



Addressing Youth Substance Use through School Services and Supports

Lessons from the District of Columbia, Massachusetts, and New Mexico

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July 2022

Schools play a crucial role in children’s lives, extending beyond solely providing education to support youth’s healthy social and emotional development.¹ The importance of schools became even more apparent during the COVID-19 pandemic; policymakers, educators, parents, and children’s advocates became concerned about not just the loss of learning but the loss of nonacademic supports in schools, such as food assistance and access to health care and social services, for millions of children and their families.² With growing behavioral health care needs among school-age children and youth fueled by the pandemic (Patterson et al. 2021; Viner et al. 2022), states, communities, and school districts have increasingly been looking for ways to better support youth’s mental health and well-being (US Department of Education 2021).³

Though much attention is given to youth mental health, addressing unhealthy substance use is equally important for young people’s healthy social and emotional development and can prevent both short-term harms (such as negative impacts on educational goals or family and peer relationships) and lifelong chronic substance use disorders (Onrust et al. 2016; Volkow and Wargo 2022). Adolescents with substance use disorders also have high rates of co-occurring mental illness, and, as such, one cannot be addressed without the other (Clemans-Cope et al. 2022; SAMHSA 2021). This brief examines approaches to address youth substance use in schools that were implemented before the pandemic. Drawing on information from publicly available sources and interviews with key informants in the District of Columbia, Massachusetts, and New Mexico (box 1), we find that

- youth substance use services are mostly siloed from mental health care,

- Medicaid policy does not sufficiently support youth engagement and the provision of substance use prevention and early intervention services,
- variation in school wellness culture and resources makes implementing universal policies and substance use interventions challenging, and
- community partnerships and engagement are critical in extending supports and resources to youth within and beyond school walls.

In the remainder of this brief, we provide background on the role of schools in addressing substance use and describe key features of school-based behavioral health initiatives in the District of Columbia, Massachusetts, and New Mexico. We then present key cross-cutting findings and their implications for the education and health care systems, philanthropy, and communities that can inform the design and implementation of school-based substance use initiatives to improve equitable access to and the quality of substance use services for youth.

BOX 1

Research Methods and Limitations

In the winter and spring of 2022, we conducted 14 semistructured interviews with 16 informants in the District of Columbia, Massachusetts, and New Mexico, including state officials overseeing youth substance use programs and school-based health initiatives, school-based clinical and paraprofessional providers, consumer advocates, and others such as Medicaid health plan representatives and researchers studying youth substance use interventions. We chose these jurisdictions because they had ongoing initiatives to provide access to behavioral health services in public schools. We identified informants through a review of relevant publicly available information on each initiative and our professional networks, and we used a snowball technique whereby interviewees provided recommendations for other stakeholders to include in the study. As part of the interviews, we supplemented and verified information we had previously gathered on the goals, policies, processes, and key features of each initiative in the study. Other topics covered in interviews include specific substance use services offered in schools, youth-specific substance use services and supports available in the community, the role of Medicaid in supporting youth substance use efforts, and best practices, challenges, and lessons learned in addressing substance use problems in schools.

The study has several limitations. Given the relatively small number of stakeholders who participated, some important perspectives and experiences are likely missing and others may be overrepresented. In particular, we had limited participation among stakeholders in New Mexico, as the timing of our outreach coincided with the wildfire emergency and the end of the school year. An additional limitation is that despite multiple efforts to recruit adolescents for interviews, we were unable to talk to enough youth to make policy inferences from the direct input from youth about the ways they experience or would prefer to receive substance use services in schools and other settings. However, direct youth input is critical. This experience points to the challenges in gathering youth input in research on substance use topics and the importance of finding effective ways of meaningfully engaging youth in the design, implementation, and evaluation of substance use services. Our findings and conclusions should therefore be interpreted with these limitations in mind.

The Opportunities and Barriers for Schools to Address Substance Use

The COVID-19 pandemic has contributed to large increases in stress, anxiety, and depression among Americans, including children and adolescents (Benton, Njoroge, and Ng 2022; Golberstein, Wen, and Miller 2020; Meherali et al. 2021; Panchal et al. 2021; Viner et al. 2022). According to recent estimates, more than two-thirds of American adolescents reported that the pandemic had negative effects on their mental health (SAMHSA 2021). Co-occurring mental health and substance use problems were common among youth before the pandemic (Kim and Kim 2021), and the pandemic's negative impacts on youth psychological well-being can lead to unhealthy coping strategies such as substance use (Meherali et al. 2021). Studies examining changes in youth substance use during the pandemic have found mixed results, including decreases in alcohol use, increases in unhealthy use of nicotine and prescription drugs, and no change in the use of marijuana or in binge drinking alcohol among 12th grade students (Miech et al. 2021; Pelham et al. 2021).⁴ Experimentation or self-medication with alcohol and other drugs during adolescence can have particularly detrimental effects on social and emotional well-being and brain development, and it can increase the risk of chronic mental and behavioral health conditions, including substance use disorders (Buchmann et al. 2009; Johnston et al. 2021; McCabe et al. 2022; Squeglia and Gray 2016; Turner et al. 2004; Volkow, Koob, and McLellan 2016; Winstanley et al. 2012). Developing and implementing effective, equitable, and culturally and developmentally appropriate prevention and early intervention strategies is therefore critical to help delay experimentation with alcohol and other drugs and to decrease the risk of adverse outcomes among youth, and it should be part of any mental health and well-being intervention (Onrust et al. 2016; Volkow and Wargo 2022).

Because schools have direct contact with nearly all youth,⁵ they have been long considered a prime setting for delivering health education and health care to youth, including promoting equitable access to care to underserved youth by addressing barriers such as a lack of transportation or parental paid time off work (CPSTF 2016; Knopf et al. 2016).⁶ However, schools have also struggled to effectively provide mental health and substance use services for various administrative, cultural, political, and economic reasons (Heitzeg 2009; Katz 2020; Love et al. 2019; Zarate et al. 2020). For example, only 10 percent of US public schools today have school-based health centers (SBHCs) on campus, and in some cases they may lack full uptake of available services by students (CPTSF 2016; Love et al. 2019). Additionally, SBHCs have traditionally focused on providing primary care and have not been a large source of mental health or substance use care (CDC 2016). Little information is available to understand how many schools provide or facilitate access to mental health and substance use services and in what ways. A recent study found that few adolescents report receiving outpatient mental health services in school settings and most receive substance use prevention messaging outside school (Clemans-Cope et al. 2022).

Just as schools can promote and support positive child development and well-being, they can also cause harm and inequitable outcomes by implementing exclusionary and discriminatory discipline policies (Osher et al. 2014). Particularly when it comes to addressing substance use, schools tend to

respond with punishment; zero-tolerance policies are widespread (Porter and Clemons 2013). As such, youth with behavioral health problems, particularly substance use, may be subjected to harsh discipline that may result in suspension, expulsion, or even jail time instead of treatment (Heitzeg 2009; Okonofua, Walton, and Eberhardt 2016; Wallace et al. 2008). Youth of color are disproportionately more likely than their white counterparts to face punitive responses, leading to the “school-to-prison pipeline” for youth of color (Prins et al. 2021; Wilson 2014). School climates, discipline policies, and stigma around youth who use substances are important factors helping explain schools’ lack of health- and wellness-based approaches to youth substance use problems.

Medicaid and the Children’s Health Insurance Program (CHIP) cover one-third of all children and youth in the United States, including more than half of children of color (Brooks and Gardner 2020).⁷ As such, Medicaid/CHIP policy can be particularly influential in facilitating access to substance use services in health care, school, and other settings (Wilkinson et al. 2020).⁸ For example, states can reimburse the school-based health care services covered by a state’s Medicaid program, including mental health and substance use services, provided to all students enrolled in Medicaid/CHIP (Healthy Schools Campaign 2020; Johnson and Jackson 2021).⁹ But overly cumbersome administrative policies, including Medicaid/CHIP billing requirements and procedures that schools may not have the capacity and infrastructure to effectively handle, have posed barriers for many school districts to participate in Medicaid/CHIP (AASA 2019; Wilkinson et al. 2020).¹⁰ But even if schools can bill Medicaid, this may not necessarily expand access to behavioral health services because of severe behavioral health workforce shortages that have been worsened by the pandemic (National Council for Mental Wellbeing 2021). The limited availability of high-quality substance use care services across the country likely contributes to the lack of availability of these services in schools and communities (Bouchery and Dey 2018).

School-Based Initiatives in the District of Columbia, Massachusetts, and New Mexico

The District of Columbia’s school-based behavioral health initiative has been in development over the last two decades; the DC Department of Behavioral Health has provided clinical services in some public schools since as early as 2000. Legislation passed in 2012 called for the establishment and expansion of school-based behavioral health programming in all of the city’s public schools. The DC School Behavioral Health Program aims to provide access to culturally effective, high-quality mental health care for all K–12 students in the District’s public school system through a collaboration between schools and community-based organizations (DC DBH 2020, n.d.). The Department of Behavioral Health is responsible for developing, implementing, and overseeing the program with support from several entities, including the DC School Behavioral Health Community of Practice.¹¹ The expansion of behavioral health services to all of the city’s public and public charter schools launched in the 2018–19 school year.¹² Schools can select a community-based organization that best meets their current needs to provide multitiered services which include universal prevention services for all students (tier 1), brief intervention services designed for youth at risk of developing mental health problems (tier 2), and treatment services consisting of individual or group mental health counseling in a school or the

community (tier 3; DC DBH 2019). Though this program's main focus is mental health, the initiative supports students with co-occurring mental health and substance use, and those needing substance use treatment are referred to community providers. The DC general budget provides funding for the program, and treatment services are eligible for reimbursement from Medicaid/CHIP and private insurance.¹³

Massachusetts implemented universal Screening, Brief Intervention, and Referral to Treatment (SBIRT) in schools in 2016, pursuant to state legislation.¹⁴ The goal of the SBIRT in Schools initiative is for school districts to annually screen students for substance use concerns in one middle school and one high school grade using a validated screening tool (MA DPH 2019). The initiative rolled out across the state in 2017. It is overseen by the Massachusetts Department of Health and supported by MASBIRT TTA (Massachusetts Screening, Brief Intervention, and Referral to Treatment - Training and Technical Assistance), which is charged with developing training and resources to assist school districts with implementation.¹⁵ Services include verbal screening followed by one-on-one motivational interviewing to support students' healthy behaviors and to explore strategies for changing risky behaviors. Students found at risk of developing unhealthy substance use are referred for further assessment or treatment in the community (SHIELD, MA DPH, MASBIRT TTA 2021). School personnel such as school nurses and guidance counselors administer the screening, and the screening tool (CRAFFT2.1+N) has been translated into several languages.¹⁶ The state provides funding for the oversight of and technical support for the initiative. Though school districts do not receive any state funding for implementation, SBIRT services are eligible for Medicaid/CHIP reimbursement.¹⁷

Finally, New Mexico has a long tradition of providing school-based health care. The first SBHC opened in 1978 (Rodriguez and Center 2019), and today 82 SBHCs operated by community-based health care providers, including federally qualified health centers and hospitals, have been implemented across the state to provide integrated physical and behavioral health care to school-age children and youth regardless of their ability to pay for services.¹⁸ Services provided by SBHCs include comprehensive screening for physical and behavioral health risks, primary care, mental health and substance use counseling, and referrals to specialty care, including substance use treatment (OSAH 2019). Some SBHCs offer dental care, reproductive health care, and case management, and services may be available to faculty and staff, parents, and students from other schools.¹⁹ Like in DC, the funding for SBHCs in New Mexico is provided by the state and complemented by reimbursement from Medicaid/CHIP and private insurance (Rodriguez and Center 2019).

Table 1 provides a high-level overview of the key features of the school-based behavioral health initiatives examined in this study.

TABLE 1

Key Features of the School-Based Behavioral Health Efforts in the District of Columbia, Massachusetts, and New Mexico

	DC School Behavioral Health Program	Massachusetts SBIRT in Schools	New Mexico school-based health centers
Primary goal(s)	To provide access to behavioral health services in every public school	To identify and address substance use concerns in public schools using a validated screening tool and to build trusting relationships around education, behavior, and support related to substance use	To provide integrated preventative, physical, and behavioral health care through school-based health centers (SBHCs).
Lead agency	Department of Behavioral Health	Department of Public Health	Office of School and Adolescent Health
Supporting entities and organizations	DC School Behavioral Health Community of Practice; Coordinating Council on School Behavioral Health; Center for Health and Health Care in Schools; DC Public Schools; OSSE; DC public charter schools	MASBIRT TTA (Massachusetts Screening, Brief Intervention, and Referral to Treatment – Training and Technical Assistance); SHIELD (School Health Institute for Education and Leadership Development)	New Mexico Alliance for School-Based Health Care; managed-care organizations
Implementation date	2000; expanded in 2018	2017	1978
Implementation progress	All K–12 public and public charter schools	All middle and high schools	82 SBHCs in K–12 public schools
Services delivered in schools	Mental health and substance use prevention; early intervention; mental health counseling and/or referrals to treatment; case management; consultation with and support for school staff and teachers; crisis services	Substance use prevention; SBIRT; referrals to treatment	Health promotion; screening for physical and behavioral health risks; preventative and primary care; mental health and substance use brief intervention and counseling; referrals to treatment; case management
Culturally and linguistically effective approaches	Schools are matched with community-based organizations based on student needs, including language needs.	The screening tool and supporting materials are translated into 28 languages.	Culturally effective strategies to promote behavioral health of Indigenous students have been developed.
Providers	Mental health clinicians from DBH and community-based organizations (e.g., community health centers, youth human services organizations)	Trained school personnel (e.g., school nurses, social workers, guidance counselors)	Clinicians from health care organizations (e.g., community health centers, hospitals, Indian Health Service)
Funding sources	Local funding, Medicaid, private insurance	State funding	State funding, Indian Health Service, Medicaid, private insurance

Sources: Authors' review of publicly available state and organization sites and case study interviews conducted in the spring of 2022. The DC sources are as follows: DC DBH (DC Department of Behavioral Health), "School Behavioral Health Expansion Implementation: FY20 Strategic Plan Summary" (Washington, DC: DC DBH, 2020); "About the CoP," DC School Behavioral Health Community of Practice, accessed June 27, 2022, <http://cop.aehinst.org/about-the-cop>; "Coordinating Council on School Behavioral Health," DC DBH, accessed June 27, 2022, <https://dbh.dc.gov/page/coordinating-council-school-behavioral-health>; Center for Health and Health Care in Schools website; "School Behavioral Health Program," DC DBH, accessed June 27, 2022, <https://dbh.dc.gov/service/school-behavioral-health-program>; and DC DBH, "Guide to Comprehensive School Behavioral Health" (Washington, DC: DC DBH, 2019). The Massachusetts sources are as follows: MA DPH (Massachusetts Department of Public Health), "SBIRT in Schools: FAQs" (Boston: MA DPH, 2019); the MASBIRT TTA website; and SHIELD at Boston University, MA DPH, and MASBIRT TTA, *SBIRT in Schools Resource Toolkit: Verbal Substance Use Screening Program in Massachusetts Schools* (Boston: SHIELD at Boston University, MA DPH, and MASBIRT TTA, 2021). The New Mexico sources are as follows: New Mexico Department of Health, Office of School and Adolescent Health, and Apex, *New Mexico School-Based Health Centers: Status Report 2015* (Santa Fe, NM: Office of School and Adolescent Health and Apex, 2015); Nancy Rodriguez and Ruth Center, "New Mexico School-Based Health Centers: October 2019 Update for LHHS" (Albuquerque, NM: New Mexico Alliance for School-Based Health Care, 2019); the *New Mexico Alliance for School-Based Health Care website*; "Office of School and Adolescent Health," New Mexico Department of Health, accessed June 27, 2022, <https://www.nmhealth.org/about/phd/pchb/osah/>; OSAH (New Mexico Department of Health, Office of School and Adolescent Health), *New Mexico School-Based Health Centers 4-Year Report | 2015-2019* (Santa Fe, NM: OSAH, 2019); and "School-Based Health Center (SBHC)/Managed Care Organization (MCO) Project," New Mexico Human Services Department, accessed June 27, 2022, <https://www.hsd.state.nm.us/lookingforinformation/school-based-health-center-managed-care-organization-project/>.

Notes: OSSE = Office of the State Superintendent of Education. SBIRT = Screening, Brief Intervention, and Referral to Treatment. DBH = Department of Behavioral Health.

Substance Use and Mental Health Services Are Siloed

Research suggests adolescents with substance use disorders also have high rates of co-occurring mental illness (Auger et al. 2022; Clemans-Cope et al. 2022; SAMHSA 2021; Weinberger et al. 2020; Winstanley et al. 2012). According to recent estimates, adolescents who had a major depressive episode in the past year were more likely to use substances, including binge drinking, vaping, and using nicotine, marijuana, or illicit drugs (SAMHSA 2021). Providers and other stakeholders we interviewed for the study corroborated that mental health problems and unhealthy substance use are intertwined for the youth they serve. Many spoke about seeing youth experiencing stress, anxiety, depression, and trauma that are not necessarily diagnosed mental health conditions but nevertheless trigger or contribute to unhealthy substance use. Several informants noted that youth often turn to alcohol and other substances as a coping strategy. Similar to national trends, informants across our case studies observed increases in unhealthy alcohol and marijuana use during the pandemic, and some reported increases in opioid misuse, particularly among LGBTQ+ youth (Pelham et al. 2021).

The initiatives we examined are limited in addressing co-occurring mental health and substance use problems, largely because of a lack of care models and capacity to treat comorbid behavioral health conditions in youth. The Massachusetts SBIRT in Schools initiative, for example, was designed as a substance use prevention and early intervention strategy, and no mental health questions are currently included in the screening. Key informants in Massachusetts agreed that though they understand the importance of identifying youth mental health problems, they currently lack a validated screening tool for both conditions. Several informants pointed out that some school districts in Massachusetts conduct

separate screenings for depression and anxiety on their own, but there is currently no expectation that mental health screenings occur on a systematic, statewide basis similar to the SBIRT requirement.

The DC School Behavioral Health Program is focused on mental health prevention, early intervention, and counseling. Clinicians who provide school-based services are trained in mental health models and interventions, and informants reported that though in some cases counselors can provide treatment for co-occurring substance use, youth who need services for substance use only are referred to community providers. Some informants noted that unfortunately they see very little follow-through on referrals to community substance use treatment, even though the community currently has capacity to meet the needs of those seeking help (meaning outpatient adolescent substance use treatment programs lack waiting lists). Though some people we spoke with noted that youth in general may have a low perceived need for treatment, others thought that convenience was a factor and wondered if engagement in substance use counseling would be greater if the services were available in schools.

In New Mexico, providers who receive state funding for SBHCs must provide integrated primary and behavioral health care. One informant noted that the emphasis on adolescent behavioral health is strong; many SBHCs are staffed with twice as many behavioral health clinicians as primary care providers. But informants also noted that SBHC efforts in New Mexico have focused more on issues such as suicide and teen pregnancy and less on substance use.

In Massachusetts and New Mexico, informants reported that shortages and long waiting lists for specialty inpatient and outpatient substance use programs, including a lack of adolescent treatment options for co-occurring mental health and substance use, were a major problem in responding to youth substance use treatment needs. One informant said only one adolescent residential treatment program in Massachusetts provides treatment for comorbid behavioral health conditions. A Massachusetts state official acknowledged that designing an adolescent substance use treatment system has historically been challenging because relatively few youth need higher-level substance use services. This informant talked about the dilemma of meeting the treatment needs of youth as a catch-22, where capacity is insufficient, but as soon as additional treatment capacity is added, it does not get fully used and therefore may not be financially sustainable.

Medicaid Policy Makes It Hard for Schools to Address Substance Use

Key informants in DC and Massachusetts reported that Medicaid/CHIP reimbursement is an important source of funding for behavioral health treatment services in schools. In addition to Medicaid/CHIP and private insurance reimbursement, initiatives in both states rely on local and state grants to support the universal prevention, outreach, and early intervention components of school-based services; these components include providing resources to serve youth without health insurance and filling in gaps for services that may be reimbursable but that a provider may not be able to bill insurance for either because the provider is not credentialed with a specific private insurance plan or to maintain a young person's confidentiality. For example, informants noted that providers may absorb the cost of treatment for youth with private insurance who do not want remittances sent home to their parents.

Informants also described ways in which Medicaid policies and processes were not particularly supportive of efforts to provide substance use and mental health services in schools. Most importantly, informants across the three programs in our study lamented the lack of Medicaid reimbursement for prevention and some early intervention services, including youth peer support specialists. For example, Project Amp, developed and piloted in Massachusetts, is a brief intervention in which young adults in recovery provide developmentally and culturally appropriate counseling and support to adolescents with a low-to-moderate risk of substance use (Paquette et al. 2019).²⁰ Project Amp youth mentors have been serving in several Massachusetts schools, and study informants described this as a promising strategy for engaging at-risk youth in constructive conversations about substance use (Project Amp, n.d.). But MassHealth, the state’s Medicaid/CHIP program, currently does not provide reimbursement for the intervention or for youth peer counselors, according to study informants.

Further, informants spoke about some administrative challenges in Medicaid, such as burdensome certification requirements, cumbersome billing systems, and inflexible treatment policies. One informant in New Mexico described the Medicaid certification requirements for SBHCs as “antiquated” and overly burdensome, posing barriers for SBHCs to provide services via telehealth or, before the pandemic-related telehealth flexibilities, mobile vans; the informant described these services as a major need given the state’s rural and sparsely populated geography. Massachusetts received Centers for Medicare & Medicaid Services approval to allow school districts to bill Medicaid for any services, including SBIRT, provided to Medicaid-enrolled students. However, respondents said few, if any, school districts bill MassHealth for SBIRT.²¹ One Massachusetts informant said that the Medicaid program introduced Random Moment Time Study billing, a billing method commonly used in SBHCs to quantify the time staff spend doing reimbursable activities, and provided training to schools and SBHCs. However, schools largely lack the personnel, time, and resources required to claim Medicaid reimbursement for SBIRT, particularly when the funding would flow to a local general budget rather than back to the schools.

Lastly, key informants across the case study programs also complained about Medicaid policies’ lack of recognition of and reimbursement for youth-focused outreach and engagement in care. Providers reported that the barriers of working with youth in school settings—such as school breaks, a desire not to interfere with academics, and the absence of parents—posed challenges to completing services and paperwork in the same manner they would typically be completed in a clinic. For example, providers in DC described an often time-consuming and challenging process for obtaining parental consent to enroll youth in services, including having to facilitate a three-way phone call with parents and the Department of Behavioral Health. Additionally, one provider shared that care plans also need parental consent, which has to be submitted to DC Medicaid within 30 days of diagnosis, but providers sometimes miss the deadline and are ineligible to receive reimbursement for any of the services they provided. Overall, several informants remarked that engaging youth in interventions and treatment is time consuming and requires different approaches than for adults, including trust and relationship building and nontraditional approaches such as art therapy, but none of these efforts is currently a billable Medicaid service.

School Resources and Wellness Culture Vary

The education system in the US is decentralized; typically states and localities hold most control over school policies, programs, and funding.²² As one informant explained, each school district is its own authority, and though state departments provide guidance and funding, each school board is responsible for acting on given recommendations and allocating funding to different activities. According to study informants, the variation in local priorities, resources, and infrastructure extends to individual schools, contributing to a diversity of approaches to behavioral health initiatives. Informants said a combination of factors, including leadership and staff buy-in, culture and climate, resources, and relationships with parents and the community, underpins how interventions play out in practice school by school. DC developed the School Strengthening Tool to assess each school in the School Behavioral Health Program along four key dimensions (existing psychological supports, social and emotional climate, employee wellness, and family engagement) to develop a tailored work plan for interventions and supports in each school (DC DBH, n.d.).

The Massachusetts SBIRT in Schools initiative was envisioned as a universal statewide program, and the legislature provided for some basic parameters of the program, including implementation guidance and technical assistance for schools.²³ However, individual schools have flexibility in deciding which student cohorts will receive the screening, on what timeline, and who will administer it. According to Massachusetts informants, this flexibility, along with differing school commitments and available resources, led to considerable variation in how SBIRT was implemented across the state. For example, well-resourced schools can not only administer the screening but also provide additional resources and supports, such as more robust prevention education, counseling services, and dedicated behavioral health professionals on staff. The lack of resources was reportedly a common challenge in Massachusetts, partly driven by what some informants called an “unfunded mandate”; though the legislation includes resources for state administration of the program and technical assistance, schools do not receive any direct funding to implement SBIRT. According to informants, school personnel, such as school nurses and guidance counselors, must typically take on SBIRT as an additional responsibility without necessarily having corresponding resources or additional pay. In addition to facing a burden on staff time and resources, schools reportedly struggle with how to deliver the screening without overburdening students or having them miss classes.

Though in DC and New Mexico behavioral health interventions are delivered in schools by external community-based organizations, clinicians hired by the DC Department of Behavioral Health, and health care providers, informants reported that school resources and priorities played a role in how effectively the interventions were implemented. For example, the extent to which programs have been embraced and supported by school leadership and staff influence how and whether students get referred to services or how effectively behavioral health providers collaborate with school staff on prevention and education initiatives. A provider serving multiple schools in the District noted that though counselors in some schools have trouble getting recognition and enrolling students in services, counselors in other schools may be overwhelmed by requests for support, not just for students but for teachers and staff. One informant described New Mexico’s rural geography and lack of resources as the

greatest challenges to the expansion of SBHCs; for many small and remote school districts, opening an SBHC on campus is not practical and feasible, even if sufficient funding and workforce were available. Key informants thought mobile vans and greater reliance on telehealth (which expanded during the pandemic) were important opportunities for bringing SBHC services to underserved school districts.

Informants described school climate as another key variable in school-based behavioral health interventions, particularly the efforts to address youth substance use. For schools to be an effective setting for delivering substance use services and supports, youth must feel safe seeking the help they need without fearing punishment. However, informants in all case study sites reported that zero-tolerance attitudes and approaches were very much engrained in school culture, even if eliminated on paper. As one informant said, youth can still get suspended or barred from sports and other activities if they are caught using substances. Another informant said that some schools would reportedly remove doors from bathroom stalls to prevent youth from vaping. In DC, a provider informant observed that some schools have little trust in students and families because of past failures to educate and support youth, let alone provide services; this lack of trust contributes to absenteeism, and clinicians have had to spend as much time rebuilding relationships with youth and community trust as providing direct care. Across the case study sites, informants reported fighting a common perception among youth, educators, and parents that vaping, drinking, and using marijuana are normal and harmless for youth.

In response, many informants noted that reforming school culture, educating teachers and staff, and building trusting relationships with students and families were essential and fundamental components of the school-based programs across all three sites. Several informants thought that the culture was slowly shifting away from punitive approaches, and that the pandemic has helped garner greater recognition of and appreciation for school-based behavioral health efforts. For instance, several informants characterized the Massachusetts SBIRT initiative as a prevention tool designed to build awareness among educators, school staff, students, and parents about substance use as a health risk and condition that requires treatment, just as diabetes or asthma would. Informants said the goals of implementing universal SBIRT were to normalize conversations about substance use in school settings and to create opportunities to have brief face-to-face interactions with youth and let them know there is an adult they can confidentially speak with should they or their friends have concerns about unhealthy substance use. The implementation of SBIRT did not necessarily lead to greater identification of substance use problems in youth. In fact, many informants remarked that rates of substance use detected via SBIRT are generally lower than those reported in surveys such as the Youth Risk Behavior Surveillance System Survey. But they emphasized that was okay because the value of SBIRT is in raising awareness and creating relationships.

The key strategy programs in this study used to build trust with students and to ensure confidentiality was having a clear separation between behavioral health services and the school system. In both DC and New Mexico, informants noted that having external organizations provide school-based services was particularly helpful in making students comfortable seeking help. DC providers said that students ages 14 and older could also opt out of parental consent to obtain services. Though school staff are responsible for delivering SBIRT in Massachusetts, state officials and technical assistance providers

recommended that teachers and coaches abstain from delivering SBIRT and noted both parents and students can opt out of participating. In addition, one informant said the initiative was encouraging school vice principals, who are typically responsible for discipline policies, to be involved in the design and implementation of SBIRT to better align school discipline policies with substance use interventions. Massachusetts has also been working to ensure schools have alternative options to discipline, including introducing Project Amp youth mentors in schools and developing the iDECIDE education program (box 2), which one informant described as a low-intensity intervention for students who violate school substance use policies (Jenney and Butler 2021).²⁴

BOX 2

iDECIDE (Drug Education Curriculum: Intervention, Diversion, and Empowerment)

The iDECIDE educational curriculum was developed as an alternative to suspension, exclusion, and other punitive discipline practices for middle and high school students who violate school substance use policies. The program can be used as a secondary prevention for youth at risk of developing problematic substance use, and it is not intended to replace treatment.

iDECIDE incorporates guided discussions, educational videos, and structured activities to educate youth about the negative impacts of unhealthy substance use on adolescent brain development, to raise awareness among participants about common advertising tactics targeting adolescents, to train youth to recognize triggers for alcohol and other drug use and alternative coping strategies, and to empower youth to make healthy decisions in support of their core values and long-term wellness goals. iDECIDE is available in both English and Spanish and can be administered by trained school personnel or nonschool partner organizations in an individual or group format.

The program was developed by the Center for Addiction Medicine at Massachusetts General Hospital in collaboration with the Office of Youth and Young Adult Services at the Massachusetts Department of Public Health and the Institute for Health and Recovery. It was launched across Massachusetts in the fall of 2021. Currently, more than 90 schools are implementing the iDECIDE curriculum.

Sources: The iDECIDE website; “iDECIDE at a Glance,” MASBIRT TTA, accessed June 28, 2022, <https://www.masbirt.org/sites/www.masbirt.org/files/School%20SBIRT/iDECIDE%20Overview.pdf>.

Key informants also described ways in which they attempted to ensure culturally effective care and equitable access to services, though many recognized that they do not necessarily have disaggregated demographic and socioeconomic data to monitor disparities. In New Mexico, several SBHCs that serve in tribal communities are operated by the Indian Health Service. The SBIRT tool was translated into multiple languages, but state officials acknowledged that schools may not always be able to guarantee that a screener will speak the language the student prefers. Similarly, DC’s initiative aims to match community-based organizations with schools based on language needs, but shortages of culturally and linguistically effective providers are a concern and could lead to inequitable outcomes. For example, a DC provider noticed that Black students in one school were being referred to guidance counselors who were Black men, whereas Latinx students were referred to a mental health counselor who was also

Latinx. Although this informant believed the intention was to pair students with adults of the same racial and ethnic identity, the result was that Black students were not getting professional mental health counseling at the same rates as Latinx students. This led the provider to hire an additional Black mental health counselor for the school. In another example, a key informant shared that recovery high schools have boomed in Massachusetts,²⁵ but it was not clear whether all students have equal access to these supports.

Supports Need to Extend Beyond School Staff and Resources and School Walls

Key informants agreed that the primary benefit of delivering services in schools is the ability to reach underserved youth. For example, about a third of children and adolescents served by New Mexico's SBHCs reportedly lack other access to health care. Informants in DC similarly commented that they appreciate being able to reach youth in school who otherwise may never engage in care because of systemic barriers such as a lack of health insurance, transportation, or parental ability to take time off work. However, informants also acknowledged that school-based services have several limitations and many youth can fall through the cracks. For example, the risks of disruptions in care are greater when school is out of session; one informant noted that pediatric emergency department visits for behavioral health crises typically spike during school breaks. As described earlier, some schools have strained relationships with their communities, and youth do not feel comfortable coming in for behavioral health or other services. Interestingly, one informant noted that in more affluent school districts, youth are not used to accessing services in schools, even if these services are available, because they typically have good access to care and supports in the community. In addition, some informants shared that school climates deteriorated during the pandemic; issues such as rough transitions to virtual learning and community conflicts around school masking policies took a toll on teacher and staff well-being and led to burnout among and an exodus of school personnel. The DC initiative is including teacher wellness as one of its core components, and the behavioral health counselors can develop and deliver services aimed at school personnel as needed.

Several informants stressed the need to go beyond the school walls and ensure youth are supported and taken care of in and by the community. After all, one informant commented, schools focus on academics, and asking schools to also provide behavioral health services and other supports when they may already be struggling to fulfill their primary mission may not be efficient or even fair. But this informant added that schools could function as a hub for services to support student achievement, not only by supporting children and youth but also by supporting their families. Many informants viewed partnering with community-based organizations to deliver services in schools as the best model both to give schools the capacity and expertise they lack and to reassure students and families that services are confidential and will not affect students' academic standing. But informants noted that to equip all schools with well-trained and culturally effective behavioral health providers, states and localities must prioritize youth wellness and address severe behavioral health care workforce shortages and the lack of health-related social services and supports that undermines children's health and social and emotional well-being. Several informants said they have also been thinking about or actively engaging youth-serving organizations that provide prosocial youth programming and parent engagement (such as

YMCAs and Boys & Girls Clubs of America) and human services agencies (such as the foster care and juvenile justice systems) in youth behavioral health efforts. A New Mexico state official, for example, described a wide-ranging strategy to engage community organizations and service agencies in youth behavioral health because “there are very few people that don’t have some interaction with adolescents.” Other informants talked about community substance use coalitions as a great way to unite and mobilize the community to prevent and intervene in youth substance use.

Finally, key informants noted that youth behavioral health has taken on new importance because of the pandemic’s impact on mental health; they are finding more support for mental health and substance use services delivered in schools, including, in some cases, more funding dedicated to school-based behavioral health care. But long-standing behavioral health care workforce shortages worsened during the pandemic. One provider observed that many clinicians began to reconsider their career choices during the pandemic and left school-based services for private practice or work-from-home opportunities with better pay and benefits. Several informants called for greater investments in behavioral health workforce development, such as encouraging and supporting young people, especially youth of color, to pursue health care careers, including and especially in mental health and substance use care. DC created a workforce task force to shore up the behavioral health profession, and several community-based organizations are collaborating with local universities to recruit a prospective new workforce. Though key informants wanted to build on this momentum, they also noted that public attention is fleeting and many of the funding increases are temporary. Informants emphasized that to support young people’s healthy development and to effectively address substance use concerns firm commitments to and long-term investments in school-based behavioral health care are needed from all key stakeholders, including the education and health care sectors, philanthropy, parents, and community members.

Discussion

The public and policy focus on the pandemic’s toll on youth well-being, including increased funding for behavioral health services and funding for schools in the American Rescue Plan Act of 2021, presents opportunities to expand access to substance use services for youth in schools (Johnson and Jackson 2021).²⁶ As described in this brief, schools can facilitate access to care for often hard-to-reach and underserved populations. But punitive school discipline policies and inadequate resources can also undermine efforts to provide prevention, early intervention, and treatment services to youth in need in schools. In addition, inequities may persist if youth of color continue to disproportionately face punishment, rather than treatment, for substance use, as has historically been the case (Heitzeg 2009; Prins et al. 2021; Wilson 2014).

This study has several key takeaways:

- Schools can be an effective place for substance use interventions. However, both substance use and mental health need to be explicitly included in behavioral health interventions, which are

often designed as either mental health interventions, as this study found in DC and New Mexico, or as substance use interventions, as this study found in Massachusetts.

- Schools can be responsible for cultivating a positive environment in which youth feel supported and cared for and have a safe place to turn for help. Alternative approaches to discipline, such as Massachusetts' iDECIDE program, can provide more effective tools for schools to address substance use and move away from zero-tolerance policies.
- Schools can be more effective if they reframe youth substance use as a health condition that needs different levels of interventions in the school and the community, rather than a normal rite of passage or moral failing. They must also raise awareness among teachers, administrators, parents, and community members about health-based and evidence-informed approaches to addressing youth substance use (FrameWorks Institute 2018).
- Schools cannot be expected to successfully address youth substance use alone; they need resources in the community, including developmentally appropriate and culturally effective youth substance use services and partnerships with well-funded community-based organizations, to provide robust programs of prosocial activities that engage both youth and their parents.

Moreover, because Medicaid/CHIP is the dominant payer for youth health care and serves a disproportionate share of youth of color, improvements in Medicaid/CHIP coverage of substance use services across the continuum of care could improve access to care and promote more equitable outcomes (Brooks and Gardner 2020). More research and guidance are particularly needed to develop (1) benefits and reimbursement models for youth-specific prevention and early intervention services and (2) payment models and policy flexibilities that account for daily, nonclinical activities school-based providers may undertake when working with adolescents, such as engaging parents or transporting youth to prosocial activities (Acevedo et al. 2020). In addition, Medicaid programs can support the expansion of effective outpatient interventions and specialty treatment capacity for youth with comorbid substance use and mental health conditions. They can also address administrative hurdles that schools and school-based providers face in claiming reimbursement for services (AASA 2019; Wilkinson et al. 2020).²⁷

With state funding and guidance, communities can support schools and youth-serving community-based organizations in delivering integrated behavioral health services by developing the needed workforce of developmentally appropriate and culturally and linguistically effective behavioral health care providers. Youth peer support may be particularly important for engaging adolescents in the prevention of, early intervention for, and treatment of unhealthy substance use (Paquette et al. 2019). States and localities can invest in cultivating a “homegrown” behavioral health care workforce by creating pathway programs that encourage and support young people in the community, particularly those from racial and ethnic groups underrepresented in medicine and nursing, in pursuing substance use and mental health care professions (Taylor et al. 2022).

Funding is another key piece of support for youth substance use care. The initiatives described in this brief rely heavily on state and local funding and Medicaid/CHIP and private insurance reimbursement. But these funding streams may inadequately support the time and effort providers may undertake to build trust and engage youth in the services. Despite increased government funding, too often and for too long youth substance use and mental health services have been ignored by private philanthropy. Between 2015 and 2018, only 1.3 percent of overall foundation investments were dedicated to behavioral health, and even less was dedicated to adolescent care.²⁸ Thus, a considerable opportunity exists for philanthropy to invest in youth by supporting research into and the development of youth-centric and culturally effective prevention and early intervention services, including by advocating for changes in Medicaid policy to better support youth with substance use concerns.

Finally, an important and often missing piece in the development and implementation of school- and community-based youth substance use interventions is youth voices. Including youth in developing and implementing interventions can be challenging to do without investing time and resources to establish relationships and build trust with youth and/or organizations that serve them. A case in point is this study, in which, despite multiple attempts and strategies, we were unable to interview many youth about their experiences with and opinions on school-based substance use services. This experience gave us a new appreciation for the hard work school clinicians and guidance counselors undertake every day to prevent and address unhealthy substance use in youth. Schools, communities, health care systems, and philanthropy can do more to better support school-based providers in this critical work.

Conclusion

As another challenging and stressful pandemic school year comes to a close, communities may be wondering how to better support the behavioral health of youth. Although mental health is garnering significant attention, youth substance use problems are often overlooked or treated as a disciplinary issue within schools. The common misconception that experimenting with drugs and alcohol is part of growing up contrasts with the fact that youth substance use is a health condition that may need various health interventions that can be delivered in schools and communities. The long-standing stigma around people who develop substance or opioid use disorders contributes to the lack of attention to and investment in comprehensive, developmentally appropriate, and culturally and linguistically effective youth substance use services. Youth are often left to figure out on their own whether they might have a substance use problem or how to solve it, with little support and understanding from adults in their lives for fears of disappointing their parents or facing negative consequences at school. Schools and communities can become more nurturing and positive spaces that promote the overall health and wellness of youth and have the knowledge and resources to respond with kindness, support, and evidence-informed and equity-focused health approaches before substance use turns into a chronic, life-altering disorder. The education and health care systems, policymakers, philanthropy, parents, and community members can develop the services and supports to address youth substance use that our young people need and deserve.

Notes

- ¹ Lisa Flook, “Four Ways Schools Can Support the Whole Child,” *Greater Good Magazine*, April 23, 2019, https://greatergood.berkeley.edu/article/item/four_ways_schools_can_support_the_whole_child.
- ² David Gibson, “What the Pandemic Has Revealed about the Role of Schools,” Aspen Institute blog, September 8, 2020, <https://www.aspeninstitute.org/blog-posts/what-the-pandemic-has-revealed-about-the-role-of-schools/>.
- ³ “Lessons from the Field - Strategies for Preventing Substance Use within Multi-tiered System of Supports during the COVID-19 Pandemic,” National Center on Safe and Supportive Learning Environments, October 27, 2021, <https://safesupportivelearning.ed.gov/events/webinar/lessons-field-strategies-preventing-substance-use-within-multi-tiered-system>; Christine Vestal, “COVID Harmed Kids’ Mental Health—and Schools Are Feeling It.,” *Stateline* (blog), Pew Charitable Trusts, November 8, 2021, <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2021/11/08/covid-harmed-kids-mental-health-and-schools-are-feeling-it>.
- ⁴ National Institutes of Health, “Percentage of Adolescents Reporting Drug Use Decreased Significantly in 2021 as the COVID-19 Pandemic Endured,” news release, December 15, 2021, <https://www.nih.gov/news-events/news-releases/percentage-adolescents-reporting-drug-use-decreased-significantly-2021-covid-19-pandemic-endured>.
- ⁵ Not all children and youth are connected to schools for various reasons, including children who are homeschooled, youth who are runaways and experiencing homelessness, incarcerated youth, youth in residential treatment programs or alternative educational settings, and youth who may have sporadic connections to school systems, such as children in foster care, children of migrant farmworkers, and children in families who experience homelessness.
- ⁶ “About School-Based Health Care,” School-Based Health Alliance, accessed June 27, 2022, <https://www.sbh4all.org/what-we-do/school-based-health-care/aboutsbhcs/>.
- ⁷ “Health Insurance Coverage of Children 0-18, Timeframe: 2019,” Kaiser Family Foundation, accessed June 27, 2022, <https://www.kff.org/other/state-indicator/children-0-18/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.
- ⁸ Elinore McCance-Katz (assistant secretary for mental health and substance use) and Calder Lynch (acting deputy administrator and director, Center for Medicaid and CHIP Services), joint informational bulletin regarding “Guidance to States and School Systems on Addressing Mental Health and Substance Use Issues in Schools,” July 1, 2019, <https://store.samhsa.gov/sites/default/files/d7/priv/pep19-school-guide.pdf>; Vikki Wachino (acting director, Center for Medicaid and CHIP Services) and Pamela S. Hyde (administrator, Substance Abuse and Mental Health Services Administration), joint informational bulletin regarding “Coverage of Behavioral Health Services for Youth with Substance Use Disorders,” January 26, 2015, <https://www.medicare.gov/federal-policy-guidance/downloads/cib-01-26-2015.pdf>.
- ⁹ Cindy Mann (director, Centers for Medicare & Medicaid Services), letter to state Medicaid directors regarding “Medicaid Payment for Services Provided without Charge (Free Care),” December 15, 2014, <https://www.medicare.gov/federal-policy-guidance/downloads/smd-medicare-payment-for-services-provided-without-charge-free-care.pdf>; “State Efforts to Expand School Medicaid through the Free Care Policy Reversal,” Healthy Schools Campaign, last updated May 2022, <https://docs.google.com/document/d/1uOj1so-se8ohyl7AcHaaXIGX5l3s0PN2culDejXZQw/edit>.
- ¹⁰ AASA (School Superintendents Association); Healthy Schools Campaign; AIDS Alliance for Women, Infants, Children, Youth & Families; American Academy of Pediatrics; American Association for Marriage and Family Therapy; American Association for Psychoanalysis in Clinical Social Work; American Association of Suicidology; et al., letter to Centers for Medicare & Medicaid Services on updating school-based Medicaid guidance, February 16, 2021, <https://adaa.org/sites/default/files/Letter%20to%20CMS%20on%20Updating%20School%20Based%20Medicaid%20Guidance.pdf>.
- ¹¹ “About the CoP,” DC School Behavioral Health Community of Practice, accessed June 27, 2022, <http://cop.aehinst.org/about-the-cop>.

- ¹² “School Behavioral Health Program,” DC Department of Behavioral Health, accessed June 27, 2022, <https://dbh.dc.gov/service/school-behavioral-health-program>.
- ¹³ Peggy Sands, “Council Passes 2023 Budget; Awaits Mayor’s Signature,” *The Georgetown*, May 30, 2022, <https://georgetown.com/articles/2022/05/30/council-passes-2023-budget-awaits-mayors-signature/>.
- ¹⁴ “SBIRT in Schools,” MASBIRT TTA, accessed June 27, 2022, <https://www.masbirt.org/schools>; “Massachusetts State Plan Amendment 16-012,” Medicaid.gov, accessed June 27, 2022, <https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MA/MA-16-012.pdf>.
- ¹⁵ “SBIRT in Schools,” MASBIRT TTA; “Massachusetts State Plan Amendment 16-012,” Medicaid.gov.
- ¹⁶ “SBIRT in Schools,” MASBIRT TTA; “Massachusetts State Plan Amendment 16-012,” Medicaid.gov.
- ¹⁷ “Massachusetts State Plan Amendment 16-012,” Medicaid.gov.
- ¹⁸ “About the Office of School and Adolescent Health,” New Mexico Department of Health, accessed June 27, 2022, <https://trainmeosah.com/about-the-nmdoh-osah/>.
- ¹⁹ “New Mexico SBHC Definition,” New Mexico Alliance for School-Based Health Care, accessed June 27, 2022, <https://www.nmasbhc.org/school-based-health-centers/new-mexico-definition/>.
- ²⁰ For more about Project Amp, see <https://www.projectamp4youth.com/>.
- ²¹ “Massachusetts State Plan Amendment 16-012,” Medicaid.gov.
- ²² “Organization of U.S. Education,” US Department of Education, accessed June 27, 2022, <https://www2.ed.gov/about/offices/list/ous/international/usnei/us/edlite-org-us.html>.
- ²³ See the MASBIRT TTA [website](#).
- ²⁴ See the iDECIDE [website](#) for more information.
- ²⁵ Recovery high schools are secondary schools designed for students in recovery from substance use disorders and co-occurring conditions. In addition to academic support, students receive support from substance use counselors and mental health professionals. Recovery schools also provide support for families learning how to live with and provide support for their teenagers in recovery. For more information about recovery high schools, see <https://recoveryschools.org/>.
- ²⁶ *American Rescue Plan Act of 2021*, Pub. L. 117-2 (2021); White House, “FACT SHEET: Improving Access and Care for Youth Mental Health and Substance Use Conditions,” news release, October 19, 2021, <https://www.whitehouse.gov/briefing-room/statements-releases/2021/10/19/fact-sheet-improving-access-and-care-for-youth-mental-health-and-substance-use-conditions/>.
- ²⁷ AASA et al., letter to Centers for Medicare & Medicaid Services on updating school-based Medicaid guidance.
- ²⁸ Ken Zimmerman, “Mental Health Needs to Be a Top Priority for Philanthropy. Here’s Why,” *Inside Philanthropy*, June 29, 2020, <https://www.insidephilanthropy.com/home/2020/6/28/more-than-ever-mental-health-needs-to-a-top-priority-for-philanthropy-heres-why>.

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Acknowledgments

This brief was funded by the Foundation for Opioid Response Efforts. We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute’s funding principles is available at urban.org/fundingprinciples.

We are also grateful to the state informants who participated in our interviews and shared their experiences, knowledge, and ideas. We would like to thank Laudan Aron, Alexa Eggleston, and Kimá Joy Taylor for their thoughtful input and review. In addition, we extend our thanks to Casley Matthews for her assistance preparing this brief.



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