



How to Strengthen Substance Use Prevention and Behavioral Health Services in Schools

Research to inform and opportunities to improve the work of state health and education agencies

Overview

In 2024, 48.4 million people in the United States were estimated to have a substance use disorder (SUD) involving alcohol, cannabis, and/or other psychoactive substances.¹ The economic consequences of substance misuse and SUDs together reach more than \$400 billion annually in costs associated with crime, healthcare, and lost productivity, according to a 2016 report on addiction from the U.S. surgeon general.² Most people with an SUD began using substances as teens or young adults.³

Today, about 3.9 million young people, or 15% of those defined in national drug use surveys as ages 12 to 17, report illicit drug use. Two million, or 7.8%, have an SUD.⁴ While drug and alcohol use among teens has generally been on the decline since 2013, overdose deaths have risen sharply because of fentanyl in the drug supply.⁵ While overdose deaths among young people began to decline in 2023 and continued to drop in 2024, they remain higher than before the COVID-19 pandemic.⁶ Early substance use is strongly associated with long-term economic, health, and social challenges in adulthood.⁷ Young people with untreated behavioral health issues, including substance use, experience diminished earning potential as adults; many of them miss large stretches of work or cannot work at all.⁸

Prevention programs are critical to helping young people reduce their risk of developing SUDs or related behavioral health conditions. More than 40 years of research demonstrates the effectiveness of a range of interventions that prevent or reduce substance use and related concerning behaviors, such as vaping (the use of e-cigarettes), violence, and suicidal thoughts.⁹ Prevention programs address risk factors at the individual, family, community, and societal levels—among them depression, anxiety, child abuse, family instability, and unsafe neighborhoods—and can be delivered in a variety of ways.¹⁰

Young people receive mental healthcare in schools more often than in community clinics, and schools can be an ideal setting for substance use prevention efforts as well.¹¹ School connectedness—students’ belief that adults and peers care about their learning and well-being—is a protective factor for young people and is linked to lower rates of poor mental health, suicidal thoughts, and substance use, as well as to better academic and behavioral outcomes.¹² Schools can also function as community hubs, offering or coordinating services such as food and housing assistance and referrals to community mental health and SUD support for students with intensive needs.¹³

Evidence-based school prevention programs have shown lasting reductions in the use of substances including tobacco, alcohol, cannabis, and opioids.¹⁴ High-quality, well-implemented programs also generate cost savings by reducing the need for services and increasing productivity in adulthood.¹⁵ Yet federal health officials and researchers note that many schools lack the capacity to meet student behavioral health needs, in part because sustaining these programs is difficult without consistent funding from state and local education agencies (the latter referring to schools or school districts).¹⁶ In 2024, 54% of schools reported that inadequate funding limited their efforts to provide mental health services.¹⁷ Difficulty selecting evidence-based interventions, behavioral health workforce shortages, and limited access to training and technical assistance can further hinder schools’ ability to expand or provide services.¹⁸

States play a central role in funding, scaling, and sustaining efforts to implement SUD prevention and behavioral health services in schools. For example, states can:

- Share information to help schools select evidence-based practices.
- Promote policies that boost workforce development.
- Invest in technical and other forms of assistance.
- “Braid,” or merge, multiple funding sources to sustain services and supports.¹⁹

This brief examines data on substance use and behavioral health among young people, explores how schools implement services and assess their effectiveness, and identifies opportunities for states to strengthen school-based behavioral health supports.

Mental health and substance use are interrelated

While the risk factors contributing to youth substance use vary, mental health, suicidal thoughts, and substance use can be interrelated challenges that influence overall behavioral health. (See Figure 1.) The U.S. Centers for Disease Control and Prevention’s Youth Risk Behavior Survey (YRBS) shows a notable decline in behavioral health among high school students between 2013 and 2021—with spiking rates of suicide attempts and increased reports of hopelessness and despair during the COVID-19 pandemic.²⁰

Figure 1

Behavioral Health Encompasses Interrelated Needs

Substance use is one element of behavioral health



Source: National Center for Injury Prevention and Control, *About Behavioral Health*, Aug. 20, 2026

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The YRBS shows that during the same period, substance use by this age group generally declined, with the exception of increased alcohol use among Black teens.²¹ Other studies show that nicotine use, in multiple forms, has become increasingly popular: 23% of high school seniors and more than 11% of eighth graders reported vaping in the past year, and nicotine pouch use, on its own or in conjunction with nicotine vaping, also doubled among 10th and 12th graders from 2023 to 2024.²² Ten percent of high school students reported using illicit drugs—defined as cocaine, inhalants, heroin, methamphetamines, hallucinogens, or ecstasy—with use among LGBTQ+ and American Indian/Alaska Native youth as high as 15% and 18%, respectively.²³

Young people who experience stress, trauma, and other mental health challenges are more inclined to turn to substance use than those who do not.²⁴ A national study, published in 2024, of teens who used substances found that 44% reported the desire to forget a problem or bad memory as a factor in their use. Forty percent reported using substances to address depression or anxiety.²⁵ Another study showed that teens who have experienced a major depressive episode are more than twice as likely to use illicit drugs, cannabis, and tobacco as those who have not.²⁶

Mental Health Conditions Among Children Are Often Untreated

Each year, 1 in 5 children experience a mental health condition, and half of mental health conditions start before age 14. On average, 11 years pass from the time children first experience symptoms to when they start to receive treatment.²⁷

The relatively early onset of substance use shows the importance of starting prevention programming no later than middle school and ensuring its availability through high school. Because the behaviors and risks associated with SUDs begin in adolescence and lead to consequences felt more acutely in adulthood, experts note that taking action early on—through approaches such as screening, brief interventions to explain the risks associated with substance use, and referral to treatment—can shorten the duration of an individual’s substance use.²⁸ Moreover, given the interrelated nature of mental health and substance use, mental health treatment services should be treated as a necessary corollary to substance use prevention efforts in schools.

Schools can provide a meaningful support system

Many elementary, middle, and high schools provide substance use prevention programs and related behavioral health services using a multitiered system of supports (MTSS) framework or similar structures, such as Positive Behavioral Interventions and Supports (PBIS) or the National Center for School Mental Health's Comprehensive School Mental Health System.²⁹

These frameworks guide schools in how to best organize their resources and policies as educators, staff, and school-based behavioral health providers deliver services and support including substance use education, counseling, and crisis intervention. Such frameworks are grounded in data; for example, data gathered during universal mental health screening informs MTSS planning and implementation, and schools may use information about individual students, schoolwide data on such measures as attendance and office discipline referrals, and teacher observations to assess students' needs and monitor progress following interventions.³⁰

Why Does Prevention Matter?

Evidence-based prevention programs in schools have shown sustained effects in reducing youth substance use. Investing in prevention efforts focused on young people is particularly valuable, as behavioral health conditions that emerge before adulthood are associated with substantial healthcare costs, increased morbidity and mortality, and reduced economic productivity.³¹

The federal government spent \$4.9 trillion on healthcare in 2023, with only an estimated 3% allocated for public health and prevention.³²

Many U.S. public schools use one of these formal frameworks to support students' behavioral health needs. The Every Student Succeeds Act (ESSA) of 2015, legislation that sets federal policy for K-12 education,³³ did not mandate the use of MTSS but suggested that school districts employ the framework to improve outcomes for all students and authorized federal education funding to support its implementation.³⁴ More than 90% of state education agencies now offer guidance on MTSS policies, and about a quarter of U.S. public schools are implementing a PBIS system to serve their students, which aligns with the MTSS approach.³⁵

Schools that use MTSS implement a range of substance use prevention and behavioral health services across three tiers of support: The first tier aims to reach all students with services such as instruction in drug-refusal skills; the second provides extra help for students who show early signs of risk, such as discipline problems; and the third seeks to serve students at the highest level of need, including with referral pathways to community-based services outside school.³⁶

This tiered system helps schools use resources effectively, ensuring that substance use prevention and mental health programs reach all students and that those with more complex needs receive targeted or individualized care.

In the table below are examples of commercial prevention programs designed for each tier and their respective return on investment (ROI), defined as the future savings they produce by helping to lower costs associated with healthcare and criminal justice, as well as the labor market benefits achieved by increasing high school graduation rates.³⁷

Table 1

Tiered Interventions Help Students With Varying Needs

Services range from drug awareness to individual counseling

Tier of Service	Examples of Interventions
Tier 1: schoolwide strategies that offer prevention services for all students	<u>LifeSkills Training</u>: A three-year middle school classroom program that teaches students personal self-management, social skills, and drug awareness and resistance skills. Outcomes as measured by 12th-grade follow-ups include reductions in rates of smoking and alcohol and cannabis use. The ROI for this program is an estimated savings of \$15.97 for every dollar spent. <u>Keepin' It REAL</u>: A school-based substance use prevention program aimed at culturally diverse middle school students delivered by classroom teachers in 45-minute sessions once a week over 10 weeks. Students learn drug-resistance skills through group discussions, role-playing and games, and youth-developed videos. Outcomes as measured by two-year follow-ups include reductions in tobacco, cannabis, and alcohol initiation, as well as improvements in norms and attitudes surrounding substances and greater resistance strategies. The ROI for this program is an estimated savings of \$13.37 for every dollar spent.
Tier 2: services for students with risk factors for developing SUDs and other behavioral health condition	<u>Project Towards No Drug Abuse</u>: A program designed for high school students at risk for substance use and violence that addresses self-control skills, communication, and decision-making strategies. This program, which is appropriate for traditional public schools as well as for alternative schools that support youth with academic or disciplinary problems, can be delivered by teachers or health educators. Outcomes include reductions in the use of alcohol, tobacco, cannabis, stimulants, cocaine, hallucinogens, inhalants, ecstasy, PCP, depressants, steroids, and heroin at one-year follow-ups. The ROI for this program is an estimated savings of \$6.04 for every dollar spent. <u>Coping Cat</u>: A cognitive behavioral therapy (CBT) program that teaches young people how to recognize anxiety and how to use coping strategies in stressful situations. The program can be administered by school mental health providers in individual or group settings over a 12-week session or in more intensive interventions over two weeks. CBT programs delivered to children with anxiety have improved school attendance and overall functioning and have reduced symptoms of anxiety and depression, which increases the risk for substance use. The ROI for this program is an estimated savings of \$26.86 for every dollar spent.
Tier 3: individualized services for students with the highest level of needs	<u>Teen Intervene</u>: A program that provides targeted screening and motivational conversations with students whom school counselors have identified for possible drug or alcohol use. If students screen positive for substance use, school counselors meet twice with them for one-hour sessions over 10 days and may also meet separately with the students' parents. Outcomes include reductions in cannabis and alcohol use. The ROI for this program is an estimated savings of \$9.26 for every dollar spent. <u>Coping Power Program</u>: A program for fifth graders and sixth graders identified by teachers that combines small group sessions for students with parallel sessions for their parents, usually delivered over one to two school years by school mental health providers and staff. Student sessions focus on mitigating risk factors for substance use and behavioral problems through self-regulation, conflict resolution, and social skills, while parents practice stress management and positive communication strategies. Outcomes include reductions in aggressive and delinquent behavior and substance use. The ROI for this program is an estimated savings of \$1.29 for every dollar spent.

Sources: Behavioral Health Improvement Institute, *Substance Misuse Prevention in MTSS-B*, 2024. Washington State Institute for Public Policy, *Lifeskills Training (Middle School)*, 2024. Washington State Institute for Public Policy, *Keepin' It Real*, 2024. Office for Civil Rights, *An Overview of Exclusionary Discipline Practices in Public Schools for the 2017-18 School Year*, 2021. Ping Sun et al., *One-Year Follow-up Evaluation of the Project Towards No Drug Abuse (TND) Dissemination Trial*, 2010. Washington State Institute for Public Policy, *Project Towards No Drug Abuse*, 2024. Behin Abedi et al., *Long-Term Outcome of a Brief Intervention to Address Adolescent Drug Abuse in a School Setting*, 2019. Washington State Institute for Public Policy, *Teen Intervene*, 2024. Washington State Institute for Public Policy, *Coping Power Program*, 2024

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Experts note that many prevention curricula sold commercially to schools may need to be updated or adapted to be informed by the latest science and that commercial curricula are not the only options for schools. Open-source curricula and state-adapted programs that meet evidence-based standards are also available for free or at low cost.

Gaps in service delivery

Although school-based SUD prevention and behavioral health programs show compelling outcomes, schools have varying degrees of capacity to deliver these services and meet demand. Specifically, researchers have found that schools may face challenges including difficulty in selecting evidence-based prevention programs, insufficient workforce availability and supports, and unsustainable funding for implementation and evaluation.³⁸

The selection of evidence-based prevention programs

During the 2024-25 school year, most U.S. states required public schools to teach evidence-based prevention skills for tobacco, alcohol, and/or other drugs.³⁹ However, only 28 states provided schools with access to evidence-based substance use prevention programs.⁴⁰ A national survey in 2005, the most recent year for which data is available, showed that only 35% of elementary schools were using an evidence-based prevention program.⁴¹

Experts note that multiple factors may affect school officials' selection of a prevention program for their students. Evidence of program effectiveness is not always the highest priority and may be outweighed by familiarity, cost, and ease of implementation.⁴² When selecting an intervention, schools will ideally rely on data identifying the specific needs of their students and use evidence-based practices that align with them. Some states support schools in this process, but such resources are not consistently available nationwide, which can contribute to the use in some schools of non-evidence-based programs.⁴³

Even when states are able to point schools toward evidence-based programs, education officials may struggle to find options that are effective for the students who are most likely to experience negative outcomes. Drug overdose deaths are rising faster among Black and Hispanic youth than among other racial groups, but few prevention programs have been developed specifically for those populations.⁴⁴ A recent review of an evidence-based practice registry found that of 885 evaluations published between 2010 and 2021, only 2% and 4% of evaluated programs were tailored to Black and Hispanic youth, respectively.⁴⁵

Workforce and supports to implement programs

Schools also need staff and training to support their prevention programs. Behavioral health workforce shortages are widespread in both community and school settings, increasing the difficulty of scaling programs. During the 2023-24 school year, 96% of public schools reported providing some type of mental health services—most frequently, individual counseling, case management, or referrals for outside services—yet only 48% said they could effectively serve all students with mental health needs. Schools that said they could not effectively serve all students cited insufficient staff as the chief obstacle.⁴⁶

The prevention program workforce can include a wide range of school personnel—teachers, school social workers, counselors, prevention specialists, psychologists, nurses, and teacher aides—whose roles may be coordinated within a team-based model.⁴⁷ However, many schools lack the capacity, role clarity, and coordination systems needed to use this workforce effectively.⁴⁸ As a result, clinical staff such as school psychologists and social workers may spend substantial time on administrative or nonclinical responsibilities, limiting their availability for services that require their specialized training, such as clinical assessment, intervention planning, and consultation. Other school staff may lack sufficient training, time, or support to help students with behavioral health needs.

Research shows that while the delivery of substance use prevention programs is generally consistent with the intended curriculum, variation in training and oversight can lead to uneven execution.⁴⁹ In a recent survey, state-level leaders involved in school behavioral health programming noted that staffing shortages and lack of trained staff to manage programs hindered their ability to meet the need among students for these services.⁵⁰ Research also shows that ongoing support, such as training and technical assistance, improves implementation.⁵¹

Funding to sustain programs

States provide roughly 47% of all K-12 education funding nationwide, but state education budgets are often tight.⁵² Schools are expected to deliver a wide range of services beyond classroom instruction, and education funding must compete with other major state priorities. In recent years, states seeking to finance school-based SUD prevention and behavioral health programming have relied on a patchwork of federal funding (see Table 2) and state appropriations. A recent 25-state survey related to school mental health activities found that state education agencies and federal grants were the primary sources of funding, with Medicaid the most frequently noted secondary source.⁵³

State and school district officials have had to identify and braid together these and other funding sources to sustain their programming. For example, North Carolina's health and education agencies secured county dollars to replicate promising school mental health programs funded by Project AWARE (Advancing Wellness and Resiliency in Education) grants from the federal Substance Abuse and Mental Health Services Administration (SAMHSA).⁵⁴ The state also used Medicaid reimbursement from its school-based services program to support mental health service delivery.⁵⁵ State education officials say that braiding funding can be burdensome without guidance on how to do it and can result in siloed efforts.⁵⁶

Table 2

Multiple Federal Sources Support School-Based SUD Prevention and Behavioral Health Programs

Education Department, SAMHSA, Medicaid, and CHIP can help fund services

Select Federal Funding Sources for School-Based SUD Prevention

Education Department	Title I, Part A (Improving Basic Programs) provides funding to schools with a high percentage of students from low-income families. Schools can use these funds to implement programs and services that address the needs of disadvantaged students, including behavioral health needs. Title IV, Part A (Student Support and Academic Enrichment) seeks to improve academic achievement by providing funding to support a well-rounded education, ensure school safety, and enhance the use of technology. Schools can use these funds to provide behavioral health services.
Substance Abuse and Mental Health Services Administration	The Substance Use Prevention, Treatment, and Recovery Services Block Grant requires states to use at least 20% of this funding on substance use prevention activities, including school-based programming. Project AWARE (Advancing Wellness and Resiliency in Education) grants are administered by SAMHSA “to develop a sustainable infrastructure for school-based mental health programs and services.” The Center for Substance Abuse Prevention within SAMHSA administers the STOP Act (Sober Truth on Preventing Underage Drinking Act) and Strategic Prevention Framework—Partnerships for Success grants for states and Tribal organizations. These can be used to support local programs aimed at preventing underage drinking and substance abuse, as well as mental health promotion activities.
Medicaid and Children's Health Insurance Program	Medicaid school-based services allow states to receive the same Federal Medical Assistance Percentage, also known as federal financial participation, for services provided in schools as for other Medicaid and CHIP services in the state. This reimbursement, for providing certain eligible students with health-related services including mental health services, can be directed back to local education agencies (LEAs). LEAs can also receive reimbursement for administrative services, such as helping children and families enroll in Medicaid. The Children's Health Insurance Program (CHIP) allows states to use a portion of federal CHIP funding to design Health Services Initiatives (HSIs) for low-income children, including those not enrolled in Medicaid or CHIP. HSIs may provide direct services, public health initiatives, and/or behavioral health programs.

Sources: U.S. Findlaw Staff, 20 U.S.C. § 6301—U.S. Code—Unannotated Title 20. Education § 6301. Statement of Purpose, 2024. Office of Elementary and Secondary Education, *Student Support and Academic Enrichment Program (Title IV, Part A)*, March 16, 2026. Substance Abuse and Mental Health Services Administration, *Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)*, 2023. Substance Abuse and Mental Health Services Administration, *Project AWARE*, Aug. 1, 2023. Center for Medicaid and CHIP Services, *Frequently Asked Questions Health Services Initiative*, 2017. Centers for Medicare & Medicaid Services, *Delivering Services in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming*, 2023. Substance Abuse and Mental Health Services Administration, *Sober Truth on Preventing Underage Drinking Act Grants*, July 16, 2026. Substance Abuse and Mental Health Services Administration, *Strategic Prevention Framework—Partnerships for Success for States*, July 16, 2026

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Opportunities for states to act

States seeking to strengthen school-based prevention programming can pursue multiple strategies. Agency officials should be prepared to support schools in identifying evidence-based programs, expanding and adequately staffing roles, and providing training and technical assistance. Equally important is the alignment of funding and reimbursement dollars to cover and sustain programs over time.

Share clear guidance on program selection

State health and education agencies can support schools in selecting effective programs by directing them to evidence-based practice registries—such as SAMHSA’s Evidence-Based Practices Resource Center and the U.S. Education Department’s What Works Clearinghouse—that curate youth behavioral health interventions with strong scientific support.⁵⁷ States can also support schools by adapting existing evidence-based programs and using open access curricula as cost-efficient alternatives to commercial programs.

School administrators, who play a critical role in program selection and implementation, need access to local data to identify student needs and clear evidence of program effectiveness to inform their decision-making.⁵⁸ States can help by equipping administrators with this data and evidence. Also, state or local education agencies can appoint school or district substance use prevention leaders to oversee programming, including selecting evidence-based curricula and monitoring adherence.⁵⁹

Strengthen the school behavioral health workforce

The ratio of students to school behavioral health providers can indicate a school’s ability to offer prevention services and other behavioral health supports. State policy mandates for specific student-behavioral health provider ratios boost access to clinical care, elevate critical workforce needs, and ideally guide state and local education budget appropriations.

State and local education agencies can maximize the impact of their existing workforce by clarifying roles for clinical professionals, teachers, and other school staff within team-based models such as MTSS. This approach can help schools better coordinate prevention services and allow specialized behavioral health providers to focus on higher-intensity student needs. The existing school-based workforce can also be strengthened by partnering with hospitals, universities, and community behavioral health organizations to place additional providers in schools.⁶⁰ For example, the Lyon County School District (LCSD) in Nevada has partnered with a community-based prevention coalition to improve students’ access to behavioral health supports and augment LCSD’s school staff with prevention specialists from the coalition.⁶¹ Schools may also partner with a local law enforcement agency or a school resource officer. It is important for law enforcement partners to be trained in mental health first aid, conflict resolution practices, and awareness of unintentional biases as they support schools’ prevention activities.⁶²

States can also build the school behavioral health workforce pipeline by strategically enhancing awareness and interest in the field. For example, the Michigan Department of Education has an initiative to help steer students toward potential careers as much-needed behavioral health providers. The agency has also funded a community health worker certification program to expand the pipeline for future school social workers.

Invest in implementation supports and technical assistance

Researchers and experts note that implementation challenges, including those that extend beyond funding, significantly undercut the potential of prevention programs.⁶³ State agencies seeking to support school administrators and staff who manage and run these programs can invest in assistance at the district and school building levels.⁶⁴ For example, states can offer training for school staff and providers in youth mental health first aid, an evidence-based course on how to identify signs of mental health and substance use issues and offer initial support.⁶⁵ Also, states that implement prevention programs should ensure that staff are appropriately trained in the program's protocols and have support available.

State Spotlights: Targeted Assistance for Schools

Nevada's Division of Health Care Financing and Policy is establishing a School Health Access Resource Center to provide technical assistance and infrastructure support to local education agencies in delivering school health services and seeking reimbursement from Medicaid.⁶⁶

Michigan's education agency is exploring ways that school nurses can support other staff in implementing the state health department's tobacco-free schools programming.⁶⁷

States also report that coordination across the state education, health, and/or behavioral health agencies and with professional associations has been crucial in boosting school-based prevention.⁶⁸ Work groups, consistent cross-agency meetings and phone calls, and other efforts to cultivate relationships create a strong foundation for advancing multiagency policy priorities and supporting youth substance use prevention and improved behavioral healthcare in schools.

State Spotlights: Interagency Coordination

North Carolina's School Mental Health Initiative (SMHI) is a collaboration among the state education agency, government leaders, educators, university officials, families, and community-based mental health professionals to provide policy support and recommendations that expand the availability of mental health services in schools. The SMHI meets every two to three months, virtually or in person, and eight regional support networks support school districts with planning and implementing programs and troubleshooting challenges. The work group also prioritizes sharing knowledge and resources from Project AWARE grantees with other school districts to boost understanding of what works in improving school mental health. The initiative also collected data on the perceptions of and access to youth mental health services in the state, conducted research, and developed a report with implementation recommendations for state officials.⁶⁹

Nevada's education agency works with the state Department of Human Services, local education agencies, the state Legislature, and local universities to develop a system of school-based comprehensive mental health services. Efforts have included disseminating best practices, braiding state and federal funding to bring MTSS to more schools, and working with the higher education system to expand the pipeline of school behavioral health providers. In addition, in 2023 the state passed legislation requiring all schools to develop nonpunitive disciplinary plans, which include behavioral health supports, to consider in lieu of suspension or expulsion in cases of infractions.⁷⁰

Support multisource financial investments for youth behavioral health

When Elementary and Secondary School Emergency Relief (ESSER) dollars flowed to schools during the COVID-19 pandemic, state policymakers responded to reports of declining youth mental health by making school-based behavioral health investments. Between March 2020 and December 2021, 38 states enacted a total of 92 laws supporting school behavioral health services. Twenty-six states directed federal and state funding to increase services, 12 states funded strategic planning for school mental health systems, and 24 states provided education and resources for school staff and students.⁷¹

However, with the expiration of COVID-related ESSER funds in 2025, state policymakers need to look for new ways of continuing to provide these services.⁷² States may wish to focus efforts on lower-income school districts, as they received the bulk of ESSER funding.⁷³

Opioid settlement funds—dollars secured by state and local governments through legal agreements to hold relevant companies accountable for their role in the opioid crisis—also can help states sustain prevention programs. States and localities will receive an estimated \$56 billion over 18 years in opioid settlement funds and can direct this money to youth prevention efforts for all substances, not only opioids.⁷⁴ In 2022 and 2023, states allocated an estimated 9% of their share of the funds to substance use prevention efforts.⁷⁵ For example, New York earmarked \$4 million to develop prevention education programs for use in schools in communities with higher-than-average opioid overdose deaths and hospital visits involving opioid misuse.⁷⁶ Sustaining school-based prevention efforts will depend on states' ability to coordinate multiple funding sources and ensure that investments are aligned with youth behavioral health goals.

State Spotlights: Multisource Financial Investments in Youth Prevention Services

Maine's Department of Health and Human Services used fees collected from opioid medication manufacturers to pilot a substance use screening program at three school-based health centers.⁷⁷

Colorado's school Medicaid program directed \$16.9 million in federal reimbursement to trainings on substance use, crisis prevention, life skills, and suicide prevention; increased access to community-based services; and coordinated care for students' social and emotional needs.⁷⁸

Oregon's community reinvestment mandate for managed care organizations allowed Yamhill County to purchase the PAX Good Behavior Game, a daily classroom management strategy delivered by teachers to early elementary school children, for several public schools.⁷⁹

Update school Medicaid policy and reinvestments to youth prevention

Medicaid provides more than \$7.5 billion in funding for school-based health services, including for behavioral health, annually through states' school Medicaid programs.⁸⁰ In 2023, the U.S. Centers for Medicare & Medicaid Services (CMS) released guidance clarifying that local education agencies and school-employed providers can be reimbursed by Medicaid for delivering healthcare services to any Medicaid-enrolled student, not just those receiving special education services, as the policy was originally interpreted.⁸¹ As of October 2023, 25 states have taken advantage of this allowance and are collecting reimbursements for services provided to all their Medicaid-enrolled students.

However, some states still need to make the policy changes necessary to be eligible to receive reimbursement.⁸² To collect reimbursement for school-based services, state Medicaid and education agencies should work together to update their Medicaid coverage and reimbursement policies through a state plan amendment to cover all Medicaid-enrolled students, plan how to direct reimbursement dollars toward SUD prevention and other behavioral health programs, and cultivate coordination across state and local health and education agencies to build support for directing reimbursement to behavioral health. Additionally, because Medicaid reimbursements are an important part of education agency budgets, schools should help children and families comply with administrative requirements to maintain Medicaid eligibility. Supporting children's eligibility is even more critical now, as many states are implementing policy changes related to work requirements and citizenship status that may impact children's eligibility should their parents lose coverage. Often children can maintain coverage even if parents cannot, although research shows parents may not know that their children remain eligible.⁸³ Actions to help children maintain coverage could include sending reminders to families to submit eligibility verifications to the state Medicaid agency, directing staff to help families that need extra assistance to keep their children enrolled when a parent loses coverage, and providing translation supports for non-English-speaking families.⁸⁴

In addition to seeking reimbursements from school Medicaid programs, states may consider how policies related to Medicaid managed care could support prevention programs. State Medicaid agencies also have the option to include community reinvestment requirements in managed care contracts. This option requires managed care organizations (MCOs) to reinvest some of their profits into community-identified health needs.⁸⁵ State Medicaid and education agency staff should discuss their mutual goals for youth substance use prevention and behavioral health supports and how MCO community reinvestment could advance these goals.

To strengthen the connection between Medicaid and school-based services, states may also take advantage of technical assistance provided by CMS and its contracted partners. Additionally, CMS' Rural Health Transformation grants encourage states to implement evidence-based interventions that strengthen disease prevention and behavioral health services.⁸⁶ States can use these funds to expand school-based behavioral health services and prevention programs, recognizing schools as integral components of the rural healthcare delivery system.

Conclusion

Evidence-based substance use prevention and behavioral health programs in schools offer a promising path to addressing youth substance use challenges, and schools need support from state health and education agencies to support large-scale, positive change. These programs can prevent and address serious health concerns for young people and reduce state and federal healthcare spending on costly treatment services as students age into adulthood. Studies have demonstrated the effectiveness—and economic benefit—of school-based substance use and behavioral health services in improving student outcomes, yet the degree to which states are investing in their schools as support systems varies, despite the ongoing need.

States can help schools overcome the challenges in delivering these programs. A number of states have made progress since the influx of COVID-era relief funds but need to continue adapting their approach. They may need to be creative in combining funding from multiple sources and streamlining implementation—but the result will be the long-term capacity to advance substance use prevention programs and provide the behavioral health services that young people need.

Endnotes

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For more information, please visit: pew.org/substancemisuse

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