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Improving Early Substance Use Care for Youth:

The Essential Role of Outpatient Behavioral Health Clinics

Child behavioral health clinics provide essential care for youth with behavioral and emotional problems, including those at risk for substance use. Adolescents between 12 and 17 are at greater risk for experimentation or regular substance use during this crucial stage of development. Early substance use may cause significant and long-term changes to the brain that increase the risk for addiction[1] and may result in the utilization of high levels of care, legal issues (e.g., arrests, incarceration), or even death. Fatal drug overdoses are at an all-time high, and adolescent rates have more than doubled over the past decade.[2] When outpatient clinics identify and address concerns early, more severe problems can be avoided.

Screening, engagement, and early interventions for youth using substances are recommended practices for child-serving systems, including outpatient behavioral health care.[3] Unfortunately, many factors have interfered with early substance use care, such as addiction stigma, substance use normalization, lack of provider substance use training, separate mental health and substance use treatment (i.e., bifurcated) systems, and limited reimbursement options that are below SAMHSA guidelines.[4] **Connecticut's robust child outpatient behavioral health network offers an opportunity to strengthen early substance use care through screening for substance use, addressing mental health and mild-to-moderate substance use concerns simultaneously in treatment, and facilitating referrals to specialized substance use providers.**

Youth Substance Use and Co-Occuring Disorders are Common and Widely Untreated

Youth who begin using substances before age 14 are at the greatest risk of developing a substance use disorder (SUD),[5] and only 2.8% of adolescents who need substance use treatment receive it.[6] Substance use during adolescence is high; nearly 62% of youth used alcohol and 41% used an illicit substance by the 12th grade.[7] High school youth identifying as lesbian, gay, or bisexual experience higher substance use rates than their heterosexual peers (e.g., 16%+ higher binge drinking, 87%+ higher prescription opioid misuse).[6] Though rates of SUDs are similar across racial and ethnic groups,[8] White youth receive SUD treatment at higher rates than Black and Hispanic youth (55%

and 26% higher, respectively).[9] Compounding this access issue, Black male youth may experience a fourfold increase in the risk of adult incarceration if they develop a SUD by the age of 16.[10]

Of the 2.2 million youth who met the DSM-5 criteria for a SUD in 2021, more than 42% also had at least one mental health diagnosis (i.e., co-occurring disorders, or CODs).[6] COD symptoms are interrelated, and addressing mental health and substance use symptoms with one trusted provider leads to better outcomes.[11] In a national Medicaid sample, adolescents initiating SUD treatment were 20% more likely to engage in mental health services than SUD services in the first month.[12] Youth access to SUD treatment increases by approximately 60% when mental health treatment occurs in the prior year.[9] **A natural opportunity exists to embed strategies to support youth using substances within their behavioral health care treatment.**

Challenges to Screening and Treating Youth with SUD and COD Nationally and in Connecticut

Nationwide, youth using substances face barriers that interfere with service access. People with SUD experience stigma and may be perceived as more responsible for their condition than those with a mental health diagnosis (e.g., depression).[13] This can reduce provider desire to treat youth using substances and prevent youth from accessing services, particularly when providers lack training in providing SUD/COD treatment. Bifurcated mental health and substance use treatment systems may not work together, and separate facility licensing deters providers from offering integrated COD treatment because of additional service requirements.

While many states are increasing outpatient reimbursement for substance use services, Connecticut provides reimbursement for substance use screening and follow-up for staff with specific roles in primary care settings (e.g., physicians) or Federally Qualified Health Centers, but not as a standalone service or an addition to an established behavioral health visit. In outpatient behavioral health clinics, clinicians can screen and treat youth for substance use within intake and therapy session billing codes, but only one code can be used by a clinician per day. The reimbursement rates are too low to support the added work,[14] especially given the increased demands on clinicians due to current workforce retention issues, as outlined in CHDI's "Who Will Do the Work?" policy brief. Currently, no reimbursement options are available for other direct service staff (e.g., case managers, recovery support specialists) who can be trained to conduct these activities and are essential to substance use care because of their ability to reduce clinician burden by managing school, legal, and community needs outside of therapy sessions.

Exacerbating the issues in service provision, youth perception of marijuana harmfulness has sharply declined over the past decade,[15] and substance use normalization continues to be a barrier for youth accessing services. Youth living in states with legalized marijuana report more ease in access.[16] In Connecticut, marijuana was legalized for recreational use in 2021 for individuals over age 21. Given this change, along with concerns about all forms of adolescent substance use, Connecticut has a critical window of opportunity to screen and support youth exhibiting early substance use.

Connecticut's Outpatient Behavioral Health Centers are Ideal Settings to Integrate Youth Substance Use Best Practices

Connecticut received an 1115(a) Demonstration Waiver from the Centers for Medicare & Medicaid Services in 2022. This Demonstration is a five-year statewide project with funding for the Connecticut Department of Social Services, Department of Mental Health and Addiction Services, and Department of Children and Families (DCF) to expand the continuum of SUD services for individuals using substances across the lifespan, including enhancements to reimbursement, training, and service options. Connecticut outpatient providers are well-positioned to screen and support youth with SUDs/CODs because they serve approximately 25,000 youth each year, and their clinicians are well-trained in evidence-based practices (EBPs).[17]

Improving screening and service engagement of youth with SUD/COD in the existing outpatient provider network is an important step toward better access. **Adolescent Screening, Brief Intervention, and Referral to Treatment (A-SBIRT) is a comprehensive EBP approach adapted for youth ages 12-17 that efficiently trains direct service staff to detect substance use and briefly treat substance use concerns.** A-SBIRT incorporates at least one of many

brief, validated, substance use screening tools for adolescents, including options that are self-administered and publicly available. **When universally implemented, treatment access is improved for all youth.**[18] Outpatient providers may integrate A-SBIRT screening tools into existing assessment and treatment plan protocols to accurately identify youth who may deny or minimize substance use. In addition to assessment, A-SBIRT may include a brief intervention or brief treatment with education about substances and the use of Motivational Interviewing (MI), an evidence-based, collaborative communication style to increase insight and awareness and strengthen motivation and commitment to behavior change.[19] MI tools can help clinicians use brief treatment with youth who have mild-to-moderate SUD symptoms, develop substance use change plans, integrate COD goals into treatment plans and reviews, and assess progress to inform ongoing treatment recommendations. For youth not meeting goals or screening with severe SUD/COD, providers may use MI and case management to refer youth to a more specialized or intensive intervention, such as one of the current DCF-supported substance use EBTs across Connecticut.

Recommendations to Support Screening and Engagement of Youth with Substance Use

The existing outpatient behavioral health workforce is uniquely situated to increase access to services for young people with substance use concerns. To enhance early screening and treatment in Connecticut, the following recommendations are made:

- **Expand the availability of Screening and Brief Intervention (SBI) reimbursement codes (99408 and 99409) for A-SBIRT services to child outpatient providers** who maintain a state facility license or certification (e.g., DCF licensed outpatient providers, Enhanced Care Clinics). Code modifiers (e.g., 25, 59) should be added for A-SBIRT activities conducted in tandem with established behavioral health visits so that more than one billing code can be used by an individual staff member each day and address substance use and mental health concerns together.
- **Increase rates of 99408 and 99409 reimbursement codes by 50% to match SAMHSA current recommendations.** Connecticut reimbursement rates for SBIRT activities have remained stagnant since 2015.
- **Extend SBI reimbursement codes and code modifiers to A-SBIRT trained direct service staff** (e.g., case managers, recovery support specialists) who conduct A-SBIRT services under the supervision of a health professional defined by Section 17b-262-995(26) of the Regulations of Connecticut State Agencies, which includes clinical psychologists, licensed clinical social workers, and psychiatrists.
- **Ensure access to regular and ongoing training to implement and sustain A-SBIRT universally in child outpatient behavioral health settings.** Provider access to foundational A-SBIRT training via an online platform with ongoing live practice, coaching, and consultation would expand statewide training accessibility and competencies and would ensure high-quality implementation. Integration of A-SBIRT services should be gradual and tailored to provider capacities and organizational readiness, including having a sufficient workforce to implement these practices.
- **Formalize and sustain localized collaborations** (e.g., Memoranda of Understandings or Agreements) between child outpatient behavioral health providers and other child-serving systems (e.g., education, juvenile justice) to help connect more young people with substance use concerns to treatment and potentially divert youth from more serious school conduct or legal consequences.
- **Invest in a comprehensive, integrated COD continuum of care for youth** in Connecticut, including supporting the implementation of current and novel best practices for youth with more severe SUD/COD symptoms. Strengthening the SUD/COD service array will ensure that youth identified with COD needs in outpatient care through A-SBIRT have access to essential care.

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