

BHC Behavioral Health Commission

Substance use services and supports in Virginia schools

2026

Commission draft

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Behavioral Health Commission

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Staff for this report:
John Barfield, Associate Policy Analyst

Purpose

The Commission is established in the legislative branch of state government for the purpose of studying and making recommendations for the improvement of behavioral health services and the behavioral health service system in the Commonwealth to encourage the adoption of policies to increase the quality and availability of and ensure access to the full continuum of high-quality, effective, and efficient behavioral health services for all persons in the Commonwealth. In carrying out its purpose, the Commission shall provide ongoing oversight of behavioral health services and the behavioral health service system in the Commonwealth, including monitoring and evaluation of established programs, services, and delivery and payment structures and implementation of new services and initiatives in the Commonwealth and development of recommendations for improving such programs, services, structures, and implementation.

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1 Background

Members of the Behavioral Health Commission (BHC) directed staff to evaluate the availability, scope, and effectiveness of substance use supports and services in Virginia public schools as part of the Commission's 2026 workplan. Virginia schools are required by state law to provide instruction on drug and substance use, but local school divisions otherwise retain broad autonomy over how to implement this requirement, and whether to offer anything beyond the required instruction. Local schools and school divisions are not required to report on the strategies they use to prevent or address substance use, and limited information is currently available about the breadth of their efforts, their quality, or their ability to reach all students who need them.

BHC staff used a variety of research methods to examine school-based substance use supports and services, including interviews with school, division, and state agency personnel; site visits to six public schools; a statewide survey of all public school counselors; analyses of administrative data; and a review of relevant statutes and regulations (Appendix A).

Substance use supports and services in schools are shaped by state requirements and local implementation

Public education in Virginia operates under a state-supervised, locally administered framework that balances state-mandated baseline standards with local operational autonomy. While state laws and regulations set foundational expectations for health instruction, staff professional development, and support personnel, local school boards retain broad discretion over curriculum selection, instructional delivery, and resource allocation. Consequently, the scope, depth, and evidence-based quality of school-based substance use supports and services vary significantly across the Commonwealth's 131 school divisions, depending on local administrative choices and fiscal capacity.

State standards establish broad requirements

Virginia establishes baseline expectations for school-based substance use supports and services through two primary state-level mechanisms: regulations promulgated by the Board of Education and instructional standards developed by the Department of Education. Regulations set broad operational expectations for local school divisions across several core areas. Additionally, the Virginia Department of Education (VDOE) defines student learning expectations from kindergarten through grade 10 through the Health Education Standards of Learning (SOL). Together, these state regulatory and curricular frameworks establish the mandatory baseline for substance use prevention across Virginia public schools while leaving local divisions operational discretion over how requirements are fulfilled in practice.

Board of Education sets regulatory standards

Pursuant to statutory authority in § 22.1-206 of the Code of Virginia, which directs that instruction concerning drugs and drug abuse must be provided by public schools as

prescribed by the Board of Education, the Board is responsible for establishing regulatory requirements for local school divisions. To operationalize this statutory mandate, the Board promulgated administrative regulations under 8VAC20-720-200, which establish the baseline standards for drug and substance misuse programs across the Commonwealth.

Under this standard, public schools are required to facilitate substance misuse education, staff professional development, community partnerships, and student support services. Specifically, state regulations mandate that public schools:

- **Integrate practical health instruction:** Develop and integrate a practical, impactful substance misuse prevention and education program throughout health education instruction.
- **Provide staff professional development:** Implement professional development on substance misuse prevention for all staff members.
- **Collaborate with community organizations:** Partner with authorized governmental and private organizations dedicated to student health and substance misuse prevention.
- **Foster peer-led initiatives:** Foster and support student-led initiatives and groups that promote positive peer influence in substance misuse prevention.
- **Maintain a supportive climate:** Create a positive school climate whereby students may seek and receive counseling about substance abuse and related problems.

The administrative code establishes broad expectations across these five operational areas, rather than specifying mandatory instructional hours, specific pre-approved curricula, or standardized compliance monitoring tools. Local school divisions retain broad operational discretion over how each of the state's five regulatory standards is fulfilled in practice.

Department of Education sets standards for Health SOLs

VDOE establishes learning expectations for public school students through the Health Education SOLs, covering a continuum of health instruction from kindergarten through grade 10. Within the Health SOL standards, substance use and misuse prevention is integrated as a dedicated topic area that progresses in complexity as students mature. Instruction across all grade levels is organized around three essential content strands:

- **Essential Health Concepts:** Establishes foundational knowledge regarding safe medicine use in early grades, advancing in secondary grades to the physiological, neurological, and behavioral impacts of alcohol, nicotine vaping products, marijuana, inhalants, prescription drugs, and opioids.
- **Healthy Decisions:** Focuses on evaluating health risks, analyzing social and media influences, correcting peer-use misconceptions (establishing positive drug-free social norms), and evaluating the consequences of substance misuse.
- **Advocacy and Health Promotion:** Emphasizes skill application, including age-appropriate verbal and nonverbal refusal techniques, identifying trusted adults, accessing support resources, such as local Community Services Boards (CSBs), and advocating for drug-free school and community environments.

To guide classroom delivery, the Board adopted the Health Education Standards of Learning Curriculum Framework, which delineates the minimum essential knowledge, skills, and understandings required for each grade level. The framework provides instructional guidance for educators while allowing local school divisions flexibility to incorporate these standards into broader locally developed curricula.

Because Health is not a standardized subject evaluated through statewide SOL testing, the state collects no empirical performance or assessment data to measure student comprehension or verify instructional fidelity across local divisions. State oversight is limited to annual self-certification through the Standards of Quality (SOQs) Compliance Data Collection, through which division superintendents confirm general health instruction without detailing the scope or quality of local substance prevention programs.

Localities retain significant control over implementation

Article VIII, Section 7 of the Constitution of Virginia and Title 22.1 of the Code of Virginia (§§ 22.1-71 and 22.1-79) vest the supervision of public schools directly in local school boards. While the General Assembly and the Board of Education establish state minimums, local school boards and division superintendents retain broad authority over daily operations, instructional delivery, and local resource allocation.

In the context of substance use supports and services, local school divisions exercise substantial autonomy over program design and staffing. State regulations require health instruction and encourage community partnerships, but local school boards decide whether to rely solely on basic Health SOL modules, purchase commercial evidence-based prevention programs, or collaborate with local CSBs and law enforcement. Similarly, it is up to the discretion of local school boards whether to hire dedicated, specialized positions, such as Certified Substance Abuse Counselors, to support the needs of students who may need early intervention services. Local school boards direct these choices through their annual operating budget processes (§ 22.1-88 et seq.), deciding how to prioritize local revenues to meet community needs.

Substance use supports and services in schools are funded by multiple sources

School divisions rely on a combination of state formula aid, local tax revenues, dedicated non-tax settlement funds, and targeted state agency grants to support substance use supports and services. State aid under the SOQ funding formula supports baseline generalist personnel, while local governments fund specialized personnel and expanded programming through local tax revenue. To supplement these educational funds, school divisions and community partners leverage dedicated non-taxpayer funding streams, including the Virginia Foundation for Healthy Youth (VFHY) and statewide opioid settlement distributions, to deliver targeted prevention grants, public health campaigns, and specialized recovery initiatives.

Standards of Quality fund generalists who can assist with school-based substance use efforts

Article VIII, Section 2 of the Constitution of Virginia and Chapter 13.2 (§ 22.1-253.13:1 et seq.) of the Code of Virginia establishes the SOQs. These standards define the constitutionally mandated minimum educational goals, staffing requirements, and operational standards that every public-school division must meet. The SOQ framework functions primarily as a staffing-based funding formula. It calculates a school division's total financial obligation by multiplying student enrollment by statutory staffing ratios, applying state compensation assumptions, and apportioning total costs between the Commonwealth and local governments based on local ability to pay.

The SOQs set baseline state funding requirements for generalist support positions that are often involved in delivering substance use services and supports. Statutory ratios mandate at least one full-time equivalent school counselor per 325 students and three specialized student support positions, such as school social workers, school psychologists, and school nurses, per 1,000 students. The SOQ funding formula does not provide state aid for any specialized support positions that might be needed to deliver substance use education or services, such as Certified Substance Abuse Counselors. Consequently, local governments are responsible for 100 percent of the costs for additional generalist positions needed to provide expanded prevention programming, or for specialized substance use personnel.

Virginia Foundation for Healthy Youth delivers youth prevention initiatives using dedicated settlement funds and targeted state transfers

The Virginia General Assembly established the Virginia Foundation for Healthy Youth (VFHY) in 1999 as a state entity responsible for youth health initiatives. VFHY focuses on preventing and reducing youth tobacco and nicotine use, substance use, and childhood obesity. To execute its statutory mission, VFHY administers a prevention framework across four primary functional areas: (1) classroom-based prevention programs, (2) statewide public health communication campaigns, (3) teen leadership initiatives, and (4) university research grants. VFHY allocates grant funding to local school divisions, CSBs, and non-profit organizations to deliver evidence-based classroom curricula, such as CATCH My Breath, Too Good for Drugs, and Botvin LifeSkills Training. Additionally, VFHY manages public health marketing campaigns targeting youth, including vaping prevention, cannabis awareness, and fentanyl prevention, while funding university research projects to examine youth substance trends, vaping chemistry, and policy interventions.

Core operations for VFHY do not rely on state general tax revenues. Instead, state law allocates a statutory 8.5 percent share of Virginia’s annual Tobacco Master Settlement Agreement (MSA) payments to the Virginia Tobacco Settlement Fund to support VFHY programs. In FY 2025, MSA allocations provided $9.9 million toward VFHY's $15.3 million in total revenue. While VFHY's primary funding consists of non-taxpayer settlement dollars, the agency also receives additional funding through grants, reimbursables, and other revenues, including inter-agency fund transfers. Inter-agency fund transfers include $1.0 million annually from the Electronic Nicotine Delivery Systems Fund for youth vaping campaigns, $500,000 annually from the Commonwealth Opioid Abatement and Remediation Fund for

fentanyl awareness, and $900,000 annually in general funds transferred through the Department of Behavioral Health and Developmental Services for a statewide underage cannabis prevention campaign.

Opioid abatement funds may be used to support substance use supports and services

National settlement agreements with opioid manufacturers, distributors, and retail pharmacies created a major dedicated funding stream for substance use prevention, treatment, and recovery across the Commonwealth. State law and court orders allow direct settlement payments only to political subdivisions, specifically cities, counties, and state agencies. However, these entities may partner with public school divisions to fund local substance use supports and services. Localities and state agencies use inter-agency partnerships and pass-through grants to direct these funds into school settings. Across Virginia, opioid abatement dollars support dedicated school-based prevention specialists, regional recovery high schools, evidence-based youth prevention curricula, and emergency overdose reversal supplies in public schools.

Opioid funds are near their highest levels, but will decline through 2041

Virginia will receive an estimated $1.1 billion to $1.2 billion in total opioid settlement payments through 2041 under a 20-year payment schedule. Initial annual settlement revenues were heavily front-loaded following major settlements and bankruptcy resolutions involving wholesale distributors and pharmaceutical manufacturers. As a result, the Commonwealth is currently at or near its peak level of annual settlement payouts. Annual settlement payments will steadily taper over the coming years until payments terminate in 2041. In FY 2025, the Virginia Opioid Abatement Authority (OAA) awarded a total of $46.7 million in new funding, including $32.7 million in grants to 81 cities and counties and $14 million to 18 state agencies. Approximately $3 million went to school-based initiatives across 14 school divisions.

Declining settlement revenues require the OAA and local government awardees to manage grant distributions carefully to avoid fiscal cliffs as funding scales down. To maintain long-term program sustainability, the OAA requires grant applicants to demonstrate how funded positions and initiatives, such as school-based counselors or youth prevention programs, will transition to alternative revenue sources over time. As new settlement awards decrease, the OAA is shifting its primary focus from awarding initial grants toward compliance monitoring, outcome evaluation, and multi-year award management.

Opioid funding may be used to support substance use supports and services through one of three mechanisms

State law (§ 2.2-2300 et seq. and § 2.2-2374) and a statewide Allocation Memorandum of Understanding signed by all 133 cities and counties govern the distribution of incoming opioid settlement revenues. These agreements divide all settlement disbursements across three mandatory distribution mechanisms:

- **Direct Local Share (30 percent):** The settlement administrator distributes 30 percent of settlement funds directly to Virginia's 133 cities and counties. Calculations rely on a harm-based formula measuring relative local impact. Cities and counties may transfer direct local allocations to school divisions to support substance use services and supports, such as hiring dedicated substance abuse prevention specialists or purchasing student wellness programming.
- **Opioid Abatement Authority Share (55 percent):** The Opioid Abatement Fund receives 55 percent of settlement revenues. OAA distributes competitive and formula grants to cities, counties, regional partnerships, and state agencies. Although school divisions cannot apply directly for OAA grants, local governments and state agencies may act as fiscal agents to pass grant awards through to public schools.
- **Commonwealth Share / COAR Fund (15 percent):** The Commonwealth receives 15 percent of settlement receipts, deposited into the statutory Commonwealth Opioid Abatement and Remediation (COAR) Fund (§ 2.2-2377). The General Assembly appropriates COAR funds directly through the state budget for agency-led abatement priorities. In school settings, COAR appropriations fund targeted state agency initiatives, including Virginia Department of Health purchases of opioid reversal agents (naloxone) for public schools, VFHY fentanyl awareness campaigns, and the statewide Substance Use Data Analytics platform.

Adolescent substance use has direct and long-term negative effects on individuals, schools, and the state

Social and environmental factors, including peer influence, academic stress, and childhood trauma, further accelerate the transition from initial exposure to use. Research shows that an individual who reaches age 21 without smoking, abusing alcohol, or using drugs is highly likely never to do so, making delayed onset the cornerstone of reducing lifelong addiction rates.

Adolescent substance use can disrupt classroom milieu and burden school administrators and staff

Student substance use can degrade classroom climates and interrupt core instruction. Adolescent substance use increases behavioral disruptions, truancy, and academic disengagement by shifting student focus away from educational goals toward immediate rewards according to the research literature. School staff interviewed for this study indicated that teachers sometimes must manage active in-class vaping, student impairment, and behavioral outbursts, which detracts from core academic instruction and creates safety concerns for non-using peers.

Investigating infractions and managing student crises impose operational strain on school personnel. Addressing substance-related incidents requires administrators and frontline staff to dedicate time to disciplinary and investigative protocols such as monitoring restrooms, responding to vape detectors, conducting searches, and maintaining chain-of-custody evidence. Administrators interviewed for this study noted that investigating

substance infractions can easily become a daily task. School administrators, counselors, nurses, and support personnel may also experience burnout as they balance routine administrative duties with continuous crisis triage, mental health screenings, and external care coordination.

Nationally, untreated adolescent substance use creates recurring costs for public education systems. Substance-linked expenditures, including specialized educational supports, property damage, heightened security, legal fees, and lost staff productivity, consume a notable share of public education budgets.

Adolescent substance use can have serious long-term negative consequences for the adolescent

Substance use during adolescence impairs brain development and increases lifetime health and mortality risks. Adolescent substance exposure alters neural pathways and brain structures, causing long-lasting deficits in memory, attention, executive functioning, and decision-making, according to clinical and epidemiological research literature.

Early initiation has been shown to significantly increase lifetime addiction risk; over 90 percent of adults living with a substance use disorder (SUD) initiated use during adolescence, and individuals who begin using substances before age 18 are six times more likely to develop an SUD than those who delay until age 21. Adolescents experience heightened neurobiological vulnerability to SUDs compared to adults. During this developmental period, adolescents undergo rapid brain development that creates a functional gap between emotional reward centers and decision-making regions. Brain regions that process dopamine and pleasure mature early in youth, whereas the prefrontal cortex, which governs impulse control, judgment, and long-term planning, continues developing through early adulthood. A higher density of dopamine receptors makes the adolescent brain uniquely sensitive to rewarding stimuli. Adolescent exposure to addictive substances alters neural reward circuits more rapidly and intensely than in adults, accelerating the development of tolerance, cravings, and physiological dependence after brief periods of experimentation.

Beyond the risk of long-term addiction, substance use has been found to elevate the risk of severe physical health conditions, including cardiovascular disease, impaired lung development, hypertension, and cancer, as well as mental health conditions such as depression, anxiety, and psychosis. Furthermore, substance use contributes directly to the three leading causes of adolescent mortality: unintentional injuries, suicide, and homicide.

Adolescent substance use disrupts educational attainment, economic mobility, and social stability. Substance experimentation in high school strongly correlates with truancy, lower academic performance, disciplinary actions, and high school dropout. These academic setbacks create lasting economic consequences in adulthood, resulting in lower college completion rates, reduced workforce participation, higher unemployment, and decreased lifetime earning potential. Adolescent substance use increases likelihood of involvement with the criminal justice system, higher rates of risky health behaviors, and long-term relationship instability.

Substance use disorders drive public expenditure across healthcare, social services, and criminal justice

Substance use disorders overwhelmingly originate during adolescence, generate recurring public expenditures across healthcare, justice, and social service systems. An SUD is a pattern of substance use that causes damage to physical or mental health or leads to clinically significant functional impairment or distress, according to the U.S. National Institute on Drug Abuse. Healthcare consistently represents the single largest area of public financial burden, with state and federal programs such as Medicaid absorbing significant costs to treat acute overdoses, poisonings, physical injuries, chronic illnesses, and co-occurring mental health conditions, according to the research literature. The criminal and juvenile justice systems also bear a share of the substance use-related costs to state and local governments. About 80 percent of arrested adults and juvenile offenders are substance-involved, according to the National Center on Addiction and Substance Abuse. Consequently, substance use is a driver of public expenditures across law enforcement, judicial adjudication, local detention, state correctional facilities, and community supervision. SUDs also increase public outlays for social services, including child welfare investigations, foster care placements, housing assistance, and income support programs.

Nationally, public spending remains concentrated on reactive crisis response rather than primary prevention. Most public substance-related dollars support reactive responses to acute health crises, criminal justice involvement, and social safety net interventions, while fewer resources go towards proactive prevention and early intervention. Economic evaluations consistently demonstrate that investing in universal adolescent prevention yields high long-term returns by reducing substance use initiation before it creates lifelong financial obligations for state and local governments.

Proactive investment in effective school-based substance use services can mitigate negative consequences

Proactive investments in school-based substance use supports and services can interrupt the trajectory of addiction before it takes hold and leads to negative personal and community impacts, including costly healthcare, criminal justice, and social welfare expenditures. Because adolescents who experiment with substances earlier in life are at greater risk of developing an SUD later in life, compared to those who delay use until adulthood, primary prevention and delayed initiation remain essential public health strategies. Although public substance-related spending has historically focused on reacting to the consequences of untreated addiction, economic evaluations demonstrate that shifting resources toward proactive, school-based frameworks yields high returns on investment and significant societal cost-offsets for state and local governments.

Universal education and prevention

Universal education and prevention curricula delivered in middle and high schools demonstrate strong cost-effectiveness and positive cost-benefit. Overall, multi-component universal curricula consistently generate nearly a 10:1 return on investment by avoiding future public burden costs. For example, cost-benefit analyses show that universal

Cooperative Learning in middle schools yields lifetime cost savings between $8.79 and $39.54 for every dollar invested by preventing regular use of alcohol, tobacco, and cannabis. Similarly, Social and Emotional Training delivers $13.90 in societal benefits per dollar spent, while Project ALERT demonstrates high cost-utility over a lifetime time horizon.

Early intervention

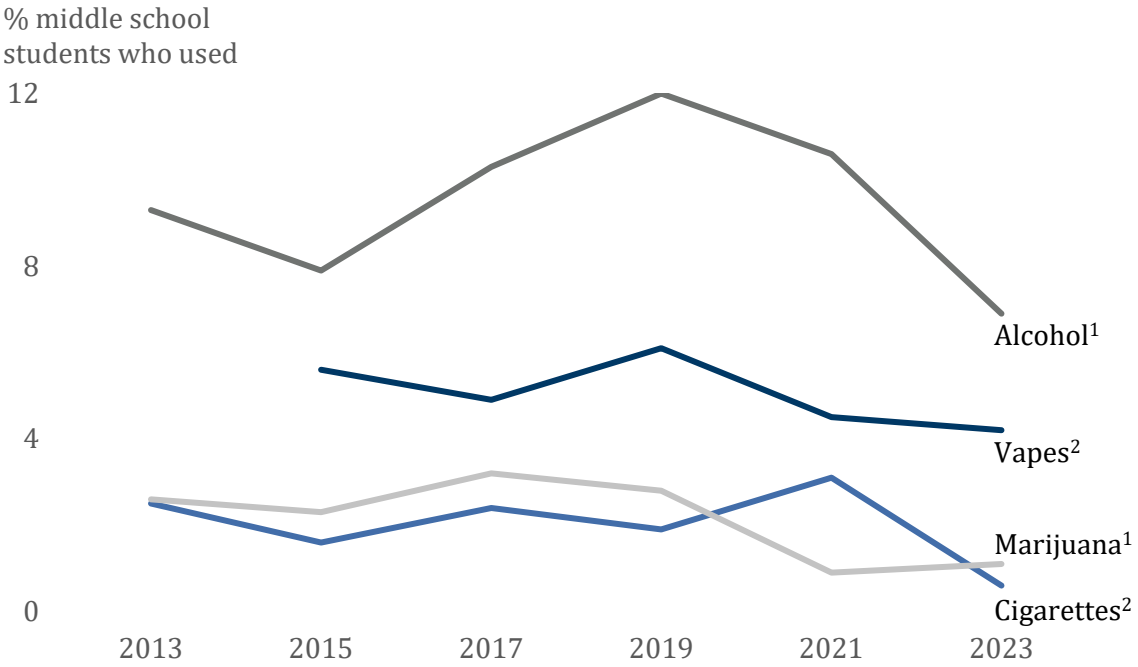
Early intervention services, including Screening, Brief Intervention, and Referral to Treatment (SBIRT), adolescent counseling, and specialized diversion programs, generate direct taxpayer savings by identifying at-risk youth before clinical disorders fully develop. School- and health-based SBIRT protocols reduce emergency department visits by up to 20 percent and hospitalizations by up to 37 percent, directly lowering Medicaid and public safety-net expenditures, according to research conducted by the National Center on Addiction and Substance Abuse. Targeted early intervention frameworks like Juvenile Drug Courts yield net economic benefits ranging from $82,249 to $133,472 per participant, primarily by reducing criminal justice system involvement, lowering healthcare utilization, and preventing academic absenteeism.

Youth substance use is in long-term decline, but absolute consumption levels and potency are concerning

There has been an overall long-term decline in adolescent substance use, according to data from the Youth Risk Behavior Survey (YRBS), a biennial national survey that monitors youth behaviors. This is true among both middle school and high school students. Still, tens of thousands of Virginia students are currently engaging in substance use, and they face increasingly potent and addictive products.

Indicators of substance use among Virginia's middle schoolers were generally at the lowest point in a decade as of 2023, the most recent year for which data is available for this age group (Figure 1-1). Less than one percent (0.6 percent) of surveyed middle school students were current cigarette users, a 75 percent decline relative to 2013. Current use of electronic vaping products has also declined over the past decade, but to a lesser degree: about 4.2 percent of middle school students reported vaping in 2023, down from a high of 6.1 percent in 2019. No data exists on the current use of alcohol and marijuana among middle school students, but rates of early experimentation (first use before age 11) were at their lowest point in 2023 for alcohol, and near-lowest for marijuana, which increased slightly between 2021 and 2023. Comparing Virginia's middle schoolers to all students nationwide is not possible because most states do not participate in YRBS for middle schools. However, Virginia consistently ranked better than the average across substance use indicators for alcohol, vapes, marijuana, and cigarettes compared to states whose middle schools participated in YRBS in 2023.

Figure 1-1
Substance use and early experimentation among Virginia middle schoolers was generally at lowest rate in 10 years as of 2023



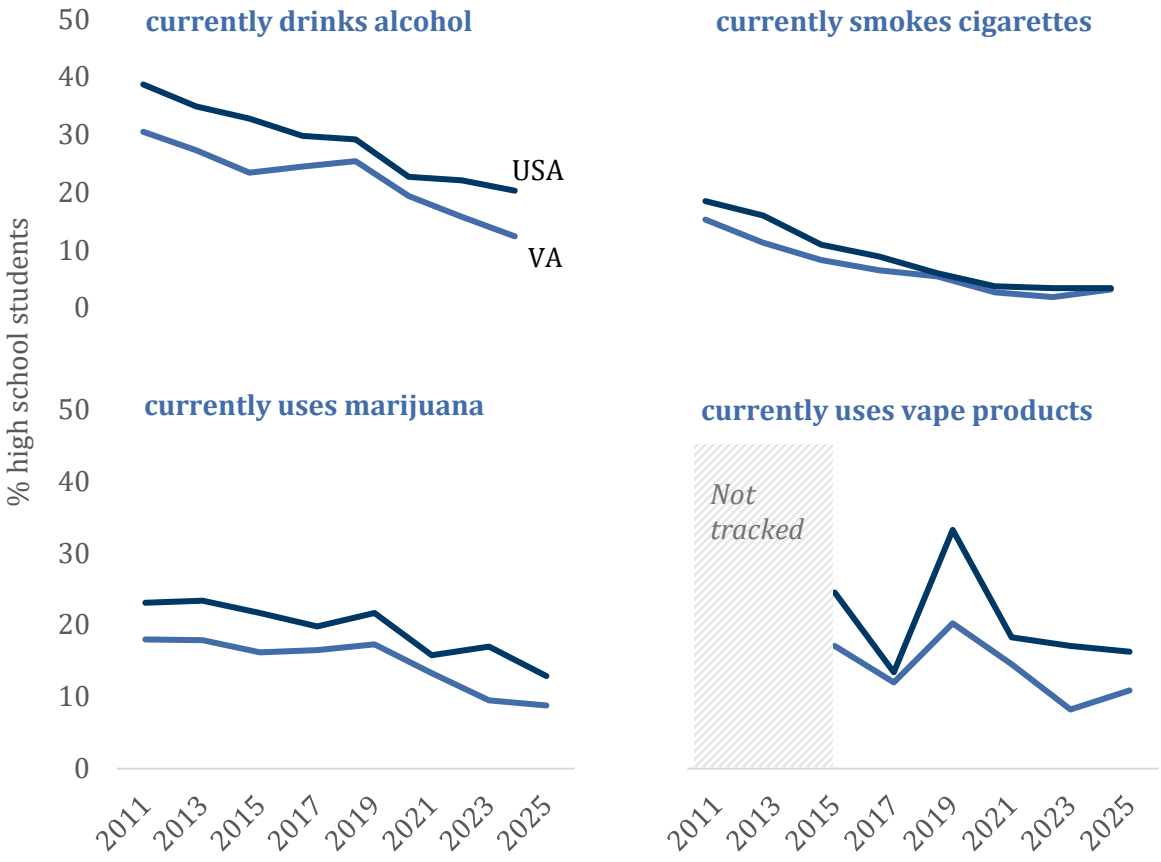
[1]Use before age 11; [2]Current use
Source: BHC staff analysis of data from the Youth Risk Behavior Survey, U.S. Centers for Disease Control and Prevention (2013-2023)

Virginia high school students also reported lower rates of current use across alcohol, cigarettes, electronic vapor products, and marijuana over time (Figure 1-2). This pattern mirrors a national downward trend, and current use among Virginia high schoolers has generally remained lower than the national average. About 12.4 percent of high school students in Virginia reported being current alcohol drinkers, and 8.8 percent indicated being current marijuana users in 2025. The current use of cigarettes was the lowest among all substances reported, at 3.3 percent in 2025.

Another notable trend is the rise of adolescent electronic vapor (vape) products (Figure 1-3). As adolescent cigarette use has steadily declined, vape products have grown in popularity among youth. By 2014, electronic vapor product use had surpassed conventional combustible cigarette smoking for the first time, prompting the Center for Disease Control to add questions about vaping to its biennial survey starting in 2015. Although vaping among Virginia's high schoolers is down from its peak of 20 percent in 2019, use remains high, with reported use at 10.7 percent in 2025, which represents a 2.6 percentage point increase from the 2023 survey. By comparison, national adolescent vape use dropped slightly from 2023 to 2025. Data on the use of other illicit drugs among adolescents, excluding marijuana, is not available in the YRBS. However, according to the National Survey on Drug Use and Health, the

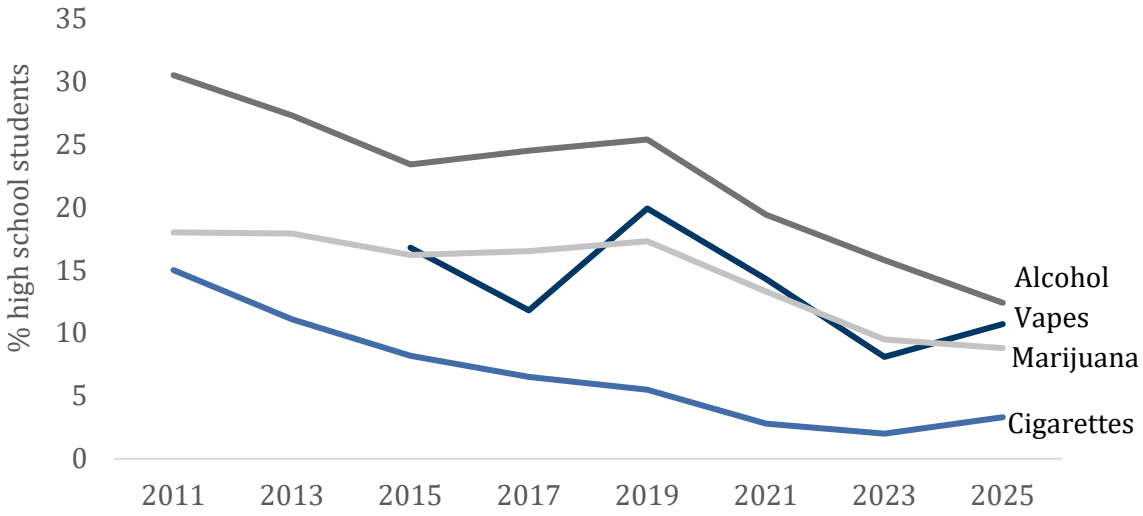
rate among Virginia youth aged 12–17 closely matched the national rate, with both standing at 1.6 percent.

Figure 1-2
Virginia high schoolers follow overall downward trend in adolescent substance use, and are generally below national average



Source: BHC staff analysis of data from the Youth Risk Behavior Survey, U.S. Centers for Disease Control and Prevention (2011-2025)

Figure 1-3
Vaping has become the second most commonly used substance among Virginia high school students, after alcohol



Source: BHC staff analysis of data from the Youth Risk Behavior Survey, U.S. Centers for Disease Control and Prevention (2011-2025)

Tens of thousands of adolescents report using alcohol, marijuana, vapes, or tobacco

Virginia adolescent use of alcohol, nicotine, and marijuana has reached historic lows in recent years, and youth overdose fatalities have declined since their peak during the 2021–2022 academic year according to Virginia Department of Health data. Despite these overall declines, absolute consumption levels remain substantial across adolescents in Virginia. An estimated 67,900 secondary school students were current users of alcohol; 53,800 used electronic vapor products; 37,400 used marijuana; and 16,000 smoked cigarettes, based on the current use rates reported in the most recent YRBS.

Potency of available substances has increased over time

Young people who engage in substance use face increasingly potent formulations that escalate risks of daily consumption, addiction, and severe health harms. During the height of the opioid epidemic, a sharp increase in adolescent overdose fatalities occurred during a period when overall youth drug use was in decline and was driven primarily by the extreme toxicity of counterfeit pills and synthetic fentanyl. In nicotine vaping, the market has shifted toward smooth, high-concentration nicotine, which reduces inhalation harshness while delivering higher nicotine levels and accelerates a transition from casual experimentation to daily or frequent use among young users. Similarly, the proliferation of high-potency cannabis is strongly linked to higher rates of frequent use, cannabis dependence, and anxiety disorders compared to lower-potency strains. Across the United States, the concentration of tetrahydrocannabinol (THC), the primary psychoactive compound found in cannabis, rose

from approximately 4 percent in 1995 to 12 percent in 2014. Higher psychoactive potency is linked to increased severity of cannabis use disorder, higher risk of psychotic disorders, and increased rates of emergency department visits.

Electronic vapor products represent the primary substance use challenge in schools

Adolescent vaping can cause significant physical, neurological, and behavioral harms and is associated with greater likelihood of future tobacco, marijuana, and alcohol use. Compounding these health risks, lax retail age verification and discreet device designs—frequently disguised as everyday items—facilitate pervasive use on school grounds, placing a heavy operational and disciplinary strain on educators. In response, Virginia's 2026 Vape Enforcement Act established a dual-agency framework dividing oversight between the Virginia Alcoholic Beverage Control Authority (ABC) and the Office of the Attorney General (OAG) to restrict youth access and purge unauthorized products from the market.

Electronic vapor products can cause physical and behavioral health problems in adolescents

Adolescent e-cigarette use can cause significant physical and respiratory health complications. Vaping significantly increases the risk of an asthma diagnosis and attacks. Aerosol inhalation also causes persistent coughing, wheezing, bronchitis, and acute lung injuries like E-cigarette or Vaping Use-Associated Lung Injury (EVALI). On average, nearly one-quarter of EVALI medical claims in Virginia occurred among youth aged 20 or younger from 2020 to 2024. Inhaling e-cigarette aerosol exposes adolescents to toxic chemicals and heavy metals, including lead, nickel, chromium, arsenic, and antimony. These chemical exposures elevate cancer risks, disrupt hormones, and cause long-lasting structural changes to the developing brain. Vaping can also cause cardiovascular strain, including elevated blood pressure and blood vessel damage. E-cigarette use also leads to gum disease, tooth decay, and severe dry mouth. Finally, vaping is linked to the onset of seizures and poses risks of physical burn injuries from exploding device batteries.

High nicotine exposure poses substantial risks to the developing adolescent brain. Many standard vape products contain the nicotine equivalent of a pack of cigarettes, with some larger models significantly exceeding that. Modern vapes are also designed to reduce inhalation harshness compared to cigarettes, making long vaping sessions less physically harsh. Nicotine exposure disrupts normal neural pathways and impairs concentration, impulse control, attention, learning, and memory. Nicotine addiction also exacerbates psychological struggles among youth. Specifically, vaping substantially increases the risk of insufficient sleep and elevates the likelihood of an adolescent depression diagnosis. Nicotine use is associated with higher rates of anxiety, stress, attention deficit/hyperactivity disorder (ADHD), eating disorders, and suicidal ideation. Additionally, adolescent vaping serves as a primary driver of broader substance use patterns. Teenagers who vape are three times more likely to transition to conventional tobacco smoking. Vaping youth also face substantially higher odds of subsequent marijuana use, alcohol use, binge drinking, and non-prescribed stimulant use.

Ease of access and concealability disrupt instructional time and strain school administrative resources

Virginia schools prohibit students from possessing vapor products on school property. However, widespread commercial access and easy-to-hide product designs make school-level vaping prevention exceptionally difficult. Students readily obtain nicotine and THC devices through local gas stations, smoke shops, and online retailers with lax age verification, as well as through discreet home deliveries or family members. Furthermore, manufacturers intentionally disguise vaping devices as everyday items, including writing pens, hoodie drawstrings, game controllers, and flash drives, enabling undetected use on school grounds.

This high concealability directly disrupts classroom instruction and impairs the broader school climate. Students routinely vape inside classrooms or excuse themselves to restrooms, which personnel report have become focal points for vaping, drug transactions, and fights over stolen devices. To maintain safety, staff are forced to divert attention from instruction to monitor hallways, inspect restrooms, and track high-risk students throughout the day.

Managing these infractions creates a heavy operational and administrative burden for school personnel. Administrators, staff, and school resource officers spend substantial bandwidth responding to vape detector alerts, conducting searches, contacting parents, facilitating multi-day diversion programs, and managing chain-of-custody handoffs—the formal, documented transfer of confiscated vapes, THC cartridges, or unknown substances from seizing staff directly to law enforcement. School leaders report that vape enforcement requires near-constant attention, consuming significant staff capacity and diverting critical resources away from core educational priorities.

2026 legislation created new regulatory framework for enforcing retail tobacco products

Virginia's 2026 Vape Enforcement Act modernized state oversight by closing statutory loopholes and establishing a coordinated, dual-agency regulatory framework. Under this system, enforcement responsibilities are divided between retail operations and product legality. The Virginia ABC manages retail permitting and enforces age-verification standards, while the OAG polices market inventory through the state's authorized vape directory and consumer protection laws.

2026 legislation closed definition loopholes in statute and consolidated enforcement authority

Virginia's 2026 Vape Enforcement Act (Chapter 1021) closed long-standing statutory loopholes by expanding the legal definitions of "electronic smoking device" and "retail tobacco product." The updated law, which took effect on October 1, 2026, captures all vaporizing hardware regardless of nicotine content, zero-nicotine liquids, component parts, and deceptively packaged items engineered to evade regulation. To enforce these standards, the legislation established a dual-agency oversight framework split between Virginia ABC and the OAG. Virginia ABC serves as the primary retail permitting authority, conducting mandatory, unannounced underage compliance checks. Meanwhile, the OAG's newly

established Regulated Products Enforcement Unit polices store inventory by managing the state's U.S. Food and Drug Administration (FDA)-authorized vape directory, seizing unlisted contraband, and filing circuit court actions against non-compliant retailers and manufacturers.

ABC is responsible for enforcing licensing and compliance with age restrictions

Virginia ABC serves as the central state body empowered to issue, monitor, suspend, and revoke Retail Tobacco Permits under Chapter 1021 of the 2026 Acts of Assembly. All entities selling tobacco, liquid nicotine, or vapor products, including convenience stores, vape shops, grocery stores, and remote delivery sellers, must obtain an annual permit, pass background checks, and pay a $400 fee ($300 for businesses holding an existing ABC alcohol license). All permit fees and administrative penalties are deposited into a dedicated Retail Tobacco Enforcement Fund to support ABC's operational costs.

To enforce the statutory ban on sales to individuals under 21, ABC special agents are mandated to conduct unannounced underage compliance checks at every permitted establishment at least once every 24 months. Retailers that fail an inspection face a mandatory follow-up check within six months and escalating civil penalties: $1,000 for a first offense, $5,000 for a second offense, and $10,000 for a third offense within three years, alongside potential permit suspension or revocation. Store clerks must inspect photo ID for anyone appearing under 30, while online and mail-order distributors must verify buyer identities against commercial databases and require an adult (21+) signature upon delivery.

OAG is responsible for enforcing what products may be legally sold

The OAG enforces product legality across the Commonwealth by administering Virginia's official Liquid Nicotine and Nicotine Vapor Products Directory. Under this framework, manufacturers must submit annual certifications and fees demonstrating that each product has received marketing authorization from the FDA or has an active premarket application under review. Any vapor product omitted from the directory is strictly prohibited from sale, distribution, or import for resale in Virginia. Beyond liquid nicotine, the OAG's specialized Regulated Products Enforcement Unit oversees retail sales of THC, synthetic hemp, kratom, and emerging intoxicants, enforcing Virginia Consumer Protection Act provisions against deceptively packaged, imitator, or youth-targeted products.

To maintain market compliance, the unit conducts routine and unannounced shelf audits at retail establishments, treating unlisted items as illegal contraband. The Attorney General (AG) and law enforcement officers hold explicit statutory authority to seize, forfeit, and destroy non-directory products at the non-compliant seller's expense. The AG can also file civil actions in circuit court to obtain court orders halting future illegal sales and collect steep product-level civil penalties—ranging from $5,000 for a first offense up to $15,000 per unauthorized product for third or subsequent violations.

2 Education and prevention

Although the state sets minimum standards for school-based substance use education and prevention, the scope of each school division's efforts varies widely and few schools provide the multidimensional approach recommended by the research literature. Investing in evidence-based, multi-layered prevention is well established as a cost-effective strategy that mitigates youth substance use while reducing long-term state expenditures in healthcare, criminal justice, and social services. Most schools offer dedicated prevention programs and activities to supplement the Standards of Learning (SOL) content required in Virginia. However, programs are not consistently rooted in evidence, especially among elementary schools, and community involvement is inconsistent. Limited staffing capacity and funding appear to be common barriers that prevent school divisions from providing comprehensive, research-based prevention programs.

Virginia schools use a variety of approaches for substance use education and prevention

Virginia public schools use a variety of substance use prevention approaches, which vary between schools but also by school level. All schools are required to provide students in grades K-12 with substance misuse prevention as part of Health classes, which must follow a curriculum aligned with the SOLs developed by the Virginia Department of Education. Many schools supplement this requirement with additional programs and activities delivered on their own or with the support of community partners.

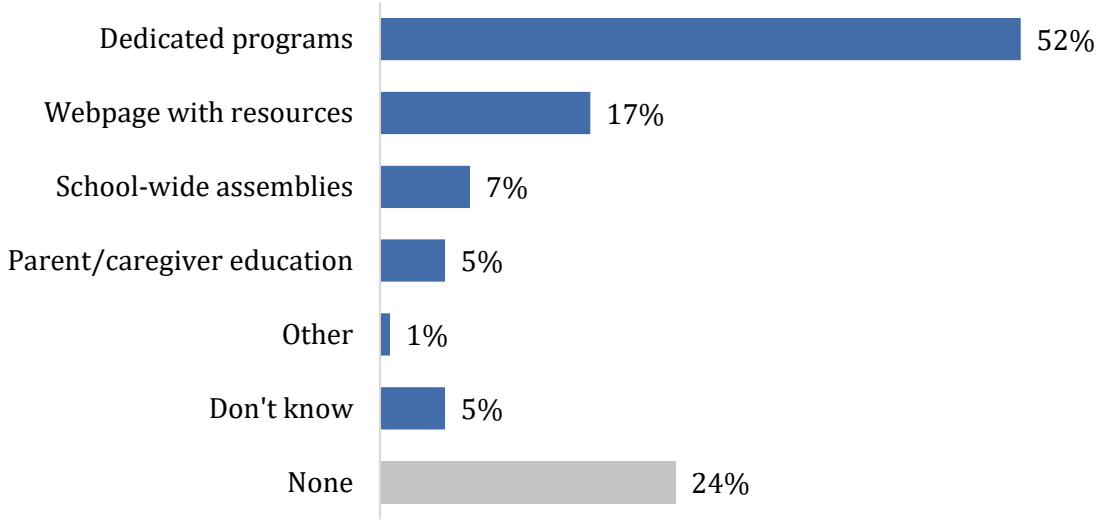
Education and prevention efforts in elementary schools focus on safety and wellness rather than explicit drug instruction

Substance use prevention at the elementary level differs fundamentally from secondary schools. The focus at the elementary level is social-emotional learning, overall wellness, and the foundational skills necessary to refuse substance use later in life. Intentional substance use is extremely uncommon at the elementary level. Rare instances of substance use at that age typically involve unwitting ingestion, such as mistaking a family member's tetrahydrocannabinol (THC) edibles for candy, or mistaking alcohol for fruit juice. Accordingly, the elementary Health SOL standards focus on foundational medicine safety, taking medications only under adult supervision, recognizing household poison hazards, and learning basic refusal skills. Upper elementary grades expand on this to examine how alcohol, nicotine/vaping, cannabis, inhalants, and prescription misuse affect body systems, while practicing peer pressure resistance, refusal tactics, and understanding addiction.

Among elementary schools that responded to a BHC staff survey of school counselors, the most commonly reported form of substance use education and prevention were dedicated programs or curricula, with many elementary schools indicating that they participate in the D.A.R.E. program or Red Ribbon Week—an annual substance abuse awareness and

prevention campaign observed every October in the United States to educate youth and encourage drug-free living (Figure 2-1). About a quarter of elementary school respondents indicated that their school does not routinely provide substance use education and prevention to all students. This reflects the view expressed during site visits with elementary school administrators that education and prevention with an explicit focus on drugs and alcohol is not appropriate for all elementary students. Many elementary counselors indicated that fifth grade is the only appropriate elementary grade-level to introduce an explicit drug curriculum, according to a statewide survey of school counselors.

Figure 2-1
Most elementary schools provide multiple forms of substance use education and prevention, most commonly dedicated programs



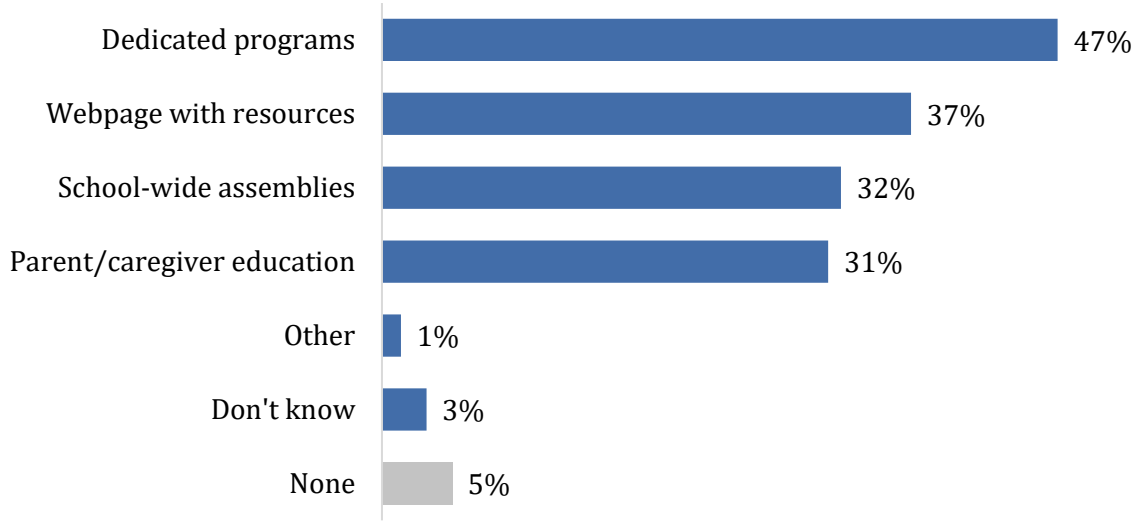
Note: n=232; Schools could select more than one response
Source: BHC staff analysis of statewide survey of school counselors (September 2026)

Education and prevention efforts in secondary schools focus on explicit drug instruction

Substance use prevention and education in middle and high schools shifts to a curriculum that is much more explicit, acknowledging that intentional substance experimentation, and in some cases dependence, is far more common at the secondary school level. Nearly half of responding secondary schools offered dedicated programs specific to substance use in addition to SOL instruction, and about 37 percent had created an online hub containing resources for students and families (Figure 2-2). About 30 percent of schools also held information sessions with parents and schoolwide assemblies as part of their substance use prevention and education activities. For example, a high school visited for this study held an annual mental health fair featuring a mock-bedroom exhibit created with local community partners to educate parents on subtle warning signs and hidden contraband locations. The interactive walkthrough allowed parents to see firsthand how everyday household items and

disguised objects are used to conceal vapes, alcohol, and drugs. A minority of schools (five percent) indicated they did not provide other forms of substance use prevention.

Figure 2-2
Most secondary schools provide multiple forms of substance use education and prevention



Note: n=214; schools could select more than one response
Source: BHC staff analysis of statewide survey of school counselors (September 2026)

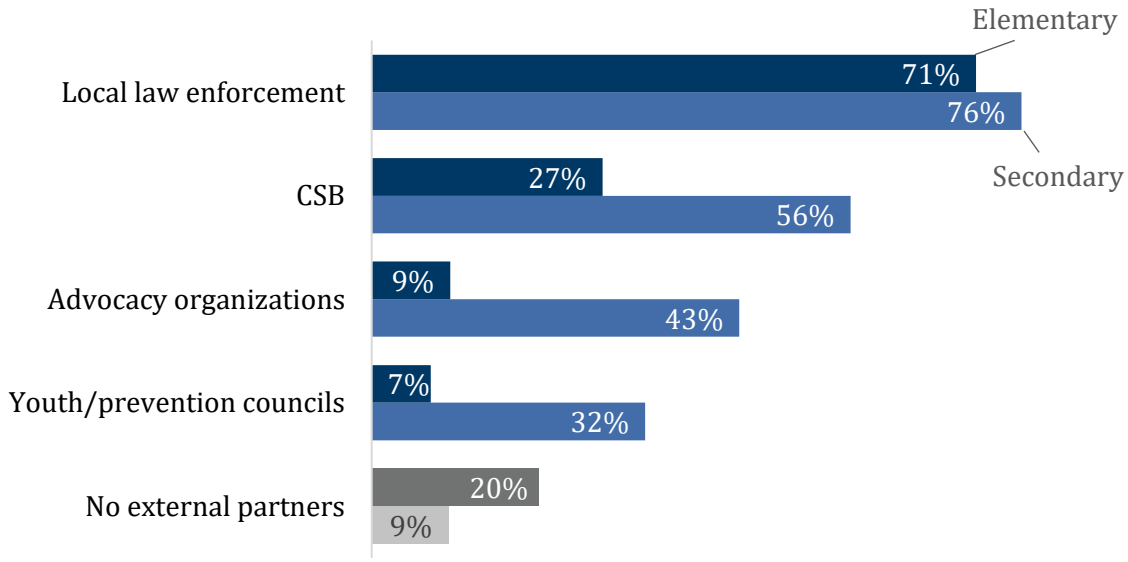
Most schools have community partnerships to deliver substance use education and prevention

School staff deliver much of the substance use prevention and education programming, but most schools also rely on community partners to deliver substance use prevention and education. Public schools are required by state regulations to collaborate with governmental and private organizations dedicated to student health, and school staff interviewed for this study indicated that partners play an important role in supplementing their efforts. Most elementary and secondary schools (71 percent and 76 percent respectively) that responded to the BHC staff survey indicated partnering with local law enforcement agencies and School Resource Officers (SROs) (Figure 2-3). Schools visited for this study used law enforcement and SRO partners for a variety of prevention activities including educating students on impaired driving, guest-speaking about diversion programs, distributing prevention literature, and testing confiscated substances.

Other types of partnerships differed markedly between elementary and secondary schools. Secondary schools were more likely to partner with Community Services Boards (CSBs), mental health advocacy organizations, and regional offices on youth. These patterns reflect a difference in approaches to substance use education and prevention, as well as age-related differences in substance use prevalence. More than half of secondary schools reported

partnering with their local CSBs. CSB staff helped deliver evidence-based classroom curricula, hosted vaping and overdose awareness sessions, and conducted parent workshops in the schools visited for this study. Nonprofit recovery groups were brought in to reinforce classroom instruction through testimonials from individuals in recovery and facilitate student support groups.

Figure 2-3
Most schools have community partners to supplement substance use education and prevention efforts



Note: secondary schools n=191, elementary schools n=174; schools could select more than one response
Source: BHC staff analysis of statewide survey of school counselors (September 2026)

Most schools offer some, but not all elements of effective substance use prevention approaches

Most Virginia schools use multiple avenues to conduct substance use education and prevention, rather than relying solely on classroom-based instruction. However, the majority of schools are unable to provide all the dimensions that have been found to make prevention efforts most effective. Research shows that classroom instruction alone yields modest results at best, whereas multi-layered approaches, such as combining classroom learning, programs that help build refusal skills, and community coalitions, generate significantly larger and longer-lasting reductions in substance initiation. Virginia schools with multi-layered prevention efforts reported greater effectiveness in preventing or delaying substance use, as well as higher student participation in education and prevention programs based on responses from school counselors surveyed for this study. Schools that do not have multi-layered prevention efforts are typically hindered by a shortage of financial resources and limited staff bandwidth.

Multi-layered substance use education and prevention is more effective than classroom-based curriculum alone

Prevention science demonstrates a clear hierarchy among youth substance use intervention strategies. Purely knowledge-focused instruction proves ineffective, but combining knowledge with skills training yields a modest positive impact, and integrating community coalitions generates the greatest overall results. Traditional, knowledge-focused instruction is largely ineffective at altering behavior related to substance use. Instruction alone increases factual substance knowledge but fails to produce meaningful reductions in drug initiation or actual use. By contrast, educational programs that integrate skills as well as knowledge achieve meaningful reductions in substance initiation and short-term use by building refusal self-efficacy and correcting normative misconceptions. For example, evidence-based programs such as Life Skills Training and Project ALERT focus on personal self-management and social resistance strategies, including decision-making, emotional regulation, assertiveness, and peer refusal techniques. However, the public health effect sizes of skills-based programs, even when they are evidence based, is relatively modest when they operate in isolation within a single setting, such as the classroom.

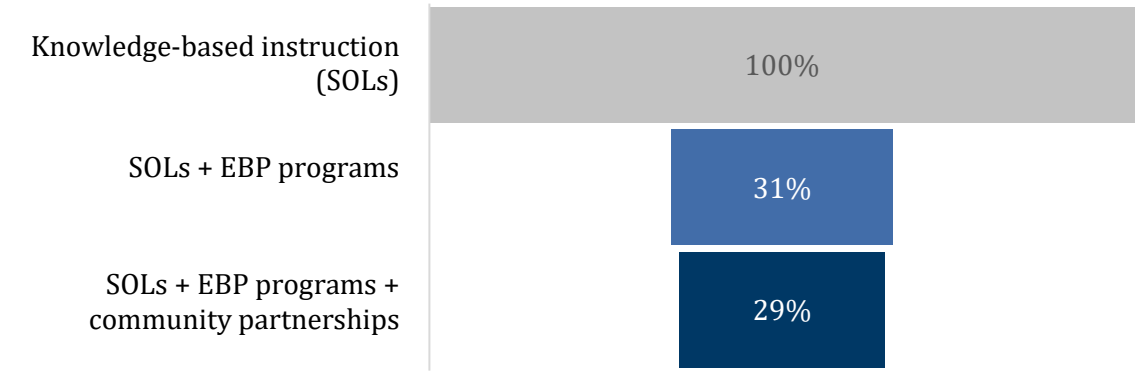
To achieve lasting, population-level impact, the research literature emphasizes integrated models that combine instruction and programs with local community coalitions and parental engagement. This multi-layered approach targets risk and protective factors across individual, family, school, and community environments. Multi-layered systems yield significantly greater and more durable reductions in youth alcohol, tobacco, and illicit drug initiation than isolated classroom programs, according to randomized longitudinal trials.

Most schools provide elements of a multi-layered substance use education and prevention, but a minority offer all

Approximately 29 percent of responding secondary schools appear to provide all elements of the multi-layered programming found to be most effective in the research literature (Figure 2-4). This is significantly higher than for elementary schools, of which only 11 percent use a multi-layered approach. This disparity exists primarily because elementary schools are less likely than secondary schools to use evidence-based programs and to provide parent education and information sessions. Differences in approach between elementary and secondary levels may reflect differences in actual substance use rates as well as perceptions of what is developmentally appropriate for each age group. Most schools that did not have all three elements of a multi-layered approach to substance use education and prevention implemented some strategies beyond knowledge-based instruction. All Virginia schools are required to provide K-12 students with instruction related to substance use education and prevention, which follows Health SOL standards. This serves as the universal knowledge baseline for substance use education and prevention. Nearly half of schools supplement this baseline with substance use programs, but they do not consistently use programs that are evidence-based. In addition to Evidence-Based Practices (EBPs) sometimes being cost prohibitive, multi-week EBPs also face scheduling constraints due to tight semester blocks and competing pressure to meet core academic testing and accreditation requirements. Most respondents also indicated that their school maintains at least one partnership with a

community partner, but far fewer involved parents through skills training. Overall, survey respondents from schools implementing a broader range of substance use education and prevention strategies reported stronger program efficacy and higher student participation than those who relied on Health SOL education alone.

Figure 2-4
Approximately 29 percent of secondary schools have implemented all elements of multi-layered approach to substance use education and prevention



Note: n=221
Source: BHC staff analysis of statewide survey of school counselors (September 2026)

Many schools have adopted substance use programs, but those are not consistently evidence-based

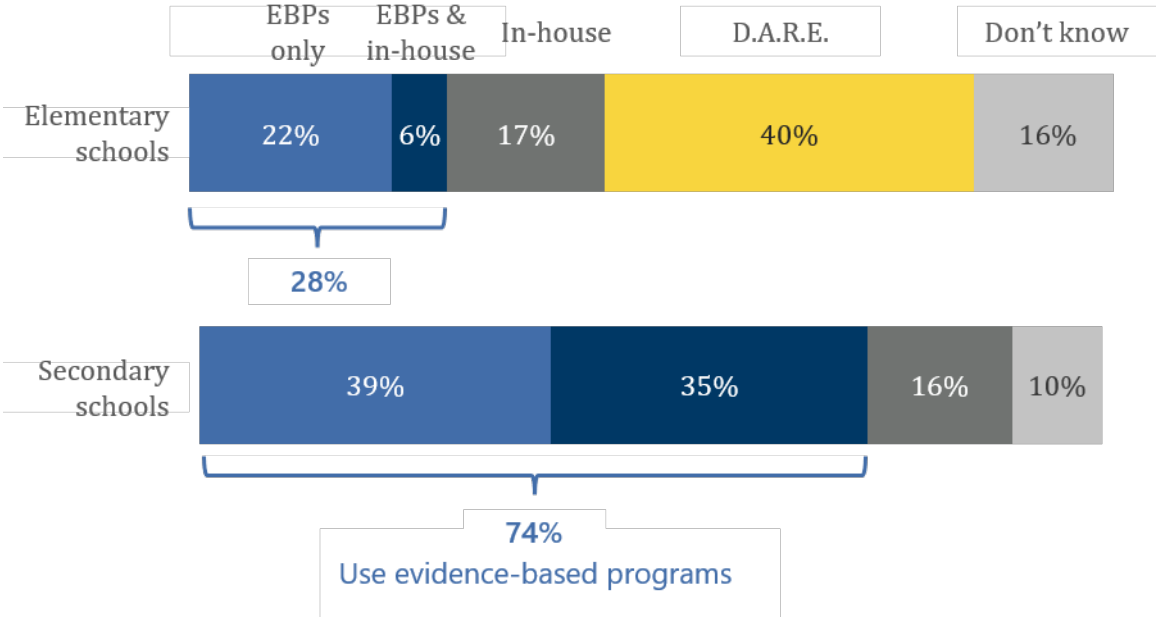
Most elementary and secondary schools lack access to research-based substance use education and prevention programs that have been demonstrated to alter student behavior. About half of elementary and secondary schools indicated that they do not have a dedicated program or curriculum specific to substance use, according to a statewide survey of school counselors.

Among elementary schools that have a substance use program, only about 28 percent use EBPs to some degree: about 22 percent rely exclusively on EBPs and another 6 percent use EBPs alongside, in-house programs that lack an evidence base (Figure 2-5). About 17 percent of elementary schools used in-house programs exclusively. Notably, about 40 percent reported using the D.A.R.E program, which has been rated as ineffective at preventing substance abuse by the National Institute of Justice. Despite a large body of research that suggests D.A.R.E. is ineffective, schools may continue to use the program because it enjoys strong community support and builds positive relationships between students and local law enforcement, as noted in a 2018 report by the Department of Criminal Justice Services.

Among secondary schools that have a dedicated program or specific curricula, approximately three quarters use evidence-based programs to some degree: 39 percent rely exclusively on EBPs and another 35 percent use EBPs alongside unverified, in-house programs (Figure 2-5). About 16 percent of secondary schools indicated exclusively using a substance use program

designed by division staff. School divisions struggle to implement formal evidence-based programs despite their clear perceived value. General school counselors lack the classroom time and bandwidth required to facilitate multi-week modules without dedicated, state-funded personnel, forcing under-resourced divisions to rely on external partners or default to piecemealed programming.

Figure 2-5
Nearly 30 percent of elementary and 75 percent of secondary schools with substance use prevention programs rely on evidence-based practices, at least in part



Note: n=108 elementary schools; n=93 secondary schools
Source: BHC staff analysis of statewide survey of school counselors (September 2026)

Evidence-based prevention programs have been shown to meaningfully reduce youth drug initiation, current use, and long-term misuse. Schools relying on unproven, in-house curricula operate without evidence of whether their instruction achieves intended outcomes. Counselors at secondary schools utilizing evidence-based programs were less likely to report low perceived effectiveness (16 percent compared to 47 percent) on a BHC survey and more than four times as likely to report high effectiveness (39 percent compared to nine percent) compared to schools without research-based curricula.

Most schools have forged community partnerships, but activities to engage parents and caregivers are less common

Most schools maintain at least one relationship with an external entity to supplement their prevention and education efforts. This includes relationships with local law enforcement and SROs, CSBs, local mental health organizations, prevention councils, and regional offices on

youth. Approximately 20 percent of elementary and nine percent of secondary school counselors indicated that their school does not maintain any relationships with community partners to supplement education and prevention. Some schools engaged multiple community partners. Respondents from schools with more community partnerships reported higher student participation and greater program effectiveness compared to those with fewer partners, while schools with no partnerships reported the lowest participation and efficacy.

Another component of school-community partnership includes parent engagement and outreach. Approximately five percent of elementary and 31 percent of secondary school respondents indicated that parent or caregiver education or information sessions was a part of their school's overall education and prevention strategy. About 21 percent of elementary schools and nine percent of secondary schools indicated having virtually no community engagement, indicating that the school neither maintains any community partnerships nor engages in parent education or information sessions.

Differences in scope and use of evidence-based programs driven by school and division resources

Across Virginia public schools, the scope and quality of substance use education are fundamentally shaped by local fiscal capacity and division-level staffing. While larger divisions and those with strong local government financial support may have the bandwidth to successfully identify, vet, purchase, and implement evidence-based programs, divisions with less staff capacity and funding may piecemeal instruction together using free online platforms, general health websites, or one-off "shock value" assemblies that lack proven long-term efficacy. Those divisions also lack bandwidth to identify and coordinate appropriate community partnerships and implement effective parent outreach initiatives. Without access to research-backed prevention, youth in lower-resourced divisions face heightened risks of unmanaged substance misuse, academic disruption, and crisis escalation, perpetuating health disparities and placing long-term strain on state systems.

The implementation of evidence-based programs is often spearheaded by school divisions rather than individual schools, in part because it requires extensive time and research. Division staff must identify and vet multiple programs to determine the best fit for their community and work out how to roll them out in schools. The cost of implementing an EBP can also be a barrier. Division staff interviewed during site visits indicated that costly training, certification dues, and maintenance fees paid to EBP purveyors were barriers to adopting EBPs. Counselors at schools lacking dedicated prevention programming were more than twice as likely to identify funding as a primary barrier compared to those with dedicated programs according to survey results. Similarly, counselors at schools that provided only SOL instruction were nearly twice as likely as those offering multi-layered prevention to identify a lack of dedicated funding for evidence-based programs as a primary barrier limiting their school's education and prevention effectiveness.

Establishing and sustaining community partnerships places an extensive administrative demand on smaller school divisions, requiring staff bandwidth to identify, coordinate, and maintain ongoing provider relationships. In smaller divisions with limited central office

capacity, managing these multi-agency connections alongside parent outreach creates significant operational strain. As one of many responsibilities in a small division, one administrator interviewed for this study reported spending nine months leading community committees and engagement meetings to vet and select an appropriate SEL curriculum. Some division staff described the time-consuming process of creating and maintaining an up-to-date directory of available behavioral health providers in the area. Others described the ongoing liaison duties involved in organizing prevention activities such as assemblies and guest speakers. Some divisions (21 percent) employ dedicated specialists who can assist in identifying or developing research-based education and prevention curriculum, train school staff, facilitate community partnerships, and directly deliver classroom-based lessons. However, specialists tend to be in more affluent school divisions, because these positions do not receive any state funding through the SOQs and must be entirely locally funded.

To address the resource and operational constraints faced by school divisions that are smaller or that have fewer resources, the General Assembly may wish to

- Create and fund a staffed, state-level structure within the Office of Behavioral Health and Student Safety at the Virginia Department of Education (VDOE) to provide information, support, and technical assistance to school divisions; and
- Direct VDOE to conduct a detailed needs assessment to determine the number and types of positions and other resources needed by school divisions to offer comprehensive and effective substance use supports and services. The assessment should include the estimated cost of meeting divisions' needs; recommended staffing ratios for division- and school-level personnel needed to facilitate the provision of substance use supports and services; and recommendations for a mechanism to allocate funding among school divisions.

These broad recommendations are intended to help address capacity barriers described in this and subsequent chapters of this report. They are explained more fully in Chapter 5, along with potential funding sources.

Establishing a centralized support and technical assistance structure would help alleviate the burden on school division staff of identifying and vetting EBPs and establishing and maintaining community partnerships and family outreach. To this end, VDOE, in collaboration with the Department of Behavioral Health and Developmental Services, could (1) establish and maintain a centralized clearinghouse of research-based substance use education and prevention programs and practices for community and parental engagement; implementation toolkits; and professional development resources; and (2) provide ongoing technical assistance to assist divisions with program selection and implementation (see Chapter 5 for more details).

A statewide needs assessment would help the state obtain detailed information about the specific needs of each school division, including the division-level personnel required to oversee program implementation and lead external stakeholder engagement, and funding needs for evidence-based programs.

3 Early identification and intervention

Virginia public schools rely heavily on informal observation and on school counselors to identify students and deliver early intervention services. Few schools utilize formal screening tools to identify students who need extra assistance, and few have access to dedicated substance use counselors who can help meet students' needs. Most school divisions continue to use punitive suspensions for drug infractions rather than health-centered diversion programs to address the underlying root causes of substance use, and a new state law that prioritizes restorative practices specifically exempts drug-related infractions. Effective early intervention strategies increase the likelihood of diverting at-risk students before they require acute clinical care and experience a wide variety of adverse outcomes. These limitations stem from insufficient bandwidth among school counselors and division-level staff. To address these challenges, the General Assembly could provide state-level technical assistance and resources on universal screeners and diversion programs, examine the need for additional division staffing, and amend state code to prioritize health-based restorative diversion over exclusionary discipline.

Identification of at-risk students relies primarily on informal staff observation rather than universal screening

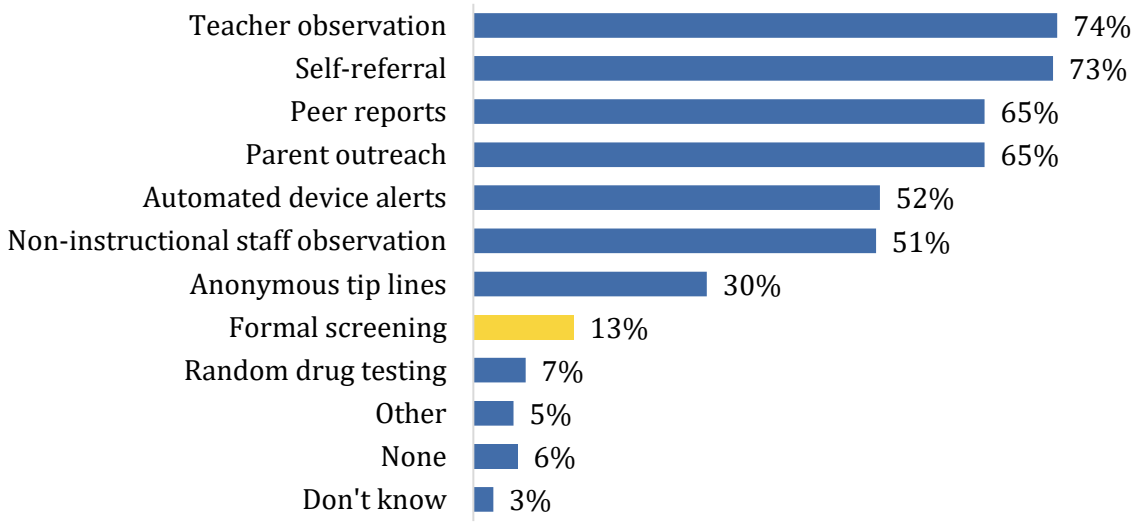
Universal substance use screening in middle and high schools remains relatively rare despite strong clinical evidence demonstrating its effectiveness for early identification. Only 13 percent of secondary schools routinely utilize a formal screening instrument, based on responses to a Behavioral Health Commission (BHC) staff survey of school counselors (Figure 3-1). Instead, schools tend to rely on informal methods like staff observation or student self-referral. Failing to identify struggling students allows substance use to escalate, generating severe negative impacts on academic achievement, school climate, and public expenditures across state healthcare, social service, and justice systems. School staff report hesitating to use formal screening tools out of concern that identifying the full extent of student need would overwhelm internal capacity and local treatment networks. Under-resourced divisions also lack the administrative bandwidth to research and select appropriate tools. To relieve local burdens, the state could establish a centralized clearinghouse of pre-vetted screening instruments, toolkits, and professional development resources. Providing ongoing technical assistance through this framework would support school divisions that wish to implement an effective universal screener.

Schools rely primarily on informal observations and self-referrals to identify students who need additional supports related to substance use

Schools rely heavily on teacher and other school staff observation to identify students who are exhibiting warning signs of substance use, abuse, or dependence. Although teachers and other relevant personnel are required by law to complete a mental health awareness training, there is no requirement for recurrent training, and substance use identification generally constitutes a small subset of the topics covered. For example, Youth Mental Health First aid, which can be used to meet the statutory training requirement, is a one-day training that covers a broad range of topics including anxiety, depression, eating disorders, bullying, social media, substance use, and attention-deficit/hyperactivity disorder (ADHD). School personnel interviewed during site visits indicated that teachers feel ill-equipped to identify students who need help; they are sometimes concerned about making inaccurate referrals and generally are more concerned with meeting academic and other classroom demands.

Student self-referral is the other most common method reported for identifying students who may be in need of support. Although many schools rely on self-referral as a way to identify students in need, school counselors and administrators report that very few students actually come forward on their own. Instead, school staff indicated that students were more likely to admit to having an issue after being caught using an illegal substance.

Figure 3-1
Universal screeners are less common than student self-disclosure and teacher observation in Virginia secondary schools



Note: n=220 secondary schools; schools could select multiple options
Source: BHC staff analysis of statewide survey of school counselors (September 2026)

Universal screeners are an effective means of early identification of students at risk of substance use

Although informal approaches can identify some struggling students, they are far less effective at detecting at-risk youth than validated screeners, especially for students who do not cause overt classroom disruptions. Universal screening tools, such as the CRAFFT, Screening to Brief Intervention, and Problem Oriented Screening Instrument for Teenagers, demonstrate strong diagnostic validity for detecting adolescent substance use. These instruments require minimal time to administer, making them well-suited for school nurses, counselors, and school-based health centers. In educational settings, universal screening identifies at least twice as many at-risk students as informal approaches like teacher observation. This approach is particularly effective at capturing youth who are not overtly disruptive, enabling health professionals to intervene before experimental use escalates into a clinical disorder.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based public health framework that triages youth by risk level, delivers short motivational conversations, and connects high-risk students to specialized care. Integrating screening tools into school-based SBIRT frameworks offers a logistically feasible model that capitalizes on teachable moments and enhances student readiness to change. Prioritizing student confidentiality enables high participation rates and strong outcomes in middle school settings. Specifically, exposure to school-based SBIRT significantly curbs the growth of cannabis and e-cigarette use among younger students while reinforcing intentions to abstain.

Schools face resource constraints to implementing universal screeners

School staff interviewed for this study reported concerns that using universal screeners would reveal a scale of student need far exceeding existing counseling capacity and local provider networks. School counselors emphasized that they are not licensed clinical therapists, leaving them constrained by scope-of-practice boundaries when attempting to manage serious behavioral health or addiction crises. Uncovering a large volume of documented student need without the on-site clinical workforce or external community treatment slots to deliver care creates a severe ethical and operational bind for frontline educators, who feel ill-equipped to handle high-acuity reports on their own.

Low adoption of formal substance use screeners across school divisions also stems from substantial administrative hurdles in searching for, evaluating, and implementing appropriate instruments. Personnel in smaller and under-resourced schools and divisions juggle academic guidance, mandatory state testing, and daily crisis triage, leaving little bandwidth to research and vet screening tools. To relieve local administrative burdens and streamline early identification, the state could establish a centralized clearinghouse of pre-vetted universal substance use screening instruments, implementation toolkits, and professional development resources for divisions that wish to implement a screener. Providing ongoing training and technical assistance through this framework would support interested school divisions in selecting, adopting, and administering effective universal screeners. This is part of a broader recommendation to create and fund a staffed, state-level structure within the Office of Behavioral Health and Student Safety at the Virginia

Department of Education (VDOE) to provide information, support, and technical assistance to school divisions. This recommendation is explained more fully in Chapter 5, along with potential funding sources.

Access to school-based early intervention services is varied and limited across divisions

Access to school-based early intervention and health diversion varies widely across Virginia, leaving some students without effective support when substance use occurs. About 15 percent of responding secondary schools indicated that their school did not provide any early intervention substance use supports and services for students. Early intervention bridges universal drug prevention and education and acute clinical care by delivering targeted supports and services like short-term individual or group counseling and clinical triage when needed. However, some schools do not provide any early intervention services to students who need extra help related to substance use, and a minority of school divisions employ dedicated specialist support staff, who are instrumental to effectively implementing these programs. Instead, general school counselors serve as primary response staff despite heavy student caseloads, extensive administrative duties, and limited training and expertise in substance use counseling. Disparities between schools stem from limited resources to provide early intervention services, particularly for specialized substance use personnel.

Early intervention bridges substance use education and prevention, and acute clinical care

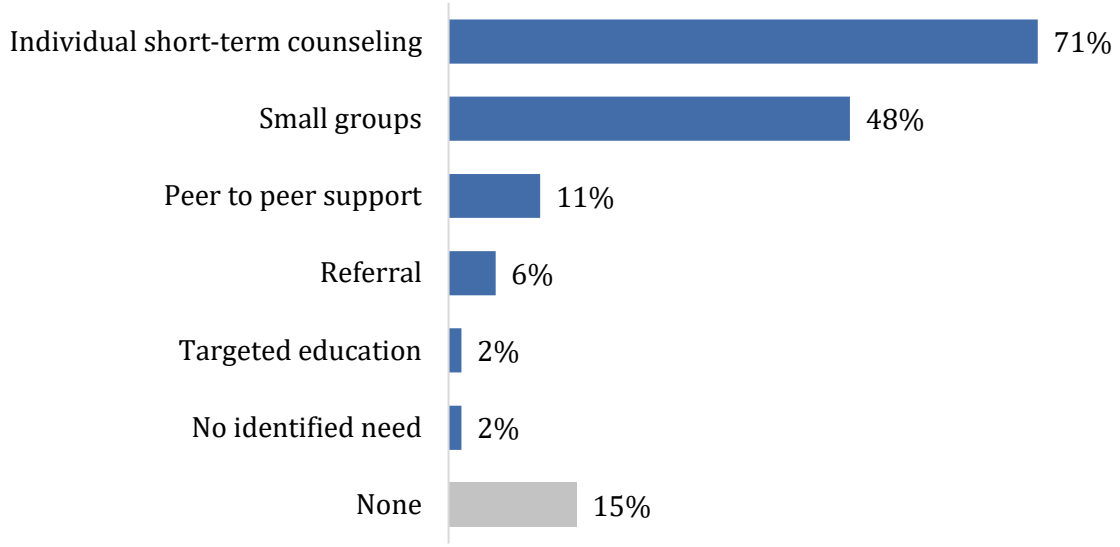
Early intervention services and supports can help interrupt adolescent substance use before initial experimentation escalates into chronic dependency, co-occurring mental health disorders, or severe academic harm. Within the student support continuum, early intervention serves as an operational bridge between universal classroom prevention and acute clinical care. Universal prevention delivers baseline drug education and skills to the entire student body, but it is not designed to provide targeted support to high-risk youth. By contrast, acute clinical care provides highly targeted, intensive treatment for established use or dependency, addressing needs that exceed standard school capacity. Early intervention specifically targets students displaying initial risk factors, early use, or self-identify as needing help. Deploying early intervention supports and services can help stop use from escalating during a crucial developmental window.

Services and supports provided by school staff include individual short-term and small group counseling

While schools are not expected to do intensive clinical treatment for students with a substance use disorder, most schools do provide early intervention supports to students exhibiting early warning signs of substance use, use, or dependence, according to a BHC staff survey. These supports are generally provided by school counselors. The most common service provided was individual short-term counseling, which constitutes short-term, brief solution-focused counseling, rather than ongoing clinical therapy. This service is offered by about 70 percent of secondary school counselors who responded to the BHC staff survey

(Figure 3-2). School counselors indicated that this type of counseling focuses on helping students manage daily stress and cravings to get through the school day and may also be used as a means of triaging students to determine if a higher tier of treatment is warranted.

Figure 3-2
Most secondary schools in Virginia provide some early intervention services, most commonly individual counseling



Note: n = 195 secondary schools; schools could select more than one option
Source: BHC staff analysis of statewide survey of school counselors (September 2026)

Another early intervention provided in schools is small-group counseling, with approximately 27 percent of counselors offering group sessions that, while not specifically oriented to substance use, help address the underlying mental health factors that can contribute to substance use. A majority of counselors interviewed during site visits stated that adolescent substance use is often driven by underlying mental health challenges such as stress, depression, anxiety, and trauma. Small group sessions are designed to help teach alternative coping mechanisms and stress management. Less commonly, counselors provided substance use-specific small group sessions. Overall, counselors in responding schools estimated that 2.5 percent of their student population (2,261 students) had received early intervention services in the 2025-2026 school year. Approximately 15 percent of counselors indicated that their school does not provide any early intervention services.

School counselors serve as primary early intervention providers but may lack bandwidth and expertise

School counselors currently serve as the primary staff for responding to student substance use concerns in most schools, yet their operational bandwidth for providing substance support is severely constrained by their extensive portfolio of other duties. In addition to responding to student behavioral concerns, counselors manage course scheduling,

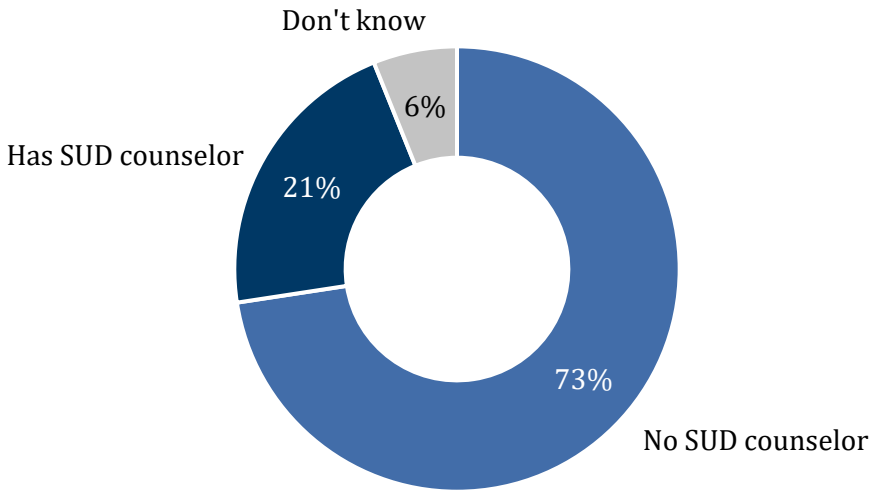
standardized testing coordination, graduation tracking, college planning, enrollment, and attendance meetings. Approximately 27 percent of secondary school counselors indicated that their high workload and capacity constraints were barriers preventing students from receiving appropriate school-based substance use support.

Counselors may also lack training and expertise to address substance use, and some felt ill-equipped to effectively respond to students' substance use concerns. About 47 percent of respondents indicated lacking staff with specialized training as a primary barrier to providing early intervention support to students. Several school staff across site visits echoed this concern. One interviewee stated, "that's not what they were trained to do. They were trained to do career, college, academic counseling and a little bit of helping kids on the side." Another interviewee stated, "we're just not qualified to treat addictions here. None of our training helps us to do that." Traditional graduate preparation for school counselors emphasizes academic development, career planning, and brief check-ins rather than more intensive interventions. General school counselors lack the bandwidth and training to conduct 45- to 60-minute individual sessions during the school day.

Dedicated substance abuse counselors are available in a minority of school divisions

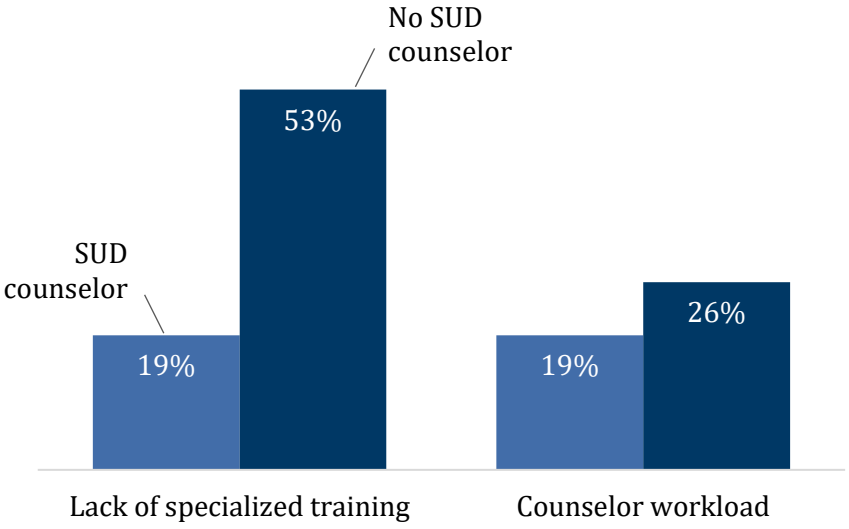
Specialized counselors help ensure students struggling with substance use receive the targeted services and supports they need, but only about 21 percent of responding schools reported having a dedicated substance abuse counselor (Figure 3-3). Dedicated substance use counselors can augment the early intervention services provided in a school by filling in specialized gaps in school counselors' expertise and providing substance use specific one on one and small group services. Furthermore, absorbing the complex behavioral health workload provides essential operational relief to general school counselors, allowing academic staff to focus on course scheduling, testing, and career guidance. Survey respondents without access to a substance abuse counselor were nearly twice as likely to report counselor workload as a barrier to student care, and nearly five times as likely to cite a lack of specialized training (Figure 3-4). In addition to augmenting schools' early intervention capacity, schools can leverage substance abuse counselors to provide a wide array of other services and supports. Divisions that employ substance abuse counselors indicated that those counselors delivered classroom-based education and prevention, led family education and workshops, administered substance use screeners, and acted as liaisons between schools and community partners by managing warm handoffs and tracking students returning from treatment.

Figure 3-3
Substance abuse counselors are available in a minority of secondary schools in Virginia



Note: n=197 secondary schools
Source: BHC staff analysis of statewide survey of school counselors (September 2026)

Figure 3-4
Schools without substance abuse counselors identified training and workload as more frequent obstacles to providing appropriate supports and services



Note: n=197 secondary schools
Source: BHC staff analysis of statewide survey of school counselors (September 2026)

Funding appears to be the primary barrier to schools being able to employ a substance abuse counselor. Schools that reported having a substance abuse counselor were disproportionately located in more affluent areas. The median household income in localities where schools indicated having access to a substance abuse counselor was approximately $122,000 on average, while the median household income in localities where schools indicated not having access to a substance abuse counselor was $79,000.

To improve access to early intervention substance use supports and services across school divisions, additional staffing may be necessary, including counselors who specialize in substance use. A statewide needs assessment would help the state obtain detailed information about the specific needs of each school division, including the type and number of division-level personnel required to strengthen the provision of early intervention services. This is part of a broader recommendation to direct VDOE to conduct a detailed needs assessment to determine the number and types of positions and other resources needed by school divisions to offer comprehensive and effective substance use supports and services. This recommendation is explained more fully in Chapter 5, along with potential funding sources.

Exclusionary school drug policies can be harmful, but serve as the statutory default

Virginia's student discipline framework maintains an expulsion-first default for drug violations and specifically carves out drug offenses from mandatory restorative practices, despite evidence that exclusionary discipline harms students. At least 1,317 students were suspended for substance use-related infractions during calendar year 2024-2025, and 27 were expelled, among the 108 secondary schools that responded to the BHC staff survey of school counselors. Longitudinal research and major public health authorities confirm that suspensions and expulsions fail to deter substance use. Student substance use on school property can be an early indicator of unmanaged trauma, escalating chemical dependency, and co-occurring mental health crises that require diversion, restoration, and treatment rather than removal from school. Statute establishes expulsion as the default disciplinary response for violations that involve drugs, but not other substances like alcohol or tobacco. The General Assembly may wish to strike the drug offense carveout from statute, ensuring that schools take a restorative first approach to student drug violations.

Research shows negative impacts of punitive school responses to student substance use violations

Remedial and health-centered responses to student substance use reduce adolescent drug involvement significantly more than traditional punitive discipline, according to longitudinal research. Providing supportive measures after a substance policy infraction cuts the likelihood of subsequent student drug use by nearly 50 percent according to the research. Educational diversion and community health frameworks also increase high school graduation rates by 20 percent and reduce juvenile felony rates by nearly 50 percent.

Punitive measures, such as out-of-school suspensions, expulsions, and law enforcement involvement have been found ineffective in deterring substance use and instead appear to actively exacerbate student harm. Attending a school that regularly issues out-of-school suspensions for substance use violations increases a student's likelihood of marijuana use one year later by 1.6 times. Higher school-wide rates of exclusionary discipline consistently predict increased student cannabis, alcohol, and tobacco use. Experiencing even a single out-of-school suspension in ninth grade triples a student's risk of dropping out of school. Exclusionary discipline catalyzes these negative outcomes by severing protective bonds with educators, increasing unsupervised time, and causing academic alienation without delivering behavioral support.

Major medical, psychological, legal, and public health organizations explicitly condemn zero-tolerance mandates in favor of health-based diversion and restorative practices. Standard-setting bodies, including the World Health Organization, the American Academy of Pediatrics, the American Psychological Association, the American Bar Association, and the Substance Abuse and Mental Health Services Administration (SAMHSA), advise local education agencies to dismantle mandatory suspension policies. These organizations recommend replacing punitive sanctions with trauma-informed care, positive behavioral supports, confidential counseling, and direct community treatment linkages.

In recognition of the growing body of evidence of the detrimental impact of suspensions and expulsions, the Virginia Board of Education published Model Guidance for Positive and Preventive Code of Student Conduct Policy and Alternatives to Suspension. In it, the Board recognizes that, while suspension may have at one time encouraged students to change their behaviors, it is no longer an effective strategy. The Board goes on to state that while school safety continues to be a viable reason for excluding students from a particular school setting, there is no evidence that traditional exclusionary practices change student behavior.

Restorative policies remain the exception for drug-related violations

Section 22.1-277.08 of the Code of Virginia requires students to be expelled if the school board determines they brought drugs onto school property or to a school-sponsored activity, including controlled substances, imitation controlled substances, and marijuana. This statute does not apply to alcohol, tobacco, or vape products. Statutory language gives school boards broad discretionary authority to identify special circumstances, allowing them to waive penalties or substitute alternative disciplinary measures. Administrators generally exercise this discretion, reserving expulsion for repeat offenses.

Consistent with the Board's Model Guidance for Positive, Preventive Code of Student Conduct Policy and Alternatives to Suspension, House Bill 298 (2026) requires public K–12 schools to evaluate an evidence-based restorative discipline practice before suspending or expelling a student. Whenever a school proceeds with exclusionary discipline instead of a restorative approach, staff must document the justification in the student's disciplinary record. However, HB 298 includes an exception specifically for drug offenses, pursuant to §22.1-277.08. This exception creates an inconsistency in the law. Because the exception covers only cannabis and scheduled controlled substances, excluding other harmful products like alcohol, tobacco, and nicotine vapes, it forces school administrators to apply a restoration-first approach to certain illicit substances while defaulting to an exclusion-first model for others. The

detrimental impacts of exclusionary discipline, as recognized by the Board of Education, are identical regardless of the substance involved. The exception may also be confusing for school administrators, who will have to consider two separate sets of policies depending on the specific substance infraction students commit. The overall effect of the statutory carveout for drug violations is that students who may need substance use supports and services are not covered by the requirement that schools seek evidence-based restorative discipline practice before suspending or expelling them. This is problematic because many school counselors and administrators indicated that substance use on school grounds can be an early sign of dependence, trauma, underlying mental health issues, and high-risk behaviors.

Adolescent substance use on school grounds can be a coping mechanism for unmanaged mental health struggles, emotional distress, and underlying trauma, rather than casual experimentation. Students frequently turn to substances to self-medicate and numb emotional pain stemming from difficult home environments, adverse childhood experiences, anxiety, and depression. In some cases, students report using substances during the school day because they lack healthy emotional regulation tools. These observations were consistently reported by school counselors and administrators across site visits.

Risking disciplinary actions by engaging in substance use directly on school property serves as an early indicator of physical addiction and escalating behavioral health crises. In-school substance violations function as an early warning sign for severe co-occurring challenges, including academic disengagement, clinical depression, and suicidal ideation. Identifying these behaviors highlights a critical need for immediate clinical triage and trauma-informed support rather than punitive measures. Catching a student using substances at school provides an essential opportunity for immediate health screening and supportive care. Applying purely punitive discipline fails to address underlying behavioral health needs and risks increasing student isolation.

The General Assembly may wish to consider amending § 22.1-279.6:1, which is set to become effective on July 1, 2027, to remove the exceptions for certain drug offenses listed in §22.1-277.08. Removing this exception would not compromise school boards' authority to suspend or expel students when aggravated circumstances are present—such as repeated prior disciplinary offenses, or if the student's continued presence poses a continuing danger to persons or property or is an ongoing threat of disruption.

RECOMMENDATION 1

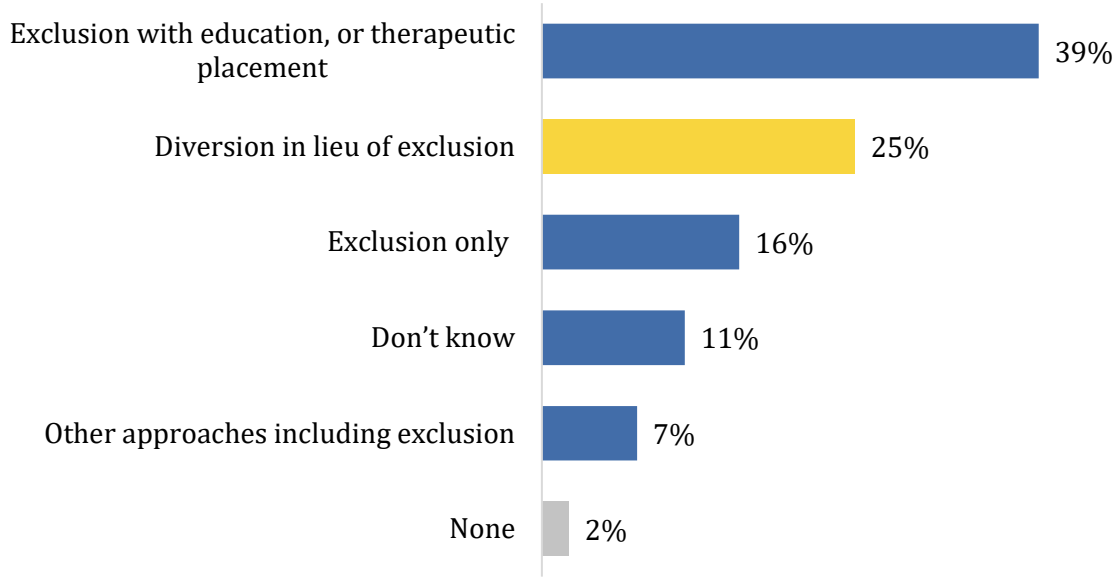
The General Assembly may wish to consider amending subsection B of § 22.1-279.6:1, effective July 1, 2027, to remove the exception for drug offenses listed in §22.1-277.08 from the requirement that no public elementary or secondary school student shall be suspended, expelled, or excluded from attendance at school unless the school first considers at least on evidence-based restorative disciplinary practice.

Some school divisions are using restorative practices and diversionary programs

Some divisions report using restorative practices in addition to or in lieu of traditional suspension. Most commonly, secondary schools combine suspensions with a restorative

activity or therapeutic placement, such as requiring students to complete a substance use education module or temporarily assigning them to an off-site educational center or therapeutic program, based on responses to the BHC survey (Figure 3-5). Approximately 25 percent of responding secondary schools indicated using diversionary responses to substance use policy violations in lieu of suspensions. About 16 percent of schools address drug policy violations strictly with punitive consequences, including suspensions, social probation, and revocation of privileges.

Figure 3-5
A quarter of schools offer diversion options in lieu of suspensions for substance-related reasons



Note: n=188 secondary schools
Source: BHC staff analysis of statewide survey of school counselors (September 2026)

Several school divisions report deploying division-designed, in-house early intervention programs that replace a strictly punitive approach to substance use with health-centered care while functioning as a vital clinical triage point. Rather than defaulting to out-of-school suspensions, health-based diversion programs keep youth safely connected to school while delivering behavioral support.

Arlington County's RESET program and Botetourt County's Youth Wellness Initiative demonstrate how local divisions leverage specialized professionals to develop early screening and behavioral support in practice.

Case study: Botetourt Youth Wellness Program

Created by Botetourt County Public Schools alongside local partners and Blue Ridge Behavioral Healthcare, the Botetourt Youth Wellness Program serves as a rehabilitative alternative to traditional suspensions and expulsions for student tetrahydrocannabinol (THC)

and alcohol violations. Replacing an untenable policy that automatically triggered expulsion recommendations after a second offense, the model diverts first-time offenders to a 10-day off-site placement at the Botetourt Technical Education Center. Youth maintain coursework while receiving meals, transportation, and counseling from Student Assistance Program counselors and second-time offenders are routed to a 60-day placement featuring evidence-based clinical therapy and mandatory family engagement. By preserving academic continuity and embedding behavioral health care directly into the disciplinary pipeline, the initiative reduced district-wide repeat offenses from ten down to just three in its first year.

Case study: Arlington Reset Program

Arlington Public Schools' RESET program (formerly Second Chance) serves as an in-house, restorative alternative to suspension for students in grades 6–12 facing alcohol, nicotine, or THC infractions. Facilitated directly by the division's Certified Substance Abuse Counselors (C-SACs), the program utilizes the Substance Abuse Subtle Screening Inventory to triage youth, directing lower-risk students to monthly group education and escalating higher-risk youth to individualized clinical care or external community referrals. Delivered in English and Spanish, RESET requires parent co-participation to foster restorative family dialogue, incorporates pre- and post-assessments, and brings in multi-agency guest speakers, such as law enforcement and recovery advocates, to deliver comprehensive legal and health education. While this in-house model strengthens trust and keeps infractions off permanent records, division leaders acknowledge an operational trade-off, as dedicating two counselors to facilitate multi-day monthly sessions temporarily pulls specialized behavioral health staff away from daily on-site school crisis response.

The variation in divisions' approaches reflects differences in resources as well as knowledge of available alternatives. VDOE staff interviewed for this study indicated that ongoing training was critical to ensuring that local school boards are aware of the options available to them in responding to student drug violations. Staff in smaller and under-resourced divisions may also lack the bandwidth to explore restorative and diversion options that could be implemented in their schools.

To address the resource and operational constraints faced by some divisions, additional staffing may be necessary. A statewide needs assessment would help the state obtain detailed information about the specific needs of each school division, including the type and number of division-level personnel required to identify and implement restorative options to suspension for drug-related violations. In addition, establishing a centralized support and technical assistance structure at VDOE could help divisions gain access to information about alternatives to suspension, effective diversion programs, and best practices about other divisions' strategies.

These are part of two broader recommendations to direct VDOE to conduct a detailed needs assessment and to establish a centralized support and technical assistance structure. These recommendations are explained more fully in Chapter 5, along with potential funding sources.

4 Referrals to clinical treatment

Public schools rely heavily on external providers for specialized substance use treatment because school personnel often lack the expertise, clinical licensure, infrastructure, and mandate to provide intensive care. Yet, a quarter of schools maintain no formal partnerships with providers in the community due to the administrative challenges of establishing and maintaining a provider network and frequent provider shortages. Schools also frequently face difficulties getting the parental support needed to successfully refer students to treatment, and parents who want to link their child to services often face transportation barriers and scheduling conflicts. To help families overcome logistical constraints, many schools offer access to clinical treatment onsite during the school day, but offering consistent provider coverage can be challenging due to staffing turnover and volatile funding streams. Unaddressed substance use leads to student health deterioration and academic decline, while forcing ill-equipped school staff to internally manage high-acuity students. To help link students with substance use treatment, the General Assembly could examine the need for additional division staffing to develop and facilitate provider partnerships, and for funding strategies to embed clinical providers directly within schools.

Students face significant barriers to accessing clinical substance use treatment

Students and families face substantial obstacles to accessing external substance use care through school referrals. One-quarter of public schools maintain no active community partnerships, based on a statewide survey of school counselors. Even where partnerships exist, most students are unable to receive off-site care because of barriers that include a lack of parental engagement, costs, logistical challenges, and a lack of provider availability. These obstacles cause external referral pathways to stall or collapse, leaving vulnerable students without essential treatment. When needed treatment is not provided, school staff are forced to internally manage acute behavioral crises.

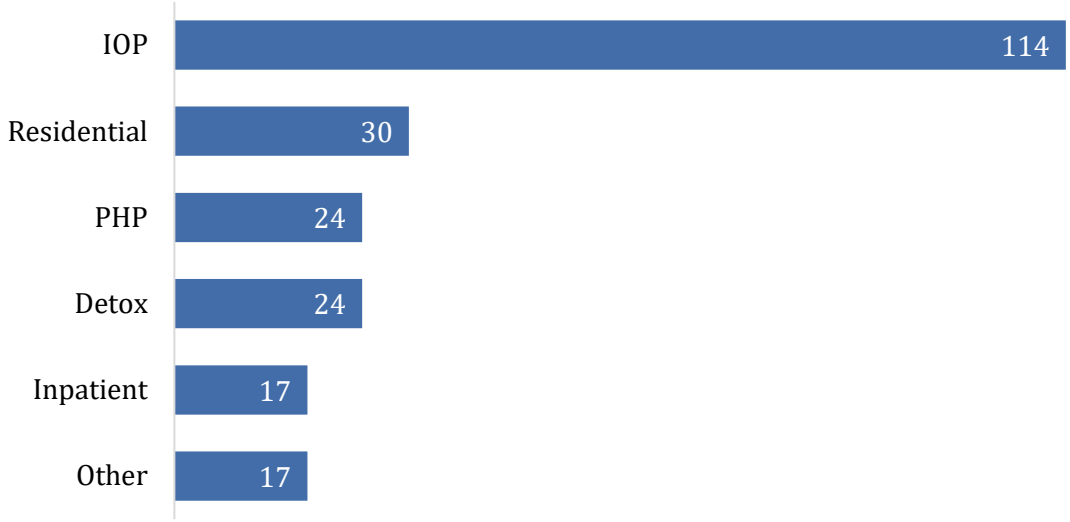
Public schools often rely on referrals to community providers for clinical substance use care

When students have a substance use disorder (SUD), schools depend on formal referral networks and warm handoffs to connect youth with community providers. Public schools generally rely on referrals to community providers for specialized substance use care because schools are not intended to deliver clinical care. While school counselors and other school staff deliver baseline prevention and early intervention, school personnel lack the expertise and clinical licensure required for treatment.

Secondary schools that responded to the BHC survey reported a total of 977 referrals to outpatient substance use services during the 2025-2026 school year, or just over one percent of those schools' student populations. The median number of referrals per school was four

students. Referrals to more intensive services were far less common; Intensive Outpatient Programs (IOP) were the most frequent intensive substance use service referral, followed by residential treatment programs and partial hospitalization (PHP) programs (Figure 4-1).

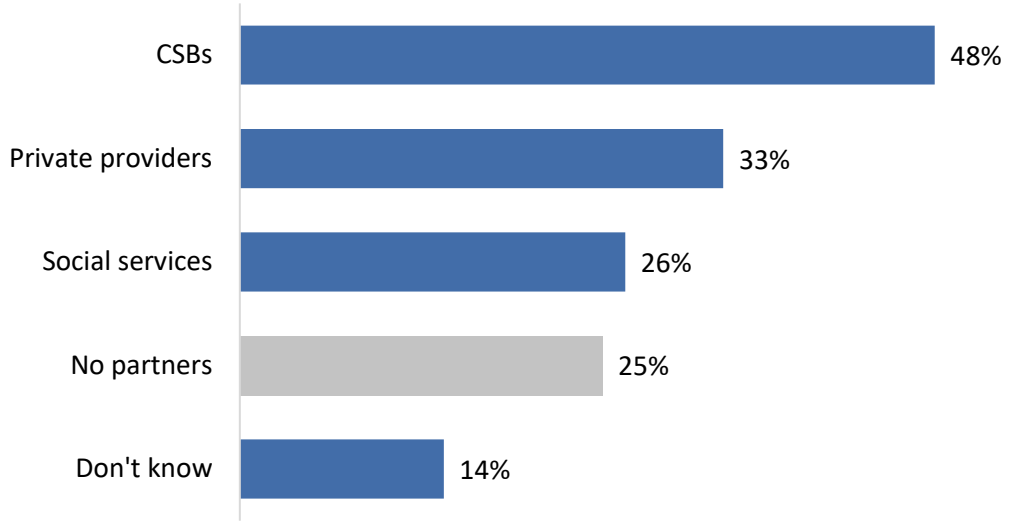
Figure 4-1
Most common intensive substance use service referral was for intensive outpatient programs (IOP)



Note: n=95 secondary schools
Source: BHC staff analysis of statewide survey of school counselors (September 2026)

About 60 percent of secondary schools had developed partnerships with external providers of outpatient substance use services. These partnerships most frequently included Community Services Boards (CSBs) (48 percent), alongside select private and social service agencies (Figure 4-2). Partnerships can range from informal relationships forged by school counselors to formal arrangements. For example, a school counselor interviewed during a site visit explained that they cultivated a network of community-based providers whom they could contact directly to support students in need. However, this task is more frequently done at the division level because it centralizes the process of negotiating Memoranda of Understanding (MOUs), issuing Request for Proposals, and managing vendor contracts. Central office staff generally execute these duties to ensure division-wide coverage and safeguard school staff bandwidth.

Figure 4-2
Majority of secondary schools have developed partnerships with community-based providers of outpatient substance use services



Note: n=193 secondary schools; schools could select multiple answers
Source: BHC staff analysis of statewide survey of school counselors (September 2026)

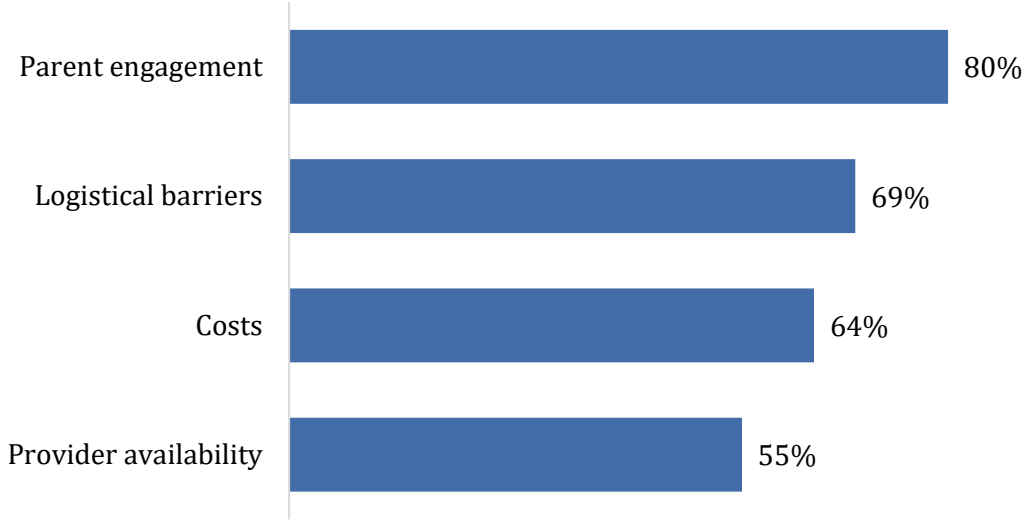
A quarter of respondents indicated that their school does not maintain any community partnerships. Maintaining partnerships offers a number of benefits compared to school counselors doing ad-hoc searches for providers when the need arises. Without a formal agreement, the Health Insurance Portability and Accountability Act (HIPAA) and privacy rules may prevent external providers from communicating with the school. Formal partnerships allow counselors to call ahead, coordinate with providers, and follow up directly to verify whether the student is receiving care. Centralized, formal partnerships also establish clear, reliable referral pathways that save counseling staff time. Relying on ad-hoc searches forces school counselors to spend extensive time calling around to verify providers who have availability and whether they accept a student's insurance.

Parental engagement and practical barriers undermine student access to community providers

Students who are identified by school personnel as needing outpatient substance use services do not always receive these services due to a variety of barriers ranging from societal to practical. A lack of parental engagement was the most frequently cited barrier to linking students with the services they need, according to school counselors who responded to the BHC staff survey (Figure 4-3). Parents and guardians who want to facilitate their children's access to community providers face a variety of practical barriers, including employment conflicts, travel constraints, and financial or insurance gaps. These obstacles are often further amplified by provider shortages. Together, these systemic and logistical hurdles can lead to

delayed or foregone clinical care. School counselors estimated that only 32 percent of students they referred to outpatient substance use services actually received those services.

Figure 4-3
Parental engagement is most common barrier to linking students to needed services



Note: n=180 secondary schools; schools who selected barriers as moderate or significant
Source: BHC staff analysis of statewide survey of school counselors (September 2026)

Parental and caregiver engagement

School staff interviewed for this study indicated that parents are not always willing to engage or follow through on referrals to community-based services. In some cases, deep-seated social and cultural dynamics may prevent families from seeking clinical support. These entrenched factors, ranging from community stigma and fear of institutional judgment to household normalization of substance use, can lead some parents to delay or avoid needed treatment.

In some communities in Virginia, the social stigma and reputational concerns related to substance use create significant cultural resistance that prevents families from seeking services. Public behavioral health agencies like CSBs may carry long-standing negative stereotypes, with families fearing that accepting services labels their child or household as fundamentally unstable. A cultural emphasis on self-reliance further encourages families to manage behavioral issues privately rather than relying on formal counseling or psychiatric care. Furthermore, parents may fear institutional judgment, worrying that disclosing adolescent substance use will lead school personnel or community providers to deem them "bad parents," scrutinize their home environment, or trigger unwanted involvement from law enforcement and Child Protective Services.

In some instances, parental attitudes and household normalization of substance use present a barrier to effective clinical intervention. Across school districts visited for this study,

educators observed that adolescent vaping, nicotine use, and marijuana consumption were sometimes normalized within the home, with some parents actively providing or sharing substances or leaving substances accessible to youth. When notified of school infractions, some parents exhibit denial or defensiveness, refusing to acknowledge the severity of the issue. Interviewees reported that, overwhelmed by external life stressors, non-parent guardians may default to the path of least resistance, maintaining permissive boundaries and tolerating substance use at home rather than enforcing consequences or pursuing rigorous clinical care.

Logistical barriers

Parents who want to connect their children to services may be unable to do so because they lack the time or reliable transportation necessary to attend appointments. Because community providers and CSBs typically operate during standard daytime business hours, parents must take time off from work to transport youth to attend appointments. Initial clinical intakes are often multi-hour procedures requiring parents to forfeit half or full workdays, which may pose financial and job-security risks for hourly employees or adults working multiple jobs. When programs or evaluations require joint parent-student attendance, parents struggle to reconcile these time-intensive demands with their work schedules, resulting in missed appointments or uncompleted referrals.

Transportation constraints further exacerbate access challenges, particularly for lower-income families and those within rural school divisions. Low-income families may lack reliable private vehicles or money for gas, relying instead on public transit or walking. In rural jurisdictions where CSB offices or specialized clinicians are located outside county borders, parents face significant round-trip commutes. Additionally, because mid-day transportation to off-site clinical facilities takes substantial travel time, parents often keep students out of school for an entire day rather than returning them to class after an appointment.

Costs

Financial limitations and insurance gaps can also create substantial financial barriers for families seeking external care. Families without health insurance, or those with commercial policies featuring high co-pays and deductibles, struggle to afford private outpatient counseling or residential treatment. Some private providers cited low state Medicaid reimbursement rates as a reason for refusing Medicaid, limiting options for lower-income youth. Furthermore, school staff highlighted the burden services may place on working-class families who earn too much to qualify for Medicaid but cannot afford high out-of-pocket costs for commercial behavioral health services.

Provider availability

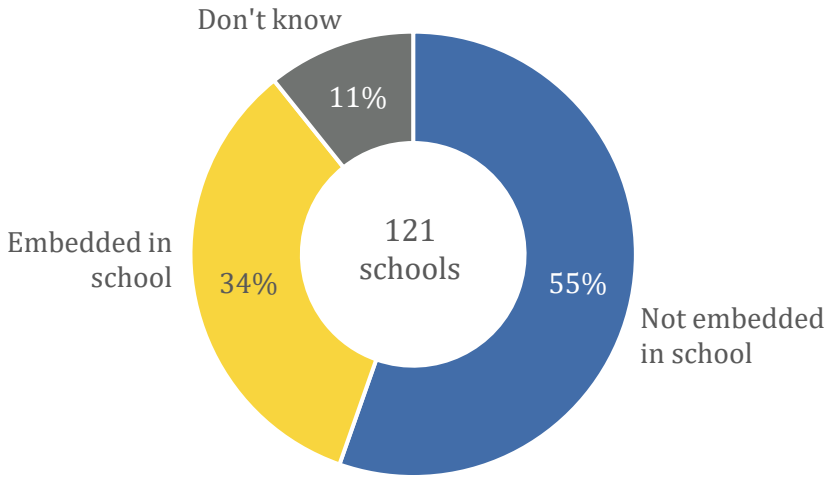
Shortages in provider availability leave families facing delays or outright gaps in adolescent clinical care. The behavioral health workforce shortage contributes to extended waitlists, forcing families to wait anywhere from several weeks to six months for an intake or individual counseling. In some localities, community providers maintain no physical footprint or active service delivery within county borders. Furthermore, frequent clinician turnover at external

agencies routinely disrupts care continuity, placing cases back onto waitlists or forcing families to restart the intake process from scratch.

Some schools integrate clinical providers directly into schools

To reduce barriers to external referrals and expand student access to care, some schools directly integrate clinical behavioral health providers into their schools. Among schools that reported partnering with community providers to provide substance use services, about 34 percent of schools reported embedding community providers in their buildings (Figure 4-4). Divisions operationalize this service model in a number of different ways. Some divisions directly employ licensed clinical behavioral health providers to provide clinical services in their schools. However, this constitutes a minority of schools. Among respondents, only about 13 percent indicated that their school had access to division-employed clinicians. Far more commonly, schools rely on partnership with community providers.

Figure 4-4
One-third of schools with community partnerships embedded community providers into their buildings



Source: BHC staff analysis of statewide survey of school counselors (September 2026)

To deliver on-site mental and behavioral health care, school divisions partner with public, private, and healthcare organizations to co-locate licensed clinicians in dedicated campus spaces. For example, in Amelia County, Elk Hill provides on-site, one-on-one therapy directly within schools during the school day. In Arlington, the County Department of Human Services co-locates therapists inside high schools three to four days per week, providing year-round 12-month care continuity, even during summer school. Carroll County partners with Tri-Area Community Health, a Federally Qualified Health Center, to operate a full-service School-Based

Health Center that combines primary care with integrated behavioral health to assist students facing emotional crises or disciplinary infractions. The availability of embedded clinical personnel exhibits wide variation across school divisions, spanning from permanent, full-time daily integration to part-time, rotating, or schedule-dependent visits. Among schools that have embedded providers, almost all reported them being available in person, and a telehealth option was also available in about 44 percent of those schools.

Multiple challenges exist with establishing and maintaining reliable partnerships:

- **Clinician Turnover at Partner Agencies:** School-based clinical services rely on specific individuals assigned by external agencies. Partnering agencies can face high staff turnover. When a clinician leaves, partner agencies may lack a replacement, causing the school's coverage to be abruptly eliminated.
- **Expiration of Grant Funding:** Some community partnerships are funded through temporary grants. When grants expire and local funds cannot absorb the cost, the provider position disappears.
- **Medicaid Funding Constraints & Caseload Thresholds:** External providers rely heavily on Medicaid billing to support school-based staff, but low perceived state reimbursement rates combined with minimum student volume requirements make on-site placements financially unviable. Community agencies often require a baseline caseload, with a specified minimum number of Medicaid-funded clients in a single building, to justify assigning a clinician. When schools cannot guarantee this volume, or when reimbursement rates fail to support competitive salaries, providers are forced to withdraw from school contracts or bypass lower-income and rural districts altogether.
- **Provider Withdrawals and Rural Coverage Gaps:** School administrators in rural divisions confirm that agencies struggle to recruit clinicians who are willing to commute to remote buildings, resulting in providers bypassing smaller districts or abruptly withdrawing coverage when an assigned clinician resigns and cannot be replaced.
- **Administrative Turnover Within the School Division:** Sustaining MOUs and Medicaid billing partnerships requires significant central office oversight. When key administrative staff who manage these contracts leave the division, the organizational capacity needed to maintain or renew partner agreements may be lost.

Embedding clinicians directly within public schools circumvents major practical and cultural barriers by bringing clinical care directly into the student's daily environment. Co-located providers allow students to receive therapy during the school day, eliminating the need for parents to take time off work, arrange daytime transportation, or navigate long commutes to treatment. This model keeps students engaged in instruction rather than missing full days for off-site appointments, while also insulating families from perceived negative social stigma sometimes associated with substance use care. By shifting scheduling, classroom pull-outs, and follow-up logistics to embedded therapists, the burden on families is reduced to simply signing consent paperwork, resulting in significantly higher service access and completion rates.

To facilitate more widespread availability of embedded clinicians and more sustainable arrangements, the General Assembly could examine the cost and feasibility of funding CSBs to co-locate providers in schools. A statewide needs assessment would help the state obtain detailed information about the specific needs of each school division. This is part of a broader recommendation directing Virginia Department of Education to conduct a detailed needs assessment, which explained more fully in Chapter 5, along with potential funding sources.

5 Options and funding streams

Virginia public schools struggle to provide a comprehensive array of substance use prevention efforts, early intervention services, and external referrals that meet the needs of students. Challenges typically stem from insufficient staff capacity to plan for and implement programs and activities that are not required or strictly essential. A few divisions have specialized personnel to take on these roles, but smaller divisions and those without dedicated local support must rely on existing resources. Centralized state support and technical assistance would help school divisions with some of the administrative aspects of setting up more comprehensive and effective programs and practices. However, additional staffing and resources will be required for school divisions to actually provide supports and services. A detailed needs assessment would help the state better understand the individual needs of school divisions and determine how best to target funding. The enactment of Virginia's adult-use retail cannabis market establishes a dedicated and growing state revenue stream that can support school-based substance use supports and services. These emerging funds align directly with the policy recommendations outlined in this chapter, offering a sustainable mechanism to expand school-based prevention and intervention, and to facilitate access to treatment.

Policy recommendations to support school-based substance use prevention and services

Virginia schools do not consistently offer comprehensive and effective substance use prevention efforts and early intervention services, and external referrals to treatment are not always successful. The scope of each school division's education and prevention efforts varies widely, and few schools are able to provide the multi-layered approach recommended in the research literature. Few schools utilize formal screening tools to identify students who need extra assistance, and few have access to dedicated substance use counselors who can help meet students' needs and develop restorative alternatives to suspensions when students are caught using. Many schools offer access to clinical treatment onsite to help families overcome logistical barriers to access, but offering consistent provider coverage can be challenging due to staffing turnover and volatile funding streams.

In many cases, schools and divisions are limited by the bandwidth of their staff, who often play multiple roles, and by a lack of funding for resources such as evidence-based programs. This is especially true for small divisions and those that receive limited financial support from their local governments. To address the resource and operational constraints faced by smaller and less-resourced school divisions, the General Assembly may wish to

- Create and fund a staffed, state-level structure within the Office of Behavioral Health and Student Safety at the Virginia Department of Education (VDOE) to provide information, support, and technical assistance to school divisions for purposes of

strengthening school-based substance use prevention and early intervention efforts, and establishing community partnerships; and

- Direct VDOE to conduct a detailed needs assessment to determine the number and types of positions and other resources needed by school divisions to offer comprehensive and effective supports and services for substance use prevention and early intervention, and to facilitate access to treatment with community providers.

Centralized support and technical assistance from VDOE

Establishing a centralized support and technical assistance structure would help alleviate the burden on school divisions and school staff of identifying, vetting, and implementing research-based programs and practices for:

- offering comprehensive and effective school-based prevention and early intervention services and supports, including formal screening tools (Chapter 2); and alternatives to suspension and effective diversion programs (Chapter 3);
- establishing and maintaining partnerships with community-based organizations (Chapter 2); and community-based service providers (Chapter 4); and
- engaging parents and caregivers (Chapter 2, Chapter 4).

The Office of Behavioral Health and Student Safety at VDOE is well-positioned to lead this effort given its mission and existing responsibilities. The Office is responsible for programs and activities that focus on positive school climates and learning environments; the safety and well-being of students and staff; the healthy social, emotional, and physical development of children and youth; and student learning and academic achievement, in concert with families and the community. The Office has previously been charged with providing technical assistance on effective practices and implementation to school divisions across Virginia in support of the Community Schools model, pursuant to a 2019 Virginia General Assembly directive. The Office also has an established partnership with the Department of Behavioral Health Services and Developmental Services (DBHDS) and an understanding of the behavioral health challenges facing school divisions, following joint work on a grant program for school-based mental health services.

RECOMMENDATION 2

The General Assembly may wish to consider including language, additional funding, and one Full-Time Equivalent (FTE) for a dedicated Substance Use Prevention Specialist in the 2027 Appropriation Act and to direct the Virginia Department of Education (VDOE) to establish a formal structure within the Office of Behavioral Health and Student Safety to support school divisions with school-based substance use prevention and early intervention efforts, and referrals to treatment. VDOE, in collaboration with the Department of Behavioral Health and Developmental Services, should establish and maintain a centralized clearinghouse of research-based programs and practices related to school-based substance use prevention; early intervention; alternatives to suspension and restorative diversion; universal

screening instruments; the engagement of parents, caregiver, and community organizations; and the establishment of partnerships with community-based service providers. The clearinghouse should also include implementation toolkits and professional development resources.

VDOE, in partnership with other state agencies with requisite subject matter expertise, should also provide ongoing technical assistance and training to assist divisions with the selection and implementation of school-based substance use prevention, early intervention, and restorative diversion programs and practices. VDOE should also facilitate the cross-division sharing of best practices related to school-based substance use programs and practices. The Office of Behavioral Health and Student Safety should report to the Behavioral Health Commission on the implementation status and contents of the centralized clearinghouse; nature and extent of its technical assistance training and efforts; and new programs and practices adopted by school divisions that received support from the Office by December 1, 2027 and provide a follow-up report by December 1, 2028.

Comprehensive needs assessment to target funding

Centralized state support could help local personnel expand their current bandwidth, but some school divisions will still require additional staff and funding to perform the on-site activities needed to offer comprehensive and effective substance use supports and services. The needs of each school division differ substantially. In addition to differences in local financial support, school divisions have different office and staffing structures, community norms and expectations, and geography that shape the types of positions and funding that would best fit their individual needs. A statewide needs assessment conducted by VDOE would help the state obtain detailed information about the specific needs of each school division so that funding can be effectively targeted. The assessment would help identify the need for:

- School- and division-level staff, including specialized substance use counselors, to
  - oversee the implementation of and administer evidence-based early intervention programs and formal screening tools; and lead outreach to and manage community partners (Chapter 2);
  - oversee the delivery of and provide early intervention services; and implement restorative options to suspensions and expulsions (Chapter 3);
  - establish and maintain formal relationships with community-based service providers; and establish in-school provider arrangements (Chapter 4); and
- Other funding to
  - implement programs and practices, such as licensing and training for evidence-based models (Chapter 2); and
  - establish sustainable in-school provider arrangements (Chapter 4).

In addition to identifying needs, the assessment should include the estimated cost of meeting divisions' needs; recommended staffing ratios for division- and school-level personnel

needed to facilitate the provision of substance use supports and services; and recommendations for a mechanism to allocate funding among school divisions. VDOE, in partnership with DBHDS, should also examine the need for co-locating additional providers of outpatient substance use services in schools and the cost and feasibility of funding Community Services Boards (CSBs) to be embedded in schools determined to need such arrangements. The General Assembly could use this information to determine how much funding, if any, it wishes to appropriate using new state marijuana tax revenue and/or General Funds during the 2028 legislative session.

RECOMMENDATION 3

The General Assembly may wish to consider including language in the 2027 Appropriation Act directing the Virginia Department of Education (VDOE) to conduct a detailed statewide needs assessment to determine what resources school divisions need to offer comprehensive and effective supports and services for substance use prevention and early intervention. Specifically, the needs assessment should (i) examine the positions and other resources required for divisions to implement validated screening tools; deliver evidence-based prevention programs; provide early intervention services; and lead community partnerships; (ii) include recommended staffing ratios for school division personnel and/or specialized substance use personnel needed to carry out the responsibilities listed in (i); (iii) estimate the cost of funding the recommended staffing ratios and other resource needs identified; and (iv) recommend a methodology for allocating funding to school divisions, evaluating whether a formula-based or grant-based mechanism best meets divisions' needs. VDOE, in partnership with the Department of Behavioral Health and Developmental Services, should also examine the need for, cost, and feasibility of funding Community Services Boards (CSBs) to co-locate providers of outpatient substance use services in schools. VDOE should report to the Chairs of the Behavioral Health Commission and the Joint Commission to Oversee the Transition of the Commonwealth into a Cannabis Retail Market on the results of the needs assessment and on the feasibility of embedding CSB providers in schools no later than December 1, 2027.

Biennial survey to monitor ongoing school needs

A comprehensive needs assessment is necessary to determine a baseline of what positions and other resources would be required to deliver a comprehensive continuum of substance use supports and services and the associated costs. However, ongoing periodic reassessment will be required to track emerging and changing needs and trends. Ongoing reassessment should encompass school-based mental health and substance use because of the close interrelation of the two, with substance use and mental health issues often reinforcing each other.

School counselors and administrators consistently emphasized how deeply intertwined adolescent substance use and underlying mental and behavioral health struggles are. School staff noted that students often use substances to self-medicate for emotional or psychological pain, calm anxiety, or cope with difficult home environments, and stressed the importance of addressing underlying mental health root causes.

To continually monitor and evaluate the extent to which students' needs for mental health and substance use supports and services are being met, the General Assembly may wish to direct VDOE to conduct a biennial survey of all school divisions to assess how services are being provided in schools and how schools are coordinating with community partners to meet students' needs.

RECOMMENDATION 4

The General Assembly may wish to consider including language in the 2027 Appropriation Act directing the Virginia Department of Education (VDOE) to survey each local education agency (LEA) in the Commonwealth biennially, beginning in 2028, to determine (i) what school-based mental health and substance use programs, supports, and services are made available by each LEA, including those targeted at education, prevention, and early intervention; and (ii) how public schools governed by such LEA facilitate access to local departments of social services, Community Services Boards, and other community-based providers of mental health and substance use treatment and services. The Department should submit a report on its findings and recommendations to the Behavioral Health Commission by November 1 of each year during which the biennial survey is administered.

Retail cannabis market will provide a new and ongoing funding stream for efforts to address substance use

The enactment of Virginia's adult-use retail cannabis market establishes a steady and growing state revenue stream that could be used to fund key substance use supports and services in public schools. The retail cannabis market will launch on July 1, 2027 and the state and localities are expected to derive substantial revenue over time through a combination of new state taxes on marijuana sales as well as state and local sales and use taxes. Revenue from the new taxes on marijuana must be used for specific purposes set forth in Virginia Code, including the support of elementary and secondary education as well as the provision of substance use prevention and treatment services. Many of the funding needs identified in this report align with one or more of the categories designated for state marijuana tax revenue. Allocating funds through these established categories would enable the General Assembly to address the challenges faced by schools in meeting the needs of their students for substance use supports and services with a reliable, dedicated source of funding.

Revenues are predicted to grow significantly over time

During the 2026 legislative session, Virginia established a regulatory framework for a recreational cannabis market in Virginia. Starting on July 1, 2027, retail transactions will be subject to a 6 percent state marijuana tax, which will increase to 8 percent on July 1, 2029. Transactions will also be subject to the regular state sales and use tax of 5.3 percent, and a new local tax ranging between 1.0 percent and 3.5 percent, as selected by the locality. Using these assumptions, Virginia is projected to raise $11.3 million in additional revenue from the new state tax on marijuana in FY 2028, rising to $74 million by FY 2032 due to market growth and the tax rate increase to 8 percent in FY 2030 (Table 5-1). The state is also expected to

collect approximately $54 million in additional sales taxes by FY 2032, and localities could raise up to $32 million if they adopt the maximum local tax rate of 3.5 percent.

Table 5-1
Estimated retail cannabis tax revenue is projected to grow during the projection period(in millions)

Fiscal year	State marijuana tax rate	State marijuana tax revenue	State sales tax revenue (5.3%)	Local sales tax revenue (1.0-3.5%)	Total state and local tax revenue
FY28	6%	$11.3	$10.8	$1.9-$6.6	$24.0 -$28.7
FY29	6%	$22.9	$22.1	$3.8-$13.4	$48.8-$58.4
FY30	8%	$47.1	$34.0	$5.9-$20.6	$87.0 - $101.7
FY31	8%	$61.5	$44.4	$7.7-$26.9	$113.6-$132.8
FY32	8%	$74.0	$53.5	$9.3-$32.4	$136.8-$159.9

Source: BHC staff analysis of fiscal impact statements on House Bill 642 (2026) prepared by the Department of Planning and Budget

Portion of new revenue is designated for K-12 and substance use prevention and treatment programs

A portion of new revenue from the retail cannabis market (specifically, the new state marijuana tax, based on fiscal impact statements from the Department of Planning and Budget) has been designated for specific purposes that align with the funding needs described in this report. The Cannabis Control Act specifies that "state marijuana tax profits" can only be appropriated to the following sources:

- **Early Childhood & K-12:** Funding designated to support early childhood care, pre-kindergarten education, and elementary and secondary (K-12) public education across the Commonwealth.
- **Cannabis Equity Reinvestment Fund:** Funding dedicated to supporting individuals, families, and communities historically and disproportionately impacted by drug enforcement through scholarship opportunities, job training, workforce development, reentry services, indigent defense, and business loans.
- **Substance Use Disorder Prevention & Treatment:** Funding distributed through DBHDS to local CSBs to administer local substance use disorder prevention and treatment programs.
- **Public Health Programs:** Dedicated funding for public health awareness campaigns designed to prevent driving while under the influence, discourage underage consumption, and inform the public of health risks.

There is limited specificity in the Code and the Appropriation Act regarding the distribution of funding between categories, or between the different components of each category (e.g., the education stream includes elementary and secondary (K-12) public education alongside early childhood care). Earlier drafts of the section creating the retail cannabis market included fixed percentages for how tax revenue should be distributed between each of the four categories, but those were removed in the final budget.

Moreover, neither statute nor the Appropriation Act specify how funding will be allocated across agencies and other entities. The education category does not specify whether funding is intended for the Department of Education, school divisions, schools, or other entities. It also does not contemplate on what basis funding should be distributed to its intended recipients; for example, funding could be made available to schools based on a formula, through grant applications, or other means.

Budget language directs the Joint Commission to Oversee the Transition of the Commonwealth into a Cannabis Retail Market to examine and recommend the optimal distribution of net profits among these four statutory categories. The Joint Commission is required to report its findings and recommendations for subsequent Appropriation Acts to the Secretary of Finance and the Chairs of the House Appropriations Committee and the Senate Committee on Finance and Appropriations by November 1, 2026.

Recommendations and options: Substance use services and supports in Virginia schools

BHC staff typically offer recommendations or options to address findings identified in its reports. Staff will usually propose options, rather than recommendations, when (i) the action proposed is a policy judgment best made by the General Assembly or other elected officials; (ii) the evidence indicates that addressing a report finding could be beneficial but the impact may not be significant; or (iii) there are multiple ways to address a finding, and there is insufficient evidence to determine the single best way to address the finding.

Recommendations

RECOMMENDATION 1

The General Assembly may wish to consider amending subsection B of § 22.1-279.6:1, effective July 1, 2027, to remove the exception for drug offenses listed in §22.1-277.08 from the requirement that no public elementary or secondary school student shall be suspended, expelled, or excluded from attendance at school unless the school first considers at least on evidence-based restorative disciplinary practice.

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Appendix A: Research activities and methods

Key research activities performed for this study included:

- structured interviews with state agencies, school counselors, principals, and school division staff;
- site visits to elementary, middle, and high schools;
- a statewide survey of public-school counselors;
- review of national research;
- reviews of state law and policies relevant to substance use supports and services in public schools
- review of previous Virginia on substance use supports and services in public schools
- analyses of Virginia Department of Education (VDOE) data including Fall Membership, Positions and Exits Collection, and Student Behavior and Administrative Response Collection

Interviews

Structured interviews were a key research method for this report. Interviewees were asked about topics such as their experiences managing adolescent substance use in K-12 settings, the implementation of multi-tiered systems of support, the benefits and operational challenges of restorative diversion programs and alternatives to suspension models, staffing constraints, community provider partnerships, and recommendations for improving state substance use supports and services in public schools. Key interviewees included:

- school division leaders
- school administrators, including elementary, middle, and high school principals
- school-based behavioral health staff, including school counselors and substance abuse counselors
- community partners and clinical service providers, including representatives from private providers and offices on youth
- Staff of VDOE, the Virginia Alcoholic Beverage Control Authority (ABC), and the Opioid Abatement Authority (OAA)

Site visits to schools

BHC staff conducted in-person site visits to six public school divisions, which included meetings with central office administrators, school principals, school counselors, certified substance abuse counselors, and community partners. Schools were selected to offer variation in school level, geography, population density, school size, student enrollment, substance abuse prevalence, and counselor-to-student ratios. The purpose of the visits was to learn about the implementation of substance use prevention, early intervention, and

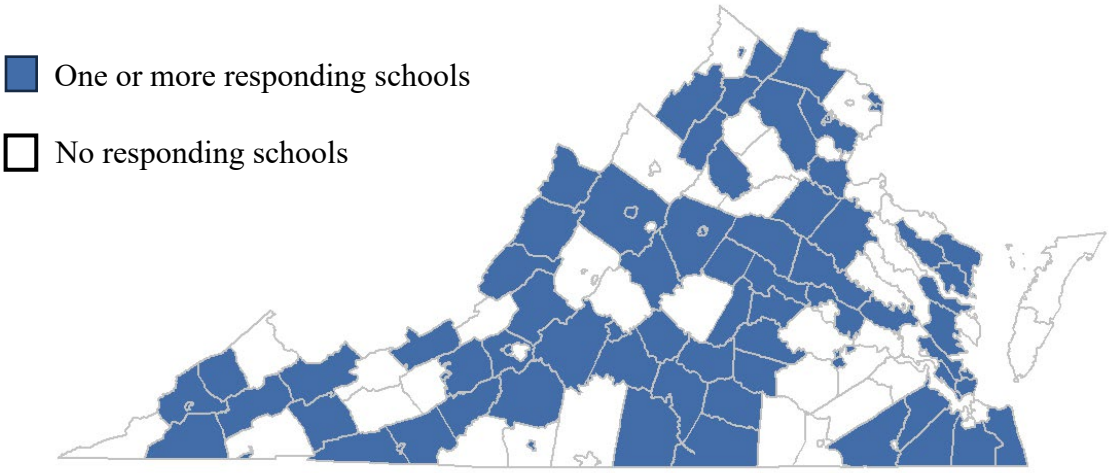
behavioral health supports in K–12 settings and hear staff perspectives on operational challenges, opportunities, and resource needs. Visits were conducted at the following schools:

- Amelia County Elementary School
- Wakefield High School
- James River High School
- Galax Middle School
- Oscar Smith High School
- Staunton High School

Survey

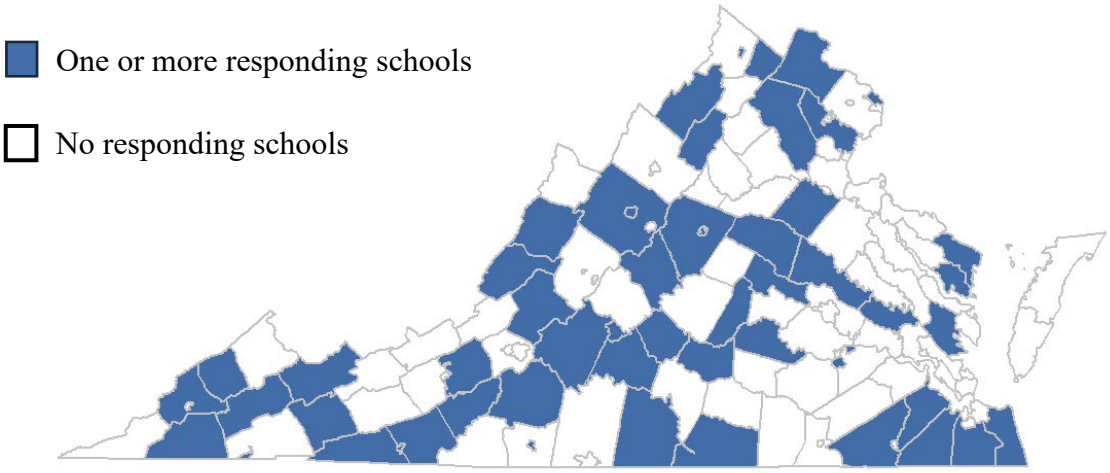
BHC staff designed a 38-question survey covering substance use education and prevention, supports and services provided by school personnel, outpatient treatment referrals, and substance use trends and school policy. BHC staff collaborated with VDOE to distribute the survey to all school counselors across the state. There were 468 responses from 82 school divisions (Exhibit A-1). The 468 responding schools account for approximately 25 percent of all public schools; they represent 320,000 public school students, or about 25 percent of Virginia's 1.25 million total public-school students.

Exhibit A-1
School counselors from 468 schools spanning 82 divisions responded to BHC survey



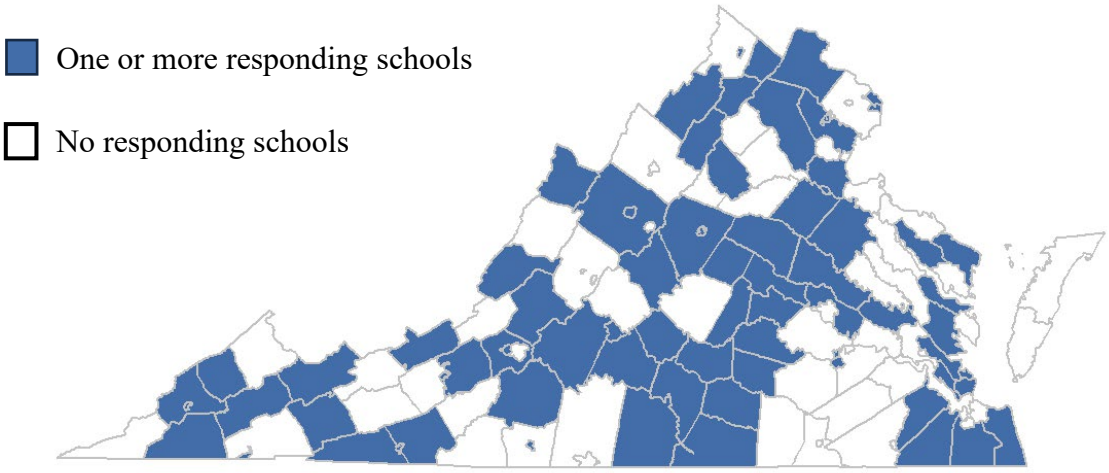
There were 247 elementary schools that responded to the survey across 55 school divisions, accounting for 21 percent of approximately 1,100 total elementary schools across the state (Exhibit A-2).

Exhibit A-2
Elementary school counselors from 247 schools spanning 55 divisions responded to BHC survey



There were 221 secondary schools that responded to the survey across 77 school divisions, accounting for 34 percent of approximately 650 secondary schools across the state (Exhibit A-3).

Exhibit A-3
Secondary school counselors from 221 schools spanning 77 divisions responded to BHC survey



Data analysis

BHC staff analyzed VDOE administrative data on student enrollment, staffing vacancies, and disciplinary incidents including drugs, alcohol or tobacco. This data was analyzed at the state, division, and school level to help inform site visit selection to get a representative cross

section of schools across the state. Staff also analyzed Census data on median household income to estimate the extent to which economic differences between divisions varied with the scope and effectiveness of substance use supports and services.

Review of documents and literature

BHC staff reviewed numerous documents and research literature pertaining to substance use supports and services in Virginia public schools, including:

- Prior reports from state agencies on substance use supports and services and mental health in Virginia public schools
- Virginia statutes and regulations governing substance use supports and services in Virginia schools
- Medical, public health, education, and other research literature on adolescent substance misuse, universal school-based prevention, and the comparative effectiveness of knowledge-based instruction, interactive skill-building, and multi-layered community coalitions across elementary and secondary levels
- Medical, public health, education, and other research on validated screening tools and health-centered diversion, the impacts of zero-tolerance exclusionary discipline, the clinical feasibility and behavioral outcomes of embedded school-based care, and the return on investment and public cost-offsets of early intervention

Appendix B: Letter from the Superintendent of Public Instruction

COMMONWEALTH of VIRGINIA

Jenna Conway
Superintendent of Public Instruction

DEPARTMENT OF EDUCATION
P.O. BOX 2120
RICHMOND, VA 23218-2120

Office: (804) 225-2057
Fax: (804) 371-2099

October 23, 2026

The Honorable Nathalie Molliet-Ribet
Executive Director
Behavioral Health Commission
411 East Franklin Street, Suite 505
Richmond, VA 23219

Dear Director Molliet-Ribet:

The Virginia Department of Education (VDOE) has reviewed the forthcoming Behavioral Health Commission Report *Substance Use Services and Supports in Virginia Schools*. The agency extends its appreciation to you and your team for your diligence in this important work. Your approach to gathering information from VDOE, school-level personnel, and state agency partners is key to ensuring accurate and practical implications are captured. The VDOE supports the findings in this review and reaffirms the commitment to supporting students' behavioral health needs, especially as it relates to substance use prevention and response efforts. The VDOE commits to addressing and supporting the major findings and recommendations that emerged from this study, including conducting a detailed needs assessment of local education agencies (LEAs) and establishing a centralized support and technical assistance structure through the Office of Behavioral Health and Student Safety.

Improving instruction and overall student outcomes through comprehensive behavioral health service provision is a key priority for the VDOE and we take our responsibilities to serve students, partner with parents, and support and train LEAs seriously.

The VDOE pledges to address the areas mentioned in the report and we look forward to working with you to make the necessary policy and financial commitments for the agency to deliver evidence-based substance abuse prevention programming and training to all staff and students throughout the Commonwealth.

Sincerely,



Jenna Conway
Superintendent of Public Instruction


BHC
Behavioral
Health
Commission