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Report on Approaches to Illicit Drug Use in Minnesota

EVIDENCE-BASED APPROACHES TO DRUG POLICY

A ROADMAP FOR MINNESOTA

February 2025

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Acknowledgements

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Definitions of Key Terms

Criminalization

"Criminalization refers to the act of determining in law that the commission of a specified illegal act constitutes a criminal offense." [1]

Decriminalization

"Decriminalization refers to the removal in law and in practice of criminal status from a certain behavior or action. Within a decriminalized model, a person found to be in possession of a certain quantity of a substance or substances, in line with limits to be set in regulations, would not be breaking the law, and therefore would not receive a criminal sanction or criminal record." [2]

Depenalization

"Depenalization generally refers to the policy of closing a criminal case without imposing punishment, for example because the case is considered 'minor' or if prosecution is not in the public interest." [3]

Diversion

"Diversion refers to any mechanism that supports a person who uses drugs away from the path of punishment by the criminal justice system and towards a health-oriented response such as counselling, treatment, or social reintegration." [4]

Drug offences

"Activities related to drug use and trafficking that are criminalized. The main offences are cultivation, production, importation and exportation, supply, and possession." [5]

Expungement of criminal records

"The removal of a criminal offence, for which someone was previously convicted, from someone's official criminal record. Expungement of criminal records is an essential social equity principle of drug law reform and is currently a feature of some cannabis decriminalization and legalization frameworks."[6]

Health-led responses

"Health-led responses are those which focus on actions or interventions that address drug use and associated health and social harms, such as deaths, the spread of infectious diseases, dependency, mental health disorders and social exclusion. Health-led responses depend on State authorities, including the police, social services, and health authorities, having the legal powers necessary to implement diversion having the capacity to support diversion, so that a person found in possession of drugs for personal use, whether that be problematic or non-problematic drug use, will can be referred to the relevant health authority, dissuasion Committee etc. in the first instance. Health-led responses

seek to strike an optimal balance between important policy objectives, including diversion measures away from prosecution towards health interventions, dissuasion measures, depenalization measures and decriminalization measures. The optimum legal framework to strike this balance will vary from jurisdiction to jurisdiction, depending on the provisions of their legal system and political will." [7]

Legalization

"Legalization refers to the process of moving from prohibition to regulation, rendering lawful an act that was previously prohibited. With legalization, regulations can be introduced to limit the extent of permissions involved, as is seen with restrictions for alcohol and tobacco, where regulations govern who can sell, purchase, and use these products. Within a legalized and regulated regime for drugs, it would remain illegal for non-regulated bodies to sell drugs. There are different ways to regulate the sale of currently controlled drugs, ranging from state monopolies to free market approaches. Penalties for breaching these regulations may be criminal or non-criminal." [8]

Net-widening

"This term describes the phenomenon whereby a criminal reform, including decriminalization models, increase police and criminal justice interactions with the population. An example is when, after criminal sanctions for drug possession are replaced with administrative sanctions, more people end up being fined than were previously criminally sanctioned."[9]

Prohibition

"Prohibition refers to forbidding something by criminal law." [10]

Safer supply

"A harm reduction intervention that prescribes alternatives to illicit substances, providing regulated, pharmaceutical-grade drugs to people at risk of overdose. It is typically distinguished from opioid agonist treatment because safer supply projects are more commonly community-led and / or focused on preventing overdoses rather than treatment." [11]

Simple drug possession

"Possession of controlled drugs for personal use. This is the activity for which most decriminalization models remove criminal penalties." [12]

Social supply of drugs

"Supply without remuneration, meaning giving and sharing drugs without making a profit and typically between groups of people, such as friends and family." [13]

Commonly Used Acronyms

ACRONYM	MEANING
ADA	Americans with Disabilities Act
ADP	Alternative-to-discipline programs
AG	Attorney General
AIDS	Acquired immunodeficiency syndrome
ASAM	American Society of Addiction Medicine
BIPOC	Black, Indigenous, and People of Color
CBO	Community Based Organization
CCA	Community Corrections Act
CDC	Centers for Disease Control and Prevention
CHI	Catholic Health Initiatives
COVID-19	Coronavirus disease
CPO	County probation officer
DCYF	Minnesota Department of Children, Youth, and Families
DHS	Minnesota Department of Human Services
DIH	Drug-induced homicide
DOC	Minnesota Department of Corrections
DOE	Minnesota Department of Education
DPS	Minnesota Department of Public Safety
ECHO	Extension for Community Healthcare Outcomes
EMT	Emergency medical technician
FDA	Food and Drug Administration
FTIR	Fourier transform infrared
GSL	Good Samaritan Law
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus

ACRONYM	MEANING
LEAD	Let Everyone Advance with Dignity
LGBTQ+	Lesbian, gay, bisexual, transgender and queer
MASH	Minnesota Association of Sober Homes
MDH	Minnesota Department of Health
MDHR	Minnesota Department of Human Rights
MFIP	Minnesota Family Investment Program
MN	Minnesota
MOUD	Medications for opioid use disorder
OAR	Minnesota Office of Addiction and Recovery
OERAC	Opioid Epidemic Response Advisory Council
OPC	Overdose prevention center
OSPRI	Opioid Settlement Principles Resource and Indicators
OTP	Opioid treatment program
OUD	Opioid use disorder
PAARI	Police Assisted Addiction and Recovery Initiative
RFP	Request for proposals
SAMHSA	Substance Abuse and Mental Health Services Administration
SCAO	State Court Administrative Office
SMARTIE	Specific, measurable, attainable, relevant, time-based, inclusive, equitable
SNAP	Supplemental Nutrition Assistance Program
SSP	Syringe services program
SUD	Substance use disorder
TANF	Temporary Assistance for Needy Families
US	United States

EXECUTIVE SUMMARY

This report is the second of a two-part investigation on illicit drug use and policy in Minnesota. The first report, released in 2024, summarized the state of the scientific literature on drug policy, evaluating prevalent policies and interventions for their alignment with public safety, health, and socioeconomic goals. In this report, we turn specifically to Minnesota.

By distilling findings from Minnesota laws, policies, and statutes as well as the opinions of key experts around the state and comparing them to the best practices surfaced in the first report, we identified areas of incongruity: places where Minnesota's practices are not aligned with the best evidence and are potentially ripe for reform. The final product is an exhaustive set of recommendations that can bring drug policy in Minnesota to the vanguard, centering the health and wellness of Minnesotans impacted by substance use and addiction as well as the safety of all communities.

Recommendations are organized using the same four domains of drug policy employed in the first report: healthcare, harm reduction, social determinants of health, and drug policing.[14]

⇒ *Healthcare*. In healthcare, a selection of recommendations includes expanding access to medications for opioid use disorder, including in settings such as pharmacies and for people in detention settings and on community supervision, and bringing Minnesota's opioid treatment program standards in line with best practices.

⇒ *Harm reduction*. Within the harm reduction domain, recommendations include creating exemptions for possession charges to allow people to make use of drug checking services and fully funding the state's naloxone saturation plan and naloxone portal, among several other recommendations.

⇒ *Social determinants of health*. To address social determinants of health, we present a variety of recommendations aimed at increasing housing options for people living in encampments, at shelters, and people unstably housed, such as the development of more Housing First models. We recommend eliminating random drug testing for SNAP and TANF beneficiaries and enforcing "Ban the Box" provisions that ensure employers do not discriminate against people with a criminal history.

⇒ *Drug policing*. Within the domain of drug policing, we recommend that criminal and civil penalties for the personal and social use and possession of illicit drugs are removed, that diversion programs and other "off ramps" from the criminal-legal system are available to connect individuals with evidence-based services, and that drug sentencing grids are reviewed comprehensively with an eye toward racial disparities.

We have included two additional sections of recommendations, following the findings from the first report: recommendations regarding data collection and evaluation, and "crosscutting" recommendations that cut across multiple domains simultaneously.

⇒ *Data collection and evaluation*. For data collection and evaluation, for example, we recommend legislation that would require a periodic strategic planning process and review of all statewide drug policies. And while we recommend more detailed data be collected in some instances, such as by race and ethnicity in order to better allocate funding to inequitably impacted communities, this recommendation should balance data collection processes that are minimally burdensome so as not to pose barriers to uptake of services.

⇒ *Crosscutting*. Crosscutting recommendations vary widely. Some are aimed at improving the integration of people with lived and living experience in decision-making capacities; some target the expansion of services specifically for youth; some seek to strengthen anti-discrimination protections for people who use drugs.

In each section, recommendations are presented with guidance and model policies from other jurisdictions where available. The sections flag key populations impacted by the recommendations, state agency actors that would be involved in the implementation, and indicators that could be used to measure the success of the recommendation. Taken together, these recommendations can serve as a roadmap for Minnesota policymakers and advocates who are working to improve the lives of people who use drugs and their communities.

Minnesota is in a markedly different place than it was one year ago when the first report was published. A new federal administration may drastically change the ways in which healthcare and public safety are regulated and funded. At the population level, overdose mortality rates are levelling off, and even decreasing in some places, both nationally and at home in Minnesota, for the first time in over five years. Still, drug overdose continues to kill over 1,000 Minnesotans annually, racial disparity rates in Minnesota remain some of the worst in the nation, and fentanyl and other synthetic adulterants continue to inflict unpredictability and heightened potency on the drug supply.[15]

Given the severity of the overdose crisis, Minnesotans deserve drug policy that is rooted in evidence, that builds on the state's strengths, and that leverages lessons learned from the experience of other jurisdictions. If taken up, the recommendations that follow would bring our state closer to a "holistic and effective response to illicit drug use and the illicit drug trade that reduces and, where possible, prevents harm and expands individual and community health, safety, and autonomy."

INTRODUCTION

This report is the final of two research studies commissioned by the Minnesota State Legislature during the 2023 to address the lack of a unified drug policy and that current approaches, rooted in prohibition, are not working for Minnesotans:

> "Year over year, deaths attributed to drug use continue to increase, killing more than 1,000 people in Minnesota annually–more than the number killed by firearms or COVID-19. Racially disproportionate sentencing, law enforcement overreach, HIV and HCV epidemics, and collateral consequences that follow people for years and sometimes decades cascade down from these policies." ("Drug Policy: State of the Evidence," 2024)

The mandate of the appropriations bill (Minnesota Laws 2023, Chapter 52, Article 2, Sec. 3, Subd. 8(v)) was to:

1) Describe the state's current policy, practice, and funding responses to illicit drug use,
2) Review alternative approaches utilized in other jurisdictions, and
3) Make policy and funding recommendations for a holistic and effective response to illicit drug use and the illicit drug trade that "reduces and, where possible, prevents harm and expands individual and community health, safety, and autonomy."

Legislation also articulated that the recommendations must consider "impacts on public safety, racial equity, accessibility of health and ancillary supportive social services, and the intersections between drug policy and mental health, housing and homelessness, overdose and infectious disease, child welfare, and employment."

Summary of the Initial Report

The initial report, submitted to Legislative leadership in February 2024, presented the evidence base for approaches to drug policy across four main domains: Healthcare, Harm Reduction, Social Determinants of Health, and Drug Policing, with two additional sections about Special Populations and Data Collection and Evaluation. Classifying the policies required first defining "successful" drug policy. The definition of "successful" was derived from the appropriations bill's directive to develop drug policy recommendations consistent with goals of "individual and community health, safety, and autonomy."

The review of the evidence led to an *a priori* consensus about the outcomes associated with successful drug policy. The outcomes are:

- Improved health outcomes, as evidenced by measures of morbidity and mortality at the individual level and the population level, as well as improved access to healthcare and treatment.
- Improved safety outcomes, defined as decreased violent crime and decreased drug-related harms.
- Improved socioeconomic outcomes, such as employment, education, poverty, housing, and houselessness.

There are multiple challenges inherent in evaluating drug policy, described in greater detail in the Methods section Year 1 Report. In brief:

- It is difficult to disentangle the effects of single policies from other policy and population trends happening at the same time.
- It is difficult to compare the outcomes of the same policy intervention in different places and times, given the heterogeneity of implementation and contexts.
- Much of the available research focuses on specific cases of reform, like Portugal's decriminalization policy, or cannabis legalization in the United States.
- Research often examines the outcomes of policy changes but does not analyze the specific mechanism of the policy change that contributed to the outcomes.
- Similarly, research into alternatives to drug policy rarely examines the effect of the political or cultural context in which the policy changes are transpiring.
- Research about alternatives to decriminalization often focuses on prevalence of drug use as an outcome of interest, even though this outcome has limited responsiveness to drug policy.

A rigorous review of the literature identified a set of key policies and interventions in each of the four domain areas. Table 1 presents these policies and interventions and identifies whether, for each policy or intervention: (1) the evidence base meets standards for successful drug policy, (2) the evidence base is mixed or inconclusive, or (3) the evidence base does not meet standards for successful drug policy.

Table 1. Summary of evidence base for key drug policies and interventions

Domain	Key policies and interventions	Evidence base meets standards for successful drug policy	Evidence base is mixed or limited	Evidence base does not meet standards for successful drug policy
Healthcare	Medicaid coverage for treatment for substance use disorder (SUD)	X		
	Medications for opioid use disorder with telehealth flexibilities that increase their accessibility	X		
	Peer support/recovery coaching	X		
	Substance use disorder treatment that is voluntary, available on demand, culturally appropriate, and geographically accessible	X		
	Across provider types, increased competency working with people who use drugs (PWUD), including harm reduction techniques and expanding training and education curricula	X		
	Prescription drug monitoring programs		X	
	Policies requiring prior authorization, abstinence, drug screening, and/or counseling before initiating HIV, HCV, or SUD treatment			X
	Prescription drug take-back programs			X
	Compulsory treatment			X
	Involuntary civil commitment			X
	Residential rehabilitation houses			X
Harm Reduction	Safer drug use supplies	X		
	Access to naloxone, including distribution directly to PWUD	X		
	Overdose prevention centers	X		
	Fentanyl test strips	X		
	911 Good Samaritan laws		X	

Table 1. Summary of evidence base for key drug policies and interventions, continued

Domain	Key policies and interventions	Evidence base meets standards for successful drug policy	Evidence base is mixed or limited	Evidence base does not meet standards for successful drug policy
Social Determinants of Health	Housing First and other programs that ease access to housing for PWUD	X		
	Criminal record expungement	X		
	Supporting families to remain together in cases of caretaker drug misuse	X		
	Ensuring access to employment opportunities, public benefits, and higher education for people with criminal histories	X		
	Restricting access to housing based on criminal history			X
	Placing children in the foster care system for parental drug misuse			X
	Policy barriers to employment, education, and public benefits based on criminal history or drug use			X
	Laws that prohibit public behaviors associated with houselessness, like sleeping or camping in public, begging, and loitering			X
	Fines, fees, and debt associated with criminal-legal system involvement			X
	Access to naloxone, including distribution directly to PWUD	X		
	Overdose prevention centers	X		

Table 1. Summary of evidence base for key drug policies and interventions, continued

Domain	Key policies and interventions	Evidence base meets standards for successful drug policy	Evidence base is mixed or limited	Evidence base does not meet standards for successful drug policy
Drug Policing	Decriminalization with targeted diversion to health/social services	X		
	Defelonization	X		
	Diversion to drug treatment for people who need it and that is tailored to the individual	X		
	Sentence commutations	X		
	Depenalization		X	
	De facto and de jure police diversion		X	
	Decriminalization with civil or administrative penalties		X	
	Decriminalization with no sanctions attached		X	
	Regulation		X	
	Arresting people for drug use and criminal repercussion for simple possession			X
	Imprisoning people for drug use			X
	Drug paraphernalia laws			X
	Drug-induced homicide laws			X
	Opioid-related drug seizures			X
	Laws that prohibit public behaviors associated with houselessness, like sleeping or camping in public, begging, and loitering			X

What's in this Report?

This report picks up where the first report left off. It compares Minnesota's current policies in these areas to the gold standards laid out in the initial report and makes recommendations toward closing gaps where they exist.

Because the legislative mandate was for recommendations toward a "holistic" response to drug policy, because of the many (worthy) areas that legislation asked us to consider, and because the evidence base indicates that successful drug policy only follows from a whole-of-government approach, there are roughly 150 recommendations in this report.

It is not a comprehensive list of recommendations, but those that followed from the evidence surfaced in the first report, interviews with experts across the state, a gray literature review, and a comparison of Minnesota statutes to evidence-based state drug policy reform priorities. (See more in the Methods section below.)

Where possible, this report also places Minnesota's policy approach in the context of how other states are working to bring their own approaches to drug policies in line with the evidence.

For example, the Legislative Analysis and Public Policy Association recommends ten key policies that states can implement to reduce overdose deaths and increase access to treatment for SUD (many of which are included in this report). Only five states have adopted seven to ten of these strategies: Maine, Maryland, New Hampshire, Pennsylvania, and Rhode Island. Only Maryland has adopted all ten. Fourteen states, Minnesota among them, have adopted five or six strategies. Thirty-two states and the District of Columbia (DC) have adopted four of fewer.[16] Thus, while Minnesota performs modestly well in terms of healthcare and harm reduction policies compared to its peers, there is room to do more.

Finally, we recognize that this report is not the only effort to bring Minnesota's approach to drug policy in line with the evidence. Where possible, our recommendations flag adjacent processes that intersect with drug policy and that are putting forward aligned recommendations, including:

- Task Force on Pregnancy Health and Substance Use Disorders
- Comprehensive Review of Minnesota Sentencing Guidelines
- Minnesota's Interagency Council on Homelessness' Crossroads to Justice: Minnesota's New Pathways to Housing, Racial and Health Justice for People Facing Homelessness
- Minnesota's Community Supervision Advisory Committee
- Task Force on Holistic and Effective Responses to Illicit Drug Use

How to use this Report

Rather than re-stating the evidence from the first report supporting the recommendations, hyperlinks throughout the report link to the appropriate sections in the initial report.

High-level, abridged recommendations are included in the tables throughout the body of the report.

The success of these policies often lies in the details, and the detailed recommendations are found in Appendix A, accompanied by links to helpful guidance documents, like model and actual laws, reports, and program materials.

For each recommendation, one or more expected outcomes are identified. This is to specify where changes may occur if the recommendations were to be implemented, as no single change in drug policy can be expected to impact all intended health and safety outcomes. More detailed recommendations on how to measure the effectiveness of changes to Minnesota's drug policy can be found in the Data Collection and Evaluation section.

METHODOLOGY

The primary aim of this analysis was to assess how Minnesota's policy context compares to the evidence outlined in the Year 1 Report. The analysis uses qualitative methods and combines multiple data sources, outlined in greater detail below, to formulate evidence-based recommendations for the Minnesota state legislature.

Assessment of Minnesota Policy Context

The first step in the analysis was to collect and analyze Minnesota's policy context in light of the evidence presented in the Year 1 Report. The assessment of Minnesota's policy context relied on several sources of data and analysis methods:

⇒ *Statutory analysis.* Research for the second stage began with an in-depth review of Minnesota state laws. All statutes in state law related to drug policy were included in the analysis. Search terms included "controlled substances," "chemical health," "substance use" and "substance use disorder." Statutes were also scanned and included if relevant based on authors' expertise. Statutes were mapped to their relevant domain(s): healthcare, harm reduction, social determinants, drug policing, data collection, and crosscutting. Administrative rules and regulations were not included in the analysis. Technical assistance during this part of the process was provided by public health legal experts at Vital Strategies' Overdose Prevention Program.

⇒ *Review of reports and guidance from expert sources.* Minnesota state statutes were compared against best practices outlined in Report 1, and areas of incongruity were highlighted. Information and reports that shed light on how Minnesota fares in relation to best practices, such as administrative data and state working group reports, were also reviewed. To contextualize Minnesota's laws, model laws and scans of state-level legislative responses by the Legislative Analysis and Public Policy Association, non-partisan policy and research for state government officials by the Council of State Governments Justice Center, public health data sets housed at Temple University's Center for Public health Law Research, and others trusted resources also were reviewed.

⇒ *Key informant interviews.* In order to understand how drug policy is experienced in Minnesota, where it is working effectively, and where improvements are needed, experts from a wide variety of fields impacted by drug policy were interviewed. Key informants were purposively sampled to represent the different domain areas of this study and a variety of professional roles. Key informants included staff from state and local government agencies, hospital and

clinical staff, non-profit social service providers, and law enforcement, among others. We also intentionally sampled key informants for geographic diversity, from the metro Twin Cities area as well as greater Minnesota, and intentionally interviewed people from organizations that serve disproportionately impacted populations, such as African Americans, Native Americans, unhoused individuals, families, women and children, and immigrant groups.

To identify additional interviewees, we utilized a snowball sampling approach. At the end of each interview, key informants were asked: "Who else do you feel is important we hear from?" Interviewees suggested individuals by name as well as roles, titles, agencies, and domains.

Table 2. Number of interviewees, by domain[1]

Domain	Number	Percentage
Healthcare	18	32.7%
Harm reduction	10	18.2%
Social determinants of health	13	23.6%
Drug policing	14	25.5%
Total	55	100%

In total, we conducted 48 key informant interviews sessions with 55 key informants (some interview sessions were held with two or more people together, such as two staff from the same agency). Table 2 shows the total number of interviewees by domain.

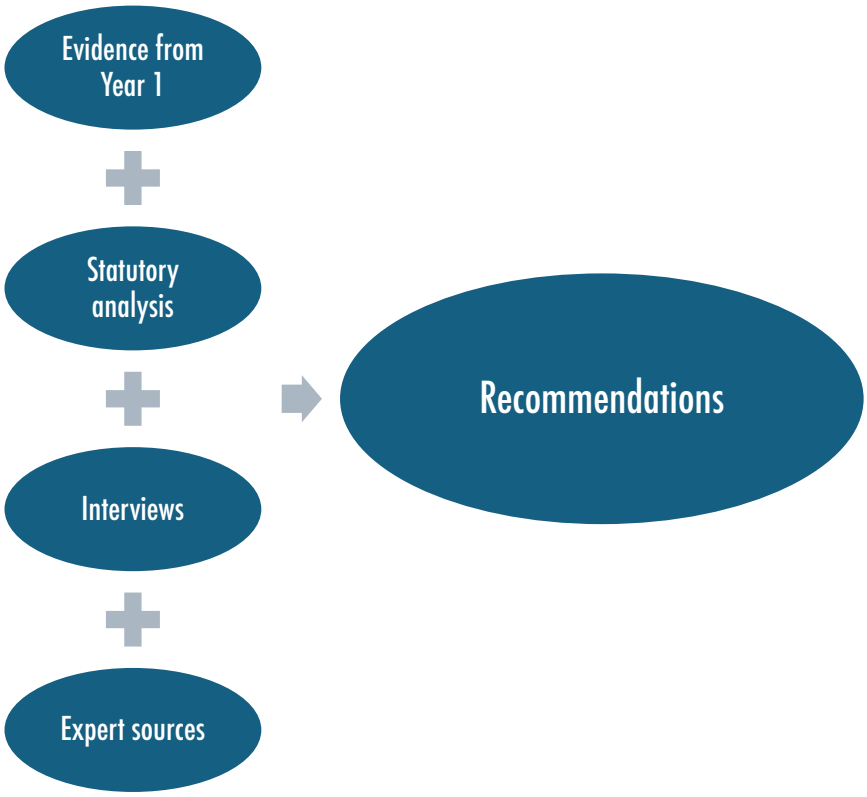
Interviews were conducted via videoconference and were recorded with the key informants' consent. Interviews were guided by a semi-structured topic guide aimed at assessing the key informants' opinions on areas of drug policy (see Appendix C for interview topic guide). Recordings were transcribed and key themes were extracted, first using an AI-supported qualitative research tool, CoLoop,[2] and then hand reviewed by the research team.

Recommendations

The report offers a set of recommendations that can bring Minnesota policy in line with drug policy best practices. The report identifies gaps between the evidence and Minnesota policies, themes generated from key informant interviews, and expert sources to build out the recommendations (see Figure 1).

[1] A complete list of experts interviewed is available in Appendix B.
[2] See https://www.coloop.ai/.

Figure 1. Overview of data supporting recommendations



We estimate the potential impact of each recommendation as low, medium, or high. While not a rigorous metric, this marker is meant to convey the relative effect of each recommendation on overall community health and safety outcomes and should primarily be used to compare across recommendations in this report. The impact levels also consider proximity to policy change: for example, the potential impact associated with legislative change is higher than the potential impact of a report that will offer non-binding recommendations.

This includes sample policies from jurisdictions that have implemented similar laws and guidance from policy research institutes, academics, and trade groups on how to approach implementation.

Last, indicators are offered for each recommendation to clearly specify where we suspect changes in outcomes and impact may occur if the recommendation were to be implemented. It is important to note that no single recommendation can achieve all the goals of successful drug policy, such as improving community safety, reducing drug-related arrests and incarcerations, improving access to treatment, and reducing overdose mortality. As such, expectations must be clearly delimited to connect each recommendation with the outcome(s) we suspect it will affect.

HEALTHCARE

As described in the initial report, healthcare-based responses to drug policy issues like substance use disorder (SUD) and overdose boast strong evidence bases.

The federal government has made important policy changes to enhance healthcare-related drug policies in the last few years, including removing restrictions on healthcare providers' ability to prescribe buprenorphine for opioid use disorder. At the state level, Minnesota is moving in the direction of evidence-based healthcare approaches to drug policy, including removing unnecessary barriers to scale up access to medications for opioid use disorder in jails and prisons, and implementing the American Society of Addiction Medicine (ASAM) criteria to strengthen the state's behavioral healthcare system.[17]

Several positive trends indicate that, by some measures, Minnesota is on the right track:

- From 2020 to 2022, the number of admissions for opioid use disorder (OUD) treatment increased after a period of relative stability.[18]
- The number of Medicaid recipients who have received medications for opioid use disorder has been increasing, with a 70% increase from 2020 to 2023.[19]
- In one study, primary care provider attendees of a government-funded buprenorphine "boot camp" program increased their buprenorphine prescribing to patients with a history of opioid use disorder by 6.8% more than the comparison group.[20]

Still, there is room for improvement:

- In 2021 and 2022, Minnesota ranked in the second quintile among all states and DC for the percentage of people with SUD[3] aged 12 and over in the past year.[4] For people aged 18 to 25, Minnesota ranked in the first quintile.[215]
- In the same period, Minnesota ranked in the second quintile for the percentage of people with drug use disorders.[226]
- Also in the same period, Minnesota ranked in the fourth quintile among all states and DC for the percentage of people 12 and older who received substance use treatment in the past year.[7]

[3] Includes both alcohol use disorders and other drug use disorders.
[4] 18.04% - 19.68%. States in the first quintile had 19.69 - 23.40% of people aged 12 and older with substance use disorders in the past year.
[5] 31.99-36.83%. States in the fifth quintile had 20.19 - 25.05% of people aged 18 to 25 with substance use disorders in the past year.
[6] 9.77-11.63%. States in the first quintile had 11.64-15.95% of people aged 12 or older with drug use disorders in the past year. The term "drug use disorders" excludes people with alcohol use disorders.
[7] 4.31-4.87%. States in the first quintile had 5.64-7.63% of people aged 12 or older receiving substance use treatment in the past year.

- From 2018-2019, Minnesota ranked 23rd among all states for the portion of individuals reporting needing but not receiving treatment for illicit drug use in the past year for adults 18 and over, at 2.6%.[23]
- The number of patients who have completed their OUD treatment at the time of discharge has been decreasing. In 2021, seven out of ten patients had not completed their OUD treatment at the time of discharge.[24,8]

Key informants discussed a range of topics related to healthcare and drug policy, including challenges faced by people in accessing drug treatment and recovery services across the state. Many noted the positive role of community engagement and peer support in enhancing drug policy and treatment outcomes. Some talked about innovative service delivery models to expand access to medications for opioid use disorder (MOUD) in target populations. Finally, many key informants identified systemic problems within the healthcare framework related to drug policy and the need for comprehensive reform.

This section reviews recommendations to support evidence-based and comprehensive healthcare for PWUD, both directly for SUD treatment, as well as to support health holistically.

Policy - Medicaid and Other Insurance

> "Our public program systems, our Medicaid system, our MinnesotaCare system are great if you're benchmarking against other states, but I think if we're benchmarking against ourselves and where we want to be, we need to do a lot more in this space in terms of putting in the resources to make these systems sustainable. And I think even more than sustainable, if we really want to get to a place where we're, where we have thriving systems and very fast, easy, timely, equitable, all the good adjectives, access, we have to be putting a lot more resource into this."

> "Let's not treat chemical dependency without treating our mental health. All insurance should cover all mental health and all chemical dependency, from soup to nuts, A to Z."

Funding to treat SUD lags that of other recognized chronic illnesses. Our initial report outlined the importance of leveraging Medicaid and other insurance to improve access to treatment for SUD. Perhaps the greatest opportunity to do so involves leveraging the Medicaid 1115 Waiver process, which allows states to use Medicaid funds to pay for health-related social needs (e.g., food access, housing instability).[25] The waiver can meet the needs of special populations identified in the initial report, such as people experiencing houselessness, pregnant and parenting people, racial and ethnic minorities, and people in detention settings. That said, the Trump Administration may change its policies

[8] "Not completing OUD treatment" means that the patient left without staff approval, was transferred, or was incarcerated.

regarding this type of waiver, and state lawmakers are advised to consider state-based pathways for extending care as well.[9]

Relatedly, Minnesota lawmakers can adjust reimbursement rates for treatment of SUD to achieve parity with physical health reimbursement rates. A report by the Center for Healthcare Strategies lays out ten recommendations for state financing for spending related to substance use, including using Medicaid funds strategically to build out evidence-based practices, ensuring patients are in the appropriate level of care, and deploying opioid settlement to projects that are not otherwise fundable by existing federal or state funding streams.[26] Minnesota can also follow the example of Maine, which in 2023 increased behavioral health spending to make payment improvements.[27]

Key informants noted challenges and benefits associated with Medicaid billing and reimbursement policies in Minnesota. One noted that Medicaid does not bill outside of the "four walls" of a clinic, creating a burden on clinics to justify outreach models. Another said that the billing structure under Medicaid often prioritizes provider visits over community health workers or peer specialists, leading to lower reimbursement rates for non-provider services. There were additional concerns about the complexity and inefficiency of Medicaid's administrative processes, such as the requirement for extensive paperwork and prior authorizations, which can delay or deny necessary services.

The recommendations below address some options to advance insurance practices to improve access to care for SUDs.

[9] At the time of publication, the authors were tracking the Trump Administration's mixed statements on cuts to Medicaid and the potential for federal pushback on waivers of this kind. See, for example, KFF Health News, "Medicaid: What to Watch in 2025."

Table 3. Recommendations to advance insurance practices to improve access to care for SUD

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
	Health insurance, general				
1	Fund a study to understand and make recommendations to address payment-related barriers to medications for opioid use disorders	High	DHS, OAR	Improve access to medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
2	Enact a comprehensive parity law that requires plans to provide behavioral health coverage.	Medium	DHS, OAR	Improve utilization of substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
3	Enact a law requiring health insurers to maintain an adequate provider network to assure access to all covered benefits	Medium	DHS, OAR	Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
4	Require public and private health insurers to cover all formulations of naloxone	Low	DHS, OAR	Improve access to naloxone	Reduce overdose mortality
5	Create a task force to determine best use of federal and state funds for financing substance use care.	Low	DCYF, DHS, DOC, DOE, MDH, OAR	Improve access to substance use disorder treatment; Improve access to healthcare	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
	Health insurance, public				
6	Implement findings from the Minnesota Healthcare Programs Fee for Service Outpatient Services Rates Study	High	DHS, OAR	Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
7	Pass legislation to apply for Medicaid 1115 waiver for health-related social needs	High	DHS, DPS, Minnesota Housing, OAR	Improve access to healthcare	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
8	Ensure 1115 Medicaid Reentry Waiver implementation includes pregnant and postpartum people (key populations: people in detention settings; pregnant people)	Medium	DCYF, DHS, OAR	Increase access to substance use disorder treatment; Improve continuity of care	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
9	Allocate Medicaid funds for community-based mobile crisis intervention services	Medium	DHS, DPS, OAR	Improve access to healthcare	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
10	Expand Medicaid to cover peer support services for youth (key population: youth)	Low	DCYF, DHS, OAR	Improve access to substance use disorder treatment, Improve utilization of substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

Key Acronyms: Minnesota Department of Children, Youth, and Families (DCYF); Minnesota Department of Corrections (DOC); Minnesota Department of Education (MDE); Minnesota Department of Health (MDH); Minnesota Department of Human Services (DHS); Minnesota Office of Addiction and Recovery (OAR); Minnesota Department of Public Safety (DPS)

Interventions

Medications for Opioid Use Disorder

> "[Medication] saves lives. It helps a lot of people."

Medications for opioid use disorder (MOUD) are considered the gold standard treatment for opioid use disorder. Comprised of the three medications approved by the US Food and Drug Administration (FDA) – methadone, buprenorphine, and naltrexone – this treatment approach is effective in the reduction of overdose deaths, the reduction or elimination of opioid use, retention in treatment, and other positive health outcomes. While all three medications are FDA-approved, it is important to distinguish the relative efficacy of agonist medications like buprenorphine and methadone relative to antagonist medications like naltrexone. Treatment with buprenorphine or methadone are associated with reductions in overdose and serious opioid-related acute care use compared with other treatments.[28]

The use of MOUD is endorsed by all federal agencies concerned with addressing SUD, including the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Institute on Drug Abuse (NIDA), the FDA, and the Centers for Disease Control and Prevention (CDC).

Minnesotans' access to these medications is mixed.

On the one hand, the number of Medicaid recipients in the state who have received MOUD, like buprenorphine, has been increasing, and M Health Fairview – University of Minnesota is piloting a new program to connect people to buprenorphine in an emergency room setting.[29] In the program's first year, 500 patients were connected to ongoing treatment and peer support.[30]

However, patients who take methadone continue to face numerous barriers to access. The onerous rules regulating Opioid Treatment Programs (OTP), where methadone is administered and dispensed, are established at the federal level, but states can add additional regulations. As one example, Minnesota lawmakers could prevent OTPs from terminating treatment when drug use during treatment continues, as return to use is inherent to SUD.[31]

A study conducted by the Pew Charitable Trusts analyzing laws across states found that Minnesota was a leader in some respects (for example, by not requiring additional pharmacy licensure or pharmacist services, hours of operation that extend beyond the typical business, and allowances for take-home medications).[32] Advocates and lawmakers worked together during the 2024 session to reduce unnecessary barriers further and bring state requirements in line with federal requirements.[33]

In addition, access to all three forms of MOUD in Minnesota's jail settings is subpar. A 2021 statewide survey found that fewer than half the responding organizations administered MOUD in jails, and only one-third were aware of a standard OUD screening process for people involved in the criminal-legal

system in their county. The primary barriers to the provision of MOUD were a lack of resources, including funding and qualified staff, and concerns about risks, including security concerns, diversion of drugs, and liability. Of the jails that did offer MOUD, buprenorphine was the most commonly administered drug (84%). Only 11% of respondents offering MOUD provided all three FDA-approved medications.[34] A working group convened by the Governor's Office of Addiction and Recovery is working to expand access to MOUD across county jails.[35]

Possession of buprenorphine, another MOUD commonly prescribed to people with opioid use disorder, has not been decriminalized in Minnesota (see the section Drug Policing for more on this topic).[36] However, the state leads peers in other aspects of buprenorphine access by not requiring prior authorization for at least some forms of buprenorphine for Medicaid recipients and in implementing Medicaid payment incentives for certain providers who work to address disparities in treatment uptake for target groups (for example, people experiencing homelessness).[37]

Key informants found there to be insufficient access to MOUD and that low barrier models to increase access could include telehealth and mobile options, emergency medical services initiation, and integrating MOUD into harm reduction providers and non-specialty settings.

The evidence suggests the following recommendations to ensure that all Minnesotans with opioid use disorder have access to MOUDs. Some recommendations are focused on expanded access to MOUD for all populations, while others focus on people with opioid use disorder who are particularly vulnerable to overdose and other adverse outcomes, such as people exiting incarceration and pregnant and postpartum persons.

Table 4. Recommendations related to medications for opioid use disorder

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
	Treatment providers (pharmacies, emergency service providers, healthcare providers, and OTP)				
11	Expand telehealth treatment access	High	DHS, MDH Buprenorphine Prescribers Community of Practice, OAR	Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
12	Require addiction treatment providers to facilitate access to evidence-based care, including MOUD	High	DHS, OAR	Improve access to medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
13	Expand MOUD access in pharmacy settings	High	Board of Pharmacy, DHS, MDH, OAR	Improve access to medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
14	Require pharmacies to stock buprenorphine	Medium	Board of Pharmacy, DHS, MDH, OAR	Improve access to medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
15	Facilitate adoption of OTP best practices at the state level	Medium	DHS, OAR	Improve access to medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
16	Support expanded MOUD access in primary care and non-specialty healthcare settings	Medium	DHS, MDH, OAR	Improve access to medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
17	Pass a "Model Substance Use Disorder Treatment in Emergency Settings Act"	Medium	DHS, MDH, OAR	Improve utilization of healthcare	Improve access to harm reduction services, Shift towards a more public health approach within our health and human services systems
18	Support paramedics' ability to initiate buprenorphine treatment	Low	Board of Pharmacy, Emergency Medical Service Regulatory Board, DHS, MDH, OAR	Improve access to medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

Key Acronyms: Minnesota Community Corrections Act Counties (CCA); Minnesota County Probation Officers (CPO); Minnesota Department of Children, Youth, and Families (DCYF); Minnesota Department of Corrections (DOC); Minnesota Department of Health (MDH); Minnesota Department of Human Services (DHS); Minnesota Office of Addiction and Recovery (OAR); Minnesota Department of Public Safety (DPS)

Table 4. Recommendations related to medications for opioid use disorder, continued

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
	Special populations (people involved in the justice system; people who are homeless)				
19	Study and make recommendations around how current OTP laws could be leveraged to expand MOUD access	High	DHS, MDH, OAR	Improve access to medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
20	Expand MOUD access for incarcerated people	High	DHS, DOC, MDH, Medications for Opioid Use Disorder in Jails Workgroup, OAR	Improve access to medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
21	Expand MOUD access for people on community supervision	Medium	CCA, CPO, DOC	Improve access to medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
22	Mandate screening for substance use disorders and pregnancy upon entry into detention	Low	DOC, OAR, Minnesota Perinatal Quality Collaborative	Improve screening and early identification of substance use disorder, Improve access to substance use disorder treatment, Improve access to healthcare	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
	Special populations (pregnant people)				
23	Pass a "Model Substance Use During Pregnancy and Family Care Act"	Medium	MDH, DHS, Office of Addiction and Recovery, Task Force on Pregnancy Health and Substance Use Disorders	Improve access to medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
24	Continue to fund programs that expand access to evidence-based services for pregnant and post-partum families	Medium	MDH, Minnesota Perinatal Quality Collaborative, Task Force on Pregnancy Health and Substance Use Disorders	Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
25	Integrate MOUD care in OBGYN settings	Medium	DCYF; DHS, Minnesota Perinatal Quality Collaborative, Task Force on Pregnancy Health and Substance Use Disorders, OAR	Improve access to medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

Key Acronyms: Minnesota Community Corrections Act Counties (CCA); Minnesota County Probation Officers (CPO); Minnesota Department of Children, Youth, and Families (DCYF); Minnesota Department of Corrections (DOC); Minnesota Department of Health (MDH); Minnesota Department of Human Services (DHS); Minnesota Office of Addiction and Recovery (OAR); Minnesota Department of Public Safety (DPS)

Treatment for Stimulant Use Disorder

> "I think there's an urgency to roll out contingency management in a thoughtful way that can be evaluated and understood, and collectively across the state or at least across a region, so that each health system doesn't have to figure it out independently."

The overdose crisis in the US has entered a fourth wave, in which people engage in polysubstance use that leads to overdose—often, opioid overdose deaths by people who are also using stimulants or who think they are using stimulants only.[38] In one study, people who used methamphetamines in combination with opioids compared to opioids alone reported higher numbers of lifetime nonfatal overdose experiences.[39]

There are no FDA-approved medications to treat stimulant use disorder, and overall, treatment remains understudied.[40] However, there are signs of progress.

Contingency management, in which people are provided with positive rewards for reduced or complete cessation of substances, is an effective treatment model for stimulant use disorder. However, its use to date has been limited by the need for provider education, reducing associated stigma, identifying sustainable funding, and state and federal legal barriers. [41]

Another promising intervention described in our first report, the Extension for Community Healthcare Outcomes (ECHO) model, has been applied successfully in Minnesota to encourage healthcare providers to increase the prescription of buprenorphine to patients with OUD.[42] Implementing an ECHO program for providers who care for people with stimulant use disorder could be an effective way to increase the use of contingency management approaches.[43]

Finally, like agonist treatments for opioid use disorder such as buprenorphine, doctors could prescribe stimulant agonist medications for patients with stimulant use disorder.[44] This is a novel approach that warrants deeper exploration.

Key informants echoed some of the challenges noted above, specifically that evidence-based treatments like contingency management are needed to address stimulant use effectively but that they have not been widely adopted in Minnesota.

To address these concerns and leverage current and emerging evidence-based interventions for stimulant disorders, the evidence points to three recommendations.

Table 5. Recommendations for the treatment of stimulant disorders

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
26	Expand ECHO model for people using psychostimulants	Medium	DHS, MDH, OAR	Improve utilization of healthcare	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
27	Expand contingency management for people with stimulant use disorder	Medium	DHS, MDH, OAR	Improve utilization of substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
28	Expand agonist prescriptions for stimulant use disorder	Medium	DHS, OAR	Improve utilization of medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

Key Acronyms: Minnesota Department of Health (MDH); Minnesota Department of Human Services (DHS); Minnesota Office of Addiction and Recovery (OAR)

Incarceration and Re-entry Interventions

> "Jails especially are the front lines for people who are withdrawing, and jails are limited to county general funds that are very limited. And there's an incentive for jail administrators to delay or forgo care because it's, at the end of the day, their money. But ultimately, you're saving a buck or two here, delaying care, but when you get lawsuits from people dying from withdrawal, you're not saving any money."

Many key informants discussed the unique healthcare needs and structural vulnerabilities of currently and formerly incarcerated people and pregnant and parenting people, including during withdrawal.

Heroin withdrawal is marked by severe pain, chills, restlessness, and anxiety. Opioid withdrawal in the fentanyl era is further exacerbated due to fentanyl's short half-life, leading people to use more frequently. In addition, fentanyl is lipophilic (rapidly absorbed in certain tissues and distributed to muscle and fat) and therefore extends the period of withdrawal. [45] Indeed, people withdrawing from fentanyl compared to heroin report greater discomfort and the need for greater medication intervention, making updated withdrawal protocols vital for people who cease opioid use.[46] Severe withdrawal is best managed in a qualified medical setting,[47] but many of the people experiencing it do so in jail or prison, making evidence-based withdrawal protocols in those settings absolutely necessary.

Addressing people's vulnerability to overdose inside detention settings is also critical. From 2001 to 2018, the number of people who died of alcohol or drug intoxication in state prisons across the country rose by more than 600%.[48] In county jail, overdose deaths increased by more than 200% over the same period.[49] In 2023, 20 people died in Minnesota county jails, up from 13 the year before. Some of them were ruled accidental drug overdoses.[50] To address this problem, the Minnesota Department of Corrections (DOC) is hearing proposed revisions to Rule 2911 to increase supports for people with mental health issues and SUD in jail settings.[51]

In addition to the withdrawal period, the weeks immediately after release from detention are incredibly risky. After ceasing opioid use, a person's tolerance to the drug decreases. If someone returns to use after a period of abstinence (such as after completing inpatient treatment or a period of incarceration), overdose risk is amplified.[52] In their seminal study on overdose risk after incarceration, Binswanger et al found that the first two weeks after release from prison were associated with a three- to eight-fold increase in risk of overdose death.[53] Therefore, reentry poses a critical moment to link PWUD to evidence-based care, including supportive structures to help prevent future reincarceration.

This is doubly important for intersectional populations, such as pregnant and parenting people (see more on this group in the Social Determinants of Health section). For example, California established via its Penal Code the Community Participant Mother Program, which prioritizes reentry programming and reuniting incarcerated pregnant and parenting people to encourage parent-child bonding. A 24-bed facility can house up to 24 participants and 40 children.[54]

The evidence identifies two recommendations to improve healthcare for these two key populations.

Table 6. Recommendations to improve the healthcare of people incarcerated and at re-entry

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
29	Develop reentry programs tailored to meet the needs of all people, including those with special vulnerabilities.	Low	DOC, DCYF, OAR, Task Force on Pregnancy Health and Substance Use Disorders, Minnesota Perinatal Quality Collaborative	Improve access to healthcare, Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
30	Improve withdrawal protocols for people in detention settings	Low	DOC, OAR, Medications for Opioid Use Disorder in Jails Workgroup	Improve access to healthcare, Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities, Reduce incarceration

Key Acronyms: Minnesota Department of Children, Youth, and Families (DCYF); Minnesota Department of Corrections (DOC); Minnesota Department of Human Services (DHS); Minnesota Office of Addiction and Recovery (OAR)

Involuntary Treatment

> "The data show that if you force somebody into treatment against their will, that when they leave that treatment, their risk of overdose and death is very high."

There is no rigorous evidence-base supporting the use of involuntary treatment, with some studies showing harmful outcomes.[55] A recent analysis of epidemiological data available through the CDC found that opioid overdose death rates were higher in states with civil commitment laws.[56]

Involuntary treatment is an umbrella term for two separate approaches – civil commitment and mandated treatment. Civil commitment is a legal process wherein people may be mandated to treatment for a SUD when they are considered a threat to themselves. It is seen by its proponents as protecting people who have impaired autonomy to make decisions in their own best interests. However, critics argue that civil commitment is in conflict with the 14th Amendment to the US Constitution, which protects individual liberty and freedom.[57] It is also a harmful practice that is associated with an increase in overdose, and it is highly stigmatizing and corrosive to the rights of people who use drugs.[58]

Mandated treatment refers here to a process within the criminal-legal system in which someone may be forced into treatment for a SUD in lieu of, or as a complement to, incarceration.[59] A systemic review of mandated treatment programs found little evidence of its effectiveness, with over three quarters of included studies finding no impact or harmful impacts of such programs.[60]

One driving concern with involuntary treatment is that people may be "matched" with a treatment modality that does not meet their needs.[61] Another is that treatment available in connection with the criminal-legal system may not offer what is currently recognized as evidence-based treatment, and that contracted community-based providers also routinely offer sub-par, non-evidence-based care.[62]

Data on the prevalence of involuntary treatment is limited. A review of state policies found that as of December 2024, Minnesota was one of 34 states, DC, Puerto Rico, and the US Virgin Islands that allowed for civil commitment for people with a primary diagnosis of SUD, with considerable heterogeneity across statutes (e.g., who can petition the court for the commitment, types of treatment mandated, and length of time for which someone can be committed). Minnesota is one of 43 states that allows judges to mandate people to inpatient or outpatient treatment. It also has one of the highest maximum lengths of the initial involuntary commitment period, at up to 180 days. The most common maximum length is 90.[63]

Key informants raised ethical concerns about involuntary treatment, emphasizing the importance of autonomy and dignity for individuals undergoing treatment. This was especially true for marginalized populations. For example, fear of involuntary commitment deterred pregnant people from seeking help, leading to worse health outcomes and degraded trust in the healthcare system. Civil commitment processes for pregnant people were viewed as punitive and ineffective, often undermining family reunification and treatment success.

Table 7. Recommendations on the use of involuntary and compulsory treatment

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
31	Fund a study to understand where and when compulsory treatment is happening	Low	DHS, DPS, Minnesota Judicial Branch	Improve utilization of substance use disorder treatment	Improve the autonomy and dignity of people who use drugs
32	Evaluate potential changes and make recommendations as to how involuntary civil commitment statutes apply to and have been implemented among "Chemically dependent person[s]," noting also the broad inclusion of pregnant persons, seemingly without any requirement to find risk of harm.	Low	DCYF, Minnesota Perinatal Quality Collaborative, OAR, Task Force on Pregnancy Health and Substance Use Disorders	Improve utilization of substance use disorder treatment	Improve the autonomy and dignity of people who use drugs

Key Acronyms: Minnesota Department of Children, Youth, and Families (DCYF); Minnesota Department of Human Services (DHS); Minnesota Department of Public Safety (DPS); Minnesota Office of Addiction and Recovery (OAR)

Treatment on Demand that is Evidence-Based and Culturally Appropriate

- "There's barely any treatments available for [immigrant youth] right now, let alone culturally relevant treatment centers. If they want to go to treatment, they probably have to wait three, four months, and by the time they're available to take them, the kid is gone. And even if they get into treatment, it's not culturally relevant."

- "I think for Minnesota at least they've really done a good job supporting culturally specific treatment in regards of incorporating cultural aspects and religious aspects to treatment centers. And it really resonates well with those individuals that are seeking help."

- "There's not parity, for instance, in treatment centers around interpreter access… there is not funding for individuals who don't speak English to have an interpreter…. It's really hard, almost impossible to get them into residential treatment or just outpatient treatment in general. A lot of places will reject folks, regardless of their appropriateness for their [American Society of Addiction Medicine] level of care, based on the fact that they're going to have to pay out of their own pocket for the interpreter. And that's killing people, it's killing immigrants, it's killing refugees, and it's unbelievably racist in this other way that is so harmful that we've tried talking about it for years … It's against the law for you to discriminate based on interpreter needs if you're taking medical assistance."

As noted in the first report, how treatment for SUD is delivered matters as much as the types of services offered. The need for culturally appropriate care is important for all people with SUD, but some groups are impacted more than others by the dearth of treatment options. This includes historically marginalized groups, such as Black, Indigenous, and People of Color (BIPOC) communities, as well as other special populations, such as youth. These groups traditionally have had impaired access to quality treatment for SUD.[64] When evidence-based models of care are adapted for specific populations, treatment outcomes improve.[65]

In Minnesota, for example, the Cultural and Ethnic Minority Infrastructure grants have funded such efforts for many years. The grant aims to provide culturally specific mental health and SUD services to key cultural and minority communities in Minnesota. In the past, target groups have included African, African American, American Indian, Hispanic and Latine, Asian, Immigrant, Refugee, and LGBTQ+ communities.[66]

Key informant interviews often touched on the need for culturally appropriate care. Some were representatives of organizations that served refugee and other immigrant populations. Others worked with Native American communities and called for spiritually focused treatment. These key informants discussed the vital role their organizations played in providing tailored treatment, and all indicated a need to expand these services.

Table 8. Recommendations for on-demand treatment that is culturally responsive

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
33	Expand access to treatment and recovery services for youth, especially services that are not religious.	Medium	DCYF, DHS, OAR	Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
34	Continue to fund traditional healing for substance use disorder across the continuum of care	Medium	DHS, MDH, Minnesota Indian Affairs Council, OAR	Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities, Reduce disparities
35	Enhance services for Hmong and East African communities	Medium	DHS, MDH, OAR	Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities, Reduce disparities
36	Ensure the availability of translation services in substance use disorder treatment settings	Low	AG, DHS, MDHR, Mid-Minnesota Legal Aid (federally designated Protection and Advocacy agency for people with disabilities in Minnesota), OAR	Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities, Reduce disparities

Key Acronyms: Minnesota Attorney General's Office (AG); Minnesota Department of Children, Youth, and Families (DCYF); Minnesota Department of Human Rights (MDHR); Minnesota Department of Human Services (DHS); Minnesota Office of Addiction and Recovery (OAR)

Workforce

> "I see that happening with peer recovery specialists. Like, let's put a peer everywhere. Great, that's a tool. But the peer has to be in an environment that understands peer support, has to be supported by a culture that's committed to person-centered recovery, has to be connected to a network that will support that individual in their recovery … It's like, okay, we're going to get more peers in places. Great. Let's also fund a statewide initiative to increase organizational capacity, to have peers be embedded and integrated into the delivery of services. So we never go to that organizational capacity or regional capacity place to support the new innovations."

The workforce providing care to people with SUD is a critical component of treatment. Ideally, the workforce will meet demand for availability, training, life experiences, and cultural appropriateness. However, the number of qualified professionals currently in the workforce does not meet demand.[67] In our first report, we outlined SAMHSA's key strategies to recruit and retain a diverse behavioral health workforce. These strategies include training and technical assistance, adequate financial compensation and supportive services to enhance retention, and meaningful incorporation of people with lived and living experiences of substance use in leadership roles, and our recommendations echo those strategies.[68]

People in treatment for SUD often note how working with behavioral treatment providers who have lived and living experiences of substance use are helpful to build rapport and establish legitimacy as experts.[69] Despite this clear need, there are barriers to incorporating these professionals into the workforce.

Discrimination

Discrimination commonly occurs against people who take MOUD, including healthcare providers who use the medications. There are no national standards for clinicians with OUD to return to work during or after treatment, leaving states with the responsibility to establish protocols.[70]

For example, as of 2022 there were at least 40 state alternative-to-discipline programs (ADP) leveraged by Boards of Nursing to allow for nurses to engage in treatment in lieu of job termination for drug use. Of 23 ADPs that responded to a survey, only seven permitted the use of MOUD; all seven put other restrictions on the use of MOUD once they return to work, including urine drug screens and attendance at meetings.[71]

State medical boards also vary in their approach to MOUD. While there are no federal regulations about how these programs should operate, the Federation of State Physician Health Programs offers guidelines highlight MOUDs as the standard of care.[72]

This ambiguity poses a missed opportunity to encourage evidence-based treatment along with other supportive measures to return to work with people with SUD. For example, New Jersey has allowed physicians on MOUD to continue working, without one single adverse event reported in over 30 years. It is a violation of the Americans with Disabilities Act (ADA) not to allow MOUD.[73]

Minnesota's Alternative to Discipline Plan, the Health Professionals Services Program, connects licensed healthcare professionals to medical treatment for illnesses that may impact their ability to practice safely. This includes stigmatized health conditions like substance use and mental health disorders, for which healthcare practitioners may be hesitant to seek treatment. Importantly, the program provides access to confidential treatment and monitoring that does not need to be reported to a licensing board. The program's website does not list any restrictions on treatment options or providers.[74] While this study was not able to examine all applications for licensed healthcare providers, the application for physicians asks about untreated conditions, impairment from alcohol or chemical substances, the use of illegal drugs, and the illegal use of legal drugs. The application does not enquire about the use of MOUD.[75]

Minnesota's Health Professionals Services Program could do more to encourage licensed providers to seek MOUD, including by explicitly recommending that medical boards permit their licensees to return to work while receiving MOUDs and including information about MOUD in licensure applications.

Peer Support

Peers with lived and living experiences of substance use are uniquely positioned to connect with patients who have SUD and, as current or former consumers of the treatment system themselves, they can effectively guide patients through enrolling in treatment.[76] Peers are frequently utilized in traditional treatment settings and are invaluable in other settings such as emergency departments and detention settings. Evaluation of peer programs show that they help retain patients in care and decrease acute care.[77]

Despite the increasing recognition of the vital role peers can play, the path to certification and professionalism is often unclear. Peers are at times not fully incorporated into treatment teams and may need ongoing emotional support to continue their work without experiencing trauma or re-traumatization.

The complicated nature of billing for peer services also poses a barrier to uptake, and states vary on the levels of education and other requirements for peer services to be insurance billable. For example, in almost all states, peers must report to a supervisor with a masters-level degree. Minnesota's laws are more expansive, and peer supervisors must possess a current certification or licensure in a behavioral health field and fulfill education requirements on a range of topics, including ethical conduct, peer recovery domains, and relevant rules and statutes.[78] In many states, only peers with high school degrees or the equivalent can bill for services,[79] but in Minnesota, certified recovery peers can bill for certain services if they have a current credential from the Minnesota Certification Board or similar organizations.[80]

Separate certification standards for peers working in SUD and mental health specialties also needlessly complicates service provision, according to key informants.

Supporting a Diverse Workforce

> "The health department found there were like 3,000 people who finished grad school and then didn't go on and become licensed...we did a non-scientific survey and what we found from a lot of people is that they couldn't afford to do their supervision hours for free or to pay for them, and that people couldn't find a culturally relevant supervisor. And so we did pass a small program that gives some money to providers who do like at least 25% Medicaid and either are in rural Minnesota or do kind of culturally specific to actually provide supervision for free, which helps."

BIPOC and other historically underserved communities are less likely than other groups to receive traditional healthcare services for SUD; instead, they often receive care from community-based organizations (CBOs) that offer more holistic care that can include support for families and harm reduction services. While they are well-placed to reduce racial disparities, these organizations often face capacity limitations that prevent them from billing Medicaid, including bureaucratic reporting, staffing, and licensing requirements. State lawmakers can help community-based organizations overcome these and other administrative barriers by funding technical assistance and investing in the organizations' long-term growth out of Medicaid or state funding pools. [81]

Project ECHO in Minnesota

Project ECHO links new MOUD providers, including primary care providers to more established providers. Mentors at more established providers support providers lacking specialized training, who are often located in rural and other underserved communities. Evaluations of two longstanding Minnesota-based programs, Hennepin Healthcare and Catholic Health Initiatives (CHI) – St. Gabriel's, found that providers connected to these programs were more likely to prescribe MOUD. The study authors offered that continued and expanded use of the ECHO model is a valuable tool for mitigating the harms of opioids in Minnesota communities.[82]

General Healthcare

Finally, the general population of licensed healthcare providers lack specialized training on working with PWUD. Trauma-informed curricula on a variety of topics could improve their capacity to treat these patients, who often have a higher burden of acute and chronic illnesses than the general population.[83] State lawmakers can require training on these topics.

Key informants spoke at length about the SUD workforce. They noted how peers are uniquely positioned to develop rapport with patients and help them achieve substance-related goals, as well as to link them to obtaining resources needed to stabilize their lives. More broadly, they indicated that the entire workforce needs more training, specifically in the areas of trauma-informed care and culturally appropriate care. They also observed medical silos that exist between the medical and behavioral workforces. Finally, some said the workforce should reflect the populations being served and called for greater workforce diversity, specifically in regard to race/ethnicity, immigration status, and language. People of color, from immigrant backgrounds, and whose primary language is other than English may need more supports to enter the behavioral health workforce.

Recommendations related to the SUD workforce are included in Table 9 (next page).

Table 9. Recommendations pertaining to the SUD workforce

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
	Capacity building for current providers				
37	Allocate funding for technical assistance to community-based providers to become Medicaid providers.	Medium	DHS, OAR	Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
38	Dedicate funding to offer targeted technical assistance including grant management support, strategic planning, and budget development to small and BIPOC-led CBOs.	Medium	DHS, MDH, OAR	Improve access to substance use disorder treatment	Reduce disparities; Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
39	Continue to expand ECHO model to increase treatment access in rural Minnesota by training general practitioners to prescribe buprenorphine.	Medium	DHS, MDH, OAR	Improve access to medications for opioid use disorder	Reduce disparities; Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
40	Mandate training on harm reduction, MOUD, trauma-informed care, and other issues related to substance use, for all licensed healthcare providers.	Low	DHS, MDH, Minnesota Health Licensing Boards, OAR	Improve access to healthcare, Improve utilization of healthcare	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
	Expanding/diversifying SUD workforce				
41	Pass legislation to diversify the substance use disorder workforce.	Medium	DHS, DOE, OAR, Minnesota State, Minnesota Health Licensing Boards, Board of Pharmacy, Tribal Colleges and Universities	Improve access to substance use disorder treatment	Reduce disparities; Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
42	Expand high quality peer support services by addressing professionalization, equitable compensation, and reimbursement issues.	Medium	DHS, OAR	Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities, Improve the autonomy and dignity of people who use drugs
43	Streamline peer certification programs.	Medium	DHS	Improve access to substance use disorder treatment, Improve utilization of substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

Table 9. Recommendations pertaining to the SUD workforce, continued

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
44	Consider state funding and policy mechanisms to promote organization-level infrastructure that facilitates the integration of peers and people with lived and living experience in the behavioral health workforce.	Medium	DHS	Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities, Improve the autonomy and dignity of people who use drugs
45	Invest in programs that expand racial diversity in the behavioral health workforce.	Medium	DHS	Improve access to substance use disorder treatment	Reduce disparities; Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
46	Establish and fund programs to create access for people with substance use disorders to peer recovery specialists in jails and prisons, emergency departments, and other innovative settings.	Medium	DHS, DOC, Minnesota Health Licensing Boards, OAR	Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities, Improve the autonomy and dignity of people who use drugs
47	Consider ways to ease access to medications for substance use disorder for licensed healthcare professionals, including by leveraging licensure questionnaires to encourage providers to seek treatment.	Low	DHS, MDH, Minnesota Health Licensing Boards, OAR	Improve access to medications for opioid use disorder	Improve the autonomy and dignity of people who use drugs, Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

Key Acronyms: Minnesota Department of Corrections (DOC); Minnesota Department of Education (DOE); Minnesota Department of Health (MDH); Minnesota Department of Human Services (DHS); Minnesota Office of Addiction and Recovery (OAR)

HARM REDUCTION

Harm reduction is both a philosophy and a set of health interventions. As an ideology, harm reduction asks providers to "meet people where they're at" - that people who are unwilling, unable, or uninterested in ceasing their drug use are nevertheless deserving of dignified, high quality health services. The harm reduction philosophy also centers the voices of PWUD in identifying and implementing the responses to minimize the harms of drug use.

Harm reduction health interventions including syringe services programs, overdose education and naloxone distribution, overdose prevention centers, and drug checking programs aim to curb the harms of criminalized drug use, like overdose and infectious disease transmission, with public health approaches. The evidence supporting these interventions is summarized in the Year 1 Report.

911 Good Samaritan Laws

> "[W]e've had people drop someone off at our door more than once, you know, dropped them out of a car and left them because they're afraid. They're afraid to go to jail. They're afraid of what will happen to them for trying to help someone. And that's a big problem."

Good Samaritan Laws (GSLs) provide certain legal protections to people who call 911 in case of an overdose emergency, to encourage people to call for help. As of April 2024, 48 states and the District of Columbia had such laws on the books; only Kansas and Wyoming did not. The first was implemented in 2007. Since then, 24 jurisdictions have substantively amended their statutes to expand the groups of people who are eligible for protections. Minnesota is not among them.[84]

The Year 1 Report noted that the evidence supporting GSLs was mixed, largely because of the heterogeneity in practices and implementation. The scientific literature also has surfaced multiple policy barriers to the intended benefits of GSLs. A recent study found that the main barrier to calling 911 was concern over the presence of police at the scene of the overdose, as well as fear of arrest, incarceration, eviction, loss of employment, and involvement with child welfare and subsequent loss of child custody.[85] Facilitators for calling 911 included awareness about the law among PWUD and law enforcement, expanded legal protections for callers, and reduced police involvement in overdoses cases.[86] Other barriers to calling for help include having to provide your full name to law enforcement, remaining on the scene, and cooperating with responding officers.[87] None of these policy provisions are necessary to keep someone who is overdosing alive.

Indeed, these policy barriers to calling 911 are frequently experienced by Minnesotans. For example, one key informant at a CBO noted that the lack of protection for people who are on probation or who have a warrant poses a significant barrier to calling for help. A harm reduction services provider noted

that the fear of arrest leads people to drop off peers experiencing an overdose at the front door of their office, rather than calling 911.

To provide more context about Minnesota's law:[88]

- Some states' Good Samaritan Laws offer immunity from drug possession and drug delivery offenses; Minnesota's law protects against possession, sharing, and use offenses but not delivery offenses.
- Minnesota's law protects against charging and prosecution, but not arrest, which itself poses a significant disincentive to calling for help.
- One environmental scan found that 27 states and DC offer protections against probation and parole violations.[89] Minnesota explicitly prohibits revocation based on an incident for which someone is immune from prosecution under the GSL.[10]
- Minnesota is one of at least ten states that do not offer protections for people seeking help during the execution of an arrest warrant, search warrant, or lawful search. Others include North Dakota, Iowa, Texas, and Utah.[90]
- Minnesota law requires that the person calling for help provides identifying information and waits until first responders arrive on the scene.
- Minnesota's law provides protections only for those who seek help or act in concert with someone seeking help, rather than anyone who renders aid.
- No state protects against civil system penalties, like child protection interventions, for calling for help.

A key recommendation is for legislators to expand protections afforded in Minnesota's GSL, known as "Steve's Law," to people who seek help or render aid in the case of an overdose.

Table 10. Recommendations to strengthen Minnesota's Good Samaritan Law

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
48	Add protections to "Steve's Law," Minnesota's Good Samaritan law, and create funding to educate people who use drugs and law enforcement about the protections in Steve's Law.	Medium	DHS, DPS, MDH, OAR,	Improve access to healthcare, Reduce arrest, Reduce incarceration	Reduce overdose mortality

Key Acronyms: Minnesota Department of Health (MDH); Minnesota Department of Human Services (DHS); Minnesota Department of Public Safety (DPS); Minnesota Office of Addiction and Recovery (OAR)

[10] See MN Stat. 604A.05, Subd. 3.

Naloxone

> "We need to create a [naloxone saturation] plan... but there's the lack of funding and lack of coordinated response, which I think is being worked on [by the state government] as well ... The [lack of naloxone supply through the] portal has been a really big issue and needs to be addressed. I think there needs to be diverse funding [for naloxone], and I think it really needs to prioritize organizations...that work with people who use drugs.

Naloxone is the antidote for an opioid overdose. The evidence supporting its distribution, including directly to PWUD, was laid out in the Year 1 Report. Since the publication of the first report, new evidence has emerged showing that administering higher doses of naloxone to people overdosing does not increase survival rates but more than doubles the risk of withdrawal.[91]

Over the last few decades, state policies have evolved to expand access to naloxone, including who may prescribe, dispense, administer, or receive it. For example, Minnesota recently required that schools have naloxone available, and nationally naloxone is now available over the counter.

Naloxone distribution by the states is uneven. Minnesota had one of the lowest rates of naloxone dispensing by retail pharmacies, one proxy for access, among all US states, alongside Georgia, Iowa, New Hampshire, South Dakota, and Texas.[92] Community distribution is a critical mode of access that is not covered by this metric, and the Naloxone Saturation Project led by the Office of Addiction Recovery is working to improve data collection about naloxone access.[93] Minnesota also has a Naloxone Portal, which most states do not. At the same time, the ability to order naloxone form the Portal is often disabled, as the state lacks funds to keep sufficient supply on hand. For example, on February 20, 2025, a note on the Portal's website read "The Portal is currently inactive. There is a hold on fulfilling orders, as of 7/24/2024."[94]

Multiple key informants expressed their desire for increased access to naloxone in order to reverse overdoses, especially in communities most impacted by overdose mortality, at harm reduction providers, in public places like schools and libraries, and for sale at pharmacies. They advocated for sufficient, long-term funding for the Minnesota Department of Health, to ensure naloxone is available across the state. In Minnesota and most states, naloxone is funded primarily through state and federal grant programs, with some state-level discretion as to how funding is distributed.[95]

Some jurisdictions have laws supporting the bulk purchase of naloxone to lower costs to community organizations and non-profits distributing it. Colorado, for example, established in statute the "Naloxone Bulk Fund." With $9 million from federal funding sources, the program distributed 300,000 doses of naloxone at no cost to 500 partner organizations across the state during the 2022-2023 fiscal year.[96] Minnesota does not currently have such a law.

Key informants also spoke about law enforcement confiscating naloxone and officers who refused to carry it, which demonstrated to them the amount of stigma directed at people who use drugs.

A recent modelling study found that community-based and pharmacy-initiated naloxone distribution warrant substantial expansion in early every US state in order to avert overdose deaths.[97] Policy recommendations about naloxone thus aim to continue expanding access to this lifesaving drug across a range of settings and distribution points. Insurance policy measures to expand access to naloxone are addressed in the Healthcare portion of this report.

Table 11. Recommendations to improve naloxone access

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
49	Fund the build out of the state's naloxone portal and naloxone saturation plan, including expanding formulations available on the portal beyond nasal to include intramuscular.	High	DHS, OAR	Improve access to naloxone	Reduce overdose mortality
50	Mandate and fund the distribution of "harm reduction kits" to all Minnesotans exiting detention settings, including local facilities.	Medium	DOC	Improve access to naloxone	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
51	Enact a law requiring pharmacies to maintain stocks of naloxone.	Low		Improve access to naloxone	Reduce overdose mortality
52	Address the problem of law enforcement officers who confiscate or refuse to carry naloxone.	Low	DPS	Improve access to naloxone	Reduce overdose mortality

Key Acronyms: Minnesota Department of Corrections (DOC); Minnesota Department of Human Services (DHS); Minnesota Department of Public Safety (DPS); Minnesota Office of Addiction and Recovery (OAR)

Syringe Services Programs and Safer Use Practices for Non-Injecting Drugs

> "State funding... it's never enough money, but the money that is offered, too, is necessary because without it, you can't do this. Like, it's not possible."

Minnesota is one of 39 states and DC that supports access to syringe services programs (SSPs) with jurisdiction-wide laws. Minnesota's SSPs are explicitly authorized by law; other jurisdictions that either explicitly or implicitly authorize SSPs do so via law, regulation, or Executive Order. [98] The definition of SSPs established during the 2023 session allows for smaller and less formal operators to provide services.[99]

Minnesota is also among the states with the fewest barriers to SSPs' operation, which is considered best practice. Other states pose barriers to SSP uptake by requiring, for example, that programs operate on a one-to-one model, wherein participants only receive as many syringes from the SSP as they return. Indiana, Kentucky, and Maryland allow local authorities to terminate SSPs, and eleven states condition the operation of an SSP on local approval.[100]

As discussed in the Year 1 Report, syringes services programs are one of the most-studied harm reduction interventions. There is a robust evidence base highlighting their impact on a range of public health outcomes, including reducing the incidence of infectious disease caused by injection drug use, increasing linkages to treatment for SUD and other healthcare services, and access to overdose prevention tools like naloxone and fentanyl test strips. There is also significant research base showing that SSPs do not harm the communities where they are located.

Key informants expressed gratitude that Minnesota provides state funding for SSPs, which not all states do. They also spoke positively about staff at the Minnesota Department of Health (MDH) seeking their input about what is working on the ground. At the same time, SSPs in Minnesota face barriers to meet the needs of their communities, including inconsistent and inflexible funding, a workforce that faces trauma and other difficult working conditions, negative law enforcement interactions, and frequent displacement of houseless individuals who are SSP participants.

Beyond calling for more funding in general, key informants also appealed for more funding for safer smoking and snorting equipment specifically. Evidence shows that certain cultural and ethnic groups prefer certain routes of ingestion over others;[101] key informants named the Somali community and people between the ages of 18 and 30 as groups less likely to inject. Some evidence also indicates that smoking and snorting may be safer consumption routes than injecting.[102] These items are expensive, however, and some programs struggle to purchase enough to meet demand.

> "A couple of years ago, when we were really pushing to be able to give out smoking supplies, we ran a survey with our participants that had asked them... if we were to offer smoking supplies, would you... inject less often? And the overwhelming response was... yeah, but, you know, it's easier to get needles than it is to get pipes or stems...which is wild to me, but that was true."

Another way to expand syringe access in Minnesota is to leverage community pharmacies. Key informants working for a SSP found that "detailing" at local pharmacies had encouraged the pharmacies to begin selling syringes. This method is also supported by the academic literature as an effective way to increase distribution of harm reduction materials among.[103] Detailing is a term for providing one-on-one education about products to medical professionals. Pharmacies' participation in Minnesota's Syringe Access Initiative is voluntary, but anecdotally, some pharmacies decline to participate because of the stigma associated with injection drug use. Updates to Minnesota's law in 2023 allowed for the purchase of an unlimited number of new syringes without a prescription; before the change, purchases were limited to ten.[104]

Finally, key informants emphasized that strict one-for-one exchange, wherein participants only receive as many syringes from the SSP as they return, conflicts with MDH guidance and best practice. Nevertheless, some programs in the state continue to require one-for-one exchange, either because they lack funding to distribute on the basis of need or because they refuse to adopt evidence-based best practices.

> "And whenever somebody's looking for clean needles...we don't turn them away and we don't... try to put a black cloud. We just, without question, give them a ten pack of needles. And...we don't make it a trade that you have to bring back needles."

Table 12 includes recommendations aimed at expanding access to safer drug use materials.

Table 12. Recommendations to improve access to sterile supplies

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
53	Ensure adequate, sustainable, flexible funding for community-based syringe services programs.	High	MDH	Improve access to harm reduction services	Reduce drug-related infectious disease transmission/other morbidities
54	Increase funding for a broad range of safer smoking supplies to encourage transitions from injecting to other modes of administration or prevent initiation of injecting.	High	MDH	Improve access to harm reduction services	Reduce drug-related infectious disease transmission/other morbidities
55	Create funding for a statewide, self-governed body to coordinate all syringe services programs, measure effectiveness, reduce duplication of services, expand where necessary, and bring coordinated requests and recommendations asks to the Minnesota Department of Health.	Medium	MDH	Improve access to harm reduction services	Reduce drug-related infectious disease transmission/other morbidities
56	Direct the Minnesota Department of Health to ensure syringes services programs are not requiring that participants return syringes to receive new ones.	Low	MDH	Improve access to harm reduction services	Reduce drug-related infectious disease transmission/other morbidities
57	Conduct health department-led "detailing" to pharmacies about the importance of syringe access.	Low	MDH, Board of Pharmacy	Improve access to harm reduction services	Reduce drug-related infectious disease transmission/other morbidities

Key Acronyms: Minnesota Department of Health (MDH)

Drug Checking

As described in the first report, drug checking technologies like fentanyl and xylazine test strips allow PWUD to understand the contents of their drugs and adjust their behaviors to reduce risk associated with a volatile drug supply infiltrated by toxic contaminants. Almost all states make carve outs to their drug paraphernalia laws for fentanyl test strips. More than half of US jurisdictions also create access to test strips for other drugs, like xylazine.[105]

More advanced technologies, like Fourier-transform infrared (FTIR) spectroscopy machines, provide much more detailed qualitative and quantitative analysis about a drug's composition. Such machines are expensive, costing more than $40,000 for the machine and reference library, require extensive training, and are large enough that they tend to be hosted by harm reduction organizations or health departments.[106] At least two large syringe services programs in Minnesota have these machines and are in the process of bringing them online, but the high costs are prohibitive for many programs.

Key informants surfaced legal barriers to operating FTIR machines, including the fear of arrest for possession for participants who bring their drugs to a harm reduction organization to be tested and for staff who are testing the drugs. They also voiced concern about how the test results are used and whether there are sufficient protections in place to prevent information going to law enforcement or to the state to implicate individuals.

> "We have a criminalization issue of, if somebody is coming with drugs that we're checking, are they going to be arrested outside? Am I going to be arrested as a harm reduction provider for having the drug on me?"

Finally, key informants expressed interest in expanding partnerships between a local university partner with a sophisticated lab and harm reduction organizations on confirmatory drug testing, similar to the relationship between the North Carolina Survivors Union and the University of North Carolina.[107] Due to the lack of a local partner, one Minnesota program works with the University of California Los Angeles.

Table 13. Recommendations to implement drug checking

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
58	Provide funding for statewide drug checking programs. Allowable expenditures should include FTIR (Fourier transform infrared spectroscopy) machines, training, and confirmatory/complementary testing through a reputable lab (potentially at the University of Minnesota).	Medium	MDH, DHS	Improve access to harm reduction services	Reduce overdose mortality
59	Create exemptions from possession charges for people using drug checking services and staff operating drug checking services. Regulations should allow for drug checking services to be stationary or mobile, depending on local and cultural needs. They should also protect the private information of people using the services.	Low	MDH, DHS, DPS	Improve access to harm reduction services	Reduce overdose mortality

Key Acronyms: Minnesota Department of Health (MDH); Minnesota Department of Human Services (DHS); Minnesota Department of Public Safety (DPS)

Overdose Prevention Centers

The evidence supporting the efficacy of overdose prevention centers (OPCs) is voluminous, yet as of January 2025, there are only two above-ground sites operating in the US, both in New York City. OPCs, where people can bring their own drugs and ingest them under supervision, have been shown to reduce overdose, calls to EMS, and HIV transmission.

The principal federal concern for jurisdictions seeking to open an OPC is 21 U.S.C. § 856, known as the "crack house" statute. The statute makes it illegal to "knowingly open, lease, rent, use, or maintain any place, whether permanently or temporarily, for the purpose of manufacturing, distributing, or using any controlled substance." It is also unlawful to "manage or control any place … and knowingly and intentionally rent, lease, profit from, or make available for use, with or without compensation, the place for the purpose of unlawfully manufacturing, storing, distributing, or using a controlled substance." At the time the law was created, however, legislators did not consider the applicability to OPCs because they did not yet exist.[108]

This disjuncture between the intent of the federal law and the intent of OPCs has left a legal gray area for state and local governments. The Biden Administration took no official stance on OPCs but declined to prosecute the New York City sites. There have been no legal cases addressing whether OPCs would violate state law. Whether the sites violate federal law has been settled only in the Third Circuit Court of Appeals, which ruled that OPCs do violate federal law. The Third Circuit does not include Minnesota.

That said, legal experts have advised that state or local legislation authorizing OPCs would provide the best protection against the risk of federal intervention.[109] Only two states have laws explicitly authorizing overdose prevention centers: Rhode Island and Vermont. Minnesota's 2023 budget authorized the use of funds for "safe recovery sites," but Minnesota law does not yet offer full legal protections for people to use or operate such sites.[110] Key informants interviewed as part of this study expressed concern that that staff and participants of OPCs would face police harassment without explicit protections in place.

Key informants also advocated for OPC regulations that support a range of drug consumption methods, including smoking, and a range of settings. As written in the appropriation (bill?), Minnesota's funding for safe recovery spaces is limited to safer injecting only.[111]

Table 14 contains one recommendation related to implementing overdose prevention centers.

Table 14. Recommendation to implement overdose prevention centers

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
60	Enact legislation supporting the existence of "safe recovery sites" and creating protections for people who use and operate them. Regulations should allow for multiple models that can meet the needs of different geographies, modes of drug use, and levels of medicalization.	Medium	DHS, OAR	Improve access to harm reduction services	Reduce overdose mortality

Key Acronyms: Minnesota Department of Human Services (DHS); Minnesota Department of Public Safety (DPS)

SOCIAL DETERMINANTS OF HEALTH

As stated by Healthy People 2030, the social determinants of health are "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[112] Experts estimate that approximately 40% of one's health status is determined by social and economic factors and 10% by the physical environment.[113] Therefore, it is critical that housing, employment, and banking are available to everyone in Minnesota, including people who use drugs.

The Year 1 Report identified several social determinants of health of particular salience to PWUD. These determinants, which are grouped under the categories of children and families, consumer finance, education, employment, encampments, housing, immigration, public benefits, and retroactive expungement, all have policy opportunities to improve health outcomes. Each is addressed in sections below.

Two highly regarded projects attempt to measure social determinants of health within and/or between states. The first of these is the County Health Rankings & Roadmaps, which identifies a number of indicators in which Minnesota as a whole performs relatively well compared to the general population of the US. Indicators include better than average access to healthy foods and lower food insecurity, a lower uninsured rate, greater educational attainment, fewer children living in poverty and fewer problems with housing quality, and lower HIV prevalence. However, the state population has a higher prevalence of excessive drinking and alcohol-related driving deaths. Relevant to this report, Minnesota has fewer overdoses relative to the general US population. However, rates are still high and are not evenly distributed across the state, with northern and eastern counties disproportionately impacted.[114]

The second ranking system is the Scorecard on State Health System Performance, which is generated by The Commonwealth Fund. Their 2023 scorecard found that Minnesota ranked 5th on health outcomes and healthy behaviors,11th on health system performance in 2023, and 13th on reproductive care and women's health. Minnesota scored poorly on avoidable deaths among American Indian/Alaska Natives.[115]

This last measure illustrates the "Minnesota Paradox," which holds that while Minnesota is a top state for quality of life when looking across races, it is one of the worst states to live in for people of color.[11] Examples include:

- 77% of white households in the state own their homes, compared to 49% for Hispanic households, 44% for Native American households, and 29% of Black Minnesotans.[116]

[11] See "The Minnesota Paradox," by Samuel Myers.

- White Minnesotans are 15 percentage points more likely to graduate from high school than Black Minnesotans, the sixth-highest disparity in the nation.[117]
- In 2019, Minnesota had the largest gap in education rates in the country between students of color and white students.[118]
- Minnesota schools suspend and expel children of color at disproportionately high rates.[119]
- Rates of unemployment are higher among Black Minnesotans than among white Minnesotans, despite more participation in the labor market.[120]

Such indicators suggest that policies and interventions addressing social determinants of health may be particularly important for Minnesotans of color, who experience adverse outcomes at particularly high rates. Indeed, key informants emphasized that drug policies must consider broader social determinants of health and noted challenges in accessing public benefits and healthcare for PWUD and the importance of community-based networks and targeted support for specific populations. Because social determinants of health are only indirectly related to drug impacts, recommendation tables in this section include expected outcomes but exclude expected impacts.

Housing

> "Yes, they have severe chemical dependency. Yes, they deserve shelter like a human being. And then it's up to us to provide all those resources to make sure that they stay housed and alive and work towards their goals."

> "Any policies that go against Housing First that push people onto the street are incredibly harmful, especially when there's the increased sweeps that are happening with encampments. So it puts people in a place where people get kicked out of shelters because they're using [drugs], or engaging in other activities related to drug use or homelessness that aren't allowed at those sites, and it doesn't give people a place to go, or the policies at those shelters and places just lead to not great living environments for people."

> "Everyone deserves to have a safe space to sleep at night."

The initial report laid out the strong evidence base for Housing First models that support PWUD to remain in housing without requiring abstinence or participation in certain services and the negative impacts of preventing people from accessing housing.

Indeed, evidence underscores that people without access to stable housing put a disproportionate amount of their income towards housing, move frequently, and experience poor housing conditions. This has downstream effects on access to healthcare and physical health, and the effect is exacerbated for people with criminal histories. Homelessness is linked to a higher prevalence of chronic health conditions, poor mental health, and much greater premature death risk compared to the housed population.[121]

There is also a strong link between drug use and housing instability or homelessness. In a recent study, one in ten substance use deaths in Minnesota were among people experiencing homelessness. This rate is ten times higher than the general Minnesota population. The evidence suggests that housing should be prioritized as a key method of preventing fatal opioid overdoses among people experiencing homelessness. This recommendation is also supported by research that has established an association between state-level homelessness and overdose mortality (though more research is needed to understand the moderators between the two).[122]

Drug-related evictions also remove people from their homes. Evictions from public housing do not require an arrest or criminal conviction, and once evicted, people lose access to public housing for three years.[123] For private housing, many cities allow landlords to evict people who call emergency services due to an overdose, which may disincline people from seeking help. In Minneapolis, it is unlawful for landlords to evict someone for calls for emergency services, and St. Louis Park, Golden Valley, Robbinsdale, and Bloomington have all taken action suspend, review, or amend these ordinances.[124]

Housing was the most discussed social determinant of health among key informants. Individuals described how policies often bar people with criminal records or who are actively using drugs from accessing housing. Many advocated for Housing First-type models, wherein housing is provided without preconditions like abstinence. Key informants also advocated for housing options for PWUD that include supportive services, noting that that housing needs were particularly acute among specific populations of PWUD, including parents with children, youth, and the East African community.

Many key informants spoke at length about how homeless encampments, for some people, are a source of stability that are disrupted during "sweeps," when social networks and other supports are often displaced. Most importantly, however, key informants said that policies criminalizing homelessness worsen conditions for PWUD.

Finally, sober homes, or recovery housing, are a special class of housing. One report estimated that there are 159 unique sober homes in Minnesota, but this is likely an undercount. According to the Minnesota Department of Human Services (DHS):

> "In Minnesota, sober homes are often drug and alcohol-free living environments designed to cultivate positive change and progress toward recovery. Many rely on a peer support model, focusing on the power of working toward recovery with other individuals who share the same goal. These homes are not intended to provide treatment or other types of clinical services. Many require, or strongly encourage, participation in 12-step programs, such as Alcoholics Anonymous (AA). Additionally, sober homes ask that residents abide by house rules that may include things such as maintaining abstinence, paying rent, helping with house chores, or attending house meetings."[125]

As of 2023, Minnesota was one of 23 states that did not regulate sober homes. Currently, recovery homes in Minnesota are self-regulated by the Minnesota Association of Sober Homes (MASH).[126] Without consistent regulation, and because recovery homes have for so long operated outside the

traditional treatment and supportive housing systems, there are inconsistencies in the quality of housing, the proliferation of fraudulent kick-back schemes, and exploitative operators. These practices can endanger the lives and well-being of people who seek these facilities.[127]

Due to the protective nature of housing and shelter vis-à-vis SUD and overdose, this report proposes a number of recommendations to improve access to this critical social determinant of health, including stronger state oversight of recovery housing. Recommendations related to housing and homelessness are included in Table 15.

Table 15. Recommendations related to housing and homelessness

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected
61	Continue to oversee the implementation of the Department of Corrections' Homeless Mitigation Plan.	High	DOC	Improve housing/Reduce homelessness
62	Consider the recommendations issued by the Minnesota Advisory Committee to the U.S. Commission on Civil Rights to expand equitable access to housing.	High	Minnesota Housing Finance Agency	Improve housing/Reduce homelessness
63	Expand Harm Reduction, Health, and Housing grants program administered by MDH and other programs that facilitate access to treatment for substance use disorders and other social supports for people experiencing homelessness.	High	MDH	Improve housing/Reduce homelessness
64	Ensure the availability of Housing First models, including for people with warrants, with severe mental health issues, and with severe substance use disorders.	Medium	Minnesota Housing, Minnesota Interagency Council on Homelessness	Improve housing/Reduce homelessness
65	Implement recommendations from the Task Force on Shelter, including creating an Ombuds for Shelter Oversight.	Medium	DHS, Minnesota Interagency Council on Homelessness	Improve housing/Reduce homelessness
66	Designate funding for tailored shelter settings that can meet the needs of diverse populations.	Medium	DHS, Minnesota Interagency Council on Homelessness	Improve housing/Reduce homelessness
67	Enact and enforce legislation that prohibits the criminalization of homelessness.	High	DPS	Improve housing/Reduce homelessness

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected
68	Increase state oversight of ongoing homeless encampments and sweeps.	Medium	DHS, DPS, MDH, Minnesota Interagency Council on Homelessness, OAR	Improve housing/Reduce homelessness
69	Study alternatives to homeless encampments like temporary shelter facilities, temporary authorized encampments, and safe parking lots.	Low	DHS, Minnesota Interagency Council on Homelessness	Improve housing/Reduce homelessness
70	Create policy that homeless shelters may not deny access to people seeking shelter based on mental or chemical health status.	Low	DHS, DPS, MDH, Minnesota Interagency Council on Homelessness	Improve housing/Reduce homelessness
71	Regulate recovery homes to ensure high quality services.	Low	DHS	Improve housing/Reduce homelessness
72	Pass legislation to pre-empt local 911 nuisance and "crime-free housing" ordinances.	Medium	DPS, Minnesota Housing, Minnesota Interagency Council on Homelessness	Improve housing/Reduce homelessness
73	Amend MN Stat 504B.171 to remove requirements that residential leases include drug-free provisions and anti-sex work provisions.	Low	DPS, Minnesota Housing, Minnesota Interagency Council on Homelessness	Improve housing/Reduce homelessness
74	Ensure local-level implementation of changes to Minn. Stat. 504B.205 subd. 2 and 3, which bar landlords from penalizing tenants for calling police or emergency services for health crises (including overdose) and preempts inconsistent local ordinances or rules.	Low	Minnesota Housing	Improve housing/Reduce homelessness

Key Acronyms: Minnesota Department of Corrections (DOC); Minnesota Department of Health (MDH); Minnesota Department of Human Services (DHS); Minnesota Department of Public Safety (DPS); Minnesota Office of Addiction and Recovery (OAR)

Employment

> "The judge lets them go … They do well for three, four months. Now what? Now they need housing. They need a job. 'Oh, sorry, you've got five felonies. Sorry, you can't get a job.'"

> "When you're looking at jobs and backgrounding and licensing, and you hear these anecdotal stories of they might have had an addiction that led to some criminal activity, or their significant other had criminal activity. So, they have these things on their record or all of these stories, and then they're automatically disqualified, or they're disqualified from jobs that would actually help them, prevent them from getting back into that situation in the first place and provide more stability for their kids."

Employment is key to income stability and linked to a number of health outcomes. Despite this, employment is difficult to obtain and maintain for many PWUD due to prior criminal convictions and punitive policies, such as employment-related urine drug screens.[128] As noted in the Year 1 Report, removing barriers to employment reduces recidivism, offers financial stability, and has community-wide benefits from tax revenues. Key informants noted that the lack of employment opportunities for people with criminal records is a major obstacle to their reintegration into the community and a barrier to recovery.

As of October 2021, Minnesota was one of only 15 states that extended its "ban-the-box" laws to private employers.[129] These laws prohibit employers from asking about a job applicant's criminal history until the applicant has been selected for an interview or offered employment. (The law does not apply to the DOC or other agencies that are obligated by statute to consider employees' criminal history during the hiring process.)

Nevertheless, Minnesota retains many legal provisions related to occupational and business licensing and the ability of employers to discriminate based on prior convictions. Employers in Minnesota can require drug testing for broadly: allowable reasons to drug test include after a job offer has been extended, during a routine physical examination, random testing for certain specialties, and when there is reasonable suspicion of substance use that violates employer policy or caused an injury or accident, or during treatment for SUD or up to two years after.[130]

A less punitive approach is for lawmakers to pursue policies that support PWUD and with drug felony convictions attain employment, including by continuing to extend laws in the spirit of "ban the box" and reforming DHS' background check process, which has been discussed at the state legislature for at least several years.

The evidence suggests a set of recommendations to support PWUD gain and maintain employment. If enacted, these would have wide-ranging benefits for all members of the community.

Table 16. Recommendations related to the employment of PWUD

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected
75	Increase funding for recovery-friendly workplace programming.	Medium	DHS, MDH	Improve employment, Reduce poverty
76	Allocate funding for "supported employment" programs for people with substance use disorders and serious mental health issues.	Medium		Improve employment, Reduce poverty
77	Establish minimum wage laws to a level sufficient to allow a full-time worker to rise above the poverty line and obtain stable housing.	High	Department of Labor and Industry	Improve employment, Reduce poverty
78	Implement findings from the DHS background study task force.	High	DHS, OAR	Improve employment, Reduce poverty
79	Improve compliance and enforcement of "ban the box" provisions.	Medium	MDHR	Improve employment, Reduce poverty
80	Establish that it is state policy to do business only with contractors that have adopted and employ written policies, practices, and standards that are consistent with the "Ban the Box" requirements applicable to public employers.	Medium	MDHR	Improve employment, Reduce poverty
81	Consider modifying criteria for whether convictions are directly related to employment in line with the National Employment Law Project model.	Medium	MDHR	Improve employment, Reduce poverty
82	Extend Minn. Stat. Ann. § 364.03, Subd. 1., which describes when convictions may be disqualifying, to include private employers.	Medium	MDHR	Improve employment, Reduce poverty
83	Amend Minn. Stat. Ann. § 364.021(a) to prohibit a public or private employer from inquiring into, considering, or requiring disclosure of the criminal record/history of an applicant until a conditional offer of employment, regardless of whether there is an interview.	Medium	MDHR	Improve employment, Reduce poverty
84	Extend the "Ban the Box" statutes governing evidence of rehabilitation to private employers.	Medium	MDHR	Improve employment, Reduce poverty

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected
85	Amend Minn. Stat. Ann. § 364.05 to add protections associated with "Ban the Box" laws, for example, by requiring written notice before a final decision to deny employment or licensure.	Medium	MDHR	Improve employment, Reduce poverty
86	Amend Minn. Stat. Ann. § 364.05, requiring employers to provide written notice after denial of employment or licensure, by extending it to private employers.	Medium	MDHR	Improve employment, Reduce poverty
87	Consider policies that address the use of an individual's criminal-legal system involvement in post-hiring adverse employment actions (i.e., discipline and/or termination).	Low	MDHR	Improve employment, Reduce poverty
88	Restrict drug testing of job applicants by private employers to safety-sensitive industries, with exceptions for when such testing is required by federal law. Increase specificity around the definition of safety-sensitive industries to limit net-widening.	Medium	MDHR	Improve employment, Reduce poverty

Key Acronyms: Minnesota Department of Health (MDH); Minnesota Department of Human Rights (MDHR); Minnesota Department of Human Services (DHS); Minnesota Department of Public Safety (DPS); Minnesota Office of Addiction and Recovery (OAR)

Consumer Finance

For people who use drugs, contact with the criminal-legal system can have negative impacts on their financial security throughout and after the process. This burden is felt most acutely by African Americans.[131]

In response, Minnesota has made several important policy changes to limit the impact of fines, restitution, and fees that may be imposed on people in the criminal-legal system. For example, state law no longer allows the revocation of drivers' licenses and extensions of probation due to nonpayment. Still, a recent report from the Robina Institute focused on fines and fees imposed at the moment of criminal conviction found that two key policy improvements are needed: first, to require that a person's ability to pay is assessed before a fine or fee is imposed, and second, to establish or adjust the fine or fee amount based on the person's ability to pay. Additionally, there is wide variation across the state around the ways waivers for financial obligations are granted with discretion by the court, sheriff, corrections, and other agencies. Establishing consistent policies, like waiving financial obligations for people receiving means-tested public benefits, would enhance equity and consistency.[132]

Key informants discussed the relationship between financial insecurity and cycles of returning to substance use and reincarceration. Often, the combination of unstable housing and a lack of financial support leads people back to environments where drug use is prevalent. Recommendations therefore focus on reducing the financial obligations faced by people with criminal-legal system involvement.

Table 17. Recommendations related to consumer finance

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected
89	Consider the recommendations in the National Center for Access to Justice's Fines and Fees Index.	Medium	Minnesota Judicial Branch, DPS, Board of Public Defense	Reduce poverty
90	Review data around legal financial obligations incurred after incarceration, including child support policies. Consider implementing automatic freezing of obligations during incarceration and integrating payment assistance into reentry programs.	Medium	DOC	Reduce poverty
91	Consider the impact of mandatory child support payments on people with other financial legal obligations and possible policy responses.	Low	DOC, DPS	Reduce poverty
92	Fund programs that provide financial guidance to people entering the criminal-legal system, and as they reenter the community after incarceration, to help minimize the impact of incarceration on personal debt and credit.	Low	DOC, Minnesota Judicial Branch, DPS	Reduce poverty
93	Enact strong protections against high bank overdraft fees.	Low	Minnesota Department of Commerce, Attorney General	Reduce poverty
94	Pass legislation to facilitate guaranteed income programs.	Medium	Department of Commerce, DHS	Reduce poverty

Key Acronyms: Minnesota Department of Corrections (DOC); Minnesota Department of Human Services (DHS); Minnesota Department of Public Safety (DPS)

Access to Public Benefits

> "Youth who are college students, it's almost impossible oftentimes for them to get food stamps or other supportive resources, EBT, et cetera, because there's all these weird, horrible stipulations in place. So when you enter or start college, oftentimes they lose their benefits. And when they lose their benefits, they're destabilized."

As described in the initial report, public benefits provide critical access to other social determinants of health named in this report, and drug felony convictions can restrict access to these benefits.

Minnesota is one of 24 states that place a modified ban on federal food assistance benefits (SNAP) as well as benefits from the Minnesota Family Investment Program (MFIP), Minnesota's Temporary Assistance for Needy Families (TANF) program.[133] While the state recently eased its testing conditions to no longer disqualify people with drug convictions from receiving benefits, it retains the ability to conduct random drug testing within ten years of a drug felony conviction for SNAP and MFIP recipients. The county must provide resources about treatment for SUD to people who test positive for drugs.[134] This perpetuates stigma associated with drug use, and research shows that even modified bans "are not inherently less punitive" than full bans.[135]

The recommended best practice is to opt out from restrictions on benefits for people with drug felony convictions as far as the federal law[12] governing the bans allows. Twenty-five states and DC have taken this step, including Mississippi and South Dakota, which moved from full bans on benefits for people with drug felony convictions to fully opting out.[136] This key recommendation is included below.

Key informants highlighted the role that access to public benefits play for people who are attempting to cease substance use or enter long term abstinence from all substances.

Table 18. Recommendation to improve access to public benefits

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected
95	Eliminate random drug testing for SNAP and TANF beneficiaries with felony drug convictions.	Low	DHS	Reduce poverty

Key Acronyms: Minnesota Department of Human Services (DHS)

[12] The 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA).

Education

> "School guidance counselors, school nurses, school homelessness liaisons … so many of those people are also the first line when it comes to youth who use substances, with preventing youth from getting kicked out of school, preventing youth who use drugs from criminal records, having arrests."

The initial report laid out how drug felony convictions can pose barriers to accessing education, and how higher education can lead to employment and higher incomes. Even before a child has a criminal record, however, schools can either act as entry points into the criminal-legal system or support students to avoid the system.

As of 2022, 22 US jurisdictions, including Minnesota, did not require a drug-related incident at school to be reported to law enforcement.[137] This is an evidence-based approach that encourages a non-punitive response to drug-related incidents. However, other factors, like the presence of school resource officers and exclusionary discipline practices like suspensions and expulsions, can promote punitive or exclusionary approaches to drug incidents at school that can have long-term negative consequences.[138]

A history of incarceration poses a massive barrier to postsecondary education. However, Minnesota is one of only two states (Maine is the other) with three out of four recommended building blocks in place for ensuring that high-quality post-secondary education is accessible to currently and formerly incarcerated people, as recommended by the Council of State Governments' Justice Center (no state has all four building blocks in place):[139]

1. Funding: State and Federal funding streams may be used for programs both during and after incarceration.
2. Offerings: Minnesota provides incarcerated people with a range of programs and training for which there is employer and industry demand.
3. Incentives and Supports: Minnesota provides incentives and other support to encourage postsecondary education.

Minnesota lacks a building block around eliminating statutory and/or administrative restrictions that limit eligibility for postsecondary education while incarcerated. Among other restrictions, access to post-secondary education programs is based on behavior and length of sentence.[140]

Finally, access to evidence-based drug education curricula and counseling services can support students' health and wellbeing. The evidence suggests four recommendations to help all students achieve their full educational potential.

Table 19. Recommendations to increase educational opportunities for PWUD

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected
96	Consider legislation based on the findings from Education Minnesota's report to enhance restorative and trauma-informed schools in Minnesota.	Medium	DOE	Improve education
97	Pass a Model School Response to Drugs and Drug-related Incidents Act.	Low	DHS, DOE, DPS	Improve education
98	Direct state agencies to assess schools' drug education programs and drug counseling services for their adherence to evidence base.	Low	DOE, Minnesota State Colleges and Universities	Prevent people from developing substance use disorders
99	Conduct a review statutes and rules to understand the ability of the state and private and public post-secondary institutions to restrict or deny access to student housing, aid, scholarships, or ability to participate in student government, activities, or sports based on drug arrests or convictions.	Low	DOE, Minnesota State Colleges and Universities	Improve education, Reduce poverty

Key Acronyms: Minnesota Department of Education (DOE); Minnesota Department of Human Services (DHS); Minnesota Department of Public Safety (DPS)

Children and Families

> "The system is just really incredibly ineffective at responding in a meaningful way to families and is resorting to, oftentimes, removal pretty early on. And when they remove, they have a really hard time reunifying. And as we know with substance use, there's oftentimes relapse - with the timelines in child welfare in Minnesota, we have pretty strict timelines in order."

> "Instead of bringing a family in based solely on the fact that this parent was found to have used an illegal substance, assess for child safety and give them the option to voluntarily engage in treatment services and supports, but not mandated or facilitated through child protection, defer them to a community agency that is equipped to respond to whatever the root mental health issues are that causes a person to rely on a substance."

The first report described how punitive drug laws have become a key driver of family separation, and how family separation is disproportionally imposed on Black, Native American, and Hispanic families. Research has not established a causal link between drug use and child maltreatment but has established how family separation and the foster care system harm both children and parents.

Substance use is also growing issue in the pregnant population. A nationwide study from 2017-2020 found that almost one in six pregnancy deaths were overdose-related, with a large increase in fentanyl-related deaths.[141] Pregnant people who use drugs are affected by high variability in care access by state and stigma from healthcare providers across settings.[142] They also face myriad barriers to accessing care: for example, they may fear being reported to Child Protective Services, may have trouble finding doctors who will starting seeing them during their third trimester, and may worry about the health impacts of their drug use on the baby—driving them to delay care.[143]

In Minnesota, two thirds of out-of-home foster care placements for children under age three are due to prenatal exposure to drugs or alcohol, or caretaker use of drugs or alcohol,[144] and fewer than half of children in out-of-home placements due to caregiver substance misuse were reunited with their caretaker at the end of their placement in 2021. While the number of children in out-of-home care in Minnesota has trended down over the last few years, from just over 16,000 in 2017 to approximately 12,300 in 2021,[145] racial disparities among youth in Minnesota's foster care system are among the highest in the nation. Children who identify as African American, Native American, as two or more races, and as Hispanic of any race continue to be overrepresented in out-of-home care compared to white children.

State-level indicators attest to the severity of disparities. One study found that in 2021:

- Native American children were 16 times more likely than white children to be in out-of-home care.
- Children who identified as two or more races were seven times more likely than white children to be in out-of-home care.

- African American children and children who identified as Hispanic, of any race, were two times more likely than white children to be in out-of-home care.
- 19% of youth in the state's foster care system identify as non-Hispanic American Indian. Only Montana, North Dakota, Alaska, and South Dakota have a higher representation of non-Hispanic American Indian youth in foster care.[146]

Key informants spoke at length about children and families. They said that fear of child protective services deters pregnant people from accessing treatment services, indicating a need for policy changes to support rather than penalize those seeking help. They noted that family separation due to parental substance use does not necessarily enhance child safety, saying instead that alternatives like safety plans involving the family's natural support network can lead to better outcomes for children.

Key informants also spoke about new efforts to foment change, including the State's Task Force on Pregnancy Health and Substance Use Disorders, tasked with creating protocols and guidelines for toxicology testing and creating recommendations for testing and reporting procedures to align practices across the state and use best practices, and Hennepin County's Health Equity Legal Project, which convenes parent mentors, social workers, and attorneys to liaise with hospitals and pediatric practices to link parents with histories of drug use with resources to obviate the involvement of child protective services.

In addition, Minnesota's African American Family Preservation and Child Welfare Disproportionality Act began phasing in in January of 2025 in two counties. The purpose of the act is to prevent out-of-home placement and support family reunification. This is accomplished through determining what disparities exist in the child welfare system, implementing safety plans, and limiting the use of emergency removals, foster care placements, and terminations of parental rights. The act also requires cultural competency training for people working in the child welfare system and mandates case reviews and summary reports.[147]

At the same time, key informants criticized Minnesota's approach to prenatal exposure to substances, which often triggers a punitive rather than supportive response. While substance withdrawal is not a form of neglect on its own in state law, it can be used as evidence of prenatal substance exposure, which is definitionally considered neglect. Medical experts agree that withdrawal does not necessarily mean that harm has occurred.[148] Key informants noted how parents with SUD face significant barriers to accessing treatment, particularly when facilities do not allow families or lack childcare support.

It is critically important that policies not conflate drug or alcohol use with child endangerment. As of November 2023, eight states had specific policies (in statute or otherwise) designed to support pregnant and postpartum people with SUD or who are using drugs to seek help. These laws do two things: supporting access to treatment by creating family care plans, and not automatically considering substance use during pregnancy to be child abuse or neglect. The states are California, Delaware, Maine, Maryland, Nevada, New Hampshire, New Mexico, and Pennsylvania.[149]

The following recommendations, based on research defining best practices, innovative programs in the state, and feedback from key informants, can help ensure that all families receive evidence-based, dignified support that allows them to remain together.

Table 20. Recommendations to improve children and families impacted by drug use

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected
100	Invest in macro-level policies like childcare subsidies and child cash benefits that decrease the risk of SUD.	Medium	DCYF	Reduce poverty
101	Create state policies that enable pregnant and postpartum people to seek supportive, non-punitive treatment and address the needs of families, including in family care plans by passing a "Model Substance Use During Pregnancy and Family Care Plans Act."	Medium	Task Force on Pregnancy Health and Substance Use Disorders, DHS	Improve access to substance use disorder treatment, Keep families together
102	Pass legislation removing prenatal substance exposure from the definition of child neglect in Minn. Stat. Sec. 260E.03, subdv. 15; and providing that prenatal substance exposure on its own may not be the basis of investigation by child welfare.	Medium	Task Force on Pregnancy Health and Substance Use Disorders, DHS	Keep families together
103	Pass a statewide policy around toxicology screening and testing of pregnant people, to create consistency across the state in terms of what substances are screened/tested for and what the threshold is for reporting where the test is positive for an infant.	Medium	Task Force on Pregnancy Health and Substance Use Disorders, DHS	Keep families together
104	Pass legislation that extends the timeline for permanency decisions to terminate parental rights to allow parents the opportunity to meet milestones and successfully reunify the family.	Low	Task Force on Pregnancy Health and Substance Use Disorders, DHS	Keep families together
105	Allocate funding to co-located treatment, where families can remain together.	Medium	Task Force on Pregnancy Health and Substance Use Disorders, DHS	Keep families together, Improve access to substance use disorder treatment
106	Provide funding to scale up projects like Hennepin County's Health Equity Legal Project, which brings social workers, parent mentors, and attorneys together with hospitals to identify pregnant patients who use drugs to help families access needed resources.	Medium	Task Force on Pregnancy Health and Substance Use Disorders, DHS	Improve screening and early identification of substance use disorder, Improve access to substance use disorder treatment, Keep families together

Key Acronyms: Minnesota Department of Children, Youth, and Families (DCYF); Minnesota Department of Human Services (DHS)

Immigration

Immigrants who use drugs represent an especially vulnerable population, as noted in the Year 1 Report. They can face potentially catastrophic immigration consequences for committing drug crimes, including deportation.

While immigration law is set at the federal level, there are several possible state-level strategies for minimizing the effect of punitive approaches to drug use on this group. These involve creating specific diversion programs, funding immigration-specific law clinics, and ensuring that participation records could not be used to threaten someone's immigration status in the future.

Table 21. Recommendations to improve the treatment of SUD for immigrants

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected
107	Create and fund culturally specific grant programs to prevent drug use among immigrant youth and youth from refugee families.	High	DHS, MDE, MDH	Prevent people from developing substance use disorders
108	Pass legislation to prohibit local law enforcement from collaborating with federal immigration enforcement.	Medium	DPS, Minnesota Judicial Branch	Reduce arrests, reduce incarceration
109	Allow immigrants to enter a plea or access diversion programs without requiring them to admit to violating state criminal law, thereby avoiding application of federal immigration laws.	Low	Minnesota Judicial Branch, MN Board of Public Defense	Reduce arrests, reduce incarceration, increase access to substance use disorder treatment
110	Fully fund legal services that ensure immigrants can defend against deportation and obtain immigration benefits for which they are eligible.	Low	Minnesota Judicial Branch, MN Board of Public Defense	Improve access to legal council, Reduce incarceration
111	Codify in state law the requirements of Padilla v. Kentucky so people charged with drug offenses have full and accurate advice from defense counsel about the immigration penalties of plea offers and guilty pleas.	Low	Minnesota Judicial Branch	Improve access to legal council, Reduce incarceration
112	Bring Minnesota's fifth degree possession law in line with federal immigration court standards.	Low	DPS	Reduce arrests
113	Expand access to post-conviction relief for immigrants with drug offenses by ending legal barriers to judicial review of legally invalid convictions and providing funding for counsel.	Low	Minnesota Judicial Branch	Improve access to legal council, Reduce incarceration
114	Ensure expungement does not limit a court's jurisdiction to consider other forms of post-conviction relief or access to one's own criminal case files.	Low	Minnesota Judicial Branch, MN Board of Public Defense	

Key Acronyms: Minnesota Department of Human Services (DHS); Minnesota Department of Health (MDH); Minnesota Department of Public Safety (DPS)

Expungement

> "So that we're not then putting people into a cycle of, well, you've been charged and convicted of a felony for drug possession once. Now the rest of your life, you're never going to be able to get back on your feet because we've now made it impossible for you."

Expunging criminal records can have an impact on all social determinants of health. As we outlined in the first report, expungement of criminal records related to illicit substances is recommended by ASAM, the US Civil Rights Commission, the American Public Health Association (APHA), and the Minnesota Medical Association. Key informants, too, emphasized that criminal record expungement allows people to access housing, obtain employment, and decreases recidivism, and that the process should be accessible to all.

Minnesota passed three major new laws related to criminal records reform in 2023,[150] extending its legacy as a leader in the space.

1. Expungement was made automatic for both non-convictions and a range of convictions records, effective January 1, 2025. Some drug convictions are eligible for automatic expungement for the first time. Minnesota was the twelfth state to make this policy change.[151]
2. The pardon process underwent a major overhaul. A new Commission was established to advise the three-member Board of Pardons,[152] and the Board no longer must vote unanimously.[153] This type of relief is now more widely available, and the expungement of pardoned convictions is now automatic.[154]
3. The law legalizing adult use cannabis made expungement automatic for a wide range of cannabis-connected convictions.[155] Records that did not qualify for automatic expungement may be reviewed for relief by the new Cannabis Expungement Board.[156]

Importantly, the cannabis expungement process works from the assumption that expungement is "presumed to be in the public interest unless there is clear and convincing evidence that an expungement or resentencing to a lesser offense would create a risk to public safety."[157] At the bill signing, Governor Tim Walz declared that "Legalizing adult-use cannabis and expunging or resentencing cannabis convictions will strengthen communities."[158] Lt. Governor Peggy Flanagan also affirmed that a punitive approach to drug use has not worked for Minnesotans:

> "Legalizing adult-use cannabis is about keeping our communities safe, advancing justice for Minnesotans, and investing in a strong economic future. Prohibiting the use of cannabis hasn't worked and has disproportionately harmed communities of color across the state. By expunging nonviolent cannabis convictions, we are removing the barriers that prevent thousands of Minnesotans from fully returning to work, to their communities, and to their lives. This is how we make safer communities."[159]

In enacting such policies, Minnesota policymakers are acknowledging a supportive, rather than punitive, approach to drug policy that the evidence suggests will strengthen communities. Key informants recommended that lawmakers continue to pursue expungement policies, including automatic

expungement for records related to drug use while ensuring people have access to their own records afterwards.

Table 22. Recommendations related to the expungement of criminal records

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected
115	Consider building on the new automatic expungement process and the modifications to the existing petition-based expungement for criminal convictions, including for convictions of certain controlled substance offenses.	Medium	DPS, Minnesota Judicial Branch	Improve employment, Improve access to housing, Reduce poverty
116	Grant people with cleared records the explicit right to deny and refuse to acknowledge the existence of such records.	Low	DHS, DPS	Improve employment, Improve access to housing, Reduce poverty
117	Require applications that inquire about criminal history to include a notice that cleared records should not be disclosed.	Medium	DHS, DPS, Department of Labor and Industry	Improve employment, Improve access to housing, Reduce poverty

Key Acronyms: Minnesota Department of Human Services (DHS); Minnesota Department of Public Safety (DPS)

DRUG POLICING

The Year 1 Report determined that the following drug policing policies were supported by the evidence base as having positive impacts on population health and safety:

1. Decriminalization with targeted diversion to health and social services
2. Defelonization
3. Diversion to voluntary drug treatment for people who need it and that is tailored to the individual
4. Sentence commutations

At the same time, the report established that several prevalent drug policing policies and interventions do not meet the criteria for successful drug policies: arresting people for drug use and criminal repercussions for simple possession; imprisoning people for drug use; drug paraphernalia laws; drug-induced homicide laws; and opioid-related drug seizures.

Evidence was mixed or limited for depenalization; de facto and de jure police diversion; decriminalization with civil or administrative penalties; decriminalization with no sanctions attached; and regulation.

This section offers recommendations toward bringing Minnesota's current approach to drug policing in line with the evidence base.

Decriminalization

> "Criminal penalties for simple possession yield numerous real harms to population health. These harms include, but are not limited to, arrests, convictions, incarcerations, criminal records, and diverted public investment. And, you know, implicitly folded in there are the social determinants of health that are affected by criminal records."

The first report determined that prohibition-type approaches including arresting people for drug use and criminal repercussions for simple possession, imprisoning people for drug use, drug paraphernalia laws, drug-induced homicide laws, and opioid-related drug seizures did not meet the criteria for successful drug policies as they were associated with negative health and safety outcomes.

That report reviews a paper by Hughes, Stevens, Hulme, and Cassidy (2019) that analyzed models of decriminalization and delineated the advantages and disadvantages of the different models (see Table 23). All models reduced the burden on the criminal-legal system. A few increased voluntary access to treatment, and almost all reduced drug-related health harms and increased social reintegration. The risks of net-widening and differential application, as well as start-up costs, were variable.

Table 23. Summary of findings from Hughes et al. (2019), from Year 1 Report

	Model	Start-up requirements	Prevalence of recent use	Criminal - legal system burden	Treatment/ harm reduction service access	Drug-related health harm	Social reintegration	Net-widening	Differential application
1	Depenalization	Low	No change	↓	↑(v)	No change	No change	High	High
2	Police diversion (de facto)	Moderate	No change	↓↓	↑↑↑↑	↓↓	↑↑	Low	High
3	Police diversion (de jure)	High	No change	↓↓	↑↑↑↑↑	↓↓↓	↑↑	??	Low
4	Decriminalization with civil or administrative sanctions	Moderate	No change	↓↓↓	↑↑(v)	↓	↑↑	High	Moderate
5	Decriminalization with targeted diversion to health/social services	Very high	No change	↓↓↓↓	↑↑↑	↓↓↓	↑↑↑↑	Low	Low
6	Decriminalization with no sanctions attached	Moderate	No change	↓↓↓↓	↑↑(v)	↓↓	↑↑↑	Low	Low

Of the six approaches analyzed by Hughes and colleagues, the most successful was "Decriminalization with targeted diversion to health and social services." This approach had the most positive impacts on health and safety with the fewest opportunities for net-widening and differential application.

While "Decriminalization with no sanctions attached" had similar positive impacts on health and safety, it did not have enough evidence to meet our research criteria for successful drug policy outines in the Year 1 Report. Specifically, Hughes and colleagues' analysis of the model's advantages and disadvantages were drawn primarily from the case of Germany, which in 1994 decriminalized possession of small amounts of drugs for personal use if there was no danger to third parties. There was wide variation in how the policy was implemented across the country's 16 states.[160]

Nevertheless, as outlined in the first report, this model is supported by multiple normative bodies on the strength of the evidence against prohibition. These groups include ASAM and APHA, as well as Health Canada Expert Task Force on Substance Use, and international bodies (the International Guidelines on Human Rights and Drug Policy, the Global Commission on Drug Policy).

Oregon's Measure 110

In 2020, Oregon voters approved a ballot initiative known as Measure 110, or the Drug Addiction Treatment and Recovery Act. The measure had two pieces: the first changing the legality of possession of controlled substances, and the second expanding health services. Measure 110 made Oregon the first state in the country to remove criminal penalties for personal possession of small amounts of all drugs. Prior to Measure 110, possession of small amounts of drugs were charged with a misdemeanor criminal offense. After, possession resulted in a citation and fine of up to $100 that could be waived if the person submitted verification of undergoing a health needs screening to a court. Failure to pay the fine would not lead to additional penalties or incarceration.

The second part of the initiative allocated hundreds of millions of dollars annually to a broad range of services for people with SUD, including low-barrier treatment for SUD, housing, peer support, and others. Funding primarily was sourced from state tax revenues from cannabis sales. Services were evidence-based and provided at no cost to the individual. Drug possession was recriminalized in 2024.

In addition, new evidence supporting Oregon's four-year period of decriminalization has been published since we submitted our initial report.

- Contrary to what opponents to Measure 110 claimed, there was no association between decriminalization and fatal overdose rates. Instead, the authors found that the spread of fentanyl across Oregon acted as a confounder, obscuring the relationship between the policy change and overdose rates.[161]
- As of November 2024, 42 newly established Behavioral Health Resource Networks (BHRNs) have received $265 million to provide comprehensive treatment, harm reduction services, and recovery supports to Oregonians free of charge. Eleven Tribes received $11.4 million.[162]
- Engagement with the BHRN's continues to increase, with 300,000 client encounters during the most recent quarterly reporting period, compared to 87,000 encounters 21 months ago, the first quarter in which data was available, a 340% increase. Services include street outreach, peer services, job services, and MOUD, among others.[163]

Earlier research established that:

- Measure 110 was associated with a significant decrease in arrests for drug possession. It did not increase arrests for crime overall or violent crime.[164] Criminal records can pose barriers to employment, housing, and education, as laid out in the first report.

- The same study found an increase in displaced arrests, wherein law enforcement substitute arrests for other crimes in lieu of arrest for drug or paraphernalia possession (for example, curfew violations, loitering, vagrancy).[165] This indicates the need to gain law enforcement's buy in for such a change.
- Measure 110 saved Oregonians $40 million that would have otherwise been spent on probation, jail, and supervision.[166]

Finally, there is a wealth of evidence delineating the harms of criminalization across health, public safety, and social determinants of health outcomes.

This report therefore recommendations that Minnesota 1) decriminalize the personal possession and use and sharing of drugs with no sanctions attached, while 2) creating voluntary, community-based pathways to health, harm reduction, and social services for people who want them (i.e. decriminalization with targeted diversion to health and social services). Consistent with Hughes and colleagues review, the recommendation includes application of multiple models within a single location, which is based on the totality of the evidence, including the myriad harms of prohibition policies, evidence of the benefits of alternative approaches, and the guidance of key expert groups.

There is also evidence that in the case of Oregon, state leaders could have done more to ensure Measure 110's success – learnings that are integrated into the recommendations below. This includes:

- The need for training and education for law enforcement officers. Oregon's legislature declined to fund a $50,000 online course that would have instructed officers on how to use the new law. The legislature also did not work to bring police leadership, who had campaigned against the measure, on board.[167]
- The state's judicial department could have supported implementation by printing a new specialized ticket for drug possession that would have prominently featured the treatment hotline number and information about waiving the associated fee. Instead, police used the standard ticket without the special information.[168]
- A state audit found that the Oregon Health Authority had not provided adequate support to a citizen's panel overseeing the disbursement of funds,[169] meaning the funds were deployed very slowly – thereby preventing the implementation of measures like street outreach that might have addressed some portion of homelessness and public drug use.
- Homelessness in Oregon has increased in association with eviction rates, housing costs, and limited housing supply.[170] It also has the highest rate of chronic homelessness in the nation.[171]
- Nevertheless, public drug use was part of the reason Measure 110 lost the support of some original proponents. Thus, the recommendations below ask lawmakers to consider ways to address public drug use—importantly, without reverting to criminalization—so that the public does not ask for decriminalization's reversal.

Given the many forms that decriminalization can take, there is not an exact account of the number of countries implementing the policy. A 2016 study counted roughly 30 countries implementing some form

of the policy, depending on the definition used.[172] While the policy has received endorsements from numerous important bodies and journals over the last decade, decriminalization is not in fact a new approach. The effectiveness of such a policy will be determined by the policy details that make it meaningful or not; supportive of not. For example, some countries that have decriminalized personal possession have made the thresholds defining the personal amounts of drugs so low as to be meaningless; countries in Southeast Asia have replaced incarceration with forced treatment centers that are akin to labor camps.[173]

In the US, several states had introduced legislation to decriminalize personal possession of controlled substance as of July 2022, including Kansas, Maine, Maryland, Vermont, and Washington.[174] Oregon had a law that decriminalized personal possession for roughly four years before it was rolled back in September 2024.

Vermont and Rhode Island have decriminalized the possession of non-prescribed buprenorphine, in recognition of the harms associated with entanglement with the criminal-legal system, and the protective public health effects of buprenorphine on overdose, whether it is obtained with a prescription or not.[175]

In addition, decriminalization must be paired with investments in healthcare, harm reduction, and social determinants of health supports to fully realize its benefits.

Finally, it is important to clarify what decriminalization can and cannot do.

- ⇒ It cannot end an overdose crisis that is driven by an adulterated, toxic drug supply where people lack information about the content of their drugs.
- ⇒ It cannot end homelessness in cities and towns where there is not enough high-quality, supportive housing.
- ⇒ It cannot end public behavioral health crises at a time when behavioral health providers are closing across the state, especially in rural areas.

That said, the evidence suggests that decriminalization, if implemented correctly and paired with investments in health and social supports, can have important positive public health and safety outcomes:

- ⇒ It can reduce people's contact with the criminal-legal system
- ⇒ It can reduce racial disparities in the criminal-legal system
- ⇒ It can encourage people to seek treatment and harm reduction services
- ⇒ It can begin to dispel stigma associated with drug use and PWUD

As ever with policy, the success of the policy rests in the details. Thresholds, social supply and "user-dealers," and voluntary connections to services are three aspects of decriminalization that require special attention.

Thresholds

In the context of decriminalization of personal and social use and possession, using drug weight and quantity thresholds to distinguish between decriminalized activities, like personal possession, and criminalized activities, like drugs sales, are often unscientific and arbitrary.[176] Best practice indicates that the state should have to prove intent to supply for remuneration in order to reduce the number of Minnesotans who are pulled into contact with the criminal-legal system.

Social Supply and User-Dealers

Social supply refers to the socially motivated sharing of drugs among friends and peers that is different from commercially motivated dealing.[177] In some countries, there is more normative recognition of the concept than there is in the US, and it is referenced in law as distinct from drug sales in various ways. For example:

- Australia: Social supply and minimally commercial supply are referred to by name in court, and the weight of seizures is used to determine the level of commerciality and thus the seriousness of the crime.
- Belgium: The term "social supply" is not common, but the country uses a "tolerance model" for cannabis suppliers and growers that sell "at cost," as distinguished from commercial sellers.
- England Wales: Sentencing frameworks using mitigating factors like non-commercial or minimally commercial supply to protect against disproportionate sentencing.
- New Zealand: Social supply is recognized as a concept and in policies discussions, but it is not clear how it affects court or policing practices.[178]

The concept of social supply is not as developed in US policies as is internationally, and most US jurisdictions continue to rely on "relatively harsh threshold quantities to determine 'harm' and sentences or tariffs that lack the nuance on supply differences."[179]

Similarly, the term "user-dealers" is used to describe people who sell drugs primarily to support their own problematic drug use. Both social supply and user-dealers are concepts meant to nuance the picture of drug suppliers and governments' responses to them. In accordance with the Global Commission on Drug Policy, this report recommends that policymakers expand decriminalization beyond personal use and possession to include the practice of drug sharing and people who sell drugs to support their own drug use.[180] If the goal of governments is to disrupt large markets, then an appropriate approach is to target people who supply the drugs with purpose of generating a profit.

Practically, in Minnesota, this will require narrowing the definition of "sell" in statute to exclude social supply and selling to support one's habit. The current definition is quite broad: (1) to sell, give away, barter, deliver, exchange, distribute or dispose of to another, or to manufacture; or (2) to offer or agree to perform an act listed in clause (1); or (3) to possess with intent to perform an act listed in clause (1).[181]

Voluntary Connections to Services

In the context of decriminalization, policymakers should identify and fund programs to discourage and reduce drug consumption in public areas that do not rely on criminalization or exacerbate disparities for people who are experiencing homelessness and who lack private spaces to use drugs.

Voluntary, harm reduction-based connection to services can be offered by community-based programs like Let Everyone Advance with Dignity (LEAD), which operates effectively on Minneapolis' Lake Street.[182] (It is a model employed nationally.)

Key components of the model include the following:

- Provides an alternative response to non-violent community safety issues, like shoplifting and drug use in bathrooms.
- Provides intensive, long-term case management for as long as people want it
- Does not require police contact. Referrals to the program can come from residents, small businesses, LEAD case managers, and self-referrals.
- Does not impose sanctions and is not court-based.
- Takes a harm reduction approach that doesn't require abstinence and does not establish treatment as a precondition for other supports.

Also recall the public health and social services interventions like OPCs and housing can help to address public drug use.

Recommendations below build from the evidence base generated by the past several decades as well as from Oregon's four-year experiment with decriminalization.

Table 24. Recommendations related to decriminalizing personal possession of illicit drugs

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
118	Remove criminal and civil penalties for the personal and social use and possession of illicit drugs by adults (i.e. sharing) after investing in health, harm reduction, and social supports. People using drugs should be offered all available health resources and social supports but should not be criminalized for not participating in offered services.	High	DHS, DPS, MDH	Reduce arrest, Reduce incarceration, Improve access to substance use disorder treatment	Shift towards a more public health approach within our criminal-legal systems, Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
119	Consider policies and fund programs to discourage and reduce drug consumption in public areas that do not rely on criminalization or exacerbate disparities for people who are experiencing homelessness and who lack private spaces to use drugs.	Medium	DHS, DPS, MDH	Improve community safety, reduce arrest	Shift towards a more public health approach within our criminal-legal systems
120	Narrow the definition of "sell" in Minn. Stat. Sec. 152.01, Subd. 15a., and evaluate ways of narrowing the definition to exclude sharing of drugs without a profit motive.	Low		Reduce arrest, reduce incarceration	Shift towards a more public health approach within our criminal-legal systems
121	Avoid creating weight or other fixed thresholds to determine personal and social supply. Instead, focus on proving intent to supply for remuneration.	Medium	DPS, Minnesota Judicial Branch	Reduce arrest, reduce incarceration	Shift towards a more public health approach within our criminal-legal systems
122	Provide training and clear guidelines to law enforcement to operate under decriminalization.	High	DHS, DPS, MDH	Reduce arrest, reduce incarceration	Shift towards a more public health approach within our criminal-legal systems
123	In the context of decriminalization, remove law enforcement's ability to seize personal or social amounts of illicit drugs.	Medium	DPS, MDH	Reduce arrest, reduce incarceration	Shift towards a more public health approach within our criminal-legal systems
124	Fund education campaigns about decriminalization, to (1) reduce misinformation about what the policy change is and does, and (2) targeted at people who use drugs, to protect their civil liberties and support their decision-making around drug use.	Medium	DHS, DPS, MDH	Reduce arrest, reduce incarceration	Improve the autonomy and dignity of people who use drugs
125	Eliminate all criminal and civil penalties for buprenorphine possession by creating a carve-out under the state's Controlled Substances Act.	Low	DPS, MDH	Improve access to medications for opioid use disorder, Reduce arrest, reduce incarceration	Shift towards a more public health approach within our criminal-legal systems

Key Acronyms: Minnesota Department of Health (MDH); Minnesota Department of Human Services (DHS); Minnesota Department of Public Safety (DPS)

Concurrent Change

The following recommendations can take place concurrently with decriminalization or precede it.

Figure 2. Sequential Intercept Model

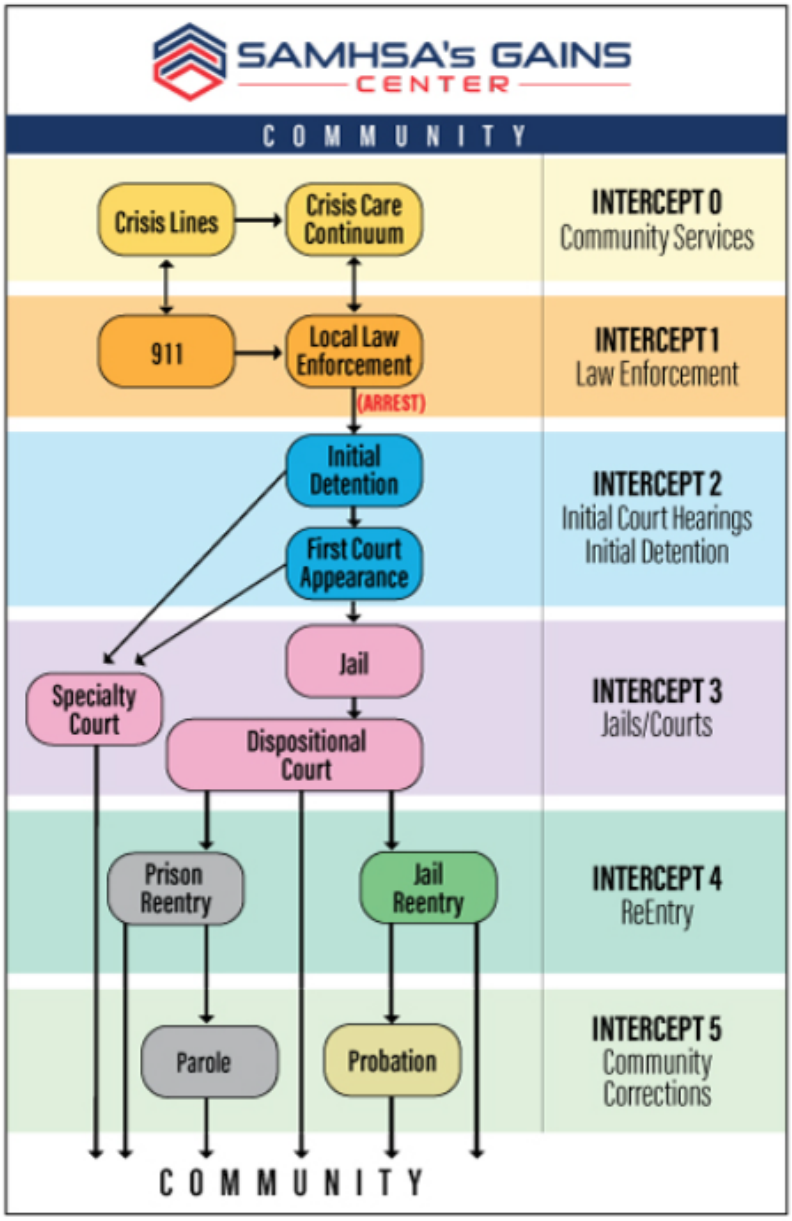


Image source: https://www.samhsa.gov/communities/criminal-juvenile-justice/sequential-intercept-model

Off-Ramps

The first report described how "off-ramping" people from the criminal-legal system can happen in the context of prohibition-based drug policies and under alternative legal frameworks like decriminalization. While off-ramping can occur at every stage of the Sequential Intercept Model, the most harm is avoided by disentangling from the system as early as possible.

As noted in the Year 1 Report: "The Sequential Intercept Model maps the paths of people with mental health and substance use disorders through the criminal-legal system, from community services and law enforcement through to jails and prisons and community corrections. The model has been successfully applied by communities seeking to address the impact of the overdose crisis by helping community partners identify places where people can access health and social services supports to increase prevention, treatment for opioid use disorder, reduce overdose, and disentangle people from the criminal-legal system."

Community Responder Models

> "It's almost a guarantee that the first couple calls of the day for us is going to be a citizen driving to work and seeing somebody sleeping on a park bench or they're sleeping in the bus shelter or something along those lines, and we just can't not respond. But our response today is with a uniformed police officer sometimes, too, when, you know, is there a homeless outreach team? Is there a case manager or somebody that that call could go to when they just go down and check on them."

Community responder models can take various forms, and they are sometimes referred to as Alternative Crisis Response or Mobile Crisis Response programs. In general, the programs aim to off-ramp people from the criminal-legal system by creating an alternative to 911 for calls for service that do not require a law enforcement response. Calls for service occur at Intercept 0 and 1 of the Sequential Intercept Model: community services and law enforcement.[183]

Though they have existed for decades, the programs are increasingly popular: from January 2020 to July 2022, at least 19 of the top 50 law enforcement jurisdictions, including Minneapolis, created new first responder programs that offer alternatives to law enforcement.[184]

As a state-based example, the Minneapolis Behavioral Crisis Response program was established in 2021 and is operated by Canopy Roots, a community-based organization. Since launching, it has responded to more than 20,000 calls with zero injuries to recipients or responders and hired a team of responders of mental health professionals whose identities reflect the communities they serve.[185] Responders are unarmed and respond 24 hours a day, seven days a week, via 911.[186]

Key informants interviewed as part of this project offered several opinions about community responder models. Social services providers advocated for increased investment in these programs, as they have witnessed police presence in behavioral health crises escalate or cause harm. It also well-documented in the literature that law enforcements' presence at the scene of behavioral health crises often results in injury and death.[187] Key informants for this research study working in the law enforcement field also understood the limitations of a law enforcement response to behavioral health issues and appreciated partnerships with behavioral health workers. One senior law enforcement key informant spoke to the utility of behavioral crisis response teams and wondered if the same approach could be applied to crisis situations involving drug use (some programs exclude responses to these situations):

> "We've got the behavioral crisis response team advocate that we quadruple that effort. They're great, and they can take some of that off of [law enforcement] and, or help more professionally train people that can deal with that. But that type of approach to drugs might be worth considering down the line where we have... the behavioral crisis response that can help take some of that work into maybe a more, more trained group of people that can handle that. But it's kind of overlaps with law enforcement, medical and behavior."

Another senior law enforcement informant appears to appreciate the alternative response teams staffed by law enforcement officers and civilians but stated that the preferred approach would be to remove law enforcement from the teams completely:

> "We have our substance use response team and we have our core response team, which is two officers, a [registered nurse], two social workers with another part time social worker who does reentry work out of the jail with probation … I think ideally, we'd like to be out of that side of it, right out of the social, you know, even with our substance use response team, I'm really happy that they're with us, but we only know what we know as cops… I'd like to keep them embedded with my agency, but I would so love to have them tied to [county health and human services] because they're the experts in treatment. We're not.

Post-overdose response required special consideration, largely due to the stigma around these events and the discrimination faced by PWUD in Minnesota, especially Native American people and Black people. One key informant who works for a social services agency that serves Native American people spoke about the hurdles her community faces when trying to access emergency care, stating that a dedicated overdose response team would benefit her community.

> "One of the things that also concerns me, is the response times for overdoses. When you say that there's an overdose, the response time seems to take longer for everyone. And so, we instruct people, do not say that it's an overdose, say they are unresponsive, and then when [EMTs] arrive, you can tell them the rest of the story and what's going on… I think that having an overdose response team, especially in…areas where people are overdosing pretty much every day, that would be an amazing thing to have."

Alternative crisis response initiatives have at times avoided responding to overdoses. But the Minneapolis Police Department's Consent Decree with the Department of Justice states that "The City's Policies and Protocols shall not exclude Mobile Crisis Response as a potential response solely because the 911 caller is a third-party or because substance use is involved.[188] Similar language has appeared in other Consent Decrees, including Louisville's.[189]

Post-overdose Response Teams

Post-overdose response teams are a special type of behavioral crisis response that connects providers with people who have experienced an overdose in the roughly 72 hours following the event. The intervention is less of an "off-ramp" than some of the other strategies in this section because it is often not occurring in lieu of a criminal-legal system response.

That said, the goal is to bridge people to harm reduction services and tools like naloxone, make warm hand-offs to social services providers, and connect people to evidence-based treatment or recovery services as needed.[190] Only post-overdose response programs that link people to social services have been associated with community-level declines in overdose.[191]

There are harms associated with improperly implemented post-overdose response programs, especially when non-health-related personnel or inadequately trained teams go to people's homes. This includes subjecting people who have experienced an overdose and their families to additional trauma, putting them at increased risk of arrest or incarceration which increases overdose risk, and directing people to treatment options that are not evidence-based.[192]

While alternative crisis response and community response models are typically implemented at the county or local level, state actions, like legislation and executive orders, can help foment their growth. For example:

- In 2020, Virginia legislators passed the Marcus-David Peters Act which mandates the creation of a community care teams in each county to respond to behavioral health crises.[193] The state provided important support by creating best practices and protocols; creating trainings and competencies for law enforcement; creating a statewide public service campaign; and providing technical assistance for counties' integration of the 911 system and a new "Marcus" alert system for behavioral health, SUD, intellectual disability, and other similar issues.[194]
- Oregon's legislature created funding incentives for communities to expand their existing crisis response systems for behavioral health issues to include community responder programs.[195]
- New Jersey created a Community Crisis Response Advisory Council to advise state legislators on best practices, including how to establish a pipeline of mental health screeners for "directly impacted communities." The Governor appoints public members with a mix of experience, including prior involvement with the criminal-legal system, expertise in crisis response and harm reduction, community advocates, and social justice and civil rights reformers, to 7 of 13 positions.[196]

Table 25. Recommendations for changes concurrent with decriminalization

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
126	Mandate that localities implement 988/911 interoperability to enhance opportunities for alternative crisis response to behavioral health matters; Allocate funding for implementation and technical assistance to localities	High	Association of MN Counties DHS, DPS	Improve access to healthcare	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
127	Expand access to alternative, non-law enforcement responses to substance use and behavioral health issues (for example, overdose, mental health crises, post-overdose response) by requiring localities to implement these programs or incentivize local jurisdictions to create new or expand existing crisis response programs by providing funding, evaluation support, and/or other technical assistance	High	Association of MN Counties, DHS, DPS, MDH	Reduce arrest, Improve community safety, Improve access to healthcare, Improve utilization of healthcare	Shift towards a more public health approach within our criminal-legal systems, Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

Key Acronyms: Minnesota Department of Health (MDH); Minnesota Department of Human Services (DHS); Minnesota Department of Public Safety (DPS)

Treatment Courts

> "When [drug court is] done right and best practices are followed, people do get their life back and they pay it forward and they don't recidivate. And so, I am… a champion of a good drug court, a treatment court."

Treatment courts and other specialty courts aim to off-ramp people from the criminal-legal system at Intercept 3 of the Sequential Intercept Model, Jails and Courts, by providing an alternative to incarceration. The first report detailed the mixed evidence for treatment courts and the variability in implementation and adherence to the evidence base from court to court and judge to judge.

Some key informants in this study who work in or as evaluators of the court system echoed this concern and advocated for a range of fixes, including:

- Providing education to court systems, including judges, about how MOUD is a gold standard treatment;
- Tailoring treatment options to the individual, including offering outpatient services when inpatient programs could disrupt their lives;
- Removing or reducing punitive responses to return to use for drug court participants;
- Ensuring that participant evaluations include metrics other than abstinence from drugs.

Some also argued that diversion programs like treatment courts should not receive funding if they are not evidence-based. They allowed that municipalities should be permitted to tailor programs to their local contexts, but that adherence to the evidence base was not negotiable.

One key informant working in the court system who found treatment courts to be effective advised that courts focus their efforts on people with 1st, 2nd, and 3rd degree drug offenses who would find more benefit from the process than people with low-level drug offenses who the court can work with using other processes.

Minnesota's drug courts are overseen by the Minnesota Judicial Branch, which convenes the Drug Court Initiative Advisory Committee to oversee implementation and funding for Minnesota's drug courts. While the state's drug courts are meant to follow a set of standards published by the National Association of Drug Court Professionals (recently rebranded as All Rise),[197] there is less explicit oversight in Minnesota than in other states. For example, per statute, Michigan's and Georgia's treatment courts are required to be certified to operate as a drug court generally, as well as to receive state funding.[198] Georgia's treatment courts must submit data quarterly to maintain their certifications.

A bill supporting Michigan's certification law articulates why a certification process is important, even while acknowledging that most courts in the state already follow best practices:

> The State Court Administrative Office (SCAO) publishes manuals and recommends a variety of evidence-based best practices for specialty courts. According to the SCAO, most courts implement at least the majority of those recommendations; however, there is no direct incentive

> for them to do so because adoption of the recommendations is not mandatory. Under the bills, as a condition of acquiring its certification, a specialty court will be required to implement, among other things, evidence-based practices. If a specialty court fails to comply with the SCAO procedures for certification, it will be prohibited from performing any of its functions, including receiving State funding, until it complies. Certification by the SCAO will ensure that Michigan's specialty courts follow the best-known approaches, as well as comply with statutory requirements. The bills will help to ensure that specialty courts provide a consistent experience for participants, and may help reduce recidivism rates, increase the effectiveness of these courts, and set participants on the best path for success.[199]

This report recommends that Minnesota establish a certification process for treatment courts to ensure they are implemented with fidelity to the evidence base and that Minnesotans' outcomes are equitable with regard to geography, race, and other identities and characteristics.

Table 26. Recommendation to enforce standards among treatment courts

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
128	Create a state-run certification to compel drug treatment courts to follow the standards maintained by the Minnesota Judicial Branch	Medium	Minnesota Judicial Branch	Reduce incarceration, Improve access to substance use disorder treatment, Improve utilization of medications for opioid use disorder	Shift towards a more public health approach within our criminal-legal systems, Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

Key Acronyms: Minnesota Department of Health (MDH); Minnesota Department of Human Services (DHS); Minnesota Department of Public Safety (DPS)

Community Supervision and Drug Testing

Drug testing is common, both in diversion programs and for people on community supervision. Operating at Intercept 5 (Community Supervision) of the Sequential Intercept Model, drug testing programs have the potential to extend entanglement of PWUD with the system needlessly.
As stated in the first report, there is no evidence that drug testing people improves public safety. Quite the opposite, more testing is associated with more violations and revocations, which detracts from community safety by putting more people in prison away from their families, schools, and jobs. Despite the lack of evidence, drug testing is both ubiquitous and heterogenous, and testing practices vary across the US as demonstrated in the cross walk of supervision agencies.[200]

Figure 3. Example policies from supervision agencies

Case Study Sites	Is drug testing a standard condition?	Fees for testing?	Violate for marijuana?	How often?
Alameda County, CA Adult Probation	Not standard, but frequently imposed.	No	No	Usually in regular PO meeting
Brazoria County, TX Adult Probation	Yes	$18.55	Yes	At PO discretion. Client must call-in daily
State of California Adult Parole	Not standard, but frequently imposed.	No	No	Usually in regular agent meeting
Hennepin County, MN Community Corrections	Not standard, but frequently imposed.	No	Rarely	At officer discretion. Client must call-in daily
Monroe County, IN Adult Probation	Yes	$25	Yes	Once per month, once every two months, or at discretion
State of Oregon Community Corrections	Yes*	No	Rarely	At PO discretion. Client must call-in daily

**In 2022, Oregon's legislature passed a reform policy that will remove drug testing as a standard condition beginning in 2023 (Oregon, 2022).*

Image source: https://www.arnoldventures.org/stories/the-fraught-and-expensive-cycle-of-drug-testing

Still, some community supervision agencies are pursuing reforms to reduce the negative impact of drug tests on violations and revocations and to implement best practices, like abolishing testing fees and incentivizing good behavior with rewards rather than penalizing positive screens.

For example, Hennepin County's reforms were highlighted by the criminal-legal system reform funder Arnold Ventures. The county implemented the following changes to align with best practices, increase efficiency, and reduce burdens on staff and clients:

1. A client must have a court order or condition of release to test in order for the Department to test them. A court order or condition of release to test occurs when a client has a documented substance use issue that relates to their likelihood of reoffending.
2. Clients who are tested must have a substance issue linked to criminal behavior.
3. Clients cannot be double tested (e.g., if they are already being tested in a treatment program, probation cannot test them).
4. Clients will not be panel tested–the department only tests for drugs of concern to the client.
5. Any marijuana testing orders must be approved by a supervisor.
6. Staff are directed to reinforce negative tests with verbal affirmation and develop an action plan in collaboration with a client in response to a positive test.
7. Testing frequency, continuance, and the staff response to results must be tied to a client's unique needs according to a substance use assessment that a client completes when they begin supervision. For example, a client with a history of drug use but who is not currently using and unlikely to relapse should be tested less frequently than someone who is beginning recovery

Hennepin County officials reported positive outcomes from the changes.[201]

Minnesota's Community Supervision Advisory Committee, tasked with developing "evidence-based, statewide standards and practices that ensure fair, effective, and consistent supervision across all jurisdictions," delivered its legislatively mandated report in November 2024.[202] The report notes that the Council of State Government's Justice Center is developing a statewide behavior response grid for people under community supervision, in collaboration with the Minnesota Rehabilitation and Reinvestment Act. The report also advises that work to "limit standard conditions for all individuals on supervision across all supervision systems and judicial districts, ensuring that conditions of supervision are directly related to the offense of the individual on supervision, and tailoring special conditions to individuals on supervision identified as high risk and high need" will transpire in 2025.

Ideally, all recommendations surfaced by the Committee relevant to drug testing will align with the evidence base.

Table 27. Recommendation to end universal drug testing

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
129	End universal drug testing as a standard condition and testing for all known substances for people on probation. The use of drug testing should be tailored to the individual and conducted only where it is materially relevant to underlying offense/reason for supervision.	Medium	DPS	Reduce incarceration	Shift towards a more public health approach within our criminal-legal systems

Key Acronyms: Minnesota Department of Public Safety (DPS)

Other Diversion Programs

With respect to other diversion programs, state legislators might create a statutory pathway to enable and fund evidence-based off-ramp programs operating at intercepts 0 and 1 of the Sequential Intercept Model like Minneapolis' LEAD (described above under Decriminalization). Minnesota already has such a program in place for intercepts 2 and 3 (initial detention and court hearings, jails and courts): Minn. Stat. 401.065 directs county attorneys to create pretrial diversion programs for adults.

Police key informants were generally supportive of diversion programs and recommended investing more funding in them. One key informant in this study recommended that local agencies utilize resources from the Police Assisted Addiction and Recovery Initiative (PAARI) to acculturate law enforcement to the utility and evidence base supporting diversion and harm reduction-based practice. However, law enforcement need not be involved in the programs.

Washington's Recovery Navigator Program is one example of a state-wide program for intercepts 0 and 1. The program is codified in state law and offers pre-arrest and pre-trial diversion programs. Similar to LEAD, it serves people who have frequent criminal-legal system contact, referrals from first responders, and referrals from other community sources. Program offerings include case management and connections to behavioral health and other services.[203]

Importantly, people must not be diverted to mandatory treatment, in the contexts of both criminalization and decriminalization, as mandatory treatment did not meet the definition of successful drug policy in the initial report.

Table 28. Recommendation to enable and fund off ramps from the criminal-legal system

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
130	Create a statutory pathway to enable and fund evidence-based "off ramps" from the criminal-legal system at intercepts 0 (community) and 1 (law enforcement) of the Sequential Intercept Model.	High	DHS, DPS, MDH	Reduce arrest	Shift towards a more public health approach within our criminal-legal systems, Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

Key Acronyms: Minnesota Department of Health (MDH); Minnesota Department of Human Services (DHS); Minnesota Department of Public Safety (DPS)

Sentencing

The last major change to Minnesota's drug sentencing scheme occurred in 2016. Smaller changes to the scheme take place annually.

However, a legislatively directed comprehensive review of Minnesota's Sentencing Guidelines is currently underway (2023 Minn. Laws Ch. 52, Art. 2, § 2(d)). Initial findings are available in the Sentencing Commission's 2025 Report to the Legislature. The most highly prioritized areas for action within the Commission's direct scope include reviewing relative severity levels, simplifying the guidelines manual, changes to criminal history scores, and revisiting departures from the grid.

As the Sentencing Guidelines Commission works to address these areas in the coming year, an important priority is to analyze how drug sentencing is driving racial and geographic disparities, a stated objective. This analysis must address ways in which disparities resulting from sentencing are distinct from, and additive to, disparities resulting from policing practices, charging, etc.

For example, drug convictions are assigned a severity value for the purpose of determining a defendant's criminal history score. Does this drive racial disparities in sentencing in the context of over-policing in BIPOC communities? As another example, departures from sentencing grids often favor white defendants. How does this look in Minnesota? Finally, some states provide a great deal of

guidance for courts on considerations at each stage of sentencing, including on how to avoid racial disparities.

In addition, legal experts noted that while the presumptive durations in Minnesota's Drug Offender Grid did not appear extreme when compared to other states, the available ranges were wide. For example, for 1st degree-controlled substances offenses, presumptive ranges within which a court may sentence without it being a departure extend from 22 to 43 months. Pennsylvania's presumptive ranges, by contrast, are not as wide, but the Commonwealth's Commission on Sentencing offers a much more granular breakdown for offense gravity and severity, which arguably permits more precise sentencing ranges.[204]

For context, 22 states categorize simple possession of the smallest amount of drugs specified in law as a misdemeanor.[13] In Minnesota, a first offense is a gross misdemeanor. Other states in this category include Alaska, Iowa, and North Dakota. In eight states, it can be either a misdemeanor or a felony, largely dependent on the drug involved. In 21 states, possession is almost always a felony.[205]

Finally, to address the large number of families that are impacted by separation due to parents' incarceration, one approach is for judges to consider a person's status as a caregiver as a mitigating factor at the time of sentencing, when considering alternatives to incarceration, and placements. Parental incarceration can adversely affect childhood development, with negative downstream impacts on health, employment, and education. Twelve states have taken steps in this direction. Tennessee and Massachusetts permit or require primary caregiver status and available alternatives to incarceration to be considered for certain defendants prior to sentencing, and New Jersey requires incarcerated parents be placed as close to their minor child's place of residence as possible, allows contact visits, prohibits restrictions on the number of minor children allowed to visit an incarcerated parent, and also requires visitation be available at least six days a week. [206]

[13] For a person with no previous convictions.

Table 29. Recommendations related to drug sentencing

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
131	Establish in statute periodic comprehensive reviews of the drug sentencing grids. Direct the Minnesota Sentencing Guidelines Commission to analyze how drug sentencing is driving racial and geographic disparities.	Medium	Minnesota Sentencing Commission	Reduce incarceration	Shift towards a more public health approach within our criminal-legal systems, Reduce disparities
132	Revise 152.023, subdivision 2(a)(4) so that people travelling through sentencing enhancement zones (schools, public parks, public housing) may not be charged with third degree felonies unless they have more than a residual amount of the listed controlled substances.	Low	DPS, Minnesota County Attorneys Association	Reduce arrest, reduce incarceration	Shift towards a more public health approach within our criminal-legal systems
133	Pass legislation requiring that a parent's status as a caregiver be considered at the time of sentencing and when considering alternatives to incarceration and that if a parent is incarcerated, they should be placed as close to their family as possible.	Low	DOC, Minnesota Judicial Branch, Country Attorneys Association, Board of Public Defense, Minnesota Sentencing Commission	Reduce incarceration	Shift towards a more public health approach within our criminal-legal systems

Key Acronyms: Minnesota Department of Corrections (DOC)

Scheduling

Criminalizing emerging forms of illicit drugs by adding them to the schedule in the Controlled Substances Act perpetuates the Iron Law of Prohibition described in the initial report. The law states that increasing levels of criminalization increase the harms associated with the drug, as the markets adjust to the enforcement measures by making more dense, easily transportable forms of a drug or adding more dangerous substances to the supply.[207] This trend can be seen in the evolution from pharmaceutical opioids, to heroin, to fentanyl, to carfentanil, to xylazine as suppliers try to get ahead of enforcement measures. Data also suggests that class-wide drug scheduling increases mass incarceration and exacerbates racial disparities in the carceral system.[208] In response to efforts to schedule xylazine, experts on overdose at Brown University wrote that:

> "The emphasis on scheduling and criminalization neglects evidence-based harm reduction strategies, including drug checking and xylazine test strips and reducing barriers to accessing wound care and medications for opioid use disorder.... Rather than amplifying punitive measures, which can lead to unintended consequences, we encourage policymakers to consider this issue from a public health perspective and dedicate resources to expanding harm reduction services instead."[209]

Table 30. Recommendation to avoid using scheduling as a policy response to overdose

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
134	Avoid using drug scheduling as a policy response to overdose.	Medium	DPS, Minnesota County Attorneys Association, Minnesota Judicial Branch	Reduce arrest, reduce incarceration	Reduce overdose mortality

Key Acronyms: Minnesota Department of Public Safety (DPS);

Drug Paraphernalia

Minnesota is the only state to have largely repealed its drug paraphernalia laws, though many states dedicate carve outs to drug use equipment commonly associated with harm reductions approaches, like syringes and fentanyl test strips.[210] The repeal was based on evidence showing that drug paraphernalia laws do not discourage drug use and instead keep PWUD from seeking harm reduction supplies like safer smoking and snorting tools and of disposing of used materials safely.[211]

Key informants noticed the impact of the policy change in their communities as participants at harm reduction organizations were more likely to safely dispose of used drug use equipment:

> "Our syringe return rate, MDH wants our syringe return rate to be about 90% of what we put out needs to come back in. And we are over 100% all the time. So we get syringes returned to us that we didn't put out into the community. Some of that is decriminalization. Some of that is...our relationships with participants... The decriminalization allows people to dispose of things properly instead of just trying to offload them as quick as they can."

However, there is a need for more education for PWUD and law enforcement about the law, and clean-up legislation is needed to fully realize the spirit of the law.

Table 31. Recommendations related to drug paraphernalia

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
135	Preempt the ability of local jurisdictions to circumvent state laws designed to increase access to safer use supplies and provide funding to educate law enforcement and people who use drugs about the law.	Low	DPS	Reduce arrest, reduce incarceration, Improve access to harm reduction services	Reduce drug-related infectious disease transmission/other morbidities, reduce overdose mortality
136	Close the "loopholes" associated with the legalization of drug paraphernalia.	Low	DPS	Reduce arrest, reduce incarceration	Shift towards a more public health approach within our criminal-legal systems

Key Acronyms: Minnesota Department of Public Safety (DPS)

Drug-Induced Homicide

> "And this idea of prosecuting people, they're not prosecuting major suppliers. They're prosecuting friends, brothers, sisters, cousins, people they hang out with for sharing drugs and somebody dies. I just think that's a misapplication of what statute really means to accomplish, and that is going after larger drug dealers who are, you know, putting large amounts of, like, fentanyl in the street, you know, versus people who are sharing drugs on a camping trip and somebody dies ... 99% of the time, it's not going after large drug dealers."

Drug-induced homicide (DIH) refers to criminal charges for distributing drugs that result in death. The Year 1 Report surfaced a lack of evidence for this practice. As of April 2024, Minnesota was one of 33 US states, DC, Guam, and the US Virgin Islands to have explicit DIH laws that can be used to charge someone who delivers a drug that results in an accidental overdose death. In other states, prosecutors may use other existing laws to prosecute DIH, like murder or negligent manslaughter. [212]

Several state legislatures (in Colorado, Utah, and Wyoming) have pushed back on bills that would have created explicit DIH laws on the grounds that such laws are used wrongly to convict people with SUD.[213]

In this study, a key informant from the court system acknowledged the deep pain and anger that families feel after the death of a loved one but noted that almost none of the people prosecuted under the state's DIH law are major suppliers (despite the intent of the law) and that sending someone to prison does not solve the problem and compounds the harm. Indeed, people prosecuted in these cases are often friends of the person who died and were using drugs together in a "social supply" context.[214] A national study of media reports about DIH prosecutions between 2000 and 2006 found that half of the people charged were social contacts of the person who died, not "dealers" in the traditional sense. The people who were deemed dealers were at the very bottom of the supply chain.[215]

There is also evidence that DIH laws deter people from calling 911 in the event of an overdose (in Minnesota, this is "Steve's Law").[216]

Seven states establish that making a good faith effort to promptly seek medical assistance in the case of an overdose is an affirmative defense for the DIH charge. They are Delaware, Illinois, Kentucky, Mississippi, Rhode Island, North Dakota, and Vermont.[217]

Table 32. Recommendation to repeal Minnesota's drug-induced homicide law

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
137	Repeal 609.195(b), Minnesota's drug-induced homicide law. In addition, create a carveout in statutes governing murder or manslaughter in the first and second degrees (secs. 609.20 and 609.205) such that these statutes may not apply to deaths resulting from accidental overdose.	Medium	DOC, DPS, MN Board of Public Defense, Minnesota County Attorneys Association, Minnesota Judicial Branch	Reduce arrest, reduce incarceration	Shift towards a more public health approach within our criminal-legal systems

Key Acronyms: Minnesota Department of Corrections (DOC); Minnesota Department of Public Safety (DPS)

Sex Work

> "Drugs are a thing of value for a lot of people. The thing that is being exchanged for sex are drugs. And a lot of times those two economies are very intertwined... But so many sex workers are drug users and drug users are selling sex."

The initial report established the health outcomes associated with decriminalizing sex work, including significant reduction in HIV transmission and violence against sex workers. There is evidence that decriminalization of consensual sex work among adults would contribute to successful drug policy in other ways. For example:

- People who are criminalized fear calling 911 in the event of an overdose. This includes sex workers.
- Criminal prosecution can pose barriers to people trying to access health and social services, including housing and public benefits. Lack of housing is a key driver of problematic drug use.
- Fear of prosecution can also deter sex workers from talking openly with healthcare or social services providers about their needs, including their drug use.[218]
- Fear of police can lead to risky condom use and drug use practices, which can lead to higher rates of HIV and sexually transmitted diseases.[219]

Globally, full decriminalization of sex work among consenting adults is practiced in New Zealand (since 2003), Belgium (since 2022) and two Australian states.[220]

In the US, multiple jurisdictions have considered full decriminalization of sex work, but none have yet passed legislation (with certain exceptions in California and for Nevada's legalization model). Legislators in DC have been working to decriminalize sex work since 2017 via the Community Safety and Health Amendment Act.[221] The state of Vermont considered such legislation during the 2021-2022 session, but it did not proceed out of committee.[222] Rhode Island legislators brought a bill in 2022 that did not proceed.[223] Baltimore decriminalized sex work on a de facto basis during COVID-19 and experienced no negative public safety outcomes.[224]

Key informants who work in the sex trade advocated for the full decriminalization of sex work, as opposed to the "Nordic model" that continues to criminalize the purchase of sex:

> "...we advocate for full decrim, which removes criminal penalties for the person who sells sex and the person who purchases sex. And it typically, usually removes third party charges as well. So...a landlord would be immune from sex work happening in their place."

The Nordic model has been shown to create safety hazards for sex workers when purchasers of sex seek more clandestine meeting places to avoid arrest.[225] Finally, the same key informant clarified that consenting sex workers have the same level of autonomy and agency as workers in other fields but the system of criminalization causes them undue harm, similar to PWUD:

"I think a lot of people are assuming that sex workers don't have agency, and I think that's very similar for drug users as well, where...whether they're high or they're not...they still have complete bodily autonomy and choice within them. And it's about creating the conditions for them to exercise that."

Table 33. Recommendation to decriminalize sex work

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
138	Decriminalize sex work among consenting adults.	Low	DPS, MDH	Reduce arrest, reduce incarceration	Shift towards a more public health approach within our criminal-legal systems

Key Acronyms: Minnesota Department of Health (MDH); Minnesota Department of Public Safety (DPS)

DATA COLLECTION & EVALUATION

> "Across all areas of drug policy, improvements must be driven by data, and the successes (or failures) of reform must be evaluated with data. Effectively measuring the impacts of drug policy reform is not an impossible task, but it has rarely been done well. For example, the most predominant metric used to measure drug policy is prevalence of use, despite its limited clinical significance and minimal association with policy change." ("Drug Policy: State of the Evidence," 2024)

Creating an approach to drug policy that maximizes health and safety requires that we evaluate our policies accurately. Data collection and evaluation should accurately and comprehensively track the full breadth of outcomes associated with drug policies, and should be evaluated and revisited at a regular cadence.

Ethical principles

The first report proposed seven principles to guide the ethical collection and oversight of data in the evaluation of drug policy:

1. The entire data life cycle, from conceptualization of metrics to collection, analysis, and dissemination, should be informed by people with lived and living experience. PWUD, people who have utilized treatment and harm reduction services, and people impacted by the criminal-legal system are closest to the problem and can play key roles in clearly identifying process and outcome measures, interpreting results, and disseminating findings to stakeholder communities.
2. Use data to identify racial inequities and assist in driving policy change. Data can be used strategically to identify key disparities and gaps in treatment access and utilization, morbidity and mortality outcomes, social determinants of health outcomes, and public safety outcomes. Data should be specifically and intentionally collected and stratified to illuminate the experiences of disproportionately affected communities, primarily BIPOC communities, women, and people impacted by houselessness. These data can help fill important gaps in public health data.
3. Particular attention should be paid to measuring access (and the lack thereof), as well as specific barriers to access. Outcomes such as MOUD availability by county, as well as the policy and administrative restrictions put in place by local authorities and clinics, can provide valuable information to guide policy and practice.

4. Findings, and the data they are based on, should be communicated transparently. Data is a public good, and should be owned, at a maximum, and accessible, at a minimum, by the communities that produce it.
5. Protect individual privacy and confidentiality. It is important to balance the principle of transparency with the principle of individual privacy in order to reduce any risk of reidentification and minimize the ways in which sensitive data can impact people and communities. One way to ensure this is to minimize the collection of personally identifiable data whenever possible.
6. We know that there are often unintended consequences of policy change, and this is true in the criminal-legal and drug policy arena, just as it is elsewhere. Where there is historical precedent of policy changes inadvertently impacting communities disparately, evidence should be collected pro-actively to track them. Examples of unintended consequences include but are not limited to net widening, up-charging, other areas where there's judicial discretion.
7. Publicly place value on data-driven practice by encouraging and incentivizing evidence-based practices in licensing, accrediting, and reimbursement structures. For example, outpatient clinics could be required to regularly report on the modalities of treatment employed, stratified by sociodemographic indicators, with extra documentation required when non-evidence-based treatments are given.

Expected Outcomes and Impact

> "The evaluation of drug policy reform also frequently suffers from a lack of alignment between the stated goal of the policy change and the outcomes measured. For example, if a jurisdiction removes or reduces criminal sanctions with the goal of preventing negative sequalae of criminal-legal system involvement, drug-related criminal-legal system involvement following policy change must be measured. Similarly, if improving the health and wellness of people who use drugs is a policy goal, physical and mental health outcomes of PWUD need to be systematically measured, beyond just prevalence of use." ("Drug Policy: State of the Evidence," 2024)

As noted above, in the evaluation of drug policy reform, there is a lack of alignment between goals of policy changes and outcomes measured. To address this shortcoming, each recommendation in this report includes an expected outcome, with the aim of clarifying expectations around what outcomes can reasonably be expected from a recommendation. No single recommendation taken by itself can successfully improve health and wellbeing, reduce mortality, and improve community safety. By identifying specific outcomes that can reasonably be expected to change associated with the recommendation, we aim to help stakeholders think clearly and concretely about what they can expect from the implementation of each recommendation.

Expected impacts are also noted, where relevant. In general, recommendations in the healthcare domain, such as those related to expanding access to MOUD, have impacts related to morbidity and mortality. Recommendations within the drug policing domain, such as funding non-law enforcement responses to behavioral health issues, can be expected to reduce arrests and incarcerations, but may also lead more distally to improvements in drug-related morbidity and mortality.

Including Process Indicators

Additionally, it is important that process indicators are also tracked. Process indicators assess the implementation of a policy or intervention and are used to help ascertain the success of the implementation and determine if it is possible to attribute any change in outcome to the change in implementation from the proposed model. Process indicators will be specific to each government agency and are not included in the recommendations for that reason.

To illustrate the importance of process indicators, much of what has been noted as the "failure" of Oregon's Measure 110 can in fact be nuanced by analyzing process indicators that reveal the impediments to implementation experienced in 2020-2021. For example, funding designated for increased services was delayed in its allocation, and the state did not provide training or standardized citation forms to law enforcement that could have helped link individuals to services. Therefore, at least some of the failure to improve intended outcomes, such as increasing access to care and decreasing drug-related morbidity and mortality, can be attributed not to the failure the model that the measure was based on, but to a failure in implementation.

Opioid Settlement Principles Resource and Indicators (OSPRI)

Opioid Settlement Principles Resource and Indicators (OSPRI) developed by Johns Hopkins Bloomberg School of Public Health and Vital Strategies is an interactive tool created to aid jurisdictions in measuring the effectiveness of their opioid settlement funding dollars. Jurisdictions can select one or more indicators to monitor specific targeted areas, such as broadening access to naloxone, increasing the use of MOUD, or enriching prevention strategies.

In the areas of healthcare and harm reduction specifically, advocates and researchers have devoted resources in recent years to developing robust indicators for key areas of substance use and overdose response. The Opioid Settlement Principles Resource and Indicators (OSPRI) is one such tool. Lawmakers and researchers can benefit from employing indicators such as those developed by OSPRI to make evaluation metrics consistent across jurisdictions and time periods.

It is important for process indicators to be SMARTIE: specific, measurable, attainable, relevant, time-bound, inclusive, and equitable. When adapted,

the implementer will need to add specific elements, such as time periods, that most adequately measure the effectiveness of the recommendation.

> "When the right types are collected and findings are disseminated quickly and accessibly to nonmedical, non-academic audiences, data can be a tool to improve health and wellbeing. They can also identify racial, ethnic, and other inequities and reduce disparities." ("Drug Policy: State of the Evidence," 2024)

Key informants had several recommendations in this area, covering data collection, monitoring and evaluation, and data application.

- Informants recommended the state collect data on who is disproportionately impacted by overdose deaths in order to make more accurate, effective, and equitable funding decisions. Data collected should not conflate heterogeneous groups with cultural differences (e.g., East African data with African American data).
- Data should also be used to inform policymakers about "touchpoints" of the system to improve outreach to groups impacted by overdose.
- Informants recommended the state allocating funding for qualitative and quantitative data collection to evaluate the impact of drug-related policies.
- At the programmatic level, informants identified a need to ensure evaluative data collection did not impede service access because it was cumbersome to participants or staff.

Limitations to evaluating drug policy

> "If the data is missing, how are you allocating funds? ... It's a scale, right? And that scale is data informed. And if the data is not accurate, then how are you making sound decisions policy wise? ... if both sides of that data is not really accurate, then the state is kind of in the dark in terms of how to allocate funds."

As the subject matter quoted above noted, evaluations can be hampered by missing data, as well as inaccurate data. Additionally, because changes are not implemented in a vacuum, is it not possible to fully control for the effects of other, external variables. Oregon, for example, implemented Measure 110 at the same time that the COVID-19 pandemic struck and as fentanyl was entering the local drug supply – two processes that impacted homelessness and drug overdose mortality and that were independent of Measure 110. Rigorous evaluations can attempt to transparently document such confounders, but real world conditions do not allow for the evaluation drug policy in the same controlled manner as, for example, clinical trials for medications.

The table below includes several recommendations relate to data collection and evaluation to advance drug policy in Minnesota

Table 34. Recommendations for measuring outcomes related to drug policy

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
139	Legislate a periodic strategic planning process and review of all statewide drug policies, including the impacts of drug policing policies on public health, public safety, and social determinants of health. This should include attention to racial disparities in all outcomes of interest.	High	DHS, DPS, MDH, OAR	Increase our understanding of overdose risks to inform our response strategy	Shift towards a more public health approach within our criminal-legal systems, Reduce disparities, Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
140	Mandate that the appropriate state agencies track and make publicly available the costs related to drug law enforcement.	Low	DOC; DPS, Minnesota Judicial Branch,	Increase our understanding of overdose risks to inform our response strategy	Shift towards a more public health approach within our criminal-legal systems
141	Direct the Department of Public Safety provide demographic breakdowns for each offense, not only for arrests generally, in the MN Uniform Crime Report.	Low	DPS	Increase our understanding of overdose risks to inform our response strategy	Shift towards a more public health approach within our criminal-legal systems
142	Collect disaggregated data to understand how drug-related offenses contribute to mass supervision, as well as supervision violations (both technical violations and new offenses) as a basis for prolonged supervision and/or incarceration. For substance-related technical violations, data should be collected and disaggregated around missed appointments and positive drug screens specifically. Ensure that demographic data is integrated across the board.	Low	DOC	Increase our understanding of overdose risks to inform our response strategy	Shift towards a more public health approach within our criminal-legal systems
143	Collect more granular epidemiological overdose data on race and ethnicity, and use this data to allocate funding to inequitably impacted communities.	Low	MDH	Increase our understanding of overdose risks to inform our response strategy	Reduce disparities
144	Allocate sustainable funding to link housing and homelessness data to public health data, in line with findings from MDH's Minnesota Homeless Mortality Brief.	Low	DHS, MDH	Increase our understanding of overdose risks to inform our response strategy	Shift towards a more public health approach within our health and human services systems
145	Allocate sustainable funding to link housing and homelessness data to public health data, in line with findings from MDH's Minnesota Homeless Mortality Brief.	Low	DHS, DPS, MDH,	Increase our understanding of overdose risks to inform our response strategy	Shift towards a more public health approach within our health and human services systems

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
146	Create data infrastructure and collect data about overdose and access to treatment for pregnant and parenting people, stratified by race and ethnicity, in order to ensure equitable access.	Low	DHS, MDH	Increase our understanding of overdose risks to inform our response strategy	Reduce disparities, Shift towards a more public health approach within our health and human services systems
147	Direct the Department of Administration's Grants Management to review the data collection requirements of grants within its purview, and implement findings from DHS' report on paperwork reduction in substance use disorder treatment (forthcoming).		Department of Administration	Improve access to harm reduction services, Improve access to healthcare	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

Key Acronyms: Minnesota Department of Corrections (DOC); Minnesota Department of Health (MDH); Minnesota Department of Human Services (DHS); Minnesota Department of Public Safety (DPS)

CROSSCUTTING

This section is new to the second report in this series. It brings together recommendations that "cut across," or overlap with, the other five domains.

Relatedly, the first report had a section dedicated to Special Populations: groups that required special consideration in the context of drug policy, including for example racial and ethnic minority groups, people in detention settings, and people experiencing houselessness. In this report, most of the recommendations specific to those groups were moved to the most relevant domain. The recommendations for special populations that cut across all the other domains are included in this new Crosscutting chapter.

Please note that the following sub-sections are not exclusive; rather, recommendations regarding the inclusion of people with lived experience and funding transparency have obvious overlap.

Safe Supply and Regulation

> "...prescription fentanyl or safe access to drugs, like drug supply, is really essential, I think, to adequately addressing this because, yeah, it just feels so dependent on how much fentanyl is in the street and people being able to accurately dose themselves."

The Year 1 Report explained that alternatives to prohibition-based drug policies like decriminalization cannot solve for the harms of an unregulated drug supply. As long as illicit drugs continue to be produced by criminalized suppliers, they will be of unknown quality and continue to pose dangerous risks to people who use them.

In contrast, regulated legal markets, like those for alcohol and tobacco, allow for government oversight and quality control. Various models of safe supply include:

- Medical prescription for the riskiest drugs. Heroin-assisted treatment is the prescription of diamorphine (medical-grade heroin) to people with chronic opioid use disorder in supervised, clinical settings. It has been practiced for 40 years in countries including Switzerland, the Netherlands, Germany, Spain, Canada, England, and Belgium. A systematic review found the treatment to be more effective than methadone in retaining people in care and reducing illicit drug use.[226]
- Licensed retail outlets for cannabis products, which operate in many US states and the Tribal nations that share the same geography, including the White Earth Nation in Minnesota.
- Licensed premises, like bars and Amsterdam-style cannabis "coffee shops," where people can consume lower-risk drugs on site.[227]

The Global Commission on Drug Policy, a body composed of former Presidents and other international leaders, recommends that "Policymakers should seek evidence on the legal regulation of drugs, and must open local and national participatory processes to shape the reforms."[228] This report echoes that recommendation and proposes that Minnesota lawmakers consider Washington State's model of creating a working group to study the issues.

Table 35. Recommendation to create a safe supply work group

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
148	Create and fund a safe supply work group, similar to that convened by the state of Washington.	Low	Board of Pharmacy, DPS, MDH	Improve access to harm reduction services	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

Key Acronyms: Minnesota Department of Health (MDH); Minnesota Department of Public Safety (DPS)

Special Populations

> "So, I think that if we're going to talk about equity in such a way, we need to have direct state agencies, need direct instruction to utilize joint powers agreements from a government-to-government space, government-to-government connection, not competitive RFPs, not any of that racket; those providers, those communities, those community partners those nations are dealing with. You step into that American Indian SUD Summit, all you could feel was the trauma. Nine of the eleven Tribal Nation leaders were sitting up on a stage telling us about all of their traumas. All of them had either been incarcerated, have had a child incarcerated, been experiencing recovery on their own, or lost children

The first report detailed policy measures to support the unique needs of special populations. Recommendations specific to Native American people and Youth are included in this section.

Absolutely critical to meeting the needs of Native American people and Youth (like all disparately impacted groups) is to center their voices in the policy process lest policymakers miss the nuance that will cause a policy to success or fail. For example, one key informant spoke to the nuance of providing harm reduction services to young PWUD:

> "And so much of the [youth] who are using meth, we see are using it as like a self-protection strategy for like, you know, sleeping outside … we see a lot of [youth] smoke drugs…Whereas it's the older population that we work with that most often is injecting drugs or booty bumping and some of that stuff. Um, and so having access to smoking supplies was really huge because it was always really devastating when someone would be like, hey, do you have smoking supplies? And be like, nope, we have syringes. And they'd be like, ugh, I guess I'll take them."

Indeed, a peer-reviewed article in the Journal of Pediatrics proposed two principles of harm reduction for young PWUD: first, that harm reduction services are critical to keeping young adults alive and healthy and can offer pathways for future treatment; and that all evidence-based harm reduction strategies available to adults should be available to young adults in a tailored, developmentally appropriate form when possible.[229] For example, because many overdoses among youth take place at home, experts recommend that caregivers or peers who live with the adolescents have keep naloxone in the home.[230]

Similarly, the recommendations specific to Native American communities were agreed to during a 2023 summit by representatives from Minnesota's Tribal Nations, American Indian Urban organizations, the American Indian Advisory Council, and American Indian community members. (A follow-up event is being planned for 2025.)

The recommendations here come directly from Minnesota's Native American communities (from the 2023 American Indian Substance Use Disorder Summit) and youth participants in focus groups convened by the University of Minnesota Department of Pediatrics' Youth Health and Housing Lab and the Bridge for Youth, a community-based organization serving youth who are experiencing homelessness.[231]

Table 36. Recommendations specific to American Indians and youth

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
149	Implement the twelve legislative recommendations from the 2023 American Indian Substance Use Disorder Summit, including around access to treatment, funding, and culturally specific resources for people leaving detention settings.	High	MDH, Minnesota Indian Affairs Council, OAR	Improve access to substance use disorder treatment, Improve access to naloxone, Improve access to healthcare	Reduce disparities, Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
150	Expand services for youth experiencing homelessness and using drugs, including drop-in centers, support groups, and therapy that don't mandate sobriety or limit their freedom.	Medium	DCYF, DHS, MDH, OAR	Improve access to substance use disorder treatment, Improve access to harm reduction services, Improve housing/Reduce homelessness	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

Key Acronyms: Minnesota Department for Children, Youth, and Families (DCYF); Minnesota Department of Health (MDH); Minnesota Department of Human Services (DHS); Office of Addiction and Recovery (OAR)

Discrimination

According the to the Legal Action Center, anti-discrimination laws protect the rights of people who use(d) drugs to access treatment, healthcare, housing, work, and more. These laws can operate at both the federal level, like the ADA, and at the state level, like state human rights laws. Anti-discrimination laws protect people with a disability, defined as 1) an impairment 2) that substantially limits one or more major life activities.[14] Federal laws protect people with SUD who are not in active drug use, with the exception that even people in active drug use may not be denied medical services (though they may be denied employment, housing, and more).[232]

Previous sections in this report make recommendations to eliminate specific discriminatory practices that result in disparate health and public safety outcomes, including policies like setting clear standards for when toxicology testing should be performed at birth and ensuring that people with SUD in detention settings have access to the same treatment options as people in the community.

In addition, however, stronger and broader anti-discrimination policies and government mechanisms are needed to protect PWUD.

Table 37. Recommendations to protect PWUD from discrimination

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
151	Adopt robust anti-discrimination protections for people who use(d) drugs across settings and sectors, including individuals in active substance use, and develop guidance materials to support implementation.	Medium	MDHR	Improve access to housing, employment, education, healthcare, and other sectors	Improve the autonomy and dignity of people who use drugs
152	Bolster state agencies' abilities to address discrimination against people who use drugs.	Low	Minnesota Department of Human Services, Attorney General's Office, MDHR, DHS, Mid-Minnesota Legal Aid (the federally designated Protection and Advocacy agency for people with disabilities in Minnesota), OAR	Improve access to healthcare and other sectors	Improve the autonomy and dignity of people who use drugs

Key Acronyms: Minnesota Department of Human Rights (MDHR); Minnesota Department of Human Services (DHS); Office of Addiction and Recovery (OAR)

[14] This includes current disability, a record of disability, as well as those who are regarded as having a disability.

Lived Experience

> "And who, on city and local and county level government, knows these communities better than those communities? The people who live there, the people who have experienced, the people in recovery. These are the people. And the people who are currently using. These are the people that should have a voice at the table to say where this funding goes, because they know exactly what they need."

The evidence indicates that the most effective policies and programs are those that have been designed by and for the people who use them. Indeed, both the federal government and the state of Minnesota have acknowledged this tenet:

- At the federal level, the Ryan White program funds services like medical care, transportation, and case management for low-income people who are living with HIV and AIDS. Ryan White Planning Councils set the funding priorities for local jurisdictions. By law, at least 33% of members must be people living with HIV who use Ryan White-funded services.[233]
- Crossroads to Justice, the state's strategic plan for addressing homelessness, was developed with the input of 14 paid consultants with lived experience of homelessness. The implementation phase of the plan, now in process, is also paying people with lived experience as advisers.
- The Opioid Epidemic Response Advisory Council (OERAC), mandated to deploy the state's portion of opioid settlement funds, by statute must include at least one person who in "opioid addiction recovery, and "of the members appointed by the commissioner, to the extent practicable, at least one member must represent a community of color disproportionately affected by the opioid epidemic."[234]

For context, of the almost $50 billion in opioid settlement funds nationally, only $1 in $7 is overseen by boards that reserve at least one seat for someone who is using or has used drugs. Experts agree that including people with lived and living experience in these decisions helps to ensure the funds move to the right places and speedily.[235]

These processes are excellent starting places for structurally involving people with lived experience in all aspects of drug policy, including funding allocations (county and state government dollars as well as opioid settlement funds) and strategic planning and review processes.

Table 38. Recommendations to improve the involvement of people with lived experience in decision-making

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
153	Identify methods of meaningfully integrating the voices of people with lived and living experience at every level of the drug policy development process and funding distribution process, including opioid settlement funds.	Medium	Minnesota Interagency Council on Homelessness		Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
154	Include harm reduction expertise and lived expertise in the selection process of reviewers for harm reduction grants and other competitive processes.	Medium	MDH, DHS, Department of Administration	Improve access to harm reduction services, Improve utilization to harm reduction services	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities, Improve the autonomy and dignity of people who use drugs

Key Acronyms: Minnesota Department of Health (MDH); Minnesota Department of Human Services (DHS)

Funding

The need for sustained, flexible, and culturally tailored funding is another area that cuts across the domains. Where the first report articulated the evidence supporting the need for such funding, key informants interviewed as part of this report reiterated this call.

Specifically, informants spoke in depth about the deployment of opioid settlement funds, including both local and state allocations. Some key informants did not see opioid settlement funds flowing into their communities or saw the dollars funding "harmful" programs. They underscored that opioid settlement funds should not be used to support programs that criminalize drug use, including funding law enforcement. Rather, funds should be used for evidence-based approaches, including harm reduction services and basic needs like housing and food for people who are hungry. There was also a worry that counties would replicate services already being provided by community groups who were better placed to do the work.

For context, Minnesota is one of only twelve states that have committed to publicly report on 100% of how opioid settlement funds are being used, including local shares.[236] As such, Minnesota's localities are required to submit spending reports to DHS, which in turn compiles a public dashboard that encourages evidence-based spending. Nevertheless, the City of Minnetonka spent roughly $85,000 to protect first responders from exposure to fentanyl, a non-existent hazard that has been debunked multiple times. Renville County used $100,000 to buy a body scanner for the jail. It scanned 300 people and found no hidden drugs.[237]

In the same vein, key informants working at community-based service providers called for increased transparency around how the funds are being deployed after they are allocated to providers:

> "On the other hand, too, is we got a lot of opioid settlement money, and I would like to know where some of it's going, because we've - I've had word on the street from reliable people that they've been screwed over by some people that got the money, and they haven't... been given reliable housing or these things that you say you're going to do and you're not going to do them...I would like a little more accountability...this money, which we all deserve - we just need to know where it is, actually."

Others wanted to ensure that settlement dollars were benefitting Native Americans and Tribal Nations. One key informant working at an organization serving Native American people in Greater Minnesota noted that her application for county opioid settlement funds was funded at a fraction of the original request, whereas all other applicants in the funding round received the majority or all of their original asks. She attributed this to discrimination against Native American groups in the award process. Another service provider working in Greater Minnesota echoed the notion that opioid settlement dollars are not reaching Native American people due to discrimination on the part of county allocation processes.

Thus, directly impacted communities must be a part of all funding decisions and in all parts of the process. As described above, OERAC is one example of using state law to integrate the voices of people with lived experience in the funding allocation process. Even that process, however, is far from perfect: key informants expressed a need for more representation from Black communities and funding allocated directly to community organizations that excel in serving Black communities. Instead, bureaucratic funding practices and high threshold grant applications often prevent culturally specific organizations from winning funding:

> "I think we need to change the way we engage with Black organizations around substance use. I think we need to fund them. I think they need to be directly [written] into legislation so that [there are direct] appropriations, instead of allowing it to go to DHS, and then DHS does RFP, and it's too many different layers of bureaucracy when these communities know what they need to recover. Right? If we fund them at the levels that we fund Hennepin healthcare systems, at the level that we fund Allina, you know, these communities, they know who folks trust. So they have that cultural competency as well as the knowledge and history to allocate these funds, to mobilize these funds."

Finally, key informants expressed disappointment at the discontinuation of COVID-era dollars that had initially let them expand services. The attendant cycle of expansion and contraction is frustrating and inefficient for provider organizations and harmful for the people they serve. Because opioid settlement funds themselves are impermanent, experts at Duke University have recommended planning for the eventual end of opioid settlements funds by identifying sustainable funding sources for services they currently fund and establishing effective policies and practices rather than funding programs only.[238] Savings can be found by right-sizing the state's criminal justice system and redeploying funds to supports like housing and healthcare, as in Minnesota's CanRenew grant program.[239]

Table 39. Recommendations related to funding

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
155	Re-invest savings and revenue from the criminal-legal system into community-based supports, like job placement and mental health services.	Medium	Department of Employment and Economic Development, DPS, MDH,	Improve access to healthcare, Improve access to harm reduction services, Improve employment	Shift towards a more public health approach within our health and human services systems
156	Create sustainable, flexible, and equity-focused funding opportunities for organizations whose missions include advancing the health of BIPOC communities and who can demonstrate a track record of doing so in a way that is inclusive of directly impacted communities.	Medium	DHS, MDH	Improve access to substance use disorder treatment, Improve access to harm reduction services	Reduce disparities, Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
157	Plan for the eventual end of opioid settlement funds by deploying funds to establish evidence-based, effective policies and practices, rather than funding only programs. (Find sustainable funding sources for programs.)	Medium	DHS		Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
158	Direct DHS to use its current powers to enforce local jurisdictions' opioid settlement spending, particularly their spend on non-evidence based practices and programs that perpetuate criminalization.	Low	DHS	Improve access to substance use disorder treatment, Improve access to harm reduction services	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

Key Acronyms: Minnesota Department of Health (MDH); Minnesota Department of Human Services (DHS); Minnesota Department of Public Safety (DPS)

Agency Reform

One recommendation focused on the operations of state agencies and the need for more collaboration to improve health outcomes for PWUD. This recommendation comes from the Governor's Subcabinet on Opioids, Substance Use, and Addiction, and the Minnesota Interagency Council on Homelessness' Crossroads to Justice Plan. States including Kansas, Maine, and Pennsylvania are innovating to bring together multiple state agencies to address overdose and SUD.[240]

Table 40. Recommendation to integrate state agencies that oversee harm reduction and treatment services

#	Abridged Recommendation	Potential impact	Key state partners	Primary outcome expected	Primary impact expected
159	Integrate the state's harm reduction services, housed primarily within MDH, and the state's treatment and recovery services, housed primarily within DHS.	Medium	Minnesota Interagency Council on Homelessness; OAR	Improve access to harm reduction services, Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

Key Acronyms: Office of Addiction and Recovery (OAR)

CONCLUSION

As the Chair of the Global Commission on Drug Policy, Helen Clark, stated in her call for an evidence-based approach that prioritizes health, human rights, and dignity, "This is not about being 'soft' on crime; it's about being sensible, humane, and just. It's about ensuring that drug policies promote safety, equity, and well-being for everyone."[241]

Following a rigorous review of the evidence in the author's first report, this report makes recommendations that, if taken up, could result in a cohesive approach to drug policy aligned with the evidence that maximizes health and safety for all Minnesotans. It triangulates findings from an assessment of the Minnesota policy context, including state statute review, interviews with subject matter experts around the state representing a diverse array of backgrounds, and reports and guidance from expert groups working in drug policy.

Recommendations are presented in alignment with the four domains of drug policy: healthcare, harm reduction, social determinants of health, and drug policing. Additionally, we've proposed recommendations related to data collection and evaluation, and "crosscutting" recommendations that are relevant across multiple domains.

The recommendations are bolstered by guidance documents, policy briefs, or model legislation, where available, to help lawmakers think through the intricacies of creating these changes. Recommendations are also presented with an estimated level of impact, the populations in Minnesota who merit special consideration, key state agency partners critical to the implementation of the recommendation, and expected outcomes.

This roadmap aims to help lawmakers hew carefully to the evidence when making decisions regarding drug policy. Public opinion around drug policy shifts on a pendulum, often affected primarily by emotion and sometimes by improper attributions. We urge lawmakers to counter this din and instead return to what we know from the science, from the experience of other jurisdictions, and from the expert opinions of government, medical and scientific bodies.

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A. Appendix A -- Table of detailed recommendations

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
1	Health care	Medicaid and other insurance	Fund a study to understand and make recommendations to address payment-related barriers to medications for opioid use disorders	Fund a study to understand and make recommendations to address payment-related barriers to medications for opioid use disorders that are experienced by both patients (often related to insurance coverage and health plan design) and providers (reimbursement rates, administrative burden, program start-up costs) using the framework developed by Bowser and colleagues in their paper "Payment-related barriers to medications for opioid use disorder: A critical review of the literature and real-world application."	High	Payment-related barriers to medications for opioid use disorder: A critical review of the literature and real-world application - Journal of Substance Use and Addiction Treatment Impact of Medicaid Restrictions on Availability of Buprenorphine in Addiction Treatment Programs - American Journal of Public Health		DHS, OAR	Improve access to medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
2	Health care	Medicaid and other insurance	Enact a comprehensive parity law that requires plans to provide behavioral health coverage.	Enact a comprehensive parity law that requires plans to provide behavioral health coverage. (Current parity law only applies to plans that do offer such coverage). Allocate funding for meaningful accountability/enforcement is critical.	Medium	Minnesota | ParityTrack Mental Health and Substance Use Disorder Insurance Parity - Summary of State Laws Model Parity Legislation - American Psychiatric Association The Essential Aspects of Parity: A Training Tool for Policymakers - SAMHSA The Legal Path to a Whole of Government Opioids Response | Public Health Law Research		DHS, OAR	Improve utilization of substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
3	Health care	Medicaid and other insurance	Enact a law requiring health insurers to maintain an adequate provider network to assure access to all covered benefits	Enact a law requiring health insurers to maintain an adequate provider network to assure access to all covered benefits, including those for behavioral health, without unreasonable delay. (This is in line with new rules from the Federal government.)	Medium	Health Benefit Plan Network Access and Adequacy Model Act - National Association of Insurance Commissioners Colorado Title 10. Insurance § 10-16-704 Fact Sheet: Final Rules under the Mental Health Parity and Addiction Equity Act (MHPAEA) | U.S. Department of Labor The Legal Path to a Whole of Government Opioids Response | Public Health Law Research Note that states lack legal authority to impose a coverage mandate for self-funded plans (e.g., what many large employers offer), which are exclusively governed by the federal Employee Retirement Income Security Act law, or ERISA.		DHS, OAR	Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
4	Health care	Medicaid and other insurance	Require public and private health insurers to cover all formulations of naloxone	Require public and private health insurers to cover all formulations of naloxone, including prescription-only and over-the-counter formulations, except for high dose formulations.	Low	Naloxone Insurance Coverage Mandates - Network for Public Health Law Minnesota Medicaid Preferred Drug List Program A call for compassionate opioid overdose response - International Journal of Drug Policy Note also that inclusion of over-the-counter formulations could trigger complicated federal provisions around the state having to pay insurers, if done outside the state's essential health benefits benchmarking process. See Naloxone is Now Available Over-the-Counter. Will it Still be Affordable? - National Health Law Program Note also that the state lacks legal authority to impose a coverage mandate for self-funded plans (e.g., what many large employers offer), which are exclusively governed by the federal Employee Retirement Income Security Act law, or ERISA.		DHS, OAR	Improve access to naloxone	Reduce overdose mortality

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
5	Health care	Medicaid and other insurance	Create a task force to determine best use of federal and state funds for financing substance use care.	Strategically braid federal and state funds by creating a task force to bring together key stakeholders including representatives from the governor's office, the Medicaid director's office, MDH, DHS, DOC, the Department of Children, Youth and Families, representatives from the different systems that people with SUD interact with, such as housing services, criminal legal services, and schools. People with lived and living experience and subject matter experts are also critical stakeholders to include. Assess which services are best funded with Medicaid, other federal grants, opioid settlement funds, and other state funding pools.	Low	State Principles for Financing Substance Use Care, Treatment, and Support Services - Center for Health Care Strategies		DCYF, DHS, DOC, DOE, MDH, OAR	Improve access to substance use disorder treatment, Improve access to healthcare	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
6	Health care	Medicaid and other insurance	Implement findings from the Minnesota Health Care Programs Fee for Service Outpatient Services Rates Study	Implement findings from the Minnesota Health Care Programs Fee for Service Outpatient Services Rates Study	High	Minnesota Health Care Programs Fee for Service Outpatient Services Rates Study See also, Maine DHHS Announces Historic Payment Reforms for Behavioral Health | Department of Health and Human Services		DHS, OAR	Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
7	Health care	Medicaid and other insurance	Pass legislation to apply for Medicaid 1115 waiver for health-related social needs	Pass legislation to apply for Medicaid 1115 waiver for health-related social needs (HRSNs) to cover services like care coordination, peer support services, improved integration of behavioral health services, and supportive housing.	High	Section 1115 Medicaid Waiver Watch: A Closer Look at Recent Approvals to Address Health-Related Social Needs (HRSN) - KFF The Legal Path to a Whole of Government Opioids Response | Public Health Law Research		DHS, DPS, Minnesota Housing, OAR	Increase access to substance use disorder treatment; Improved continuity of care	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
8	Health care	Medicaid and other insurance	Ensure 1115 Medicaid Reentry Waiver implementation includes pregnant and postpartum people	Ensure that the 1115 Medicaid Reentry Waiver program implementation recognizes pregnant or postpartum people as eligible populations and creates tailored supports for pregnant and postpartum people leaving detention settings.	Medium	Improving Access to Care for Pregnant and Postpartum People with Opioid Use Disorder: Recommendations for Policymakers - American Medical Association	People in detention settings, pregnant people	DCYF, DHS, OAR	Improve access to substance use disorder treatment, Improve access to healthcare	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
9	Health care	Medicaid and other insurance	Allocate Medicaid funds for community-based mobile crisis intervention services	Pass legislation to make a Medicaid state plan amendment or apply for a 1115 demonstration project to use Medicaid funds for community-based mobile crisis interventions services.	Medium	Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services - Center for Medicare and Medicaid Services State Option to Provide Qualifying Community-Based Mobile Crisis Intervention Services - Center for Medicare and Medicaid Services		DHS, DPS, OAR	Improve access to healthcare	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
10	Health care	Medicaid and other insurance	Expand Medicaid to cover peer support services for youth.	Expand Medicaid to cover peer support services for youth.	Low	Frequently Asked Questions on Medicaid and CHIP Coverage of Peer Support Services - Center for Medicare and Medicaid Services Medicaid Funding for Family and Youth Peer Support Programs in the United States - SAMHSA	Youth	DCYF, DHS, OAR	Improve access to substance use disorder treatment, Improve utilization of substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
11	Health care	Expand access to MOUD	Expand telehealth treatment access	Direct state agencies to consider and make recommendations to expand access to telehealth treatment for substance use disorders.	High	State Policy Changes Could Increase Access to Opioid Treatment via Telehealth - Pew Charitable Trusts		DHS, MDH buprenorphine prescribers community of practice, OAR	Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
12	Health care	Expand access to MOUD	Require addiction treatment providers to facilitate access to evidence-based care, including MOUD	Require all providers that offer addiction treatment to provide directly, or facilitate access to, evidence-based treatment, including all FDA-approved forms of medications for substance use disorder, within a transitional time period.	High	State Principles for Financing Substance Use Care, Treatment, and Support Services - Center for Healthcare Strategies		DHS, OAR	Improve access to medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
13	Health care	Expand access to MOUD	Expand MOUD access in pharmacy settings	Create low-barrier access to medications for opioid use disorder in pharmacy settings by passing a "Model Pharmacist Collaboration for Medication for Opioid Use Disorder Act."	High	Model Pharmacist Collaboration for Medication for Opioid Use Disorder act - Legislative Analysis and Public Policy Association Medication-Assisted Treatment - National Association of Boards of Pharmacy The Role of Pharmacists in Medications for Addiction Treatment - American Society of Addiction Medicine		Board of Pharmacy, DHS, MDH, OAR	Improve access to medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
14	Health care	Expand access to MOUD	Require pharmacies to stock buprenorphine	Enact a law requiring pharmacies to maintain stocks of buprenorphine. (This is also an issue that must be addressed at the wholesaler/distributor level, as pharmacies are often unable to get sufficient quantities of buprenorphine even when they want to. See the linked memo from New Mexico's Overdose Prevention and Pain Management's Advisory Council, urging the Governor to issue an Executive Order that would attempt to address this issue.)	Medium	The Role of Pharmacists in Medications for Addiction Treatment - American Society of Addiction Medicine New Mexico Overdose Prevention and Pain Managament's Advisory Council Buprenorphine Access Recommendation 05/08/2024 San Francisco Ordinance No. 206-24 Requiring Retail Pharmacies to Stock Buprenorphine Philadelphia Ordinance § 9-637. Opioid Antidote Availability. Pharmacy Availability of Buprenorphine for Opioid Use Disorder Treatment in the US - JAMA Open Network The Legal Path to a Whole of Government Opioids Response | Public Health Law Research		Board of Pharmacy, DHS, MDH, OAR	Improve access to medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
15	Health care	Expand access to MOUD	Facilitate adoption of OTP best practices at the state level	Create legislation that goes above and beyond federal opioid treatment program (OTP) standards when doing so benefits OTP patients. For example, as of 2022, nine states required OTPs to be open outside of regular business hours to provide flexibility for patients attend to work, education, or child care responsibilities. Two states prohibit administrative discharge from OTPs for patients who are not abstinent. No states prohibit administrative discharge for missed methadone doses. State law could also create provisions to hold accountable OTPs that refuse to provide the maximum number of take-home doses.	Medium	State Opioid Treatment Program Regulations Put Evidence-Based Care Out of Reach for Many - Pew Charitable Trusts Liberating Methadone: A Roadmap for Change. Conference Proceedings and Recommendations Methadone Treatment for Opioid Use Disorder: Improving Access through Regulatory and Legal Change - National Academies of Sciences, Engineering, and Medicine	Racial and ethnic minorities	DHS, OAR	Improve access to medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
16	Health care	Expand access to MOUD	Support expanded MOUD access in primary care and non-specialty healthcare settings	Review state policies for processes that may impede access to medications for opioid use disorder in non-specialty settings, including at syringe services programs and primary care clinics, and pass policies to address those barriers. Fund pilot programs that innovate around the challenge of integrating the treatment of substance use disorder into primary care practices - for example, that	Medium	Envisioning Minimally Disruptive Opioid Use Disorder Care - Journal of General Internal Medicine Primary Care-Based Models for the Treatment of Opioid Use Disorder: A Scoping Review Three Strategies to Help Primary Care Teams Treat Substance Use Disorders - California Improvement Network		DHS, MDH, OAR	Improve access to medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

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				explore team coverage models of patients with substance use disorders.						
17	Health care	Expand access to MOUD	Pass a "Model Substance Use Disorder Treatment in Emergency Settings Act"	Pass a comprehensive "Model Substance Use Disorder Treatment in Emergency Settings Act." Such an act would establish and align mechanisms for leveraging emergency medical settings to support people who people with substance use disorders, people who experience overdose, and their families. Consider supplemental language that would prohibit doctors from reporting patients who possess controlled substance to law enforcement.	Medium	Model Substance Use Disorder Treatment in Emergency Settings Act - Legislative Analysis and Public Policy Association 50-State Survey SUD-Related Emergency Department Mandates - Network for Public Health Law https://mhealthfairview.org/blog/First-Step-program-provides-evidence-based-opioid-use-disorder-treatment		DHS, MDH, OAR	Improve utilization of healthcare, Improve access to harm reduction services,	Shift towards a more public health approach within our health and human services systems

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
18	Health care	Expand access to MOUD	Support paramedics' ability to initiate buprenorphine treatment	Create statewide protocols for, establish, and fund programs for paramedics to initiate buprenorphine treatment for patients who are at high risk for overdose death. See, for example, programs currently operating on White Earth Nation and Hennepin County. Address the policy barrier that prohibits EMS from dispensing buprenorphine without first conducting a telehealth visit with a prescriber.	Low	Legal Authority for Emergency Medical Services to Increase Access to Buprenorphine Treatment for Opioid Use Disorder - Annals of Emergency Medicine Hennepin EMS protocols include treatment for opioid withdrawal - Hennepin Healthcare New Bridge Over White Earth Troubled Waters? - Anishinaabeg Today Reaching people where they are–using EMS to start buprenorphine - Johns Hopkins School of Public Health Best Practice of the Month EMS Field-Based Buprenorphine Administration: An Emerging Practice - Rural Communities Opioid Response Program - Technical Assistance		Board of Pharmacy, DHS, Emergency Medical Service Regulatory Board, MDH, OAR	Improve access to medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
19	Health care	Expand access to MOUD	Study and make recommendations around how current OTP laws could be leveraged to expand MOUD access	Study and make recommendations regarding how flexibilities in Minn. Stat. § 245G.07, Subd. 4. governing Opioid Treatment Programs' "location of service provision" are, or are not, being leveraged to expand access to medications for substance use disorder. In theory, units affiliated with a licensed OTP could be both mobile and non-mobile, for example in homeless shelters, jails and prisons, or rural counties. (According to the linked Pew resource, 11 states explicitly permit "medication units" affiliated with a licensed OTP, while Minnesota statute has more general language.)	High	State Opioid Treatment Program Regulations Put Evidence-Based Care Out of Reach for Many - Pew Charitable Trust Innovations in Methadone Medication for Opioid Use Disorder: A Scoping Review - National Academies of Medicine Mobile Clinic Model for Improving Access to Medication for Opioid Use Disorder (MOUD) - RHIhub Toolkit The Legal Path to a Whole of Government Opioids Response | Public Health Law Research	People in detention settings, people experiencing homelessness	DHS, MDH, OAR	Improve access to medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

20	Health care	Expand access to MOUD	Expand MOUD access for incarcerated people	Require in statute, and fund access to, all three FDA-approved forms of medications for opioid use disorder (MOUD) in all state and local correctional facilities. Enhance data collection to understand nuances of access to MOUD in corrections facilities, including access to agonist treatments, access for all groups in addition to pregnant people only, and outside of withdrawal support only. The LAPPA model, linked at right, is a good start for legislation, but we recommend the following addenda: - Explicitly permit a participant to resume medication even after a voluntary discontinuation or other interruption. (This is to counter the common scenario of people being forced onto Sublocade or Vivitrol where there is alleged diversion but also consider the importance of participants being able to switch medications should they desire and it's medically appropriate.) - Engagement with any service must be voluntary. There is a protection as to counseling in the LAPPA model: "..shall not condition participation in such services as a requirement for receiving medication for addiction treatment" but this should be extended to any ancillary service, including, for example,	High	Model Access to Medication for Addiction Treatment in Correctional Settings Act - Legislative Analysis and Public Policy Association Expanding Access to Medications for Opioid Use Disorder in Corrections and Community Settings - National Governors' Association Recommendations to the Governor's Subcabinet on Opioids, Substance Use, and Addiction Treating Opioid Use Disorder for Criminal-Justice-Involved Individuals - Minnesota Management and Budget Medications for Opioid Use Disorder in Jails Workgroup Gets Underway - Minnesota Medical Association One MN Plan Expanding Access to Methadone Treatment for Opioid Use Disorder in Carceral Settings - Johns Hopkins Bloomberg School of Public Health	People in detention settings	DHS, DOC, MDH, Medications for Opioid Use Disorder in Jails Workgroup, OAR	Improve access to medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

				engagement with peer support workers. This is something to be mindful of across the entire model: the reentry section calls for referrals and affirmative linkages to care “to supportive therapy as clinically indicated” but should add language along lines of “and as desired by the participant” - Supply of medications at reentry/release should be at least 30 days. (LAPPA model: “supply of any necessary medication…to continue his or her tx regimen”) - Reentry services should include connection to harm reduction and legal services - Reporting section should include the number of people whose medication is discontinued and the reason for the discontinuation. Public sharing of reporting is permitted/discretionary in the LAPPA model but should be required. - Certification/compliance: the LAPPA model refers only to extant programs certifying annually that they have met or exceeded the program requirements, but there is nothing about facilities that are standing up programs. There should be assurance of compliance from all facilities, whether or not they had an extant program (e.g., by							

				submitting a certification, all SOPs and policy documents, as well as the required data reporting at least annually). There should also be stipulations about the consequences of non-compliance. - The LAPPA model does not include a standalone section on participant safeguards, which we strongly recommend (there is only Section V(g) ("No person shall be dismissed from the medication for addiction treatment program on the basis of a positive drug screen. No person shall be removed from the medication for addiction treatment program due to administrative segregation or as a result of having committed any disciplinary infraction, including those not related to drug use") This does not address: •Drug screens that are negative for prescribed medication •Other punitive measures such as dosage reductions or medication switching •Medication diversion: Alleged or actual medication diversion should never result in medication discontinuation •Due process protections: participants should receive a copy of all program policies and procedures, grievance						

				procedures should be prominently displayed, etc.						

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
21	Health care	Expand access to MOUD	Expand MOUD access for people on community supervision	Direct the Department of Corrections to study and then implement changes to expand access to medications for opioid use disorder for people on community supervision.	Medium	Integration of Medications to Treat OUD in Probation and Parole Settings - Opioid Response Network State Strategies to Support OUD Treatment across the Criminal Legal System - National Academy for State Health Policy		Community Corrections Act Counties (CCA), DOC, and County Probation Officers (CPO)	Improve access to medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
22	Health care	Expand access to MOUD	Mandate screening for substance use disorders and pregnancy upon entry into detention	Require detention settings to implement universal screening programs for substance use disorder and pregnancy upon entry.	Low	Improving Access to Care for Pregnant and Postpartum People with Opioid Use Disorder: Recommendations for Policymakers - American Medical Association Opioid Use Disorder Treatment in Correctional Settings - National Commission on Correctional Health Care	People in detention settings, pregnant people	DOC, Minnesota Perinatal Quality Collaborative, OAR	Improve screening and early identification of substance use disorder, Improve access to substance use disorder treatment, Improve access to healthcare	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
23	Health care	Expand access to MOUD	Pass a "Model Substance Use During Pregnancy and Family Care Act"	Create protections for pregnant and postpartum people with substance use disorders to access medications for opioid use disorder by passing a "Model Substance Use During Pregnancy and Family Care Plans Act."	Medium	Model Substance Use During Pregnancy and Family Care Plans Act | Legislative Analysis and Public Policy Association Improving Access to Care for Pregnant and Postpartum People with Opioid Use Disorder: Recommendations for Policymakers - American Medical Association	Pregnant people	DHS, MDH, OAR, Task Force on Pregnancy Health and Substance Use Disorders	Improve access to medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
24	Health care	Expand access to MOUD	Continue to fund programs that expand access to evidence-based services for pregnant and post-partum families	Continue to fund programs that expand access to evidence-based services for pregnant and post-partum families in line with the 2023 Comprehensive Drug Overdose and Morbidity Prevention Act (Minnesota Statutes 144.0528).	Medium	Improving Access to Care for Pregnant and Postpartum People with Opioid Use Disorder: Recommendations for Policymakers - American Medical Association Enhancing outcomes for pregnant/postpartum families impacted by substance use disorders RFP - MN Department of Health Minnesota Maternal Mortality Report 2017-2018 - MN Department of Health Neonatal Abstinence Syndrome (NAS) road map - Minnesota Hospital Association Evidence-based, Whole-person care For Pregnant People Who Have Opioid Use Disorder - SAMHSA	Pregnant people	MDH, Minnesota Perinatal Quality Collaborative, Task Force on Pregnancy Health and Substance Use Disorders	Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
25	Health care	Expand access to MOUD	Integrate MOUD care in OBGYN settings	Pass legislation to integrate medications for opioid use disorder and substance use care in obstetric and gynecologic settings. Consider Oregon's Project Nurture program.	Medium	Improving Access to Care for Pregnant and Postpartum People with Opioid Use Disorder: Recommendations for Policymakers - American Medical Association Nurture Oregon Progress Report State Options for Promoting Recovery among Pregnant and Parenting Women with Opioid or Substance Use Disorder - National Academy for State Health Policy	Pregnant people	DCYF, DHS, Minnesota Perinatal Quality Collaborative, OAR, Task Force on Pregnancy Health and Substance	Improve access to medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
								Use Disorders		
26	Health care	Treatment for stimulant use disorder	Expand ECHO model for people using psychostimulants	Expand ECHO model to provide training for providers and first responders who encounter people using psychostimulants like methamphetamines.	Medium	Plan to Address Methamphetamine Supply, Use, and Consequences - Office of National Drug Control Policy Stimulant Use Disorder Guideline - American Society of Addiction Medicine		DHS, MDH, OAR	Improve utilization of healthcare	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
27	Health care	Treatment for stimulant use disorder	Expand contingency management for people with stimulant use disorder	Expand Contingency Management treatment for people with stimulant use disorder, either by applying for an 1115 Medicaid waiver or with other state funds.	Medium	A Decades-Old Treatment Can Reduce Stimulant Use—and Overdose Deaths | The Pew Charitable Trusts Note that implementation is complicated outside the context of an 1115 waiver, as even using non-federal funds does not eliminate barriers related to federal anti-kickback and beneficiary inducement laws. One way to avoid this is to contract with an organization that has gotten an advisory opinion from the federal department of Health and Human Services' Office of the Inspector General (DynamiCare Health), but that has its drawbacks too (e.g., it's an app-based program): HHS-OIG Issues Favorable Advisory Opinion on App-based Motivational Incentives for Substance Use Disorders — DynamiCare Health		DHS, MDH, OAR	Improve utilization of substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
28	Health care	Treatment for stimulant use disorder	Expand agonist prescriptions for stimulant use disorder	Expand agonist prescriptions for stimulant use disorder by asking state agencies to consider treating this as an acceptable medical practice. State-level policy approaches could include the state medical board supporting the practice or legislation/regulations affirmatively authorizing it (there	Medium	Prescribing Controlled Psychostimulants for Stimulant Use Disorder - A Brief Guide on Legal Considerations - American Society of Addiction Medicince and Vital Strategies		DHS, OAR	Improve utilization of medications for opioid use disorder	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
				are no known US examples of the latter).						
29	Health care	Other interventions	Develop reentry programs tailored to meet the needs of all people, especially those with special vulnerabilities.	Require correctional facilities to collaborate with multidisciplinary care teams to develop reentry programs tailored to meet the needs of all people, with special attention to pregnant and postpartum people and their families who have special needs.	Low	Improving Access to Care for Pregnant and Postpartum People with Opioid Use Disorder: Recommendations for Policymakers - American Medical Association Community Participant Mother Program - California Division of Rehabilitative Programs (DRP)	People in detention settings, pregnant people	DCYF, DOC, Minnesota Perinatal Quality Collaborative, OAR, Task Force on Pregnancy Health and Substance Use Disorders	Improve access to healthcare, Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
30	Health care	Other interventions	Improve withdrawal protocols for people in detention settings	Require best-practice, timely withdrawal protocols in state and local correctional settings. Increase the number of facilities equipped to handle withdrawal outside of correctional settings, and ensure transportation to these facilities is seamless.	Low	Model Withdrawal Management Protocol in Correctional Settings Act - Legislative Analysis and Public Policy Association Model Access to Medication for Addiction Treatment in Correctional Settings Act - Legislative Analysis and Public Policy Association Substance Use Disorder (SUD) Withdrawal Management Services - MN Department of Human Services	People in detention settings	DOC, Medications for Opioid Use Disorder in Jails Workgroup, OAR	Improve access to healthcare, Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities, Reduce incarceration

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
31	Health care	Compulsory treatment	Fund a study to understand where and when compulsory treatment is happening	Fund a study to understand where/when compulsory treatment is happening, e.g., in criminal legal system, to access shelter services, etc, and make recommendations to limit these occurrences.	Low	The effectiveness of compulsory drug treatment: A systematic review - International Journal of Drug Policy		DHS, DPS, Minnesota Judicial Branch	Improve utilization of substance use disorder treatment	Improve the autonomy and dignity of people who use drugs
32	Health care	Involuntary civil commitment	Evaluate potential changes and make recommendations as to how involuntary civil commitment statutes apply to and have been implemented among "Chemically dependent person[s]," noting also the broad inclusion of pregnant persons, seemingly without any requirement to find risk of harm.	Evaluate potential changes and make recommendations as to how Minn. Stat. § 253B.09 (involuntary civil commitment) applies to and has been implemented among "Chemically dependent person[s]" as defined in Minn. Stat. § 253B.02, Subd. 2. (Note broad inclusion of pregnant persons, seemingly without any requirement to find risk of harm.)	Low	Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice - SAMHSA Involuntary Commitment of Those with Substance Use Disorders: Summary of State Laws - Legislative Analysis and Public Policy Association		DCYF, Minnesota Perinatal Quality Collaborative, OAR, Task Force on Pregnancy Health and Substance Use Disorders	Improve utilization of substance use disorder treatment	Improve the autonomy and dignity of people who use drugs

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
33	Health care	Voluntary access to evidence-based treatment on demand that is culturally appropriate.	Expand access to treatment and recovery services for youth, especially services that are not religious.	Expand access to treatment and recovery services for youth, especially services that are not religious.	Medium	State Principles for Financing Substance Use Care, Treatment, and Support Services - Center for Health Care Strategies	Youth	DCYF, DHS, OAR	Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
34	Health care	Voluntary access to evidence-based treatment on demand that is culturally appropriate.	Continue to fund traditional healing for substance use disorder across the continuum of care.	Continue to fund traditional healing for substance use disorder across the continuum of care. Expand funding to cover all minority communities in Minnesota.	Medium	Recommendations to the Governor's Subcabinet on Opioids, Substance Use, and Addiction	Racial and ethnic minorities	DHS, MDH, Minnesota Indian Affairs Council, OAR	Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities, Reduce disparities
35	Health care	Voluntary access to evidence-based treatment on demand that is culturally appropriate.	Enhance services for Hmong and East African communities	Allocate funding for substance use disorder services across the continuum of care that are tailored to Hmong and East African communities, similar to funding initiatives focused on traditional healing for Native communities.	Medium	The Cultural and Ethnic Minority Infrastructure Grant (CEMIG) operated from 2018 to 2022: Culturally Specific Mental Health and Substance Use Disorder Services / Minnesota Department of Human Services Traditional Healing For Native Communities - MN Department of Human Services	Racial and ethnic minorities	DHS, MDH, OAR	Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities, Reduce disparities

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36	Health care	Voluntary access to evidence-based treatment on demand that is culturally appropriate.	Ensure the availability of translation services in substance use disorder treatment settings	Ensure the availability of translation services in substance use disorder treatment settings, especially at higher levels of care, in line with federal civil rights law. Dedicate funding to workforce development to hire more translators, and allocate funding to the Minnesota Department of Human Rights to expand oversight on this issue. Align behavioral health billing codes with medical codes to allow translation services to be billed.	Low	Adequate language access is mandated by federal civil rights laws, including ADA and § 1557. See, e.g., § 92.201 Meaningful access for individuals with limited English proficiency.	Racial and ethnic minorities	AG, DHS, Mid-Minnesota Legal Aid (the federally designated Protection and Advocacy agency for people with disabilities in Minnesota), Minnesota Department of Human Rights, OAR	Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities, Reduce disparities
37	Health care	Workforce	Allocate funding for technical assistance to community-based providers to become Medicaid providers.	Allocate funding for technical assistance to community-based providers to become Medicaid providers.	Medium	State Principles for Financing Substance Use Care, Treatment, and Support Services - Center for Health Care Strategies		DHS, OAR	Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
38	Health care	Workforce	Dedicate funding to offer targeted technical assistance including grant	Dedicate funding to offer targeted technical assistance including grant management support, strategic planning, and budget development to small and	Medium	State Principles for Financing Substance Use Care, Treatment, and Support Services - Center for Health Care Strategies		DHS, MDH, OAR	Improve access to substance use disorder treatment	Reduce disparities; Reduce overdose mortality, Reduce drug-related

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			management support, strategic planning, and budget development to small and BIPOC-owned CBOs.	BIPOC-owned CBOs to support increasing capacity and prioritize reaching these providers when releasing/disseminating request for proposals or other stateprovider funding mechanisms.						infectious disease transmission/other morbidities
39	Health care	Workforce	Continue to expand ECHO model to increase treatment access in rural Minnesota by training general practitioners to prescribe buprenorphine.	Continue to expand ECHO model to increase treatment access in rural Minnesota by training general practitioners to prescribe buprenorphine.	Medium	Evaluation of Opioid-Focused ECHO Programs in Minnesota - Minnesota Management and Budget		DHS, MDH, OAR	Improve access to medications for opioid use disorder	Reduce disparities; Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

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40	Health care	Workforce	Mandate training on harm reduction, MOUD, trauma-informed care, and other issues related to substance use, for all licensed healthcare providers.	Mandate specific training for all licensed healthcare providers, not only those practicing addiction medicine, on harm reduction, medications for opioid use disorder, working with people who use drugs, and trauma-informed care.	Low	The 3Cs Framework for Pain and Unhealthy Substance Use: Minimum Core Competencies for Interprofessional Education and Practice - National Academy of Medicine SUD for the Healthcare Team - Providers Clinical Support System-MOUD Guide to Harm Reduction - Overdose Lifeline Learning Recommendations for Curricular Elements in Substance Use Disorders Training | SAMHSA COPE - Coalition on Physician Education in Substance Use Disorders		DHS, MDH, Minnesota Health Licensing Boards, OAR	Improve access to healthcare, Improve utilization of healthcare	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
41	Health care	Workforce	Pass legislation to diversify the substance use disorder workforce.	Pass legislation to diversify the substance use disorder workforce. Leverage federal funding opportunities and create partnerships with with local colleges and universities, including Tribal colleges.	Medium	State Principles for Financing Substance Use Care, Treatment, and Support Services	Racial and ethnic minorities	Board of Pharmacy, DHS, MDE, Minnesota Health Licensing Boards, Minnesota State, OAR, Tribal Colleges and	Improve access to substance use disorder treatment	Reduce disparities; Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

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								Universities		
42	Health care	Workforce	Expand high quality peer support services by addressing professionalization, equitable compensation, and reimbursement issues.	Expand high quality peer support services by addressing professionalization, equitable compensation, and reimbursement issues. Allocate funding to organizations who hire peers to integrate them more meaningfully within the workplace and provide additional supports. Decrease or eliminate the cost of peer certification to recruits a diverse peer workforce that meets the needs of diverse Minnesotans.	Medium	Model Expanding Access to Peer Recovery Support Services Act | LAPPA National Modern Standards for Peer Support Certification - SAMHSA The Legal Path to a Whole of Government Opioids Response | Public Health Law Research		DHS, OAR	Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities, Improve the autonomy and dignity of people who use drugs
43	Health care	Workforce	Streamline peer certification programs.	Streamline peer certification programs to eliminate separate certifications for mental health and substance use disorder specialities.	Medium	National Model Standards for Peer Support Certification - SAMHSA		DHS	Improve access to substance use disorder treatment, Improve utilization of substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

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44	Health Care	Peer support	Consider state funding and policy mechanisms to promote organization-level infrastructure that facilitates the integration of peers and people with lived and living experience in the behavioral health workforce.	Consider state funding and policy mechanisms to promote organization-level infrastructure that facilitates the integration of peers and people with lived and living experience in the behavioral health workforce. For example, see Philadelphia's Peer Support Toolkit.	Medium	Peer Support Toolkit - City of Philadelphia Department of Behavioral Health Enhancing the Peer Provider Workforce: Recruitment, Supervision and Retention - National Association of State Mental Health Program Directors Florida Peer Services Handbook		DHS	Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities, Improve the autonomy and dignity of people who use drugs
45	Health Care	Special Populations	Invest in programs that expand racial diversity in the behavioral health workforce.	Invest in programs that expand racial diversity in the behavioral health workforce. For example, Oregon passed a law that provides financial incentives and assistance to recruit and retain BIPOC, tribal, and rural behavioral health providers.	Medium	State Strategies to Increase Diversity in the Behavioral Health Workforce - National Academy for State Health Policy Oregon House Bill 2949	Racial and ethnic minorities	DHS	Improve access to substance use disorder treatment	Reduce disparities; Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
46	Health care	Workforce	Establish and fund programs to create access for people with substance use disorders to peer recovery specialists in jails and prisons, emergency departments, and	Establish and fund programs to create access for people with substance use disorders to peer recovery specialists in jails and prisons, emergency departments, and other innovative settings. Explore establishing Forensic Peer Recovery Specialist as a certified, MA-reimbursable service. As part of this, consider how peer navigators and peer	Medium	Recommendations to the Governor's Subcabinet on Opioids, Substance Use, and Addiction State Principles for Financing Substance Use Care, Treatment, and Support Services - Center for Health Care Strategy	people in detention settings	DHS, DOC, Minnesota Health Licensing Boards, OAR	Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities, Improve the autonomy and dignity of people who use drugs

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			other innovative settings.	recovery specialists can smooth access to the "second prescription" for buprenorphine after the initial induction.						
47	Health care	Workforce	Consider ways to ease access to medications for substance use disorder for licensed healthcare professional, including by leveraging licensure questionnaires to encourage providers to seek treatment.	Consider ways to ease access to medications for substance use disorder for licensed healthcare professional, including by leveraging licensure questionnaires to encourage providers to seek treatment.	Low	Justice Department Secures Settlement Agreement with the Indiana State Nursing Board Addressing Discrimination Against People with Opioid Use Disorder - US Department of Justice Discrimination Against Physicians in Treatment with Medication for Opioid Use Disorders (MOUD) H-95.913 - American Medical Association		DHS, MDH, Minnesota Health Licensing Boards, OAR	Improve access to medications for opioid use disorder	Improve the autonomy and dignity of people who use drugs, Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

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48	Harm Reduction	911 Good Samaritan laws		Add protections to "Steve's Law," Minnesota's Good Samaritan law. - For example, some state's Good Samaritan Law offer immunity from drug possession and drug delivery offenses; Minnesota's law protects against possession, sharing, and use offenses only. - Minnesota's law only protects against charging and prosecution, but not arrest - which poses a significant disincentive to calling for help. - Protect against non-criminal consequences like evictions or child welfare system involvement (Maine's law is considered the strongest, and even if it does not offer such protections.) - Reduce onerous requirements for the caller (giving identifying information, waiting on the scene, etc). It is also unclear how those requirements apply to scenarios where a bystander is "acting in concert with a person seeking medical assistance." - Broaden protections for anyone who renders aid (not just those who seek help or act in concert with someone seeking help)	Medium	Barriers to calling emergency services amongst people who use substances in the event of overdose: A scoping review - International Journal of Drug Policy Effective, Equity-focused Overdose Good Samaritan Laws: Maine Leads the Way - Network for Public Health Law Maine Title 17-A, §1111-B: Immunity from arrest, prosecution and revocation and termination proceedings when assistance has been requested for suspected drug-related overdose		DHS, DPS, MDH, OAR	Improve access to healthcare, Reduce arrest, Reduce incarceration	Reduce overdose mortality

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				Create funding to educate people who use drugs about the protections in Steve's Law to encourage calling 911. Educate law enforcement about Steve's Law to prevent them from arresting people who are assisting during an overdose.						

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49	Harm Reduction	Naloxone	Fund the build out of the state's naloxone portal and naloxone saturation plan, including expanding formulations available on the portal beyond nasal to include intramuscular.	Fund the build out of the state's naloxone portal and naloxone saturation plan, including expanding formulations available on the portal beyond nasal to include intramuscular. (Also keep in mind evidence that high dose and long-acting opioid antagonists have no use in acute opioid response.) Designate a sustainable funding source for supporting naloxone access across the state. Mandate priority distribution to groups documented to be facilitating the most overdose reversals, like harm reduction organizations.	High	Naloxone Distribution Project - California Department of Health Care Services Minnesota Department of Health Naloxone Portal Naloxone Saturation Convening / Minnesota Management and Budget (MMB) Measuring Naloxone Distribution and Use in Minnesota: A Brief Landscape Analysis A call for compassionate opioid overdose response - International Journal of Drug Policy		DHS, OAR	Improve access to naloxone	Reduce overdose mortality
50	Harm Reduction	Naloxone	Mandate and fund the distribution of "harm reduction kits" to all Minnesotans exiting detention settings, including local facilities.	Mandate and fund the distribution of "harm reduction kits" to all Minnesotans exiting detention settings, including local facilities. For example, the Department of Corrections currently distributes "harm reduction kits" containing naloxone, fentanyl test strips, and other resources to people with opioid use disorders who are leaving DOC facilities. This program should be expanded to all county-run facilities and codified in statute.	Medium	MN Statute 641.155 Discharge Plans MN DOC - Harm Reduction Kits A Primer for Implementation of Overdose Education and Naloxone Distribution in Jails and Prisons - RTI Impact of Naloxone Availability and Distribution within the California Department of Corrections and Rehabilitation (CDCR)	People in detention settings	DOC	Improve access to naloxone	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

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				In addition, make naloxone available inside facilities (including to detained/incarcerated people, not just staff).						
51	Harm Reduction	Naloxone	Enact a law requiring pharmacies to maintain stocks of naloxone.	Enact a law requiring pharmacies to maintain stocks of naloxone.	low	City of Philadelphia Code § 9-637. Opioid Antidote Availability. Naloxone Availability in Retail Pharmacies and Neighborhood Inequities in Access - American Journal of Preventive Medicine The Legal Path to a Whole of Government Opioids Response | Public Health Law Research		MDH	Improve access to naloxone	Reduce overdose mortality

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52	Harm Reduction	Naloxone	Address the problem of law enforcement officers who confiscate or refuse to carry naloxone.	Law enforcement officers across the state continue to confiscate naloxone and/or refuse to carry naloxone. Refusing to carry naloxone is a violation of state law. For failure to carry, one policy option would be to integrate explicit consequences for failure to comply into statute in Sec. 626.8443 (around Peace Officer standards for carrying naloxone). Sec. 626.8469, Subdiv. 3 notes that "The board may impose licensing sanctions and seek injunctive relief under section 214.11 for failure to comply with the requirements of this section". The Board referenced is the Board of Peace Officer Standards and Training (see Sec. 626.84). Regarding confiscation, Secs. 626.21-626.223 in criminal procedure address unlawful search and seizure. A new statute could expressly prohibit the seizure of naloxone or using naloxone as the basis for search.	Low	Sec. 626.8443 MN Statutes Sec. 626.21 MN Statutes		DPS	Improve access to naloxone	Reduce overdose mortality

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53	Harm Reduction	Syringe Services Programs	Ensure adequate, sustainable, flexible funding for community-based syringe services programs.	Ensure adequate, sustainable, flexible funding for community-based syringe services programs.	High	Comparing harm reduction and overdose response services between community-based and public health department syringe service programmes using a national cross-sectional survey - Lancet Reg Health Am		MDH	Improve access to harm reduction services	Reduce drug-related infectious disease transmission/other morbidities
54	Harm Reduction	Syringe Services Programs	Increase funding for a broad range of safer smoking supplies to encourage transitions from injecting to other modes of administration or prevent initiation of injecting.	Increase funding for a broad range of safer smoking supplies to encourage transitions from injecting to other modes of administration or prevent initiation of injecting. Smoking and snorting were cited by key informants as more prevalent among youth and BIPOC communities, so increased funding for these materials is a health equity issue.	High	The utilization and delivery of safer smoking practices and services: a narrative synthesis of the literature - Harm Reduction Journal	Youth, Racial and Ethnic Minorities	MDH	Improve access to harm reduction services	Reduce drug-related infectious disease transmission/other morbidities
55	Harm Reduction	Syringe Services Programs	Create funding for a statewide, self-governed body to coordinate all syringe services programs, measure effectiveness, reduce duplication of services, expand where necessary, and bring coordinated requests and recommendations	Create funding for a statewide, self-governed body to coordinate all syringe services programs, measure effectiveness, reduce duplication of services, expand where necessary, and bring coordinated asks to the Minnesota Department of Health. For example, see the linked study from New York's Injection Drug Use Health Alliance.	Medium	Harm Reduction in New York City - Injection Drug Users Health Alliance (IDUHA)		MDH	Improve access to harm reduction services	Reduce drug-related infectious disease transmission/other morbidities

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			asks to the Minnesota Department of Health.							
56	Harm reduction	Syringe Services Programs	Direct the Minnesota Department of Health to ensure syringes services programs are not requiring that participants return syringes to receive new ones.	Direct the Minnesota Department of Health to ensure syringes services programs are not requiring that participants return syringes to receive new ones. This practice is prohibited with by Minnesota Department of Health grantees but continues nevertheless at some programs. This can happen when programs lack sufficient funding for syringes and may also be a sign of discrimination against people who use drugs.	Low	Syringe Services Programs - Minnesota Department of Health		MDH	Improve access to harm reduction services	Reduce drug-related infectious disease transmission/other morbidities
57	Harm Reduction	Syringe Services Programs	Conduct health department-led "detailing" to pharmacies about the importance of syringe access.	Conduct health department-led "detailing" to pharmacies about the importance of syringe access. One key informant found this to be an effective way to encourage pharmacies to sell syringes and dispel stigma related to people who use drugs.	Low	Minnesota Pharmacy Syringe/Needle Access Initiative - Minnesota Department of Health		Board of Pharmacy, MDH	Improve access to harm reduction services	Reduce drug-related infectious disease transmission/other morbidities

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58	Harm Reduction	Drug checking	Provide funding for statewide drug checking programs. Allowable expenditures should include FTIR (Fourier transform infrared spectroscopy) machines, training, and confirmatory/complementary testing through a reputable lab (potentially at the University of Minnesota).	Provide funding for statewide drug checking programs. Allowable expenditures should include FTIR (Fourier transform infrared spectroscopy) machines, training, and confirmatory/complementary testing through a reputable lab (potentially at the University of Minnesota).	Medium	Enhancing Harm Reduction Services in Health Departments - National Council on Mental Wellbeing Drug Checking | Opioid Science		DHS, MDH	Improve access to harm reduction services	Reduce overdose mortality
59	Harm Reduction	Drug checking	Create exemptions from possession charges for people using drug checking services and staff operating drug checking services. Regulations should allow for drug checking services to be stationary or mobile, depending	Create exemptions from possession charges for people using drug checking services and staff operating drug checking services. Regulations should allow for drug checking services to be stationary or mobile, depending on local and cultural needs. They should also protect the private information of people using the services.	Low	Drug Checking Equipment, Needles/Syringes, and Drug Paraphernalia: Summary of State Laws - Legislative Analysis and Public Policy Association		DHS, DPS, MDH	Improve access to harm reduction services	Reduce overdose mortality

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			on local and cultural needs. They should also protect the private information of people using the services.							
60	Harm Reduction	Overdose prevention centers	Enact legislation supporting the existence of "safe recovery sites" and creating protections for people who use and operate them.	Enact legislation supporting the existence of "safe recovery sites" and creating protections for people who use and operate them. Regulations should allow for multiple models that can meet the needs of different geographies, modes of drug use, and levels of medicalization.	Medium	Key Considerations for Regulating Overdose Prevention Centers (OPCs) - Drug Policy Alliance Policy on Harm Reduction of Illicit Drug Use - Minnesota Medical Association Overdose Prevention Centers: State of the Law - Drug Policy Alliance R.I. Gen. Laws §23-12.10-1 Vermont Laws § 4256. Overdose Prevention Centers		DHS, OAR	Improve access to harm reduction services	Reduce overdose mortality
61	Social Determinants	Housing	Continue to oversee the implementation of the Department of Corrections' Homeless Mitigation Plan.	Continue to oversee the implementation of the Department of Corrections' Homeless Mitigation Plan. Consider policy proposals and funding increases to facilitate ending homelessness for people leaving state prisons.	High	2023 Homelessness Report: Minnesota Department of Corrections Homelessness Mitigation Plan 2022 Legislative Report - Minnesota Department of Corrections	People in detention settings, people experiencing homelessness	DOC	Improve housing/Reduce homelessness	

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62	Social Determinants	Housing	Consider the recommendations issued by the Minnesota Advisory Committee to the U.S. Commission on Civil Rights to expand equitable access to housing.	Consider the recommendations issued by the Minnesota Advisory Committee to the U.S. Commission on Civil Rights to expand equitable access to housing.	High	Examining Fair Housing and Equal Access to Housing Opportunities in Minnesota - Minnesota Advisory Committee to the U.S. Commission on Civil Rights	People experiencing homelessness	Minnesota Housing Finance Agency	Improve housing/Reduce homelessness	
63	Social Determinants	Housing	Expand Harm Reduction, Health, and Housing grants program administered by MDH and other programs that facilitate access to treatment for substance use disorders and other social supports for people experiencing homelessness.	Expand Harm Reduction, Health, and Housing grants program administered by MDH and other programs that facilitate access to treatment for substance use disorders and other social supports for people experiencing homelessness.	High	Harm Reduction, Health, and Housing Hubs Grant - MN Dept. of Health Center of Excellence on Public Health and Homelessness - MN Dept. of Health	People experiencing homelessness	MDH	Improve housing/Reduce homelessness	
64	Social Determinants	Housing	Ensure the availability of Housing First models, including for people with warrants, with severe mental	Ensure the availability of Housing First models, including for people with warrants, with severe mental health issues, and with severe substance use disorders. Leverage the historic $2 billion in funding from the 2023 legislative	Medium	Crossroads to Justice: Minnesota's New Pathways to Housing, Racial and Health Justice for People Facing Homelessness	People experiencing homelessness	Minnesota Housing, Minnesota Interagency Council on	Improve housing/Reduce homelessness	

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
			health issues, and with severe substance use disorders.	session. This recommendation is in line with the Minnesota Interagency Council on Homelessness' "Pathway to Justice" plan Result 4, Strategy 1: Fund and develop a variety of housing options with fewer restrictions and barriers.				Homelessness		
65	Social Determinants	Housing	Implement recommendations from the Task Force on Shelter, including creating an Ombuds for Shelter Oversight.	Implement recommendations from the Task Force on Shelter, including creating an Ombuds for Shelter Oversight.	Medium	Task Force on Shelter Final Report - Minnesota Interagency Council on Homelessness Minnesota Homeless Mortality Brief: Insight from People with Lived Experience - Minnesota Department of Health	People experiencing homelessness	DHS, Minnesota Interagency Council on Homelessness	Improve housing/Reduce homelessness	
66	Social Determinants	Housing	Designate funding for tailored shelter settings that can meet the needs of diverse populations.	Designate funding for tailored shelter settings that can meet the needs of diverse populations, including youth, women experiencing intimate partner violence, the East African community, and for couples and families with children to be sheltered together. Leverage the historic $1 billion in funding from the 2023 legislative session.	Medium	Task Force on Shelter Final Report - Minnesota Interagency Council on Homelessness	Youth, Women, Racial and Ethnic Minorities; People experiencing homelessness	DHS, Minnesota Interagency Council on Homelessness	Improve housing/Reduce homelessness	

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67	Social Determinants	Housing	Enact and enforce legislation that prohibits the criminalization of homelessness.	Enact and enforce legislation that prohibits the criminalization of homelessness and linked life-sustaining activities.	High	The Housing Not Handcuffs Act of 2017: Stop Criminalization of Homelessness, Eliminate Unjust Evictions, & Increase Access - National Law Center on Homelessness and Poverty Housing Not Handcuffs 2019: Ending the Criminalization of Homelessness in U.S. Cities - National Law Center on Homelessness & Poverty No Safe Place: The Criminalization of Homelessness in U.S. Cities - National Law Center on Homelessness & Poverty	People experiencing homelessness	DPS	Improve housing/Reduce homelessness	

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
68	Social Determinants	Housing	Increase state oversight of ongoing homeless encampments and sweeps.	Increase state oversight of ongoing homeless encampments and sweeps. See, for example, SF5259 from the 2024 legislative session, as a starting point. Integrate the "Encampment Principles and Practices" from the National Law Center on Homelessness & Poverty.	Medium	State of Minnesota 93rd Legislative Session, S.F. No. 5259 Housing Not Handcuffs 2019: Ending the Criminalization of Homelessness in U.S. Cities - National Law Center on Homelessness & Poverty Encampment Principles & Best Practices - National Law Center on Homelessness & Poverty Gloria Johnson Template Legislation - National Law Center on Homelessness & Poverty Impact of Encampment Sweeps on People Experiencing Homelessness - National Healthcare for the Homeless Council An Overview of Homeless Encampments for City Leaders - National League of Cities	People experiencing homelessness	DHS, DPS, MDH, Minnesota Interagency Council on Homelessness, OAR	Improve housing/Reduce homelessness	

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69	Social Determinants	Housing	Study alternatives to homeless encampments like temporary shelter facilities, temporary authorized encampments, and safe parking lots.	Study alternatives to homeless encampments like temporary shelter facilities, temporary authorized encampments, and safe parking lots.	Low	Housing Not Handcuffs 2019: Ending the Criminalization of Homelessness in U.S. Cities - National Law Center on Homelessness & Poverty Encampment Principles & Best Practices - National Law Center on Homelessness & Poverty Gloria Johnson Template Legislation - National Law Center on Homelessness & Poverty Impact of Encampment Sweeps on People Experiencing Homelessness - National Healthcare for the Homeless Council An Overview of Homeless Encampments for City Leaders - National League of Cities Safe Bay Duluth	People experiencing homelessness	DHS, Minnesota Interagency Council on Homelessness	Improve housing/Reduce homelessness	
70	Social Determinants	Housing	Create policy that homeless shelters may not deny access to people seeking shelter based on mental or chemical health status.	Create policy that homeless shelters may not deny access to people seeking shelter based on mental or chemical health status, in line with recommendation from the Minnesota Task Force on Shelter.	Low	Task Force on Shelter Final Report - Minnesota Interagency Council on Homelessness	People experiencing homelessness	DHS, DPS, MDH, Minnesota Interagency Council on Homelessness	Improve housing/Reduce homelessness	

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
71	Social Determinants	Housing	Regulate recovery homes to ensure high quality services.	Regulate recovery homes to ensure high quality services. This should include, for example: - Requiring that recovery homes are certified as meeting national standards, such the National Association for Recovery Residence standards - Enforcing quality standards my making the receipt of referrals and funds dependent upon meeting those standards. - Investing in the development and sustainability of certified recovery housing	Low	Sober Homes Situational Analysis - MN Department of Human Services Legislative Report State Policy Guide for Supporting Recovery Housing - National Council for Behavioral Health Standards | National Alliance for Recovery Residences		DHS	Improve housing/Reduce homelessness	
72	Social Determinants	Housing	Pass legislation to pre-empt local 911 nuisance and "crime-free housing" ordinances.	Pass legislation to pre-empt local 911 nuisance and "crime-free housing" ordinances.	Medium	Cities and Counties in California RE: Updated Guidance on Crime-Free Housing Policies - State of California Office of the Attorney General Legal Challenges to Crime-Free Housing Ordinances Bring Effectiveness into Question - Urban Institute Crime/Drug-Free, disorderly/nuisance conduct rental ordinances in Minnesota — HOME Line		DPS, Minnesota Housing, Minnesota Interagency Council on Homelessness	Improve housing/Reduce homelessness	
73	Social Determinants	Housing	Amend MN Stat 504B.171 to remove requirements that residential leases include drug-free	Amend MN Stat 504B.171 to remove requirements that residential leases include drug-free provisions and anti-sex work provisions.	Low	National Tenants Bill of Rights - National Housing Law Project		DPS, Minnesota Housing, Minnesota Interagency Council	Improve housing/Reduce homelessness	

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			provisions and anti-sex work provisions.					on Homelessness		
74	Social Determinants	Housing	Ensure local-level implementation of changes to Minn. Stat. 504B.205 subd. 2 and 3, which bar landlords from penalizing tenants for calling police or emergency services for health crises (including overdose) and preempts inconsistent local ordinances or rules.	Ensure local-level implementation of changes to Minn. Stat. 504B.205 subd. 2 and 3, which bar landlords from penalizing tenants for calling police or emergency services for health crises (including overdose) and preempts inconsistent local ordinances or rules.	Low	Chapter 118 - MN Laws Legal Challenges to Crime-Free Housing Ordinances Bring Effectiveness into Question - Urban Institute Crime/Drug-Free, disorderly/nuisance conduct rental ordinances in Minnesota — HOME Line		Minnesota Housing	Improve housing/Reduce homelessness	
75	Social Determinants	Employment	Increase funding for recovery-friendly workplace programming.	Increase funding for recovery-friendly workplace programming.	Medium	State Profiles: Recovery Friendly Workplace Landscape Analysis Workplace Supported Recovery | Substance Use and Work | CDC Opioid Epidemic Response: Employer Toolkit - MN Department of Health		DHS, MDH	Improve employment, Reduce poverty	
76	Social Determinants	Employment	Allocate funding for "supported employment" programs for	Allocate funding for "supported employment" programs for people with substance use	Medium	Individual Placement and Support (IPS) - A Supported Employment Model - SAMHSA		DHS, MDH	Improve employment, Reduce poverty	

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
			people with substance use disorders and serious mental health issues.	disorders and serious mental health issues.						
77	Social Determinants	Employment	Establish minimum wage laws to a level sufficient to allow a full-time worker to rise above the poverty line and obtain stable housing.	Establish minimum wage laws to a level sufficient to allow a full-time worker to rise above the poverty line and obtain stable housing.	High	New Jersey Revised Statutes Section 34:11-56a (2023) - Minimum wage level; establishment Minnesota minimum wage report 2023 The Legal Path to a Whole of Government Opioids Response | Public Health Law Research		Department of Labor and Industry	Improve employment, Reduce poverty	
78	Social Determinants	Employment	Implement findings from the DHS background study task force.	Implement findings from the DHS background study task force. In addition, follow the recommendations for the Governor's Subcabinet on Opioids, Substance Use, and Addiction to decrease the timeline for reconsiderations and remove onerous barriers to application.	High	Human Services Background Study Eligibility Task Force Final Report to the Minnesota Legislature Recommendations to the Governor's Subcabinet on Opioids, Substance Use, and Addiction		DHS, OAR	Improve employment, Reduce poverty	

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79	Social Determinants	Employment	Improve compliance and enforcement of "ban the box" provisions.	For compliance and enforcement of "ban the box" provisions: • Increase per violation penalties for private employers and eliminate monthly limits. • Establish a private right of action with fee shifting (i.e., ability to recover attorneys' fees) for violations by private employers. • Establish recordkeeping and data reporting requirements for private and public employers, consistent with the National Employment Law Project model law. • Establish a rebuttable presumption that a private employer is in violation if they do not maintain or retain adequate records or allow the enforcing agency sufficient access to such records. • Require proactive audits, compliance reviews, and public reporting for public employers, consistent with the National Employment Law Project model.	Medium	Best Practices and Model Policies: Creating a Fair Chance Policy - National Employment Law Project		Minnesota Department of Human Rights	Improve employment, Reduce poverty	

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80	Social Determinants	Employment	Establish that it is state policy to do business only with contractors that have adopted and employ written policies, practices, and standards that are consistent with the "Ban the Box" requirements applicable to public employers.	Establish that it is state policy to do business only with contractors that have adopted and employ written policies, practices, and standards that are consistent with the "Ban the Box" requirements applicable to public employers. Require state agencies to review contractors' background check policies for consistency with the state "Ban the Box" policy and consider background check policies and practices among the performance criteria in evaluating a contract.	Medium	Best Practices and Model Policies: Creating a Fair Chance Policy - National Employment Law Project Ban-the-Box and Criminal Records in Employment - Minnesota Department of Human Rights		Minnesota Department of Human Rights	Improve employment, Reduce poverty	
81	Social Determinants	Employment	Consider modifying criteria for whether convictions are directly related to employment in line with the National Employment Law Project model.	Consider modifying criteria for whether convictions are directly related to employment in line with the National Employment Law Project model (e.g., opportunity for same/similar offense, whether circumstances will recur, length of time). Extend the law to apply to private employers. Minn. Stat. Ann. § 364.03, Subd. 2.	Medium	Best Practices and Model Policies: Creating a Fair Chance Policy - National Employment Law Project Ban-the-Box and Criminal Records in Employment - Minnesota Department of Human Rights		Minnesota Department of Human Rights	Improve employment, Reduce poverty	
82	Social Determinants	Employment	Extend Minn. Stat. Ann. § 364.03, Subd. 1., which describes when convictions may be disqualifying, to	Extend Minn. Stat. Ann. § 364.03, Subd. 1., which describes when convictions may be disqualifying, to include private employers. The conviction must be directly related to the position of employment sought or to the	Medium	Best Practices and Model Policies: Creating a Fair Chance Policy - National Employment Law Project Ban-the-Box and Criminal Records in Employment - Minnesota Department of Human Rights		Minnesota Department of Human Rights	Improve employment, Reduce poverty	

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			include private employers.	occupation for which the license is sought, to be disqualifying.						
83	Social Determinants	Employment	Amend Minn. Stat. Ann. § 364.021(a) to prohibit a public or private employer from inquiring into, considering, or requiring disclosure of the criminal record/history of an applicant until a conditional offer of employment, regardless of whether there is an interview.	Amend Minn. Stat. Ann. § 364.021(a) to prohibit a public or private employer from inquiring into, considering, or requiring disclosure of the criminal record/history of an applicant until a conditional offer of employment, regardless of whether there is an interview.	Medium	Best Practices and Model Policies: Creating a Fair Chance Policy - National Employment Law Project Ban-the-Box and Criminal Records in Employment - Minnesota Department of Human Rights		Minnesota Department of Human Rights	Improve employment, Reduce poverty	
84	Social Determinants	Employment	Extend the "Ban the Box" statutes governing evidence of rehabilitation to private employers.	Extend the "Ban the Box" statutes governing evidence of rehabilitation to private employers. Minn. Stat. Ann. § 364.03, Subd. 3.	Medium	Best Practices and Model Policies: Creating a Fair Chance Policy - National Employment Law Project Ban-the-Box and Criminal Records in Employment - Minnesota Department of Human Rights		Minnesota Department of Human Rights	Improve employment, Reduce poverty	

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85	Social Determinants	Employment	Amend Minn. Stat. Ann. § 364.05 to add protections associated with "Ban the Box" laws, for example, by requiring written notice before a final decision to deny employment or licensure.	Amend Minn. Stat. Ann. § 364.05 or enact a new statutory section that: • Requires written notice before a final decision to deny employment or licensure. • Provides individuals with a reasonable opportunity to submit corrective information or evidence of rehabilitation. • Require employers to hold open the position until they complete an individualized assessment based on submitted materials. These requirements should extend to private employers.	Medium	Best Practices and Model Policies: Creating a Fair Chance Policy - National Employment Law Project Ban-the-Box and Criminal Records in Employment - Minnesota Department of Human Rights		Minnesota Department of Human Rights	Improve employment, Reduce poverty	
86	Social Determinants	Employment	Amend Minn. Stat. Ann. § 364.05, requiring employers to provide written notice after denial of employment or licensure, by extending it to private employers.	Amend Minn. Stat. Ann. § 364.05, requiring employers to provide written notice after denial of employment or licensure, by extending it to private employers.	Medium	Best Practices and Model Policies: Creating a Fair Chance Policy - National Employment Law Project Ban-the-Box and Criminal Records in Employment - Minnesota Department of Human Rights		Minnesota Department of Human Rights	Improve employment, Reduce poverty	
87	Social Determinants	Employment	Consider policies that address the use of an individual's criminal-legal system involvement in	Consider policies that address the use of an individual's criminal-legal system involvement in post-hiring adverse employment actions (i.e., discipline and/or termination).	Low	Worker Power in the Carceral State - National Employment Law Project		Minnesota Department of Human Rights	Improve employment, Reduce poverty	

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			post-hiring adverse employment actions (i.e., discipline and/or termination).							
88	Social Determinants	Employment	Restrict drug testing of job applicants by private employers to safety-sensitive industries, with exceptions for when such testing is required by federal law. Increase specificity around the definition of safety-sensitive industries to limit net-widening.	Restrict drug testing of job applicants by private employers to safety-sensitive industries, with exceptions for when such testing is required by federal law. Increase specificity around the definition of safety-sensitive industries to limit net-widening.	Medium	Sec. 181.951 MN Statutes State-by-State Workplace Drug Testing Laws | American Civil Liberties Union		Department of Labor and Industry	Improve employment, Reduce poverty	

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89	Social Determinants	Consumer Finance	Consider the recommendations in the National Center for Access to Justice's Fines and Fees Index.	Consider the recommendations in the National Center for Access to Justice's Fines and Fees Index, such as the below (see the resource for the full list): - Abolishing fees for appointed counsel and incarceration fees - Abolishing all juvenile court fines and fees - Ensuring that revenue generated by fines and fees does not flow to law enforcement or court budgets - Amending the law to codify Minnesota's practice of not using private collection firms to collect fines and fees debt - Requiring courts to assess people's ability to pay when imposing a fine, fee, assessment, or surcharge - Eliminating incarceration as a sanction for failure to pay. Alternatively, require the government to prove that a person's failure to pay was "willful" before ordering incarceration or other sanctions. - Codifying a substantive ability-to-pay standard that all state and local courts must use.	Medium	Fines and Fees Index Minnesota - National Center for Access to Justice at Fordham Law School Understanding the Landscape of Fines, Restitution, and Fees for Criminal Convictions in Minnesota - Robina Institute	People in detention settings	Board of Public Defense, DPS, Minnesota Judicial Branch	Reduce poverty	

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				- Codifying a clear threshold at which a person is presumed unable to afford fines or fees. - Authorizing judges' discretion in waiving or modifying all fines, fees, and other costs.						
90	Social Determinants	Consumer Finance	Review data around legal financial obligations incurred after incarceration, including child support policies. Consider implementing automatic freezing of obligations	Review data around legal financial obligations incurred after incarceration, including child support policies. Consider implementing automatic freezing of obligations during incarceration and integrating payment assistance into reentry programs.	Medium	Debt, Incarceration, and Re-entry: a Scoping Review - American Journal of Criminal Justice Dual Debt: Child Support and Criminal Legal Financial Obligations - Center for Advanced Studies in Child Welfare	People in detention settings	DOC	Reduce poverty	

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
			during incarceration and integrating payment assistance into reentry programs.							
91	Social Determinants	Consumer Finance	Consider the impact of mandatory child support payments on people with other financial legal obligations and possible policy responses.	Consider the impact of mandatory child support payments on people with other financial legal obligations. Policy measures could include: - Ceasing or dramatically reducing wage garnishment for people with low incomes - Civil and criminal systems should consider fees imposed by the other system when imposing sanctions - Abolishing, or reducing considerably, state-imposed debts.	Low	Dual Debt: Child Support and Criminal Legal Financial Obligations - Center for Advanced Studies in Child Welfare Minnesota's Child Support Laws - MN House Research		DOC, DPS	Reduce poverty	
92	Social Determinants	Consumer Finance	Fund programs that provide financial guidance to people entering the criminal-legal system, and as they reenter the community after incarceration, to help minimize the impact of	Fund programs that provide financial guidance to people entering the criminal-legal system, and as they reenter the community after incarceration, to help minimize the impact of incarceration on personal debt and credit.	Low	Everyone deserves a second chance. Use our tools to financially empower people in transition from incarceration - Consumer Finance Protection Bureau	People in detention settings	DOC, DPS, Minnesota Judicial Branch	Reduce poverty	

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
			incarceration on personal debt and credit.							
93	Social Determinants	Consumer Finance	Enact strong protections against high bank overdraft fees.	Enact strong protections against high bank overdraft fees.	Low	See N.Y. Comp. Codes R. & Regs tit 3 §§ 32.1-32.2 for example of high bank overdraft protections. See N.M. Stat. 58-7-7 for an example of predatory lending protections, including a 36% maximum annual interest rate cap on small loans. The Legal Path to a Whole of Government Opioids Response | Public Health Law Research		Attorney General, Department of Commerce	Reduce poverty	
94	Social Determinants	Consumer Finance	Pass legislation to facilitate guaranteed income programs.	Pass legislation to facilitate guaranteed income programs.	Medium	The American Guaranteed Income Studies: Saint Paul, Minnesota State Strategies to Strengthen Family Economic Stability and Opportunity - Minnesota Department of Human Services States Should Protect Guaranteed Income Initiatives and Other Unrestricted Cash Programs | Center on Budget and Policy Priorities		DHS, Department of Commerce	Reduce poverty	

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95	Social Determinants	Public Benefits	Eliminate random drug testing for SNAP and TANF beneficiaries with felony drug convictions.	Eliminate random drug testing for SNAP and TANF beneficiaries with felony drug convictions.	Low	No More Double Punishments: Lifting the Ban on SNAP and TANF for People with Prior Felony Drug Convictions - Center for Law and Social Policy		DHS	Reduce poverty	Reduce poverty
96	Social Determinants	Education	Consider legislation based on the findings from Education Minnesota's report to enhance restorative and trauma-informed schools in Minnesota.	Consider legislation based on the findings from Education Minnesota's report to enhance restorative and trauma-informed schools in Minnesota, including: - Providing funding for school workers and school districts to transition all schools to a restorative model - Providing funding for research-based strategies that reduce exclusionary practices - Mandate that children from birth to grade 3 should not receive suspensions or expulsions.	Medium	Interrupting Racism, Strengthening Communities, and Accelerating Student Learning: The Need for Restorative Practices and Trauma-Informed Schools in Minnesota - Educator Policy Innovation Center	youth	MDE	Improve education	
97	Social Determinants	Education	Pass a Model School Response to Drugs and Drug-related Incidents Act.	Pass the Model School Response to Drugs and Drug-related Incidents Act. In addition, add to the model legislation an explicit prohibition on law enforcement involvement and reporting, including where the required fact-finding of "Where the student(s) obtained the drug(s)" determines that another student was the source	Low	Model School Response to Drugs and Drug-related Incidents Act | LAPPA	youth	DHS, DPS, Department of Education	Improve education	

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				(i.e., protect that student from law enforcement involvement too).						
98	Social Determinants	Education	Direct state agencies to assess schools' drug education programs and drug counseling services for their adherence to evidence base.	Direct state agencies to assess schools' drug education programs and drug counseling services for their adherence to evidence base.	Low	Safety First | Halpern-Felsher REACH Lab | Stanford Medicine	youth	MDE, Minnesota State Colleges and Universities	Prevent people from developing substance use disorders	
99	Social Determinants	Education	Conduct a review statutes and rules to understand the ability of the state and private and public post-secondary institutions to restrict or deny access to student housing, aid, scholarships, or ability to participate in student government, activities, or sports based on drug	Conduct a review statutes and rules to understand the ability of the state and private and public post-secondary institutions to restrict or deny access to student housing, aid, scholarships, or ability to participate in student government, activities, or sports based on drug arrests or convictions.	Low	Collateral Consequences of Juvenile Court Involvement: Obstacles to Opportunities - National Council of Juvenile and Family Court Judges	youth	Department of Education, Minnesota State Colleges and Universities	Improve education, Reduce poverty	

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
			arrests or convictions.							
100	Social Determinants	Children and families	Invest in macro-level policies like child care subsidies and child cash benefits that decrease the risk of SUD.	Invest in programs like child care subsidies and child cash benefits. According to the National Academy of Medicine, "Macro-level policies reduce low-income families' strain to meet basic needs and decrease socioeconomic risks for parents and their children. They also decrease risk for SUD."	Medium	Primary, Secondary, and Tertiary Prevention of Substance Use Disorders through Socioecological Strategies - National Academy of Medicine		DCYF	Reduce poverty	

101	Social Determinants	Children and families	Create state policies that enable pregnant and postpartum people to seek supportive, non-punitive treatment and address the needs of families, including in family care plans by passing a "Model Substance Use During Pregnancy and Family Care Plans Act."	Create state policies that enable pregnant and postpartum people to seek supportive, non-punitive treatment and address the needs of families, including in family care plans by passing a "Model Substance Use During Pregnancy and Family Care Plans Act." This recommendation is in line with the findings from the state Task Force on Pregnancy and Substance Use Disorder. Policies should: - Ensure state laws clearly distinguish between a “notification” and a “report” when there is a substance-exposed newborn or a pregnant or postpartum individual receiving MOUD - Establish separate and distinct pathways for notification and reporting. - Allow for de-identified reporting to child protection agencies in cases of babies born affected by substance use. - Support education and training opportunities for the perinatal workforce. - Publicize and encourage non-punitive clinical screening and treatment. - Develop family care plans using a public health approach. - Collect and publish data to evaluate and improve the efficacy of family care plans	Medium	MN law around reporting of prenatal substance exposure has major problems akin to those associated with more regressive states (eg. WI and Act 292). See Minn. Stat. § 260E.31. - Reporting is not limited to demonstrable impact on the infant. This is the basic standard needed to meet federal law, although states are free to exceed it (as does Minnesota). Instead, reporting is triggered when a "person knows or has reason to believe that a woman is pregnant and has used a controlled substance for a non medical purpose during the pregnancy," which includes cannabis. - Although there is a carveout for health care workers and/or social service providers currently providing care to a parent and their infant in subsection 1(b), we are not confident that this is sufficiently protective. In addition, the exception lapses if care is discontinued. - When the report is received, child welfare agency conducts an assessment and can recommend treatment or prenatal care - this is fairly standard. But the child welfare agency must seek an emergency admission under Minn. Stat. § 253B.051 "if the pregnant woman refuses recommended voluntary services or fails recommended treatment." (Recommendations around involuntary civil commitment are located in the Health Care domain.) Model Substance Use During Pregnancy and Family Care Plans Act - Legislative Analysis and Public Policy Association Improving Access to Care for Pregnant and Postpartum People with Opioid Use Disorder: Recommendations for Policymakers - American Medical Association	Pregnant and parenting people	DHS, Task Force on Pregnancy Health and Substance Use Disorders	Improve access to substance use disorder treatment, Keep families together	

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
102	Social Determinants	Children and families	Pass legislation removing prenatal substance exposure from the definition of child neglect in Minn. Stat. Sec. 260E.03, subdv. 15; and providing that prenatal substance exposure on its own may not be the basis of investigation by child welfare.	Pass legislation removing prenatal substance exposure from the definition of child neglect in 260E.03, subdv. 15; and providing that prenatal substance exposure on its own may not be the basis of investigation by child welfare.	Medium	Model Substance Use During Pregnancy and Family Care Plans Act | LAPPA Improving Access to Care for Pregnant and Postpartum People with Opioid Use Disorder: Recommendations for Policymakers - American Medical Association Minn. Stat. § 260E.03(15)(a)(5) includes in the definition of neglect prenatal substance exposure, and § 260E.03(15)(a)(7) also includes "chronic and severe use of alcohol or a controlled substance by a person responsible for the child's care that adversely affects the child's basic needs and safety." This definition treats parental substance use as inherently threatening/risky.	Pregnant and parenting people	DHS, Task Force on Pregnancy Health and Substance Use Disorders	Keep families together	

103	Social Determinants	Children and families	Pass a statewide policy around toxicology screening and testing of pregnant people, to create consistency across the state in terms of what substances are screened/tested for and what the threshold is for reporting where the test is positive for an infant.	Pass a statewide policy around toxicology screening and testing of pregnant people, to create consistency across the state in terms of what substances are screened/tested for and what the threshold is for reporting (See Minn. Stat. § 260E.32(2)(b): where the test is positive for an infant, statute requires it to be reported as neglect.) Recommendations around testing should provide for informed consent and ensure that patients understand the ramifications of a positive test. In addition, policy should consider how statute should avoid normalizing or encouraging universal urine drug toxicology for pregnant and/or birthing ppl in Minnesota hospitals, a practice which has been challenged as illegal in some jurisdictions. See, e.g., this recent action brought by the NJ attorney general.	Medium	Substance Abuse Reporting and Pregnancy: The Role of the Obstetrician–Gynecologist - American College of Obstetricians and Gynecologists "Seeking obstetric–gynecologic care should not expose a woman to criminal or civil penalties, such as incarceration, involuntary commitment, loss of custody of her children, or loss of housing" and "Legally mandated testing and reporting puts the therapeutic relationship between the obstetrician–gynecologist and the patient at risk, potentially placing the physician in an adversarial relationship with the patient." Creating safe care: Supporting pregnant and parenting patients who use drugs - Camden Coalition Substance Use and Substance Use Disorder Among Pregnant and Postpartum People - American Society of Addiction Medicine "[E]quating a positive toxicology test with child abuse or neglect is scientifically inaccurate and inappropriate, and can lead to an unnecessarily punitive approach, which harms clinician-patient trust and persons' engagement with healthcare services." Opioid Use and Opioid Use Disorder in Pregnancy - American College of Obstetricians and Gynecologists When creating policy, it is important to distinguish between testing and screening. See this resource from ACOG on the contrast/implications of each in context of OUD.	Pregnant and parenting people	DHS, Task Force on Pregnancy Health and Substance Use Disorders	Keep families together	

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
104	Social Determinants	Children and families	Pass legislation that extends the timeline for permanency decisions to terminate parental rights to allow parents the opportunity to meet milestones and successfully reunify the family.	Pass legislation that extends the timeline for permanency decisions to terminate parental rights to allow parents the opportunity to meet milestones (for example, those related to treatment for substance use disorder) and successfully reunify the family.	Low	Integration of Medications to Treat OUD in Probation and Parole Settings - Opioid Response Network State Strategies to Support OUD Treatment across the Criminal Legal System - National Academy for State Health Policy Overdose Prevention and Response in Community Corrections: An Environmental Scan - National Council for Mental Wellbeing Overdose among mothers: The association between child removal and unintentional drug overdose in a longitudinal cohort of marginalised women in Canada - International Journal of Drug Policy	Pregnant and parenting people	DHS, Task Force on Pregnancy Health and Substance Use Disorders	Keep families together	
105	Social Determinants	Children and families	Allocate funding to co-located treatment, where families can remain together.	Allocate funding to co-located treatment, where families can remain together.	Medium	How can family-based residential treatment programs help reduce substance use and improve child welfare outcomes? - Casey Family Programs	Pregnant and parenting people	DHS, Task Force on Pregnancy Health and Substance Use Disorders	Keep families together, Improve access to substance use disorder treatment	
106	Social Determinants	Children and families	Provide funding to scale up projects like Hennepin County's Health Equity Legal Project, which brings social	Provide funding to scale up projects like Hennepin County's Health Equity Legal Project, which brings social workers, parent mentors, and attorneys together with hospitals to identify pregnant patients who use drugs	Medium	Health Equity Legal Project - Bureau of Justice Assistance	Pregnant and parenting people	DHS, Task Force on Pregnancy Health and Substance Use Disorders	Improve screening and early identification of substance use disorder, Improve access to	

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
			workers, parent mentors, and attorneys together with hospitals to identify pregnant patients who use drugs to help families access needed resources.	to help families access needed resources like housing and treatment for substance use disorder. Note that federal grants for legal services often exclude undocumented immigrants, so ensure that is included in state funding.					substance use disorder treatment, Keep families together	
107	Social Determinants	Immigration	Create and fund culturally specific grant programs to prevent drug use among immigrant youth and youth from refugee families.	Create and fund culturally specific grant programs to prevent drug use among immigrant youth and youth from refugee families.	High	Elevate Youth California		DHS, MDE, MDH	Prevent people from developing substance use disorders	
108	Social Determinants	Immigration	Pass legislation to prohibit local law enforcement from collaborating with federal immigration enforcement.	Pass legislation to prohibit local law enforcement from collaborating with federal immigration enforcement. (Drug offenses are a significant driver of such cooperation and they account for a substantial number of arrests.)	Medium	What's a Sanctuary Policy? FAQ on Federal, State and Local Action on Immigration Enforcement - National Council of State Legislatures		DPS, Minnesota Judicial Branch	Reduce arrests, reduce incarceration	

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
109	Social Determinants	Immigration	Allow immigrants to enter a plea or access diversion programs without requiring them to admit to violating state criminal law, thereby avoiding application of federal immigration laws.	Allow immigrants to enter a plea or access diversion programs without requiring them to admit to violating state criminal law, thereby avoiding application of federal immigration laws. See, for example, California's 2018 "pre-trial" diversion statute or the state's 2022 Alternate Plea Act.	Low	California Pretrial Diversion for Minor Drug Charges - Immigrant Legal Resource Center California AB 2195 California Legislature Approves a Bill Addressing the Impact of Drug Convictions on California Residents | Immigrant Legal Resource Center		MN Board of Public Defense, Minnesota Judicial Branch	Reduce arrests, reduce incarceration, increase access to substance use disorder treatment	
110	Social Determinants	Immigration	Fully fund legal services that ensure immigrants can defend against deportation and obtain immigration benefits for which they are eligible.	Fully fund legal services that ensure immigrants can defend against deportation and obtain immigration benefits for which they are eligible.	Low	"Disrupt and Vilify": The War on Immigrants Inside the U.S. War on Drugs - Drug Policy Alliance		MN Board of Public Defense, Minnesota Judicial Branch	Improve access to legal council, Reduce incarceration	Reduce disparities, Reduce poverty
111	Social Determinants	Immigration	Codify in state law the requirements of Padilla v. Kentucky so people charged with drug offenses have full and accurate advice from defense counsel about the immigration penalties of plea	Codify in state law the requirements of Padilla v. Kentucky so people charged with drug offenses have full and accurate advice from defense counsel about the immigration penalties of plea offers and guilty pleas. Fully fund the implementation of the law.	Low	At the intersection of criminal and immigration law - Immigrant Law Center of Minnesota Implications of Padilla v. Kentucky on the Duties of State Court Criminal Judges - Center for Public Policy Studies		Minnesota Judicial Branch	Improve access to legal council, Reduce incarceration	

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
			offers and guilty pleas.							
112	Social Determinants	Immigration	Bring Minnesota's fifth degree possession law in line with federal immigration court standards.	Bring Minnesota's fifth degree possession law in line with federal immigration court standards. As written, the fifth degree possession statute is considered too broad, causing people to be unjustly deported.	Low	Immigration Consequences from A Conviction Under Minn. Stat. § 152.025.2(1), Fifth Degree Possession of A Controlled Substance and Current Litigation — Contreras & Metelska, PA		DPS	Reduce arrests	
113	Social Determinants	Immigration	Expand access to post-conviction relief for immigrants with drug offenses by ending legal barriers to judicial review of legally invalid convictions and providing funding for counsel.	Expand access to post-conviction relief for immigrants with drug offenses by ending legal barriers to judicial review of legally invalid convictions and providing funding for counsel.	Low	"Disrupt and Vilify": The War on Immigrants Inside the U.S. War on Drugs - Drug Policy Alliance		Minnesota Judicial Branch	Improve access to legal council, Reduce incarceration	
114	Social Determinants	Immigration	Ensure expungement does not limit a court's jurisdiction to consider other forms of post-	Ensure expungement does not limit a court's jurisdiction to consider other forms of post-conviction relief or access to one's own criminal case files.	Low	"Disrupt and Vilify": The War on Immigrants Inside the U.S. War on Drugs - Drug Policy Alliance		MN Board of Public Defense, Minnesota Judicial Branch		

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
			conviction relief or access to one's own criminal case files.							
115	Social Determinants	Retroactive Expungement	Consider building on the new automatic expungement process and the modifications to the existing petition-based expungement for criminal convictions, including for convictions of certain controlled substance offenses.	Consider building on the new automatic expungement process and the modifications to the existing petition-based expungement for criminal convictions, including for convictions of certain controlled substance offenses. Potential improvement could include: • Ensure less serious offenses (e.g., violation of Minn. Stat. § 152.027, Subd. 2) are not inadvertently excluded from automatic expungement. • Prohibit the use of expunged records in future prosecutions, including plea bargaining. • Reduce the applicable waiting period(s) for automatic expungement. • Add possession of a controlled substance in the fourth and/or third degree as a qualifying offense for automatic expungement (currently eligible only for expungement by petition). • Authorize expungement petitions for convictions for	Medium	50-State Comparison: Expungement, Sealing & Other Record Relief | Collateral Consequences Resource Center		DPS, Minnesota Judicial Branch	Improve employment, Improve access to housing, Reduce poverty	

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				possession of a controlled substance in the second degree and/or first degree. • Expand petition-based and/or automatic expungement eligibility for convictions involving the distribution and/or sale of controlled substances in the fourth, third, second, and/or first degree. • Evaluate the use of expunged convictions in DHS background studies and educator licensure process and the need for any changes to such use.						
116	Social Determinants	Retroactive Expungement	Grant people with cleared records the explicit right to deny and refuse to acknowledge the existence of such records.	Grant people with cleared records the explicit right to deny and refuse to acknowledge the existence of such records.	Low	Beyond Confidentiality: Modernizing Criminal Record Clearance Policies in the Digital Age - Council of State Governments Justice Center		DHS, DPS	Improve employment, Improve access to housing, Reduce poverty	
117	Social Determinants	Retroactive Expungement	Require applications that inquire about criminal history to include a notice that cleared	Require applications that inquire about criminal history to include a notice that cleared records should not be disclosed.	Medium	Beyond Confidentiality: Modernizing Criminal Record Clearance Policies in the Digital Age - Council of State Governments Justice Center		DHS, DPS, Department of Labor and Industry	Improve employment, Improve access to housing, Reduce poverty	

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
			records should not be disclosed.							
118	Drug Policing	Decriminalization	Remove criminal and civil penalties for the personal and social use and possession of illicit drugs by adults (i.e. sharing) after investing in health, harm reduction, and social supports. People using drugs should be offered all available health resources and social supports but should not be criminalized for not participating in offered services.	Remove criminal and civil penalties for the personal and social use and possession of illicit drugs by adults (i.e. sharing) after investing in health, harm reduction, and social supports. People using drugs should be offered all available health resources and social supports but should not be criminalized for not participating in offered services.	High	Joint Committee on Drug Use Interim Report - Irish Oireachtas Beyond Punishment: From Criminal Justice Responses to Drug Policy Reform - Global Commission on Drug Policy In Support of the Decriminalization of Personal Drug and Paraphernalia Use and Possession: Position Statement of AMERSA, Inc (Association for Multidisciplinary Education, Research, Substance Use and Addiction) Distinguishing personal use of drugs from drug supply: Approaches and challenges - International Journal of Drug Policy		DHS, DPS, MDH	Reduce arrest, Reduce incarceration, Improve access to substance use disorder treatment	Shift towards a more public health approach within our criminal legal systems, Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
119	Drug Policing	Decriminalization	Consider policies and fund programs to discourage and reduce drug consumption in public areas that do not rely on criminalization or exacerbate disparities for people who are experiencing homelessness and who lack private spaces to use drugs.	In the context of decriminalization, consider policies and fund programs to discourage and reduce drug consumption in public areas that do not rely on criminalization or exacerbate disparities for people who are experiencing homelessness and who lack private spaces to use drugs. (See also recommended related to alternative crisis response.) For example, expand funding for programs like LEAD on Minneapolis' East Lake Street. Key components of the model: - Provides an alternative response to non-violent community safety issues, like shoplifting and drug use in bathrooms. - Provides intensive, long-term case management for as long as people want it - Does not require police contact. Referrals to the program can come from residents, small businesses, and LEAD case managers, and self-referrals. - Does not impose sanctions and is not court-based.	Medium	Joint Committee on Drug Use Interim Report - Irish Oireachtas Let Everyone Advance with Dignity (LEAD) Minneapolis	People experiencing homelessness	DHS, DPS, MDH	Improve community safety, reduce arrest	Shift towards a more public health approach within our criminal legal systems

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				- Takes a harm reduction approach that doesn't require abstinence and does not establish treatment as a precondition for other supports. Also recall the public health and social services interventions like overdose prevention centers and housing can help to address public drug use.						
120	Drug Policing		Narrow the definition of "sell" in Minn. Stat. Sec. 152.01, Subd. 15a., and evaluate ways of narrowing the definition to exclude sharing of drugs without a profit motive.	Narrow the definition of "sell" in Minn. Stat. Sec. 152.01, Subd. 15a., and evaluate ways of narrowing the definition to exclude sharing of drugs without a profit motive.	Low	The burgeoning recognition and accommodation of the social supply of drugs in international criminal justice systems: An eleven-nation comparative overview - International Journal of Drug Policy Distinguishing personal use of drugs from drug supply: Approaches and challenges - International Journal of Drug Policy		DPS, Minnesota Judicial Branch	Reduce arrest, reduce incarceration	Shift towards a more public health approach within our criminal legal systems

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
121	Drug Policing	Decriminalization	Avoid creating weight or other fixed thresholds to determine personal and social supply. Instead, focus on proving intent to supply for remuneration.	In the context of decriminalization, avoid creating weight or other fixed thresholds to determine personal and social supply. Instead, focus on proving intent to supply for remuneration. For example, the British government considers the several factors in determining intent to supply, including: "- Possession of a quantity inconsistent with personal use. - Possession of uncut drugs or drugs in an unusually pure state suggesting proximity to their manufacturer or importer. - Possession of a variety of drugs may indicate sale rather than consumption. - Evidence that the drug has been prepared for sale. If a drug has been cut into small portions and those portions are wrapped in foil or film, then there is a clear inference that sale is the object. - Drug related equipment in the care and/or control of the suspect, such as weighing scales, cutting agents, bags or wraps of foil (provided their presence is not consistent with normal domestic use).	Medium	Beyond Punishment: From Criminal Justice Responses to Drug Policy Reform - Global Commission on Drug Policy Joint Committee on Drug Use Interim Report - Ireland's Oireachtas Distinguishing personal use of drugs from drug supply: Approaches and challenges - International Journal of Drug Policy The burgeoning recognition and accommodation of the social supply of drugs in international criminal justice systems: An eleven-nation comparative overview - International Journal of Drug Policy Drug Offences | The Crown Prosecution Service		DPS, Minnesota Judicial Branch	Reduce arrest, reduce incarceration	Shift towards a more public health approach within our criminal legal systems

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
				- Diaries or other documents containing information tending to confirm drug dealing, which are supportive of a future intent to supply, for example, records of customers' telephone numbers together with quantities or descriptions of drugs." - In addition, the "absence of any financial gain, for example joint purchase for no profit, or sharing minimum quantity between peers on non-commercial basis" can reduce sentencing of someone charge with a supply offense.						

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
122	Drug Policing	Decriminalization	Provide training and clear guidelines to law enforcement to operate under decriminalization.	Provide training and clear guidelines to law enforcement to operate under decriminalization.	High	"BM 110 implementation also lacked any training and education for law enforcement officers. Departments simply received a simple question-and-answer guide from the state and officers were unclear about how best to handle situations involving drug possession and PWUD, leading to additional frustration." - "All carrots and no stick": Perceived impacts, changes in practices, and attitudes among law enforcement following drug decriminalization in Oregon State, USA - International Journal of Drug Policy "Governments considering drug decriminalization laws should consider ensuring appropriate training and guidelines for law enforcement to prevent net-widening practices so that the intended health-related goals of these drug policy changes can be fully actualized." Criminal legal system engagement among people who use drugs in Oregon following decriminalization of drug possession - Journal of Drug and Alcohol Dependence		DHS, DPS, MDH	Reduce arrest, reduce incarceration	Shift towards a more public health approach within our criminal legal systems
123	Drug Policing	Decriminalization	In the context of decriminalization, remove law enforcement's ability to seize personal or social	In the context of decriminalization, remove law enforcement's ability to seize personal or social amounts of illicit drugs.	Medium	Spatiotemporal Analysis Exploring the Effect of Law Enforcement Drug Market Disruptions on Overdose, Indianapolis, Indiana, 2020-2021 - American Journal of Public Health		DPS, MDH	Reduce arrest, reduce incarceration	Shift towards a more public health approach within our criminal legal systems

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
			amounts of illicit drugs.							
124	Drug Policing	Decriminalization	Fund education campaigns about decriminalization, to (1) reduce misinformation about what the policy change is and does, and (2) targeted at people who use drugs, to protect their civil liberties and support their decision-making around drug use.	Fund education campaigns about decriminalization, to (1) reduce misinformation about what the policy change is and does, and (2) targeted at people who use drugs, to protect their civil liberties and support their decision-making around drug use. (One study of Oregon's experiment with decriminalization found that only 2 out of 10 people who use drugs knew fentanyl had been decriminalized.)	Medium	Criminal legal system engagement among people who use drugs in Oregon following decriminalization of drug possession - Journal of Drug and Alcohol Dependence Awareness and knowledge of drug decriminalization among people who use drugs in British Columbia: a multi-method pre-implementation study | BMC Public Health Depenalizing and Decriminalizing Drug Possession in the US: Emerging Models and Recommendations for Policy Design and Implementation - Johns Hopkins School of Public Health		DHS, DPS, MDH	Reduce arrest, reduce incarceration	Improve the autonomy and dignity of people who use drugs

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
125	Drug Policing	Decriminalization	Eliminate all criminal and civil penalties for buprenorphine possession by creating a carve-out under the state's Controlled Substances Act.	Eliminate all criminal and civil penalties for buprenorphine possession by creating a carve-out under the state's Controlled Substances Act, similar to Rhode Island. Preempt localities from subsequently criminalizing buprenorphine possession.	Low	Against Our Instincts: Decriminalization of Buprenorphine - American Board of Family Medicine Rhode Island Legislature, Chapter 100 2021 -- S 0065 SUBSTITUTE A Enacted 07/01/2021 Attitudes and beliefs about Vermont's 2021 buprenorphine decriminalization law among residents who use illicit opioids - Journal of Drug and Alcohol Dependence		DPS, MDH	Improve access to medications for opioid use disorder, Reduce arrest, reduce incarceration	Shift towards a more public health approach within our criminal legal systems
126	Drug Policing	Community responder models/Alternative crisis response	Mandate that localities implement 988/911 interoperability to enhance opportunities for alternative crisis response to behavioral health matters. Allocate funding for implementation and technical assistance to localities.	Mandate that localities implement 988/911 interoperability to enhance opportunities for alternative crisis response to behavioral health matters. Allocate funding for implementation and technical assistance to localities.	High	Virginia Develops Statewide 911 Call Matrix to Divert Mental Health and Substance Use Crises - Crisis Now Virginia's 2020 Special Session I, Article 16. Mental Health Awareness Response and Community Understanding Services (Marcus) Alert System The Road to 988/911 Interoperability: Three Case Studies on Call Transfer, Colocation, and Community Response - RAND Summary: State Plan for the Implementation of the Marcus-David Peters Act		DHS, DPS	Improve access to healthcare	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
127	Drug Policing	Community responder models/Alternative crisis response	Expand access to alternative, non-law enforcement responses to substance use and behavioral health issues (for example, overdose, mental health crises, post-overdose response) by requiring localities to implement these programs or incentivize local jurisdictions to create new or expand existing crisis response programs by providing funding, evaluation support, and/or other technical assistance.	Expand access to alternative, non-law enforcement responses to substance use and behavioral health issues (for example, overdose, mental health crises, post-overdose response) by requiring localities to implement these programs using a phased approach. (See Virginia's Marcus-David Peters Act.) Alternatively, incentivize local jurisdictions to create new or expand existing crisis response programs by providing funding, evaluation support, and/or other technical assistance. (See, for example, Oregon's State House Bill 2147, linked at right.) Consider creating an advisory council to support state policy on this topic. See New Jersey's statute, linked at right. For post-overdose response programs specifically, ensure the integration of referrals to harm reduction programs and broader social support services, as opposed to treatment only.	High	Three Ways State Leaders Can Support Community Responder Programs - CSG Justice Center Expanding First Response: A Toolkit for Community Responder Programs - CSG Justice Center Oregon House Bill 2417 New Jersey Bill A5326 Aca (1R) Virginia 2020 Special Session I, Article 16. Mental Health Awareness Response and Community Understanding Services (Marcus) Alert System The Model Behavioral Health Crisis Mobile Response Team Act - SSRN "The City's Policies and Protocols shall not exclude Mobile Crisis Response as a potential response solely because the 911 caller is a third-party or because substance use is involved." - Consent Decree: Minneapolis Police Department and the U.S. Department of Justice, para 183. Post-Overdose Response Teams - National Association of Counties Opioid Solutions Center Partnerships for Post-Overdose Outreach (PRONTO)		DHS, DPS, MDH	Reduce arrest, Improve community safety, Improve access to healthcare, Improve utilization of healthcare	Shift towards a more public health approach within our criminal legal systems, Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
128	Drug Policing	Treatment Courts	Create a state-run certification to compel drug treatment courts to follow the standards maintained by the Minnesota Judicial Branch.	Create a state-run certification to compel drug treatment courts to follow the standards maintained by the Minnesota Judicial Branch. Other states' certification programs determine courts' eligibility for funding.	Medium	Drug Treatment Courts: An Evidence-Based Review with Recommendations for Improvement - Canadian Centre on Substance Use and Addiction A Practical Guide to Establishing a Statewide Drug Court Certification Program | Center for Justice Innovation Minnesota Drug Court Standards Michigan SB0435: ANALYSIS AS ENACTED (Date Completed: 11-20-17) - SCAO CERTIFICATION OF COURTS		Minnesota Judicial Branch	Reduce incarceration, Improve access to substance use disorder treatment, Improve utilization of medications for opioid use disorder	Shift towards a more public health approach within our criminal legal systems, Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
129	Drug Policing	Drug testing	End universal drug testing as a standard condition and testing for all known substances for people on probation. The use of drug testing should be tailored to the individual and conducted only where it is materially relevant to underlying offense/reason for supervision.	End universal drug testing as a standard condition and testing for all known substances for people on probation. The use of drug testing should be tailored to the individual and conducted only where it is materially relevant to the underlying offense/reason for supervision. Testing should be used only as a way to identify health needs, and to discuss treatment options, safety, and harm reduction measures like naloxone. Testing should not be responded to with punitive measures.	Medium	Community Supervision Advisory Committee Recommendations Drug Testing on Supervision - Arnold Ventures Drug Testing as a Condition of Supervision - Robina Institute ORS 137.540 – Conditions of probation		DPS	Reduce incarceration	Shift towards a more public health approach within our criminal legal systems

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
130	Drug Policing	Diversion	Create a statutory pathway to enable and fund evidence-based "off ramps" from the criminal-legal system at intercepts 0 (community) and 1 (law enforcement) of the Sequential Intercept Model.	Create a statutory pathway to enable and fund evidence-based "off ramps" from the criminal-legal system at intercepts 0 (community) and 1 (law enforcement) of the Sequential Intercept Model. Minnesota already has such a program in place for intercepts 2 and 3 (initial detention and court hearings, jails and courts); statute 401.065 directs county attorneys to create pretrial diversion programs for adults. Washington's Recovery Navigator Program is one example of a state program for intercepts 0 and 1. Importantly, people must not be diverted to mandatory treatment.	High	State Principles for Financing Substance Use Care, Treatment, and Support Services - Center for Health Care Strategies Minn. Stat. Sec. 401.065 Substance Use and Recovery Services Plan Recommendation - Washington State Health Care Authority RCW 71.24.115: Recovery navigator programs. On the harms of even short jail stays: Research roundup: Evidence that a single day in jail causes immediate and long-lasting harms | Prison Policy Initiative		DHS, DPS, MDH	Reduce arrest	Shift towards a more public health approach within our criminal legal systems, Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
131	Drug Policing	Sentencing	Establish in statute periodic comprehensive reviews of the drug sentencing grids. Direct the Minnesota Sentencing Guidelines Commission to analyze how drug sentencing is driving racial and	Establish in statute periodic comprehensive reviews of the drug sentencing grids. Direct the Minnesota Sentencing Guidelines Commission to analyze how drug sentencing (as distinct from, and additive to, disparities resulting from policing practices, charging, etc.) is driving racial and geographic disparities.	Medium	2025 Report to the Legislature - Minnesota Sentencing Guidelines Commission Massachusetts Sentencing Guidelines		Minnesota Sentencing Commision	Reduce incarceration	Shift towards a more public health approach within our criminal legal systems, Reduce disparities

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
			geographic disparities.							
132	Drug Policing	Sentencing	Revise 152.023, subdivision 2(a)(4) so that people travelling through sentencing enhancement zones (schools, public parks, public housing) may not be charged with third degree felonies unless they have more than a residual amount of the listed controlled substances.	Revise 152.023, subdivision 2(a)(4) so that people travelling through sentencing enhancement zones (schools, public parks, public housing) may not be charged with third degree felonies unless they have more than a residual amount of the listed controlled substances.	Low	Polk County, with less than 1% of Minnesota's population, charges the most prohibited zones drug crimes - Grand Forks Herald		DPS, Minnesota County Attorneys Association	Reduce arrest, reduce incarceration	Shift towards a more public health approach within our criminal legal systems

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
133	Drug Policing	Sentencing	Pass legislation requiring that a parent's status as a caregiver be considered at the time of sentencing and when considering alternatives to incarceration and that if a parent is incarcerated, they should be placed as close to their family as possible.	Pass legislation requiring that a parent's status as a caregiver be considered at the time of sentencing and when considering alternatives to incarceration. If a parent is incarcerated, they should be placed as close to their family as possible, and meaningful transportation options (such as state-funded ride programs) should be available to guarantee that children are able to regularly visit incarcerated parents.	Low	Tennessee's law permits alternatives to incarceration to be considered for caregivers prior to sentencing. New Jersey law requires incarcerated parents be placed as close to their minor child's place of residence as possible, allows contact visits, prohibits restrictions on the number of minor children allowed to visit an incarcerated parent, and also requires visitation be available at least six days a week. Tenn. Code Ann. § 40-35-103, Sentencing Considerations Model legislation: Louisiana's HB264 from 2018 would have allowed courts to vacate the judgment of conviction for primary caretakers who complete programming offered by Operation Restoration, a community-based organization. NJ SA 30:1B-6.5 to 30:1B-6.9 et al, "Dignity for Incarcerated Primary Caretaker Parents Act." How 12 states are addressing family separation by incarceration — and why they can and should do more - Prison Policy Initiative 2024 Minnesota Sentencing Guidelines & Commentary	Pregnant and parenting people	Board of Public Defense, DOC, Minnesota Judicial Branch, Minnesota Sentencing Commission	Reduce incarceration	Shift towards a more public health approach within our criminal legal systems

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
134	Drug Policing	Scheduling	Avoid using drug scheduling as a policy response to overdose.	Avoid using drug scheduling as a policy response to overdose. Scheduling to restrict the drug supply leads to harmful unintended consequences and gives rise to even more toxic and potent additives to the supply.	Medium	U.S. policy responses to xylazine: Thinking bigger - International Journal of Drug Policy Potential unintended consequences of class-wide drug scheduling based on chemical structure: A cautionary tale for fentanyl-related compounds - Journal of Drug and Alcohol Dependence The Overdose Crisis: Interagency Proposal to Combat Illicit Fentanyl-Related Substances | National Institute on Drug Abuse (NIDA) Groups Urge US to End Emergency Scheduling of Fentanyl-related Substances | Human Rights Watch The Controlled Substances Act (CSA): A Legal Overview for the 118th Congress		DPS, Minnesota County Attorneys Association, Minnesota Judicial Branch	Reduce arrest, reduce incarceration	Reduce overdose mortality
135	Drug Policing	Drug paraphernalia	Preempt the ability of local jurisdictions to circumvent state laws designed to increase access to safer use supplies and provide funding to educate law enforcement and people who	Preempt the ability of local jurisdictions to circumvent state laws designed to increase access to safer use supplies and provide funding to educate law enforcement and people who use drugs about the law.	Low	Minn. Stat. Sec. 152.205		DPS	Reduce arrest, reduce incarceration, Improve access to harm reduction services	Reduce drug-related infectious disease transmission/other morbidities, reduce overdose mortality

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
			use drugs about the law.							
136	Drug Policing	Drug paraphernalia	Close the "loopholes" associated with the legalization of drug paraphernalia.	Close the "loopholes" associated with the legalization of drug paraphernalia during the 2023 legislative session to (1) remove penalties associated with residue on any surface (ie. baggies), not just drug paraphernalia as defined in statute and (2) clarify that people should not be charged with crime of possession of residual amounts of controlled substances when it is found in a syringe. (Prosecutors say that syringes are not paraphernalia because they were previously exempted from the definition of paraphernalia to expand access to sterile syringes, an aligned public health goal.)	Low	Minn. Stat. Sec 152.01, Subd. 18		DPS	Reduce arrest, reduce incarceration	Shift towards a more public health approach within our criminal legal systems
137	Drug Policing	Drug-induced homicide	Repeal 609.195(b), Minnesota's drug-induced homicide law. In addition, create a carveout in statutes governing murder	Repeal 609.195(b), Minnesota's drug-induced homicide law. In addition, create a carveout in statutes governing murder or manslaughter in the first and second degrees (secs. 609.20 and 609.205) such that these statutes may not apply to deaths	Medium	Drug-Induced Homicide Prosecutions - Fair and Just Prosecution		DOC, DPS, MN Board of Public Defense, Minnesota County Attorneys Association	Reduce arrest, reduce incarceration	Shift towards a more public health approach within our criminal legal systems

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
			or manslaughter in the first and second degrees (secs. 609.20 and 609.205) such that these statutes may not apply to deaths resulting from accidental overdose.	resulting from accidental overdose.				, Minnesota Judicial Branch		
138	Drug Policing	Sex Work	Decriminalize sex work among consenting adults.	Decriminalize sex work among consenting adults.	Low	Right of everyone to the enjoyment of the highest attainable standard of physical and mental health - United Nations General Assembly A/79/177 B23-0318 - Community Safety and Health Amendment Act of 2019 - District of Columbia Vermont House Bill 630		DPS, MDH	Reduce arrest, reduce incarceration	Shift towards a more public health approach within our criminal legal systems

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
139	Data Collection	Data Analysis (challenges specific to evaluating drug policy)	Legislate a periodic strategic planning process and review of all statewide drug policies, including the impacts of drug policing policies on public health, public safety, and social determinants of health. This should include attention to racial disparities in all outcomes of interest.	Legislate a periodic strategic planning process and review of all statewide drug policies, including the impacts of drug policing policies on public health, public safety, and social determinants of health. This should include attention to racial disparities in all outcomes of interest. The periodic review could be led by the Office of Addiction and Recovery. The review should include community engagement sessions, quantitative and qualitative data gathering, and focus on communities of color that have been unduly harmed by criminalization. It should also include interim and process measures that can track progress toward population-level health goals (like reductions in overdose fatalities). Meaningful evaluations will: - Identify metrics that respond to drug policy. (Prevalence of use, a common metric to assess drug policy reform, has limited responsiveness to drug policy.)	High	Aligning Agendas: Drugs, Sustainable Development, and the Drive for Policy Coherence - International Expert Group on Drug Policy Metrics The Global Drug Policy Index 2021 Impact evaluations of drug decriminalisation and legal regulation on drug use, health and social harms: a systematic review - BMJ Open Methodological Challenges and Proposed Solutions for Evaluating Opioid Policy Effectiveness - Health Services Outcomes Research Methodology The Australian 'drug budget': Government drug policy expenditure 2021/22		DHS, DPS, MDH, OAR	Increase our understanding of overdose risks to inform our response strategy	Shift towards a more public health approach within our criminal legal systems, Reduce disparities, Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
				- Align the stated policy objectives of drug law reform and the metrics used to assess its impact. For example, drug policy reforms that are meant to improve the health of people who use drugs must measure those outcomes.						
140	Data Collection	Data Collection and Evaluation	Mandate that the appropriate state agencies track and make publicly available the costs related to drug law enforcement.	Mandate that the appropriate state agencies track and make publicly available the costs related to drug law enforcement.	Low	The Australian 'drug budget': Government drug policy expenditure 2021/22		DOC, DPS, Minnesota Judicial Branch	Increase our understanding of overdose risks to inform our response strategy	Shift towards a more public health approach within our criminal legal systems
141	Data Collection	Data Collection and Evaluation	Direct the Department of Public Safety provide demographic breakdowns for	Direct the Department of Public Safety provide demographic breakdowns for each offense, not only for arrests generally, in the MN Uniform Crime Report.	Low	2023 Uniform Crime Report	Racial and ethnic minorities	DPS	Increase our understanding of overdose risks to inform our response strategy	Shift towards a more public health approach within our criminal legal systems

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
			each offense, not only for arrests generally, in the MN Uniform Crime Report.							
142	Data Collection	Data Collection and Evaluation	Collect disaggregated data to understand how drug-related offenses contribute to mass supervision, as well as supervision violations (both technical violations and new offenses) as a basis for prolonged supervision and/or incarceration. For substance-related technical violations, data should be collected and disaggregated around missed appointments and positive drug screens specifically. Ensure that demographic data	Collect disaggregated data to understand how drug-related offenses contribute to mass supervision, as well as supervision violations (both technical violations and new offenses) as a basis for prolonged supervision and/or incarceration. For substance-related technical violations, data should be collected and disaggregated around missed appointments and positive drug screens specifically. Ensure that demographic data is integrated across the board.	Low	Policy Reforms Can Strengthen Community Supervision - The Pew Charitable Trusts		DOC	Increase our understanding of overdose risks to inform our response strategy	Shift towards a more public health approach within our criminal legal systems

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
			is integrated across the board.							
143	Data Collection	Data Collection and Evaluation	Collect more granular epidemiological overdose data on race and ethnicity, and use this data to allocate funding to inequitably impacted communities.	Collect more granular epidemiological overdose data on race and ethnicity, and use this data to allocate funding to inequitably impacted communities. Data collected on race and ethnicity for overdose decedents does not capture cultural nuance (e.g., between East African and West African communities), which misses an opportunity for more tailored responses to different communities.	Low	The Minnesota Department of Education's "Counting All Students" initiative is one example of this. Racial and ethnic data justice: The urgency of surveillance data disaggregation - Drug and Alcohol Dependence	Racial and ethnic minorities	MDH	Increase our understanding of overdose risks to inform our response strategy	Reduce disparities
144	Data Collection	Data Collection and Evaluation	Allocate sustainable funding to link housing and homelessness data to public health data, in line	Allocate sustainable funding to link housing and homelessness data to public health data, in line with findings from MDH's Minnesota Homeless Mortality Brief.	Low	Minnesota Homeless Mortality Brief: Insight from People with Lived Experience - Minnesota Department of Health	People experiencing homelessness	DHS, MDH	Increase our understanding of overdose risks to inform our response strategy	Shift towards a more public health approach within our health and human services systems

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
			with findings from MDH's Minnesota Homeless Mortality Brief.							
145	Data Collection	Data Collection and Evaluation	Allocate sustainable funding to link housing and homelessness data to public health data, in line with findings from MDH's Minnesota Homeless Mortality Brief.	Take stock of state agencies' data collection and analysis efforts and consider policy actions that could improve access to care and equitable outcomes. For example: - Massachusetts law requires the all-payer claims database, public safety, courts, and other agencies to share data with the department of public health to analyze the treatment and criminal justice history of people who died of an overdose. - Collect patient outcomes data from substance use disorder treatment providers	Low	State Principles for Financing Substance Use Care, Treatment, and Support Services - Center for Health Care Strategies Massachusetts Acts of 2015 Chapter 55 - Session Laws		DHS, DPS, MDH	Increase our understanding of overdose risks to inform our response strategy	Shift towards a more public health approach within our health and human services systems
146	Data Collection	Data Collection and Evaluation	Create data infrastructure and collect data about overdose and access to treatment for pregnant and parenting people, stratified by race and ethnicity, in	Create data infrastructure and collect data about overdose and access to treatment for pregnant and parenting people, stratified by race and ethnicity, in order to ensure equitable access.	Low	Improving Access to Care for Pregnant and Postpartum People with Opioid Use Disorder: Recommendations for Policymakers - American Medical Association	Racial and ethnic minorities, pregnant and parenting people	DHS, MDH	Increase our understanding of overdose risks to inform our response strategy	Reduce disparities, Shift towards a more public health approach within our health and human services systems

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
			order to ensure equitable access.							
147	Data Collection	Data Collection and Evaluation	Direct the Department of Administration's Grants Management to review the data collection requirements of grants within its purview, and implement findings from DHS' report on paperwork reduction in substance use disorder treatment (forthcoming).	Direct the Department of Administration's Grants Management to review the data collection requirements of grants within its purview, and implement findings from DHS' report on paperwork reduction in substance use disorder treatment (forthcoming). Data collection required by state grants should not impede access to harm reduction, health, or other services because it is cumbersome to participants or program staff.	Low	SSP Indicators Implementation Guide: Brief to Funders - Supporting Harm Reduction Programs Team, University of Washington Legislative Proposal re: paperwork reduction in substance use disorder treatment - Minnesota Association of Resources for Recovery and Chemical Health		Department of Administration	Improve access to harm reduction services, Improve access to healthcare	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
148	Crosscutting	Safe supply and Regulation	Create and fund a safe supply work group, similar to that convened by the state of Washington.	Create and fund a safe supply work group. Washington State's committee was tasked with: "• Examining the concept of "safe supply," defined as a legal and regulated supply of mind or body altering substances that traditionally only have been accessible through illicit markets. • Examining whether there is evidence that a proposed "safe supply" would have an impact on fatal or nonfatal overdose, drug diversion, or associated health and community impacts. • Examining whether there is evidence that a proposed "safe supply" would be accompanied by increased risks to individuals, the community, or other entities or jurisdictions. • Examining historical evidence regarding the overprescribing of opioids; and • Examining whether there is evidence that a proposed "safe supply" would be accompanied by any other benefits or consequences."	Low	Safe Supply Workgoup Recommendations - Washington State Health Care Authority		Board of Pharmacy, DPS, MDH	Improve access to harm reduction services	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
149	Crosscutting	Special Populations	Implement the twelve legislative recommendations from the 2023 American Indian Substance Use Disorder Summit, including around access to treatment, funding, and sulturally specific resources for people leaving detention settings.	Implement the twelve legislative recommendations from the 2023 American Indian Substance Use Disorder Summit, including: - Increased funding for American Indian Substance Use Disorder programs - Providing support to the Upper Midwest Indian Council on Addictive Disorders (UMICAD) to establish a presence in all 11 Tribal Nations in Minnesota - Expanding the definition of first responders to include community, to increase access to naloxone for American Indian programs - Incorporating peers, spiritual leaders, and ceremony in release planning for people leaving detention facilities	High	Tribal Opioid Response National Strategic Agenda - Northwest Portland Area Indian Health Board 2016 Tribal-State Opioid Summit Final Report Tribal Action Plan - Minnesota Chippewa Tribe's Tribal Executive Committee Unfortunately, there is no public link for the summary of the 2023 American Indian Substance Use Disorder Summit. Please reach out to the Office of Addiction and Recovery for a copy.	Racial and ethnic minorities	MDH, Minnesota Indian Affairs Council, OAR	Improve access to substance use disorder treatment, Improve access to naloxone, Improve access to healthcare	Reduce disparities, Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
150	Crosscutting	Special Populations	Expand services for youth experiencing homelessness and using drugs, including drop-in centers, support groups, and therapy that don't mandate sobriety or limit their freedom.	Expand services for youth experiencing homelessness and using drugs, including drop-in centers, support groups, and therapy that don't mandate sobriety or limit their freedom.	Medium	Evidence-Based Treatment for Young Adults with Substance Use Disorders - Journal of Pediatrics How Should Harm Reduction Strategies Differ for Adolescents and Adults? - Journal of Ethics, American Medical Association Facilitators and barriers of drop-in center use among homeless youth - Journal of Adolescent Health	Youth	DCYF, DHS, MDH, OAR	Improve access to substance use disorder treatment, Improve access to harm reduction services, Improve housing/Reduce homelessness	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
151	Crosscutting	Discrimination	Adopt robust anti-discrimination protections for people who use(d) drugs across settings and sectors, including individuals in active substance use, and develop guidance materials to support implementation.	Adopt robust anti-discrimination protections for people who use(d) drugs across settings and sectors, including individuals in active substance use, and develop guidance materials to support implementation. Current law isn't entirely clear about if/how people actively using drugs illegally are covered. See MN Human Rights Act (Minn. Stat. § 363A.03) Note that federal law also protects people in active use/using illegal drugs as to denial of health services, or services provided in connection with drug rehabilitation. See 42 U.S.C. 12210(c), 28 C.F.R. § 35.131(b)(1). Minnesota state law is free to exceed the federal standard.	Medium	MN Human Rights Act (Minn. Stat. § 363A.03) Legal Help for People Who Use(d) Drugs & Alcohol - Legal Action Center Frequent experience of discrimination among people who inject drugs: Links with health and wellbeing - Drug and Alcohol Dependence		Minnesota Department of Human Rights	Improve access to housing, employment, education, healthcare, and other sectors	Improve the autonomy and dignity of people who use drugs

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
152	Crosscutting	Discrimination	Bolster state agencies' abilities to address discrimination against people who use drugs.	To address discrimination against people who use(d) drugs, have a substance use disorder, or are taking medications for substance use disorder in all healthcare and supportive settings, including in skilled nursing facilities, criminal legal system settings, healthcare settings, and the child welfare system: - Create an advisory body in the Department of Human Rights that includes people with lived and living experience to issue guidance, take enforcement action, and publish reports. - Allocate funding for the advisory body and for enforcement measures - Redefine the mission of the Office of Ombudsman for Mental Health and Developmental Disabilities to provide justice for people with "mental health, developmental disabilities, chemical dependency or emotional disturbance" even if they are not receiving services. - Allocate funding to Mid-Minnesota Legal Aid, the state's federally recognized Protection & Advocacy organization, to work on this issue.	Low	Opioid Use Disorder - ADA.gov Office of Ombudsman for Mental Health and Developmental Disabilities - mn.gov Legal Help for People Who Use(d) Drugs & Alcohol - Legal Action Center		Attorney General's Office, DHS, Mid-Minnesota Legal Aid (the federally designated Protection and Advocacy agency for people with disabilities in Minnesota), Minnesota Department of Human Rights, OAR	Improve access to healthcare and other sectors	Improve the autonomy and dignity of people who use drugs

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
153	Crosscutting	Lived experience	Identify methods of meaningfully integrating the voices of people with lived and living experience at every level of the drug policy development process and funding distribution process, including opioid settlement funds.	Identify methods of meaningfully integrating the voices of people with lived and living experience at every level of the drug policy development process and funding distribution process, including opioid settlement funds. This could include robust community engagement plans that meet communities where they are and providing stipends for representatives from unduly impacted communities to participate in advisory bodies. The hire of 14 Implementation Consultants to guide the Crossroads to Justice strategic plan to end homelessness is an excellent example of this.	Medium	Crossroads to Justice: Minnesota's New Pathways to Housing, Racial and Health Justice for People Facing Homelessness was developed with the input of Implementation Consultants with lived experience, who were compensated for their time. Ryan White Planning Councils are another example of government mechanisms to integrate community feedback. Engaging with People with Lived Experience in Opioid Settlement Decision-Making - National Academy for State Health Policy Engaging People with Lived Experience to Improve Federal Research, Policy, and Practice - Health and Human Services		Minnesota Interagency Council on Homelessness		Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities
154	Crosscutting	Lived experience	Include harm reduction expertise and lived expertise in the selection process of reviewers for harm reduction grants and other competitive processes.	Include harm reduction expertise and lived expertise in the selection process of reviewers for harm reduction grants and other competitive processes.	Medium	How to become a SAMHSA Grant Reviewer - SAMHSA		DHS, Department of Administration, MDH	Improve access to harm reduction services, Improve utilization to harm reduction services	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities, Improve the autonomy and dignity of people who use drugs

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
155	Crosscutting	Funding	Re-invest savings and revenue from the criminal-legal system into community-based supports, like job placement and mental health services.	Re-invest savings and revenue from the criminal-legal system into community-based supports, like job placement and mental health services.	Medium	Explainer: Minnesota's Justice Reinvestment Legislation Results in $43.6 Million Annual Increase in Community Supervision System - Council of State Governments Justice Center California Community Reinvestment Grants Program - State of California 'A form of reparation': Minnesota will send money to communities harmed by marijuana prohibition - Star Tribune The costs of crime during and after publicly-funded treatment for opioid use disorders: a population-level study for the state of California - Journal of Addiction		DPS, Department of Employment and Economic Development, MDH	Improve access to healthcare, Improve access to harm reduction services, Improve employment	Shift towards a more public health approach within our health and human services systems
156	Crosscutting	Funding	Create sustainable, flexible, and equity-focused funding opportunities for organizations whose missions include advancing the health of BIPOC communities and who can demonstrate a track record of doing so in a way	Create sustainable, flexible, and equity-focused funding opportunities for organizations whose missions include advancing the health of BIPOC communities and who can demonstrate a track record of doing so in a way that is inclusive of directly impacted communities. These groups tend to be grassroots, hyperlocal, and are often unable to access to traditional state funding streams. To address the aspects of grant making that themselves reinforce	Medium	Recommendations to the Governor's Subcabinet on Opioids, Substance Use, and Addiction Year-End Report Equity in Minnesota State Grantmaking	Racial and ethnic minorities	DHS, MDH	Improve access to substance use disorder treatment, Improve access to harm reduction services	Reduce disparities, Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
			that is inclusive of directly impacted communities.	inequities, legislators can ask agencies to streamline the process, offer technical assistance to applicants, and offer general operating support.						
157	Crosscutting	Funding	Plan for the eventual end of opioid settlement funds by deploying funds to establish evidence-based, effective policies and practices, rather than funding only programs. (Find sustainable funding sources for programs.)	Plan for the eventual end of opioid settlement funds by deploying funds to establish evidence-based, effective policies and practices, rather than funding only programs. (Find sustainable funding sources for programs.)	Medium	Pathways to Progress: A Community Guide for Sustainable Opioid Settlement Fund Investments - Duke University, Margolis Institute for Health Policy		DHS		Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
158	Crosscutting	Funding	Direct DHS to use its current powers to enforce local jurisdictions' opioid settlement spending, particularly their spend on non-evidence based practices and programs that perpetuate criminalization.	Direct DHS to use its current powers to enforce local jurisdictions' opioid settlement spending, particularly their spend on non-evidence based practices and programs that perpetuate criminalization. Local Health Departments are designated as jurisdictions' "chief strategists" in responding to local opioid-related issues and distributing settlement funds. See the Amended Minnesota Opioids State-Subdivision Memorandum of Agreement, Sec. IV(b). Opioid settlement funds should not be used to perpetuate criminalization. Instead, funds should be used to pilot, evaluate, or otherwise kickstart alternative approaches, like depenalization, expanding Good Samaritan laws, or implementing guidelines for prosecutorial or law enforcement discretion to reduce arrests.	Low	Localities are already required to submit spending reports to DHS which in turn compiles a public dashboard; see Minn Stat. Sec. 256.042, subdiv. 5(d)-(f). See also the reporting and compliance addendum to MN's state-local Memorandum of Agreement. Nevertheless, the City of Minnetonka spent roughly $85,000 to protect first responders from exposure to fentanyl, a non-existent hazard that has been debunked time and again. Renville County used $100,000 to buy a body scanner for the jail. It scanned 300 people and found no hidden drugs. To Guide Jurisdictions in the Use of Opioid Litigation Funds, We Encourage the Adoption of Five Guiding Principles - Johns Hopkins School of Public Health Evidence-based Strategies for Abatement of Harms from the Opioid Epidemic - Harvard Medical School, Blavatnik Institute for Health Care Policy From the War on Drugs to Harm Reduction: Imagining a Just Overdose Crisis Response - FXB Center for Health & Human Rights at Harvard University		DHS	Improve access to substance use disorder treatment, Improve access to harm reduction services	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

#	Domain	Year One Report Section	Abridged Recommendation	Detailed Recommendation	Potential impact	Guidance	Populations impacted	Key state partners	Primary Outcome Expected	Primary Impact Expected
159	Crosscutting	Agency Reform	Integrate the state's harm reduction services, housed primarily within MDH, and the state's treatment and recovery services, housed primarily within DHS.	Integrate the state's harm reduction services, housed primarily within MDH, and the state's treatment and recovery services, housed primarily within DHS.	Medium	The Governor's Office of Addiction and Recovery is working on coordination and integration through a National Governors Association Policy Academy. What are Human Services, and How Do State Governments Structure Them? - Urban Institute State Approaches to Cross-Agency Organization and Funding for Substance Use Disorder: Spotlight on Kansas, Maine, and Pennsylvania - NASHP		Minnesota Interagency Council on Homelessness, OAR	Improve access to harm reduction services, Improve access to substance use disorder treatment	Reduce overdose mortality, Reduce drug-related infectious disease transmission/other morbidities

Appendix B. Subject Matter Experts Interviewed

The authors wish to thank the experts interviewed for their generous donation of time and expertise. While their names are not published in an effort to keep their interviews confidential, a sampling of roles and agencies that were interviewed are included below.

Agencies Interviewed

- Alliance Wellness Center
- Avivo
- Essentia Health
- Governor's Advisory Council on Opioids, Substance Use and Addiction
- Greater Minneapolis Council of Churches
- Harm Reduction Sisters
- Hennepin County Mental Health Center
- Hennepin Healthcare
- Indigenous People's Task Force
- Minnesota Medical Association
- MN Alliance for Recovery Community Organizations
- MN Association of Community Mental Health Programs
- MN Association of Resources for Recovery and Chemical Health
- MN Board of Public Defense
- MN Department of Corrections
- MN Department of Health
- MN Department of Public Safety
- MN Management and Budget
- MN Recovery Policy Alliance
- NAMI Minnesota
- NorthPoint Health and Wellness Center
- Northwest Indian Community Development Center
- Project Turnabout
- Southside Harm Reduction Services
- Steve Rummler HOPE Network
- StreetWorks Collaborative
- University of MN Law School
- University of MN Medical School
- University of MN School of Public Health
- Urban Village
- Various large, medium and small city and county governments in MN

Titles Interviewed

- Assistant Commissioner of Community Services and Reentry
- Associate Professor
- Chief Executive Officer
- Chief of Police
- Commissioner of Community Safety
- Community Health Educator
- County Attorney
- Director of Addiction Medicine
- Director of Public Safety
- Executive Director
- Family Medicine Physician
- Harm Reduction Counselor
- Harm Reduction Program Specialist
- Health Policy Analyst
- Judge
- Lieutenant
- Opioid Response Coordinator
- Opioid Safety Project Coordinator
- Public Defender
- Senior Program Manager
- Staff nurse

C. Appendix C – Key Informant Interview Topic Guide.

Introductions

- Brief intro to the researchers
- Background on the project
    - Mandate details
    - Background slides summarizing the report
    - Year 1 Report available online
- Plan for Year 2 Report and role of key experts

What to expect from this interview

- We will ask broad questions, there are no right or wrong answers, you are the expert
- The interview is confidential, and findings will be aggregated with findings from other interviews of experts around the state
- Permission to audio-record interview (the recording and transcript will only be available to our internal team)

Questionnaire

1. Can you start by telling us your title, where you work, how long you've been there, and a little bit about what you do, as it relates to drugs and drug policy?

2. We're going to ask you your opinion on drug policy in Minnesota. When we say drug policy, we mean laws, rules, regulations, and other policies about illegal drugs and drug use, as well as all of the other laws and policies that affect people who use illegal drugs – such as laws and policies about housing, drug treatment, probation and parole, corrections, public safety, education, public benefits, etc. What do you think Minnesota is doing right, when it comes to drug policies?

3. Where are the areas you think Minnesota's policies are most harmful to people who use drugs?

    PROBE: How so? Can you explain in more detail?

    PROBE: What others can you think of? perhaps as it relates to individual health harms and death caused? Community harms?

    PROBE: (if hasn't been touched on yet) What about drug possession? Drug use? Access to treatment? What about drug trade?

4. Where would you prioritize changes?

   PROBE: What are the changes that would be most impactful to people in MN who use drugs?

   PROBE: What are the changes that would be easiest, the lowest hanging fruit?

   PROBE FOR DOMAINS:
   - Drug policing
   - Healthcare
   - Harm reduction
   - Social determinants
   - Special populations, i.e., people in detention settings, racial and ethnic minoritized communities, youth, pregnant and parenting people, immigrants
   - Data and evaluation

5. What are the things you think would be the most intractable or hardest to change here in MN? Why?

6. Who do you see as some of the key players influencing drug policy in MN? These could be people in government, people who work in drug treatment or service provision, advocates, policy makers or PWUD?

   PROBE: Who do you think we need to hear from? Can you connect us with them?

7. Are there other things that you think are important for us to know that we didn't get a chance to talk about today?

Thank you so much for your time today. We will be back in touch over the next several months to let you know how the project is progressing. If you think of anything else you'd like us to know, or if any new papers or policies come out that we should read, please do not hesitate to reach out.

D. Appendix D -- Summary of Guidance and Recommendations Issued by Government, Medical, and Other Expert Bodies.

US/ Global	Title	Source	Date	Conclusion	URL
US	In Support of the Decriminalization of Personal Drug and Paraphernalia Use and Possession: Position Statement of AMERSA	Association for Multidisciplinary Education, Research, Substance Use and Addiction (AMERSA)	2025	Recommends removing criminal sanctions for drug and paraphernalia possession for personal use for all currently illicit drugs and associated equipment.	https://journals.sagepub.com/doi/full/10.1177/29767342241277619
US	In Support of Overdose Prevention Centers: Position Statement of AMERSA	Association for Multidisciplinary Education, Research, Substance Use and Addiction (AMERSA)	2024	Recommends increased access to overdose prevention centers as a method of providing lifesaving services and additional harm reduction supplies.	https://journals.sagepub.com/doi/full/10.1177/29767342241252590
US	Drug Overdose: Promising Strategies	Center for Disease Control and Prevention	n.d.	To prevent overdose and enhance health, improve prescribing practices, increased access to evidence-based treatment, expand access to naloxone, consider Good Samaritan laws, and more.	https://www.cdc.gov/drugoverdose/strategies/index.html
US	A Transformative Whole-of-Government Model to Reduce Opioid Use Harms and Deaths	Center for Public Health Law Research, Temple University Beasley School of Law	2023	Describes how different arms of the government are working in opposition to one another in traditional drug policy approaches. Recommends drug decriminalization as the key component of transforming drug policy.	https://phlr.org/sites/default/files/uploaded_images/CPHLR-WGDrugPolicy_Pt1-WGModelandRecs.pdf
US	Harm Reduction Framework	Substance Abuse and Mental Health Services Administration	2023	The first document to comprehensively outline harm reduction and its role within the federal government's Department of Health and Human Services. Defines harm reduction six pillars, twelve supporting pillars, and core practice areas.	https://www.samhsa.gov/sites/default/files/harm-reduction-framework.pdf
US	Primary, Secondary, and Tertiary Prevention of Substance Use Disorders through Socioecological Strategies	National Academy of Medicine	2023	A socioecological approach to prevention identifies additional structural factors that can contribute to the development of substance use disorder and overdose risk, including housing, welfare, and criminal-legal system policies.	https://nam.edu/primary-secondary-and-tertiary-prevention-of-substance-use-disorders-through-socioecological-strategies/
US	Reduction of Public Health Consequences and Public Health Consequences of Drug Use	American Medical Association	2023	Recommends expanding harm reduction measures, medications for opioid use disorder, removing laws that restrict access to syringe services programs, and fully evaluating US state-based drug legalization models.	https://policysearch.ama-assn.org/policyfinder/detail/*?uri=%2FAMADoc%2FHOD.xml-0-5333.xml

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US	Support, don't punish: Drug decriminalization is harm reduction	American Pharmacists Association	2023	Decriminalization of drug use and possession is urgently needed. Decriminalization will reduce the negative impacts of drug use and keep communities healthy and safe.	https://pubmed.ncbi.nlm.nih.gov/36682855/#:~:text=Decriminalization%20of%20drug%20use%20and,keeping%20communities%20safe%20and%20healthy.
US	Decriminalization of Simple Possession of Illicit Drugs Policy	Minnesota Medical Association	2022	Remove criminal penalties associated with simple possession, release people who are currently incarcerated for simple possession, and expunge criminal records associated with simple possession. Expand statewide access to harm reduction and medications for opioid use disorder.	https://www.mnmed.org/application/files/3916/8676/6277/MMA_Decriminalization_HR_Policies.pdf
US	National Drug Control Strategy	Office of National Drug Control Policy	2022	The federal government's drug strategy document focuses on seven key areas, among them expanding access to evidence-based treatment, particularly medications for opioid use disorder; advancing racial equity; enhancing harm reduction efforts; reducing the supply of illicit substances; and expanding access to recovery services.	https://www.whitehouse.gov/wp-content/uploads/2022/04/National-Drug-Control-2022Strategy.pdf
US	Public Policy Statement on Racial Justice Beyond Healthcare: Addressing the Broader Structural Issues at the Intersection of Racism, Drug Use, and Addiction	American Society of Addiction Medicine	2022	Recommends shifting the national response to personal drug use away from criminality and toward health and wellness, highlighting racial disparities in the criminal response. ASAM recommends policy responses to address the social determinants of health, like removing bans on TANF and SNAP and housing for people who commit drug offenses.	https://downloads.asam.org/sitefinity-production-blobs/docs/default-source/advocacy/racial-justice/2022-pps-recs-on-adv-rj-beyond-health-care.pdf?sfvrsn=f4e11c74_5
US	Addiction Should Be Treated, Not Penalized	National Institute on Drug Abuse	2021	Substance use disorder should be treated with high quality care and compassion. A punitive approach is ineffective and exacerbates racial disparities.	https://nida.nih.gov/about-nida/noras-blog/2021/05/addiction-should-be-treated-not-penalized
US	Advancing Public Health Interventions to Address the Harms of the Carceral System	American Public Health Association	2021	To advance the public's health, calls for evidence-based policies that reduce the number of people who are incarcerated, invest more in social determinants of health like housing and employment, explore restorative and transformative justice, and investing in community-based mental healthcare.	https://www.apha.org/Policies-and-Advocacy/Public-Health-Policy-Statements/Policy-Database/2022/01/07/Advancing-Public-Health-Interventions-to-Address-the-Harms-of-the-Carceral-System
US	Collateral Consequences: The Crossroads of Punishment, Redemption, and the Effects on Communities	US Civil Rights Commission	2019	Racial discrimination in collateral consequences constitutes a civil rights issue. Recommends that policymakers roll back and avoid punitive mandatory consequences that don't serve public safety, are not connected to the offense committed, and impede people from entering and contributing to society. This includes restrictions on TANF and SNAP, housing, student loans, and employment.	https://www.usccr.gov/files/pubs/2019/06-13-Collateral-Consequences.pdf
US	Four Decades and Counting: The Continued Failure of the War on Drugs	Cato Institute	2017	Drug criminalization is associated with significant economic costs. Decriminalization and legalization should be considered at the state, federal, and international levels.	https://www.cato.org/sites/cato.org/files/pubs/pdf/pa-811-updated.pdf

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US	Every 25 Seconds: The Human Toll of Criminalizing Drug Use in the United States	Human Rights Watch	2016	Finds that criminalizing drug use does not prevent problematic use. Recommends instead that governments end criminalization of simple possession, as well as expand access to prevention education and evidence-based treatment available outside the court and prison system.	https://www.hrw.org/sites/default/files/report_pdf/usdrug1016_web_0.pdf
US	Defining and Implementing a Public Health Response to Drug Use and Misuse	American Public Health Association	2013	Finds that a criminal-legal system response to drug use and misuse is ineffective and leads to other public health problems. Recommends ending the criminalization of drugs and people who use drugs and prioritizing health and harm reduction approaches and asks all stakeholders to pivot toward a health approach and examine promising practices implemented in other jurisdictions.	https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/08/08/04/defining-and-implementing-a-public-health-response-to-drug-use-and-misuse
Global	Beyond Punishment: From Criminal Justice Responses to Drug Policy Reform	The Global Commission on Drug Policy	2024	A call to action for governments, the United Nations, civil society, and the research community - with a set of recommendations for each - to push for evidence-based policies that prioritize health and human rights.	https://www.globalcommissionondrugs.org/wp-content/uploads/2024/12/241127-GCDP_Report2024_EN.pdf
Global	Summary of the Intersessional Panel Discussion on Human Rights Challenges in Addressing and Countering All Aspects of the World Drug Problem	Office of the United Nationals High Commissioner for Human Rights (OHCHR)	2024	A summary of discussions on the need for a rights- and evidence-based approach to drug policy held February 5, 2024, chaired by President of the Human Rights Council Omar Zniber, with opening statements by UN High Commissioner for Human Rights Volker Turk and Chair of the Commission on Narcotic Drugs, Philbert Johnson of Ghana.	https://idpc.net/publications/2024/09/summary-of-the-intersessional-panel-discussion-on-human-rights-challenges-in-addressing-and
Global	HIV, Hepatitis & Drug Policy Reform	Global Commission on Drug Policy	2023	Calls for countries to make several policy changes to reduce HIV and Hepatitis C, including decriminalizing drug use, drug possession for personal use, and the possession of drug paraphernalia; ensure that health and harm reduction services are widely available; and consider legal regulation of drugs as a way to combat illicit drug markets.	https://www.globalcommissionondrugs.org/reports/hiv-hepatitis-drug-policy-reform

Global	Human rights challenges in addressing and countering all aspects of the world drug problem	United Nations of the High Commissioner for Human Rights	2023	Offers roughly twenty recommendations for developing effective drug policies rooted in human rights, including considering decriminalization of drug use and developing regulatory systems for legal access to all controlled substances, ensuring that drug treatment is voluntary, protecting against discrimination, and funding harm reduction services.	https://www.ohchr.org/en/documents/thematic-reports/ahrc5453-human-rights-challenges-addressing-and-countering-all-aspects

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Global	The 8 March Principles for a Human Rights-Based Approach to Criminal Law Proscribing Conduct Associated with Sex, Reproduction, Drug Use, HIV, Homelessness and Poverty	International Commission of Jurists	2023	Addresses the harmful human rights impacts of criminal laws targeting vulnerable groups, among them people who use drugs, sell sex, are living with HIV, and are experiencing homelessness and poverty - with many intersections among them. Criminal laws targeting these groups punish, stigmatize, and deny services and rights to individuals.	https://share-netinternational.org/wp-content/uploads/2023/03/8-MARCH-Principles-FINAL-printer-version-1-MARCH-2023.pdf
Global	Recommendations on Alternatives to Criminal Penalties for Simple Possession of Controlled Substances	Health Canada Expert Task Force on Substance Use	2021	End criminal penalties related to simple possession, and end all coercive measures related to simple possession and consumption.	https://www.canada.ca/content/dam/hc-sc/documents/corporate/about-health-canada/public-engagement/external-advisory-bodies/reports/report-1-2021/report-1-HC-expert-task-force-on-substance-use-final-en.pdf
Global	Time to End Prohibition	Global Commission on Drug Policy	2021	Recommends replacing prohibition with increased focus on health and safety outcomes, focusing enforcement on organized crime, and regulating all drugs using cannabis as a model.	https://www.globalcommissionondrugs.org/wp-content/uploads/2021/12/Time_to_end_prohibition_EN_2021_report.pdf
Global	International Guidelines on Human Rights and Drug Policy	International Centre for Human Rights in Drug Policy, UNAIDS, UN Development Program, World Health Organization	2019	The Guidelines apply existing human rights law to drug control laws and policies.	https://www.humanrights-drugpolicy.org/about/
Global	United Nations Common Position on Drugs	United Nations System Chief Executives Board for Coordination	2018	A joint commitment of all relevant United Nations bodies to protect human rights in international drug control policies. Promotes alternatives to conviction and punishment, including decriminalization of drug possession for personal use. Calls for changes in drug laws and policies that threaten people's health and human rights.	https://unsceb.org/sites/default/files/2021-01/2018%20Nov%20-%20UN%20system%20common%20position%20on%20drug%20policy.pdf
Global	Public health and international drug policy	Johns Hopkins-Lancet Commission on Drug Policy and Health	2016	Recommends an evidence-based approach to drug policy that includes decriminalization of minor drug offenses; reducing violence associated with drug policing; easy access to harm reduction services and evidence-based and	https://linkinghub.elsevier.com/retrieve/pii/S0140067361600619X

				voluntary treatment; and moving gradually toward regulated drug markets with rigorous evaluation.	
Global	The Drug Problem in the Americas	Organization of American States	2013	A public health approach is needed to address drug use, and decriminalization of drug use should be a core element of any public health strategy. Adequate funding is needed to make treatment accessible.	https://www.oas.org/documents/eng/press/introduction_and_analytical_report.pdf