DEPARTMENT OF HEALTH

Recommendations on Substance Use Disorder Treatment in Rural Minnesota

WORKGROUP OF THE RURAL HEALTH ADVISORY COMMITTEE

2025

DEPARTMENT OF HEALTH

March 20, 2026

Dr. Brooke Cunningham
Minnesota Department of Health
625 North Robert Street
St. Paul, MN 55155

Dear Commissioner Cunningham:

We are pleased to present this report from the Rural Health Advisory Committee: *Recommendations on Substance Use Disorder Treatment in Rural Minnesota.*

The Rural Health Advisory Committee (RHAC) formed a workgroup to examine pain management and substance use disorder in rural Minnesota. The workgroup initially focused on pain management and substance use disorder, however, with the complexity of two issues, they focused specifically on substance use disorders. They sought to identify policy and practice recommendations that could strengthen the system in rural parts of the state. Workgroup members included mental health practitioners, crisis response services, health care systems, community clinics, government, educators, and advocacy organizations. The report offers a series of recommendations across three categories:

- Transitions in care
- Recruitment and retention of workforce
- Increasing capacity in local communities

We appreciate the opportunity to share this report and contribute to the discussion of substance use disorder in rural Minnesota. Thank you for your continued support of rural health.

Sincerely,

Laura Schwartzwald, RPh, Chair, Rural Health Advisory Committee Member,
Co-Chair, Substance Use Disorder Workgroup

Margaret Kalina, RN, Vice Chair, Rural Health Advisory Committee
Substance Use Disorder Workgroup Member

Andy Johnson, APRN, CRNA, NSPM-C, Co-Chair, Substance Use Disorder Workgroup
Former Member, Rural Health Advisory Committee

DEPARTMENT OF HEALTH

March 20, 2026

Laura Schwartzwald, RPh.
Chair
Rural Health Advisory Committee

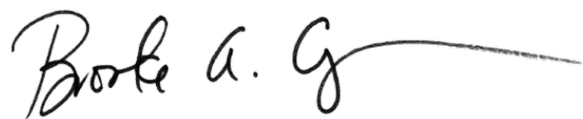
Dear Laura:

Thank you for the Rural Health Advisory Committee's report **Recommendations on Substance Use Disorder Treatment in Rural Minnesota**. We appreciate the efforts of the Rural Substance Use Disorder Work Group and the entire Rural Health Advisory Committee.

Ensuring that all Minnesotans have access to needed services is an important public health concern. The recommendations made in this report highlight the need for continued efforts to strengthen support for individuals living with and being treated for substance use disorders in rural Minnesota. The report identifies assets that can be used towards overcoming these barriers, areas where additional resources may be needed, and strategies to increase capacity in rural communities towards providing needed services to community members who desire treatment. This report helps us understand the need for increased access to services and supports for those impacted by substance use disorder in the context of rural Minnesota, and will help target resources and services to the areas where they are needed most.

Thank you for your work in this important area. The Minnesota Department of Health is committed to health equity and ensuring that all people have what they need to be healthy. The insightful recommendations found in this report provide important steps in supporting those impacted by substance use disorder. I look forward to working together to protect, maintain, and improve the health of all Minnesotans.

Sincerely,



Dr. Brooke Cunningham
Commissioner of Health
PO Box 64975
St. Paul, MN 55154

Recommendations on Substance Use Disorder Treatment in Rural Minnesota

Minnesota Department of Health
Office of Rural Health and Primary Care
PO Box 64822
St. Paul, MN 55164-0882
651-201-3838
health.RHAC@state.mn.us
www.health.state.mn.us

To obtain this information in a different format, call: 651-201-3838.

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Executive Summary

The Rural Health Advisory Committee of Minnesota identified substance use disorder as a pressing concern in rural communities and convened a diverse workgroup to examine the intersection of pain management, substance use disorder, and access to care. This report presents findings and outlines recommendations across three key focus areas.

The Challenge

Limited access to health care in rural Minnesota can lead to self-medication and increased risk of substance use disorder. Hospital-treated nonfatal opioid overdoses remain significantly higher than in 2018, despite recent modest declines. American Indians are disproportionately impacted—experiencing nonfatal opioid overdoses at 16 times the rate of white Minnesotans, and accounting for 7% of overdose deaths despite being only 1.5% of the population. To address these complex, interconnected challenges, the workgroup developed a comprehensive strategy targeting care transitions, workforce development and community capacity building.

Recommendations

1. Improve Transitions in Care: Expand peer support networks (Certified Peer Recovery Specialists), strengthen care coordination between incarceration, treatment, and reintegration and advocate for the repeal of the Medical Inmate Exclusion Policy
2. Enhance Workforce Recruitment and Retention: Partner with educational institutions to promote substance use disorder-related careers, increase financial support for training (loan forgiveness, scholarships), improve the working environment for Licensed Alcohol and Drug Counselors and recruit a diverse workforce with a focus on cultural competency
3. Increase Capacity in Local Communities: Train rural healthcare staff in substance use disorder treatment via remote learning, expand telehealth access and infrastructure, increase availability of recovery housing, remove barriers to treatment in housing settings and strengthen mental health services as a primary prevention strategy

Call to Action

The Rural Health Advisory Committee's recommendations address immediate gaps while laying the foundation for long-term, community-led solutions. Policymakers, providers, tribal leaders, and community organizations must collaborate to implement culturally responsive, trauma-informed strategies that prioritize access, dignity, and health equity. This work must extend beyond treatment to include harm reduction, prevention, and recovery support—ensuring individuals at all stages of use and recovery have access to compassionate, effective care in their home communities.

Introduction

Background on the Rural Health Advisory Committee

The Rural Health Advisory Committee (RHAC) is a diverse statewide forum for addressing rural health interests, advising the Commissioner of Health and others, and recommending and evaluating approaches to rural health issues that are sensitive to and recognize the needs of rural communities.

The Rural Health Advisory Committee identified substance use disorder (SUD) as a priority issue in rural Minnesota. In developing their work plan, Committee members focused on how access to health care affects people with substance use disorders, noting that limited access to health care leads to more people choosing to self-medicate, which can lead to substance use disorders.

Workgroup Formation and Goals

The Rural Health Advisory Committee convened a Substance Use Disorder (SUD) workgroup to study pain management and substance use disorder in rural Minnesota and identify policy and practice recommendations to strengthen the system of support for rural Minnesotans experiencing SUD.

The SUD workgroup involved stakeholders from across sectors, including mental health practitioners, crisis response services, health care systems, community clinics, tribal health directors, government, and advocacy organizations. A full list of workgroup members can be found in Appendix B.

The workgroup began by examining access to treatment for pain and for SUD, resources for rural providers treating these individuals, and support during care transitions in rural areas. The workgroup met as a group five times, consulted with professionals in the field to confirm best practices, and reconvened prior to submission of the report to further explore impact of SUC on American Indians in Minnesota.

The workgroup identified a series of recommendations and MDH staff finalized the recommendations. The workgroup reviewed the report and submitted it to RHAC for its review. RHAC supported the report and urged consideration of these recommendations in the interest of strengthening support for people living with and being treated for substance use disorders in rural Minnesota.

The workgroup identified recommendations in three categories, including:

- Transitions in care
- Recruitment and retention of workforce
- Increasing capacity in local communities

The recommendations address areas in need of additional resources and strategies to increase capacity in rural communities for providing needed services to community members who desire treatment.

Identifying the Issue

The Injury Prevention and Mental Health Division at the Minnesota Department of Health produced the Nonfatal Drug Overdose Dashboard which provides the data points noted below. The data provides a better understanding of SUD in rural Minnesota, as well as evidence of the need to develop tailored public health initiatives and policy changes that would effectively reduce overdose rates, narrow disparities in overdose rates for the American Indian population and other disproportionately impacted communities and improve support for individuals with SUD in rural Minnesota.

Nonfatal Drug Overdoses in Greater Minnesota (2019–2023)

Overall Trends:

Hospital-treated nonfatal drug overdoses fluctuated during this time period, with

- A 7% decrease in hospital-treated nonfatal drug overdoses from 2021 to 2023, but
- An increase in the overall number of overdoses, resulting in a number that was 9% higher in 2023 than in 2018

Opioid-Specific Trends:

- The number of hospital-treated nonfatal opioid overdoses increased each year from 2019 to 2021
- From 2022 to 2023, there was a **15% decrease** in hospital-treated nonfatal opioid overdoses
- Despite this decrease in hospital-treated nonfatal opioid overdoses, the number of opioid overdoses in 2023 were still **53% higher** than in 2018

According to the Nonfatal Drug Overdose Dashboard maintained by the Injury Prevention and Mental Health Division at the Minnesota Department of Health, over the five-year period from 2019 through 2023, the number of hospital-treated nonfatal drug overdoses among Greater Minnesota residents has varied. Recent data confirms a 7% decrease in hospital-treated nonfatal drug overdoses from 2021 to 2023. However, the number of hospital-treated nonfatal

drug overdoses in 2023 reveals a 9% increase when compared with 2018. Specifically focusing on hospital-treated nonfatal drug overdoses involving an opioid, among Greater Minnesota residents, the number of hospital visits increased each year from 2019 to 2021. While there was a 15% decrease in hospital-treated nonfatal opioid overdoses from 2022 to 2023, the overall number of nonfatal opioid overdoses in 2023 remains substantially higher, showing an increase of 53% compared to 2018.

Disparities in Substance Use Disorder (SUD) & Overdoses Among American Indians

There is a major disparity between the American Indian population in Minnesota and individuals that identify as other than American Indian when it comes to substance use disorder and fatal and non-fatal drug overdoses. From 2019 to 2023, American Indians in Minnesota were nine times more likely to experience a nonfatal drug overdose than white Minnesotans. During the same period American Indians in Minnesota were also 16 times more likely to experience a nonfatal opioid overdose than white Minnesotans; these figures do not include nonfatal drug overdoses related to self-harm.

Nonfatal Drug Overdose Disparities (2019–2023):

- American Indians in Minnesota were **nine times more likely** to experience a **nonfatal drug overdose** than white Minnesotans
- American Indians were **16 times more likely** to experience a **nonfatal opioid overdose** than white Minnesotans
- These figures **do not** include overdoses related to self-harm

Fatal Drug Overdose Disparities:

- Between **2018 and 2022**, Greater Minnesota saw a total **increase of 223 drug overdose deaths** (Statewide Trends in Drug Overdose: 2024 Data Update)
- In **2019**, American Indians were **seven times more likely** to die from a drug overdose than white Minnesotans (per Differences in Rates of Drug Overdose Deaths by Race)
- Although American Indians make up **1.5% of Minnesota's population**, they accounted for **7% of overdose deaths**—highlighting a disproportionate impact

Challenges in Rural Minnesota: Chronic Pain and SUD

Rural communities face significant challenges in meeting the complex needs of individuals living with SUD and/or chronic pain. Prescription opioids are misused by approximately 10 percent of patients with chronic pain, as published in Common Comorbidities with Substance Use Disorders Research Report. Those who suffer from chronic pain are more likely to experience SUD, as there are barriers to treatment and access to appropriate prescriptions. According to the 2019 National Health Interview Survey, published in the National Health Statistics Reports, Number 162, August 5, 2021, conducted in the United States and analyzed by National Health Statistics, 22.1% of adults with chronic pain reported using a prescription opioid in the three months prior to responding to the survey.

SUD and Chronic Pain Connection:

- **10% of patients with chronic pain misuse prescription opioids** (per Common Comorbidities with Substance Use Disorders Research Report)
- Individuals with chronic pain face **barriers to treatment** and **limited access to appropriate prescriptions**

Opioid Use Among Adults with Chronic Pain (2019 Survey):

- **22.1% of adults with chronic pain** reported using a prescription opioid in the **past three months** (per National Health Statistics Reports, Number 162, August 5, 2021)
- Limited pain management options may contribute to increased opioid misuse and risk of developing SUD

Data Collection and Equity Challenges

When discussing and examining SUD in rural Minnesota, it is important to acknowledge the disproportionate impacts of the opioid and substance use epidemic on the American Indian Minnesotans and to acknowledge factors that influence limitations on data collection that would more fully demonstrate the disparity.

- In "American Indian 101": Understanding the history and contemporary experiences of Native people in a United States health policy context, the State Health Access Data Assistance Center notes that data collection and sharing specific to American Indian/Alaska Native populations face significant challenges, rooted in a complex and historically harmful relationship between Native nations, the U.S. government, and academia. Issues such as incomplete datasets, deficit-focused narratives, and misclassification of American Indian/Alaska Native individuals arise from Western data aggregation practices, which often lack appropriate cultural sensitivity. In contrast, pre-colonial Native data practices (data sharing between Native Nations) emphasized reciprocity, accountability, and meaningful relationships, principles now central to the Indigenous data sovereignty movement. These challenges directly impact health policy and public health efforts, creating barriers to healthcare access and insurance coverage for Native communities.
- Given the distrust between American Indian/Alaska Native communities and governments outside of tribal nations, nations choose to implement Indigenous data sovereignty, defined in Indigenous Data in the Covid-19 Pandemic: Straddling Erasure, Terrorism, and Sovereignty as “the right of Indigenous Peoples and nations to govern data about their policies, lands, and resources.” For example, Red Lake Nation Personnel Policy (PDF) highlights that all documents and information pertaining to the band are considered property of the Red Lake Band.
- According to the Twice Invisible - Research Note (PDF) by the First Nations Development Institute, “American Indian and Alaska Native communities are an important part of the diverse fabric of the U.S. population, but they remain misunderstood or forgotten because they are often left out of major data-collection efforts.”

- American Indians who live on reservations are undercounted in the Census. According to the Post-Enumeration Surveys, the undercount on tribal lands is 5.6%.
- It can be difficult to collect data on individuals who identify with multiple race categories. In *Nearly a Third Reporting Two or More Races Were Under 18 in 2020*, the Census Bureau notes the ability of individuals to indicate multiple racial identities.

Given the limitations in data collection and classification methods, it is believed that the numbers of American Indian/Alaska Native, individuals who experience substance use disorder is higher than the data available for this report.

The Minnesota Department of Human Services has published the American Indian Symposium Briefing Book (PDF) on Mental Health & Chemical Dependency, which discussed the effects of historical trauma on the American Indian community. The American Indian community has long faced significant challenges with chemical dependency and mental health issues, with five of the top ten causes of death linked to alcohol and drug use. Efforts to address these issues have been too often hindered by a lack of culturally sensitive approaches and resources, and programs that address symptoms rather than root causes.

Many tribal leaders attribute these challenges to historical trauma stemming from cultural genocide and unresolved generational grief related to the forced disconnection from land and traditional lifestyles, compounded by assimilation policies that led to cultural voids and alienation. Acknowledging these factors is crucial when supporting American Indian/Alaska Native community, where mental health and spiritual health are deeply connected.

Collaborative efforts between tribal nations, counties, the state, and federal government are needed to ensure care for all individuals in Minnesota.

RHAC's Recommendations

RHAC is making 10 recommendations in three categories for policymakers and stakeholders to consider. Each recommendation include the rationale behind it, as well as promising practices, wherever possible.

1. Improve Transitions in Care
   - 1.1. Expand peer support networks (Certified Peer Recovery Specialists)
   - 1.2. Strengthen care coordination between incarceration, treatment and reintegration, and advocate for the repeal of the Medical Inmate Exclusion Policy
2. Enhance Workforce Recruitment and Retention
   - 2.1. Partner with educational institutions to promote SUD-related careers
   - 2.2. Increase financial support for training (loan forgiveness, scholarships)
   - 2.3. Improve the working environment for Licensed Alcohol and Drug Counselors
   - 2.4. Recruit a diverse workforce with focus on cultural competency
3. Increase Capacity in Local Communities
   - 3.1. Train rural health care staff in SUD treatment via remote learning

3.2. Expand telehealth access and infrastructure

3.3. Increase recovery housing availability and remove barriers to treatment in housing settings

3.4. Strengthen mental health services as a primary prevention strategy

Recommendation Category 1: Improve Transitions in Care

Several recommendations arose around transitions in care. Transitions in care are especially challenging times for people who are living with or recovering from a substance use disorder. These recommendations will look at ways to support individuals who are seeking treatment, leaving inpatient treatment centers, or leaving incarceration.

Current Initiatives Supporting Individuals in Minnesota

The Legislative Analysis and Public Policy Association released the 2023 State of the States: Legislative Roadmap (PDF), which contains 10 recommendations that are likely to have an impact on reducing overdose deaths. Minnesota has implemented five of the recommendations, including: syringe services programs, fentanyl test strips, drug checking equipment, schools' response to drug-related incidents, and naloxone in schools. The five remaining recommendations should also be considered, including: universal access to medications for addiction treatment in correctional settings, withdrawal management services in correctional settings, substance use treatment in emergency departments, substance use treatment during pregnancy and in family care plans, and overdose fatality review teams. Of note, Minnesota has completed a small pilot of overdose fatality review teams.

1.1. Expand peer support networks (Certified Peer Recovery Specialists)

This recommendation aims to increase support, improve access to resources, prevent return to use and reduce recidivism for individuals with SUDs as they navigate various transitions. Peer support, connection to the community, and engagement in a variety of sober activities are known facilitators of substance use recovery, as shown in *A Qualitative Study of the Role of Peer Support Specialists in Substance Use Disorder Treatment: Examining the Types of Support Provided: Alcoholism Treatment*.

What are Certified Peer Recovery Specialists?

Peer Recovery Specialists are individuals with lived experience in substance use recovery who support others who are facing substance use disorders. In Minnesota, becoming a Certified Peer Recovery Specialist requires individuals to complete 46 hours of training and pass a state exam. Certified Peer Recovery Specialists—and those with lived experience who informally take on the role of supporting others through SUD treatment and recovery—can play a powerful role in easing transitions into and out of treatment programs and out of jails or correctional facilities. It is important to note that it is not the sole responsibility of Certified Peer Recovery Specialists to make all transition and service arrangements, but to be a part of the collaboration across recovery programs in the best interests of the individual's transition and treatment plan.

Certified Peer Recovery Specialists and Peer Recover Services

Peer Recovery Services for Substance Use Disorder may be provided by non-certified peers. These peers are similar to Certified Peer Recovery Specialists, but the credentialling processes are different, and there are billing restrictions that should be considered. As noted on their website, “Peer Recovery Services is a form of non-clinical support where trained individuals who are more established in recovery come alongside people currently in the recovery journey and provide guidance in the treatment process, help in accessing resources, and offer an empathetic ear. In combination with other services in the continuum of care, Peer Recovery Services seeks to reduce harm from disordered use.” In 2018, the State of Minnesota authorized billing for peer services through Medicaid reimbursement via services provided by Certified Peer Recovery Specialists; late in 2025, DHS implemented a licensing moratorium and froze new enrollment for this service.

Peer Services in Minnesota

Potential also exists for grassroot efforts related to recovery. Community organizations such as Blue Earth County’s Yellow Line Project, CHI St. Gabriel’s Health and St. Gabriel’s Foundation: Morrison County Prescription Drug Task Force, and Sanford Bemidji Medical Center: First Steps Program, summarized in *It’s an addiction crisis*, are programs where individuals with lived experience who have not elected to become Certified Peer Recovery Specialists are extremely supportive of individuals as they transition into their communities after treatment.

The Sanford Bemidji First Steps Program and other counseling programs now allow for spiritual and cultural practices like smudging to be incorporated into sessions to bring in a spiritual component for American Indian people. Spiritual practices can be critical in the recovery process for individuals. Recommendations provided by the National Drug Early Warning System Minnesota Hot Spot Report (PDF) include: “Support cultural solutions…Traditional approaches are grounded in strengths-based practices guided by inherent Indigenous wisdom and values that have been the source of resiliency for American Indians since time immemorial.”

Two organizations, Refocus Recovery and Twin Cities Recovery Project, serve the entire state, offering virtual peer-to-peer recovery services for individuals, regardless of residence or location. While virtual services are not always preferred, it is one avenue for all Minnesotans to access peer-to-peer support. Many individuals in rural areas express the desire for in-person engagement in their medical and recovery journey, and it is important to continue to promote in-person Certified Peer Recovery Specialist teams in rural areas, not just virtual services.

Initiatives of Refocus Recovery and Twin Cities Recovery Project taking place across the state include:

- Peer support specialists meeting with prison-involved persons as they prepare for and transition back into community living
- A pilot program where existing community spaces are used as centers where people can gather and take part in activities with other people who are sober
- Teams in Bemidji and Montevideo that work to connect individuals with follow-up programs and provide weekly and monthly sober activity options

Supporting these efforts via resources and engagement with the primary certification entities in Minnesota (Minnesota Certification Board, The National Association for Addiction Professionals, and the Upper Midwest Indian Council on Addictive Disorders) would help promote Certified Peer Recovery Specialists.

1.2. Strengthen care coordination between incarceration, treatment, and reintegration, and advocate for the repeal of the *Medical Inmate Exclusion Policy*

This recommendation aims to increase continuity of care for individuals who are currently incarcerated or transitioning out of incarceration. Advocacy for policies that increase access to insurance and support individuals in receiving substance use-related health care is aligned with best practices for addressing substance use disorder challenges.

Understanding Minnesota's Incarcerated Population

Incarcerated individuals in Minnesota do not mirror the population within the state. According to the 2024 Minnesota Department Corrections report *Adult Inmate Profile (PDF)* of incarcerated adults, 49.2% identified as white, 38.5% identified as Black, 9.3% identified as American Indian, 2.7% identified as Asian and 0.3% identified as unknown/other. According to the 2024 Minnesota Department Corrections report, *Juvenile Resident Population Summary (PDF)*, among incarcerated adolescents, 10.4% identified as American Indian, 8.9% as Asian or Pacific Islander, 55.2% as Black, 7.4% as unknown/other and 17.9% as white. Increasing appropriate continuity of care for individuals experiencing incarceration and transitioning out of incarceration is important in helping this population combat SUD.

Support for Incarcerated Individuals

The Minnesota Department of Human Services (DHS) outlines a policy which assigns jails and counties responsibility in providing SUD services while individuals are incarcerated. According to the DHS fact sheet *Incarcerated Individual and Substance Use Disorder Services (PDF)*, "Jails and counties are responsible to establish a process to enable eligible incarcerated individuals to obtain SUD services while in custody because Medicaid does not cover SUD treatment services to individuals who are incarcerated."

Forced abstinence while individuals are in custody complicates their transition back into their communities and does not address the disease of addiction. Because Medicaid does not cover SUD services, the financial responsibility falls on counties and tribes who have limited financial resources for all services provided to community members. Minnesota has an extreme lack of funding for SUD treatment in the carceral system.

Minnesota Management and Budget surveyed agencies providing SUD services in Minnesota correctional facilities in 2021. The report, Medication for Opioid Use Disorder for Individuals in the Criminal Justice System (PDF), provides survey results from 136 responses across 73 counties. The survey found that lack of funding was rated as important or very important by over half of respondents, while less than 20% reported that the issue is not important or only somewhat important.

Impacts of the Medical Inmate Exclusion Policy

The Medical Inmate Exclusion Policy blocks states from using Medicaid funds for health care in jails and prisons and creates difficulties in supporting people transitioning back to the community. This policy increases challenges related to illicit drug use prevention and recidivism for these individuals.

Specifically, this policy leads to challenges completing the comprehensive assessments that are often necessary for individuals transitioning into an SUD treatment program and makes it difficult for patients to access medication-assisted treatment promptly upon release. Unable to receive essential therapies, these patients are at heightened risk of illicit drug use and overdose/death. This policy is also a barrier to innovative care team models, as providers who are not within the jail or prison system cannot get reimbursed for any care they provide.

Bills were introduced in 2023 at the federal level in both the Senate and the House of Representatives to address the Medical Inmate Exclusion Policy. H.R.3074 - 118th Congress (2023-2024): Due Process Continuity of Care Act "removes the Medicaid coverage exclusion for inmates in custody pending disposition of charges" and its companion bill S.971 - 118th Congress (2023-2024): Due Process Continuity of Care Act, introduced in the Senate, states the same purpose. Additionally, the Reentry Act of 2023, introduced in the Senate as S.1165 - 118th Congress (2023-2024): Reentry Act of 2023 and in the House as H.R.2400 - 118th Congress (2023-2024): Reentry Act of 2023, would allow states to make medical assistance available in the 30 days preceding an individual's release. The workgroup recommended support by State of Minnesota officials in these federal efforts.

In April 2023, the U.S. Department of Health and Human Services announced New Guidance to Encourage States to Apply for New Medicaid Reentry Section 1115 Demonstration Opportunity to Increase Health Care for People Leaving Carceral Facilities, an opportunity for states to apply for a waiver that would provide coverage for services after individuals leave carceral facilities. Should Minnesota apply for this waiver, the State Medicaid program would be able to cover services that address substance use disorder and establish connections with community providers prior to reentry. Minnesota DHS currently has the authority to study the feasibility and design of such a waiver.

The Northwest Indian Community Development Center operates an Ombishkaa Initiative, which "includes providing comprehensive services, information, and resources that support the stability of Indigenous men and women who have experienced incarceration. The Ombishkaa team welcomes and transitions in new and current community members in the program to help them acclimate back home and to the community." This type of initiative, in addition to the advocacy of the repeal of the Medical Inmate Exclusion Policy helps address the needs of individuals who have experienced the carceral system and the support needed as they reenter their communities.

Recommendation Category 2. Enhance Workforce Recruitment and Retention

The current composition of the Licensed Alcohol and Drug Counselor workforce in Minnesota

In Rural Minnesota, there are 2,319 individuals to every Licensed Alcohol and Drug Counselor (LADC) compared to 1,377 per LADC in the metro area; 494 individuals to every mental health provider compared to just 223 per provider in the metro area; and 90 individuals for every Registered Nurse compared to 52 for every metro Registered Nurse. Each of these professions experience high rates of burnout, which has been exacerbated by the stresses on the healthcare workforce during the COVID-19 pandemic. Currently, 18% of Licensed Alcohol and Drug Counselors, 13% of mental health providers, and 17% of nurses currently practicing in rural Minnesota plan to leave the fields within the next 5 years. Licensed Alcohol and Drug Counselors planning to leave the workforce increased from 8% in 2019 to 15% in 2022.[1]

Recruitment is a key part of building the provider workforce and increasing capacity to provide necessary services. Effective recruitment strategies are needed to encourage students to enter these fields *and* to attract and retain qualified providers in rural areas.

2.1. Partner with educational institutions to promote SUD-related careers

One component of recruitment includes outreach to students and educators to build awareness of and interest in healthcare career opportunities. The lack of Licensed Alcohol and Drug Counselor availability disproportionately impacts rural Minnesota since a higher percentage of the rural healthcare workforce plans to leave their positions due to burnout or job dissatisfaction. Of the 15% of Licensed Alcohol and Drug Counselors who plan to leave the field in the next five years, 18% practice in rural areas.[1] This recommendation aims to increase the number of students engaging in training programs and entering mental health and substance use related careers.

Legislation introduced in 2023 by the Minnesota House of Representatives (HF 1436 as introduced - 93rd Legislature (2023 - 2024)) and Minnesota Senate (SF 1679 as introduced - 93rd Legislature (2023 - 2024)) included proposals to establish a Mental Health and Substance Use Disorder Education Center within the Department of Health. Among other functions, this Center would work with schools to expose high school and college students to opportunities in the mental health and SUD field. Advocates note that a Center would help put more emphasis on recruitment efforts for Licensed Alcohol and Drug Counselors.

The workgroup also expressed support for career day events and job shadowing opportunities as specific tools to engage with students. Communities that engage youth prior to high school graduation often have more success in promoting healthcare career fields. One healthcare

[1] Fritsma, T. (2023, January 9). Brief Overview: Licensed Alcohol and Drug Counselor Workforce [Background Presentation].

career promotion program, described in the article *Hospital-based, Multidisciplinary, youth mentoring and medical exposure program positively influences and reinforces health care career choice: "The Reach One Each One Program early Experience"* in Atlanta, Georgia, resulted in 88% of participants enrolling in health science college programs. Two programs in other states that provided mentorship to rural high school students each resulted in 70% of former participants pursuing or planning to pursue post-secondary health science education.

2.2. Increase financial support for training (loan forgiveness, scholarships)

According to “The Healthcare Workforce in a Post-Pandemic World,” a Report to the Governor's Task Force on Academic Health at the U of M (PDF), a root cause of shortages of mental health workers is compensation. Substance Abuse, Behavior Disorder, and Mental Health Counselors were reimbursed at $24.93 per hour compared to other mental health providers who were reimbursed at rates from $30.53-$49.90 per hour. In Minnesota, becoming a Licensed Alcohol and Drug Counselor involves obtaining a bachelor’s degree with specific alcohol and drug counseling coursework, completing at least 880 hours of counseling practicum, and passing a comprehensive exam. While valuable, the education and practicum requirements pose barriers to individuals becoming Licensed Alcohol and Drug Counselors.

Licensed Alcohol and Drug Counselor Education Flexibility

Embedding Licensed Alcohol and Drug Counselor requirements into nursing and social work programs and increasing opportunities for practicum completion via telemedicine may make this license attainable for more people. While engaging educators from other fields to cross-teach, it is important that they also have an understanding and some training in substance use disorders. Overall, education and training can be a lengthy and expensive process. The availability of obtaining education via online classrooms also increases education accessibility in rural areas. Creating financial supports to encourage individuals to enter the field is crucial. Some entities, including the State of Minnesota, are pursuing ways to reduce the financial burden, but more needs to be done in this area.

One member of the workgroup heard of successful Licensed Alcohol and Drug Counselor recruitment by organizations that had received a grant to cover training costs. This model could be effective, as other professions have successfully implemented scholarship funding through grant funding.

Through the Minnesota Health Care Loan Forgiveness Program, Licensed Alcohol and Drug Counselors are currently an eligible profession with access to loan forgiveness awards each year. However, in the last three years, only 33 out of 70 eligible applicants were offered awards due to limited funding.

Another barrier while obtaining education is the cost for required practicums (a shorter period, generally at the mid-point of education, when a student closely observes a professional serving clients) and internships (a substantial number of hours dedicated to supervised practice at the end of an individual’s education). Providing funding for student internships is needed. Students are paying for credits through their educational institution but are typically not paid for these hours of work. Unpaid internships can be prohibitive for students entering the field. Project

Turnabout in Wilmar offers financial support to students pursuing Licensed Alcohol and Drug Counselor credentialing if they agree to work for the program for two years following licensure. This organization has experienced success promoting this program with local colleges and institutions. While some organizations are beginning to compensate interns, this is not yet the norm.

Increase Reimbursement Rates for Licensed Alcohol and Drug Counselor Services

Increasing reimbursement rates (i.e., salary) and decreasing cost burdens for providers may be an important step in helping recruit and retain Licensed Alcohol and Drug Counselors. Pay levels for practitioners are often lower in rural areas, even when considering a lower cost of living in many rural parts of the state. The 2021 Minnesota legislature authorized the Minnesota Health Care Program Outpatient Services Rates Study, which could result in a higher reimbursement rate for claims related to substance use disorder. Depending on the results of this study, additional support will likely be required to continue working toward an increase in the reimbursement rate. Increasing reimbursement rates and expanding covered hours to include those spent on administrative work, not just client time for alcohol and drug counseling, would allow organizations to increase the salary for practitioners.

Advocate for Increased Flexibility in Obtaining Licensure

Finally, by looking at the requirements to practice alcohol and drug counseling in the State of Minnesota, there may be additional ways to reduce barriers to entry into the field. The Minnesota Board of Behavioral Health and Therapy has begun conversations related to changing the limitations on temporary permits and is considering whether to develop an associate level license. Additionally, one workgroup member shared an idea of potential legislation for tiered licensing—with a two-year, four year, and master's level Licensed Alcohol and Drug Counselor option. Workgroup members showed interest and suggested this topic be explored at a later date.

2.3. Improve the working environment for Licensed Alcohol and Drug Counselors

Reduce Administrative Burden

One barrier to retaining Licensed Alcohol and Drug Counselors is the high volume of paperwork and administrative tasks required of these professionals. Confusion around requirements, a need for comprehensive trainings, and lack of streamlined processes contributes to this burden. This recommendation aims to reduce the administrative burnout and subsequent loss of Licensed Alcohol and Drug Counselors from the field.

Students and interns entering the field have shared that they were not prepared for the large amount of required paperwork and voiced concerned about the impact on patient care due to taking time away from patients. Many Licensed Alcohol and Drug Counselors spend non-billable hours completing the paperwork required by the judicial, probation, and other systems that have their own unique requirements. These non-billable hours exacerbate burnout in Licensed Alcohol and Drug Counselors.

Increase Clarity and Trainings Related to Documentation Requirements

The workgroup highlighted quarterly trainings by DHS to increase clarity around documentation requirements as one step toward improving the working environment and reducing the paperwork burden for Licensed Alcohol and Drug Counselors.

DHS has contracted with Acentra Health to perform SUD utilization management a part of the 1115 waiver SUD System Reform Demonstration. Acentra reviews provider documentation for a patient's medical necessity at the given level of care. Through the review process, Acentra works with providers on completing required, quality documentation. Acentra provides monthly training to providers on American Society of Addiction Medicine and documentation, and quarterly trainings based on missing documentation trends measured through reviews.

Utilization management is currently performed with providers enrolled in the 1115 SUD waiver. Beginning January 1, 2024, all residential SUD programs were required to enroll in the waiver, and all non-residential programs were required to enroll by Jan 1, 2025, in accordance with Minnesota Statute 256B.0759 Subd. 2. This will increase the reach of utilization review and training, essentially implementing it statewide.

DHS, in partnership with Minnesota Association of Mental Health Residential Facilities, has been working on the Substance Use Disorder Paperwork Reduction and Systems Improvement project since early 2020. Minnesota's legislature mandated a review to streamline regulatory paperwork for SUD programs, involving stakeholders like counties, tribes, and treatment associations in the project.

DHS initiated a contract in September 2023 to expand these efforts, aiming to produce a report for the legislature proposing policy, IT system, and staff changes to cut paperwork and enhance the SUD system. Since 2021, monthly steering committee meetings have engaged DHS staff, SUD providers, and advocacy groups in discussions covering topics such as counselor documentation and licensing reviews.

Notably, the reduction in utilization management reviews from 100% to 10-15%, and decreased documentation requirements for certain American Society of Addiction Medicine levels of care mark the significant progress achieved through this collaborative effort. The overarching goal of the SUD Paperwork Reduction and Systems Improvement project is to move towards paperwork and systems changes that will, primarily, positively impact and maximize benefits for the client experience, and secondarily, positively impact and maximize utility for providers, regulatory agencies, and payers.

Address Burnout for Licensed Alcohol and Drug Counselors

Those entering the field need to be prepared for the potential of burnout, and those already practicing should have supports to address burnout. According to MDH's *Pandemic-Provoked Workforce Exits, Burnout, and Shortages (PDF)*, published in 2022, 16% of Minnesota Licensed Alcohol and Drug Counselors in 2021 reported they planned to exit the profession due to burnout and job dissatisfaction, which is an increase from 8% citing similar plans in 2019. Of Licensed Alcohol and Drug Counselors in rural areas, 18% reported planning to leave their profession compared to 10% in urban areas.

To ensure there are plenty of Licensed Alcohol and Drug Counselors available, students should be prepared with strategies to avoid burnout while still in training. From addressing burnout due to being short staffed in rural areas, to stresses of the job, emotional exhaustion, and secondary trauma, equipping Licensed Alcohol and Drug Counselors with tools beyond “self-care” is crucial. One idea is helping LADCs reframe successes, going beyond extended sobriety of the clients to recognizing successes that could include paying bills on time, gaining or regaining visitations with kids, getting their driver’s license back, or getting off probation, etc.

2.4. Recruit a diverse workforce with a focus on cultural competency

Diversity in Minnesota’s Licensed Alcohol and Drug Counselor Workforce

According to Health Care Workforce Data - Demographics and Characteristics of Licensed Health Care Providers in Minnesota data, 88% of all Licensed Alcohol and Drug Counselors in the state are white, while 78% of Minnesota’s population identify as white. About three percent of Licensed Alcohol and Drug Counselors in the state identify as American Indian/Alaska Native, while 1.4% of the population in Minnesota identifies as American Indian/Alaska Native, alone, according to U.S. Census Bureau QuickFacts: Minnesota. While racial diversity among younger Licensed Alcohol and Drug Counselors is increasing compared to older providers, the field continues to exhibit a significant lack of diversity. The Minnesota Employment and Economic Development article Critical Condition: the Health Care Workforce in Minnesota notes that similar trends exist across the mental health and nursing professions, with over 85% of the total healthcare workforce in Minnesota identifying as white.

Barriers to a Diverse Licensed Alcohol and Drug Counselor Workforce

The Importance of Diversity and Inclusion in the Healthcare Workforce discusses ensuring the best possible care and outcomes for all patients. It is important that the healthcare workforce represent diversity in racial identity, sexual orientation, immigration status, gender, physical disability status, and socioeconomic levels. In addition, it is essential to work towards a society where all members within our communities are afforded equitable opportunities to pursue advanced career training. However, structural barriers, social determinants of health, and qualities of current healthcare models contribute to continued disparities within the workforce and to the challenges of entry into this workforce for many.

DHS conducted a Disparities in Background study process, which identified concerns about privacy in hiring. It is illegal to hire based on race, sexuality, gender, religion, yet assumptions are being made by hiring personnel. Recruiting providers in rural areas is often difficult as practitioners are sometimes avoidant of their clients in the community, at the grocery store or in other locations. Preserving the anonymity of the provider is often a driver for someone to practice in a more populated urban area.

Specifically for American Indian/Alaska Native communities, it is crucial for individuals to learn from educators who have a cultural understanding and are invested in their own community. The Red Lake Nation is working with higher education institutions to create exposure to the Licensed Alcohol and Drug Counselor field. They attend career and education fairs to share employment opportunities with American Indian/Alaska Native students. Another career exposure opportunity includes sharing information with individuals who have received services

from American Indian/Alaska Native, Licensed Alcohol and Drug Counselors. When individuals experience the impacts of support on their own family systems, it creates a unique connection to the profession and a desire to provide that support to others in their community.

The Upper Midwest Indian Council on Addictive Disorders UMICAD - Home certifies Alcohol and Drug Counselors to work under the supervision of Licensed Alcohol and Drug Counselor supervisors with American Indian people to ensure sufficient knowledge and skill among those supporting American Indian individuals. This certification, developed by the community, is necessary to incorporate the special skills and knowledge to address cultural, spiritual and social factors into counseling practices.

Another potential issue is implicit bias in licensing exams. Association of Social Work Boards - Contributing to the conversation found that people of color have lower pass rates than white test takers. Combined with the hurdles to obtain licensing supervision and lower reimbursement rates compared to other health professions, these issues could disproportionately limit people of color from entering the profession.[2]

Initiatives to Increase Diversity

Efforts aimed at diversifying the alcohol and drug counseling workforce do exist across the state. The workgroup discussed the Mesabi Range Community College grant to recruit and train new Licensed Alcohol and Drug Counselors from underrepresented groups. Legislation (HF 1436) was introduced in 2023 which included activities and projects aimed at increasing diversity across the health care workforce; this legislation has not yet moved forward.

In 2021, through Minnesota Statutes 2024, Chapter 254B, the legislature directed the commissioner of human services, in consultation with experts in substance use disorder, to establish a substance use disorder community of practice (CoP). The purpose of the CoP is to improve treatment outcomes for individuals with substance use disorders and reduce disparities by using evidence-based and best practices through peer-to-peer and person-to-provider sharing. The CoP will address gaps in services, enhance collective knowledge of issues, understand evidence-based practices, develop strategic plans to improve outcomes for individuals, increase knowledge about the challenges and opportunities learned by implementing strategies, and develop capacity for community advocacy. A report will be presented to the legislature.

NAADC, the Association for Addiction Professionals, has a Minority Fellowship Program which awards up to $15,000 for master's level students. The creation of a similar program for the bachelor or associate levels could be successful in helping recruit a more diverse workforce.

[2] Fritsma, T. (2022) ORHPC Workforce Diversity Data Request.

Recommendation Category 3. Increase Capacity in Local Communities

There are a variety of different ways that communities can come together to increase support for individuals experiencing SUD. Community support, especially in rural areas where providers may not always be readily available helps ensure assistance is available in a holistic way. The following recommendations reflect the workgroup's recognition of ways in which rural communities can implement initiatives to support those experiencing SUD.

3.1. Train rural healthcare staff in SUD treatment via remote learning

To improve continuity of care for patients receiving SUD treatment *and* to increase capacity for providing SUD care in rural areas, increased training and collaboration for all healthcare providers working with patients with SUDs is recommended. The use of remote learning and cross-training supports rural providers through familiar forms of collaboration. Partnerships among medical professionals in rural communities is common and can be an extremely helpful way to develop skills across a broader continuum of healthcare providers in resource-constrained environments. Patients often trust non-traditional members of their care team to provide care for them as they develop a deeper relationship with them. Ensuring that medical staff have the proper training to support individuals experiencing SUD is paramount.

Remote Learning Resources for SUD Treatment

Housed within the Center for Opioid Resources and Education, Project ECHO (Extension for Community Healthcare Outcomes): A New Model for Educating Primary Care Providers about Treatment of Substance Use Disorders is a virtual learning model designed to create opportunities for local providers in underserved locations to learn from and consult with specialists from other parts of the state or country. Virtual training and mentoring can be used as a resource to help Critical Access Hospitals (a designation given to eligible rural hospitals by Centers for Medicare and Medicaid Services).

Through Project Echo, providers who are licensed by DHS for withdrawal management program feel more prepared to provide detox services and support. There is evidence that Project ECHO can promote expansion of access to SUD treatment in underserved areas. In addition to Project ECHO, the Center for Opioid Resources and Education has other resources such as networking with other medication-assisted treatment, medications for opioid use disorder providers and trainings. These models describe the opportunities to improve access to training for providers.

Another approach to be used is Screening, Brief Intervention, and Referral to Treatment, which is a comprehensive, integrated, public health approach delivering early intervention and treatment. There is evidence, shown in *Interprofessional collaboration among nurses and physicians: making a difference in patient outcome*, that in general, increased interprofessional education and collaboration among providers improves patient outcomes.

In 2023, DHS granted funds to Project Turnabout, a program to provide specific outreach to the 77 facilities designated as Critical Access Hospitals. The funds were used to create a statewide training manual to assist emergency room personnel implementing best practices for transfer of patients experiencing substance use disorder to the closest, quickest, and most appropriate

level of care. The training will be available both digitally and onsite. Current funding only covers the development of the training and training of an initial number of sites, not all 77 Critical Access Hospitals.

While not an exclusively remote learning opportunity, communities can create programs that work in person or online based on this kit from Supported Education – A Promising Practice: Building your Program (PDF), is the Assertive Community Treatment model: "a way of delivering comprehensive and effective services to consumers who have needs that have not been well met by traditional approaches to delivering services." The goal of the Assertive Community Treatment model is to provide community care while ensuring their lives aren't dominated by mental illness. Individuals have help with basic tasks through services provided by a holistic team. With the direct delivery of services by Assertive Community Treatment Teams, team members are able to be highly integrated, cross-trained, and collaborative on assessments and day-to-day interventions. Continuing to encourage these practices, along with collaboration between SUD professionals and mental health professionals will benefit those in rural populations.

SUD Treatment Learning Initiatives

In 2019, the former MDH Injury and Violence Prevention Section received funding from a federal Bureau of Justice Assistance grant to partner with 8 regional emergency medical services (EMS) programs to implement EMS treatment linkages following non-fatal overdoses. While undergoing efforts to identify and respond to those with opioid use disorder, the West Central Minnesota EMS Regional program, in partnership with the White Earth Nation, identified an opportunity to provide pre-hospital initiation of buprenorphine treatment for opioid use disorder by paramedics, following naloxone administration for non-fatal opioid-related overdoses.

White Earth Nation Tribal Behavioral Health, White Earth Reservation Ambulance Service, West Central EMS Regional Program, and MDH have developed a pilot program to provide a buprenorphine field bridging program on White Earth lands. This pilot program allows EMS response to overdose calls, provide Narcan rescue, and provide medical examinations while responding to substance related calls.

Given current paramedic shortages in many rural EMS service areas, grant funding will help in providing support for currently uncovered areas with EMS response from sister advanced life support services surrounding the White Earth Reservation Ambulance Service primary service area. In addition, surrounding non-tribal EMS agencies adjacent to White Earth Reservation Ambulance Service primary service area can offer field-bridging, and their supervisory physicians can contribute to physician telemedicine management of their agencies' overdose survivors. Following a field-bridging encounter, the overdose survivor will be connected to ongoing care for opioid use disorder.

3.2. Expand telehealth access and infrastructure

Telehealth can be a useful tool for accessing specialty care in rural areas. However, access to technology and internet connectivity as well as payment parity for telehealth versus in person services have been barriers. This recommendation focuses on physical access to services, as

well as the availability and payment of different types of services. Equipping existing spaces within local community-based organizations such as public libraries, hospitals, clinics, county offices, pharmacies, etc., for community members to privately attend telehealth appointments is one approach to overcome access challenges in rural communities. Equipment needed to outfit these sites may include computers, cameras, microphones, and quality internet connections.

The 2023 Governor's budget recommendations included funding for the Telehealth in Libraries Grant Pilot Program. While this was not passed, it would be an innovative step to increase access to technology that helps allow individuals in rural communities to access services. The workgroup recommends that funding for this program be pursued.

It is crucial that telemedicine remains available for SUD medication prescription and assessment. COVID brought forward some reforms which allowed for medications (including medications for opioid use disorder) to be prescribed without an in person visit to a practitioner, which expanded access to medications for opioid use disorder for those in rural communities. Proposed rules to repeal this access and require in-person medical evaluation would be devastating to rural community members who need medications for opioid use disorder and do not have ready access to providers. Urgent attention to this matter is crucial to keep lifesaving treatment in place for rural Minnesotans.

3.3. Increase recovery housing availability and remove barriers to treatment in housing settings

This recommendation recognizes the need for funding and training to keep individuals safe. Lack of stable housing poses a significant barrier to recovery for individuals who are experiencing a substance use disorder. The workgroup discussed pathways and programs to increase housing availability for individuals who are actively engaged in intensive outpatient treatment *and* for housing assistance for individuals in recovery, especially those transitioning out of a residential program and those who are being released from incarceration.

Approach Housing Collaboratively

A collaborative approach to housing access, which involves social services, economic development, health care, and other community supports has the potential to meet community need while leveraging existing spaces and funding resources. Improving access to stable housing is an important part of supporting individuals in recovery and reducing their return to substance use and recidivism.

Uphold Federal Anti-Discrimination Laws Allowing Treatment While Living in All Settings

The workgroup deliberated on the issues concerning various program models, such as the licensing requirements for free-standing room and board facilities, and the reimbursement levels offered by the DHS Housing Stabilization Services program. This program funds services for individuals actively engaged in intensive outpatient treatment programs who meet the criteria for residential treatment to find and maintain housing in the community. Members of the workgroup brainstormed ideas surrounding established institutions equipped with

residential capacity. They explored the potential for these entities to transition into licensed free-standing room and board providers. This seems to be feasible, however more research and resources are required to fully evaluate.

Throughout the discussions, the workgroup emphasized the significance of enabling treatment opportunities, including medication for opioid use disorder, within living settings for individuals residing in housing models like free-standing room and board residences. The American Society of Addiction Medicine 4th Edition includes Recovery Housing, which DHS is planning to incorporate. Additionally, in the 2023 MN Legislative session, regulations for sober homes were added in Minnesota Statutes 2024, Chapter 254B.181, however enforcement is not included at this time.

3.4. Strengthen mental health services as a primary prevention strategy

While providing and improving treatment services and support for individuals with substance use disorders is essential, there is also a need for more upstream efforts aimed at prevention. SUDs often co-occur with other mental health challenges. Addressing barriers to accessing mental health services in rural areas and providing additional support to individuals and groups at increased risk are a few of the successful prevention strategies. In 2021, the Rural Health Advisory Committee issued *Recommendations on Strengthening Mental Health Care in Rural Minnesota 2021 (PDF)*, a report on strengthening mental health care in rural Minnesota. Many of the report's findings still hold true, including the insufficient ratio of mental health providers to the population in rural Minnesota. Continuing efforts to increase access to services and supports is important for developing effective prevention efforts.

One prevention effort by the Juniper Program is a chronic pain management group that provides people with an outlet and a sense of support while waiting for an appointment or a medication adjustment to address their pain. The Juniper Program houses a collection of evidence-based courses for health and wellness, and has developed an online course titled *Living Well With Chronic Pain*, which meets regularly.

The workgroup also discussed school-based early intervention approaches. Supporting youth mental health and ensuring youth with risk factors for SUD development have been connected to services are important elements of prevention. Currently, there are no formalized programs beyond standard mental health observations and screenings in schools for students in kindergarten through 12th grade. In Minnesota, Child Find (PDF) notes "schools have a responsibility to develop systems and processes to find children who reside within the district, attend private schools within the district (regardless of their district of residence), and who are homeless or migrant" and provide them with needed services. Additionally, as a part of the Individuals with Disabilities Education Act Subchapter III, all school districts are mandated to provide early intervention services to infants and toddlers with disabilities. In a best practice being conducted at the Red Lake School District, early childhood special educators are screening infants and toddlers to identify those who are experiencing developmental delays of -1.5 standard deviations on a normed reference test in any area of development. This screening aids in identifying conditions known to hinder development; alternatively, the child can qualify for services through a clinical opinion from a medical professional, who can sometimes identify children who have been exposed to opioids in utero. Infants who were exposed to substances

before birth are provided services from birth and are followed throughout their tenure in primary and secondary school.

While not an early intervention, but rather an awareness and support program, Chapter 55, Article 1, Section 2 - MN Laws now requires all school districts to maintain a supply of opiate antagonists (two doses of nasal naloxone) on-site. Minnesota also requires one training video for naloxone administration to be provided to schools by the Commissioner of Health. Further training opportunities exist for students in rural communities. Minneapolis students learn how to reverse opioid overdose through programs by M Health Fairview, through training they provided to students at Roosevelt High School in Minneapolis. This is an example of training that could be provided in rural schools as an educational opportunity on how to administer naloxone and could promote further discussion on substance use disorder.

Conclusion

The Rural Health Advisory Committee's recommendations underscore the ongoing and urgent need for a multifaceted approach to address substance use disorder (SUD) in rural Minnesota. By focusing on transitions in care, workforce recruitment and retention, and increasing local community capacity, the proposed strategies aim to create a more robust and inclusive system of support. These recommendations prioritize culturally sensitive practices, the expansion of peer and professional networks, and the integration of prevention and harm-reduction efforts.

The report emphasizes the importance of leveraging existing resources, enhancing collaboration among stakeholders, and advocating for policy changes that remove barriers to care. Through targeted investments and innovative practices, Minnesota can better support individuals and families affected by SUD, ultimately fostering healthier and more resilient rural communities.

Implementing these recommendations will not only address immediate needs, but also build a sustainable framework for long-term improvement in SUD care and recovery outcomes across the state. Policymakers, health care providers, and community organizations are encouraged to consider these strategies as a roadmap for strengthening support systems and improving the quality of life for all Minnesotans affected by SUD.

Final Considerations

Chronic Pain and Its Connection to SUD

The recommendations developed by this workgroup originally sought to address pain management as well as substance use disorders. As research and discussion by the workgroup was underway, it became clear that each topic area required separate recommendations. Additionally, a more expansive focus was needed on recommendations for those still actively using illicit drugs.

The Need for a More Comprehensive Approach

Challenges confronted by individuals with substance use disorder in rural Minnesota warrant further investigation, extending beyond the recommendations provided. These challenges

include situations where local care is impractical, unsafe, or unavailable. Furthermore, difficulties are often encountered by both communities and individuals during the transition into treatment programs and, subsequently, reintegrating into one's home community.

While challenges do exist, it is important that individuals have access to pain management support, substance use disorder treatment, recovery resources and harm reduction support within their home community immediately upon recognition of their desire. These supports ease the transition into treatment and allow individuals to remain integrated with personal support systems and community as they begin their recovery. This priority is in line with the American Society of Addiction Medicine's Speaking the Same Language About Addiction Care guidelines for individuals to be referred to the least intensive and restrictive level of care likely to be safe, efficient, and effective.

This workgroup wishes to emphasize the breadth of this issue in these recommendations. Ultimately, any solution undertaking challenges related to substance use disorders and pain management need to face the complex needs of the many rural community members who are currently experiencing SUD, are in recovery, and/or are living with chronic pain. Effective approaches need to address social determinants of health, be individualized and flexible, and remain conscious of the stigma that continues to exist around these issues. One example of social determinants of health impacting individuals is the potential need for travel to continue treatment once the individual has transitioned home. Individuals who are started on a treatment protocol, and are required to travel to receive it, will need continued social, travel, and financial support.

Complexity arises for these who are currently using or misusing substances, and abstinence is currently not their goal or seems unattainable. Access to harm reduction services like sterile equipment, fentanyl test strips, naloxone, wound care kits, condoms, infectious disease education, and treatment should be available to all. It is critical that access to services, the reduction of stigma and discrimination, and community education continue to be at the forefront of efforts to address substance use disorder in rural communities.

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Appendix A: Rural Health Advisory Committee Membership

- Ashley Berg – Representative of Local Public Health/Community Health Board
- Tashina Branchaud – Member of a Tribal Nation
- Ray Christensen – Higher Education Member
- Elizabeth Coleman – Advanced Practice Professional Member
- Tom Crowley – Hospital Member
- Sagar Dugani – Consumer Member
- Scharazard Gray – Health Professional/Advocate Working in Mental Illness
- Brekke Johnsrud – Dentist Member
- Margaret Kalina – Registered Nurse Member
- Troy Mayer – EMS Member
- Jessica Navarro – Consumer Member
- Holly Rien – Expert in Economic Development
- Amanda Schermerhorn – Consumer Member/ Advocate for Persons Who are Developmentally Disabled
- Laura Schwartzwald – Licensed Health Care Professional Member
- Penny Solberg – Long-Term Health Care Member
- Keith Stelter – Physician Member
- Lisa Stroschein – Representative of Individuals Experiencing Health Disparities

Appendix B: Workgroup Membership

- Andy Johnson, APRN, CRNA, NSPM-C - Workgroup Co-Chair - Olivia Hospital and Clinic
- Laura Schwartzwald, RPh - Workgroup Co-Chair - Rural Health Advisory Committee Member - Co-Founder, Guide Point Pharmacy
- Amy Anderson - SUD Policy Team, Department of Human Services
- Erin Bolton, MSH, LICSW, LADC - Substance Use and Recovery Unit, St. Louis County Public Health and Human Services
- Mark Cullen - Vice President of Strategy and Business Development, Trellis
- Dana Farley - Alcohol & Drug Prevention Policy Director, Drug Overdose Prevention Unit Supervisor, Minnesota Department of Health
- Scott Hable - Sheriff, Renville County
- Keri Hager, PharmD, BCACP - Professor & Associate Dean for Clinical Affairs, UMN College of Pharmacy
- Margaret Kalina - Rural Health Advisory Committee Member - Chief Nursing Officer, Alomere Health
- Josh Leopold - Senior Advisor on Health, Homelessness, and Housing, Minnesota Department of Health
- Jim Menton – Superintendent, BOLD School District
- Sarah Opitz, BA, LSW, LADC - Executive Director, Co-Founder, The Lotus Center
- Marti Paulson, CARN MSOP – CEO, Project Turnabout
- Jim Rieber – Director, Perham EMS and EMS Linkage to Care Lead
- Keith Stelter, MD, MMM, FAAFP - Rural Health Advisory Committee Member - Physician, UMN Rural Physician Associate Program Faculty
- Gary Travis - Housing Policy and Services Lead, Department of Human Services

Appendix C: Partners in SUD and Mental Health Systems

Listed are resources who are potential partners and mental health and substance use disorder service resources.

- Cansa'yapi / Lower Sioux Indian Community
- Gaa-waabaabiganikaag / White Earth Nation
- Gaa-zagaskwaajimekaag / Leech Lake Band of Ojibwe
- Gichi-Onigaming / Grand Portage Band of Lake Superior Chippewa
- Mdewakanton / Shakopee Mdewakanton Sioux Community
- Misi-zaaga'iganiing / Mille Lacs Band of Ojibwe
- Miskwaagamiiwi-Zaagaiganing / Red Lake Nation
- Nah-gah-chi-wa-nong / Fond du Lac Band of Lake Superior Chippewa
- Pezihutazizi / Oyate (Upper Sioux Community)
- Tinta Wita / Prairie Island Indian Community
- Zagaakwaandagowininiwag / Bois Forte Band of Chippewa
- Minnesota County Level Behavioral Health Services
- Project Turnabout, Wilmar
- Refocus Recovery, Minneapolis
- Twin Cities Recovery Project, Minneapolis
- Certified Community Behavioral Health Clinics:
  - Alluma, Crookston
  - Amherst H. Wilder Foundation, St. Paul
  - Canvas, Bloomington
  - Central Minnesota Mental Health Center, Elk River
  - Hiawatha Valley, Red Wing
  - Human Development Center, Duluth
  - Northern Pines Mental Health Center, Little Falls
  - People Incorporated, Minneapolis
  - Ramsey County Mental Health Center, St. Paul
  - Zumbro Valley Health Center, Rochester
  - South Central Human Relations Center, Owatonna
  - Western Mental Health Center, Redwood Falls
  - Woodland Centers, Litchfield

- Communidades Latinas Unidas En Servico (CLUES), St. Paul
- Hennepin County, Minneapolis
- North Homes, Inc., Grand Rapids
- Northland Counseling Center, Grand Rapids
- Range Mental Health Center, Inc., Virginia
- Sanford Health of Northern Minnesota, Bemidji
- Wayside Recovery Center, St. Louis Park