by 5% from 2022 levels by 2027, creating an accountability infrastructure that supports the purpose and strategy of the subcabinet.[5] As of October 2025, the state has exceeded this goal by reducing opioid overdose deaths by over 30% and all overdose deaths by over 25%.[5]

The One Minnesota Plan goal provides the strategic context for understanding why quality and health outcomes measurement matter within the SUD continuum. The metrics tracked through the 1115 SUD waiver, the measures being inventoried through the Interagency SUD Metrics Workgroup, and the equity indicators stratifying outcomes by race and ethnicity all serve a single fundamental purpose: answering whether investments in the state's prevention, harm reduction, treatment, and recovery infrastructure are achieving fewer overdose deaths while ensuring progress reaches disproportionately impacted communities.

This accountability framework ensures that statutory directives, programmatic initiatives, and quality measurement activities remain connected to saving lives and supporting recovery for all Minnesotans.[5]

Similarly, COMPA establishes specific tools to improve outbreak detection and identification of substances involved in overdoses through expansion of the MNDOSA, which strengthens the state's ability to respond to emerging threats in the drug supply.[37] Designing systems to assess, address, and prevent impacts of drug overdose and morbidity creates infrastructure for identifying populations at highest risk and targeting interventions accordingly.

OERAC's responsibility to establish goals, determine baselines, and set measurable outcomes with benchmarks creates comprehensive infrastructure for tracking Minnesota's progress across prevention, treatment access, and multigenerational impacts.[31] These measurement systems ensure accountability while providing the data necessary to identify what works, for whom, and under what circumstances which is essential information for directing state investments toward effective interventions.

Health Outcomes: Measuring Progress — OERAC's Goals and Baseline Outcomes for Minnesota's Opioid Response

OERAC was established by the Minnesota Legislature in 2019 to develop and coordinate a comprehensive statewide response to the opioid crisis. Central to this mission is the establishment of clear goals with measurable outcomes and baseline data against which progress can be monitored.[31] The Council has developed six interconnected goals that span prevention, early intervention, treatment access, and recovery, supported by systematic data collection across multiple state agencies.[90]

OERAC's Six Core Goals:

- Increase access to treatment
- Improve retention in care
- Produce measures to assess and protect access to pain medication for those in need
- Reduce unmet need for prevention, treatment, and recovery services
- Reduce opioid overdose-related deaths
- Support a comprehensive response to the opioid epidemic

To support the quality and health outcome activities required by federal and state laws, MMB's Long Range Planning (LRP) team and OAR are convening a data-focused working group to develop a better understanding of current SUD metrics collected across state agencies, identify opportunities to align measurement across key partners, and support the subcabinet in creating a measurement framework for ongoing monitoring and evaluation of the goals and objectives developed through this interagency state planning process.[91] By coordinating data collection across agencies working towards similar goals and priorities, this partnership enables the state to gain a clearer picture of which strategies and interventions improve outcomes for individuals with SUD. This data-driven approach, rooted in collaboration with people with lived experience, local government partners, Tribal nations, and other partners, provides the measurement and evaluation framework necessary for tracking whether resources are achieving their intended impact and whether Minnesotans are accessing the services they need, no matter where they are, to support recovery and prevent overdose deaths.

Surveillance and Enforcement

Effective SUD response includes a surveillance infrastructure that identifies emerging trends and threats in real-time with enforcement strategies that disrupt drug distribution while simultaneously incorporating supportive pathways to treatment and recovery. Minnesota operates surveillance activities in two distinct and unrelated ways, epidemiological and investigatory.

One example of how epidemiological surveillance is deployed is through MDH's use of syndromic surveillance which leverages near real-time data to detect unusual health patterns that may require public health investigation and response.[92] This surveillance activity can characterize the community-level burden of opioid and drug-related overdoses, which assists in identifying which populations and neighborhoods are most impacted. This approach enables public health officials to better detect, monitor, and respond to emerging health events as they develop in communities.

Minnesota's investigative surveillance and enforcement infrastructure operates through coordinated and integrated public health data systems and law enforcement intelligence to create an understanding of substance use patterns, trafficking networks, and emerging threats while protecting communities and supporting individuals toward recovery. DPS leads law enforcement and public safety responses while connecting enforcement expertise to broader public health and treatment efforts, coordinating with state agencies and partners across criminal justice, public health, treatment providers, and community organizations to support integrated responses to substance use and misuse.

Community Drug Checking: A Public Health and Harm Reduction Partnership

Legislation passed in 2023 legalized drug checking equipment and funded the DHS to implement Minnesota Community Drug Checking Sites.[93] This evidence-informed harm reduction strategy allows individuals to bring drug paraphernalia to designated sites for analysis, receiving preliminary results within 5-10 minutes. Samples are then sent to the MDH Public Health Laboratory for comprehensive testing, with results shared publicly (without identifying information) to inform community-wide prevention strategies.

The program operates through partnerships between DHS and the MDH Public Health Laboratory, with an initial pilot across four sites. Drug checking operators analyze samples, provide harm reduction counseling, and connect participants to health care and treatment resources. The program does not determine whether substances are "safe" but provides information that enables individuals to make informed decisions about their substance use.

This approach serves dual purposes by engaging individuals at high risk of overdose while also strengthening Minnesota's overdose surveillance capacity. Laboratory results complement existing MDH surveillance projects by providing real-time data on local drug supplies, helping identify emerging threats, and informing prevention messaging. Research demonstrates that drug checking programs are associated with positive behavioral changes, including reduced dosing, not using alone, or choosing not to use at all, all of which reduce the risk of overdose.[94]

To see the Public Health Lab's substance testing in action, watch the video here: Substance Testing at the Public Health Lab | Minnesota Drug Talk[95]

MDH operates critical surveillance and response systems including the MNDOSA which represents a critical surveillance innovation that provides real-time understanding of substance misuse and drug overdose patterns. Through participation in the North Central High Intensity Drug Trafficking Areas (HIDTA) and the Overdose Detection Mapping Application Program (ODMAP) programs, MDH links state-level data to local response efforts, developing prevention and response strategies grounded in community needs while supported by state expertise.

The HIDTA program provides critical infrastructure for connecting enforcement activities to public health surveillance through its Overdose Response Strategy (ORS), a national program funded by the Office of National Drug Control Policy (ONDCP) and CDC. The ORS creates networks of drug intelligence officers (DIOs) and public health analysts (PHAs) who collaborate on drug overdose issues, developing and sharing data systems to inform rapid community overdose prevention efforts, supporting immediate evidence-based response efforts and implementing promising strategies at the intersection of public health and public safety.[96] This framework creates infrastructure where enforcement intelligence about drug trafficking patterns, seizure data, and substance identification directly informs public health prevention and response strategies, while public health surveillance data about overdose patterns and emerging substances guides enforcement targeting and investigation priorities.

ODMAP: Real-Time Overdose Surveillance Supporting Coordinated Response

The Overdose Detection Mapping Application Program (ODMAP) is a free, web-based surveillance tool that enables first responders, law enforcement, and public health officials to track suspected fatal and nonfatal drug overdose events in near real-time. Developed by the Washington/Baltimore High Intensity Drug Trafficking Area program, ODMAP provides critical infrastructure connecting enforcement activities to public health surveillance.

Starting August 1, 2025, new Minnesota legislation allows suspected overdose data from emergency medical services to be automatically entered into ODMAP.[97] The platform's mobile-accessible interface minimizes data entry burden by automatically capturing GPS coordinates and timestamps, requiring only essential information from first responders in the field.

ODMAP's Spike Alert functionality automatically notifies designated officials when overdose events exceed predetermined thresholds within specific geographic areas, enabling rapid mobilization of public health and public safety resources to areas experiencing sudden increases in overdose activity.[98] Public health agencies leverage ODMAP for outbreak detection, harm reduction service deployment, and targeted community education campaigns, while law enforcement uses the data to identify overdose hotspots and coordinate multi-jurisdictional investigations.[98]

As of April 2025, more than 5,300 agencies across all 50 states participate in ODMAP, having entered nearly 3 million suspected overdose events.[98] Minnesota's participation in ODMAP demonstrates the coordinated surveillance infrastructure essential to effective overdose prevention, linking state-level data to local response efforts and enabling evidence-based strategies grounded in community needs while supported by state expertise.

The CDC Overdose Data to Action (OD2A) initiative, administered by MDH, provides additional framework and funding for Minnesota's surveillance activities. OD2A emphasizes surveillance strategies that help jurisdictions better capture, analyze, and disseminate overdose surveillance data. OD2A's framework emphasizes synthesizing and analyzing data to inform action, prioritizing feasible and evidence-informed interventions, implementing responsive programs, and evaluating strategies to make changes as needed. This creates continuous improvement cycles where surveillance data directly informs prevention and response strategies, which are then evaluated for effectiveness and refined based on outcomes.[99] These interconnected systems provide real-time data on overdose events, geographic clustering of overdoses, and emerging substance threats.

Positioning surveillance and enforcement as essential infrastructure supporting the entire continuum is grounded in both public health evidence and statutory commitments. The subcabinet's coordinating role creates the potential to align surveillance and enforcement activities with broader continuum components, including prevention, harm reduction, treatment access, and recovery support, creating more responsive interventions. As Minnesota continues developing these integrated systems, the goal is to establish a continuum that functions with real-time intelligence about substance use patterns, coordinated responses to emerging threats, and integrated strategies that protect public safety while supporting pathways toward treatment and recovery. Achieving this vision will require sustained collaboration across agencies, continued investment in data infrastructure, and ongoing refinement of protocols that connect enforcement intelligence with public health response strategies.

CONCLUSION

Substance use disorder continues to affect individuals, families, and communities across Minnesota. This report, as the first phase of the interagency substance use plan, reviews the current state of the SUD system to establish a foundation for strategic alignment.

Building on decades of engagement, statutory commitments, and prior plans, the State is positioned to coordinate prevention, harm reduction, treatment, and recovery efforts more effectively, setting the stage for future action that aligns goals, priorities, metrics, and accountability across agencies.

This alignment and coordination are more critical than ever. The hope for significant increased investment in this space must be tempered by the reality of the current federal policy landscape and state budget situation. New dollars are not guaranteed, and for the state to continue to make progress on improving outcomes for Minnesotans experiencing SUD, their families, and their communities, a more strategic use of resources will be critical.

To accomplish this the Subcabinet on Opioids, Substance Use and Addiction will be focusing on transforming the descriptive understanding in this report into strategic action with clear priorities, goals, and accountability. It will do this by identifying shared strategic priorities, identifying measurable goals, and establishing accountability mechanisms to ensure alignment. In developing this strategic action, the subcabinet will be sharing this report with stakeholders and partners to gather feedback on the report, identify what may be missing from this analysis, and better understand what their goals and priorities are in this space.

These are uncertain times and much is in flux, but with clarity, purpose, and transparency, the state is well-positioned to continue the work of creating truly person-centered and recovery oriented systems of care that support every Minnesotan no matter where they are on their recovery journey with the resources they need to live lives that are happy, joyous, and free.

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