

# Building Care Where Students Learn: Philadelphia's School-Based Mental Health System and the Case for Reform

## ***Background and Context***

Philadelphia's public schools serve more than 117,000 students, the vast majority of whom are enrolled in Medicaid and live in low-income households. In a city where many families face poverty, violence, and systemic barriers to care, schools have become the most consistent and trusted point of access for mental health support.

As Julia Hinkley, former Strategy Director in the Mayor's Office, observed, ***"Schools are on the front lines of addressing mental health, and we have to support them as if they were health clinics."***

Over the past two decades, the **School District of Philadelphia (SDP)** and **Community Behavioral Health (CBH)** have built one of the most comprehensive school-based mental health systems in the country an integrated model that combines prevention, early intervention, and clinical care through a coordinated funding and service structure.

The partnership was made possible by Philadelphia's Medicaid "carve-out," which allowed CBH to locally manage behavioral health dollars and reinvest savings into community programs, laying the foundation for services to be embedded directly in schools.

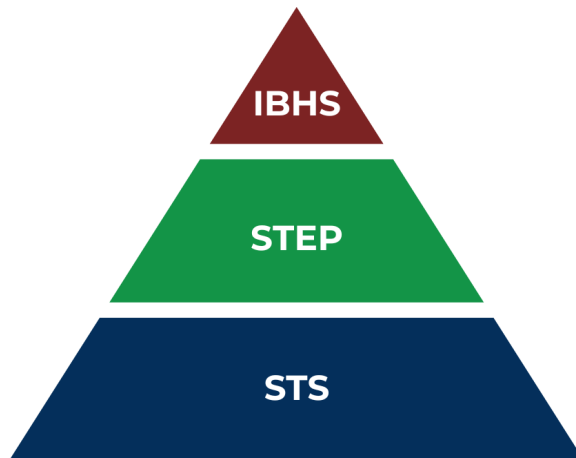
Over time, this approach evolved into a coordinated continuum of care that connects prevention, early intervention, and treatment within a single system of support.

At its core, the system functions as a pyramid of support that spans four interconnected service levels:

1. Student Therapeutic Services (STS) – foundational, school-based clinical access;
2. Support Team for Educational Partnership (STEP) – multidisciplinary coordination and prevention;
3. Intensive Behavioral Health Services (IBHS) – individualized care under Medicaid;
4. Telehealth – continuity and access across settings and seasons.



## Philadelphia's Continuum of School-Based Mental Health Supports



Running alongside these services is telehealth, which expands access and continuity of care across settings throughout the year. Telehealth can support students and families at multiple points in the system, ranging from screening and intake to direct therapeutic services and crisis response.

Each layer of the pyramid builds upon the other, allowing schools to meet students where they are and match support to need. The model is sustained through a blend of direct Medicaid reimbursement, school district investment, and discretionary Medicaid funds, local public dollars that Behavioral Health Managed Care Organizations (BHMCOs) can reinvest in community-based innovation. These are locally managed dollars that Behavioral Health Managed Care Organizations (BHMCOs) can use for innovation, coordination, and services not billable to Medicaid.

As Joan Erney, former CEO of Community Behavioral Health (CBH), explained, ***“The carve-out made us nimble. We could reinvest in ways that made sense for our communities, especially schools. The best thing we did was bring care to where families already are, because it lowers the threshold for asking for help.”***

Philadelphia's experience demonstrates that integrated school-based mental health systems are possible when schools, Medicaid agencies, and community providers work together. Sustaining and expanding these supports across Pennsylvania will require policy reforms that reduce barriers to prevention, coordination, and school-based care.

### ***Laying the Groundwork: The Student Therapeutic Services (STS) Program***

Philadelphia's current system began with Student Therapeutic Services (STS), launched in 2007–2008 as the first effort to consistently embed licensed clinicians in schools.



In some schools, everything is depended on the relationship between a principal and a provider... when one left, the partnership disappeared. That's not a system.”



**What It Is:** STS placed therapists and mental health workers in public schools to provide counseling, crisis response, and small-group supports during the school day. For the first time, schools had regular, on-site access to clinical care instead of relying on outside referrals.

**How It's Funded:** STS was built on Medicaid billing for eligible students, supplemented by discretionary Medicaid funds to cover coordination, supervision, and non-billable prevention work.



This combination allowed the model to grow steadily while maintaining financial viability.

**Lessons Learned:** STS demonstrated that school-based mental health care could be both effective and reimbursable. But it also revealed structural gaps. Services often depend on personal relationships between school leaders and providers. Without standardized systems, schools varied widely in what students received.

***“In some schools, everything is depended on the relationship between a principal and a provider,” recalled Julia Hinkley. “When one left, the partnership disappeared. That’s not a system.”***

STS proved that co-locating care worked; the next step was to institutionalize it. The lessons from STS directly informed the creation of the STEP program, which expanded individual clinical placements into coordinated schoolwide teams.

### ***Integration and Climate: The STEP Program***

In 2017, the Support Team for Educational Partnership (STEP) transformed Philadelphia’s approach from individual student response to a coordinated, citywide model.

**What It Is:** STEP embeds a multidisciplinary team in each participating school, typically a Clinical Coordinator, School Behavioral Consultant, Case Manager, and Family Peer Specialist. Together they support students’ mental health, strengthen school climate, and build staff capacity to manage trauma and behavioral challenges.

**How It's Funded:** STEP blends three main funding streams:

- + **Direct Medicaid billing** for individual therapy and clinical assessment (Tier 3);
- + **School District funds** for universal prevention and staff training (Tier 1);
- + **Discretionary Medicaid Reinvestment funds** initially were used to fund the program for students without a diagnosis and for coordination, consultation, and non-billable roles like Family Peer Specialists (Tier 2).

**Impact and Lessons:** Between 2017 and 2024, STEP expanded from 21 to 45 schools, serving more than 2,600 students annually. Schools with STEP teams report improved climate, stronger attendance, and fewer disciplinary incidents. Since 2018, Philadelphia has also seen a 78% reduction in psychiatric residential treatment facility placements and measurable improvements in school climate scores.

As Kristen Vescio, Director of Children's Services at CBH, explained, ***"STEP marked our shift from one-off experiments to a coordinated citywide model, suddenly, we had the infrastructure to treat school mental health as system-building, not afterthought."***

STEP's success lies in its coordination. Family Peer Specialists helped caregivers navigate complex systems and reduce stigma; behavioral consultants coached teachers on trauma-informed practices; and case managers linked families to community supports.

These roles, though not Medicaid-billable, proved essential to trust and continuity. As Donna Bailey noted, "Building this system wasn't just about contracts or funding. It was about trust. Schools had to believe providers were there to help, and providers had to feel like they were part of the school."

### ***Structure and Sustainability: Intensive Behavioral Health Services (IBHS)***

When Pennsylvania implemented Intensive Behavioral Health Services (IBHS) regulations in 2021, Philadelphia was ready. The groundwork laid by STS and STEP allowed the city to integrate IBHS smoothly into existing structures.

**What It Is:** IBHS replaced and updated Behavioral Health Rehabilitation Services, creating an opportunity for more innovative services with the school system. IBHS includes an array of therapeutic interventions in the home, school, and community which can be provided only by licensed IBHS Medicaid providers. These services are considered more intensive than outpatient services and have additional requirements.

The services require a written order from a licensed health professional whose scope of practice includes the diagnosis and treatment of behavioral health disorders, meeting medical necessity, and following an individual treatment plan.



These roles in the school may include: Behavioral Consultant, Mobile Therapist, and Behavioral Health Technician (BHT). IBHS works directly with the child to address their behavior and build therapeutic skills using the strategies and interventions contained in the Individualized Treatment Plan (ITP) created by the Behavior Consultant (BC) to decrease behaviors to improve the child's functioning in the classroom.

The Behavior Consultant can also work indirectly with the child through direct work with teachers, other school staff, and the child's parents or caregivers. IBHS can provide group services in a school with a written agreement with the school. A subset of IBHS services includes Applied Behavioral Analysis (ABA) for children with autism.

***How It's Funded:***

- + **Medicaid billing** reimburses licensed providers for the full array of direct and indirect clinical services.
- + **Discretionary Medicaid funds** cover training, coordination, and consultation.
- + **District funds** sustain prevention and universal supports that Medicaid does not pay for.

IBHS relies on the same braided funding structure described under STEP, with Medicaid billing at its core and discretionary Medicaid funds supporting non-billable training, coordination, and prevention activities.

***Impact and Lessons:*** IBHS brought structure, accountability, and sustainability. CBH partnered schools and providers geographically to strength relationships and coordination. Providers gained clear guidance on what could be billed, and schools gained consistent, credentialed support. As Lauren DellaCava, Clinical Manager at CBH, observed, ***"IBHS gave us a structure. It let us take what we were already doing in schools and put it into a Medicaid framework."***

The shift also strengthened workforce pipelines and documentation standards, improving quality and stability. Philadelphia's experience underscored the need for continuous workforce development, including training pipelines, bilingual staff recruitment, and manageable caseloads to prevent burnout. The broader system now reflects those gains: psychiatric residential treatment facility placements have fallen by 78%, and schools report sustained improvements in climate and coordination between providers and educators.

Although IBHS includes team-based requirements and allows services to occur in natural school settings, many of the activities that help schools function as a coordinated support system do not meet Medicaid's billable definitions.



IBHS gave us a structure. It let us take what we were already doing in schools and put it into a Medicaid framework... we had to build a bridge, not just a program.



Roles like liaisons, cultural brokers, and school-wide coordination staff perform essential work, facilitating communication, supporting families, aligning services, and helping schools manage day-to-day needs, but these activities are not reimbursable under IBHS. As a result, Philadelphia relies on local flexibility and discretionary Medicaid reinvestment funds to sustain them.

### ***Continuity and Access: Telehealth Expansion***

The COVID-19 pandemic accelerated Philadelphia's use of telehealth as a complement to in-person care, bridging access during closures and extending support year-round.

**What It Is:** Telehealth provides virtual counseling, therapy, and case management to students who face transportation or scheduling barriers. It allows continuity between school-based and community-based providers, especially over the summer or during transitions.

**How It's Funded:** Telehealth sessions are billable to Medicaid under IBHS regulations. Technology infrastructure, coordination, and training are supported through discretionary Medicaid funds and local grants.

**Lessons Learned:** Telehealth proved crucial for maintaining connections with families who might otherwise disengage from care. As Julia Hinkley put it, "we had to build a bridge, not just a program."

While challenges remain, like broadband gaps and privacy concerns, Philadelphia's experience shows that telehealth, when integrated intentionally, strengthens equity and continuity across the service pyramid.

### ***How the System Is Funded***

Philadelphia's system blends funding to match the complexity of students' needs.

- + **Direct Medicaid Billing** – the foundation for clinical care (IBHS and Tier 3 services).
- + **School District Allocations** – funding universal prevention, staff training, and climate initiatives.
- + **Discretionary Medicaid Funds** – flexible, locally managed dollars that support coordination, innovation, and non-billable services such as Behavioral Health Liaisons.

This flexibility is critical because many essential supports, family engagement, coordination, prevention, fall outside traditional Medicaid reimbursement categories. As Kristen Vescio explained, ***“Those positions aren't in the district budget, and they're not billable either. We carved them out specifically because that coordination is what keeps the system working.”***

This braided structure allows Philadelphia to respond to real-world needs quickly and creatively, a model that can be adapted by any Pennsylvania county with a BHMCO.

## ***Key Lessons for Other Counties***

Philadelphia's experience offers practical guidance for adapting school-based mental health systems across Pennsylvania:

- + Layer supports within a clear pyramid. Structure services around universal, targeted, and intensive tiers so funding and staffing align.
- + Use Medicaid strategically. Anchor clinical care in reimbursable services, while reserving flexibility for prevention and coordination.
- + Prioritize coordination roles. Fund liaisons or navigators who connect schools, providers, and families, even if not billable.
- + Invest in workforce development. Strengthen bilingual, culturally responsive pipelines and offer sustainable caseloads to reduce burnout.
- + Embed data and feedback loops. Shared dashboards, joint trainings, and regular case reviews ensure consistency across schools.
- + Engage families and youth. Family Peer Specialists and youth voice initiatives reduce stigma and make programs more relevant.

## ***Implications for State Policy***

Philadelphia's experience highlights several conditions necessary to sustain integrated school-based mental health services. Prevention and early support must be funded alongside clinical care, since many activities that help students early are not reimbursable under traditional Medicaid billing. Schools must also be recognized as central partners in delivering behavioral health services, allowing providers to work where students already spend their time.

Workforce development remains critical as well. Philadelphia's model depends on clinicians, behavioral consultants, case managers, and family peer specialists who reflect and understand the communities they serve. At the same time, administrative barriers that limit coordination and school-based service delivery must be reduced so providers can focus on supporting students rather than navigating complicated systems that prioritize diagnosis and crisis care.

Philadelphia demonstrates what is possible when these elements align. Sustaining and expanding similar systems across Pennsylvania will require policies that support prevention, access, coordination, and workforce capacity statewide.



## Conclusion

Philadelphia's journey shows that schools can serve as anchors for mental health care when health and education systems align around shared goals. What began as scattered partnerships evolved into a coordinated structure rooted in accountability, flexibility, and compassion.

As Julia Lechner, former SDP Behavioral Health Director, reflected, ***"It took years of relationship-building. You can't just throw a contract at a provider and expect transformation. You need trust and shared goals."***

That trust, between schools, providers, families, and city leadership, has become the system's strongest currency. Philadelphia's model does not prescribe a single path. It offers proof that lasting systems emerge when institutions invest together in prevention, access, and care for every child. With adaptation, those lessons can help any Pennsylvania community build its own version of that promise. The next challenge lies in ensuring these integrated supports are maintained and expanded through sustained Medicaid alignment and cross-agency commitment.

Philadelphia's experience provides a roadmap for building practical, equitable systems that make behavioral health care a standard part of every child's educational journey.

Philadelphia shows that when schools, providers, and Medicaid systems work together, students receive earlier preventative support, families access care more easily, and schools become healthier environments for learning.

The system also reveals the limits of current policy. Many of the roles and services that make school-based mental health work—family engagement, coordination, prevention, and school-based teams—remain difficult to fund under existing structures.

The reforms proposed by the Strong Minds, Bright Futures partnership would sustain and expand these essential supports in Philadelphia and across Pennsylvania.



**It took years of relationship-building. You can't just throw a contract at a provider and expect transformation. You need trust and shared goals.**



Children First  
990 Spring Garden Street  
Suite 600  
Philadelphia, PA 19123  
215-563-5848

Strong Minds Bright Futures  
c/o Children First  
990 Spring Garden Street, Suite 600  
Philadelphia, PA 19123  
215-563-5848

**Socials: @childrenfirstpa.org**

**Socials: @strongmindspa.org**