Schools at the Center of Care

How Medicaid, Child Welfare, and Community Partners Can Transform Behavioral Health Outcomes for Children and Families

Executive **Summary**

Children's behavioral health is in crisis, and no single system, agency, or provider can solve it alone. Schools, Medicaid agencies, child welfare organizations, and community partners each hold a critical piece of the solution, but too often they operate in isolation from one another.

Schools have emerged as one of the most promising settings for identifying behavioral health needs early and connecting families to support before a crisis takes hold. Medicaid provides the funding backbone to sustain many of these services, while community organizations and child welfare agencies bring specialized expertise that schools alone cannot provide.

Together, cross-system collaboration between schools, Medicaid, child welfare, and community support can create a more integrated continuum of care, one that prioritizes prevention, strengthens families, and improves long-term outcomes.

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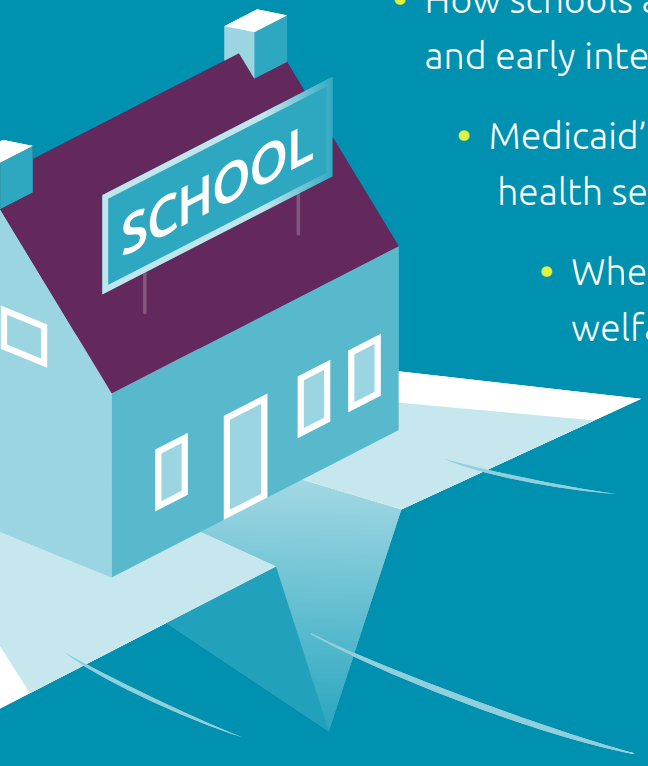
realize the opportunity.

The future of children's behavioral health depends not only on expanding services but on connecting the systems already in place so that support is easier to access, more responsive to family needs, and better aligned around shared goals. When systems work together, children and families get the right support at the right time, before challenges become crises and before opportunities for prevention are lost.

This issue brief explores how schools can serve as the connective hub for children's behavioral health outcomes. You'll learn:



- How schools are becoming active partners in prevention and early intervention
- Medicaid's role in financing school-based behavioral health services
- When behavioral health concerns become child welfare concerns
- Why supporting families and caregivers is part of the behavioral health strategy
- How to bridge systemic silos across education, child welfare, and Medicaid
- How to address workforce and data infrastructure challenges
- A path forward toward better outcomes for children and families

The New Front Door:
Why School-Based Behavioral Health Is Different This Time

Children's behavioral health has been widely written about. What hasn't gotten enough attention is where care is really starting to happen: the classroom, not the doctor's office.

The 20-20-20 Gap

1 in 5
U.S. children has a diagnosable mental, emotional, or behavioral health disorder.

1 in 5
of those children ever sees a specialized mental health provider.

1 in 5
U.S. public school students is now getting care at school instead of a clinical setting.

Source: American Academy of Pediatrics

The math is the story: access to specialty care hasn't kept pace with need, so schools are quietly filling the gap. For decades, behavioral health services were delivered almost exclusively in clinical settings, creating barriers such as limited transportation, scheduling conflicts, the stigma of seeking treatment, and a shrinking behavioral health workforce. When access is delayed, needs become more severe.

Because children spend so much of their lives in school, school-based behavioral health has become one of the most efficient ways to close that access gap. In the 2024–2025 school year, nearly one in five U.S. public school students utilized school-based mental health services, and approximately 83% of public schools provided individualized mental health intervention. More than half of U.S. public schools reported an increase in students seeking these services.

The shift that matters most isn't the volume of students being served; it's the role schools are stepping into. Rather than functioning solely as referral sources, schools are becoming active partners in treatment coordination and family support, serving as the front door to children's behavioral health.

When Every Day Matters: Schools and the Case for Early Intervention

There's an ongoing mental health crisis among children and adolescents.

Suicide is a leading cause of death for youth ages 10 to 19, and the suicide rate for children aged 10 to 14 tripled between 2007 and 2018. Against that backdrop, early identification isn't just clinically ideal; it's potentially lifesaving.

Because children spend so much time in school, educators and staff are uniquely positioned to catch early changes in behavior or emotional regulation. School settings often serve as the first site of detection for behavioral health challenges, meaning staff can flag needs before they escalate, and connect families to support earlier in the trajectory of need.

Detection is only half the equation. About one-third of U.S. schools say they can't effectively provide mental health services, largely due to funding constraints and provider shortages. Asking schools to take on this expanded role without the resources to support it risks overburdening staff who already have full-time jobs.

Early identification only leads to better outcomes when schools have the resources to act on what they see. That's where Medicaid comes in.

Follow the Funding: Medicaid's Critical Role in School-Based Behavioral Health

Medicaid is the largest payer of mental health services for children in the United States, which makes it the financial backbone of the systems that support them.

For years, Medicaid reimbursement for school-based services was limited to what was documented in a student's Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). A 2014 change to the so-called "Free Care Rule" clarified that schools could seek Medicaid payment for medically necessary services provided to Medicaid-enrolled students, regardless of whether those services were tied to an IEP or IFSP. That single policy shift meaningfully improved access to high-quality services for students nationwide.

In practice, Medicaid gives schools a way to draw down federal funding for services they may already be providing, freeing up resources that can be reinvested based on the needs and priorities of their student population.

As of July 2026, 28 states have expanded their school-based Medicaid programs to cover services outside the IEP/IFSP, enabling reimbursement for psychological assessments, counseling, and substance use treatment, among other services. CMS's 2023 guidance on school-based settings reaffirmed behavioral health as a core component of what schools can provide under Medicaid.

School-based services may include:

- Counseling and therapy services
- Behavioral health assessments
- Care coordination
- Crisis intervention
- Family engagement services
- Preventive behavioral health supports

Beyond schools, Medicaid finances a broader continuum of community-based services, including mobile crisis teams, intensive outpatient treatment, wraparound services, case management, and peer supports, all of which contribute to a more comprehensive system of care.

Go Deeper

Funding is rarely one stream; it's a patchwork of federal, state, and local dollars. Our Child Welfare Financing Playbook breaks down how those pieces fit together for child and family well-being. **Explore the playbook →**

Where Child Welfare and Behavioral Health Collide

Child welfare-involved youth carry a disproportionate behavioral health burden: up to 80% have significant mental health challenges, compared to roughly 18–22% of the general youth population. Left untreated, those challenges can contribute to family instability and school disengagement, which increases the likelihood of child welfare involvement in the first place.

Many families enter the child welfare system not because of intentional harm, but because behavioral health needs go unaddressed for too long, and available supports aren't enough.

Where Child Welfare and Behavioral Health Collide (cont.)

Here's the uncomfortable pattern: research shows mental health service utilization rises significantly after child welfare involvement occurs, not before. This suggests that many children only get support once a crisis has already escalated. Well-timed intervention delivered in schools has the potential to change the trajectory for both the child's development and the family's stability.

Trauma runs in both directions here. Exposure to abuse, neglect, violence, or family instability can create behavioral health needs, and child welfare involvement itself can compound that trauma. Youth in the child welfare system show it: almost 100% of foster care youth have experienced two or more Adverse Childhood Experiences (ACEs), and nearly 80% have experienced six or more.

That's why trauma-informed care matters so much for this population. It emphasizes safety, trust, collaboration, and empowerment, creating recovery-focused environments that promote resilience and healing rather than re-traumatization.

SAMHSA's Cooperative Agreements for School-Based Trauma-Informed Support Services and Mental Health Care for Children and Youth (TISS) program brings trauma-informed care directly into schools. Its purpose is to increase student access to evidence-based, culturally relevant trauma support and mental health care by linking local school systems with trauma-informed support and mental health systems, including those under the Indian Health Service. Grantees develop collaborative partnerships with at least one local trauma-informed support and mental health services system, along with an implementation plan covering training, family and community engagement, and long-term sustainability.

By The Numbers: SAMHSA's Trauma-Informed Support Services

5,291

school staff, students, and administrators **trained** in trauma-informed care

34,678

school-aged children and caregivers **screened** for mental health or related interventions

2,965

school-aged children and caregivers **referred** for mental health and related services

This data reflects the 2022-2023 U.S. school year *Source: SAMHSA*

Schools provide a real opportunity for prevention here. By recognizing signs of distress, connecting families to services, and coordinating care, schools and community partners can intervene before trauma compounds or a crisis occurs. Child welfare-involved youth make the case for coordinated behavioral health services especially apparent, but they're only one part of a larger system. Sustainable progress depends on integrated networks of care that support all children and families, with schools at the center of coordination.

Schools as the Backbone of a Continuum of Care

Schools provide an ideal setting for organizing a continuum of behavioral health care because they offer something clinics can't: consistent, daily access to children and ongoing opportunities for engagement. Youth are six times more likely to complete mental health treatment in schools than elsewhere, and care tends to be most effective when it's integrated into students' academic instruction rather than bolted on separately.

A SAMHSA grant, Project AWARE, supports mental health, substance use, and co-occurring disorders among school-aged youth in local education settings. It raises awareness among staff, parents, and students, and connects youth with behavioral health professionals in their communities.

First established in 2014, Project AWARE has been used in states like Colorado, where the grant helped build a coordinated, integrated school behavioral health system in partnership with the Colorado Department of Education and the Behavioral Health Administration's Office of Children, Youth, and Families.

In Washington state, counselors report that students are more engaged with stronger coping and resiliency skills, and that parents are more willing to advocate for their children's mental health once they've accessed community resources through the program.

> "Our families have a tough time being able to get off work and get to those places to access mental health services. The AWARE grant has brought those services here on campus so our students can access the services they need without having to travel and put that extra burden on the families."
>
> – **Principal,** Wahluke Junior High School, Washington state

The lesson from states that have implemented Project AWARE isn't about the grant itself. It's that effective school-based behavioral health systems depend on coordinated partnerships across education, healthcare, behavioral health, child welfare, and community organizations working toward one seamless pathway to care. As those systems mature, they also make clear that support can't stop at the child. Families and caregivers have to be part of the equation, too.

Helping Caregivers Helps Kids: Why Family Support Is a Behavioral Health Strategy

Behavioral health challenges rarely affect children in isolation. Exposure to caregiver mental illness, substance use disorders, housing instability, and other adverse experiences can increase children's risk of behavioral health challenges. The reverse is also true: a child's behavioral health needs can place significant strain on a family, creating cycles of stress that affect the whole household.

Treating behavioral health as a family issue, not just a child issue, opens the door to earlier intervention, stronger support, and better outcomes.

Schools are often the trusted institutions where families turn first. School personnel may notice caregiver stress, connect families to resources, or facilitate referrals to behavioral health providers and social services.

Community health workers extend that reach further and help offset healthcare workforce shortages. Boston Medical Center's Center for Family Navigation and Community Health Promotion, housed in its pediatrics department, is a good example: it uses "family navigators," a type of community health worker, to deliver family-centered interventions built on the premise that children can't be treated in isolation from their families.

Family navigators aren't clinicians. They don't provide clinical assessments or mental health treatment. They're the bridge between providers and systems, helping families navigate medical, community, and government processes to improve family health overall.

Health plans and Medicaid programs have their own role to play here, too, through integrated benefits, care coordination, and partnerships with community organizations. Investing in caregiver well-being isn't a side project; it's a direct investment in healthier environments for children.

The Infrastructure Gap: Workforce and Data as the Foundation for Success

None of this works without two things: a capable workforce and reliable data infrastructure. Right now, both are strained.

The Scale of the Shortage

137 million

people in the U.S., roughly 40% of the population, live in a Mental Health Professional Shortage Area (HPSA) as of December 2025.

Source: HRSA Health Workforce

Rural and underserved communities feel this most acutely. And the outlook doesn't improve on its own: substantial shortages of addiction counselors, mental health counselors, psychologists, social workers, child and adolescent psychiatrists, and school counselors are projected through 2038. Recruitment challenges, provider burnout, and reimbursement constraints all compound the problem.

Closing the gap will take more than one lever: Addressing the behavioral health workforce will require educational partnerships, training programs, reimbursement reform, and new workforce models. Peer support specialists, family advocates, community health workers, and school-based professionals can all extend the reach of traditional clinical services. Tele-behavioral health services, digital engagement tools, and hybrid care models offer another way to connect children and families to providers more easily.

Data is the other half of the foundation. Schools, healthcare providers, child welfare agencies, and health plans often operate on separate systems that don't communicate with each other, which limits coordination exactly where it matters most. Improved interoperability, data-sharing agreements, and common performance measures can support earlier identification of needs and better care coordination. Advanced analytics can help identify at-risk populations, allocate resources, evaluate outcomes, and inform workforce planning, but only if the underlying data is actually shared.

Ultimately, success has to be measured, not assumed, which requires tracking outcomes that matter to children and families like access to care, school performance, family stability, crisis utilization, and overall well-being.

The Path Forward: Making Schools the Anchor, Not Just the Access Point

No single system can solve children's behavioral health needs alone. Schools, Medicaid agencies, child welfare organizations, providers, and community partners each hold a piece of the solution, and none of them hold all of it.

For Medicaid agencies, the opportunity is to expand school-based reimbursement, strengthen community behavioral health infrastructure, and actively encourage cross-system collaboration rather than leaving it to chance.

Education leaders can build sustainable partnerships, improve referral pathways, and integrate behavioral health supports directly into school environments instead of treating them as an add-on.

Child welfare agencies can strengthen prevention efforts and work more closely with schools and healthcare partners upstream, before a case ever opens.

The real opportunity isn't any one of these moves. It's building systems that identify needs earlier, support families more effectively, and coordinate care across boundaries that were never designed with children in mind.

Schools are uniquely positioned to anchor that system. They offer trusted relationships, daily contact with children and families, and a chance to intervene before challenges become crises. By connecting schools, Medicaid, community providers, and family supports, states and communities can build a behavioral health system that moves beyond reaction toward prevention, strength, and sustainable impact.

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