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

April 15, 2026

12:00 – 1:30 p.m. Hybrid

Capitol Commons

Meeting Summary

Background

On April 15, 2026, the Minnesota Substance Use Disorder (SUD) Community of Practice (CoP) convened virtually to launch a quarter-long focus on Co-Occurring Disorders (COD)—the top-ranked priority identified by CoP participants. The meeting combined a brief framing presentation with facilitated feedback to surface system-level barriers, operational realities and opportunities to strengthen integrated COD care statewide.

Attendance

Fifty-four (54) participants attended the virtual meeting.

Objectives

- Introduce Co-Occurring Disorders as the CoP's Q2 priority topic
- Establish shared understanding of integrated COD care
- Gather participant feedback on system barriers and opportunities
- Identify themes to inform future CoP discussions

Welcome and Opening (Stephanie Devitt, SDK Strategic Services)

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

Co-Occurring Disorders Overview

Nicole Grochen provided a high-level overview of Hazelden Betty Ford's integrated COD treatment approach, including:

- Treating mental health and substance use simultaneously under Rule 36
- Delivering COD services in residential and outpatient settings

- Use of trauma-informed, individualized treatment planning
- Interdisciplinary teams and on-site medication management
- Evidence that integrated COD treatment improves client outcomes

Participant Feedback: Facilitated Discussion

Participant feedback was structured around a set of guiding questions. Key themes are summarized below.

1. Key Takeaways from the Presentation

Participants highlighted the following overarching takeaways:

- Integrated treatment of mental health and substance use improves outcomes when addressed together
- Rule 36's mental-health-first framework clarified important distinctions from 245G but raised operational questions
- Documentation and assessment requirements under Rule 36 feel difficult to implement in real-world settings
- Workforce capacity, dual licensure and interdisciplinary training remain critical challenges
- Participants expressed cautious optimism about the Rule 36 rewrite while noting concerns about scalability

Quotes from the GroupMap:

"It helped to hear how a community program is fully tackling an integrated approach with a really complex population."

"Hazelden is kind of a unicorn—what they're doing feels hard to replicate."

"I really liked the low caseload model, so you can focus on the individual."

2. If You Could Change One Thing About How the System Responds to COD, What Would Make the Biggest Difference?

Participants emphasized the need for structural rather than incremental change:

- Shift from diagnosis-driven sequencing to whole-person assessment and care
- Move from siloed mental health and SUD systems to true integration supported by policy and reimbursement

- Confusion around how programs are labeled and differentiated, making it hard to refer clients appropriately
- Improve assessment quality, workforce training and consistency across disciplines
- Concern that who conducts assessments—and how—is not aligned with expertise, leading to misdiagnosis and inappropriate placements
- Reduce fear, uncertainty and compliance-driven decision-making that undermines care
- Strengthen collaboration across programs, systems and cultural perspectives
- Participants emphasized the need to understand root causes, history and complexity rather than forcing order-of-operations decisions

Quotes from GroupMap:

"More accuracy on what is actually the primary issue—mental health or SUD—would make a big difference."

"Fear and lack of training around co-occurring disorders keeps people from addressing them."

"Concern about opening up/expanding who can conduct assessments. People without addiction knowledge may not be able to adequately assess individuals."

"So many programs are actually SUD first, would like to have a better sense of all the different programs and what they provide."

3. Where Do Payment and Coverage Rules Most Force SUD and Mental Health to Be Treated Separately?

Participants described payment and coverage structures as major drivers of fragmentation:

- Eligibility delays and interim funding gaps delay access to integrated care
- Behavioral Health Fund and other programmatic funding often cover only one condition at a time
- Insurance rules, pre-authorization requirements and rate structures reinforce separation
- Billing limitations discourage time-intensive assessments and interdisciplinary care
- The most impacted populations face the greatest barriers to accessing integrated, high-quality services

- Participants noted that funding streams often support one condition at a time, even for clearly co-occurring needs
- Participants described billing structures that make integrated care financially risky.

Quotes from GroupMap:

"Behavioral Health funding only covers SUD, even when mental health is required to enter a COD program."

"The money was probably created with good intentions, but it doesn't fit the complexity of clients now."

"You can get extra money for co-occurring, but then you can't bill for the diagnostic assessment."

"Diagnostic assessments take two plus hours, and the reimbursement just doesn't match that."

4. What Is Treated as a "Behavior Problem" That Is Actually a Medication, Withdrawal, or Side-Effect Issue?

Participants identified widespread misinterpretation of clinical and neurological symptoms:

- Participants described symptoms of recovery often being misread as noncompliance
- Many behaviors are natural responses to pain, trauma or unsafe systems.
- Fatigue, oversleeping, disengagement or cognitive difficulty related to withdrawal or medication effects
- Anxiety, grief, trauma responses and emotional expression labeled as non-compliance
- Aggression or agitation misunderstood as misconduct rather than distress or stabilization needs
- Pain reports, medication needs and cross-substance dynamics viewed through a punitive lens
- System responses shaped by stigma, risk aversion and lack of clinical training

Overall, participants emphasized that many behaviors labeled as "problems" are predictable responses to recovery, trauma, medication or system design, and require clinical—not punitive—responses.

Quotes from GroupMap:

"The need for rest in a recovering brain is huge and really underestimated."

"Nodding off can be the wrong dosage, not defiance."

"We treat trauma as a behavior problem."

"These aren't bad behaviors—they're responses to unhealthy systems."

What's Ahead

This meeting marked the beginning of a multi-session exploration of Co-Occurring Disorders within the SUD CoP. Future meetings will continue to examine practice, policy alignment and system reforms needed to support high-quality, integrated COD care across Minnesota.

- Next meeting: Wednesday, May 20, 2026 (12:00–1:30 p.m., virtual).
- Links to RSVP, a brief meeting evaluation survey, and the lived/living experience stipend request form were shared in the chat.
- Post-meeting materials (slides and GroupMap synthesis) will be distributed by the facilitation team.
- For questions, contact: SUD.CoP@SDKStrategicservices.com