CHILDREN'S MENTAL HEALTH MAPPING REPORT

NEW JERSEY HEALTH CARE
QUALITY INSTITUTE

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Executive Summary

New Jersey's children's mental health system is broad and complex. Children and families access services through many different pathways, including primary care, schools, private insurance, Medicaid, the Children's System of Care (CSOC), hospitals, community-based organizations, and, at times, the child welfare and legal systems. Which services are available, how quickly they can be accessed, and whether families can afford them often depends on a child's insurance coverage, geographic location, diagnosis, and the ability of parents and caregivers to navigate multiple systems.

Commissioned by the New Jersey Department of Children and Families under P.L. 2024, c.100, this study maps New Jersey's pediatric mental health landscape, identifies eligibility rules and access barriers, and examines how programs interact across the system. It highlights gaps in access, including those driven by payment and reimbursement structures, while recognizing the State's significant investments in children's mental health. The report's recommendations are designed to strengthen system coordination, improve access, and support more equitable, sustainable care for children and families statewide.

This report examines the full landscape of children's mental health services in New Jersey for youth ages 0-17. It includes an assessment of the State's role, insurance coverage and network adequacy, school-based and community-based services, crisis response, inpatient and out-of-home care, and the ways the legal system intersects with mental health needs. The report draws on interviews and focus groups with more than 230 stakeholders and family members, administrative and survey data, regulatory, legal, and policy analysis, and a review of state and national best practices.

Overall, the report finds that New Jersey has many strengths. The State has invested in a broad array of programs, including CSOC, the New Jersey Pediatric Psychiatry Collaborative, and mobile crisis and response services, early childhood supports, and school-based mental health initiatives. Families can access a range of services, from prevention and outpatient therapy to intensive home-based care, hospitalization, and residential treatment. Nationally, New Jersey is a model for other states, and comparatively, has more youth-focused mental health programs and resources.

At the same time, the system is difficult to navigate and does not consistently provide timely access to appropriate care. Workforce shortages, inadequate insurance networks, inconsistent school supports, fragmented coordination across agencies and systems, and insufficient capacity for high-acuity youth create significant barriers. Families often encounter delayed availability of care, long waitlists, and difficulty obtaining services for children with the most complex needs.

Landscape Analysis

The Landscape Analysis examines the major systems, programs, and pathways through which children and families access mental health services in New Jersey. It reviews the role of insurance coverage, Medicaid, CSOC, primary care, schools, community-based organizations, crisis services, inpatient and out-of-home care, and the child welfare and legal systems.

The report describes how insurance coverage shapes access to mental health care. Children covered through Medicaid, commercial insurance, or self-funded plans may have different covered benefits, provider networks, prior authorization requirements, and out-of-pocket costs. The report reviews parity requirements, network adequacy standards, and the different pathways through which families seek care.

CSOC is examined as the State's primary coordinated system for children and youth with moderate and intensive behavioral health needs. Through CSOC, families may access mobile response, care management organizations, family support organizations, intensive home-based and community-based services, and out-of-home treatment.

The report also reviews the role of primary care providers, who are often among the first professionals to identify mental health concerns and provide screening, education, referral, and treatment. It examines the increasing role of pediatric practices in addressing mental health needs and the ways in which behavioral health may be integrated into primary care settings.

Schools, including elementary through high school, are examined as another important setting for prevention, identification, and support. The report reviews school counseling, social-emotional learning, state-funded mental health programs like NJ4S, school-based youth services, and partnerships with outside providers and community organizations.

In addition, the report highlights the importance of early childhood mental health, family support organizations, community-based prevention and resilience programs, and the growing role of technology and social media in youth mental health. It also examines how family court, child welfare, probation, and the youth justice system influence access to services for some children and families.

Key Findings

The report's findings reveal systemic barriers that limit access to timely, appropriate care for children and families in six key areas.

WORKFORCE

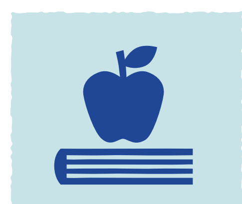
New Jersey, like the nation, faces a shortage of child-serving mental health professionals across nearly every discipline, including child psychiatrists, developmental pediatricians, therapists, psychologists, behavioral health staff in schools, and providers trained to serve youth with co-occurring mental health and intellectual or developmental disabilities. Workforce shortages exacerbate access issues in rural areas and high-acuity settings.

INSURANCE AND ACCESS TO CARE

Insurance coverage does not consistently translate into actual access to services. Provider directories are often inaccurate; in-network providers may not accept new patients, and families may experience long wait times for outpatient therapy, psychiatry, and higher levels of care. Network inadequacy is particularly significant for Medicaid and specialty services.

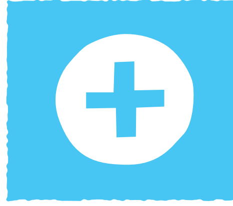
FAMILY NAVIGATION AND COORDINATION

Families frequently describe the mental health system as difficult to understand and navigate. Many do not know where to start, whether to call a pediatrician, PerformCare, the entry point to the CSOC system, a school counselor, or a crisis line. Families report repeating their child's story multiple times, experiencing poor communication between systems, and struggling to coordinate care across providers, schools, and agencies.



SCHOOL-BASED SERVICES

Schools are increasingly expected to respond to youth mental health needs but often do not have the capacity or resources to do so. School-based supports are inconsistent across districts, and many schools rely on short-term programs or crisis-oriented interventions because long-term community treatment is unavailable. Schools also face challenges supporting students getting screened, cleared, and returning to school after psychiatric crises.



CLINICAL CARE AND HIGH-ACUITY SERVICES

There are major shortages in specialized inpatient hospitalization services and out-of-home treatment beds, particularly for youth with co-occurring intellectual and developmental disabilities including autism, eating disorders, and other complex medical or behavioral needs. Many children remain in emergency departments, hospitals, or inappropriate settings while waiting for services.

GOVERNANCE AND CROSS-SYSTEM COORDINATION

Children's mental health is governed by multiple state agencies with overlapping responsibilities. Fragmented oversight responsibilities and funding streams contribute to the lack of a comprehensive view of children's mental health needs and how the State's investments and efforts are addressing those needs.

Recommendations

The report recommends coordinated action across six areas. The full recommendations are organized into 17 specific proposals:

WORKFORCE

1. Establish a Statewide Children and Youth Mental Health Data Dashboard
2. Implement Ongoing Workforce Monitoring and Capacity Planning
3. Align Workforce Pipeline Investments with Children's Mental Health Needs
4. Support Team-Based and Integrated Models of Primary Care to Extend Clinical Capacity
5. Strengthen the Pediatric Psychiatric Collaborative Care Model to Support Pediatricians in Ongoing Mental Health Management
6. Improve Licensure and Credentialling Processes to Increase Access

INSURANCE COVERAGE AND ACCESS

7. Strengthen State Enforcement of Network Adequacy and Access Requirements
8. Use Medicaid Managed Care Contracts to Improve Access and Quality Outcomes

SCHOOL-BASED MENTAL HEALTH

9. Strengthen Crisis Response, School Reentry, and Bridge Services
10. Expand School-Embedded Supports and Strengthen Cross-System Coordination
11. Establish Sustainable Funding, Expand Capacity, and Reduce Financial Barriers

FAMILY NAVIGATION AND COMMUNITY SUPPORTS

12. Improve Family Understanding of CSOC and Access to Services
13. Create Centralized Family Mental Health Access and Psychoeducation Communication and Resources

CLINICAL CARE ACROSS THE CONTINUUM

14. Expand Crisis Services Outside the Emergency Department and School-Linked Crisis Pathways Statewide
15. Develop a Coordinated Statewide Strategy for High-Acuity Pediatric Mental Health Care and Transitions

GOVERNANCE, ACCOUNTABILITY, AND CROSS-SYSTEM EDUCATION

16. Coordinate State Funding, Agency Collaboration, and Oversight
17. Strengthen and Expand Mental Health Education and Implementation Across the Justice System

Taken together, these recommendations are intended to create a more coordinated, equitable, and effective children's mental health system in New Jersey. While the State has many strong programs and engaged partners, achieving meaningful improvement will require sustained investment, greater accountability, and a significant focus on implementation with stronger coordination across agencies and systems.

Landscape Analysis

New Jersey's children's mental health landscape is shaped by a complex web of state agencies, insurance systems, publicly funded programs, and clinical service providers.

State agencies provide the regulatory framework, funding, and oversight that govern how services are designed, delivered, and accessed, from licensing clinical providers to regulating insurance coverage to administering public programs. Insurance plays a central role in determining what services a family can access and at what cost, with different rules applying depending on whether a child is covered by Medicaid, a commercial plan, or a self-funded employer plan. For families whose insurance does not cover the higher level of care their child needs, New Jersey's Children's System of Care (CSOC) serves as the public behavioral health system, coordinating access to moderate and high-acuity services through a single-entry point.

Many other services that don't require CSOC involvement are available directly through providers, schools, and community organizations. School-based services and the legal system, including family court, the youth justice system, and child protective services, represent additional and significant pathways to mental health care for many children, and are each addressed in dedicated sections of this analysis. Together, these elements form the landscape through which New Jersey families navigate children's mental health care. This section provides an overview of each major component, setting the stage for the findings and recommendations that follow.

ABOUT THIS REPORT

This report primarily focuses on access beginning when a child or caregiver seeks services in response to identified mental health or substance use treatment needs. For the purposes of this report, "mental health" is used as a common, inclusive term under the broader umbrella of behavioral health, encompassing mental health and substance use conditions. Intellectual and developmental disabilities (I/DD), including autism spectrum disorder (which is referred to as autism), and neurobehavioral disorders, including attention deficit hyperactivity disorder (ADHD), emerged as issues with added complexity in our research, particularly in relation to education policy and service eligibility. These conditions are addressed in this report through the lens of co-occurring needs that can complicate or delay access to mental health services. A deeper investigation of I/DD-specific care and policies outside of those that relate to mental health was beyond the scope of this report.

Throughout the report, the terms "children" and "youth" are used interchangeably to refer to individuals ages 0-17. We acknowledge the unique and often underserved needs in the young adult (18-26) age group, and that some of the programs referenced serve clients through age 21 or older, but these age groups are outside the scope of this report. Where relevant, we identify barriers faced by older adolescents as they transition out of youth-serving systems. Throughout this report, the term "caregiver" is generally used to refer to the adult primarily responsible for a child, most often a parent, although the terms "parent" and, where appropriate, "legal guardian" are also used. Key terms throughout this report are defined in Appendix B: Glossary.

The State's Role in Children's Mental Health

New Jersey's youth mental health system is supported by a network of state agencies, each with distinct statutory responsibilities related to program administration, regulation, financing, and service oversight. State agency priorities and budgets are set under the direction of the Governor's Office, which also oversees interagency coordination. Together, these agencies shape the policies and pathways through which children access mental health care.

Key agencies include: the Department of Children and Families (DCF), which coordinates the Children's System of Care; the Department of Education (DOE), which oversees school-based services including special education; the Department of Banking and Insurance (DOBI), which regulates insurance coverage and network adequacy; the Department of Health (DOH), which licenses and regulates health care facilities including pediatric psychiatric beds, administers the Early Intervention Program, and houses the Office of Youth Online Mental Health Safety and Awareness; the Department of Human Services (DHS), which administers Medicaid through the Division of Medical Assistance and Health Services (DMAHS), oversees the systems into which older youth transition, and houses the Division of Mental Health and Addiction Services; and the Attorney General's Office, which oversees legal and law enforcement functions, including juvenile justice, child safety, the Division of Consumer Affairs, and provider licensing.

A detailed overview of each agency and its key divisions and offices, their statutory authority, and their relationship to children's mental health is provided in Appendix C: State Agency Reference Guide: Children's Mental Health.

Health Insurance Coverage and Access to Care

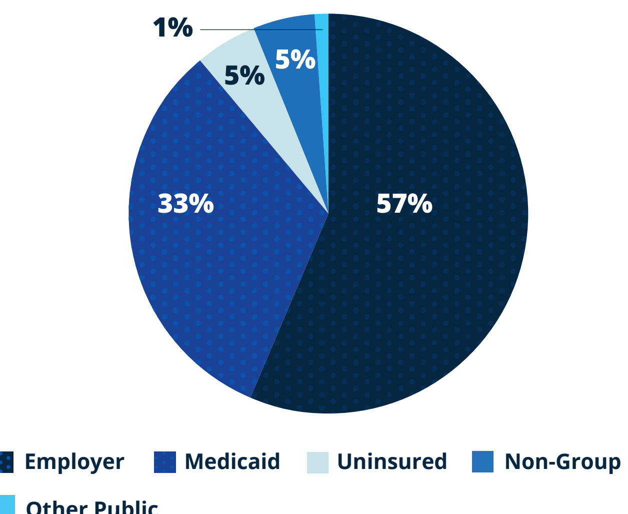
Health insurance coverage is a key determinant of many elements of access to children's mental health services in New Jersey. The type of insurance coverage a child has can determine the provider network, which services are covered, and how these services are paid.

When a child is covered by a commercial insurance plan, the health plan determines what services can be provided through prior authorization and medical necessity criteria. When a child has Medicaid coverage, the State Medicaid agency defines the services that are covered by Medicaid, while the Managed Care Organizations are responsible for utilization management including prior authorization and concurrent review.

For mental health, in Medicaid, currently the State determines the rates paid to providers. In limited circumstances in which a child has both commercial and limited Medicaid coverage through a special program because of an extenuating need, commercial insurance is considered the primary insurance, and Medicaid is the secondary payer used to cover specific services like those provided through CSOC. This makes insurance one of the most consequential factors in a family's ability to access mental health care.

The figure on page 11 shows how New Jersey children are covered, by insurance type. Each coverage type operates under distinct statutory and regulatory authorities that influence benefit design, oversight, and coordination with publicly funded systems. Appendix D: New Jersey Youth Insurance Coverage by Type includes additional data related to NJ health insurance coverage for children.

NJ Health Insurance Coverage for Children Ages 0-18 (2024)



Source: KFF State Health Facts (https://www.kff.org/state-category/health-coverage-uninsured/health-insurance-status/), estimates based on the 2008-2024 American Community Survey, 1-year estimates. Footnotes available in Appendix D: New Jersey Youth Insurance Coverage by Type.

While the chart above shows how New Jersey children are covered by insurance type, the rules governing that coverage vary significantly depending on which regulatory framework applies. There are four primary frameworks for oversight:

1. **Fully Insured Markets:** DOBI regulates the fully insured market, in which individuals or employers purchase an insurance product, and the insurance company assumes financial responsibility for covered services. Health plans must comply with all state and federal mandates related to mental health and substance use disorder whenever such regulations apply to commercial health plans.

   There are three types of fully insured markets, all of them regulated by DOBI: the individual market for New Jersey residents, the small employer market for groups of 2-50 employees, and the large employer market for groups of more than 50 employees.

2. **State Health Benefits Program (SHBP):** The state operates its own health benefits programs for state and local government employees and retirees, administered by New Jersey's Department of Treasury, Division of Pensions and Benefits and related boards. The state determines mental health benefits and preventive care coverage terms under various state and federal laws.

3. **Self-Funded Plans:** Unlike the categories of insurance, self-funded plans are not insurance plans and not regulated by the State. Instead, they are governed by federal law administered by the U.S. Department of Labor. In these plans, the employer or fund administrator, rather than the insurance company, assumes direct financial responsibility for covered members' health claims and provides direction to the health plan on how their benefits must be administered. Many self-funded groups of over 1,000 employees and an increasing number of smaller groups have self-funded plans. Some self-funded groups administer their benefits themselves. Others hire health plans to administer their benefits. These are known as Administrative Services Only (ASO) plans. Families covered by a self-funded plan may find that certain New Jersey insurance protections do not apply to them.

4. **Medicaid (NJ FamilyCare):** New Jersey's Medicaid and Children's Health Insurance Program (CHIP) is branded as NJ FamilyCare and administered by the Division of Medical Assistance and Health Services (DMAHS) within the Department of Human Services. New Jersey Medicaid determines what services are covered and how those services are paid for Medicaid members. There are five Managed Care Organizations (MCOs) that currently contract with the state to administer the State Medicaid program: Aetna, Fidelis Care, Horizon NJ Health, United Healthcare, and Wellpoint.

PARITY REQUIREMENTS

Federal and State mental health parity laws provide critical protections for consumers covered by most New Jersey health insurance plans, requiring insurance companies to cover mental health and substance use disorder benefits equally to medical and surgical benefits. This means copays, deductibles, and treatment limits (e.g., visit limits) must be comparable across physical and mental health care.[1] New Jersey laws also require coverage of certain specific mental health and substance use disorder services with specified coverage limits and restrictions on insurance companies' ability to use utilization management methods to determine medical necessity of certain services.[2] These protections apply to fully insured, SHBP, and Medicaid plans, and to self-funded plans that opt in.

[1] Services for mental health conditions and substance use disorder are required to be provided for all covered persons pursuant to N.J.S.A. 17B:27-46.1v and 46.1nn. N.J.S.A. 17B:27-46.1v contains the broad requirement that carriers cover mental health conditions and substance use disorder under the same terms and conditions as other covered sickness and in accordance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA), 42 U.S.C. 18031(j) and implementing guidance and regulations.

[2] See e.g., N.J.S.A. 17B:27-46.1nn (substance use disorder); N.J.S.A. 17B:27-46.1ii (autism spectrum disorder or other developmental disorder); N.J.S.A. 17B:27-46.1vv (major depressive disorder).

Network Adequacy

Network adequacy rules are designed to ensure that having insurance translates into actually being able to find and see a provider. When networks are inadequate, meaning too few in-network providers are available within a reasonable distance, families may face higher out-of-pocket costs for out-of-network care, longer wait times, or no meaningful access to care.

New Jersey regulations require that insurance carriers maintain networks large enough so that 90% of members in each county can access inpatient psychiatric services for children and residential substance use treatment centers within 45 miles or 60 minutes' drive time.[3] A stricter standard applies to emergency mental health services and outpatient mental health and substance use disorder services, where 90% of members within each county must have access to providers within 20 miles or 30 minutes' drive time.[4]

New Jersey law also requires carriers to submit an annual independent audit of their provider network to DOBI, with results posted publicly on DOBI's website.[5] If the audit shows a network deficiency, the DOBI Commissioner is authorized to take the action needed to bring the carrier into compliance.

NJ FAMILYCARE: NEW JERSEY'S MEDICAID PROGRAM

NJ FamilyCare, also known as Medicaid, is administered by DMAHS within DHS, with costs shared by the federal and State government. Medicaid provides comprehensive health coverage, including mental health services and substance use disorder treatment, to eligible children, pregnant individuals, adults, and other qualifying populations. Medicaid is the second largest source of health insurance coverage for New Jersey children.[6] Children under age 19 are eligible for Medicaid at income levels up to 325% of the federal poverty level, or approximately $9,512 per month for a family of four.[7] The program also includes more limited State-only funded coverage for pregnant individuals and children regardless of immigration status, through programs including Cover All Kids and the Supplemental Prenatal and Contraceptive Program.

Children and youth that do not meet the income and asset requirements for Medicaid eligibility and require CSOC services may be eligible for CSOC's 3560 look-alike program. The Medicaid look-alike program is available to cover CSOC authorized services, regardless of whether a child has commercial insurance. However, being enrolled in the look-alike program is not the same as being fully covered by NJ FamilyCare and it does not provide NJ Family Care benefits. Instead, the Medicaid look-alike program is specifically for youth who are authorized for CSOC services but are not otherwise Medicaid eligible. In these situations, it allows for the service to be billed through the Medicaid system for CSOC provider reimbursement. The cost of administering this program is fully funded through state dollars with no federal match.

Medicaid's five MCOs, which contract with the State to deliver covered services and coordinate care for enrolled members, are required to deliver physical, mental, and preventive health benefits, maintain network adequacy, and provide care management, subject to federal and State regulatory oversight.

Beginning in 2025, Medicaid initiated a phased transition of mental health and substance use treatment services from a traditional fee-for-service (FFS) model to the MCOs. Under FFS, providers were paid directly by the state for each mental health service delivered. Under the MCO carve-in model, the MCOs assume responsibility for managing and coordinating behavioral health benefits for their members. Now, all inpatient and outpatient behavioral health services are managed through MCOs. The goal of this transition was to improve care coordination and outcomes through integrated behavioral and physical health management by MCOs. Detailed Medicaid data including statistics on enrollment, utilization, and active providers is available in Appendix E: Enrollment and Behavioral Health Provider Participation.

ACCESS TO CARE FOR UNINSURED CHILDREN

Approximately 4.7% of children in New Jersey are uninsured.[8] Safety-net providers, such as Federally Qualified Health Centers (FQHCs), provide care to uninsured children through sliding fee schedules. When families access New Jersey's CSOC, care coordinators and care managers can help uninsured and underinsured families apply for Medicaid or State-authorized Medicaid look-alike programs, which are designed to ensure all children have access to treatment regardless of ability to pay.

[3] N.J.A.C. 11:24-6.2 to 6.3; N.J.A.C. 11:24A-4.10(b)3iv.

[4] N.J.A.C. 11:24A-4.10(b)3v; N.J.A.C. 11:24-6.2 (HMO-specific). The insurance coverage requirements for mental health services are more fully set forth at N.J.S.A. 17B:27-46.1v and 46.1nn

[5] N.J.S.A. 26:2SS-16.

[6] KFF State Health Facts (https://www.kff.org/state-category/health-coverage-uninsured/health-insurance-status/). See Appendix F: Children's System of Care Program and Utilization Data for detailed statistics.

[7] Income eligibility thresholds for Medicaid vary significantly by age and population. The income threshold for children is substantially higher than for most adults.

[8] The Center for Children and Families. (n.d.). *Children's health care report card – New Jersey*. Children's Health Care Report. https://kidshealthcarereport.ccf.georgetown.edu/states/new-jersey/

Pathways to Care: Children's System of Care vs. Direct Access

For most children and adolescents experiencing mental health concerns, care is accessed directly through community-based outpatient services, not through CSOC. The majority of youth mental health needs are addressed through psychotherapy provided by licensed clinicians in community settings, such as private practices, behavioral health clinics, or integrated primary care practices.

These services are typically paid for through a family's health insurance, either Medicaid or private insurance, and in some cases through self-pay arrangements. Youth are often referred to these services by primary care providers, schools, or other community organizations.

When a child's needs become more complex, such as requiring intensive home-based services, crisis stabilization, care coordination across multiple systems, or residential treatment, the CSOC pathway may become necessary. CSOC, administered by DCF and accessed through its contracted system administrator (CSA), PerformCare, functions as New Jersey's public coordinated behavioral health system for youth with moderate-to-high-acuity needs. PerformCare, in its role as CSA, determines and authorizes the type and level of services needed and either authorizes CSOC services or provides information and resources to the family regarding care they could pursue in the community or through their insurance. Once authorized, families may receive care management, and coordination of specialized supports that extend beyond what is typically available through routine outpatient care. Not all families seeking mental health services need to access CSOC. Rather, CSOC serves as a specialized pathway for youth whose clinical needs require a higher level of coordination and publicly supported services. Additionally, families who access services through CSOC may also access care directly through the community as well.

Services Primarily Accessed through CSOC (Authorized by PerformCare/CSA)	Services Primarily Accessed Directly through Insurance and/or in the Community
Intensive home-based services	Outpatient therapy
Mobile Response Stabilization Services (MRSS)/Crisis stabilization	Emergency departments
Care Management Organizations (CMO) - Complex care coordination	School-based services
Family Support Organizations	Psychiatric Emergency Screening Services (PESS)
Out-of-Home (OOH) treatments	Lower acuity services, generally
Higher acuity services	Intensive outpatient services
Eligibility application for I/DD services	Partial care/hospitalization

Children's System of Care

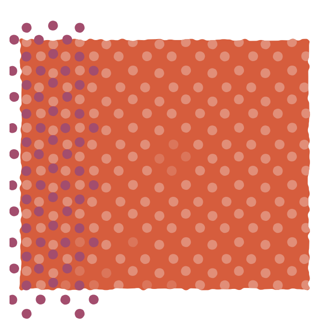
CHILDREN'S SYSTEM OF CARE OVERVIEW

As noted above, CSOC is a division within DCF and serves as a behavioral health system for children and youth. CSOC offers a single point of entry to behavioral health (also referred to as mental health herein) treatment, allowing families to access a wide range of services without navigating multiple systems. CSOC prioritizes keeping youth at home, in school, and within their community, working through a "system of care" approach that provides clinically appropriate, culturally competent, community-based accessible, individualized services in the least restrictive setting.

PerformCare, CSOC's contracted systems administrator, provides a broad range of service functions, including intake, service authorization, and utilization management. PerformCare maintains the electronic system that providers use to document their services, including the start/end time of enrollment, individualized treatment plans, and ongoing progress notes. Appendix F: Children's System of Care Program and Utilization Data includes additional data related to CSOC services including call volume and service utilization statistics.

Services are available to New Jersey youth ages 5-20 and their families where mental health concerns, substance use disorders, or intellectual or developmental disabilities meet clinical criteria. Youth ages 0-3 are primarily served by Early Intervention Services housed within DOH, with CSOC services offered for ages 0-4 under more limited circumstances.[9]

Neither CSOC nor PerformCare provides direct clinical services. PerformCare is CSOC's contracted vendor responsible for supporting families in accessing the right care at the right time and facilitating access to CSOC services through a toll-free call center that is accessible 24 hours per day/seven (7) days per week. PerformCare provides referrals to local behavioral health organizations that are contracted directly with DCF for Mobile Response and Stabilization Services (MRSS) and Care Management Organizations (CMOs). These service organizations coordinate care directly with clinical treatment providers, who then bill for the care provided either through Medicaid or Medicaid look-alike coverage.



[9] As of publication, U.S. citizenship is not required to receive mental health or substance use services through CSOC, but either the parent, guardian, or youth must be a U.S. citizen to receive I/DD services, in alignment with I/DD funding regulations.

FUNDING OF CHILDREN'S SYSTEM OF CARE SERVICES

CSOC is designed to serve all New Jersey youth regardless of a family's ability to pay. PerformCare authorizes care and CSOC-contracted agencies coordinate service delivery. Direct services are billed through commercial insurance, Medicaid, or a Medicaid look-alike program. The Medicaid look-alike program provides limited mental health coverage for commercially-insured families, depending on their benefit coverage and the service authorized.[10]

Youth Receiving CSOC Services by Type of Insurance - Monthly Average[11]

	2023 Average	2024 Average	2025 Average
Medicaid – NJ FamilyCare	14,021	12,319	10,023
Medicaid – 3560 (State-only funded Medicaid look-alike)	6,752	6,424	6,752
Medicaid – Supplemental Security Income (SSI)[12]	3,223	3,055	3,060
Private Insurance	2,139	1,863	1,778

[10] Families using commercial insurance may need prior authorization through their insurance carrier and may have cost sharing. PerformCare operators collect insurance information to assess Medicaid eligibility and determine appropriate coverage and reimbursement. To enroll in specific CSOC services such as a CMO or MRSS, families are required to submit a Medicaid application, even if they have commercial insurance or do not believe they qualify for Medicaid coverage. This process allows those who are commercially insured to be enrolled in the 3560 program to allow CSOC services to bill and receive reimbursement for these services. Additionally, some individuals with commercial insurance or no insurance may be eligible for full Medicaid enrollment based on income level or an I/DD diagnosis.

[11] These numbers are duplicated and incomplete as a single youth may have more than one type of insurance/eligibility and reporting is voluntary. Source: CIACC Report. Data is missing for: November 2024 - January 2025 and November 2025. Reported statistics reflect PerformCare service authorizations, including services that were authorized but later declined.

[12] SSI is a Medicaid only coverage for youth determined disabled and receiving Supplemental Security Income (SSI).

HOW FAMILIES ACCESS CARE THROUGH PERFORMCARE

Families can access services provided by CSOC by calling PerformCare directly. Clinicians or others may call the PerformCare 24/7 access line for resources or referrals, but only a parent or legal guardian may complete the triage process to authorize and consent to services. All services are voluntary and require the consent of both the youth and parent/guardian.

For lower-acuity needs, a PerformCare operator may suggest outside referrals to community or school-based services or have a family connect directly to their insurance provider for services that are offered in the community, such as outpatient therapy.

If the individual's situation meets clinical criteria for family-defined urgent response or moderate-to-high-intensity services, PerformCare will complete a triage process and authorize one of the following initial services: a biopsychosocial assessment (an initial in-home assessment conducted by a licensed clinician to determine the appropriate treatment) or an immediate in-person visit from a MRSS specialist for crisis stabilization services. These pathways to care are described in more detail in the sections that follow.

ORGANIZATIONAL OVERVIEW

Department of Children and Families (DCF) – Oversees all children and family related state services

Children's System of Care (CSOC) – A division of DCF managing New Jersey's public youth mental health system

Contracted Systems Administrator – PerformCare provides a single point of access and authorization for CSOC services

Care Management Entity: Mobile Response and Stabilization Services (MRSS)

Care Management Entity: Care Management Organization (CMO)

Peer Support: Family Support Organization (FSO)

SERVICES AND CARE MANAGEMENT AVAILABLE THROUGH CHILDREN'S SYSTEM OF CARE

Mobile Response and Stabilization Services

CSOC contracts with a designated behavioral health provider in each county to deliver Mobile Response and Stabilization Services (MRSS), commonly called "mobile response." MRSS provides rapid crisis intervention for youth who are experiencing a non-life-threatening mental health crisis. This includes but is not limited to internalizing and externalizing behavior, emotional outbursts, family conflict, violent behavior such as destruction of property, or thoughts of self-harm without an immediate, actionable threat. When a parent or guardian calls the PerformCare access line and the situation meets criteria, PerformCare may authorize a contracted provider to initiate the intervention either by dispatching a clinician to the child's home or another preferred location. In 2024, approximately 79% of dispatches involved sending a clinician to the child's home or another location, while 21% of dispatches were connecting with the family by phone or video call. Appendix F includes additional data related to CSOC services including MRSS dispatches.

Following the initial crisis intervention, MRSS may provide up to eight weeks of therapeutic stabilization services to support the child and family. When appropriate, the MRSS specialist may refer families for further or continued care coordination services through their local CMO.

If the clinician or caregiver decides additional services are needed to address the crisis, the clinician can support the family in contacting emergency services (911) or the county-designated Psychiatric Emergency Screening Service (PESS). A detailed discussion of the PESS system is provided in the Crisis Services overview.

WHO TO CALL FOR YOUTH IN MENTAL HEALTH CRISIS

Immediate or Imminent Danger – for example, a youth with a firearm is threatening to hurt themselves or others.

- **Call 911 immediately**
- **Request Arrive Together mental health staff where available** (see *Crisis Services - Law Enforcement* section for more information)

Youth in Need of Mental Health Evaluation – for example, a youth experiencing severe insomnia and physical panic attack symptoms, who is unable to emotionally regulate or resume routine activities.

- **Contact PESS for clinical mental health evaluation**

Youth in Need of Mental Health Support – for example, after experiencing bullying at school, a youth has an aggressive emotional outburst at home, screaming, punching a wall, and refusing to go to school.

- **Call PerformCare access line to request MRSS services**

Care Management Organizations

CMOs are independent, court vicinage-based organizations that contract with CSOC to provide local care management services. There are 15 CMOs statewide, with eleven serving individual counties and four serving two to three counties.[13] CMO workers help families identify, access, and navigate the clinical services their child needs, but the actual treatment is delivered by separate clinical providers through CMO referrals. CMOs are designed to deliver localized, community-based care coordination in partnership with families, providers, and other child-serving systems, such as child protective services.

CMOs convene child family teams, which typically include the youth, family members, clinicians, and other relevant supports, to develop individualized service plans to stabilize the youth and keep them at home and in their community. CMO care management services are only accessible through a PerformCare authorization - a family may not contact the CMO directly to request services. Families must meet eligibility requirements, including clinical criteria evaluated through a biopsychosocial assessment.

Family Support Organizations

CSOC also contracts with a statewide network of 15 court vicinage-based Family Support Organizations (FSOs), identical to the CMO regional distribution. Eleven FSOs serve individual counties and four serve two to three counties. Each FSO is run independently and tailors its services to community needs. Common offerings include: one-to-one crisis support for parents or guardians, psychoeducation (education about mental health conditions and treatment), community resource referrals, peer support groups, and advocacy assistance. Families must be referred through the CMO to access individual peer support activities, though other FSO services can be accessed directly from the community.[14]

Spotlight

CAMDEN COUNTY FAMILY SUPPORT ORGANIZATION

The Camden County FSO serves an average of 275 families each month, providing family-driven support to caregivers of youth with behavioral, mental health, educational, medical, developmental, and complex needs. In addition to one-to-one Family Support Partner services for CSOC-referred families, Camden FSO offers a range of caregiver education workshops, support groups, youth leadership programs, sibling support activities, programs for new adults with disabilities, and community engagement events.

Camden FSO also supports justice-impacted youth and families through specialized programming designed to provide mentorship, connection, and positive pathways forward. These efforts help reduce isolation and strengthen protective factors for youth navigating complex systems.

Staff provide resource navigation and practical assistance to help families access housing, employment support, adult mental health services, and other community resources that strengthen family stability.

Camden FSO uses an Open Office Hours model, allowing caregivers to receive immediate guidance and support while on the waitlist for one-to-one Family Support Partner services.

[13] PerformCare New Jersey Children's System of Care. (n.d.-a). *Care management organizations*. Retrieved April 6, 2026, from https://www.performcarenj.org/families/cmos

[14] Collectively, FSOs are supported by the New Jersey Alliance of Family Support Organizations (NJ AFSO), which provides technical assistance, training, and coordination.

Children's Interagency Coordinating Council

Each county operates a Children's Interagency Coordinating Council (CIACC), a monthly advisory body intended to promote local collaboration on children's mental health and improve service delivery, especially within the CSOC system. While CMO and FSO participation is required, membership varies by county and generally includes representatives from government agencies, nonprofit providers, and families with lived experience. CIACCs publish monthly reports on DCF's website at both the county and statewide levels, summarizing select CSOC performance metrics.

CSOC Services for Children with Substance Use Disorder

CSOC services include substance use disorder treatment for youth. As of December 2025, PerformCare may authorize services through a network of providers, including 12 outpatient and intensive outpatient program locations, one medically managed detoxification and short-term residential treatment program, and five residential treatment centers that specialize in co-occurring behavioral health and substance use disorder treatment.

Unlike other mental health and I/DD services, prior authorization from PerformCare is not required to access outpatient, withdrawal management or short-term residential substance use disorder services. Families may enroll in services either through a PerformCare access line referral or through the service provider directly. This approach widens access as schools, pediatric primary care providers, and community-based organizations can directly refer youth to services.

CSOC Services for Children with Intellectual and Developmental Disabilities

In 2013, oversight of services for youth ages 5-20 with I/DD was transferred from the New Jersey Division of Developmental Disabilities (DDD) to CSOC.[15] DDD continues to provide services for eligible individuals 21 and older. CMOs offer care transition services to help youth aging out of CSOC care.

Families with I/DD-designated youth can access CSOC services specific to I/DD youth, including clinical and therapeutic services such as applied behavior analysis (ABA) therapy[16] and individual support services to teach daily living and self-care skills.[17] CSOC also offers family support services, including respite care services, limited assistive technology, and vehicle and environmental modifications when necessary. Families are also eligible to apply for financial aid for CSOC-contracted summer camps for youth with I/DD. When in-home care is no longer meeting the child's needs, CSOC can arrange for Out-of-Home (OOH) treatment in I/DD-specific residential care as a last resort.

It is important to note that neither CSOC nor PerformCare provide direct clinical care. Families navigating the public system may experience multiple handoffs before their child begins receiving treatment, from PerformCare intake to a contracted agency to perform a biopsychosocial assessment to a CMO for care management to clinical provider.

[15] The population with intellectual and developmental disabilities has a broad range of diagnoses including Autism Spectrum Disorder, Down Syndrome, and Cerebral Palsy and spans a wide range of individual capacity levels.

[16] ABA services are only offered through CSOC if the youth is not insured by Medicaid. Youth enrolled in a Medicaid MCO must go through their Medicaid insurance provider to access ABA services.

[17] PerformCare New Jersey Children's System of Care. (n.d.-b). *NJ Children's System of Care – Intellectual and developmental disability services.* https://www.performcarenj.org/content/dam/amerihealth-caritas/performcare-nj/pdf/families/idd-services-flyer.pdf.coredownload.inline.pdf

Clinical Mental Health Care Options for Children in New Jersey

As described above, CSOC represents one critical pathway to mental health services for New Jersey children, primarily for those with moderate-to-high-acuity needs who require publicly coordinated care. However, the majority of youth in the state who need to access mental health services do so directly through community access. The sections that follow describe the full range of clinical services available to families, whether accessed through CSOC or directly through a provider.

The major categories of clinical care, as well as the primary pathways to access, are outlined below, with additional detail in the sections that follow:

- **Primary Care –** Focused on prevention and overall well-being, primary care includes well-child visits, screenings, vaccinations, and health education. Primary care providers are often the first point of contact for identifying mental health concerns and making referrals to specialists.
- **Outpatient Programs –** Clinical services, typically provided weekly or even less frequently as needed, allowing youth minimum disruption to schooling and home life while receiving care.
- **Intensive Outpatient Programs –** A higher level of care than traditional outpatient, these programs involve multiple treatment sessions per week while the child continues to reside at home. Number of hours and subsequent academic options (e.g., full- or part-time school attendance) will depend on the program.
- **Partial Care Programs –** Structured, full-day therapeutic programs usually held in hospital (partial hospitalization programs) or community-based settings. Youth participate in intensive treatment during the day, often receiving academic support directly through the program. Youth return home in the evening.
- **Crisis Care –** Emergency departments and mobile crisis teams provide crisis support including psychiatric screening and short-term services offered to stabilize the patient until referral to a longer-term outpatient program or hospital admission. CSOC involvement may be necessary to access mobile response-related programs.
- **Short-term Inpatient Programs –** Provide treatment in a hospital or residential setting for youth in acute crisis. These stays are typically time-limited, not exceeding 90 days, and focus on stabilization. CSOC involvement is often necessary to access public, non-hospital-based programs.
- **Long-term Residential Programs –** Offer continuous, full-time care for youth with severe and complex needs. These programs include therapy, schooling, and support services in a live-in setting, often over several months or longer. CSOC involvement is often necessary to access public programs.
- **Other Services-** Include intensive home-based services, care coordination and case management, and family and peer support groups. CSOC involvement is often necessary to access public programs.

PRIMARY CARE

Primary Care Providers

Primary care providers are often among the first clinicians to treat youth experiencing mental health concerns. Parents and guardians turn to their primary care providers as trusted messengers, seeking education and referrals. Early identification and intervention are critical to addressing youth mental health needs before concerns escalate. Mental health screenings can help identify early signs of emotional or behavioral challenges, particularly for youth who may be reluctant to seek help or who present with less visible symptoms. Primary care providers are the main administrators of these screenings during well-child visits. Well-child visits include mental health screening as standard of care, as outlined in the Bright Futures/American Academy of Pediatrics "Periodicity Schedule," a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence.[18]

More detailed information about primary care specializations and qualifications is contained in Appendix G: Primary Care Provider Types and Specializations.

Integrated Primary Care

Integrated primary care refers to the coordination of physical and behavioral health services for youth within a primary care setting. Integrated models bring behavioral health support into pediatric and family medicine practices, allowing for earlier intervention, streamlined care, and reduced barriers to treatment.

Two Models of Integrated Primary Care

MODEL 1: EXTERNAL CONSULTATION

Primary care providers partner with outside behavioral health specialists who are available for consultation but not on-site. The New Jersey Pediatric Psychiatry Collaborative (NJPPC) is a statewide example that uses this model of care. Funded by DCF, it connects pediatric primary care providers with regional teams, "hubs," of child and adolescent psychiatrists for timely consultation, diagnostic guidance, and care coordination support at no cost to providers or families. Since its launch in 2015, the program has served more than 29,000 children.

MODEL 2: EMBEDDED BEHAVIORAL HEALTH

Behavioral health clinicians, including psychiatrists, psychologists, and licensed social workers, are embedded directly within pediatric or family medicine practices. This enables same-day referrals for medication management, short-term therapy, and care coordination without external handoffs.

One model of embedded behavioral health care is known as the Cherokee model, in which specialty mental health and primary care teams work closely together to coordinate care.[19]

HealthySteps is an example of integrated care operating in New Jersey, embedding child development specialists who are often licensed mental health providers in pediatric practices to support families from birth through age three. Several New Jersey Federally Qualified Health Centers, including CHEMED, also embed licensed social workers in primary care practices to serve youth of all ages.

[18] American Academy of Pediatrics. (2025). *Recommendations for preventive pediatric health care (periodicity schedule).* https://www.aap.org/en/practice-management/care-delivery-approaches/periodicity-schedule/

[19] Agency for Healthcare Research and Quality. (2022, July). *Integration at Cherokee Health Systems*. AHRQ Academy for Integrating Behavioral Health and Primary Care. https://integrationacademy.ahrq.gov/expert-insight/tips/integration-cherokee-health-systems

Both models aim to normalize mental health care within primary care settings and reduce delays caused by provider shortages and referral waitlists. Primary care providers play an essential role in screening, early identification, and ongoing management of youth mental health concerns. However, most pediatric and behavioral health services continue to be reimbursed through traditional fee-for-service payment models that do not support integrated, team-based, longitudinal care, enhanced primary care models, or value-based approaches tied to improved outcomes, particularly as part of Medicaid payment.

Diagnosis

For many families, obtaining a diagnosis is a challenging but critical step in accessing appropriate mental health care. While some pediatric primary care providers may be able to diagnose certain mental health conditions depending on their training and comfort level, diagnoses are often made by specialists. These evaluations may be conducted by licensed therapists or by medical specialists such as psychiatrists or developmental pediatricians. More detailed information about the types of licensed professionals who can provide mental health services is contained in Appendix H: Understanding Mental Health Provider Credentials.

A diagnosis can provide clarity and validation for families while also serving as a gateway to services, insurance coverage, and evidence-based treatment. This is particularly important for youth with I/DD, for whom early identification and intervention are associated with improved outcomes.[20]

> ***New Jersey recently reduced barriers to care by enacting a law requiring coverage for youth who are at risk but do not yet have a formal diagnosis to receive insurance coverage for mental health care, helping families initiate treatment earlier.***[21]

OUTPATIENT SERVICES

Outpatient Therapy

For many children and youth, psychotherapy, including all types of talk therapy and play therapy, is an important component of mental health treatment.[22] Licensed providers use a range of evidence-based therapy/treatment methodologies to address symptoms. Treatment sessions may be individual, in a peer group setting, or a combination of both. While individual sessions offer opportunities to focus on the youth's specific circumstances, group settings often offer opportunities to build skills specific to the youth's symptoms, for example, a social skills group. Some therapy providers specialize in one or more types of treatment, while others may take a more integrative approach, using elements from multiple treatment approaches.

Trauma-informed care is a common phrase used across the youth mental health field and refers to an approach that recognizes the impact of traumatic events. It is a "strengths-based framework grounded in an understanding of trauma's impact on individuals, emphasizes the physical, psychological, and emotional safety for providers and survivors, and supporting survivors to build a sense of control and empowerment."[23]

[20] Clark, M.L.E., Vinen, Z., Barbaro, J., & Dissanayake, C. (2018). *School age outcomes of children diagnosed early and later with autism spectrum disorder*. Journal of Autism and Developmental Disorders, 48(1), 92–102. https://doi.org/10.1007/s10803-017-3279-x

[21] New Jersey Legislature. (2025). *P.L.2025, c.369*.

[22] American Academy of Child and Adolescent Psychiatry. (2019, April). *Psychotherapies for children and adolescents* (No. 86). https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Psychotherapies-For-Children-And-Adolescents-086.aspx

[23] American Academy of Pediatrics. (2025, August 15). *What is trauma-informed care?* https://www.aap.org/en/patient-care/national-center-for-relational-health-and-trauma-informed-care/what-is-trauma-informed-care/

COMMON TYPES OF EVIDENCE-BASED-TREATMENT APPROACHES

Licensed providers draw on a range of evidence-based treatment approaches depending on the youth's age, diagnosis, and individual needs. Below are some of the most common mental health evidence-based therapies and treatments.

Applied Behavior Analysis (ABA): Therapy targeting behavior modification amongst individuals with intellectual and developmental disabilities, including autism spectrum disorder.

Cognitive Behavior Therapy (CBT): CBT is widely used to treat a variety of youth mental health concerns including depression and anxiety. It focuses on the relationships between thoughts, feelings, and behavior and developing healthier patterns of responses between the three.[24]

Dialectical Behavior Therapy (DBT): DBT is an intensive, structured treatment for youth experiencing intense emotional responses. It is also utilized for a wide variety of diagnoses, including anxiety and depression as well as eating disorders and borderline personality disorder. DBT incorporates mindfulness and CBT as core skills in addressing symptoms. Youth who may not have experienced symptom relief with CBT may opt for DBT as a higher intensity treatment.[25]

Family Therapy: Family therapy is a broad term for many approaches that focus on working with both the child and parents to improve relationships and communication. Specific methods include Internal Family Systems, Functional Family Therapy, dyadic therapy, and more.[26]

Play Therapy: Play therapy helps children process their feelings, thoughts, and behaviors in a developmentally age-appropriate way through child-centered and led play with a licensed therapist.[27] Play therapy typically is used with young children and can be offered individually or in groups and may also work with parents or family to improve relationships.[28]

Help Hotlines

New Jersey also has a range of hotlines available to support youth mental health, including resources for parents and guardians as well as confidential, anonymous options for youth to speak with trained counselors. While some options are specific to certain regions or counties, others are available state or nationwide.

Psychiatric Emergencies: Parents and guardians have three options to call for 24/7 mobile outreach and crisis intervention services: 911 for law enforcement (and ARRIVE Together mental health staff, where available), county-based Psychiatric Emergency Screening Services (PESS) for clinical evaluation, or PerformCare[29] for mental health support. Each of these is discussed in detail in the Crisis Services section.

Hotlines for Youth Callers: Youth may access national help hotlines including the 988 Suicide & Crisis Prevention Lifeline for suicide and other mental health support that connects them with a counselor 24/7. While 988 has a mobile crisis response team for voluntary in-person visits in New Jersey, this service is available exclusively for adults age 18 and older.

[24] Vallejo, M. (2024, January 10). *CBT for teens: How it works, techniques, and FAQS*. Mental Health Center Kids. https://mentalhealthcenterkids.com/blogs/articles/cbt-for-teens

[25] Garey, J. (2025, August 27). *DBT: What is dialectical behavior therapy?* Child Mind Institute. https://childmind.org/article/dbt-dialectical-behavior-therapy/

[26] Silva, J. (n.d.). *4 types of family therapy*. MyWellbeing. https://mywellbeing.com/therapy-101/4-types-of-family-therapy

[27] University of North Texas, Center for Play Therapy. (n.d.). *What is play therapy?* https://cpt.unt.edu/what-play-therapy

[28] Evidence Based Child Therapy. (n.d.). *About us.* https://evidencebasedchildtherapy.com/about-us/

[29] PerformCare can also be called to request resources and referrals related to youth experiencing mental health concerns outside of an emergency.

Spotlight

2NDFLOOR HELPLINE

New Jersey youth ages 10–24 can also contact 2NDFLOOR, a confidential, anonymous hotline available by phone, text, or app, to speak with a licensed counselor about a wide range of concerns without parental involvement. Counselors can help youth navigate next steps, such as initiating conversations with parents about therapy or seeking support from a school counselor. On average, phone calls last 20 minutes and in 2025, 2NDFLOOR conducted an average of 1,000 contacts including calls and texts per month.

TELEHEALTH

Telehealth is widely available for mental health therapy and many other clinical services in New Jersey. For families in rural or underserved areas, or those seeking providers with specific specialties or language capabilities, telehealth significantly expands access to care. New Jersey law establishes clear rules governing how telehealth services must be covered and reimbursed.

Until July 1, 2026, New Jersey law requires telehealth payment parity, requiring state regulated commercial insurance plans, Medicaid, and the State Health Benefit Programs to reimburse for services provided via telemedicine at the same rate as in-person visits, provided those services are already covered for in-person care under the plan. This requirement may be extended if pending legislation is enacted.[30]

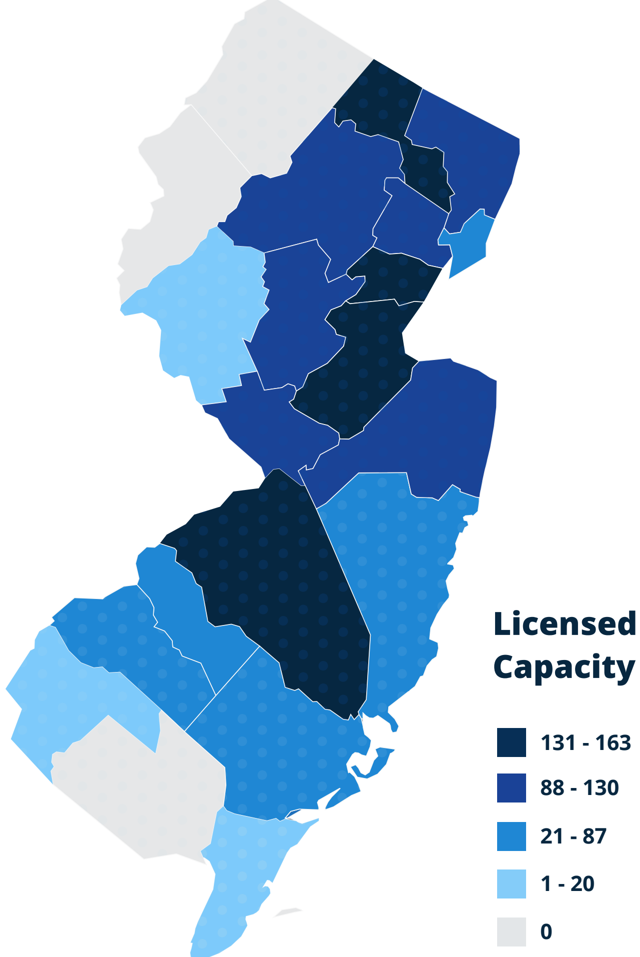
OUTPATIENT SPECIALTY PROGRAMS

Intensive Outpatient Programs and Partial Care Programs

Intensive outpatient programs and partial care programs are intensive, non-residential services for youth. Both programs typically emphasize highly structured evidence-based treatment for a wide variety of psychiatric diagnoses, typically delivered in a peer group setting integrating aspects including individual therapy, family psychoeducation, and medication management when appropriate. Some programs accept a variety of diagnoses while others are specialized in treating specific diagnoses such as substance use disorder or disordered eating.

Intensive outpatient programs may be scheduled for after-school hours to minimize disruption to a youth's education. Partial care programs, which are a higher level of intensity than intensive outpatient programs, typically integrate a school component into the full-day program, working with school districts to make appropriate arrangements. The term "partial care" is used broadly to encompass both hospital-based partial hospitalization programs and community-based partial care programs. Intensive outpatient and partial care programs may be offered in the community, mental health clinics, or hospitals, and youth return home every day after treatment.

Capacity of Partial Care and Partial Hospitalization Programs (by county)
Licensed by DCF



[30] P.L. 2024, c. 105

Early Intervention Services

Early Intervention Services are federally mandated supports for infants and toddlers with developmental disabilities or delays, authorized under the federal Individuals with Disabilities Education Act. Services are designed to address one or more of the following areas: (1) physical development, (2) cognitive development, (3) communication development, (4) social or emotional development, and (5) adaptive development and are delivered through individualized family service plans.[31]

Early intervention includes family training, counseling, home visits, psychological services, and social work services. Services are provided by qualified professionals, depending on the child's individual needs, which may include social workers, psychologists, speech and language pathologists, occupational or physical therapists, and other qualified personnel.[32]

DOH is the lead agency for implementing New Jersey's Early Intervention Service (NJEIS). NJEIS uses four Regional Early Intervention Collaboratives (REICs) that cover the state's 21 counties. The REICs serve as the regional entry point into the early intervention system and assist with connecting families to services. Family cost-sharing is required for certain early intervention services including psychological and social work services.

Coordinated Specialty Care

Coordinated Specialty Care (CSC) is widely regarded as a gold-standard early-intervention model for adolescents experiencing early-stage psychosis or who are at high risk of developing psychotic symptoms. There are three CSC programs serving the northern, central, and southern regions of the state that provide intensive, team-based services delivered in-home and in community settings. These programs aim to stabilize symptoms, improve overall functioning and well-being, and prevent psychiatric deterioration during a critical developmental window. CSC programs in New Jersey are supported through DHS grants. Data from the Division of Mental Health and Addiction Services (DMHAS) reports that statewide, CSCs typically serve 50 or fewer youth (17 years and under) annually (41 youth in 2025, 33 youth in 2024, and 50 youth in 2023). Volume statistics are available in Appendix I: Department of Mental Health and Addiction Services Program Data.

Certified Community Behavioral Health Clinics

Certified Community Behavioral Health Clinics (CCBHCs) are a nationally recognized care delivery model that provides comprehensive, integrated mental health services alongside social support. DMHAS has designated 17 clinics as CCBHCs statewide. These clinics are eligible for enhanced, flexible funding to support their delivery of comprehensive care. CCBHCs are designed to serve individuals of all ages, regardless of insurance status, ability to pay, or citizenship. They offer timely, accessible, outpatient care through a "one-stop shop" model. Core services include mobile outreach, evaluations, therapy, medication management, and holistic case management including social services program navigation. A small number of youth receive services from CCBHCs. Approximately 3,000 youth receive services annually, a number that rose annually from 2022 to 2024. Volume statistics are available in Appendix I: Department of Mental Health and Addiction Services Program Data.

CRISIS SERVICES

Emergency Departments

The emergency department (ED), also called the emergency room or ER, is often used by youth and parents when there is a mental health crisis. All EDs are obligated to serve everyone regardless of age, citizenship status, insurance coverage, or ability to pay.[33] They are open 24/7 and available for walk-in or via ambulance. Children with mental health concerns are screened and those requiring additional services may be admitted to a pediatric medical or psychiatric unit for stabilization. This is a valuable and necessary service for many acute crises.

Psychiatric Emergency Screening Services

DMHAS oversees New Jersey's PESS system, which serves both adults and children in psychiatric distress. Each county has a PESS provider responsible for psychiatric screening, crisis intervention, and referral services available 24/7 via telephone hotline. Some counties have additional designated "affiliated emergency services" (AES) providers; however, there is only one designated PESS provider. Many PESS providers are associated with a local hospital provider, offering screening service through their ED or dedicated screening center, while others are run by independent mental health provider organizations. Service models vary by county. Most provide mobile outreach, though utilization criteria differ – with some only dispatching a mobile unit if an in-person ED visit is not feasible.[34]

[31] *See* 20 U.S.C. 1432, 34 C.F.R. 303.21.

[32] *See* 34 C.F.R. 303.

[33] Through the Emergency Medical Treatment and Labor Act (EMTALA), a federal law, hospitals with EDs are required to provide a medical screening and stabilizing treatment to anyone seeking emergency care, regardless of insurance status or ability to pay.

[34] Saint Clare's Health. (n.d.). *Psychiatric emergency.* https://saintclares.com/services/psychiatric-emergency/

While the majority of youth mobile outreach is performed through PerformCare MRSS, which was previously described, only PESS is authorized to conduct a clinical evaluation to determine if a youth is eligible for hospital admission.

Pediatric Innovations

Several counties have created pediatric-specific PESS pathways designed to allow youth to receive screening outside of the ED. These models include screenings in a non-hospital environment or via mobile service which may include direct admission to a hospital when necessary, bypassing the ED all together. This is significant because emergency departments may be overwhelming for children in mental health crisis, and reducing unnecessary ED visits benefits both families and hospitals working to triage patient needs.

Spotlight

SOMERSET COUNTY - BRIDGEWAY BEHAVIORAL HEALTH SERVICES

Somerset County's PESS provider, run by Bridgeway Behavioral Health Services, offers scheduled and daily walk-in appointments available in a "living room" model of care. A living room model is a specially designed calming, non-clinical environment, with separate spaces for adults and youth patients.

In March 2026, Somerset County's PESS provider changed from Bridgeway Behavioral Health Services to Robert Wood Johnson Barnabas Health Somerset.

Spotlight

HUDSON COUNTY - HOPE HUB

Hudson County's PESS provider, Jersey City Medical Center, established the Hope Hub, a psychiatric screening center offering a non-emergency, walk-in space for individuals and families to receive support during behavioral health crises. When parents or guardians call the PESS hotline number, a screener will determine whether the youth should go directly to the ED or can be seen at the Hope Hub. The majority of patients seen by Hope Hub are referred by schools for psychiatric clearances.

The Hope Hub uses a "living room" model and offers same-day or next morning appointments or walk-ins. Youth receive the same level of clinical evaluation they would in the ED. If hospital admission is necessary, the youth can be transferred to the hospital. However, in most cases, the youth is discharged back to parents or guardians, with referrals for community outpatient services and follow-up to facilitate ongoing care. At the Hope Hub, youth are seen within an average of 5 minutes of their appointment times compared to a multi-hour visit in the ED. Services at Hope Hub are free of charge for families.

Spotlight

MONMOUTH COUNTY PESS AND CHILD AND ADOLESCENT CRISIS DIVERSION PROGRAM

The Monmouth County Child Family Crisis Clinicians (CFCC) and Child and Adolescent Crisis Diversion Program (CACDP) together create a coordinated, community-based approach to youth behavioral health crises that reduces reliance on emergency departments and traditional PESS services and supports stabilization in the least restrictive setting.

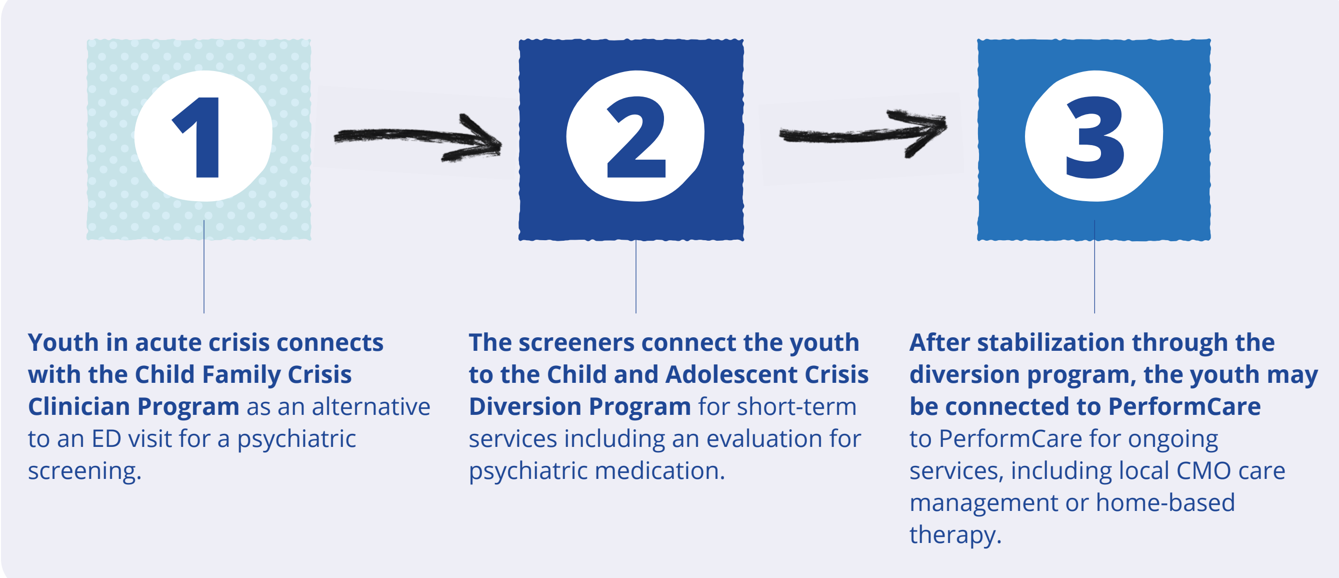
CFCC provides mobile crisis response for youth ages 5–17, deploying master's-level clinicians who are youth-specific screeners, to homes, schools, and other community locations, with telehealth as an option. Using a trauma-informed approach, clinicians assess psychiatric needs, determine the appropriate level of care, and connect youth and families to services. They also provide school clearance and follow-up support after higher levels of care. By meeting youth where they are, CFCC reduces barriers and prevents unnecessary hospital visits. The program has demonstrated strong outcomes, serving hundreds of youth annually with a hospital diversion success rate of 96–98%.

CACDP builds on this initial response by offering short-term, site-based crisis stabilization services accessible within 24–48 hours. Modeled after New Jersey's Early Intervention Support Services (EISS), CACDP provides a range of supports, including psychiatric evaluation, medication management, individual and family therapy, group therapy, and care coordination. Designed to accept referrals directly from CFCC, the program ensures continuity of care and helps connect youth to longer-term supports.

Since its launch in 2023, CACDP has delivered over 3,800 visits and successfully stabilized 81% of youth within the community.

Together, CFCC and CACDP represent an effective crisis diversion model that emphasizes early intervention, accessibility, and coordinated care - improving outcomes for youth and families while reducing strain on hospital systems.

Possible Pathway through Monmouth County Youth Behavioral Health Hospital Diversion Programs



Psychiatric School Clearance

Given increasing concerns over school safety and increasing mental health needs, threats of violence in school may lead to formal responses by school administrations. If a student exhibits concerning psychiatric symptoms at school, a school may temporarily dismiss the student and require psychiatric clearance before returning. These policies are meant to ensure the student's access to mental health resources when needed as well as protect the greater school community when the school believes the child may pose a threat to self or others.

Nationally, psychiatric school clearances, sometimes called threat assessments, have become increasingly common. The range of incidents that may trigger a school's response is broad, including comments, pictures, or actions that may have been made lightly or with ambiguous intent. While students with disabilities are covered by numerous and, at times, overlapping behavior-related guidelines and rights, general education students are often subject only to local district policies. These policies can vary widely and result in inconsistent practices across the State.[35]

Neither the State-funded school-based mental health program, NJ4S, nor CSOC MRSS offer school clearances, leaving families largely on their own to find a qualified evaluator. If a family can afford to engage a private clinician and can find one, they may obtain an evaluation for their child. Provider shortages and long waitlists make this difficult for many. In counties with a pediatric PESS, the school can refer the student directly there. In counties without tailored pediatric PESS services, families may have no option other than turning to EDs to evaluate their child, where long wait times and exposure to the stressful environment of an emergency room can compound distress. Such negative experiences in the ED may discourage a child from seeking help in the future.

Unlike other crisis services, there is no dedicated statewide pediatric-specific system pathway to obtain a psychiatric school clearance in New Jersey. Families turn to the ED if no private clinician or local public option is available.

Law Enforcement

While the PESS hotline numbers are designed to address many types of psychiatric emergencies, in situations of imminent risk of harm, 911 is the number to call for an immediate dispatch. New Jersey's Alternative Responses to Reduce Instances of Violence and Escalation Together program (ARRIVE Together), overseen by the Attorney General's Office, pairs police officers and mental health professionals together to respond to 911 calls involving mental health concerns. ARRIVE Together is available in many municipalities across all counties and serves more than 71% of New Jersey residents.[36] ARRIVE Together is not a youth-specific program but does serve youth in psychiatric distress.[37]

INPATIENT SERVICES

Hospitalization

When necessary, youth may be admitted to pediatric psychiatric beds located in hospitals across New Jersey for stabilization services. Children's Crisis Intervention Services (CCIS)[38] is a network of beds that serve youth ages 5-17 with inpatient psychiatric treatment needs. The hospitals and number of designated beds are licensed and regulated by DOH.

[35] Worthington, J. (2023, December 13). *Navigating the myriad legal requirements when addressing a student with disabilities who is considered to constitute a danger to self or others.* New Jersey Principals and Supervisors Association. https://njpsa.org/navigating-the-myriad-legal-requirements-when-addressing-a-student-with-disabilities-who-is-considered-to-constitute-a-danger-to-self-or-others/

[36] Office of the Attorney General, State of New Jersey. (2025, June 25). *Governor Murphy, Attorney General Platkin announce ARRIVE Together program's 10,000th interaction*. https://www.njoag.gov/governor-murphy-attorney-general-platkin-announce-arrive-together-programs-10000th-interaction/

[37] Ray, R. (2023, March 16). *New Jersey ARRIVE Together program could reform policing as we know it*. Brookings Institution. https://www.brookings.edu/articles/new-jersey-arrive-together-program-could-reform-policing-as-we-know-it/

[38] New Jersey hospitals and DCF use CCIS terminology, which we adopt throughout this report. DOH uses different terminology in its data systems. Aligning terminology across state agencies would improve clarity in communication, data reporting, and cross-agency collaboration.

Two hospitals [39], RWJBarnabas Health Trinitas Hospital, located in Elizabeth, and Inspira Health Center, located in Bridgeton, host intermediate inpatient units that serve as a step-down for sub-acute inpatient psychiatric needs following a CCIS unit stay. Additionally, ten intermediate-level beds are reserved for I/DD patients with co-occurring mental illness at Trinitas Hospital. This designation is not State regulated, but rather a voluntary hospital designation for coordination. To access I/DD-specific beds, patients are first admitted to their local CCIS unit for stabilization before being transferred to Trinitas for a designated I/DD bed placement.

These services are designed to be short-term until the patient is stable enough to discharge to the next level of care, typically either to in-community outpatient services or to an out-of-home (OOH) residential treatment bed.

A child with both psychiatric needs and an active medical condition is often admitted to a medical inpatient bed rather than a psychiatric bed because psychiatric units generally are not equipped or licensed to manage significant medical needs. Psychiatric beds are designed primarily for behavioral health treatment and safety monitoring. Many psychiatric units cannot provide:

- Continuous cardiac or respiratory monitoring;
- IV fluids, tube feeding, or frequent laboratory testing;
- Access to pediatric specialists, imaging, or emergency medical interventions; or
- Higher nurse-to-patient ratios needed for acute medical care.

As a result, the youth may first be admitted to a medical inpatient bed until the medical issue is stabilized. During that time, they may receive psychiatric consultation, safety observation, and behavioral health treatment while on the medical floor. Once medically cleared, if ongoing psychiatric hospitalization or treatment is still needed, the child may then transfer to an inpatient psychiatric bed, residential treatment, Medicaid-supported MLTSS facility, or home.

A medical admission may be more common for youth with eating disorders, suicide attempts by overdose, severe autism or developmental disability with co-occurring medical needs, or complex psychiatric crises accompanied by significant physical health concerns that need to be stabilized by a dedicated medical team.

INVOLUNTARY COMMITMENT

When it is determined that a youth in crisis needs to be admitted to a hospital, whether brought by a parent or guardian, community member, law enforcement, or self-referral, the parent or guardian's consent is required for the first 7-day stay. At the end of the 7 days, a youth is discharged, voluntarily signed in to the hospital, or involuntarily committed. To voluntarily sign into the hospital, youth must be 14 or older, with waivers available on a case-by-case basis for younger children. If the youth does not consent to treatment, the minor may be involuntarily committed if it is deemed they are an imminent danger to themselves, others, or property and still require the most restrictive setting of a 24/7 secure unit with mental health clinical care to maintain safety. Superior Court oversees this decision on a weekly basis as the patient progresses.

If an individual does not meet involuntary commitment criteria, there is a step-down level called conditional extension pending placement (CEPP) that applies to individuals who do not have an appropriate safe setting to be discharged to. These individuals stay on the Superior Court docket, with weekly or biweekly evaluations. This typically applies to youth who are waiting for an out-of-home treatment bed or are unable to go home due to parental refusal of custody (which triggers DCPP involvement for mediation services).

If a parent or guardian refuses treatment for their child, for example, attempting to withdraw them from inpatient care before it is medically appropriate to do so, clinicians can invoke the involuntary commitment process and involve DCPP.

Involuntary commitment is reserved for extreme circumstances and is used only when other options are unavailable or insufficient.

OUT-OF-HOME TREATMENTS

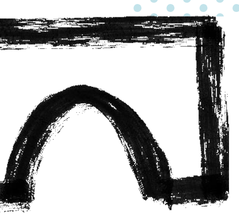
Out-of-home (OOH) treatments encompass a wide range of residential settings that offer high-intensity treatment and full-time access to care. Treatments vary and can include long-term care for youth with I/DD, shorter-term detox and substance use disorder recovery programs, campus-based programs, small group homes, and individualized therapeutic treatment homes. OOH treatment is considered to be a last resort.

[39] Summit Oaks Hospital, a psychiatric care facility in Union County, holds licensure for 22 intermediate inpatient psychiatric beds, but the Quality Institute was unable to verify whether they are currently in active use.

Families can access OOH treatments in several ways. They may work with their CMO to establish clinical need for a higher-intensity treatment plan if community-based services are insufficient to meet the youth's needs. After PerformCare authorization, the CMO would then assist the family in selecting a voluntary placement. Youth may also be referred to an OOH treatment as a step-down placement after inpatient hospitalization. When appropriate care is unavailable in-state, CSOC may partner with families to arrange for an out-of-state treatment.

A family may also choose to seek OOH treatment such as a private residential treatment center directly without contacting PerformCare, opting to pay with commercial insurance or self-pay out-of-pocket. In addition to residential treatment centers, families may also choose to enroll their child in wilderness therapy programs, which often offer therapeutic services for adolescents in outdoor camping settings designed to provide youth a new environment to reset and focus on wellness.[40]

Within CSOC, there are different levels of OOH treatments that correspond to varying levels of clinical need. Appendix J: Out-of-Home Treatment Types and Utilization includes additional data related to contracted capacity, utilization, and waiting lists of CSOC's OOH treatments.



School-Based Mental Health Services

New Jersey schools are a primary setting where youth mental health needs are identified and addressed, including concerns such as anxiety, depression, social and peer relationship challenges, and trauma-related stress. Schools respond to these needs through a continuum of supports that combine school-based services, statewide support systems, and community organizations, ranging from universal social emotional learning and prevention efforts to targeted and crisis-level interventions.

REFERRALS

Schools play a significant role in identifying and referring students to mental health supports. Referral processes vary by school district. School staff, including school counselors, student assistance counselors, social workers, nurses, or other trained staff, may serve as primary referral sources when a student demonstrates mental health concerns, typically followed by caregiver consent and intake assessment to determine appropriate supports.

In addition to school-based referral pathways, New Jersey has developed statewide supports designed to work alongside district systems and expand access to short-term and preventive services.

STATEWIDE SUPPORT SERVICES

New Jersey Statewide Student Support Services (NJ4S)

Today, New Jersey Statewide Student Support Services (NJ4S) is embedded in DCF, establishing 15 regional hubs to provide Tier 1 universal supports and services to students in grades K-12 and Tier 2 small group and Tier 3 individual supports and services to students in grades 6-12. These state-funded hubs include mental health specialists, prevention specialists, and licensed mental health clinicians who provide services to community members and schools based on referrals and requests for services from school systems. NJ4S also connects caregivers and students to additional resources, if needed,

[40] Biscontini, T. (2023). *Wilderness therapy*. EBSCO Research Starters. https://www.ebsco.com/research-starters/health-and-medicine/wilderness-therapy

who typically provide short-term 6-8 week supports to students in grades 6-12, though there is no limit on the number of sessions that may be provided. More information on Tier 1, 2 and 3 supports is provided below.

Under Governor Sherrill's proposed FY27 budget, NJ4S is scheduled to sunset in June 2026 and will not be funded in the state budget. Instead, funding is proposed in the Department of Education's FY27 budget for a program called SPARK (School-based Partnerships for Access and Resilience).[41]

School System's Connection to CSOC

Schools connect to CSOC primarily through referrals when student needs exceed school-based or NJ4S capacity. School staff work with CSOC local providers, including CMOs who coordinate delivery of services with a child and family team, and FSOs who provide support to caregivers. Information sharing between CSOC systems and schools is limited by confidentiality protections created by the federal Health Insurance Portability and Accountability Act (HIPAA), though CSOC providers may attempt to obtain a caregiver's consent to share information with school personnel.

Special Education Medicaid Initiative

New Jersey's Special Education Medicaid Initiative (SEMI) provides an existing mechanism through which schools may receive Medicaid reimbursement for certain mental health services delivered to Medicaid-eligible students with disabilities. Under SEMI, school psychologists may bill for psychological counseling services and school social workers may bill for psychotherapeutic counseling when those services are included in a student's Individualized Education Program (IEP). SEMI can help support school-based mental health capacity for a subset of students, but it is limited to Medicaid-eligible special education students and does not provide funding for broader school-based mental health services, preventive supports, or services for general education students.

MULTI-TIERED SYSTEM OF SUPPORTS

Some New Jersey schools organize mental health and behavioral supports within a Multi-Tiered System of Supports (MTSS) framework that combines universal whole-school instruction (Tier 1), targeted group interventions (Tier 2), and individualized services (Tier 3).

Tier 1 – *Universal Supports*

Tier 1 universal supports include school-wide prevention programming designed to reach all students through assemblies, classroom lessons, and psychoeducational presentations. This includes large-scale activities such as suicide prevention curricula, character education lessons, social skills education, and mental health awareness presentations delivered by school staff or external partners. Universal supports may extend beyond the classroom, including community events, webinars, parent workshops, and back-to-school presentations focused on youth mental health topics and prevention education. These initiatives aim to increase awareness, normalize conversations about mental health, and provide families with tools to support students outside of school.

Tier 2 – *Small Group Supports*

Tier 2 small group supports use targeted, referral-based group interventions designed for students who share similar emerging behavioral or mental health concerns. Schools form small groups of students who could benefit from structured, evidence-based programming on topics such as bullying, substance use, emotional regulation challenges, or grief.

Tier 3 - *Individualized Supports*

Tier 3 individualized supports include short-term, individualized clinical counseling or intervention delivered by licensed clinicians or specialized mental health staff, often through partnerships between schools and external providers. These services are typically referral-based and are initiated by school counselors, social workers, student assistance staff, or other designated school representatives when a student presents with significant mental health needs such as anxiety, depression, trauma exposure, bullying, or self-harm concerns. These services may be among the most utilized within multi-tiered systems because they address immediate and high-acuity needs and provide targeted support for students who require more intensive intervention than universal or small-group programs can offer. In some cases, individualized school-based counseling functions as a bridge while students wait for more intensive services such as outpatient therapy, partial care, or specialized treatment programs.

[41] New Jersey Department of Education. (2026, March 12). *Sherrill Administration's budget plan includes record $12.4 billion investment in K–12 education* [Press release]. https://www.nj.gov/education/news/2026/SherrillAdministrationsBudgetPlanIncludesRecord12BillionInvestmentInK12Education.pdf

SOCIAL EMOTIONAL LEARNING

Social emotional learning (SEL) serves as a primary method to support youth with mental health needs within some school systems. Social emotional learning is often implemented using an MTSS framework. Many districts embed SEL competencies including emotional regulation, coping skills, responsible decision making, and relationship building into broader mental health and wellness strategies.

At the universal level, schools implement classroom lessons, character education programs, morning meetings, and prevention initiatives such as suicide prevention curricula, mental health ambassador programs, and SEL-aligned advisory activities. These efforts aim to build foundational skills across the entire student body while normalizing conversations about emotions, relationships, and mental well-being. Targeted SEL programming, delivered through small groups and specialized curricula, is also used to address specific student needs, focusing on topics such as emotional regulation, anger management, self-esteem, grief, bullying prevention, peer pressure, and digital citizenship.

The degree of implementation of SEL strategies is wide ranging within New Jersey schools, with some schools and districts having comprehensive, school-wide MTSS systems with tiered supports, while other districts implemented a more responsive, triage system within schools.

EXTERNAL PARTNERS SUPPORTING SCHOOL MENTAL HEALTH

External partners extend the capacity of school-based systems by offering specialized prevention, treatment, and post-crisis supports that complement school and state services. These partners include private therapy and counseling practices, healthcare systems, advocacy organizations, and state-supported initiatives with specific school-focused expertise.

Below are a few external organizations that support the school mental health system:

The School-Based Youth Services Program (SBYSP) is located in 86 schools and is open to all youth. It coordinates with community resources to offer, among other things, mental health counseling, substance use disorder education and prevention, preventive health awareness including pregnancy prevention and primary medical linkages. Services are offered before, after, and during school hours.

The Mental Health Association of New Jersey: in partnership with the State and many community organizations, offers Youth Mental Health First Aid, an evidence-based, internationally implemented, eight-hour training for adults on how to recognize and respond to signs and symptoms of mental health and substance use challenges in youth. Similarly, the Teen Mental Health First Aid program focuses on teaching teens ages 15-18 how to identify and respond to signs of mental health and substance use among their friends and peers.

The Traumatic Loss Coalition: provides suicide prevention and trauma trainings in virtual and in-person formats, and at annual state conferences, and has a network of providers and licensed clinicians statewide who are able to respond to traumatic events, such as the loss of a student, at the request of school districts across New Jersey, with the goal of stabilizing students and staff or other short-term services including community referrals for clinical support.

Rutgers Center for Comprehensive School Mental Health: supports schools through training and technical assistance, professional development including evidence-based interventions, check-in check-out, and Tier 1 interventions including emotional regulation, prosocial development, and suicide prevention. Training and technical assistance includes intensive coaching support for school staff and leaders, school walk-throughs, and guidance on systems change processes that take school systems from start-to-finish in implementing comprehensive school mental health systems.

Community-Based Mental Health Services

Community-based organizations also play a vital role in New Jersey's children's mental health system, providing non-clinical services that complement clinical care. These services include childcare, prevention and early intervention programs, anti-stigma campaigns, peer and parental support, family advocacy, specialized interventions, and community training. New Jersey supports these efforts through a wide variety of funding streams and a variety of agencies and organizations.

These community-driven activities are important because many children who need mental health support never access the clinical system, whether due to stigma, cost, lack of awareness, provider shortages, or other reasons. Community-based programs can reach children and families in familiar settings such as schools, neighborhoods, or pediatric offices, before concerns escalate to crisis.

Mental health stigma, the shame, judgment, and discrimination associated with mental health conditions, is one of the most significant barriers preventing young people from seeking help. Mental health conditions often begin early in life, with approximately 50% of all lifetime mental illnesses beginning by age 14 and 75% by age 24.[42] Stigma can delay treatment, with serious long-term consequences for a child's education, relationships, and well-being. Anti-stigma efforts work by normalizing mental health as part of overall health and creating environments where young people feel safe asking for help.

EARLY CHILDHOOD MENTAL HEALTH (PRENATAL-AGE 5)

New Jersey has invested significantly in prevention-oriented mental health supports for families during pregnancy and extending through infancy and early childhood.[43] These efforts center on integrated, relationship-based models embedded in health care and community settings, reflecting an understanding that early relational health, caregiver well-being, and coordinated supports during the prenatal and early childhood years are vital to long-term mental health outcomes.

Several evidence-based models are already operating across New Jersey. CenteringPregnancy and CenteringParenting integrate clinical care, peer support, and facilitate discussion into group prenatal and well-child visits. By combining health assessment with social connection, anticipatory guidance, and stress reduction, these models promote maternal mental health, strengthen parenting confidence, and create protective factors for infants and young children while improving continuity of care.[44]

[42] National Alliance on Mental Illness. (n.d.). *Types of conditions*. https://www.nami.org/types-of-conditions

[43] For very young children, social-emotional learning is typically addressed through early childhood social-emotional development frameworks rather than traditional school-based SEL curricula. In infant and early childhood settings, social-emotional development is promoted through supportive relationships, classroom routines, play-based learning, and caregiver engagement. New Jersey has invested in several early childhood models to support this work, including the New Jersey Pyramid Model Partnership and the Socio-Emotional Formation Initiative (SEFI), which provide training and technical assistance to early childhood educators and providers serving children ages 0-5. These initiatives support universal promotion of healthy social-emotional development, early identification of children with additional needs, and more intensive supports for children experiencing behavioral or social-emotional challenges.

(Montclair State University, Center for Autism and Early Childhood Mental Health. (n.d.). *Socioemotional formation initiative (SEFI)*. https://www.montclair.edu/center-for-autism-and-early-childhood-mental-health/professional-developmentformation/socio-emotional-formation-initiative-sefi/)

[44] A list of New Jersey based locations is available here: https://centering.my.salesforce-sites.com/WebPortal/ListOfCenteringSites?stateName=NJ

HealthySteps embeds child development and behavioral health specialists directly into pediatric primary care practices, supporting families from birth through age three. HealthySteps focuses on early identification of social-emotional concerns, parent coaching, developmental screening, and warm handoffs to community resources, normalizing mental health support as part of routine pediatric care rather than as a separate or crisis-driven service.[45]

Literacy-based prevention models also contribute to early mental health promotion. Reach Out and Read, implemented in many pediatric practices statewide, strengthens the caregiver-child relationship through shared reading while reinforcing positive parenting behaviors, language development, and emotional bonding, key protective factors for early social-emotional development.

New Jersey's home visiting programs, administered by the Division of Family and Community Partnerships within DCF, provide critical mental health and prevention supports for families with young children. Programs such as Nurse-Family Partnership, Parents as Teachers, Healthy Families America, and Universal Home Visiting via Family Connects NJ offer voluntary, relationship-based services that address parental mental health, stress, and social needs alongside child development, helping families navigate challenges before they escalate into clinical concerns.

Spotlight

SOMERSET COUNTY'S EARLY CHILDHOOD WELLNESS SPECIALISTS

Somerset County's Head Start programs, operated by HOPES CAP, Inc., are supported by a Wellness Specialist who oversees mental health and disability referrals for expectant women and children from birth to age five enrolled in Early Head Start (0–3), Head Start (3–5), and other district-funded preschool classrooms. When a family member or teacher expresses concern about a child's social emotional development, behavior, or potential developmental delays, the Wellness Specialist meets with the family to review concerns and facilitate referrals for appropriate clinical evaluations and services. Referrals may include speech and language therapy, neurodevelopmental evaluations, in-house play therapy, behavioral health services through CSOC referral, Early Intervention Services, or connections to other community-based providers.

The Wellness Specialist also helps families navigate the service system, including managing waitlists, providing psychoeducation about child development and behavioral health, assisting families in understanding available resources and supporting transitions into elementary school. This includes coordination with school districts to facilitate services and develop educational plans, such as an Individualized Education Program. In the most recent program year, an investment of $85,000 served 277 children.

TRAUMA AND RESILIENCE SERVICES

The DCF Office of Resilience is devoted to raising community awareness and providing training on the impact of trauma and building resilience, connecting community resources and government agencies across the state. The Office of Resilience offers a range of free resources for individuals, families, organizations, and state agencies through its website, including trauma-informed training and assessment tools, educational materials on Adverse Childhood Experiences and Positive Childhood Experiences, consultation and coaching, and connection to the statewide Resilient NJ Collaborative.

[45] HealthySteps locations are searchable here: https://www.healthysteps.org/who-we-are/the-healthysteps-network/healthysteps-practice-directory.

PARENT SUPPORT NETWORKS

Parents and caregivers navigating the children's mental health system often benefit from peer support, advocacy assistance, and help connecting to resources. These are needs that are served by a range of parent support organizations across New Jersey. These organizations vary in structure and focus, from statewide advocacy networks like the Statewide Parent Advocacy Network (SPAN) and condition-specific organizations like Autism New Jersey, to national networks with local chapters such as National Alliance on Mental Illness (NAMI) New Jersey. In addition, the State offers more general entry points and navigation resources that can help families identify available services and where to go for assistance, including Connecting NJ and NJ 211, which connect families to community-based supports, care coordination, and local resources.

Families can find these groups online and through referrals from school and clinical settings. Many of these organizations provide invaluable assistance to families navigating complex mental health systems. They serve as trusted messengers, connecting families with peers who have lived experience, reinforcing trust in service systems. They complement government agency efforts by expanding outreach and prevention activities and maintaining accessible resource networks for families. Many parent support organizations are also active in advocacy, ensuring the voice of families with lived experience help shape policy decisions.

OTHER SPECIALIZED SUPPORTS

Some specialized programs target specific risk areas among youth. The Council on Compulsive Gambling of New Jersey, for example, offers services for youth experiencing gambling disorders, including a preventive Cognitive Perspective Restructuring Program (CPR), a ten-session training delivered at an after-school program or school setting.

Together, these programs form a broad range of support services for children and families. The sponsoring organizations often work alongside each other, and include non-mental health specific organizations from religious groups, to scouting, to sports or other interest groups. By promoting awareness of mental health, strengthening protective factors, and expanding access to early services, these efforts help create healthier school and community environments where young people in New Jersey can thrive.

Social Media and Technology: Innovations, Emerging Risks, and Policy Responses

New Jersey, through DCF, has funded several mental health apps and digital platforms, designed to connect youth with appropriate mental health resources.

Soluna is an online platform geared to teens ages 13-18 that offers free self-care mental health resources and individual coaching and counseling sessions via text-based chat.[46] 2NDFLOOR, another state funded app described earlier, connects youth with licensed counselors through a confidential, anonymous hotline.

In addition to these state-funded resources, there are many other apps for mental health and wellness, some of which are tailored to youth. But these innovations come with growing privacy and safety concerns and their long-term outcomes and effects on youth remain uncertain.

These questions arise within a broader context: the relationship between social media, technology use, and youth mental health has emerged as a significant public health concern.[47] Research has found that children and adolescents who spend more than 3 hours a day on

[46] While funded in the SFY26 budget, funding was not included in the Governor's proposed FY27 budget.

[47] Kang, C., & Tan, E. (2026, March 25). *Meta and YouTube found negligent in landmark social media addiction case. The New York Times*. https://www.nytimes.com/2026/03/25/technology/social-media-trial-verdict.html

social media may face double the risk of mental health problems, including symptoms of depression and anxiety, with 46% of adolescents aged 13-17 reporting that social media makes them feel worse about their body image.[48]

These and other issues have prompted growing attention from researchers, clinicians, and policymakers alike. New Jersey has responded with a combination of executive action, new legislation, and policy recommendations aimed at reducing harm and strengthening supports. Governor Sherrill issued EO 26-06 establishing an Office of Youth Online Mental Health Safety and Awareness within DOH that will coordinate government efforts to regulate and promote healthy and safe youth internet policies.[49] Separately, newly enacted state law[50] requires DOE to issue guidelines prohibiting students from using phones for non-academic purposes during the school day, and boards of education must adopt policies consistent with that guidance for grades K–12. The prohibition goes into effect for the 2026-27 school year. Limited exceptions apply for situations like emergencies, medical needs, and translation purposes.

The Sherrill Transition Action Team Report set forth additional recommendations for protecting children from online harms by regulating how platforms operate and strengthening supports in schools and communities.[51] Key proposals include that the State pursue an Age-Appropriate Design Code to restrict manipulative and addictive features on social media platforms, banning social media accounts for users under 16 without appropriate safeguards, imposing strict liability on AI chatbots that promote harmful content to young people, and expanding definitions of illegal content to include AI-generated child exploitation material. The report also calls for school-based curricula and standards that teach students about the healthy and ethical use of technology, digital citizenship, and awareness of social media's mental health impacts.

The report further recommends a shift toward more preventive, school-based models of student mental health support, which would include expanding mental health literacy and social-emotional learning across K–12, training educators and students in Youth Mental Health First Aid, and implementing universal screening to identify concerns before they escalate. The goal is to normalize mental health education and make early support as routine as academic intervention.

The report also calls for strengthening the full continuum of school mental health services, from universal prevention to targeted and intensive supports. Key proposals include placing mental health coordinators in schools, expanding community school partnerships to embed providers on-site, leveraging and expanding the scope of programs like the NJ Pediatric Psychiatry Collaborative, and addressing insurance and Medicaid billing barriers so schools can be reimbursed for services delivered to all students. Workforce development is a major focus, with recommendations to increase the pipeline and retention of counselors, psychologists, and social workers.

[48] U.S. Department of Health & Human Services, Office of the Surgeon General. (2025, February 19). *Social media and youth mental health*. https://www.hhs.gov/surgeongeneral/reports-and-publications/youth-mental-health/social-media/index.html

[49] https://www.nj.gov/infobank/eo/057sherrill/pdf/EO-6.pdf

[50] New Jersey Legislature. (2025). P.L.2025, c.195.

[51] State of New Jersey, Office of the Governor. (2026). *Kids' mental health report*. https://www.nj.gov/governor/library/docs/KidsMH_Report_011426.pdf

The Legal System and Children's Mental Health

New Jersey's legal system plays a critical role in shaping when, how, and under what conditions children receive mental health services, particularly for youth involved in custody matters, child welfare, or the youth justice system. Court decisions and statutory frameworks can determine who consents to treatment, whether services are voluntary or court-ordered, and where a child resides while care is provided. This section describes how various legal frameworks and systems influence pathways to children's mental health services and interact with the broader system of care.

FAMILY COURT

Family court touches the lives of many New Jersey families annually. Family court decisions about custody and parenting time can directly shape whether and how a child receives mental health services. In deciding cases of disputed custody, courts can require referrals for youth to see mental health clinicians for evaluations or therapy. This section discusses the types of services available to families and issues related to youth mental health as families navigate the legal system.

Youth mental health arises within the Family Court's broader legal directive to determine what is in a child's best interests. In contested custody cases, when determining a child's best interests, New Jersey law directs courts to consider factors such as the child's safety, the child's relationships with each parent, the parents' relationships with one another, sibling relationships, any history of domestic violence, the child's expressed preferences, the quality of the child's education, and the stability of each home environment.[52] The court may refer the parties to mediation and can order certain reports or evaluations to help decide a custody or parenting time dispute, including a home inspection report, social investigation report, or parental functioning assessment by a licensed or certified mental health professional.[53, 54]

Reunification Therapy

New Jersey family courts may assign reunification therapy if the judge believes the child would benefit from therapeutic assistance in improving their relationship with a parent.[55] Therapeutic methods vary but generally include working towards the goal of the child spending time with the non-preferred parent in the presence of a therapist.

In custody disputes, youth may be unwilling or reluctant to spend time with a non-preferred parent due to a range of factors, including their personal experiences with that parent and the influence of the preferred parent's attitudes or behaviors, sometimes referred to as "parental alienation".[56] The lack of consensus from experts on the definition and validity of reunification therapy has caused significant concerns with court mandates of involuntary reunification therapy for youth.

In January 2026, New Jersey child custody laws were amended, setting new procedures and standards for how courts consider questions of custody and under what circumstances they may order therapy, including reunification therapy.[57] The law, which was effective immediately, sets forth new processes for considering the child's preferences. Before ordering any therapy, a court must find good cause and rely on generally accepted,

[52] New Jersey Judiciary. (2019, July 1). *Notice to the bar*. https://www.njcourts.gov/sites/default/files/notices/2019/06/n190701c.pdf

[53] See N.J.S.A. 9:2-4c and N.J. Ct. R. 5:8-1 to 5:8-3 for detailed legal requirements governing custody factors, mediation, investigations, and mental health evaluations.

[54] The court may also use parent coordinators, law guardians, and guardians ad litem to assist in resolving custody and parenting disputes. A parent coordinator is a neutral person appointed by the Court to facilitate the timely resolution of day-to-day parenting issues that the parties cannot resolve on their own and may be a psychologist, attorney, or licensed social worker. A law guardian is an attorney appointed to represent the interests of the child and is the child's independent legal advocate. A guardian ad litem is an independent fact finder of the best interest of the child who serves the court and who may be an attorney, a social worker, or a mental health professional. A guardian ad litem interviews the child, the parties and other individuals with relevant information, reviews pertinent documents and may retain independent experts. The guardian ad litem files a written report with the Court with recommendations. N.J. Ct. R. 5:8-A-D.

[55] Reunification therapy can also be referred to by different names, including more generalized family therapy, which can impede data collection and enforcement efforts.

[56] https://batarsehpammer.com/2025/02/25/the-viability-of-parental-alienation-at-trial/#:~:text=There%20has%20been%20much%20debate,in%20the%20DSM%5B1%5D

[57] New Jersey Legislature. (2025). *P.L. 2025, c. 316.*

scientifically valid evidence demonstrating the safety and effectiveness of the proposed therapeutic intervention. Judges must consider factors such as the child's age and maturity, prior therapeutic history, willingness to participate, and any history of domestic violence or abuse. If therapy is ordered, the court may appoint a state-licensed mental health professional to conduct the intervention and provide updates to the court, and the court may modify or suspend therapy based on progress. In cases involving domestic violence or abuse, the law requires trauma-informed expertise and prohibits the use of therapy to separate a child from a safe, bonded parent. The law appropriates funding and directs Rutgers University School of Social Work to issue a report within 3 years regarding the law's effectiveness in addressing family reunifications and child welfare.

While family court custody disputes and court-ordered interventions represent one way the legal system shapes children's mental health care, New Jersey's youth justice system is another critical setting where court-involved youth may receive mental health services.

YOUTH JUSTICE COMMISSION

The Youth Justice Commission (YJC), formerly known as the Juvenile Justice Commission, has three primary responsibilities: to provide care, custody, and rehabilitative services to youth committed to YJC by the courts; to oversee and coordinate services for youth on parole; and to support local efforts at prevention and early intervention for at-risk or court-involved youth. The YJC is empowered to establish minimum standards for the care, treatment, governance and discipline of juveniles who are confined pending, or a result of an adjudication of delinquency.[58] Appendix K: Youth Justice Commission Data includes data including the number of youth involved at different stages of sentencing.

Delinquency refers to acts by juveniles, which if committed by an adult would be a crime, disorderly persons offence, petty disorderly persons offence or a violation of any other penal statute, ordinance or regulation, excluding certain offenses.[59] If a juvenile is judged delinquent, courts have a variety of options, including:

- placement in a county juvenile detention facility;
- probation and release to parents;
- placement with DCF for services in or out of the home;
- placement with DCF/CSOC for services for persons with developmental disabilities;
- placement with DCF/CSOC for placement in an appropriate public or private hospital or other residential facility for the treatment of persons who are mentally ill;
- placement in a residential or nonresidential program for treatment of alcohol or drug abuse;
- placement in YJC custody for placement in a private group home or private residential facility under contract with YJC; or
- incarceration in a state juvenile facility.

The YJC operates three secure facilities: the Juvenile Medium Security Facility, the Female Secure Care and Intake Facility, and the New Jersey Training School. These facilities provide education, vocational training, counseling and medical services, including group and individual counseling and drug and alcohol abuse treatment. The YJC also operates ten residential community homes that house residents with serious substance abuse problems and serious emotional disorders.

Assessments and Screenings in Juvenile Detention Facilities

The YJC has various responsibilities relating to the mental health of detained juveniles, including setting standards for suicide and mental health screening in county juvenile detention facilities and ensuring that county juvenile detention facilities provide necessary psychological or psychiatric services to juveniles.[60] The YJC and the Commissioner of DCF are also required to develop a plan for adequate and appropriate mental health services for juveniles in secure juvenile facilities and facilities operated by the YJC.[61]

Counties are responsible for operating juvenile detention facilities subject to standards set by the YJC. County

[58] N.J.S.A. 52:17B-170. Secure juvenile detention is the temporary confinement of juveniles charged with committing a delinquent act, in a locked facility, prior to the disposition of their case. A court can detain juveniles only if they are considered a danger to the community or if they are deemed at risk of not appearing in court. N.J.S.A. 2A:4A-34. Some juveniles are detained post-disposition while awaiting placement. A short-term commitment program is also a disposition option.

[59] N.J.S.A. 2A:4A-23.

[60] N.J.S.A. 52:17B-171.1 and N.J.A.C. 13:92-9.5.

[61] N.J.S.A. 52:17B-185.

facilities must provide a mental health screening within 24 to 48 hours of admission using the Massachusetts Youth Screening Instrument – 2 (MAYSI) and if additional screening or services are needed, the juvenile must be referred for services as soon as possible.[62]

In the secure facilities that the YJC operates, mental health and substance use assessments are to be performed within 72 hours of admission. The YJC has an interagency agreement with Rutgers University Correctional Health Care for mental health services for YJC residents. YJC has dedicated programs at each of its secure facilities and specific community homes for residents with mental health and substance use disorder needs.

CSOC's Care Coordination for Court-Involved Youth

CSOC also has specialized care coordination and utilization programs for youth with serious behavioral issues who are involved with the courts, probation, and the YJC. PerformCare, the contracted systems administrator for CSOC, processes requests from juvenile detention facilities for biopsychosocial evaluations of youth. Such evaluations may be requested based on the youth's score on the MAYSI, because the youth is taking psychotropic medication, at the request of the attorney or caregiver to determine the need for behavioral health treatment, or based on the youth's history of prior arrests. The YJC may request a biopsychosocial evaluation for youths who may need CSOC services upon discharge. Case management will begin before discharge from the county juvenile detention facility or the YJC facility. It will involve comprehensive service planning, including referrals for psychotherapy and/or psychiatric medication management.

DIVERSION PROGRAMS

Diversion programs are interventions aimed at steering youth away from the juvenile justice system and toward community-based services and support. New Jersey has a variety of diversion programs that can connect or provide youth with a variety of mental health services. Court-based diversion programs include the Juvenile Detention Alternatives Initiative & System Reform Unit, Intensive Supervision Programs, and Juvenile Conference Committees. These programs emphasize community-based support for a youth after justice system involvement.

There are also early intervention programs like the Family Crisis Intervention Units (FCIU), which support families at risk of entering the juvenile justice system when a youth begins to exhibit concerning behaviors such as school refusal, runaway behavior, or concerning family conflict. FCIUs work at a county-level and often offer mental health assessments, family therapy and mediation services, community-based case management, and referral services. In addition, FCIUs have crisis petitioning power to involve courts if necessary to encourage youth participation. In some counties, FCIUs are integrated with CSOC mobile response services, while in other counties they operate separately under different organizations. Youth and family can access these FCIU services without the need to go through PerformCare initially for intake and authorization, unless FCIU and CSOC mobile response services are combined.[63]

Justice-involved youth, and those considered high risk for future involvement, who are engaged with a CMO or **State**

Budgets Show Modest Increase of Youth in YJC Facilities, Services (FY 23-26)

Description	Actual FY 2023	Actual FY 2025	Rev. Estimate FY 2025	Estimate FY 2026
Average daily population in YJC community programs (residential/transitional living)	92	98	107	107
Average daily institutional population	113	128	125	125
Average parole caseload	101	98	101	101

[62] N.J.S.A. 52:17B-171.3. See also N.J.A.C. 13:92-5.3(a)14.

[63] New Jersey Care Management Organization. (n.d.). *Helping Families Navigate Juvenile Detention in New Jersey.* https://njcmo.org/services/court-involvement/navigating-juvenile-detention/

may be eligible to be connected to family therapy. Through evidence-based models targeted for adolescent behavioral issues (specifically Multisystemic Therapy and Functional Family Therapy), families can receive intensive, home-based treatment typically delivered over a six-month period.[64]

COUNTY YOUTH SERVICES COMMISSIONS

Each county has a youth services commission that provides services for youth who are involved, or at-risk of involvement, in the juvenile justice system. Each commission differs in its level of engagement and services offered. Programs may include mental health-related services as well as after-school programming, mentoring, and other well-being-centered events to engage and support youth. These services can supplement a youth's CSOC CMO involvement in offering community support.

OFFICE OF PROBATION SERVICES

The Office of Probation Services (OPS) offers services to approximately 2,700 youth across the state through several supervision tracks including:

- **Traditional juvenile probation.**
- **Juvenile Intensive Supervision Program (JISP):** an option available to the court that allows judges to place select youth on probation under a higher level of supervision and support. Youth placed on JISP typically present with higher needs or greater risk factors and therefore require more intensive supervision, structured expectations, and closer engagement with probation staff while remaining in the community.
- **Juvenile deferred dispositions:** Deferred dispositions allow youth to demonstrate accountability and make meaningful behavioral changes during a period of adjustment, typically about one year. If youth successfully complete that period, their charges may be dismissed and ultimately expunged, allowing them to move forward without the long-term consequences of a juvenile record.

These differ from parole, which occurs after a youth is released from custody.

When appropriate, OPS works with families to connect youth to mental health services (who were not already referred to services earlier in court proceedings) either through the CSOC system or through a family's private insurance coverage. CSOC services can sometimes be ordered through the court, either through a biopsychosocial or a 14-day plan, where the judge can order a CMO or DCPP to assess if there is a need for services and the types of services.

One of the challenges with CSOC services is that they are voluntary, which can cause a conflict with a court-mandated order. If a youth expresses that they do not want services, this may lead to the youth returning to court. Probation refers youth to services as appropriate and when other organizations are involved, such as the CMO or DCPP, partners with them to ensure the youth is receiving the supports and services needed to address their needs.

DIVISION OF CHILD PROTECTION AND PERMANENCY

The Division of Child Protection and Permanency (DCPP) is housed within DCF and investigates claims of child abuse and neglect and, where necessary, provides for a child's protection and their family's treatment.[65] DCPP contracts with community-based agencies to provide counseling, parenting skills classes, substance use disorder treatment, in-home services, foster care, and residential placement.[66] While many families are involved with DCPP's family services without a child being removed from the home, this report focuses on the unique pathways to mental health care for children who experience an out-of-home placement.

Once a youth is taken into state custody, they are expected to receive a Comprehensive Medical Examination (CME) as soon as possible, and within 30 days at the latest. These are most often performed at a child's medical home with their pediatrician or may be completed at a state Regional Diagnostic and Treatment Center (RDTC).[67] At a RDTC, the youth could receive a full

[64] New Jersey Adoption Resource Clearing House. (n.d.). *Youth and family guide*. https://njarch.org/wpress/wp-content/uploads/2015/11/youth-family-guide-eng.pdf

[65] DCPP was under federal court oversight for nearly 20 years. In 2023, oversight ended and the State entered into an Exit Plan and Agreement, which along with new legislation, required an annual performance review by a diverse, public stakeholder group. Staffing and Oversight Review Subcommittee, New Jersey Task Force on Child Abuse and Neglect. (2024, December). *The first annual performance report*. https://www.nj.gov/dcf/news/reportsnewsletters/taskforce/2024-sors-report.pdf

[66] See N.J.S.A. 30:4C-1 NJ legislature created the RDTCs specifically to evaluate and treat child abuse and maltreatment. DCPP uses the terms "resource" care and "resource" parents in place of "foster" care and "foster" parents. As "foster" remains the more widely understood and nationally recognized terminology, this report uses "foster" throughout for clarity and consistency.

[67] New Jersey Psychological Association. (n.d.). *Metro regional diagnostic and treatment center (RDTC)*. https://psychologynj.org/page/RDTC.

Comprehensive Health Exam for Children (CHEC) including a CME and a Comprehensive Mental Health Assessments (CMHA) when verbal capacity allows.

The state protocol for all out-of-home removals by DCPP due to abuse and neglect and foster care home relocations is to dispatch MRSS staff to support the child's mental health through the experience. At this visit, the MRSS staff member evaluates the child's mental health needs and if necessary, refers the child to services including short-term MRSS stabilization services or to the county CMO for longer term care management. Administrative barriers to care may be reduced because youth in DCPP custody are enrolled in Medicaid coverage for the duration of their out-of-home placement. While a CMO is the primary organization responsible for coordinating a child's moderate to high intensity mental health care while a child is in foster care, there is a coordinated team approach between DCPP case workers and foster families as well as court-related officials (including the Office of the Law Guardian, which represents a child in child welfare proceedings), school teachers, clinical care providers, and others.

PARENTAL REFUSAL OF CUSTODY

In New Jersey, DCPP must be notified when a parent refuses custody of a youth.[68] This often follows a period of separation, such as a detention or hospital stay, and may be precipitated by a highly traumatic event that involves high risk for physical harm to the youth or family. This may occur when a parent feels unable or unwilling to safely manage a youth's needs and declines to resume responsibility for a child returning home.

A parental refusal of custody triggers additional resources to support family stabilization and relational repair. In extreme and uncommon cases, if reunification is not possible, the youth may enter the custody of DCPP through a formal process known as parental relinquishment, which is when a parent surrenders custody without the presence of abuse or neglect.

Exact statistics are difficult to estimate, as custody relinquishment is not an officially reported data element in state or federal reporting. Parental relinquishment of higher-acuity youth is, however, an issue of increasing national attention. It may also occur as a logistical necessity when a family lacks practical means to access public health insurance for youth in need of extensive medical treatment. A 2025 national study estimated that 155 foster care entries in New Jersey, 2% of total entries, resembled custody relinquishment based on February 2017 to February 2019 data, falling below the national average of 5%.[69] Although overall out-of-home removals have decreased since the study's data collection, anecdotal reports suggest increasing prevalence of DCPP involvement with parental refusal of custody and parental relinquishment.

[68] New Jersey Department of Children and Families. (n.d.). *Mandated reporter decision tree*. https://www.nj.gov/dcf/reporting/how/Mandated-Reporter-Decision-Tree.pdf

[69] Gross, M., Keating, B., Colten, J., Miller, R., Radel, L., & Abbott, M. (2025, January). *Prevalence and characteristics of children entering foster care to receive behavioral health or disability services: An analysis of custody relinquishment using administrative data*. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.

Methodology

The Quality Institute's mixed-methods methodology for this project reflects the breadth and complexity of New Jersey's children's mental health systems.

Our study integrated qualitative interviews, quantitative analysis of administrative data, literature review of evidence and best practices, comparative review of national and state policies and initiatives, review of the New Jersey legal and regulatory frameworks, and development of our own surveys of the landscape shaping children's mental health services.

Together, these methods were intended to support understanding across data sources and provide a comprehensive assessment of system structure, access barriers, and opportunities for improvement. The Quality Institute worked with various contractors who are listed in Appendix A: Acknowledgements. To support a multidisciplinary approach, we engaged a 22-member expert advisory committee whose members are listed in Appendix A: Acknowledgements.

QUANTITATIVE DATA

The Quality Institute received data from the following agencies: Department of Children and Families (DCF); Department of Human Services (DHS); Department of Banking & Insurance (DOBI); and Department of Health (DOH). Relevant aggregate data can be found in the appendices. We also collected data from New Jersey hospitals to examine average pediatric psychiatric bed utilization and the service volume by level of care. Results are in Appendix L: Hospital Volume and Utilization Data. With a contractor, we conducted a Secret Shopper Survey of commercial fully-insured provider networks using a uniform script. Results are described below and in Appendix M: Secret Shopper Study - Commercial Insurance Network Adequacy.

QUALITATIVE DATA

The Quality Institute used semi-structured interviews as the primary qualitative data collection method, because they allow respondents to answer in their own words while providing the interviewer the opportunity to ask probing questions.

Between June 2025 and March 2026, we interviewed 236 individuals individually and in small focus groups. Participants represented a broad range of perspectives, including those working in or experiencing high-acuity clinical settings, outpatient providers, community-based organizations, school-based services, and state and local government agencies. Interviews included 39 family members with lived experience navigating the youth mental health system for children ages five and older. The Quality Institute developed standardized protocols and discussion guides that can be found in Appendix N: Qualitative Interview Protocols. The research team focused on including underrepresented geographic areas and stakeholder perspectives and conducted targeted outreach to organizations and providers in those areas to improve sample balance. The qualitative sample was developed using purposive recruitment strategy, supplemented by convenience and snowball sampling and an open call to participation sent by email to DCF partners.

For our school-based research, our contractor, SEL4NJ, interviewed school personnel and families across 11 school districts, including staff from NJ4S, CSOC, mental health-related organizations, and families. From November 2025 through February 2026, data collection took place across three counties in South (Camden), Central (Middlesex) and North (Essex) Jersey. Given the wide variation in school districts statewide, the Quality Institute chose to focus school findings on these three counties. We also selected three anonymized, demographically-diverse school districts outside of these counties to ensure the analysis sample included small- to medium-sized rural school districts inclusive of the western part of the state and the shore communities with generally racially homogeneous student populations.

LEGAL RESEARCH

Our work included an in-depth review of relevant laws, regulations, contracts, audit reports, RFPs, and state budget documents. We also reviewed the most recent CSOC contracted services administrator RFP and the New Jersey Medicaid managed care organization contract.

LIMITATIONS

This project was designed to provide a broad understanding of New Jersey's youth mental health landscape through mixed methods; however, several research limitations should be considered when interpreting the findings.

Quantitative data are subject to the limitations of the systems from which they were collected. For example, the number of licensed or credentialed providers or programs does not necessarily indicate actual availability or functional capacity. Geographic aggregation due to data availability or confidentiality concerns may also conceal meaningful local variation. The project draws on multiple data sources collected for various administrative, regulatory, operational, and research purposes. As a result, data definitions, time periods, age groups, and completeness vary across agencies and programs. Data should therefore be interpreted as a synthesis of complementary sources and comparisons should be carefully contextualized.

This project sought to capture diverse and information-rich perspectives, rather than to produce a statistically representative sample of all families, providers, schools, agencies, or system stakeholders interacting with the youth mental health system statewide. Interviews were voluntary and, with the exception of families with lived experience, uncompensated leading to self-selection on those able and willing to participate.

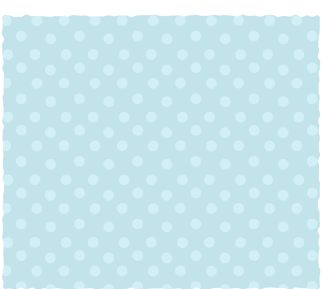
These limitations underscore the importance of interpreting this report as a systems-level overview of the major strengths, barriers, and opportunities of the youth mental health system, but not an exhaustive authority. Many worthwhile topics and programs could not be fully addressed within the project's scope, including prevention and upstream interventions, many specific mental health diagnoses and related treatments, and populations outside the age range focus for this report.

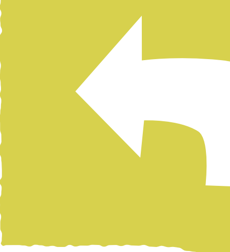
CARE PATHS

The Quality Institute developed the Care Paths as an illustrative tool to depict how families may navigate children's mental health services in New Jersey. The purpose of the Care Paths is to translate system-level findings into family-centered narratives that show how challenges to access may unfold over time across referral, treatment initiation, crisis care, and ongoing service coordination.

The Care Path narratives are fictionalized composites and are not intended to depict any single child, family, or provider. Instead, they were constructed through synthesis of recurring themes identified across qualitative interviews and focus groups conducted for this study. Specific scenarios were intentionally selected to reflect major cross-cutting findings in the report, including difficulties navigating a complex service system with multiple and often cross-cutting services, limited access to providers due to geography, time availability and whether or not a provider was accepting new patients, network adequacy, and other barriers related to health care coverage including challenges accessing clinically appropriate levels of care.

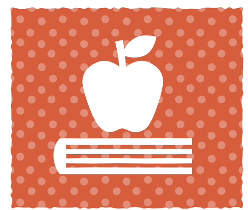
Because the Care Path is designed as an illustrative rather than a representative tool, it should be interpreted as a narrative synthesis of commonly reported experiences rather than a comprehensive account of all possible pathways into care. Its purpose is to help readers understand how structural barriers may interact in real-world settings and how these barriers may shape the experiences of children and families over the course of seeking care.





Care Paths

The following scenarios illustrate how youth and families may navigate the children's mental health system in New Jersey. While fictional, the stories are based on common themes identified through interviews. The three stories represent different time lengths and clinical pathways: short-term community-based services (Taylor), crisis-driven care navigation (Jacob), and long-term system involvement for a youth with autism (Jordan).



(14-year-old with Medicaid coverage)

1 Taylor begins to exhibit behavioral issues at their new high school. After making threatening remarks at school, the school administration requires a psychiatric clearance before Taylor can return to school.

TWO PATHS:

- **Emergency Department visit**
- **Pediatric screening center**

2 After missing a day of school to be evaluated, Taylor can return to school. The school meets with Taylor and Taylor's mother to discuss support for Taylor. The school counselor refers Taylor's mother to the PerformCare access line to inquire about future services.

TWO PATHS:

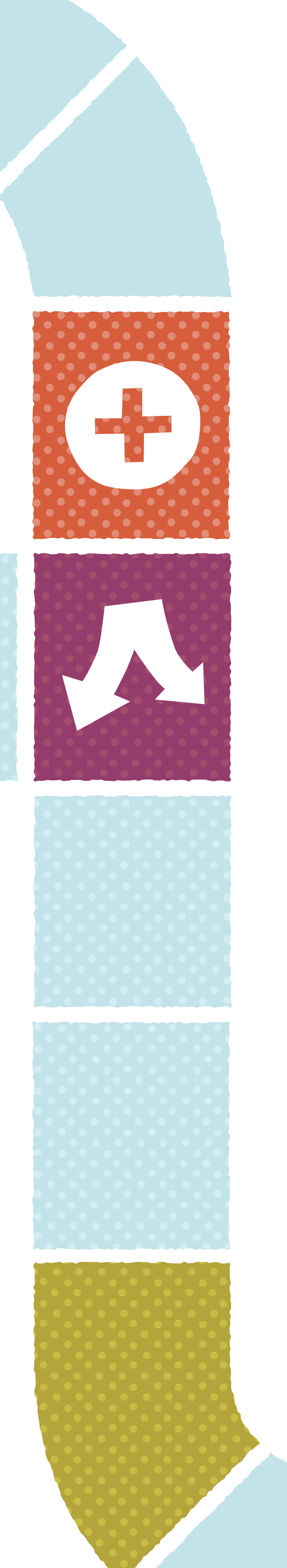
- **Taylor's mother calls the PerformCare access line and is denied services from the Children's System of Care (CSOC) because Taylor didn't meet required acuity levels. Taylor's mother is referred to find a community-based provider for outpatient therapy. (SKIP STEP 3 AND GO TO STEP 4.)**
- **The school counselor helps Taylor's mother describe Taylor's needs in a way that aligns with eligibility criteria and she is authorized to receive services through CSOC.**

3 After connecting to PerformCare, Taylor received a biopsychosocial assessment which confirms their eligibility to receive further services. Taylor is enrolled with their local Care Management Organization (CMO) and joins a waitlist to receive at-home therapy. After 6 weeks, a therapist visits Taylor at their house to begin treatment.

TWO PATHS:

- **Taylor relates well with their therapist, leading to successful sessions.**
- **Taylor does not relate to their therapist well and the family requests a new therapist, leading to delays.**

Through therapy, Taylor experiences fewer behavioral issues. After two months, short-term IIC services end.



4 The family is referred to outpatient therapy.

TWO PATHS:

Taylor's mother finds a psychotherapist and Taylor receives services.

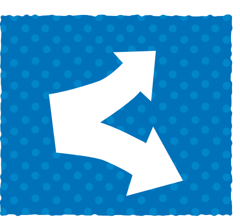
After calling several psychotherapy providers to find care with no availability, the family decides to stop searching for care as Taylor's symptoms have temporarily improved. **(SKIP STEP 5.)**

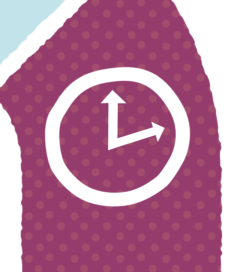
5 Taylor connects with an outpatient therapist.

TWO PATHS:

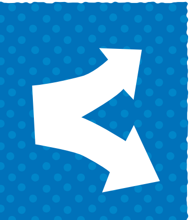
After a few months working with the outpatient therapist, all therapeutic goals are achieved, and Taylor is discharged from care.

Transportation barriers make it difficult for the family to continue services and services cease against the clinician's recommendation after a few weeks.





(16-year-old with commercial insurance)

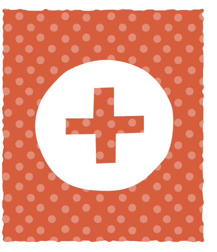


1 Jacob's family becomes concerned about his behavior. His father tries to find a therapist in their commercial insurance network.

TWO PATHS:

Jacob's father checks their health insurance plan's network directory, calls multiple providers, and leaves messages for a return call to schedule an appointment. He puts Jacob on a wait list for an in-person appointment.

Jacob's father searches the internet and calls providers who advertise that they work with youth. He leaves messages and often does not receive a call back. Sometimes the therapist calls back but is out-of-network with their health plan or does not participate with any insurers. The father decides to pay out-of-pocket and book an appointment.



2 Jacob connects with a therapist, however after Jacob shares symptoms of suicidal ideation, the therapist determines Jacob needs a higher level of care and suggests that Jacob's parents find an intensive outpatient program (IOP). The therapist continues to provide weekly therapy for Jacob while his father locates an IOP.

TWO PATHS:

Jacob's therapist provides names of IOPs that can support Jacob that are in-network with the family's health insurance plan.
(SKIP STEP 3 AND GO TO STEP 4.)

Jacob's therapist does not have any IOP recommendations.

3 Jacob's father searches for IOP programs. He contacts his health insurance plan and asks for a list of providers that offer IOPs for youth. He contacts many of the providers but the program hours or location are not convenient for the family or the program has a lengthy waitlist.

TWO PATHS:

Jacob's father opts to wait for an opening with the in-network IOP provider and joins their waitlist.

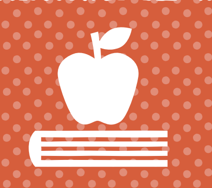
Jacob's father finds an appropriate out-of-network IOP that offers sliding scale fees and is accessible for their family. He decides to pay out-of-pocket for the out-of-network IOP provider with a specialty in treatment of suicidal ideation.

4 Jacob's IOP care team helps Jacob's family connect to a psychiatrist for a medication evaluation. Jacob's symptoms improve with IOP treatment and he completes the program after three months.

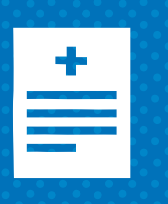
5 Jacob has a crisis that leads to emergency services. Jacob is admitted to a hospital for stabilization for four days. He returns home and his father receives a list of referrals to call for further outpatient services.

Jacob's father calls PerformCare. PerformCare refers Jacob's father to his commercial insurance provider directory for further services because Jacob's symptoms do not meet clinical criteria. Jacob is stable and already connected to therapy services and psychiatry services.

6 Jacob continues to cycle through attempts to find more intensive community-based services. He returns to the emergency department within a year for a second crisis, cycling between hospitalization and outpatient therapy.



(17-year-old with commercial insurance)

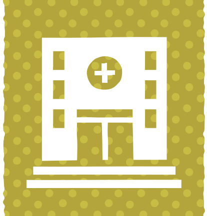


1. **Age 5:** Jordan's elementary school requests Jordan be evaluated for autism. Jordan's mother schedules an appointment with their pediatrician, who refers them to a child developmental pediatrician. The family joins a waitlist and after one year, Jordan is diagnosed with autism. With an autism diagnosis, Jordan is eligible for supportive school services and an Individualized Education Program (IEP) is established at school.

2. **Age 13:** Jordan begins to present with anxiety symptoms including school refusal. Jordan's parents call providers in their insurance network directory but cannot find an outpatient therapist that is specialized in or willing to work with Jordan because of Jordan's autism diagnosis. Jordan does not receive mental health care.

3. **Age 14:** After a medical crisis leads to an emergency department visit, Jordan has an aggressive behavioral episode in the hospital, punching a hole in the wall. The incident is documented in Jordan's medical record, which limits treatment options.

4. **Age 15:** As Jordan gets older, frequent behavioral health crises become more aggressive and harder to manage at home because of Jordan's age and size. After a crisis in which a family member is injured, Jordan's family calls PerformCare to seek services and is referred to a CMO through CSOC.



5. **Age 16:** After a year of CMO services, Jordan's family begins searching for an out-of-home treatment bed for Jordan as intensive community-based services are not sufficient. Jordan's family waits a year for an appropriate out-of-home treatment bed. The family receives respite services and check-ins from CSOC services but Jordan's behavior continues to escalate while awaiting treatment.

6. **Age 17:** Jordan is successfully placed in a high-acuity group home setting specializing in intellectual and developmental disability (I/DD) care. After meeting treatment goals in the first year, Jordan's behavior has improved and stabilized, and he is clinically ready for an out-of-home treatment bed at a lower acuity. Jordan remains in the current setting while waiting for a new community setting because no beds are available.

Findings

Systemic Challenges

New Jersey's children's mental health system is shaped by a set of interconnected challenges that cut across provider types, insurance markets, and service settings. This section presents the key factors shaping how children and families access mental health services in New Jersey. Through interviews, data analysis, and program review, six interconnected themes emerged: workforce capacity, insurance coverage, clinical care delivery, school-based supports, care coordination, and system navigation. While each presents distinct issues, they are deeply interrelated and together shape whether and how families can access care.

Mental Health Workforce Shortages

Across interviews, reports, and other evaluations, the pediatric mental health workforce shortage and resulting waitlists were the most consistently cited barrier to timely and appropriate care. The workforce issue spans a wide range of settings and provider types, reflecting a combination of shortages and mismatches rather than a single deficit. Key system barriers include limited highly specialized pediatric physicians, insufficient child-focused therapy capacity available during the times families need care, gaps in expertise for youth with high-acuity needs, reliance on out-of-network providers for timely access, and workforce instability within public-sector systems.

CRITICAL SHORTAGE OF HIGHLY TRAINED PROFESSIONALS

The most acute constraints appear in the highest-skill, longest-training specialties, notably child and adolescent psychiatrists and child developmental-behavioral pediatricians. Shortages among psychotherapists are driven less by the total number of licensed providers available than by factors such as limited specialization in pediatric care, insurance participation, appointment availability, geographic distribution, and capacity to treat children with higher-acuity or more complex needs.

New Jersey is not alone in facing these challenges. Nationally, it is projected that there will be substantial shortages across mental health professions.[70] As of December 2025, approximately 40% of the U.S. population lived in a Mental Health Professional Shortage Area.[71]

The issue is not only supply, but whether families can access the right clinician, with the appropriate expertise, in a timely and affordable manner. It is difficult to strategically address this issue because New Jersey's licensure data for most mental health providers does not indicate whether a provider is actively treating patients, treats children, or has expertise in specific clinical needs. Total provider license headcounts alone are not a reliable measure of access.

A NEED FOR PEDIATRIC PHYSICIAN SPECIALISTS

There are 39 areas in New Jersey designated as Mental Health Professional Shortage Areas, impacting approximately 404,126 residents and indicating that an estimated 48% of psychiatrist need is unmet.[72] While New Jersey ranks as the third highest state in meeting overall mental health workforce need, these measures are not youth-specific and obscure regional disparities and gaps in pediatric care.[73]

National concern over a shortage of pediatric mental health physicians has been well documented and is often attributed to the extended years of medical training required, comparative lower financial compensation to specialties with similar lengths of training, and emotionally intensive workloads. Additionally, mental health specialists are less likely than medical specialists to contract with insurance carriers, increasing inequitable access based on means.

In the academic year 2025-2026 application cycle, New Jersey hospitals listed 73 psychiatry residency positions (non-child and adolescent specific) and 9 child and adolescent post-residency fellowship positions.[74,75] Addressing the shortage of child and adolescent psychiatrists, in 2025, DHS issued a solicitation to fund four additional fellowship positions beginning July 1, 2026, with the explicit goal of increasing in-state supply and retention.[76] As child and adolescent psychiatrists require approximately 13 years of post-secondary training, their expertise cannot be easily substituted when a child presents with diagnostic complexity, medication resistance, polypharmacy, severe behavioral presentations, or co-occurring conditions.

Although pediatric primary care providers increasingly prescribe medications for common mental health conditions, their capabilities and comfort levels differ. Moreover, some youth require on-going care that is too intensive to be managed in a primary care setting. While providers reported that teleconsultation programs and pediatric primary care training initiatives help address immediate gaps in care, these strategies are not a substitute for increasing the supply of child and adolescent psychiatrists in the long-term.

Access to developmental-behavioral pediatricians, a board-certified pediatrician with specialized training in evaluating and managing children and adolescents with complex developmental, learning, or behavioral issues is even more limited.[77] Autism New Jersey reported that, as of August 2024, there were fewer than 40 developmental-behavioral pediatricians statewide, insufficient to serve

[70] Health Resources and Services Administration, Bureau of Health Workforce. (2025, December). *State of the behavioral health workforce, 2025*. U.S. Department of Health and Human Services. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/Behavioral-Health-Workforce-Brief-2025.pdf

[71] A Mental Health Professional Shortage Area is a federal designation by the Health Resources and Services Administration (HRSA) identifying areas, populations, or facilities with too few mental health providers. Most Mental Health Professional Shortage Area designations are based on psychiatrist-to-population ratios, which excludes the contributions of other mental health professionals.

KFF. (n.d.). *Mental health care health professional shortage areas (HPSAs)*. https://www.kff.org/other-health/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/

[72] This data is for the full population and not youth specific.

[73] KFF. (n.d.). *Mental health care health professional shortage areas (HPSAs)*. https://www.kff.org/other-health/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/

[74] National Resident Matching Program. (n.d.). *Advocacy*. https://www.nrmp.org/advocacy/

[75] American Medical Association. (n.d.). *FREIDA™ AMA residency & fellowship programs database*. https://freida.ama-assn.org/

[76] New Jersey Department of Human Services, Division of Mental Health and Addiction Services. (2025, September 17). *Notice of funding availability: Child and Adolescent Psychiatry (CAP) fellowship training initiative.* https://nj.gov/humanservices/notices/documents/nofa/NOFA%20-%20CAP%20Fellowship%209.17.25.pdf

[77] While some specialists including psychologists and CAPs may have additional training that allows them to also diagnose Autism Spectrum Disorder, developmental pediatricians are among the primary providers for comprehensive evaluations. (https://www.research.chop.edu/car-autism-roadmap/who-is-able-to-diagnose-autism-spectrum-disorder) Insurance providers typically require diagnostic assessments conducted by a specialist, and pediatric primary care providers generally do not conduct formal diagnoses.

the roughly 50,000 autistic New Jerseyans ages 3 to 18.[78] Diagnostic centers reported wait times of six months to two years for initial autism evaluations.[78] While families willing to pay high payments for child and adolescent psychiatrists services are often able to find out-of-network providers, nearly all families regardless of income experience long delays. While neurologists can address some aspects of care, many families report going without preferred services while on lengthy waitlists. Delayed diagnosis and limited specialty consultation may shift complex youth into suboptimal or fragmented care pathways, thereby missing critical opportunities for early intervention.

PSYCHOTHERAPISTS

The psychotherapy workforce presents a different type of access challenge. While New Jersey has a larger pool of licensed therapists than physician specialists, availability for children is much narrower than licensure counts suggest. Many licensed therapists do not serve children at all, and those who do may not accept insurance, offer evening or weekend hours, provide in-person care, or have experience with higher-acuity cases. As a result, families searching for a therapist who meets their child's needs, fits their schedule, and accepts their insurance, may find the available pool much smaller than it appears on paper.

Therapy provider organizations also reported difficulty recruiting and retaining staff for child-serving roles, particularly those requiring weekend and evening hours, in-person care, and treatment of higher-acuity populations. Providers noted that there are additional uncompensated responsibilities associated with treating children, including psychoeducation and coordination with schools, families, and other systems. Interviewees identified gaps in the specialized training needed to effectively treat youth, especially addressing family-centered dynamics, higher acuity issues such as suicidal ideation or complex trauma, and developmentally appropriate approaches. Providers expressed concern that low-quality or inconsistent treatment could cause families to burn out or disengage from therapeutic treatment altogether.

Workforce diversity and cultural responsiveness are also important components of accessible mental health care. Providers who share a child's racial, ethnic, cultural, religious, gender, or sexual identity can strengthen trust, communication, and engagement in treatment.[79] Even when provider and patient identities do not match, demonstrated competence in working with diverse communities remains essential to delivering effective pediatric mental health care.

Some parents seeking male psychotherapists for their sons reported difficulty finding an appropriate match, consistent with national workforce data showing that men remain underrepresented in psychotherapy fields (20% in psychology and 18% in social work).[80] Beyond gender representation, providers likewise identified bilingual therapists as an important resource for youth with limited English proficiency. While interpreters and translation technology can facilitate communication, direct communication in a shared language may be especially important in therapy, where rapport between provider and client is foundational to treatment.

NEW JERSEY PEDIATRIC PSYCHIATRY COLLABORATIVE (NJPPC)

The New Jersey Pediatric Psychiatry Collaborative (NJPPC) was established to help address specialist shortages by training and supporting pediatric primary care providers to manage their patients' mental health needs within primary care settings. Today, there are about 1,400 pediatricians, nurses, and residents enrolled to use the NJPPC across the state, which accepts referrals from 21 counties through nine regional hubs run by Hackensack Meridian Health and Rutgers University Behavioral Health Care (UBHC). According to NJPPC's annual report for FY 2024-2025, the program supports about 4,240 cases, almost entirely referred from pediatric providers with less than 100 referred from CMOs and NJ4S.

In a survey[81] of participating pediatric providers, respondents cited appreciation of NJPPC, with an 86% satisfaction rate. Practices reported appreciation for the ability to make referrals to specialists through NJPPC, as

78 Autism New Jersey. (2024, September 20). *Addressing diagnostic evaluation waitlists: Support and resources for NJ pediatricians*. https://autismnj.org/news/addressing-diagnostic-evaluation-waitlists-support-and-resources-for-nj-pediatricians/

79 https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/infant-mortality/meetings/racially-concordant-care-william-mcdade.pdf

80 Secker, W., & Williams, A. (2024, January 24). *Where are the men? Male representation in social work and psychology*. American Institute for Boys and Men. https://aibm.org/research/men-in-social-work-psychology/

well as for its patient navigation support, but some voiced concerns that even with the ability to consult the NJPPC Hub, they remain uncomfortable adjusting or switching medications and addressing patients' side effects. Almost 25% reported feeling very or somewhat uncomfortable initiating or managing psychotropic medications, citing limited training and prior negative clinical experiences. These issues could be addressed through more intensive education programs for pediatricians as well as enhanced reimbursement recognizing the complexity and length of these visits.

WORKFORCE INSTABILITY IN THE PUBLIC SECTOR

Public system providers, including school-based staff and CSOC-affiliated providers, also described ongoing workforce instability as an issue. In response, in 2023, DCF contracted with McKinsey Consulting to commission a labor market evaluation that confirmed the severity of the problem. The report identified compensation, workload, and burnout as primary drivers of public workforce shortages and projected that demand for public-sector behavioral health workers would outpace supply by approximately 11,000 positions over the following five years if no corrective action was taken.[82]

The report identified several compounding factors. New Jersey loses a significant share of its social services graduates to other states, with only about 47% of graduates remaining in-state. At the same time, roughly one in four social services workers in New Jersey is age 55 or older and nearing retirement, accelerating the pace of attrition. High turnover is further driven not only by compensation, but by lack of career advancement opportunities and a workplace culture in which staff feel underappreciated and unsupported.

Workforce supply is also a challenge for out-of-home treatment settings. In these challenging settings, the staff is required to manage high-acuity needs, including violence, elopement, and complex co-occurring conditions. These challenges can contribute to burnout and staff turnover in a field where positions are already challenging to fill due to the higher risk and emotionally demanding nature of the work. This high turnover leads to inconsistency of care and fewer experienced staff which can reduce fidelity to care models, hinder treatment goals, and increase behavioral incidents. These incidents affect youth receiving treatment and further strain the workforce, reinforcing a vicious cycle.

[81] Results should be interpreted with caution due to low survey response rate of 9.7%.

[82] New Jersey Department of Children and Families. (2023, June). *Labor Market Analysis.* [PDF]. https://www.nj.gov/dcf/documents/061323_Workforce.Webinar.Slides.pdf

Key Findings:

Severe shortages in specialized pediatric mental health providers: New Jersey faces significant pediatric mental health workforce shortages, with the most severe gaps among child and adolescent psychiatrists, developmental-behavioral pediatricians, and providers equipped to serve children with high-acuity or specialized needs.

Licensed workforce numbers overstate real access: The size of the licensed workforce substantially overstates actual access. Families often struggle to find providers who treat children, participate in insurance, offer appointments at convenient times, provide in-person care, or have the cultural, linguistic, and clinical expertise needed.

Workforce instability further limits capacity: Workforce shortages are compounded by instability across public-sector and child-serving systems, including high turnover, burnout, low compensation, difficulty recruiting for higher-acuity settings, and challenges retaining a diverse and specialized workforce.

Insurance Coverage and Network Performance

While commercial and Medicaid insurance markets in New Jersey have robust network adequacy and parity requirements intended to ensure that children and families can access appropriate mental health services, access remains an issue.

This section examines the performance of insurance networks in practice, drawing on interviews with families, providers, and system stakeholders, as well as original analyses of provider directory compliance, secret shopper findings, and Medicaid provider credentialing and provision of care. Across these data sources, we consistently found that insurance coverage often functions as a nominal benefit rather than a reliable pathway to care. Families frequently encounter inaccurate provider directories, long wait times, and limited availability of clinicians with appropriate pediatric expertise, particularly for higher-acuity needs.

By assessing both regulatory compliance and real-world access, this section highlights the gap between policy intent and lived experience. It further explores how reimbursement structures, administrative burden, and provider participation dynamics contribute to under-functioning networks across both commercial and Medicaid systems.

INADEQUATE NETWORKS

The core issue is not whether a provider is listed in a network, but whether a family can successfully obtain an appointment with an in-network clinician who is appropriate for the child's age, diagnosis, schedule, and level of need.

Across interviews, families consistently described insurance networks that appeared sufficient on paper but in reality, the providers listed in directories were often not accepting new patients, did not treat children of a certain age or specific conditions, or had waitlists that made access effectively unavailable. Inaccurate directories have been shown to contribute to higher rates of out-of-network use for mental health services. A listed provider may meet regulatory standards for inclusion in a network, but still not represent a viable option for timely access to care.

These experiences stand in contrast to what the law requires, with the gap between formal network adequacy and real-world access being particularly acute in pediatric mental health. Both New Jersey and federal law require that mental health services be covered comparably to medical and surgical care. New Jersey's mental health parity law prohibits more restrictive limits, cost-sharing, or utilization management for mental health and substance use disorder treatment. In addition, state regulations require carriers to maintain accurate and current provider directory information. Medicaid managed care contracts include similar requirements, mandating publicly accessible provider directories, updated at least every seven days, with carriers required to indicate whether providers are accepting new patients. MCOs must also ensure that network adequacy and appointment access standards are met, including taking corrective action where gaps are identified.

PROVIDER DIRECTORY COMPLIANCE WITH DEPARTMENT OF BANKING AND INSURANCE REGULATIONS

DOBI monitors network directories quarterly to review whether insurers meet regulatory requirements based on listed providers. Carriers submit their provider network data to a third-party contractor retained by DOBI, Quest Analytics, which uses software and a sampling methodology to evaluate and monitor whether the network (on paper) satisfies network adequacy requirements. This process does not assess whether directory information is accurate or whether providers are accepting new patients or have appointment availability. DOBI does not rely solely on the Quest Analytics reports to determine network adequacy, as there are limitations in the sampling and collection of that data. Results from DOBI's additional network adequacy verification checks, including to determine if providers are available in a particular region, and any internal agency corrections to the Quest Analytics reports, were not included in the analysis.

The Quality Institute reviewed the Quest Analytics reports for insurers in the fully insured market (20 network plans) for the fourth quarter of 2024 and 2025 (a total of 40 reports) and conducted an aggregate analysis of reported county-level provider directory compliance with network adequacy requirements. Looking at providers that provide various types of youth mental health treatment, we analyzed how the insurers performed on two required measures:

- Minimum number of providers available within a county by specialty; and

- Meeting the 90% time and distance access standard.

Across mental health provider types, compliance varied significantly:

- Board Certified Behavior Analysts (BCBAs)
    - **35% of plans reported** non-compliance - satisfying 0 of the 2 required measures in all serviced counties
    - **30% of plans reported** only partial compliance
    - Represents one of the most significant gaps in network adequacy
- Psychiatric Mental Health Nurses (PMHNs)
    - **30% of plans reported non-compliance** - satisfying 0 of the 2 required measures in all serviced counties
    - **30% reported partial compliance**– satisfying at least 1 of 2 required measures in at least one county, but not full compliance
    - Indicates limited availability across multiple regions
- Inpatient Pediatric Psychiatric Facility
    - **33% reported partial compliance**– satisfying at least 1 of 2 required measures in at least one county, but not full compliance
    - **68% reported full compliance** – satisfying 2 of the 2 required measures in all serviced counties
- Psychiatrists and Outpatient Substance Use Treatment Facilities
    - **95% of plans reported full compliance** – satisfying 2 of the 2 required measures in all serviced counties
    - **5% reported partial compliance** – meeting at least 1 of 2 required measures in some counties
    - Notably, psychiatrist data reflects all psychiatrists and does not distinguish pediatric providers

These findings demonstrate that compliance with directory-based standards varies by provider type and may overstate access, particularly for pediatric-specific care. See Appendix O: Department of Banking and Insurance Network Adequacy Reports for detailed results by provider type and additional methodological details in the footnotes.

State law also requires that every insurer conduct an independent audit of its networks annually and then post that audit on DOBI's website.[83] As of April 2026, DOBI has not implemented this law, and no independent audits have been conducted or made publicly available. With the change in administration, Acting DOBI Commissioner Ochs has committed to moving forward with implementation.

COMMERCIAL INSURANCE NETWORK ADEQUACY

In the absence of government oversight and independent audits to review, the Quality Institute created a secret shopper survey of commercial insurance networks to assess functional network access to youth mental health care. The Quality Institute engaged Rutgers Eagleton Institute to conduct the secret shopper calls and other checks of the Horizon Blue Cross Blue Shield NJ (Horizon BCBSNJ) OMNIA network, with advance notice to Horizon BCBSNJ. Horizon Omnia was selected as the Horizon product for review because it is a widely utilized commercial plan in New Jersey with broad provider participation and availability in the individual and employer markets. Initially, the commercial secret shopper methodology intended to include both Horizon and Aetna plans, as both insurers administer coverage through the State Health Benefits Program (SHBP) and maintain significant commercial market presence in New Jersey. However, due to legal language included in Aetna provider directory materials prohibiting use of the directory data for certain external review purposes and the inability to access directory data in a machine-readable format suitable for research use, the study ultimately proceeded with the Horizon commercial network analysis only.[84]

The secret shopper survey was designed to evaluate real-world access by assessing whether providers listed in the network directory could be reached, whether they were accurately represented as participating providers, and whether an adolescent with low-acuity mental health needs could obtain an in-person appointment within two weeks. The detailed methodology is in Appendix M: Secret Shopper Study - Commercial Insurance Network Adequacy.

[83] Out-of-network Consumer Protection, Transparency, Cost Containment, and Accountability Act, (P.L.2018, c.32).

[84] The Aetna Terms of Use contains the following warning language: "By using Provider Search, you acknowledge and agree that Provider Search and all of the data contained in Provider Search belongs exclusively to Aetna Inc. and is protected by copyright and other law. Provider Search is provided solely for the personal, non-commercial use of current and prospective Aetna members and providers. Use of any robot, spider or other intelligent agent to copy content from Provider Search, extract any portion of it or otherwise cause Provider Search to be burdened with unwarranted high access or transaction activity is strictly prohibited. Aetna reserves all rights to take appropriate civil, criminal or injunctive action to enforce these terms of use."

Aetna. (n.d.). *Print a provider directory.* [Data query system]. https://www.aetna.com/docfind/home.do?site_id=docfind&langpref=en&tabKey=tab5&fromDse=fromDse

Secret Shopper Findings

The secret shopper analysis found substantial gaps between the number of providers listed in Horizon BCBSNJ's Omnia directory and the number of providers who were available to deliver timely care to a 14-year-old youth. Of the 881 providers who met the study criteria, 231 were sampled. Among sampled providers, only 14.7% were able to offer in-network, in-person appointments within two weeks.

First, directory accuracy was a significant challenge. A notable share of listed providers could not be reached because phone numbers were disconnected or providers could not be identified through the directory or website. Approximately 15% of sampled provider phone calls failed due to a non-working number, incorrect number, or because the voicemail had not been set up. For providers associated with Headway, an online scheduling platform, information could not be located for 9% of providers.

Second, many providers listed in the directory did not accurately list the services they provide or their availability. Some providers did not see youth, some were not accepting new patients, some only offered virtual care, and some did not participate in the Horizon Omnia network.

Finally, of those that were in-network, treated youth, and were reachable, only a limited subset offered in-person appointments within two weeks. Although the directory suggested that almost 900 providers are available across New Jersey to accept new adolescent patients in-person, the number of providers who met all of these criteria was substantially smaller. As a result, families attempting to use the Horizon Omnia directory may experience significant delays, repeated calls, and difficulty finding timely in-network care.

The extent to which directory and appointment information could be confirmed varied across providers for several reasons. In some cases, the calls ended before all information could be collected; in others, the providers required intake forms that prevented reception staff from discussing availability; and, in some, the Headway provider pages were missing address information.

Among the 170 providers in the sample that were successfully contacted[85]:

- Network participation was reviewed for **140** providers:
  - In-Network – **132** (94%)
  - Out-of-Network – **8** (6%)
- Directory address accuracy was reviewed for 134 providers:
  - Correct Address – **88** (66%)
  - Incorrect Address – **46** (34%)
- Availability of in-person appointments was reviewed for 154 providers:
  - In-person availability within 2 weeks – **36** (23%)
  - No in-person availability within 2 weeks – **118** (77%)

Many in-person appointments could not be scheduled because some providers offered only telehealth services (a telehealth appointment within two weeks may have been available) or because the provider served only specific populations (e.g., adults over the age of 18).

- Offered telehealth appointments only – **62**
  - Phone calls – **19** (35% of all phone calls)

[85] 61 providers were unable to be contacted due to unreturned voicemails or directory accuracy issues.

- Headway searches[86] – **43** (43% of all Headway providers)
- Population Restrictions (e.g., age) – **12** (8%)

Overall, the findings suggest that the Horizon BCBSNJ Omnia directory overstates the practical availability of adolescent mental health services. The network may appear adequate on paper, but the real-world experience of families indicates meaningful deficiencies in both directory accuracy and timely access. The findings support the need for stronger standards for directory maintenance, regular verification of provider information, network adequacy requirements that measure whether adolescents can obtain an in-person appointment within a reasonable timeframe, and regulatory oversight and enforcement by DOBI.

MEDICAID NETWORK ADEQUACY

For Medicaid managed care, federal rules require states to establish and enforce maximum appointment wait-time standards for routine outpatient mental health and substance use disorder services for both adults and children, not to exceed 10 business days. States are also required to use secret shopper surveys and other monitoring tools to assess compliance with wait-time and provider directory standards.

New Jersey Medicaid conducts external annual quality reviews of MCO performance, in part, to meet these obligations. Those reviews have consistently identified the need to continue strengthening network adequacy standards, provider directory accuracy, and credentialing processes.[87]

The Medicaid MCO contract requires MCOs to maintain publicly accessible provider directories that indicate whether providers are accepting new patients. That requirement should go further: MCO directories should be machine readable and publicly accessible so that network adequacy can be monitored and enforced by external parties.

To better understand who is actually providing mental health care to children covered by Medicaid, the Quality Institute analyzed the number of Medicaid credentialed mental health providers in New Jersey and compared that to the subset who actually billed Medicaid for services for children and youth ages 0–17 between 2023 and 2025.[88]

The findings reveal a significant gap between enrollment and active practice:

- Only 42-48% of enrolled mental health providers actively billed Medicaid for services (including both youth and adults).
- For youth-specific services, only 13% to 19% of enrolled providers billed for services in a given year.
- Billing by provider varied significantly across counties, with a range of 1-180 providers billing for Medicaid youth services annually.

The analysis also reflects the impact of recent policy changes expanding Medicaid reimbursement eligibility. In 2024, New Jersey began allowing licensed clinical social workers (LCSWs), licensed marriage and family therapists (LMFTs), and licensed professional counselors (LPCs) to be credentialed and bill independently for Medicaid services. Following this change, the number of LCSWs billing Medicaid for youth-specific care increased nearly fivefold, from 93 providers in 2024 to 462 providers in 2025.

Active billing rates also varied by provider type. Credentialed psychiatrists and psychiatric mental health nurse practitioners had higher actual billing rates (17% to 28%), while psychotherapy providers, including psychologists and other licensed therapists, had lower billing rates (3% to 21%).

Overall, these findings indicate that a substantial majority of Medicaid-enrolled mental health providers are not actively seeing patients and even fewer are seeing youth, with significant variation by region and provider type. Understanding the drivers of these patterns requires better data: state licensing and Medicaid credentialing records should include whether providers treat youth, adults, or both, so that these gaps can be analyzed and addressed more precisely.

[86] Headway websites varied in reporting telehealth only availability, suggesting that telehealth-only offerings may be underestimated.

[87] New Jersey Department of Human Services, Division of Medical Assistance and Health Services. (2024). *Core Medicaid and MLTSS external quality review annual technical report*. https://www.nj.gov/humanservices/dmahs/news/2024_Core_Medicaid-MLTSS_Annual_Technical_Report.pdf

[88] CMO workers help families identify, access, and navigate the clinical services their child needs, but the actual treatment is delivered by separate clinical providers to whom the CMO refers the family.

IMPACT OF INADEQUATE NETWORKS ON CARE AND OUTCOMES

Inadequate, inaccurate, or overstated insurance networks have significant consequences for children and families seeking mental health care. Delays in accessing services can allow symptoms to worsen, disrupt family functioning, and increase the likelihood that care is ultimately delivered at a higher-acuity and higher-cost level.

Research underscores the importance of timely access to care. For example, outpatient follow-up within seven days of discharge from psychiatric hospitalization has been associated with reduced suicide risk.[89] More broadly, studies of pediatric mental health waitlists find that delays in assessment and treatment are common and have meaningful impacts on children, families, and systems of care, with limited evidence on effective strategies to mitigate these delays.

Findings from interviews reinforce these patterns. Families described spending hours contacting providers listed in insurance directories, often without success. For some families with financial means, the practical workaround was to seek out-of-network care and pay out of pocket. For others, the result was prolonged waiting, during which symptoms could escalate, and needs can become more acute. These dynamics contribute to inequitable access.

A 2024 RTI analysis of 2021 data[90] found that, in New Jersey, individuals were significantly more likely to go out of network for mental health services compared to medical or surgical care:

- **23.4 times more likely** for acute inpatient facilities
- **16.0 times more likely** for subacute inpatient facilities
- **2.4 times more likely** for outpatient facilities (non-emergency)
- **2.0 times more likely** for office visits

ACCESS CHALLENGES ALSO VARY ACROSS COVERAGE TYPES.

Commercial insurance

Families frequently reported under-functioning outpatient networks and limited coverage for higher-intensity behavioral health services. For youth requiring services such as partial hospitalization, intensive outpatient programs, wraparound supports, residential care, or applied behavior analysis (ABA) for children with intellectual and developmental disabilities, coverage was often described as narrower or more restrictive than Medicaid. Prior authorization requirements, medical necessity denials, and limits on duration of care were cited as barriers to accessing appropriate services.

Medicaid

Families enrolled in Medicaid described many of the same challenges, including difficulty identifying providers and delays in accessing care. These challenges were compounded by a smaller pool of participating providers, as well as disruptions related to coverage gaps or delays in authorization.

Uninsured youth

For children without insurance, access depends on the availability of safety-net providers, including Federally Qualified Health Centers, free clinics, and charity care programs. These systems play a critical role but have limited capacity.

UNDERLYING CAUSES OF INADEQUATE NETWORKS

Low reimbursement rates are one of the most common reasons providers opt out of insurance networks, particularly Medicaid. Providers also emphasized that youth mental health care involves significant time beyond clinical sessions, including care coordination, psychoeducation, and communication with families and schools, which is not consistently reimbursed.

Providers also cited administrative burdens as a barrier to network participation, including challenges related to documentation requirements, prior authorization processes, claim denials, and delayed payments. These issues particularly impact small practices such as solo psychotherapist providers, which often lack administrative staff. Intermediary technology companies have emerged to address some of these administrative needs by offering

[89] Fontanella, C.A., et al. (2020). Association of timely outpatient mental health services for youths after psychiatric hospitalization with risk of death by suicide. JAMA Network Open, 3(8). https://pmc.ncbi.nlm.nih.gov/articles/PMC7420244/

[90] Mark, T.L., & Parish, W.J. (2024). Behavioral health parity — pervasive disparities in access to in-network care continue. RTI International.

scheduling, billing, and insurance support to participating clinicians, though these models are still relatively new and their broader implications for the behavioral health system are still evolving.

Compounding these provider-level barriers, state and federal agencies are not enforcing network and access requirements consistently. Required oversight, including audits, surveys, and contract enforcement and accountability, is lacking. More data must be made publicly available, including whether providers see youth and accept new patients. Even with stronger oversight and more data, shortages of certain provider types will remain a challenge. Additional steps must be taken to increase the pediatric mental health workforce, including streamlined licensing and credentialing and expanding team-based care models.

Key Findings

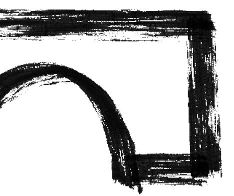
Insurance networks do not consistently provide actual access to care: Compliance with network adequacy standards does not ensure that families can obtain timely appointments with appropriate providers.

Directory-based measures overstate network capacity: Provider listings often do not reflect actual availability, pediatric expertise, or willingness to accept new patients.

Provider participation is a central constraint: Network limitations are driven not only by workforce shortages, but also by the financial and administrative challenges of participating in insurance.

Access barriers contribute to delays and inequities across the system: Families with resources to pay without insurance can bypass network limitations, while others face prolonged delays and increased risk of higher-acuity care needs.

Directory readability requirements: To support on-going secret shopper surveys, insurers should be required to make their directories machine readable for this purpose.



Family Navigation and Engagement in Care

ACCESS TO CSOC SERVICES VIA PERFORMCARE, THE CONTRACTED SERVICES ADMINISTRATOR

As described in the Landscape Analysis section, PerformCare is the contracted services administrator (CSA) for CSOC, and serves as New Jersey's single point of access and authorization of CSOC services. The findings below reflect what families, providers, and system stakeholders reported about their experiences navigating access through PerformCare, including commentary on public awareness, consistency of eligibility decisions, usability, and quality.

Gaps in Public Awareness of CSOC Services, Eligibility, and the Role of PerformCare

Awareness and understanding of CSOC's role and purpose varied significantly among those interviewed. While many school personnel and providers identified CSOC as a key resource, particularly for families facing insurance or affordability barriers, others reported an incomplete understanding of available CSOC services and described misconceptions about eligibility, including the belief that the system serves only Medicaid-enrolled youth. Many parents reported they were unaware of the system entirely, especially families in higher socioeconomic settings with commercial insurance. Even among those familiar with CSOC, some expressed uncertainty about when to contact PerformCare for authorization versus seeking services directly through private insurance or emergency crisis lines. Taken together, these findings suggest that uneven public understanding of how the system works, as well as how to access CSOC services through PerformCare, remains a meaningful barrier to access.

Consistency in Eligibility Determinations

Numerous providers raised concerns about the consistency and transparency of PerformCare's eligibility and authorization determinations. Interviewees described cases in which youth with similar circumstances appeared to receive different decisions from PerformCare access line operators. While these reports are anecdotal, the consistency with which they arose across interviews suggests a need for further review of how eligibility criteria are being interpreted and applied in practice.

The practical consequence of this was notable: multiple direct service providers reported coaching parents in advance of calls to the PerformCare access line on how to describe their child's needs in order to improve the likelihood of receiving services. CSOC was designed to serve children across income levels who meet clinical criteria for intensive services, but many providers reported that families with commercial insurance were sometimes redirected by PerformCare to pursue services through their insurance plans, even when they appear clinically eligible and even after receiving provider guidance on how to present their child's needs.

Clinical screening and eligibility determinations are necessary components of a centralized navigation system. Their effectiveness, however, depends in part on access criteria that are clearly communicated and applied consistently.

Timeliness and Adequacy of Services

CSOC was developed to support families of youth with high-acuity needs, but interviewees described several factors that could limit usability in practice. When dispatched after PerformCare authorization, Mobile Response and Stabilization Services (MRSS) is intended to respond within one hour. However, multiple families reported waiting more than a day for a provider to arrive, substantially undermining its value as a crisis response. DCF data reported among all 30,574 dispatches in 2025, 85% arrived in less than 24 hours, 10% arrived between 24-48 hours, and 5% arrived in more than 48 hours, with delays due to family request, safety, weather, or staffing emergency. Parents also described waitlists for services such as intensive-home-based therapeutic visits, as well as delays stemming from administrative barriers.

More broadly, families of youth with the most intensive needs described CSOC-linked services as insufficient to manage ongoing behavioral crises, particularly while awaiting out-of-home treatments. Interviewees reported that prolonged waits during these periods contributed to worsening symptoms, caregiver burnout, and significant household distress while the youth was unable to access appropriate care.

Quality and Accountability

The quality and experience of some of the short-term CSOC-referred therapeutic providers was raised by both parents and providers. While some parents reported helpful therapeutic providers, others reported frequent staff turnover and less experienced professionals that were not ready for complex cases of trauma or co-occurring mental health needs.

Greater public accountability over the CSA contract and CSOC is both warranted and consistent with best practice. While there are a few publicly available evaluations of CSOC, there are no publicly available outcome evaluations

of PerformCare's performance under its current contract, which has been in place since 2017. Publicly available data related to CSOC services can be accessed via the NJ Child Data Center, hosted by Rutgers.[91]

DCF recently issued a Request for Information (RFI) to inform a new RFP for contracted services administrator for CSOC. The new CSA contract should require public reporting on performance metrics, both to increase public awareness and understanding of the CSOC program, and to drive consistency in screening and referral services.

UNDERSTANDING MENTAL HEALTH SERVICES

In interviews with families and direct service-providing organizations, we heard consistently how parents struggle to navigate mental health care for their children, regardless of their insurance or medical needs. To them, the system is a maze. Parents, and others trying to support them such as school personnel, often do not know where to go, who to call, what programs exist, which intervention is best, or how to pay for it.

Many parents described uncertainty about the types of licensed providers available, treatment options, levels of severity of their child's circumstances, and mental health terminology. When they did seek treatment, families reported spending substantial time contacting providers only to encounter long waitlists or learn that available options were not appropriate for their child's age, diagnosis, or level of need. Families consistently reported that a lack of clear, accessible, and actionable information made it difficult to navigate and move efficiently through the system.

Although many families accessed generalized resource lists, parents described difficulty synthesizing information from multiple sources, including schools, primary care providers, and mental health clinicians and feeling ill-equipped to determine which options were most appropriate for their child. Multiple New Jersey state agencies have published mental health resources and service directories, as have nonprofit organizations and clinical providers, but the number of different resources and fragmentation between each can create additional confusion, particularly when information is not consistently updated or when guidance on urgent situations, such as who to contact during a youth mental health crisis, is unclear.

Interviewees identified several supports that would help: stronger navigational support from trusted sources, clearer information about available services, stronger care coordination, and psychoeducation to help them understand their child's symptoms and treatment options.

CAREGIVER BURDEN AND FAMILY SUPPORT NEEDS

System navigation places a significant burden on caregivers that extends beyond the practical challenges of locating services. Parents described the strain of caring for a child with significant mental health needs while managing repeated crises, uncertainty, and prolonged waiting. Several parents reported that provider interactions did not always adequately acknowledge caregiver distress, which in some cases negatively affected trust in care. Expanded opportunities for peer support from families with similar experiences may help caregivers not only navigate the system more effectively but also support their own emotional well-being.

For families caring for children with higher-acuity needs in community-based settings, particularly within the I/DD population, interviewees also emphasized the need for more accessible and expanded respite services. In these cases, the sustainability of care at home often depended not only on treatment availability, but also on whether caregivers had sufficient support and relief.

Families also described the burden of navigating various waitlist management practices across providers. Some providers require paperwork before enrolling a family on a waitlist while others closed waitlists entirely and encouraged parents to call frequently for cancellations. These added barriers to access may contribute to inequity for parents unable to juggle additional responsibilities.

COORDINATION ACROSS FAMILIES, MENTAL HEALTH PROVIDERS, SCHOOLS, AND OTHER SYSTEMS

Youth with mental health needs often receive care from multiple professionals and systems simultaneously, including pediatric primary care providers, school personnel, outpatient therapists, and other specialty providers. As a result, effective treatment depends on the ability of providers and systems to communicate clearly, coordinate responsibilities, and support smooth transitions across settings and levels of care. This is particularly true for youth with high-acuity symptoms, co-occurring conditions, or involvement across multiple service systems, as care coordination and communication can reduce gaps in treatment, limit duplication, and support sustained family engagement.

[91] https://njchilddata.rutgers.edu/csoc

Across interviews, school personnel, providers, and families all pointed to the need for clearer communication, better coordination, and more clarity on procedures and processes to best support youth.

Interviewees also highlighted the need for stronger cross-disciplinary understanding of the services, roles, and referral pathways that make up the broader children's mental health system. For example, judiciary staff involved in custody or juvenile justice decisions were described as having limited familiarity with clinical mental health access pathways. Similarly, some clinicians had limited understanding of the role of school counselors or school-based supports, and school staff had limited understanding of state-based supports. Some outpatient therapists also described limited awareness of specific community resources or higher levels of care. Across these examples, the common thread is that gaps in system knowledge, wherever they occur, ultimately make it harder for families to be guided toward the right care at the right time.

FAMILY ENGAGEMENT IN TREATMENT

In addition to navigation challenges, providers emphasized that successful treatment often depends on meaningful parent engagement in the therapeutic process. Interviewees described family involvement as a key determinant of treatment continuity, reinforcement of therapeutic strategies, and longer-term stabilization. Providers noted that treatment delivered during limited clinical contact may have reduced impact if parents are not also supported in understanding and reinforcing treatment approaches at home.

For this reason, several providers called for stronger pathways for parent involvement, including greater access to family therapy and other interventions that treat the child within the context of the family system. This was described as particularly important for youth affected by family trauma, complex behavioral presentations, or receiving out-of-home treatment. Providers reported that successful discharge and reintegration often depends on whether sufficient work has been done with the family before a child returns home.

Meaningful parent engagement can be difficult, however, when parents are coping with their own mental health challenges or burnout after years of managing a child's unmet needs. These challenges were especially pronounced when both parent and youth had substance use disorders, and the parent was unable to maintain a substance-free home environment, further complicating the youth's recovery.

Without adequate support for the family unit, some youth may cycle back into crisis and re-enter intensive services. Interviewees emphasized that family-centered intervention should not be viewed as optional, but rather as a core component of effective care across the continuum.

TRANSITIONS BETWEEN CLINICAL LEVELS OF CARE

Transitions between levels of care emerged as a particularly vulnerable point in the service continuum, especially when youth step down from emergency care, inpatient, or other high-acuity settings to community-based services. These transitions are especially consequential because discharge often occurs while youth remain clinically vulnerable, even if they no longer meet criteria for inpatient treatment.

Families may leave an emergency department or inpatient psychiatric unit with referral information, but without established community-based services or adequate support in navigating next steps. As a result, parents are expected to implement discharge recommendations, secure follow-up appointments, communicate treatment summaries and future goals for new providers, frequently while already managing exhaustion from repeated crises. These responsibilities can be especially difficult when outpatient capacity is limited, insurance barriers delay access, or families receive little active support in carrying out the transition.

More effective transitions require active linkage to follow-up care and clear communication between sending and receiving providers, supports that are currently inconsistent across the system.

HEALTH RECORDS

One barrier to navigation in pediatric mental health care services is the lack of interoperable electronic health records systems. Outpatient psychotherapists frequently use systems that are not connected with the hospital systems, resulting in missing critical information during transitions in care. Families are often left to communicate diagnoses, treatment history, safety concerns, and discharge instructions across multiple providers, increasing burden and the risk of miscommunication. Providers recognize, however, that interoperability for mental health records can be uniquely challenging and must account for privacy protections.

Privacy protections shape what information can be shared and when. Federal and state confidentiality protections governing psychotherapy notes limit the clinical information that can be exchanged across providers and systems, even when coordination would benefit

the patient. While these protections serve important purposes, they can complicate transitions and make it difficult for receiving providers to have a full clinical picture. Navigating consent requirements and release forms can add administrative burden and delay the flow of information at critical moments in care.

Interviewees also pointed to the need for more standardized expectations regarding information-sharing and discharge planning across providers and systems. Greater interoperability could enable existing services to function more cohesively by improving handoffs, reducing reliance on parents as the primary coordinators of care, and supporting more timely and informed clinical decision-making.[92]

STIGMA AS A BARRIER TO SUCCESSFUL FAMILY ENGAGEMENT

Although awareness and acceptance of mental health have improved, stigma continues to shape whether and when families seek care. Providers described stigma as a particularly important barrier for higher-acuity services and substance use treatment, where youth and families may be more reluctant to engage. Several interviewees suggested that stigma among parents and caregivers may be a greater barrier than stigma among youth themselves.

Providers described cultural beliefs about mental illness, concerns about labeling, and distrust of mental health systems as factors that can delay treatment initiation or reduce family participation after referral. These concerns reinforce the importance of trusted messengers, clear communication, and family-centered engagement strategies that acknowledge both the practical and emotional barriers families face in seeking care.

SOCIAL DETERMINANTS OF HEALTH

Mental health, like physical health, is shaped by many factors, including social determinants of health (SDOH), the conditions in which children are born, grow, and live. Factors such as housing stability, education, economic security, and exposure to trauma significantly influence mental health outcomes and contribute to disparities, particularly among historically marginalized communities.

Transportation is a particularly acute barrier in mental health care because treatment often requires regular, recurring attendance over extended periods, including weekly outpatient appointments or multiple visits per week for more intensive services such as IOPs. As a result, even when services exist, lack of reliable transportation can preclude sustained participation.

Additional challenges include provider shortages in high-need communities, limited language access for families with limited English proficiency, and barriers faced by undocumented populations who may avoid seeking care due to fear despite eligibility for services. Together, these factors reflect how systemic inequities in housing, language barriers, and immigration status can shape access to mental health care as profoundly as clinical or coverage barriers.

[92] PerformCare has taken important steps to ease this barrier, including through a data system that allows CCIS hospital units to document patient notes within PerformCare's platform, thereby supporting smoother care transitions.

Key Findings:

Families face confusing and fragmented pathways to care: Information about available services and how to access them is inconsistent and spread across multiple systems.

Caregiver burden is high and family supports are limited: Parents often must coordinate care, manage crises, and navigate long waits with limited access to respite, peer support, or other family-centered services.

Poor coordination across systems creates gaps in care: Communication and transitions between schools, providers, CSOC, hospitals, and other systems are inconsistent, leaving families to bridge the gaps.

Structural barriers limit equitable access and engagement: Stigma, transportation, language barriers, and other social determinants make it harder for many families, particularly those with higher-acuity needs, to access and remain in care.

School-Based Services

Many of the systemic barriers described earlier in this report, including workforce shortages, insurance obstacles, navigation complexity, stigma, and language access, shape how students and families access mental health support through and alongside schools. Rather than repeat those findings in full, this section begins by examining the mental health needs most commonly presenting in school settings, then explores how those themes manifest specifically in school settings, focused on grades K-12. It also identifies dynamics that are particular to school-based care, including the role schools play as a primary or sometimes only access point for many students, and the structural constraints that shape what schools can and cannot provide.

MENTAL HEALTH NEEDS IN SCHOOLS

Based on interviews conducted, the most consistent theme related to why students seek mental health support in school centers on challenges with social relationships and a lack of connection or belonging. School staff described students struggling with peer relationships, including bullying, friendship conflicts, romantic relationship issues, and difficulty forming or maintaining social connections. These relational challenges often trigger or intensify emotional distress, particularly anxiety and depression. Social pressures and relational stressors amplified by social media were also identified as affecting student mental health, intensifying peer comparison, conflict, and vulnerability to rejection.

Trauma was identified as a significant underlying reason students seek mental health support in schools, often presenting alongside anxiety, depression, or behavioral challenges. Family and home stress were the most commonly described trauma-related experiences. Depression was also commonly identified, frequently presenting alongside anxiety and tied to social and environmental stressors including peer relationship difficulties, bullying, challenges with belonging, and family and community stressors, including poverty, housing instability, immigration-related fears, and broader family stress.

Suicidal ideation and self-harm were described as less common than concerns such as anxiety or relationship conflict, but among the most urgent reasons students access school-based mental health supports. When mental health needs surface, school staff initiate referrals through structured processes to connect students with appropriate support. These processes, however, can vary by district, with some districts being more proactive, while in other districts, caregivers report needing to advocate for evaluations or services.

ACCESS AND NAVIGATION

Navigating Mental Health Supports in Schools

As described earlier in this report, system navigation poses significant challenges for families seeking mental health care. In the school context, the fragmented nature of the system and the lack of communication and coordination makes navigating the system challenging. Families must simultaneously navigate school-based support processes, CSOC referral pathways, outpatient provider systems, and state agency requirements, each operating independently with its own eligibility criteria and application procedures.

Respondents described that families and students typically want help, but struggle with the numerous steps required to access care, including identifying the appropriate agency, completing applications, and understanding eligibility requirements. School staff noted that even professionals sometimes struggle to fully understand how the system works, and presentations about how to access services can leave participants confused rather than informed. As a result, families may delay or abandon attempts to access services because the process feels overwhelming or unclear.

Education and Training

Interviewees consistently identified a need for mental health training and education for parents, students, and community members, with the most consistent theme being greater awareness and foundational mental health literacy. Participants described gaps in understanding basic concepts like recognizing anxiety, depression, or trauma responses, and knowing when and how to seek support. Schools and community organizations address this through workshops, assemblies, peer leadership, classroom lessons, mental health fairs, and classroom-based lessons designed to help students identify

emotions, build coping strategies, and understand when to reach out for help.

Parents and caregivers were also identified as needing training and education to support their children and navigate available services. Families often lack awareness of the systems designed to support youth mental health or feel overwhelmed by the number of programs and services available. Participants emphasized that increasing family engagement and providing accessible educational opportunities for caregivers are critical for ensuring that mental health supports extend beyond the school setting.

Training must also clarify available resources and pathways within a complex system. Even in resource-rich regions, families often remain unaware of programs or misunderstand how different services function. As a result, educational efforts frequently focus on clarifying how to access care, what different levels of support provide, and how various organizations coordinate services. Respondents emphasized the importance of culturally responsive and accessible training formats that account for language differences, transportation challenges, childcare needs, and work schedules.

COORDINATION AND CRISIS RESPONSE

HIPAA Limits Information Sharing Across Systems

As noted earlier, federal and state privacy protections limit the clinical information that can be shared across providers and systems. These constraints are particularly consequential in school settings, where coordination between schools and CSOC services is limited primarily to referrals, with information sharing restricted by HIPAA protections. CSOC providers attempt to create caregiver-signed agreements to facilitate sharing, with varying success.

Most external providers maintain limited contact with school mental health systems beyond referrals or occasional information sharing after signed release forms. Information is often not shared between health care providers and school systems even during students' mental health crises. Despite these limitations, external partners are able to share information on gaps, barriers, assets, and challenges, suggesting that some productive communication does occur even within a constrained framework.

Protocols for Referrals and Transitions

A recent study of school mental health providers across the United States found that care coordination was often not systematized and instead relied on informal, provider-initiated practices. The study further concluded that transition planning for students with mental health needs remained patchwork, with practices shaped more by individual provider preferences than by consistent institutional school-based protocols.[93]

These findings are consistent with broader literature indicating that coordination across health care and school settings can improve outcomes for youth but is often hindered by structural barriers.

Evaluation of Mental Health Services

Interviewees noted the lack of consistent outcomes evaluation across school, State, and external systems. The NJ4S system has no statewide system to measure participant outcomes, an absence acknowledged across participant groups. Instead, State systems measure outputs including the numbers of students and schools served, the ways they were served, and other descriptive information related to the delivery of services. While NJ4S is required to employ evidence-based curricula, it is unclear how this is actively monitored to ensure fidelity and efficacy and individual NJ4S hubs use uncoordinated evaluation tools.[94]

Gaps in Long-Term and Crisis Support

For students who need ongoing mental health care, the gap between short-term stabilization services and long-term community treatment is a persistent and consequential problem. Respondents described school-based and State services like NJ4S and CSOC as primarily short-term or stabilization-focused, intended to bridge students to longer-term treatment in the community. However, limited availability of outpatient providers, long waitlists for therapy programs, and shortages of child psychiatrists often delay or prevent these transitions.

Beyond the gap in long-term supports, participants also identified system-wide shortages for higher-level and urgent care, with limited program availability, long waiting lists, or programs closing due to funding constraints. In many cases, the only immediate option available during a crisis is an emergency room visit, which respondents described as an inadequate and sometimes traumatic experience for youth. Even when students are evaluated

[93] https://www.sciencedirect.com/science/article/abs/pii/S0190740923006229

[94] DCF published findings and data reflecting the impact of NJ4S. https://www.nj.gov/dcf/documents/NJ4S-Formative-Brief-2026.pdf

in hospital settings, they are frequently discharged quickly due to capacity limitations and return to school without consistent follow-up services and connection to school-based support.

Return to School from Crisis Supports and Mental Health Clearance

School staff described significant challenges with student re-entry following urgent or crisis mental health interventions, including inconsistent policies, burdensome clearance requirements, and limited coordination across systems. Schools typically require students experiencing suicidal ideation or other safety concerns to obtain an external evaluation from a hospital, crisis center, or licensed mental health provider before returning. However, these processes vary widely and can be difficult for families to navigate. Emergency departments may refuse to complete school clearance evaluations or have long wait times, often making them a last resort when timely community-based evaluations are unavailable.

In response, some districts have developed partnerships with local outpatient providers to facilitate quicker evaluations and recommendations for follow-up care. These partnerships were described by participants as critical in reducing delays, easing family burden, and improving access to appropriate supports.

Participants also highlighted a lack of coordinated transition planning once students are discharged from hospitals or crisis evaluations. Schools often receive limited guidance, leaving staff to manage referrals, organize reentry meetings, and develop informal support plans such as counselor check-ins or identifying trusted adults. Broader system challenges, including limited inpatient capacity, insurance-driven short hospital stays, and a lack of step-down or stabilization programs, further complicate reentry and continuity of care. As a result, schools frequently rely on internal resources and ad hoc solutions, underscoring the need for more structured reentry systems and on-site mental health evaluation options.

Documentation requirements for school re-entry present an additional barrier. In the absence of clear statewide standards, there is significant variation in what schools require, creating confusion for families and providers. Some schools request specific language confirming that a student is safe to return, while providers may hesitate to complete such documentation due to unclear expectations and perceived legal risk. These requirements can also raise privacy concerns for families.

Proposed legislation aims to address these issues by establishing statewide standards for mental health clearance and school re-entry.[95] The bill defines mental health clearance as an evaluation by a licensed professional to assess risk of harm and sets criteria for when schools may require such evaluations. It also mandates data collection and reporting by the New Jersey Department of Education and directs the development of guidance to ensure consistent implementation across districts. The legislation is intended to replace the current patchwork of local policies with a more uniform approach that balances student safety, due process, and access to care.

School-Embedded Supports Support Access and Families

Respondents reported a strong, consistent desire to embed preventative and responsive mental health supports within their schools. Schools wanted on-site access to services and designated structures that allow providers within the school to work directly with schools within school environments. Participants emphasized that effective school-based mental health supports require practical elements such as a school liaison to coordinate referrals, parental consent processes, and dedicated spaces and time for clinicians to meet with students individually or in small groups. Well-resourced schools with these arrangements described them as critical for making support accessible to students during the school day. Schools often serve as a central access point for families seeking help with a wide range of needs, including mental health services, housing supports, and other community resources, reinforcing the idea that embedding services within schools allows families to connect with supports through trusted relationships with educators and staff.

SCHOOL FUNDING AND CAPACITY CONSTRAINTS

Budget Constraints

Funding and budget constraints in schools can limit the scope and sustainability of mental health supports. Many school staff described relying heavily on temporary funding streams such as grants or pandemic relief funds to support counselors, social workers, and wellness center staff. As these expire, districts piece together funding from multiple sources such as Title IV funding, county funds, or principal budgets to sustain basic programming. Limited budgets also restrict schools' ability to hire additional clinicians, reduce counselor caseloads, provide staff training, or bring in specialized presenters and prevention

[95] NJ A4318/S2598, 2026–2027 session

programs. In some cases, school leaders reported having no dedicated mental health budget and needing to request funding from other departments to maintain services. Even robustly funded districts expressed concern about rising costs, noting they would likely cut mental health services before academics, highlighting the need for more sustainable, dedicated funding across socioeconomic contexts.

Another recurring barrier is the broader shortage of mental health providers and programs due to funding and workforce limitations across the system of care. Respondents noted that several treatment programs have closed because they were financially unsustainable as the cost of training and employing specialized mental health professionals, including psychiatrists and licensed clinical social workers, continues to rise. This has increased waitlists and reduced the number of options available to students requiring more intensive support. These systemic financial pressures can create a "have and have-not" landscape, where families with financial resources can access private providers quickly, while others must wait extended periods for care. As a result, schools increasingly serve as the first and sometimes only accessible point of mental health support for many students.

Time and Bandwidth Constraints

Limited time and bandwidth among school staff was frequently cited as a barrier to effective school mental health support. Counselors, social workers, and other student support personnel are responsible for addressing a growing range of mental health needs while managing academic and administrative responsibilities. Respondents consistently described counselor caseloads far beyond manageable levels, with hundreds of students assigned to individual counselors responsible for entire schools or multiple buildings. As a result, some students with mental health needs may go unnoticed or receive limited attention because counselors simply cannot keep up with requests, walk-ins, crises, and ongoing therapeutic support, while also managing scheduling, attendance, college planning, and administrative tasks.

Participants raised similar concerns about elementary school settings. Some participants noted that younger students have significant needs but fewer available resources and supports. In particular, elementary school nurses, counselors, and support staff noted serving very large student populations, often supporting hundreds of students while addressing behavioral concerns, early emotional challenges, and parent consultation needs. Interviewees emphasized the critical role elementary school staff provide in early intervention but noted they are often stretched too thin to provide consistent preventative and individualized support. Several participants also observed an increase in behavioral and emotional concerns among younger students, suggesting that demand for services is growing at the elementary level while available resources have not kept pace.

FINANCIAL BARRIERS

Insurance Coverage and Affordability

As described in the Insurance section, coverage gaps and affordability barriers significantly limit families' ability to access mental health care. These barriers are equally present in the school context. Interviewees frequently identified insurance as a critical obstacle, especially for families who lack robust commercial coverage or rely on Medicaid. Even for families with private insurance, copays for therapy or specialized services, which can be required as frequently as weekly, can accumulate quickly and become financially unsustainable. Caregivers described situations where they wanted to pursue recommended services such as therapy or behavioral interventions but were unable to afford out-of-pocket costs or faced eligibility barriers for public assistance programs. These financial constraints can delay or prevent follow-through on mental health referrals, leaving schools to manage ongoing needs without adequate external support.

Poverty and Economic Instability

Another barrier to effective school-based mental health supports is the direct impact of poverty and economic instability on students and families, which shapes both the need for services and the ability to access them. Respondents repeatedly emphasized that many mental health concerns experienced by students, particularly depression, anxiety, and trauma, are closely tied to broader socioeconomic conditions such as housing instability, food insecurity, and community displacement. Practitioners described the difficulty of addressing emotional or behavioral challenges when students' basic needs remain unmet, noting that it is challenging to focus on mental health improvement when families are experiencing homelessness, unstable housing arrangements, or lack of utilities.

CULTURAL AND SOCIAL BARRIERS

Stigma and Eligibility Barriers

As described earlier, stigma shapes whether and when families seek mental health care. This is also true in the school context. Respondents repeatedly noted that while many students are increasingly open to discussing mental health and requesting help, their parents or caregivers may be reluctant to engage in services due to long-standing cultural norms that discourage discussing emotional struggles outside the family. These attitudes can create situations in which students are willing to receive services but cannot access them because parental consent or support is lacking.

Stigma can also be reinforced by the eligibility systems families encounter when they do seek help. Interviews highlighted a tension between strengths-based philosophies and deficit-focused service eligibility systems. While practitioners strive to focus on resilience and positive attributes, service eligibility often requires documenting what children cannot do in order to qualify for supports. Caregivers described this as feeling stigmatizing and discouraging, particularly when children are denied services for not meeting strict diagnostic thresholds despite clear needs.

Language Access and Immigration-Related Fears

As noted in the Social Determinants of Health section, language barriers and immigration status both shape whether families seek and can access mental health care. Respondents noted that families who speak a language other than English may struggle to navigate school and behavioral health systems due to limited English proficiency, making it difficult for parents to understand referral processes, communicate with providers, or complete required forms, ultimately delaying or preventing access to services. Respondents also noted limited availability of bilingual and multilingual mental health professionals, which restricts schools' ability to provide culturally and linguistically appropriate services.

While some schools attempt to recruit bilingual clinicians or partner with organizations that provide services in multiple languages, demand often exceeds supply, particularly for Spanish-speaking providers and specialized communication supports, such as American Sign Language. While tools such as translated resource hubs and multilingual outreach efforts help mitigate these challenges, respondents consistently noted that expanding the multilingual mental health workforce and improving interpretation resources would significantly improve access to care for linguistically diverse families.

For undocumented families, concerns about deportation, legal instability, and sharing personal information with institutions often discourage families from engaging with services, even when students clearly need support. These fears can also contribute directly to students' mental health challenges, as youth living in undocumented households may experience chronic anxiety, stress, or trauma related to the possibility of family separation.

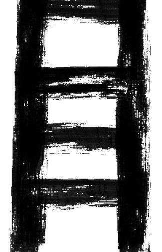
Key Findings:

Schools are a critical but strained access point for mental health care: Schools are often the first place where youth mental health needs are identified, but growing and increasingly complex needs are outpacing schools' capacity to respond.

Navigation and coordination challenges limit continuity of care: Fragmented systems, limited information-sharing, and weak connections between crisis response and ongoing treatment make it difficult for students and families to access and sustain care.

Workforce and funding constraints restrict school-based support: Staffing shortages, limited funding, and high caseloads reduce schools' ability to provide consistent, preventive, and timely mental health services.

Structural barriers and inconsistent processes create inequities: Insurance, poverty, stigma, language barriers, and the lack of standardized practices for school reentry, evaluation, and outcomes tracking limit equitable access and continuity of care.



Clinical Care across the Continuum of Need: Community, Hospital, and Out-of-Home Services

HOSPITALS & HEALTH SYSTEMS

Hospitals and health systems play a significant role in New Jersey's children's mental health landscape, serving youth across a range of settings and levels of care, from emergency department visits and inpatient medical and psychiatric admissions to outpatient services and partial hospitalization programs. For many families, hospitals function as an urgent access point when community-based services are unavailable, waitlists are too long, or a child's needs escalate to crisis. Understanding hospital capacity, utilization patterns, and the challenges hospitals face in managing pediatric behavioral health needs is therefore essential to understanding the broader system. The sections below examine bed capacity and utilization, service volume across levels of care, and the challenges hospitals report in discharging youth to appropriate community-based settings.

Hospital Psychiatric Bed Capacity

Across New Jersey, the Department of Health licenses 304 pediatric psychiatric beds. These beds are distributed across hospital types and levels of care. *A detailed map of hospital locations and capacity is provided in* Appendix P: Department of Health Program and License Data*.*

Facility Type

- **227 beds** (75%) in 10 general hospitals
- **77 beds** (25%) in 3 freestanding psychiatric hospitals

Level of Care

- **233 beds** (77%) are acute pediatric psychiatric beds for high-acuity needs and stabilization
  - Includes both:
    - Closed units (secure/locked)
    - Open units (less restrictive)
- **71 beds** (23%) are intermediate levels of care

Geographic Distribution[96]

- **Central Jersey:** 138 beds (45%)
- **Northern Jersey:** 92 beds (30%)
- **Southern Jersey:** 55 beds (18%)
- **Jersey Shore:** 19 beds (6%)

Licensed beds reflect the maximum number of beds a hospital is authorized to operate under its state license as issued by DOH. Licensed capacity often is higher than the actual number of beds available to patients because hospitals can only use beds when they have the necessary staff, space, and resources available. Fewer available beds can be the result of unavailability of staffing, renovation or temporary space constraints, or because certain patients require enhanced staffing or one-to-one observation that reduces the number of beds that can be used. In some cases, beds and units are opened and closed based on seasonal demand.

To better understand accessible bed availability, the Quality Institute analyzed hospital-reported pediatric psychiatric bed utilization. These data compare licensed capacity to usable capacity.

- Participating hospitals represented 47% of licensed pediatric psychiatric bed capacity
- Hospitals reported 12 point-in-time snapshots over one year
- Data captured beds that were:
  - Staffed
  - Operational
  - Unoccupied (available to accept a patient)
- Average bed availability ranged from 23% to 50%
- At any given time, roughly half or fewer beds were available
- Only two hospitals reported zero availability at a single point in time[97]

[96] The four regions include the following counties: Central Jersey (Hunterdon, Mercer, Middlesex, Somerset, and Union); North Jersey (Bergen, Essex, Hudson, Morris, Passaic, Sussex, and Warren); South Jersey (Burlington, Camden, Cumberland, Gloucester, and Salem); and the Jersey Shore (Atlantic, Cape May, Monmouth, and Ocean).

[97] This calculation excludes licensed but inactive pediatric psychiatric units.

Hospital Mental Health Volume

EMERGENCY DEPARTMENT AND INPATIENT ADMISSIONS[98]

Emergency department (ED) utilization data highlights both the scale of pediatric behavioral health needs in New Jersey and the extent to which hospitals are serving as a key access point for care. DOH reports that there were 43,735 ED encounters in 2023 and 45,730 encounters in 2024 among youth ages 0–17 with any listed diagnosis of a mental or behavioral disorder.[99] Detailed regional reporting of ED utilization and inpatient discharge data is provided in Appendix L: Hospital Volume and Utilization Data.

To better understand the patterns in utilization, the Quality Institute conducted a survey, inviting all New Jersey hospitals to provide ED encounter data among youth ages 0–17 with any listed diagnosis of a mental or behavioral disorder. In total, the Quality Institute collected a sample representing approximately 29-34% of statewide youth mental health ED totals in 2023 and 2024 (DOH data was unavailable for 2025 at the time of publication).

Within this sample, the Quality Institute analyzed the number of unique youth among the total encounters to better understand repeat ED use for psychiatric emergencies. Of the reported sample, 17-21% of youth were seen more than once within the same calendar year. These findings suggest that EDs are not only a frequent entry point for pediatric behavioral health care, but also a recurring point of care for a subset of youth.

Inpatient discharge data shows a similar pattern. DOH data reports 8,089 hospital discharges in 2023 and 8,404 in 2024 among youth ages 0–17 with any diagnosis of a mental or behavioral disorder.[100] The Quality Institute received hospital data representing 61-64% of statewide totals in 2023 and 2024. Among the Quality Institute's collected hospital data, 18-19% of inpatient admissions were attributable to youth who had more than one psychiatric inpatient admission within the same calendar year.

Outpatient Services

Many hospital systems also provide outpatient mental health services through affiliated clinics, which serve as important access points for youth outpatient care. Statewide, hospitals submitting survey data reported serving approximately 40,000-50,000 patients ages 0–17 annually for mental health outpatient services from 2023–2025. In addition, the same hospitals who completed the survey reported enrollment in partial hospitalization programs and intensive outpatient programs totaled approximately 10,000-15,000 youth annually. Tables and regional variation are reported in Appendix L: Hospital Volume and Utilization Data, although comparisons should be interpreted cautiously given differences in population size and hospital survey participation across regions.

Service Utilization for Eating Disorders and Substance Use Disorders

To estimate the volume of care provided to youth with specialized diagnoses, the Quality Institute asked hospitals to report the number of youth receiving mental health services across levels of care with selected diagnoses of interest: eating disorders and substance use disorders. Because these variables were less commonly tracked, hospital reporting was more variable, and some hospitals were unable to provide data due to limitations in their data systems. Among participating hospitals, reported data suggest that hospitals annually served approximately 800–1,200 youth with eating disorders and 1,400-1,800 youth with substance use disorders. Tables and regional variation are reported in Appendix L: Hospital Volume and Utilization Data.

[98] For hospital emergency department and admission data, this analysis included youth with any listed mental or behavioral health disorder diagnosis, rather than limiting cases to those with a primary mental or behavioral health diagnosis. This approach was intended to capture encounters in which the immediate presenting issue may have been physical in nature but was closely related to a behavioral health condition, such as injury related to a suicide attempt or other self-harm. However, this broader case definition also introduces the possibility of overinclusion. Some encounters may reflect treatment for a primarily medical issue unrelated to the patient's mental or behavioral health diagnosis history, such as an accidental injury in a youth who has a previously documented anxiety disorder.

In addition, the presence of a mental or behavioral health diagnosis in the record may vary across providers and hospital settings. Clinicians may differ in whether they document behavioral health conditions when those conditions are not central to the presenting complaint, and documentation may also depend on whether the condition is known to the provider or disclosed by the patient or family. As a result, the data may inconsistently capture mental and behavioral health comorbidity across otherwise similar encounters. These factors limit the precision of the measure and mean that reported counts should be interpreted as a broader indicator of hospital utilization among youth with documented mental or behavioral health conditions, rather than as a direct measure of visits primarily attributable to a behavioral health emergency.

[99] New Jersey Department of Health. (n.d.). *NJSHAD: New Jersey emergency department visit data – count query builder* [Data query system]. https://www-doh.nj.gov/doh-shad/query/builder/ub/EDState/Count.html

[100] NJ DOH data was unavailable for 2025.

Spotlight

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CHILDREN'S HOSPITAL OF PHILADELPHIA (CHOP)

The Children's Hospital of Philadelphia (CHOP), located in Philadelphia, Pennsylvania, is a nationally recognized pediatric hospital.[101] Given its reputation and proximity to New Jersey, it is a significant provider of behavioral health services for New Jersey residents, both adjacent to the state and at some locations in New Jersey.

For families living outside the Philadelphia-metropolitan region, accessing care at CHOP may involve traveling beyond their local community, including a longer commute, and more complexity in coordinating follow-up care closer to home after discharge or treatment completion because closer care at the level needed may not be available. Of the over 9,000 New Jersey youth served across all levels of care, 4,788 (52%) lived in ZIP codes more than 30 miles from CHOP's main building, 2,664 (29%) lived more than 50 miles away, and 424 (5%) lived more than 75 miles away.[102] Detailed county-level statistics are provided in Appendix L: Hospital Volume and Utilization Data.

At the highest-acuity level, 1,215 unique New Jersey patients were admitted to CHOP for mental health-related inpatient services between 2024 and 2025. During the same period, 7,973 New Jersey youth received outpatient mental health services and an additional 280 youth participated in partial hospitalization or intensive outpatient programs. Among New Jersey youth receiving mental health services at CHOP, 477 had an eating disorder diagnosis, 207 had an intellectual or developmental disability diagnosis, and 104 had a substance use disorder diagnosis.

Taken together, these findings indicate that a substantial number of New Jersey youth receive behavioral health care out of state, including many who travel significant distances to do so. This pattern may reflect both the draw of CHOP's specialized services and gaps in the availability, perceived quality, or other accessibility of comparable in-state care. The findings also underscore the importance of strong cross-state care coordination, particularly for youth requiring ongoing community-based follow-up after receiving services at CHOP.

Hospital Discharge Delays

Hospital staff and administration described delayed discharge as one of the most persistent challenges in pediatric behavioral health care. Once a youth is clinically stabilized, discharge may still be delayed for days, weeks, or longer while an appropriate placement is secured. Interviewees emphasized that these prolonged hospital stays can be harmful for youth, who remain in a level of care that is no longer clinically appropriate, while also straining hospital resources. In addition to the financial and administrative burden of extended stays, caring for youth with high behavioral health needs over prolonged periods can place substantial strain on staff and contribute to burnout.

Hospitals reported that discharge delays occur across multiple hospital-based settings, including emergency departments and inpatient medical and psychiatric beds. Two circumstances were described most often. First, youth were clinically ready for discharge but could not safely return home because the home environment was not currently able to support them, including cases involving parent or guardian refusal of custody after a planned discharge or delays as parents tried to secure community-based outpatient care appointments before discharge. Second, youth requiring more intensive out-of-home treatment or for youth in DCPP custody, discharge was delayed

[101] https://www.chop.edu/about-us/us-news-world-report

[102] Geospatial analysis was based on patient ZIP code of residence rather than exact address and may therefore underestimate actual travel distance, particularly in more rural or larger ZIP Code Tabulation Areas.

because no clinically appropriate out-of-home treatment or placement was available, particularly for youth with high-acuity needs, I/DD, or complex co-occurring conditions. In these cases, hospitals functioned as holding environments while other systems searched for treatment.

Hospitals described these discharge delays as evidence of broader gaps in the continuum of care, particularly the shortage of clinically appropriate out-of-home treatment beds. Inadequate community-based and residential capacity contributes not only to prolonged hospitalization, but also to avoidable readmissions when youth are discharged without sufficient supports in place.

Parent Refusal of Custody

Interviewees described parent refusal of custody as an extreme and distressing response to prolonged unmet need, often following repeated crises, ED visits, or hospitalizations. Parents reported reaching a point at which they no longer believed they could safely manage their child's needs at home and feared harm to the child, other family members, or themselves if the youth returned without additional supports. These accounts suggest that refusal of custody often reflects broader gaps in the continuum of community-based care in the absence of adequate treatment, respite, and discharge support.

Interviewees also pointed to tension between hospital discharge practices and family perceptions of readiness to return home. As inpatient psychiatric care is designed for short-term stabilization rather than sustained behavioral improvement, hospitals are often expected to discharge youth once acute clinical criteria are met, even when families do not feel prepared to safely manage the child's needs at home. This mismatch highlights the importance of stronger family psychoeducation and supports during care transitions to prevent repeated cycles of discharge, crisis, and readmission.

PSYCHIATRIC EMERGENCY SCREENING SERVICES

Across interviews, providers consistently emphasized the need for pediatric-specific access to emergency psychiatric screening services for youth with mental health needs to reduce unnecessary ED visits. Parents and providers described long waits and the general environment of the ED as overwhelming and traumatizing for youth, especially those experiencing mental instability. Although some counties have developed alternatives to ED-based psychiatric screening for children and adolescents, these models are not available statewide.

In practice, ED psychiatric screening services are used not only for many youth in acute behavioral health crisis, but also for students who may be stable but are required to obtain a mental health clearance before returning to school. The documentation and process challenges this creates for families and schools are discussed in the School-Based Services section.

Spotlight

Monmouth County implemented a Children's System Review Committee (CSRC) that is a quarterly closed meeting specific to hospital crisis units. Data is submitted monthly by each crisis unit for team review to quickly identify gaps, trends, and barriers to care. See Appendix R: Monmouth County's Children's System Review Committee for more detailed information on data collection.

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Key Findings

Hospitals serve as a critical access point for youth mental health care when risk is heightened or urgent, with high and growing demand reflected in ED visits, inpatient admissions, and repeat utilization.

Limited capacity and workforce constraints reduce usable psychiatric beds, while a significant number of youth seek care out of state, indicating gaps in in-state availability and specialization.

Discharge delays are widespread due to shortages in appropriate level of care in community-based and out-of-home treatments, leading to prolonged hospital stays, including medical and psychiatric admissions, strain on staff, and poor care continuity.

System gaps in crisis response and care transitions, including lack of pediatric-specific screening options and insufficient family support, contribute to avoidable emergency department visits, repeat crises, and readmissions.

OUT-OF-HOME TREATMENT AVAILABILITY

Out-of-home (OOH) treatments, often referred to as residential treatment, are used when a youth's CMO Child-Family Team has determined that behavioral health needs cannot be safely or effectively addressed through community-based services, with PerformCare authorization. Within New Jersey's CSOC, these placements are intended to serve youth with the highest levels of clinical acuity who require structured, around-the-clock therapeutic supervision. OOH programs provide intensive treatment in residential settings that range from campus-based residential treatment centers to smaller community-based group homes and individualized treatment homes.

These placement decisions are made through a CMO-led process involving clinicians, the youth, and their family. Because CSOC services are voluntary, youth and families must consent to the treatment plan and ultimately select among available placement options.

New Jersey's residential continuum includes several types of treatments designed for different clinical needs and levels of intensity of service, including Psychiatric Community Homes (PCHs), Residential Treatment Centers (RTCs), specialty residential programs, therapeutic group homes, and treatment homes designed for youth transitioning from higher-acuity settings back to community living. Each site is licensed to serve a specific population defined by criteria such as age, gender, diagnosis, and behavioral needs. As a result, the total number of available licensed beds does not mean that all of those beds are available or appropriate for every youth in need of a placement.

Across interviews with providers, clinicians, and families, all consistently reported that limited availability of appropriate OOH treatments was a challenge. Participants reported persistent shortages of appropriate placements for youth with complex behavioral health needs, particularly those with co-occurring intellectual or developmental disabilities (I/DD) or severe psychiatric conditions. These shortages contribute to delays in accessing the appropriate level of care and create bottlenecks throughout the youth mental health system.

Capacity and Utilization of Out-of-Home Treatments

New Jersey's CSOC system currently contracts with 25 providers operating 127 residential program locations across 18 counties, with a maximum licensed capacity of 1,411 youth across 16 intensity-of-service (IOS) levels, including treatments specifically designed for youth with substance use disorders or I/DD.[103]

As noted, aggregate capacity can obscure the true availability of placements. Beyond logistical constraints such as staffing shortages, a youth must match the OOH site's eligibility criteria to be placed there. These criteria include gender, age, diagnostic profile, behavioral needs, cognitive capacity, and adaptive functioning. Thus, the number of available placements for each individual is lower than the statewide bed count.

As of July 31, 2025, there were 1,042 youth under age 21 receiving OOH treatments and 463 youth waiting for treatment, with youth waiting in a variety of settings including with parents at home, hospitals, and at other OOH treatment levels of care deemed no longer appropriate. Waitlists exist across multiple levels of care. Demand for residential treatments varies by population. Among youth currently placed, 698 youth (67%) were in treatments primarily serving behavioral health needs, 284 youth (27%) were in treatments serving youth with I/DD or co-occurring behavioral health conditions, and 60 youth (6%) were in treatments serving substance use disorder needs.

Waitlist patterns differ across these populations. While more youth were waiting for behavioral health placements (275 youth) than for I/DD placements (149 youth), youth seeking I/DD placements often experienced significantly longer waits. At most levels of service – eight of nine I/DD-specific levels and four of five behavioral health – youth have been waiting more than a year for treatment.

Certain high-acuity placements had particularly long waiting periods. Psychiatric Community Homes (PCHs)[104], which serve youth with severe psychiatric needs, had some of the longest waitlists in the system. As of July 31, 2025, 70 youth were waiting for behavioral health PCH treatments, with an average wait of 111 days and a maximum wait of 554 days (over 1.5 years). Among youth with I/DD needs, 39 were waiting for PCH-IDD treatments, with an average wait of 223 days and a maximum wait of 1,645 days (over 4.5 years).

[103] PerformCare Website (https://www.performcarenj.org/content/dam/amerihealth-caritas/performcare-nj/pdf/families/find-provider/ooh-listing.pdf.coredownload.inline.pdf). Updated January 5, 2026. These statistics do not include contracted out-of-state out-of-home treatment beds or transitionary intense clinical beds such as Intensive Residential Treatment Services (IRTS).

[104] This does not include I/DD Intensive PCH.

In addition to capacity constraints, providers reported challenges related to placement matching. For example, "treatment homes" are a level of care designed to support youth transitioning from higher-acuity residential settings into family-like environments living with trained "treatment parents" who offer structured support. However, placement requires a mutually consenting match. Although CSOC contracts 358 treatment home beds, these placements depend on the availability and willingness of individual "treatment parents" to accept a specific youth into their home. Gender availability also affects placement options. Of the 1,411 licensed residential beds statewide, 233 are designated for females, 444 for males, and 744 for all genders. Providers reported challenges in identifying appropriate options for females.

When appropriate in-state placements cannot be identified, youth may be placed outside New Jersey. However, there is no formal policy establishing the threshold or designated point at which case workers are required to begin pursuing out-of-state options. As of July 31, 2025, 49 youth with I/DD needs were receiving care in out-of-state residential treatments.

Cost and Reimbursement for Residential Care

Residential treatment represents one of the most intensive and costly services within the CSOC system due to requirements for 24-hour supervision, clinical treatment, and specialized staffing. New Jersey reimburses residential providers using per-diem payments that vary depending on the level of service and program type.

Recent DCF procurement documents illustrate the approximate reimbursement levels: a Level 2 therapeutic group home contract RFP provides approximately $934,400 annually for a five-bed program, equivalent to roughly $512 per youth per day for boarding, while specialty residential treatment programs have rates of approximately $430–$445 per day, depending on accreditation status. These rates correspond to annual costs of approximately $157,000 to $187,000 per youth.[105] State regulations also establish a minimum residential reimbursement floor of $155 per day, though actual contract rates are substantially higher due to the clinical staffing and service requirements of residential programs.[106]

DCF budget testimony to the Legislature in 2025 highlighted the financial pressures facing residential providers, including rising workforce costs and the need to maintain specialized clinical staffing. Providers interviewed for this report described financial challenges due to high staffing ratios, specialized training, compliance with extensive licensing requirements, and property expenses such as increased safety measures and frequent facility damage.[107]

Impact of Placement Shortages

Stakeholders consistently reported that shortages of residential treatment beds have significant impacts across the broader behavioral health system. When appropriate placements are unavailable, youth may remain in less appropriate settings while waiting for an opening. These interim settings can include inpatient hospital units, other residential programs that do not match the youth's clinical needs, or the youth's home.

Clinicians emphasized that delays in accessing appropriate levels of care can lead to worsening behavioral health conditions and missed opportunities for earlier intervention. Families and providers described waiting periods as highly stressful and clinically precarious, as youth remain in environments that were previously determined to be insufficient to meet their clinical needs.

Shortages of residential treatment beds can also create cascading effects across the system. When youth remain in higher-acuity residential treatment beds longer than clinically necessary due to limited step-down residential options, beds become unavailable for youth who require immediate high-acuity bed placement. These delays can propagate throughout the continuum of care, contributing to backlogs in stabilization beds and other crisis services.

Providers and clinicians reported particular concern about youth who remain at home while awaiting residential treatment. Interviewees described situations in which families, hospital staff, or community providers were unable to safely manage severe behavioral health needs during these waiting periods. National research shows similar patterns across states, where prolonged delays in accessing residential care are associated with increased safety risks for youth, families, and clinical staff.[108]

[105] New Jersey Department of Children and Families. (2020). *Request for proposals: Group home level 2 for youth with intellectual/developmental disabilities (CSOC GHL2)*. https://www.nj.gov/dcf/providers/notices/rfparchive/2020-RFP-CSOC-GHL2.pdf

[106] New Jersey Administrative Code. (2025). N.J.A.C. 10:77-3.6, *Basis of reimbursement.* https://regulations.justia.com/states/new-jersey/title-10/chapter-77/subchapter-3/section-10-77-3-6/

[107] New Jersey Legislature, Office of Legislative Services. (2025). *Department of Children and Families response to questions from the FY 2026 Governor's Budget hearing*. https://pub.njleg.state.nj.us/publications/budget/governors-budget/2026/dcf_response_2026.pdf

[108] Snow, K., Mansbach, J. M., Cortina, C., Berry, J., Growdon, A., Stoeck, P. A., & Walsh, K. (2025). *Pediatric mental health boarding: 2017 to 2023. Pediatrics*, 155(3), e2024068283. https://doi.org/10.1542/peds.2024-068283

Private and Out-of-State Residential Options

Outside the residential options available through the CSOC system, in-state residential behavioral health options for New Jersey youth are limited. Despite best efforts, we were unable to identify an existing comprehensive statewide list of licensed non-CSOC residential programs in New Jersey.

Some families pursue private residential programs outside New Jersey when CSOC placements are unavailable or when they seek alternative treatment models. These programs can present significant financial barriers for families. Commercial insurance plans often limit coverage for residential behavioral health treatment or require substantial cost-sharing, and some programs do not accept insurance.

Several interviewees suggested that expanding safe and well-regulated residential treatment options within New Jersey could allow youth to remain closer to family and support networks while receiving treatment. At the same time, stakeholders noted that the broader residential treatment industry has faced scrutiny regarding oversight and safety concerns, underscoring the importance of strong regulatory frameworks and greater transparency on the quality and safety of these programs.

Key Findings

Demand for higher-acuity mental health services exceeds available capacity: Hospitals, emergency departments, and out-of-home treatments are serving growing numbers of youth, with repeated crises and increasing reliance on intensive levels of care.

Limited in-state OOH capacity restricts access to appropriate care: Residential treatments are in short supply, particularly for youth with high-acuity needs, co-occurring I/DD, or other specialized needs.

Delays in discharge and placement create bottlenecks across the continuum: Youth often remain in hospitals, emergency departments, or home settings longer than clinically appropriate because community-based and out-of-home options are unavailable.

Gaps in crisis response, care transitions, and family support contribute to repeat crises: Limited pediatric-specific crisis options, weak care transitions, and insufficient family support increase the likelihood of avoidable emergency department visits, readmissions, and prolonged system involvement.

Legal System

Youth involved with the legal system, including those in DCPP custody, family court proceedings, and the youth justice system, face distinct and often compounded barriers to accessing mental health care. These youth are among the most vulnerable in the state, navigating systems that were not always designed with their mental health needs as a primary consideration. The sections below examine how each of these legal system contexts shapes access to and quality of mental health care.

DIVISION OF CHILD PROTECTION AND PERMANENCY

From 2022 through 2025, the Division of Child Protection and Permanency (DCPP) oversaw approximately 3,000 youth annually in out-of-home placements under State custody for a variety of reasons, based on end-of-year point-in-time counts.[109] Although this represents a small share of all youth in New Jersey, interviewees consistently identified youth in DCPP custody as among the state's most vulnerable populations, particularly those requiring higher-acuity mental health care.

Mental Health Screenings

Once a youth is taken into state custody, they are expected to receive a full Comprehensive Health Exam for Children (CHEC) including a Comprehensive Medical Examination (CME) and a Comprehensive Mental Health Assessment (CMHA), when verbal capacity allows, at a state Regional Diagnostic and Treatment Center (RDTC).[110] The CME portion may also be completed through their pediatrician. The Quality Institute's analysis of DCF data found high compliance for CME completion (1,318 youth received a CME in FY 2024 (93% of youth requiring a CME) and 1,382 in FY 2025 (95% youth requiring a CME); however, much fewer youth received CMHAs (487 youth received a CMHA in FY 2024 and 446 youth received one in FY 2025). The total number of youth with ability to respond verbally (generally based on the age of the child) to require a CMHA was not reported; therefore, mental health screening compliance could not be calculated. Interviewees directly involved in these processes report that there is a gap between the established screening guidelines and what occurs in actual practice.

DCPP Youth in OOH Treatment

Interviewees repeatedly raised concerns about the limited availability of OOH treatments for DCPP-involved youth with higher-acuity mental health needs. Providers described youth who remained unable to discharge from EDs, inpatient psychiatric units, or other out-of-home treatments because no appropriate next placement was available, particularly for youth with histories of high-risk behaviors.

Foster care settings may be difficult to secure for youth with behaviors such as physical aggression, fire-setting, or problematic sexual behavior, while shelters may exclude youth based on age or other criteria. In extreme situations when both foster care and shelter options are exhausted, providers reported that youth may be placed temporarily with staff in motel or office settings until a placement becomes available. Interviewees described these interim arrangements as highly unsafe, with significant risk of behavioral decompensation, violence, and ED usage, exacerbating cycles of instability.

DCF operates a limited number of Stabilization and Assessment Services (STAS) beds for youth in DCPP custody, as well as for youth at high risk of DCPP involvement who are transitioning between levels of high-acuity care. STAS beds are intended for youth who are clinically stable and do not require hospital admission, but who are still in crisis and need intensive supervision and treatment support. Although intended to be brief stays, shortages in long-term placements have created bottlenecks, leaving STAS beds frequently occupied for extended periods and therefore unavailable for new occupants. When STAS beds are unavailable, youth may remain in hospital settings until a high-acuity bed becomes available through CSOC.

[109] New Jersey Child Welfare Data Hub. (n.d.). *Children in placement (point in time)*. Retrieved March 28, 2026, from https://njchilddata.rutgers.edu/portal/children-in-placement.

[110] NJ legislature created the RDTCs specifically to evaluate and treat child abuse and maltreatment. New Jersey Psychological Association. (n.d.). *Metro regional diagnostic and treatment center (RDTC)*. https://psychologynj.org/page/RDTC

FAMILY COURT

Across both the family court and youth justice system, interviewees described the need for enhanced mental health education for judges and those in the court system focused on best practices, accepted therapies, care coordination, clinical best practices for mental health treatment, and New Jersey specific processes and pathways to care.

Interviewees identified the ordering of reunification treatment as a particular area of concern at the intersection of youth mental health services and contentious family court proceedings. These concerns led in part to changes to N.J.S.A. 9:2-4, the law that governs child custody and visitation, as to how Family Court Judges make decisions that relate to a youth's mental health and best interests. The revisions clarify that a child's safety must be the court's foremost priority, and judges must address safety concerns, such as domestic violence, abuse, or risk of harm before focusing on issues such as parenting schedules or shared custody.

Additionally, the revisions open the door for the court to consider reports from the child's therapist to assist the court in making custody determinations in the child's best interest. When a child is old enough and mature enough to express a reasoned preference, the court must consider that preference. If a judge orders a custody arrangement that is contrary to what the child has expressed, the judge must explain the reasons on the record. The revisions also specifically place limits on court-ordered therapy. The court shall not order any therapy unless there is generally accepted and scientifically valid proof of the safety, effectiveness, and therapeutic value of the therapy. The court shall require a showing of good cause that therapy is appropriate prior to ordering such therapy. The court must also monitor therapy and has the authority to change or stop it if it is not benefiting the child. These changes are significant and call for an examination of the appropriate role, readiness, resources, and training of Family Court Judges and the court system in matters over children's mental health. The law's impact is to be studied by Rutgers University School of Social Work.[111]

JUSTICE-INVOLVED YOUTH

Although a range of statewide mental health services exist for justice-involved youth and youth at high risk of system involvement, interviewees suggested that access to and quality of those services often depended heavily on local resources. For youth living in the community, CSOC services were described as a primary source of support, though interviewees noted the same variability in service quality described elsewhere in this report. For youth with higher-acuity needs, interviewees emphasized the detrimental impact of the shortage of OOH treatment beds and resulting waitlists. Stakeholders raised concerns about the quality and effectiveness of some OOH treatment settings and the lack of long-term placements for a small minority of youth requiring the highest-intensity mental health treatment. Some pointed to the numbers of youth cycling between treatment settings and criminal involvement as evidence of a system ill-equipped to meet their mental health needs effectively.

Interviewees noted that once a youth enters detention, available mental health services may vary by facility, program model, and the youth's specific diagnoses and circumstances. Sources observed that mental health services – including evaluations for youth – can be quite limited, with lengthy waiting lists for required evaluations and appropriate services. As a result, some youth spend extended periods in detention while awaiting placement in mental health facilities. Additionally, some youth justice cases remain unresolved due to the incompetency of the youth and the lack of appropriate services to support their competency trial.

Detention may also disrupt services the youth had been receiving in the community, including CMO involvement, underscoring the importance of strong care coordination during transitions into and out of detention.

[111] *P.L.* 2025, c. 316 (N.J. 2025).

Key Findings:

Justice-involved youth face inadequate access to mental health care across settings.
Significant gaps remain in access to evaluations, care coordination, service availability, and access to appropriate out-of-home treatment, particularly for youth with the highest-acuity needs.

Courts may inconsistently apply evidence-based best practices in youth mental health.
Courts ordering therapy for a child in a contested divorce or a parental visitation matter must give greater consideration to the wishes of the child, consider therapists' opinions, and monitor ordered therapy. Increasing the Court's responsibility over the child's best mental health interests. While Family Court Judges receive training annually where mental health topics are offered, more specific, enhanced training sessions are needed and should be required to better support judges in promoting the safety of the child in the cases before them.

Unique Considerations

Across interviews, stakeholders consistently emphasized that while many youth mental health needs can be addressed through community-based services, a subset of youth present with more complex clinical profiles that require specialized, intensive, and often difficult-to-access care. These youth are not only navigating mental health conditions, but also overlapping developmental, medical, and social system challenges, including interactions with schools, and the child welfare system.

Several populations were consistently identified as particularly complex and underserved across the state, including youth with intellectual and developmental disabilities (I/DD), co-occurring disorders, and eating disorders. Although these groups differ clinically, they were linked by a common set of access challenges: exclusionary program criteria, fragmentation across systems, and a shortage of specialized services at higher levels of care.

CROSS-AGENCY HIGH-ACUITY YOUTH

In recent years, greater attention has been focused on youth with both high-acuity mental health needs and involvement across multiple systems, such as youth involved with both the justice system and DCPP, including through parental refusal or relinquishment of custody. Although this population is relatively small, interviewees consistently described it as particularly complex to serve effectively. In response, DCF established a Youth Mental Health Roundtable Steering Committee workgroup in December 2025 to examine these challenges and identify potential solutions. The Quality Institute's research findings support the need for stronger cross-agency coordination and expanded high-acuity OOH capacity to better serve this population.

INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

Youth with intellectual and developmental disabilities (I/DD) were the population most consistently described as underserved within the children's mental health system. The I/DD population encompasses a wide range of diagnoses, functional abilities, and support needs; however, interviewees most often centered on youth with autism spectrum disorder, particularly those with high support needs, including nonverbal youth and youth with aggressive tendencies.

Interviewees described exclusionary criteria as a primary barrier to accessing much of the children's mental health system, preventing participation even when a provider believes a youth's psychiatric symptoms are treatable in a given setting. An I/DD diagnosis closes doors for these youth regardless of severity or potential to benefit from treatment. At the same time, diagnosis is essential to seek, as youth without a formal autism diagnosis, for example, may be ineligible for services such as community-based applied behavior analysis, limiting access to supports that could help stabilize care in the home and community.

Providers and families consistently emphasized the need for more I/DD-inclusive clinicians and programs across the full continuum of care. In addition to the general barriers described elsewhere in this report, youth with I/DD, particularly those with high support needs, were described as having only a fraction of the treatment options available to other youth.

PROVISION OF APPLIED BEHAVIOR ANALYSIS SERVICES

Applied Behavior Analysis is a widely used, evidence-based intervention for youth with autism and other developmental needs. It is designed to improve functioning and support skill development through structured behavioral interventions.[112] Access to ABA remains uneven. Medicaid covers ABA for eligible youth when medically necessary, but commercial coverage can be more variable, creating inequities in access. As with other services discussed in this report, insurance design and provider availability both shape whether families can obtain care. More information about licensed ABA therapists can be found in Appendix Q: Licensed Board-Certified Behavior Analysts.

[112] Cleveland Clinic. (2023, August 16). *Applied behavior analysis.* https://my.clevelandclinic.org/health/treatments/25197-applied-behavior-analysis

HIGH-ACUITY CARE FOR YOUTH WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

The shortage of high-acuity care options for youth with I/DD emerged as one of the most urgent concerns raised in interviews. Although New Jersey has some specialized resources, including 10 I/DD-designated pediatric psychiatric hospital beds at Trinitas Regional Medical Center in Union County and 404 CSOC-contracted I/DD-specific out-of-home treatment beds, interviewees consistently described these options as far too limited relative to need. Providers described prolonged waits for appropriate placements and very few options for youth who could no longer be safely treated at home.

This shortage is especially consequential because standard models of psychiatric and out-of-home treatment do not always align with the needs of youth with significant I/DD-related support needs. Unlike many behavioral health or substance use placements, which are generally designed as short- to medium-term interventions, some I/DD placements require a longer-term orientation. For certain youth with significant support needs, discharge to the family home may not be a realistic or safe outcome, particularly as youth age and caregiving demands become more physically difficult to sustain. In these cases, long-term planning may involve continued out-of-home care until transitioning into adult developmental disability services.

Parents and providers expressed concern that existing care pathways do not always reflect these realities. Interviewees called for expanded I/DD-specific out-of-home capacity, greater availability of respite while youth await placement, and stronger staff training and sensitivity to the specific needs of this population.

YOUTH WITH CO-OCCURRING DISORDERS

Youth with co-occurring disorders were also described as facing heightened barriers to care, particularly as many programs are not equipped to treat both conditions concurrently. These challenges are not solely a function of access. For many co-occurring psychiatric, developmental, and behavioral presentations, assessment and treatment are clinically complex because symptoms may overlap, conditions may exacerbate one another, and evidence-based approaches to integrated treatment remain limited.[113] More broadly, literature on physical-mental multimorbidity in children and youth underscores that overlapping psychiatric, developmental, and medical conditions introduce additional complexity that many condition-specific care models are not designed to manage.[114]

As a result, families may be told to address one condition before another, even when the conditions are clinically intertwined. This can delay treatment and increase the likelihood that youth deteriorate while awaiting appropriate care.

EATING DISORDERS

Eating disorders were consistently described as a high-need area requiring both psychiatric and medical expertise. Depending on severity, treatment may involve outpatient care coordinated across primary care providers, therapists, dietitians, and other specialists, or intensive services such as intensive outpatient treatment, inpatient hospitalization, or specialized residential out-of-home care.

Providers described growing demand and persistent waitlists for eating disorder services, with shortages especially acute for higher-acuity care, Medicaid-participating services, and services for males. Interviewees also emphasized insurance barriers, particularly for inpatient and residential treatment, noting that in New Jersey, there are only two youth-serving eating disorder hospital-based programs that accept Medicaid.

Youth may need to seek out-of-state care to access the highest intensity of care for eating disorder treatment. One such provider is CHOP in Philadelphia, Pennsylvania, which offers a broad range of eating disorder services. CHOP served 477 New Jersey youth with eating disorder diagnoses from 2024 to 2025. These NJ youth were residents of 20 of the 21 NJ counties, suggesting widespread geographical need for eating disorder services.

[113] Marshall, T., Reeson, M., Loverock, A., Lewis, A. E., King, I., Ilyas, R., Caruso Dixon, C., Viste, D., Azer, B., Chow, E., Safi, F., Kennedy, M., Abba-Aji, A., & Greenshaw, A. J. (2025). Evidence-based interventions for youth with concurrent mental health and substance use disorders: A scoping review. The Canadian Journal of Psychiatry. https://doi.org/10.1177/07067437241300957

Rosen, T. E., Mazefsky, C. A., Vasa, R. A., & Lerner, M. D. (2018). Co-occurring psychiatric conditions in autism spectrum disorder. International Review of Psychiatry, 30(1), 40–61. https://doi.org/10.1080/09540261.2018.1450229

[114] Romano, I., Buchan, C., BaioccoRomano, L., & Ferro, M. A. (2021). Physicalmental multimorbidity in children and youth: A scoping review. *BMJ Open, 11*(5), e043124. https://doi.org/10.1136/bmjopen2020043124

Providers reported that in some cases, insurers denied continued or higher-intensity treatment despite clinical recommendations, including by relying on criteria such as weight-based thresholds that may not align with current best practice. In addition to limiting access, these authorization disputes and appeals burden clinicians, hospitals, and families.

Key Findings

Youth with I/DD face gaps in access to appropriate mental health care: Many programs exclude youth with intellectual and developmental disabilities, particularly autism and high support needs, and there are too few I/DD-inclusive providers, high-acuity programs, and out-of-home treatment beds.

Fragmented systems do not adequately serve youth with co-occurring needs: Youth with overlapping mental health, developmental, and medical conditions often experience delays because services are typically designed to address only one condition at a time.

Specialized eating disorder treatment is difficult to access: Shortages of specialized programs, especially higher-acuity and Medicaid-participating services, contribute to long waitlists, insurance barriers, and reliance on out-of-state care.

Recommendations

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RECOMMENDATIONS
APPENDICES

The following recommendations address the key issues identified in the Landscape Analysis and Findings sections of this report. They are organized into six areas: workforce development; insurance coverage and access; school-based mental health; family navigation of resources; clinical care across the continuum; and state oversight and cross-sector education and coordination.

No single recommendation will be sufficient to address these issues. Improving outcomes and resources for children and families will require coordinated action across state agencies, insurers, providers, schools, and community organizations. Many of these recommendations build on existing programs, structures and investments that the State has already made. Across all recommendations, the Quality Institute's focus is on equity, access, transparency, and accountability, with particular attention to families and communities that face the greatest barriers to appropriate care.

Workforce

1 Establish a Statewide Youth Mental Health Data Dashboard

The Issue:

Data on workforce, network adequacy, and service capacity across levels of care are fragmented, limiting the public's ability to assess true access to care. A dashboard can be used as an evolution tool: empowering users to see changes over time and thereby more easily assess progress toward goals. The data will enable better planning, funding, and decision making.

The Recommendation:

New Jersey should establish a centralized, publicly accessible Youth Mental Health Data Dashboard, led by an authority or public university, working in partnership with the Departments of Banking and Insurance (DOBI), Children and Families (DCF), Education (DOE), Health (DOH), Human Services (DHS), and the Division of Consumer Affairs. It would integrate data on the full continuum of care, including workforce, community-based services, insurance networks, and higher levels of care such as residential, out-of-home treatment beds.

The dashboard should include standardized, regularly updated information on provider supply, specialties, insurance participation, geographic distribution, provider availability, appointment access, directory accuracy, residential bed availability, waitlists, length of stay, and placement matching challenges. It should specifically track high-acuity levels of care, including residential treatment facilities and specialized out-of-home treatment beds, where limited capacity and prolonged waits create significant bottlenecks that delay discharge from hospitals and leave youth in inappropriate settings.

The lead entity should issue an annual public report to the Legislature on system performance, access, and capacity across the continuum of care. The dashboard should serve as a single, authoritative source of information for policymakers, researchers, providers, insurers, and advocates, and should be used to identify unmet needs and disparities, define network adequacy based on whether children and families can truly access appropriate care, inform Medicaid managed care contract requirements, and guide licensing and state budget decisions. Data should be used by the State for submitting public grant applications.

2 Implement Ongoing Workforce Monitoring and Capacity Planning

The Issue:

New Jersey does not have a coordinated, data-driven approach to monitoring the pediatric mental health workforce or aligning workforce development with system needs.

The Recommendation:

New Jersey should establish a formal data-driven process for ongoing pediatric mental health workforce monitoring and multi-year capacity planning. The State should collect and analyze detailed workforce data, including pediatric-specific practice patterns, specialties, service capacity, geographic distribution, insurance participation, and workforce demographics, to better understand current supply and projected need. New Jersey should build on existing models,

such as the New Jersey Center for Nursing[115] and workforce data centers in other states[116]. This effort could be housed within an existing structure such as the New Jersey Statewide Data System[117] while expanding participation to include agencies that regulate and finance health care.

Using this data, the State should develop and regularly update a children's mental health workforce and capacity plan with measurable targets for expanding youth-serving providers, addressing geographic shortages, strengthening workforce diversity, and increasing capacity at higher levels of care. The plan should specifically address shortages of highly specialized providers, insurance network adequacy oversight, and bottlenecks in residential and out-of-home treatment settings. Findings should directly inform state policy, budget, reimbursement, training, and service expansion decisions.

3 Align Workforce Pipeline Investments with Children's Mental Health Needs

The Issue:

Workforce shortages persist across children's mental health and current investments are not consistently aligned with areas of greatest need.

The Recommendation:

New Jersey should expand and strategically align workforce pipeline investments to increase the number of clinicians specializing in children's mental health, building on existing analyses and models. The State should operationalize the findings from DCF's Labor Market Analysis conducted by McKinsey into a coordinated, multi-year implementation strategy, with dedicated funding, clear targets, and ongoing accountability.

Using data from the State's workforce monitoring and planning efforts, New Jersey should target scholarships, loan redemption programs, graduate medical education funding, and supervised training opportunities toward high-need pediatric specialties and underserved regions. Investments should prioritize disciplines with the greatest shortages, including child and adolescent psychiatry, developmental-behavioral pediatrics, and child-focused psychotherapy, while creating incentives for psychologists, counselors, psychiatrists, and social workers to treat children and adolescents, including those currently focused on adults. The State should also expand workforce initiatives that have demonstrated success, such as recent investments in child and adolescent psychiatry fellowship positions, and replicate these models across other high-need specialties with service commitments in underserved communities.

New professionals should receive structured supervision, mentorship, and graduated clinical responsibilities to reduce burnout and ensure that clinicians are not placed in settings with a level of clinical severity beyond their training and experience.

[115] Rutgers School of Nursing. (n.d.). *New Jersey Collaborating Center for Nursing (NJCCN)*. https://nursing.rutgers.edu/research-centers-old/njccn

[116] https://www.oregon.gov/oha/hpa/analytics/pages/health-care-workforce-reporting.aspx, https://www.health.ny.gov/facilities/healthcare_workforce_innovation/

[117] https://njsds.nj.gov/about/

4 Support Team-Based and Integrated Care Models to Extend Clinical Capacity

The Issue:

Workforce shortages, combined with increasing clinical complexity among children and youth, limit the ability of traditional, clinician-only care models to meet demand for pediatric mental health services.

The Recommendation:

New Jersey should expand and sustain team-based and integrated care models that extend clinical capacity and improve access to pediatric mental health services across settings. To address workforce shortages and increasing clinical complexity, the State should support interprofessional teams in which each provider is able to use the full range of services and expertise authorized under their license. This includes expanding training, certification pathways, and sustainable reimbursement for family support specialists, peer providers, behavioral health technicians, care coordinators, and other multidisciplinary team members who can support engagement, navigation, follow-up, and ongoing care. New Jersey should also expand peer support models for parents and older youth, including approaches adapted from substance use disorder treatment, in which individuals with lived experience are trained and reimbursed to provide mentorship and recovery-oriented support.

The State should also strengthen integration between primary care and mental health services by supporting evidence-based models that embed behavioral health clinicians, family support specialists, and care navigation directly within pediatric and family medicine practices. Programs such as HealthySteps, CenteringParenting, Healthy Minds, Healthy Kids[118], and the Cherokee model demonstrate how pediatric practices can provide routine screening, early intervention, ongoing treatment, and coordinated referrals within a trusted setting. Expanding these models would improve early identification, reduce reliance on external referrals, strengthen coordination with schools and community providers, and allow pediatric and family Medicaid practices and health centers to better meet the mental health needs of children and adolescents.

5 Strengthen the NJ Pediatric Psychiatry Collaborative Model to Support Pediatricians in Ongoing Mental Health Management

The Issue:

Pediatricians are often the first point of contact for children with mental health needs, yet many report limited training, confidence, and ongoing support in managing mental health conditions, particularly for medication management and higher-acuity presentations. As a result, care is frequently referred to a limited pool of specialists, contributing to delays and unmet need.

The Recommendation:

New Jersey should strengthen the NJ Pediatric Psychiatry Collaborative (NJPPC) model to better support pediatricians in delivering ongoing, longitudinal mental health care within primary care settings.

The State should evolve the existing NJPPC model beyond consultation and referral support to include more robust, longitudinal care partnership and training for primary care providers that builds pediatrician and family practice autonomy in managing common and moderate mental health conditions. This includes expanding access to real-time

[118] https://healthymindshealthykids.org/

psychiatric consultation, as well as structured follow-up support and clinical guidance that enables pediatricians to initiate, adjust, and manage treatment over time. Case-based learning collaboratives, such as Project Echo, can be used to address key gaps such as psychotropic medication management, side effect monitoring, co-occurring conditions, and care for youth with more complex presentations.[119]

In addition, reimbursement structures should be updated to support pediatricians in delivering mental health care, including payment for longer visits, care coordination, and participation in consultation and training activities. Aligning financial incentives with clinical expectations is critical to enabling pediatric practices to sustainably integrate mental health care into routine care delivery.

The Issue:

Delays in licensure processing, fragmented Medicaid credentialing requirements, and restrictive practice rules limit the availability of qualified mental health providers and discourage participation in Medicaid, constraining timely access to care.

The Recommendation:

New Jersey should modernize and streamline licensure processes and implement universal credentialing across Medicaid managed care organizations (MCOs). The State should invest in upgraded technology systems and increased staffing at the Division of Consumer Affairs to reduce licensing delays, improve transparency, and ensure timely onboarding of qualified providers. Licensing timelines should be tracked and publicly reported to promote accountability and continuous improvement. New Jersey should also pursue participation in relevant interstate licensure compacts to expand the available workforce and facilitate cross-state practice, particularly for high-need specialties.

Further, the State should comply with the federal 21st Century Cures Act[120], and establish a uniform credentialing system for Medicaid that enables providers to be credentialed on one platform across all Medicaid MCOs that a provider participates in. The State should issue a request for proposals for a credentialing vendor and prioritize rapid implementation. Streamlining credentialing would put New Jersey in compliance with federal law, as well as reduce administrative burden, accelerate provider participation, and address a longstanding barrier to Medicaid network adequacy.

[119] https://projectecho.rutgers.edu/

[120] https://www.govinfo.gov/content/pkg/PLAW-114publ255/pdf/PLAW-114publ255.pdf

Insurance Coverage and Access

Strengthen State Enforcement of Network Adequacy and Access Requirements

The Issue:

Mental health network adequacy standards and access requirements are not being meaningfully enforced, resulting in insurance networks that appear sufficient on paper but in some circumstances fail to provide the required access to care in practice.

The Recommendation:

State regulators, specifically DOBI and DHS, must enforce existing laws related to network adequacy, access rules, and managed care contract requirements to ensure that children can access mental health services as required under law. These Departments should increase staffing and expertise dedicated to regulatory oversight; under State law, DOBI is entirely funded through industry fees and assessments for this purpose. The State should execute regular market conduct reviews and secret shopper surveys to assess real-world access, require carriers to maintain accurate and regularly verified provider directories, and ensure compliance with appointment access standards. Any insurer doing business with the State should also be required to maintain a network directory in a downloadable, machine-readable format to support independent research, verification, and monitoring of network adequacy and access.

The State should also require insurance plans to collect, report, and publicly disclose information regarding utilization management practices for children's mental health services, including prior authorization requirements, denial rates, appeal outcomes, turnaround times, and approval rates for specialty services such as intensive outpatient, partial hospitalization, residential treatment, and eating disorder care. Regulators should review these data to identify patterns that create barriers to medically necessary care and ensure that prior authorization and medical necessity criteria are applied consistently with mental health parity requirements.

When carriers fail to meet network adequacy, parity, or access requirements, they should be subject to corrective action plans and meaningful enforcement mechanisms, including financial penalties, fines, and, where appropriate, curtailment of member enrollment. To support transparency and oversight, DOBI and DHS should report annually to the Legislature on network performance, access to care, utilization management trends, and enforcement actions taken.

Use the Medicaid Managed Care Contract to Improve Access and Quality

The Issue:

The existing Medicaid managed care contract is not written to drive accountability for timely access, care coordination, and quality outcomes in children's mental health.

The Recommendation:

New Jersey should revise and strengthen its Medicaid MCO contract by establishing clear, enforceable expectations for children's mental health access, quality, screening, and care coordination. The contract should include measurable performance benchmarks that are directly connected to payments to the MCOs, which include timely access to mental health care, including follow-up after hospitalization and emergency department visits, continuity of care, coordination across providers and systems, and routine use of age-appropriate behavioral health screening tools in pediatric primary care.

Medicaid should provide reimbursement specifically for behavioral health screening in addition to reimbursement for a well-child visit and for the time required to discuss results, provide brief intervention, and coordinate follow-up care. The State should establish a state-based set of standardized metrics and public reporting on rates of screening, follow-up after positive screens, connection to behavioral health services, and other quality measures, and incorporate these expectations into managed care oversight and value-based payment arrangements.

The State should also advance payment reforms that promote early intervention, integrated care, and improved outcomes for children with mental health needs, including enhanced primary care models that integrate behavioral health and support team-based, longitudinal care. Payment approaches should allow pediatric providers to manage mental health needs within a medical home model and ensure that Federally Qualified Health Centers can participate in value-based arrangements through reimbursement beyond the traditional prospective payment system visit rate. MCOs that fail to meet contract requirements or quality benchmarks should be subject to corrective action plans and escalating enforcement mechanisms.

School-Based Mental Health Access, Coordination, and Capacity

9 Strengthen Crisis Response, School Reentry, and Bridge Services

The Issue:

Students experiencing a mental health crisis often end up utilizing the emergency department. Families and school staff describe these visits as lengthy, traumatic, and poorly connected to ongoing support. In addition, inconsistent school reentry and mental health clearance policies, combined with long waits for outpatient treatment, leave many students without adequate follow-up care after a crisis.

The Recommendation:

New Jersey should establish uniform statewide guidance regarding psychiatric clearance, communication, and school reentry following psychiatric emergencies, crisis evaluations, or hospitalization. State guidance should clarify when schools may request an external evaluation, what documentation is appropriate, and how schools, families, and providers should communicate while protecting student privacy. The guidance should also promote greater consistency across districts and reduce unnecessary or burdensome requirements that delay a student's return to school.

The State should further encourage schools to develop a written transition and support process for students returning from a mental health crisis, including communication with families, coordination with outside providers when appropriate, and short-term follow-up supports within the school.

10 Expand School-Embedded Supports and Strengthen Cross-System Coordination

The Issue:

Schools are often the first, and sometimes only, place where students and families can access mental health support, yet many schools lack on-site clinicians, strong partnerships with community providers, and consistent coordination with health care, crisis response, and child-serving systems. Fragmented communication and inconsistent understanding of privacy rules (i.e., HIPAA) leave families responsible for navigating disconnected systems on their own.

The Recommendation:

New Jersey should expand school-embedded mental health supports and formalize partnerships between schools, health care providers, New Jersey's Children's System of Care (CSOC), crisis providers, and community-based organizations. Schools should have access to on-site or school-linked therapists, care coordinators, crisis response providers, and dedicated school liaisons who can coordinate referrals, facilitate communication, and help families connect to needed supports. Schools should also provide psychoeducation and training for teachers and school staff through programs such as Mental Health First Aid and other evidence-based approaches to improve mental health literacy, early identification, classroom response, and referral to appropriate services. Many schools currently rely on NJ4S services. To avoid gaps in school based mental health services, as the State considers changes to current programs, it should account for transition plans, if needed.

The State should also establish clearer statewide guidance and standardized processes for information sharing and care coordination, including common consent forms, guidance regarding HIPAA privacy rules, and regional or school-based care coordination teams.

11 Establish Sustainable Funding, Expand Capacity, and Reduce Financial Barriers

The Issue:

School mental health services are constrained by temporary and insufficient funding, workforce shortages, high staff caseloads, and limited availability of community-based providers and higher levels of care. Families also face significant financial barriers, including lack of insurance, inadequate coverage, high out-of-pocket costs, and limited provider networks, which create inequitable access to care.

The Recommendation:

New Jersey should establish a stable, dedicated funding stream for school mental health services rather than relying on temporary grants or short-term local resources. The State should provide recurring funding for counselors, social workers, school psychologists, school nurses, wellness centers, and school-based mental health partnerships while prioritizing high-need districts and supporting contracts with community-based providers.

Family Navigation of Resources

12 Improve Family Understanding of CSOC and Access to Services

The Issue:

There is confusion over what services are available through New Jersey's CSOC. Questions exist over who is eligible and how families access services. CSOC provides access to moderate and high-acuity services. It is not designed to provide access to lower-acuity or more routine outpatient mental health care. Improving public understanding and usability of CSOC will make it easier to navigate.

The Recommendation:

DCF should improve public understanding of what services are provided by CSOC and how to access services through its Contracted Service Administrator (CSA) (currently PerformCare). DCF should provide clear, family-friendly information explaining the full range of moderate and high-acuity services available through CSOC, as well as the types of lower-acuity and routine outpatient care that families can access elsewhere. Materials should be written at accessible health literacy levels, available in multiple languages, and distributed broadly through schools, pediatric practices, hospitals, emergency departments, and community organizations.

In its forthcoming CSA Request for Proposal (RFP), DCF should increase transparency around CSOC services and accountability over services provided by the CSA. Specifically, the RFP should include performance measures such as response times, wait times, referral outcomes, service utilization, and family experience. Performance should be publicly reported. DCF should conduct periodic independent evaluations of the CSA contract performance, and establish a regular rebid schedule that promotes competition, accountability, transparency, and quality.

13 Create Centralized Family Mental Health Access, Education, and Resources

The Issue:

New Jersey's children's mental health system includes multiple entry points and service systems, including outpatient providers, schools, CSOC, crisis services, insurance plans, and community-based organizations. Families, school personnel, and health care providers may not know what services are available, which system is responsible, how to make a referral, or how to determine the appropriate level of care. Information is spread across department websites, often fragmented, inconsistent, difficult to locate, or unavailable in accessible and linguistically appropriate formats.

The Recommendation:

The State should develop coordinated, family-friendly materials and a centralized online resource that clearly explains how families can obtain mental health services, crisis assistance, and ongoing support for children and youth. The resource should describe the full range of available services, eligibility requirements, referral pathways, and how to access care across systems, including outpatient providers, schools, crisis services, insurance plans, and how to use the CSA (PerformCare) to access CSOC. It should also help families understand the different types and levels of care available, when each is appropriate, and which systems are responsible for what. The State should require insurers to share these materials with covered youth and families.

The State should also create a comprehensive family mental health education resource to reduce stigma and help families better understand children's mental health needs and treatment options, as well as associated resources and care for parents to receive mental health treatment and support. This resource should include information on common diagnoses and warning signs, available evidence-based treatments, statewide programs for specific conditions, and the different types of mental health professionals and their credentials in New Jersey. Because families often struggle to understand the differences among providers, the resource should explain who provides what services and how to choose the right provider.

These materials should be available in multiple languages and formats and designed to meet different health literacy needs. They should also be adapted for use in schools to train school personnel, who often serve as key navigators for students and families, and for health care providers, especially pediatric and primary care practices, so that providers can more consistently identify needs, reduce stigma, explain available options, and connect families to the appropriate services.

Clinical Care across the Continuum of Need: Community, Hospital, and Out-of-Home Services

14 Expand Crisis Services Outside of the Emergency Department and Increase School-Linked Crisis Pathways Statewide

The Issue:

Children experiencing a mental health crisis are often evaluated in hospital emergency departments, even when they do not require emergency medical care. This can result in long waits, stressful environments, unnecessary hospital use, and delays in connecting families to the appropriate level of care. Many school districts lack a clear pathway for where to send a student in crisis or how to support a safe return to school after an evaluation.

The Recommendation:

A small number of counties have developed pediatric-focused "Living Room" or similar crisis stabilization models through their Psychiatric Emergency Screening Services (PESS), providing assessment and short-term stabilization in a dedicated, child-friendly space separate from the emergency department. In addition, some counties provide mobile PESS services, meeting families in a location of their choosing or in their home.

New Jersey should expand pediatric "Living Room" crisis stabilization models from a limited number of counties to all 21 counties. The State should require or incentivize each county's PESS provider to establish a designated pediatric crisis assessment and stabilization setting outside of the hospital, or where this is not possible, a clearly separate pediatric area onsite but outside of the general ED. These settings should provide rapid behavioral health assessment, short-term stabilization, family support, and referral to appropriate follow-up care.

New Jersey should also develop stronger connections between these crisis stabilization sites and local school districts. Every school district should have a designated pediatric crisis resource in its county that is not a general emergency department and should have a clear protocol for when and how students are referred for assessment. These pathways should support school staff in obtaining timely mental health evaluations for students in crisis and should also provide a mechanism for determining when a student can safely return to school and what supports are needed upon reentry.

The State should encourage counties to develop formal school-linked crisis response and reentry protocols involving schools, county PESS providers, hospitals, CSOC and PerformCare, and community-based providers. These protocols should include communication expectations, follow-up planning, and connection to outpatient or school-based supports after the crisis has resolved. Existing county models can serve as examples for statewide expansion.

15 Develop a Coordinated Statewide Strategy for High-Acuity Pediatric Mental Health Care and Transitions

The Issue:

New Jersey lacks a coordinated statewide strategy for children and youth with the highest-acuity behavioral health needs. Inpatient, residential, and step-down services are fragmented, with variation in availability, admission criteria, and transition processes across providers and regions. Children with complex needs may experience prolonged emergency department or inpatient medical or psychiatric boarding, delayed placement into the appropriate level of care, repeated crises, and poor coordination during transitions between settings, particularly related to not having enough residential treatment beds that meet the youth's needs.

The Recommendation:

New Jersey should convene a statewide task force of administrative and clinical leadership from state agencies, hospitals, residential providers, managed care organizations, CSOC, and community-based providers to develop a comprehensive plan for high-acuity pediatric behavioral health services. The task force should assess current capacity and geographic gaps and establish a coordinated statewide strategy for inpatient, residential, partial hospitalization, intensive outpatient, and other step-down services to ensure that children with complex needs have access to the appropriate level of care.

The task force should also develop consistent statewide standards for transitions between levels of care, including discharge planning, warm handoffs, care coordination, communication with schools and community providers, medication management, and timely follow-up after emergency department visits, hospitalization, residential treatment, or other crisis episodes. Standards should address the needs of children with co-occurring developmental, medical, substance use, or social service needs and should include clear expectations for the roles of hospitals, residential providers, managed care organizations, CSOC, schools, and outpatient providers.

New Jersey should also strengthen oversight of pediatric mental health boarding and delayed placements. The State should require hospitals and other providers to report standardized data on emergency department boarding, inpatient boarding, length of stay after a child is clinically ready for discharge, delayed placements, and transfers to out-of-state facilities. This information should be publicly reported and used to guide planning, identify service gaps, prioritize capacity development, and support policy and funding decisions to expand access to necessary care including out-of-home treatment beds.

Strengthen State Oversight and Cross-Sector Education and Coordination

16 Coordinate State Funding, Agency Collaboration, and Oversight

The Issue:

New Jersey's children's mental health system is financed, regulated, and administered across multiple agencies, including DCF, DHS, DOH, DOE, and DOBI, with Medicaid and DHS supporting most of the public funding for CSOC and many community-based and high-acuity services. Recent changes, including creation of the Office of Youth Online Mental Health Safety and Awareness within DOH, further increase the need for coordination.

This fragmented structure can result in siloed planning, inconsistent oversight, and disconnected policy and financing decisions. Different parts of the continuum are governed by different agencies and rules, and because DHS and Medicaid are not always fully integrated into broader children's mental health planning, there is a risk that financing, regulation, and service delivery are not aligned.

The Recommendation:

New Jersey should strengthen and formalize cross-agency collaboration on children's mental health among DCF, DHS, DOH, DOE, DOBI, the new Office of Children's Mental Health Safety and Awareness, Medicaid managed care organizations, providers, and family representatives. This collaboration should support development of a shared statewide strategy, better alignment of policy and financing decisions, and more coordinated oversight across the full continuum of children's mental health services. Agencies should contribute to the data dashboard described in Recommendation 1 above, and regularly share and review common data on service utilization, access, wait times, network adequacy, crisis response, hospital boarding, school-based services, and outcomes to identify gaps, coordinate planning, and guide future investments.

As Medicaid managed care organizations assume increasing responsibility for behavioral health services, the State should closely monitor the planned transition of CSOC services into managed care to ensure that timely access, care coordination, crisis response, and family supports are preserved. Because Medicaid finances most of these services, DHS and DMAHS should play a central role in statewide planning and oversight. The State should also identify opportunities to better align standards, licensing, reporting, and accountability across agencies so that the system is more coordinated and understandable for families, providers, and policymakers.

17 Strengthen Mental Health Education and Implementation Across the Family Court and Youth Justice System

The Issue:

From family court to youth justice proceedings, there is a need for greater understanding of children's mental health needs, as well as available, appropriate options to support youth and families or caregivers.

Judges and the professionals within the court and youth justice systems can play a significant role in children's mental health and overall well-being. It is important that they have access to tailored, evidence-based training on mental health to further their ability to act in the child's best interests.

The Recommendation:

New Jersey should support expanded statewide education, technical assistance, and outreach for professionals involved in the child welfare and justice systems, including judges, prosecutors, public defenders, guardians ad litem, attorneys, court staff, and mental health professionals. Training for those working in this sector of the legal system should include topics such as child development and youth mental health, and trauma. Focus should be given to helping youth justice and family law professionals better understand the range of available mental health services for children and families.

The State should also develop practical implementation guidance, model forms, and educational materials for families and professionals to promote consistent application across courts and systems; and study and consider further steps to include youth mental health in decision making, such as creating separate specialized pathways for the most complex matters.

Acknowledgements

The New Jersey Health Care Quality Institute thanks the New Jersey State Legislature for commissioning the Children's Mental Health Mapping project. We also thank the New Jersey Department of Children and Families for its partnership on this project.

We would like to recognize the New Jersey Health Care Quality Institute staff whose expertise, time, and collaboration made this report possible including: Linda Schwimmer, JD, President and CEO; Kate Shamszad, MS, MPH, Vice President of Policy; Julie DeSimone, LSW, Vice President of Community Health; Emily Davies, MPA, Policy Fellow; Katie Bisaha, Program Officer, Kristy Li, MSW intern; and Jillian Holmes, JD, Advisor.

With tremendous appreciation, the Quality Institute acknowledges the contributions of the Children's Mental Health Mapping Advisory Committee. Committee members met monthly to provide expertise and feedback to inform this report.[121] They are:

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[121] Advisory Committee members may be employed by, affiliated with, or contracted to organizations and programs referenced in this report. They did create the recommendations and their participation does not imply endorsement of specific recommendations.

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The Quality Institute also acknowledges and thanks its partners in this research. Social Emotional Learning for New Jersey (SEL4NJ), led by Dr. Ross Whiting, conducted interviews and focus groups with school staff, community organizations, system partners, and families.

Central Jersey Family Health Consortium conducted qualitative interviews and focus groups with pediatric providers and families.

Gale Simon, JD, provided legal and regulatory research.

The State University of NJ Rutgers' Eagleton Institute of Politics' Center for Public Interest Polling supported a secret shopper analysis of commercial insurance network directories for mental health providers.

These recommendations represent the collective ideas of a multi-stakeholder group, and each individual contributing organization may not endorse every recommendation.

Suggested Citation: Emily Davies, Kate Shamszad, Julie DeSimone, and Linda Schwimmer, *Children's Mental Health Mapping Report*, New Jersey Health Care Quality Institute, June 2026 (https://njhcqi.info/cmhm).

Glossary

ADHD: Attention deficit hyperactivity disorder

ASD: Autism spectrum disorder

Behavioral Assistance (BA): Services are used to help a youth and family develop and practice healthy coping strategies to improve functioning in the home and community. Interventions are designed to target specific behaviors that are identified through an individualized assessment process.

CCIS: Children's Crisis Intervention Service

CIACC: Children's InterAgency Coordinating Council, (pronounced "kayak")

CSA: Contracted system administrator – CSOC's CSA is PerformCare

CSC: Coordinated Specialty Care

CSOC: Children's System of Care

CMO: Care Management Organization

DCF: NJ Department of Children and Families

DCPP: NJ Division of Child Protection and Permanency, also known as DCP&P. Formerly known as the Division of Youth and Family Services (DYFS)

DDD: NJ Division of Developmental Disabilities

DMAHS: NJ Division of Medical Assistance and Health Services (Medicaid)

DMHAS: NJ Division of Mental Health and Addiction Services

DOBI: NJ Department of Banking and Insurance, (pronounced "**dough**-bee")

EIS: Early Intervention Services

FSO: Family Support Organization

I/DD: Intellectual and Developmental Disorders

IEP: Individualized Education Program

IIC: Intensive In-Community services, PerformCare-authorized CSOC clinical services typically delivered in the home.

IIH: Intensive In-Home services, PerformCare-authorized CSOC clinical services specifically for I/DD youth typically delivered in the home.

IOP: Intensive Outpatient Program

JJC: NJ Juvenile Justice Commission, former name of the current Youth Justice Commission (YJC)

MCO: Managed Care Organization

Mobile Response: Commonly referring to CSOC's mobile response stabilization services, also known as MRSS

MRSS: CSOC's mobile response stabilization services, also known as "mobile response"

NJ FamilyCare: New Jersey's publicly funded health insurance program administered by the Department of Human Services, Division of Medical Assistance and Health Services.

OOH: Out-of-home

PerformCare: Contracted system administrator for CSOC

PESS: Psychiatric Emergency Screening Service, state designated emergency screening services

PHP: Partial Hospitalization Program

Respite Care: Temporary, short-term care provided to support individuals with intensive needs and to give their primary caregivers relief from ongoing caregiving responsibilities.

RTC: Residential Treatment Centers

SPAN: Statewide Parent Advocacy Network

Wraparound care/services: A family-centered, strengths-based, team-driven care planning process that coordinates individualized services and natural supports across systems to help children with complex behavioral health or social needs remain successfully in their homes, schools, and communities.

YJC: NJ Youth Justice Commission, formerly known as the Juvenile Justice Commission (JJC)

State Agency Reference Guide

NJ State Government Agencies Involved in Children's Mental Health

- **NJ Governor's Office:** Sets statewide policy priorities, proposes the state budget shaping department funding, and oversees all agencies and departments providing interagency coordination.
- **Attorney General's Office:** Oversees legal and law enforcement functions including juvenile justice, child safety, consumer protection, and provider licensing.
    - **Division of Consumer Affairs:** Regulates licensure and professional standards for clinical and mental health providers.
    - **Youth Justice Commission (YJC):** Oversees the state's youth justice system, providing custody, rehabilitation, and reentry services for justice-involved youth.
- **Department of Banking & Insurance (DOBI):** Regulates health benefits insurers to protect consumers and ensure the stability of insurance markets. Oversees health insurance compliance with coverage requirements, network adequacy, and parity enforcement, affecting reimbursement and service availability in New Jersey regulated insurance markets.
- **Department for Children and Families (DCF):** Leads NJ's efforts to support the safety, permanency, and well-being of children and families through prevention, protection, and treatment services.
    - **Children's System of Care (CSOC):** Coordinates and funds mental health, intellectual and developmental disability (I/DD), and substance use services for children and youth ages 0-20.
    - **Department for Child Protection and Permanency (DCPP):** Investigates allegations of child abuse and neglect and provides services to ensure child safety, permanency, and family stability.
- **Department of Education (DOE):** Shapes youth mental health through school-based services, special education, and early identification and intervention efforts.
- **Department of Health (DOH):** Protects and promotes public health by regulating health care facilities (including hospital pediatric psychiatric beds), monitoring population health, and administering public health programs.
    - **Division of Family Health Services (FHS):** Oversees maternal, child, and family health programs that promote early childhood development, prevention, and access to mental health services including Early Intervention Services.
    - **Office of Youth Online Mental Health Safety and Awareness:** Coordinates state efforts to protect children from online harms, such as excessive social media use and algorithmic-driven content.
- **Department of Human Services (DHS):** Administers a broad range of social service programs supporting low-income individuals and adults with mental health or disability-related needs.
    - **Division of Developmental Disabilities (DDD):** Supports adults ages 21+ with intellectual and developmental disabilities. While CSOC provides all services for youth ages 0-21, DDD is responsible for authorizing eligibility applications for older youth ages 18-21.
    - **Division of Medical Assistance & Health Services (DMAHS):** Administers state Medicaid and CHIP programs through NJ FamilyCare, determining eligibility and overseeing health care benefits for enrolled populations.
    - **Division of Mental Health and Addiction Services (DMHAS):** Oversees and funds mental health and substance use disorder community-based services for adults and a limited number of programs that serve both adults and youth (e.g., Coordinated Specialty Care programs for psychosis). At age 21, youth receiving CSOC community-based services may be eligible to transition into DMHAS' programs.

New Jersey Youth Insurance Coverage by Type

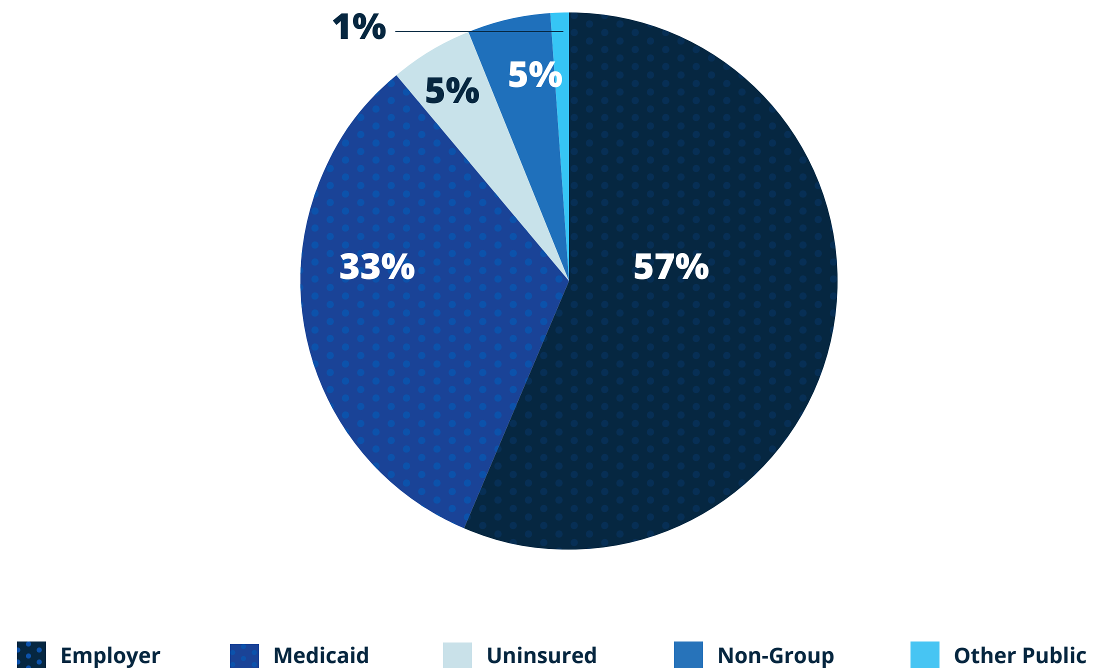
Table D1

NJ Health Insurance Coverage for Children
Ages 0-18 (2024)

Employer	1,214,600	57%
Medicaid	688,700	33%
Uninsured	97,200	5%
Non-Group	96,900	5%
Other Public	22,400	1%
Total	2,119,900	100%

Figure D2

NJ Health Insurance Coverage for Children Ages 0-18 (2024)



Source: KFF State Health Facts (https://www.kff.org/state-category/health-coverage-uninsured/health-insurance-status/), estimates based on the 2008-2024 American Community Survey, 1-year estimates.

The ACS asks respondents about their health insurance coverage throughout the previous calendar year. Respondents may report having more than one type of coverage. In this analysis, individuals are sorted into only one category of insurance coverage using the following hierarchy:

Medicaid: Includes those covered by Medicaid, Medical Assistance, Children's Health Insurance Plan (CHIP) or any kind of government-assistance plan for those with low incomes or a disability, as well as those who have both Medicaid and another type of coverage, such as dual eligibles who are also covered by Medicare.

Employer: Includes those covered through a current or former employer or union, either as policyholder or as dependent.

Other Public: Includes Medicare enrollees ages 0-18 as well as those covered under the military or Veterans Administration.

Non-Group: Includes those covered by a policy purchased directly from an insurance company, either as policyholder or as dependent.

Uninsured: Includes those without health insurance and those who have coverage under the Indian Health Service only.

APPENDIX E:

Medicaid - Enrollment and Behavioral Health Provider Participation

Table E1

New Jersey Youth Medicaid Enrollment by County

County	January 2026 Enrollment[1] (Ages 0-18)	Population Estimate of Children[2] (Ages 0-17)	Estimated Percentage of Children Enrolled in Medicaid[3]
Atlantic	29,134	56,729	51%
Bergen	49,597	201,694	25%
Burlington	29,382	96,272	31%
Camden	56,574	119,827	47%
Cape May	6,633	15,647	42%
Cumberland	24,013	37,710	64%
Essex	101,832	205,811	49%
Gloucester	20,164	65,160	31%
Hudson	71,968	141,223	51%
Hunterdon	4,310	24,967	17%
Mercer	39,075	86,317	45%
Middlesex	65,165	187,435	35%
Monmouth	35,244	132,733	27%
Morris	19,164	106,446	18%
Ocean	97,652	166,276	59%
Passaic	68,865	123,669	56%
Salem	6,613	14,449	46%
Somerset	16,223	73,710	22%
Sussex	6,200	28,630	22%
Union	59,180	139,069	43%
Warren	7,043	21,209	33%
Other[4]	628	-	-
NJ Total	**814,659**	**2,044,983**	**40%**

Source: NJ DMAHS Website, U.S. Census Bureau.

[1] Includes individuals enrolled at any point in January 2026.

[2] U.S. Census Bureau population estimates for July 1, 2024.

[3] Due to varying time frames and different age cut offs defining youth, the estimated percentage of youth on Medicaid is an estimate.

[3] Other county undefined in public data.

Table E2

Medicaid Behavioral Health Service Patients by Count and Type of Service
(Number of Unique Individuals, age 0-17 at time of service)

	2024	2025	Total of 2024 - 2025[8]
Children 0-17 Enrolled in Medicaid[1]	1,092,321	831,677	
Psychotherapy Service	12,744	17,150	24,584
Outpatient (OP) Hospital Service[2]	7,881	6,587	12,007
OP Hospital Behavioral Health (BH) Diagnostic Evaluation[3]	2,761	1,570	4,181
OP Hospital BH Therapy Service[4]	6,622	4,842	9,254
Intensive In-Community (IIC) Service[5]	37,466	37,325	57,563
Partial Care Program			4,410
Hospital-Based (PHP)	1,980	1,796	2,954
Clinic Care	962	943	1,681
Substance Use Disorder (SUD) Program			7,991
SUD IOP[6]	4	34	36
SUD Residential Treatment[7]	4,759	3,512	7,960

Source: NJ DHS DMAHS Data Request.

[1] Medicaid enrollment defined as at least one active day enrolled.

[2] OP Hospital Services include: Claim Revenue Codes 900, 901, 914, 915, and 916.

[3] OP Hospital Behavioral Health Diagnostic Evaluation include the following Claim Procedure Names: "PSYCH DIAGNOSTIC EVALUATION" and "PSYCH DIAG EVAL W/MED SRVCS".

[4] OP Hospital Behavioral Health Therapy Service include the following Claim Revenue Codes: 914-916.

[5] IIC services are represented by the following codes: H0036TJU1, TJU2, TJU3, TJHQ, H0036U1UN, and U1UP.

[6] SUD IOP is referenced as the following claim codes: H0010HF, H0018HF, H0019HF, and H0015HF.

[7] SUD Intensive Outpatient Program (IOP) is referenced as the following claim codes: H0010HF, H0018HF, H0019HF, and H0015HF.

[8] The total of 2024 and 2025 does not equal the sum of 2024 and 2025 as there were youth who received services in both 2024 and 2025.

Table E3

Medicaid Count of Youth Served and Claims for Behavioral Health (BH) Services for Children in DCPP Out-of-Home Placement

	2024	2025
Total Number of Youth[1]	15,133	14,385
BH Screening[2]	2,973	2,940
BH Evaluation[3]	1,937	1,982
Psychotherapy or Outpatient BH Service	1,506	1,613
Residential Treatment Center Admission[4]	349	360
BH Inpatient Hospital Service[5]	38	35
Alcohol/Drug Service[6]	28	44
Total Number of BH Claims Submitted[7]	10,347	14,482
BH Screening[2]	3,936	3,598
BH Evaluation[3]	2,749	2,756

Source: NJ DHS DMAHS Data Request.

The DCPP out-of-home placement population includes all youth removed from their homes, including, but not limited to, those placed in out-of-home treatment programs for behavioral health.

[1] This includes all youth (ages 0-17) at the time of service who are covered by Medicaid and have an open home removal DCPP case at the time of service (indicated through a PSC of 600 or 620).

[2] Behavioral health (BH) screening include the following Claim Provider Specialty Codes: 96127,96160,96161,96136-96139.

[3] Behavioral health (BH) evaluation include the following Claim Provider Specialty Codes: 90791/90792.

[4] Residential Treatment Center (RTC) defined as the category of service for RTCs).

[5] Behavioral health (BH) inpatient hospital service include diagnosis F01-F09 and F20-F99 as primary diagnosis.

[6] Alcohol/Drug Services include claims including E/M visit, H0015 with F10-F1999.

[7] CPT Codes include: 96127, 0345U, 1000F, 1220F, 3725F, 4004F, 80320, 80345, 80348, 80353, 80354, 80358, 80365, 80377, 90785, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90846, 96130, 96131, 96136, 96137, 96138, 96139, 96146, 96156, 96158, 96159, 96167, 96168, 96170, 96171, 97129, 97130, 97153, 97155, 97156, 99492, 99494, D9920, D9993, G0447, G8431, G8432, G9903, H0001, H0002, H0003, H0007, H0015, H0017, H0018, H0019, H0023, H0025, H0046, H2011, H2014, H2019, H2020, H2027, OP912, OP913, S9484, T1016, T1041, T2022, T2034, Y9533, and Y9534.

Table E4

Behavioral Health Providers Enrolled as a Medicaid Provider and Billing for Services Provided

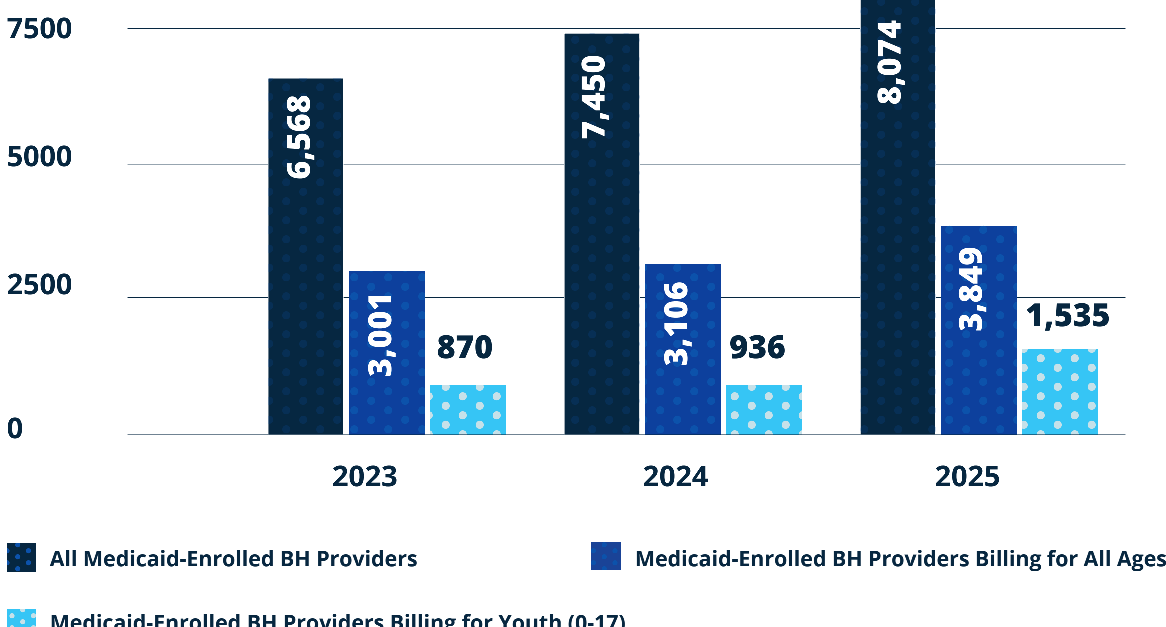
	2023	2024	2025
All Medicaid Enrolled BH Providers	6,568	7,450	8,074
Licensed Clinical Social Worker (LCSW)	2,856	3,379	3,459
Licensed Marriage and Family Therapist (LMFT)	-	8	59
Licensed Professional Counselor (LPC)	1	24	176
Nurse Practitioner (NP) Psychiatric Mental Health	1,214	1,446	1,793
Psychiatry	2,226	2,319	2,290
Psychiatry; Neurology	319	396	484
Psychologists	963	1,176	1,219
Medicaid Enrolled BH Providers Billing for Youth (0-17)	870	936	1,535
Percent of Total Medicaid Enrolled BH Providers	13%	13%	19%
Licensed Clinical Social Worker (LCSW)	95	93	462
Licensed Marriage and Family Therapist (LMFT)	-	-	4
Licensed Professional Counselor (LPC)	-	1	14
NP Psychiatric Mental Health	280	344	507
Psychiatry	377	392	426
Psychiatry; Neurology	78	94	129
Psychologists	147	197	265
Medicaid Enrolled BH Providers Billing for All Ages	3,001	3,106	3,849
Percent of Total Medicaid Enrolled BH Providers	46%	42%	48%
Licensed Clinical Social Worker (ACA)	862	867	1,269
Licensed Marriage and Family Therapist (LMFT)	-	1	19
Licensed Professional Counselor (LPC)	1	5	57
NP Psychiatric Mental Health	750	857	1,101
Psychiatry	1,072	1,054	1,064
Psychiatry; Neurology	187	219	289
Psychologists	477	517	575

Source: NJ DHS DMAHS Data Request

Billing Providers refers to providers who have been successfully paid by March 2026 when data was accessed. Most providers (~95%) bill as individually, with less than 5% practices with multiple providers.

Figure E5

Behavioral Health (BH) Providers Enrolled as a Medicaid Provider



All Medicaid-Enrolled BH Providers

Medicaid-Enrolled BH Providers Billing for All Ages

Medicaid-Enrolled BH Providers Billing for Youth (0-17)

Source: NJ DHS DMAHS Data Request
Billing Providers refers to providers who have been successfully paid by March 2026 when data was accessed.

Map E6

Behavioral Health Providers Enrolled as a Medicaid Provider and Billing for Services Provided to Youth (0-17)

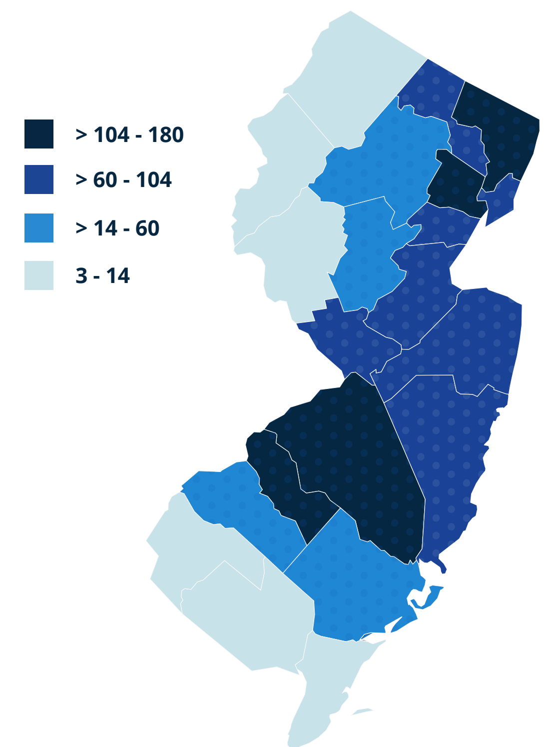


Table E7

Behavioral Health Providers Enrolled as a Medicaid Provider and Billing for Services Provided to Youth (0-17)

County	Number of Unique Providers
Atlantic	45
Bergen	143
Burlington	179
Camden	145
Cape May	3
Cumberland	11
Essex	180
Gloucester	59
Hudson	73
Hunterdon	9
Mercer	70
Middlesex	104
Monmouth	90
Morris	51
Ocean	130
Passaic	75
Salem	4
Somerset	60
Sussex	14
Union	81
Warren	9
NJ Total	**1,535**

Source: NJ DHS DMAHS Data Request.

Billing providers refers to providers who have been successfully paid by March 2026 when data was accessed. Most providers (~95%) bill individually, with less than 5% practices with multiple providers.

Children's System of Care Program and Utilization Data

Table F1

Youth Receiving CSOC Services - Monthly Average

	2023	2024	2025
Youth[1] Receiving Services	32,102	31,448	31,180
Insurance Coverage[2]			
Medicaid - NJ FamilyCare	14,021	12,319	10,023
Medicaid - Look-Alike (3560)	6,752	6,424	6,752
Medicaid - Supplemental Security Income (SSI)[3]	3,223	3,055	3,060
Private Insurance	2,139	1,863	1,778

Source: DCF CIACC Reports
Data is missing for November 2024 - January 2025 and November 2025. Reported statistics reflect PerformCare service authorizations, including services that were authorized but later declined.

[1] Inclusive of all youth receiving services, typically ages 5-20.

[2] These numbers are duplicated and incomplete as a single youth may have more than one type of insurance/eligibility and reporting is voluntary.

[3] SSI is a Medicaid only coverage for youth determined disabled and receiving Supplemental Security Income (SSI).

Table F2

PerformCare Service Authorizations - Monthly Average	2023	2024	2025
Youth[1] Receiving Services	32,102	31,448	31,180
PerformCare Access Line			
Caregiver/Youth PerformCare Access Line Calls	8,960	8,262	7,901
Unique Youth with PerformCare Access Line Call Activity	7,462	7,095	6,641
Newly Registered Youth[2]	2,844	2,517	2,313
CSOC Services			
Biopsychosocial Assessment (BPS)	1,547	1,362	995
Mobile Response Initial	3,228	2,822	3,130
Mobile Response Stabilization	7,259	6,311	6,962
Care Management Organization (CMO)	20,556	20,908	20,334
Intensive in Community (IIC)	28,259	28,747	28,816
Behavioral Assistance	6,162	6,608	7,273
CSOC SUD Services			
Substance Use Treatment	52	16	30
Unique Youth with a Substance Use Indicator[3]	1,786	901	1,296
CSOC I/DD Services			
Intensive In Home (IIH)	1,575	1,433	1,249
Family Support Services	5,117	5,748	6,444
Respite Care[4]	3,666	3,986	4,530
Assistive Technology	76	113	95
DD Eligibility Applications Received	191	189	214
DD Eligibility Applications Approved	137	140	151
Percentage Approved	72%	74%	71%
Currently DD Eligible Youth	13,521	13,827	14,288
DD Youth Engaged with PerformCare Care Management Entity[5]	2,950	2,907	2,910
CSOC Justice-Involved Youth			
Family Functional or Multi-Systemic Therapy	70	77	89

Source: DCF CIACC Reports.

Data is missing for November 2024 - January 2025 and November 2025. Reported statistics reflect PerformCare service authorizations, including services that were authorized but later declined.

[1] Inclusive of all youth receiving services, typically ages 5-20.

[2] Indicating the first contact that the youth ever had with PerformCare.

[3] Count represents the unique youth with at least one of the 6 types of indicators:

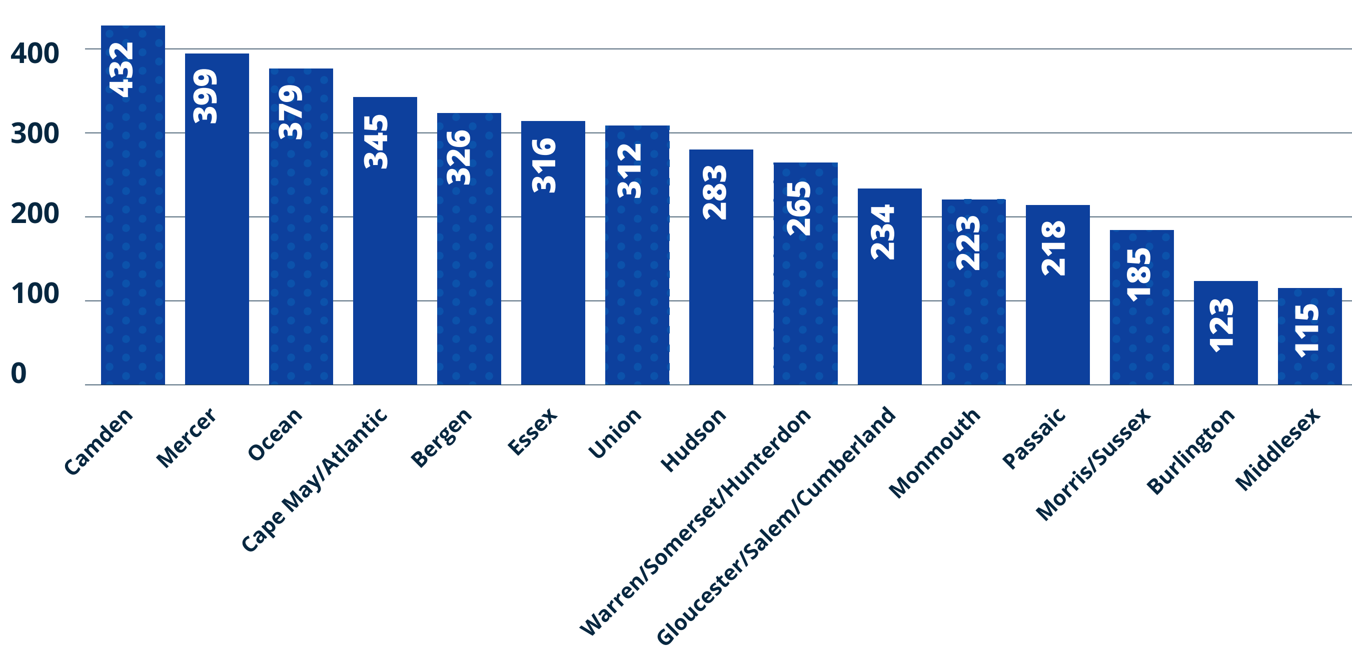
1. A call with an SU Reason or Resolution Code entered in the report period.
2. An open SU Tracking Element active at anytime in the report period.
3. An Active SU Authorization or SU related Wrap Flex Authorization active at anytime in the report period.
4. An indication via a Strength & Needs Assessment created in the report period (score of 1, 2 or 3 in Risk Behaviors).
5. An indication as the result of a Clinical Triage completed in the report period.
6. An OOH Referral indication or Transitional Joint Care Review (TJCR) indication completed in the report period.

[4] Respite care total includes: After School Respite, Agency Respite, Overnight Respite, Self Hired Respite, and Weekend Recreation.

[5] PerformCare Care Management Entities include Care Management Organizations and Mobile Response Stabilization Services.

Figure F3

Families Actively Served by CSOC Family Support Organizations
July 31, 2025

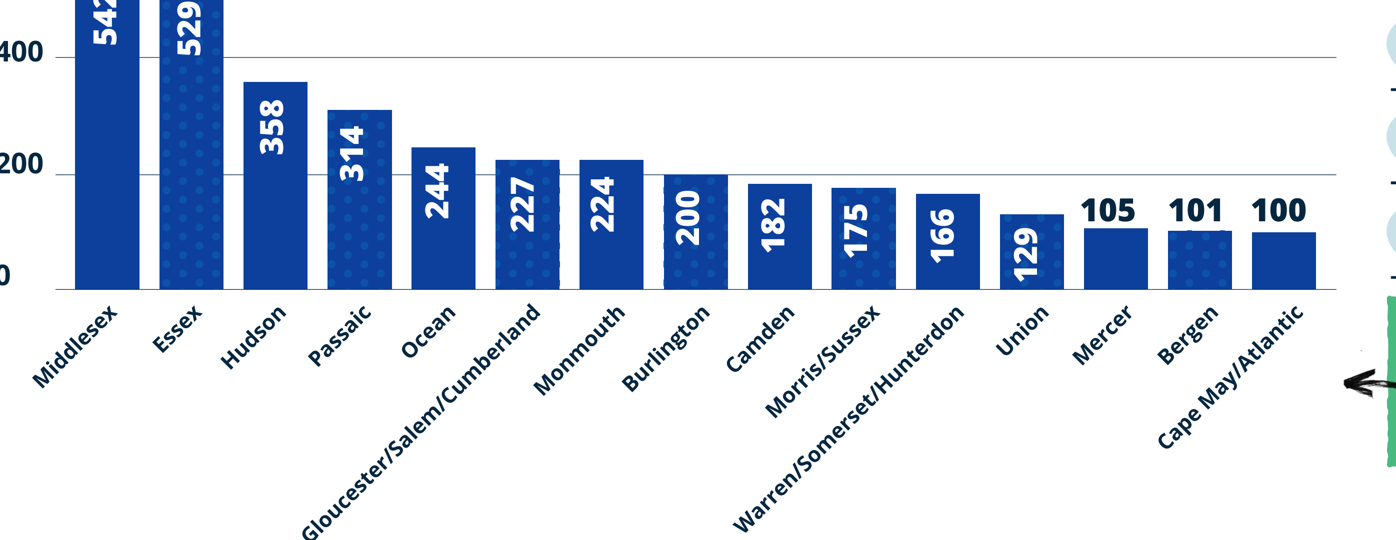


Source: DCF Data Request. Point-in-time count on July 31, 2025.
Family Support Organizations (FSO) participation may vary throughout the year, especially in non-academic summer months.

Figure F4

Youth Actively Served by CSOC Mobile Response Agencies

July 31, 2025



Source: DCF Data Request. Point-in-time count on July 31, 2025.
Mobile Response participation may vary throughout the year, especially in non-academic summer months.

Figure F5

Youth Actively Served by CSOC Care Management Organizations

July 31, 2025

Source: DCF Data Request. Point-in-time count on July 31, 2025.
Care Management Organization (CMO) participation may vary throughout the year, especially in non-academic summer months.

Table F6

Youth Served Through CSOC July 31, 2024 - July 31, 2025	
Youth enrolled in CSOC between 7/31/24-7/31/25	**298,096**
Youth with no CSOC services between 7/31/24-7/31/25, but a history of services	**164,013**
Youth who never received CSOC services, only a PerformCare access line intervention	**70,304**
Youth with CSOC services between 7/31/24-7/31/25	**63,779**
Youth with an open episode as of 7/31/25	**34,410**
Newly enrolled in the last year with a first authorization	**23,874**

Source: DCF Data Request. Accessed on July 31, 2025.
Youth include individuals under 21 years of age.

Table F7

DCPP Out-of-Home Population - Comprehensive Medical Examinations and Mental Health Assessments

Comprehensive Medical Examinations (CME)	FY 24	FY 25
Children Requiring CMEs	1,410	1,455
CMEs completed	1,318	1,382
Percentage Received	93%	95%
Comprehensive Mental Health Assessments (CMHA)		
CMHAs completed	487	446

Source: DCF Data Request
The DCPP out-of-home placement population includes all youth removed from their homes, including, but not limited to, those placed in out-of-home treatment programs for behavioral health. All youth are to receive a Comprehensive Medical Examination (CME) within 30 days of entering DCPP custody. CMEs are completed at the child medical home with their pediatrician or at a NJ Regional Diagnostic Treatment Center (RDTC). At a RDTC, the youth may receive Comprehensive Mental Health Assessments (CMHA) when verbal capacity allows (generally based on the age of the child).

Table F8

NJ Licensed Children Partial Care and Partial Hospitalization Programs

County	Licensed Capacity
Atlantic	70
Bergen	129
Burlington	160
Camden	42
Cape May	15
Cumberland	0
Essex	130
Gloucester	55
Hudson	75
Hunterdon	15
Mercer	130
Middlesex	163
Monmouth	125
Morris	105
Ocean	87
Passaic	162
Salem	20
Somerset	125
Sussex	0
Union	40
Warren	0
NJ Total	**1,648**

Source: DCF Data Request
Licensed capacity reflect the maximum number of individuals a program is authorized to operate with under its state license. Licensed capacity often is higher than the actual number of slots available to youth due to constraints including staff, space, and resources available. License directory updated June 9, 2025.

Map F9

Capacity of Partial Care and Partial Hospitalization Programs (by county)
Licensed by DCF

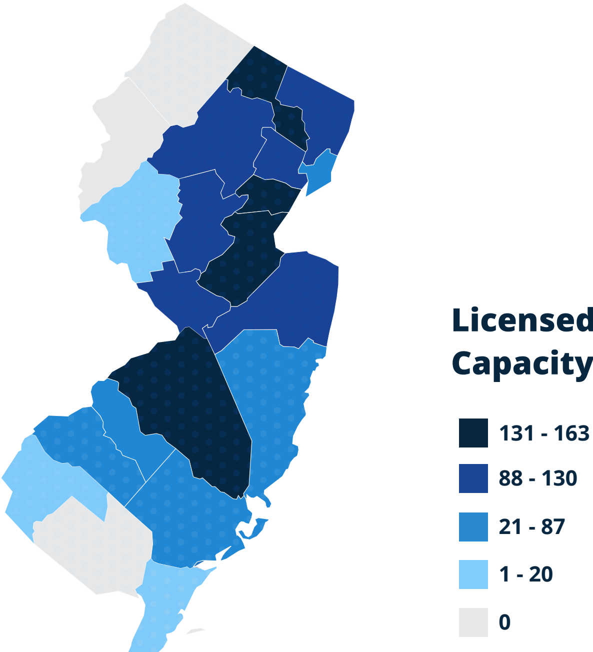


Table F10

CSOC Mobile Response Dispatches

	2022	2023	2024	2025
All Mobile Response Dispatches	34,024	31,998	28,340	NA
Statewide Telehealth Dispatches	15,283	12,386	5,851	4,172
Telehealth as a Percentage of All Mobile Response Dispatches	45%	39%	21%	NA
Youth Referred to Law Enforcement or PESS	154	119	32	18
Crisis Stabilized	15,138	12,274	5,823	4,154
Audio/Visual Response[1]	12,465	10,504	5,149	3,720
Audio Only Response[1]	2,673	1,770	674	434
Percentage Audio Only[1]	18%	14%	12%	10%

Source: DCF Data Request

[1] Telehealth dispatch type (audio only or audio visual) data unavailable if youth was referred to law enforcement or Psychiatric Emergency Screening Services (PESS).

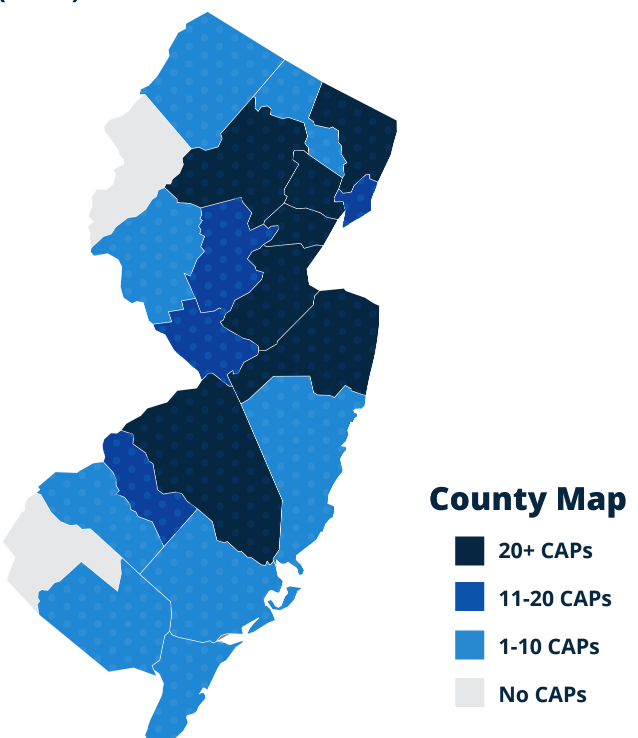
Primary Care Provider Types and Specializations

While some clinicians treat youth from birth through late adolescents, others specialize in specific age groups. Although primary care providers are clinically trained to treat youth, their training is more generalized, not specifically focused on mental health.

- **Pediatricians:** Doctors specializing in children and adolescents.
- **Family Medicine Physicians:** Doctors specializing in generalized medicine and trained to treat patients of all ages including youth.
- **Child Developmental Pediatricians:** Specialized pediatricians that have received additional training in developmental behavioral disorders including diagnosing and treating intellectual and developmental disabilities (I/DD).
- **Child and Adolescent Psychiatrists:** Doctors trained in mental health for children and adolescents, including related medications. Some may also provide mental health therapy services. Adult psychiatrists may also treat youth, especially older adolescents, at their own discretion but do not have pediatric-specific training.
- **Advanced Practice Nurses (APNs):** APNs (also called advanced practice registered nurses (APRN) are registered nurses (RNs) who have completed graduate-level education in an advanced nursing specialty.
- **Nurse Practitioners (NPs):** NPs are a type of APN who receive advanced training focused on a specific patient population (e.g., family, pediatric, or psychiatric-mental health).
- **Physician Assistants (PA):** PAs complete an accredited graduate-level PA program and work directly under the supervision of a physician.

Figure G1

NJ Practicing Child and Adolescent Psychiatrists (CAPs)



Source: American Academy of Child & Adolescent Psychiatry (AACAP) - https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx. Accessed April 2, 2026. "American Medical Association (AMA) is the source for the raw physician data; statistics, tables or tabulations were prepared by the American Academy of Child and Adolescent Psychiatry (AACAP) using AMA Masterfile data received January 2024.

I
II
III
IV

APPENDICES

Understanding Mental Health Provider Credentials

The following types of professional licensees provide mental health services to youth[122] and are overseen by the NJ Office of the Attorney General (OAG), Division of Consumer Affairs (Div.CA). Each profession has a board which requires specific education, examinations, supervised hours, and imposes other ongoing oversight. These professionals are not allowed to prescribe medication.

- **Licensed Clinical Social Workers (LCSW):** LCSWs complete a master's degree in social work and 3,000 supervised hours. Licensed Social Workers (LSW) have completed their master's degree but must work under supervision.
- **Licensed Marriage and Family Therapists (LMFT):** LMFTs complete a master's degree in marriage and family therapy (or related major) and 4,500 supervised hours. Licensed Associate Marriage and Family Therapists (LAMFT) have completed their master's degree but must work under supervision.
- **Licensed Professional Counselors (LPC):** LPCs complete a master's degree in counseling (or related major) and 3,000-4,500 supervised hours. Licensed Associate Counselors (LAC) have completed their master's degree but must work under supervision.
- **Psychologists:** Psychologists complete a doctoral degree, either a PhD or a PsyD, typically completing 5-8 or 4-6 years of schooling respectively, and 3,500 supervised hours. Additional postdoctoral training may be required depending on the program.[123]

Note: See section "Provision of Applied Behavior Analysis (ABA) Services" for information about Applied Behavior Analysts.

[122] Claibourne Counseling. (n.d.). *What do all those letters mean (LPC, LCSW, LMFT, PsyD)?* https://claibournecounseling.com/what-do-all-those-letters-mean-lpc-lcsw-lmft-psyd/

[123] https://www.psychology.org/degrees/phd/

Table H1

Psychotherapy Providers Actively Licensed in New Jersey

License Type	Number of Individuals
Practicing Psychologist	3,499
Psychologist (Three-Year Permit)*	174
Marriage and Family Therapist	653
Associate Marriage and Family Therapist*	374
Professional Counselor	7,215
Associate Counselor*	2,963
Licensed Clinical Social Worker	12,256
Licensed Social Worker*	9,552
Provider Without Required Supervision	23,623
Provider With Required Supervision*	13,063
Total	**36,686**

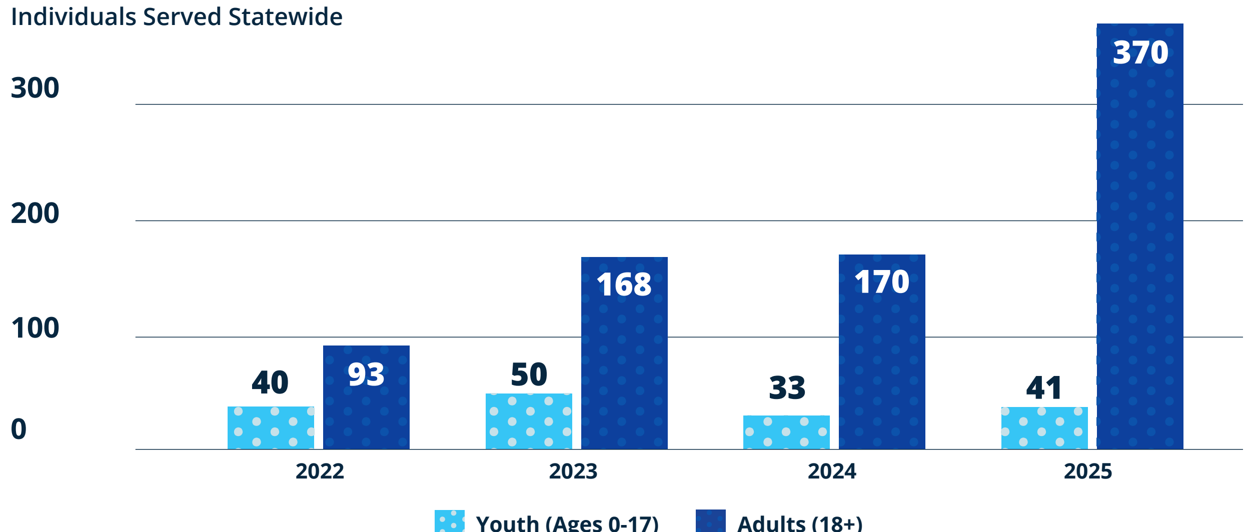
Source: NJ Div. CA License Directory. Accessed March 28, 2026.

Providers without asterisks are licensed to practice without supervision while providers with asterisks are need to practice under supervision. Number of individuals includes only those with an active license and a New Jersey address on file. Individuals who reported New Jersey residency but listed addresses clearly located outside the United States were excluded; addresses were not otherwise fully verified. Some listed addresses include P.O. boxes and may not reflect the individual's primary residence or practice location in New Jersey. Although all individuals included are licensed to provide services, not all may provide psychotherapy.

Department of Mental Health and Addiction Services Program Data

Figure I1

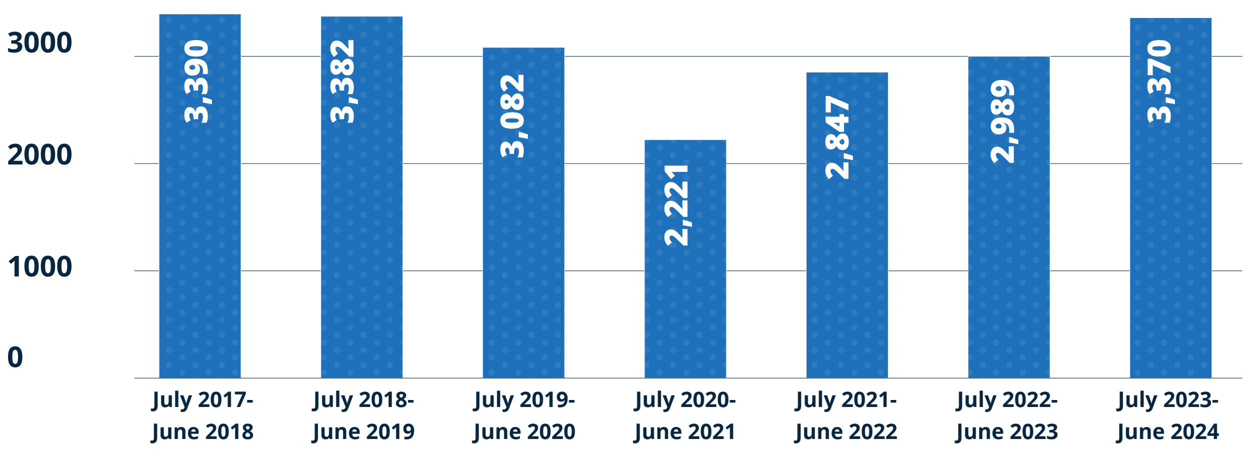
Coordinated Specialty Care
Individuals Served Statewide



Source: NJ DMHAS Data Request

Figure I2

NJ Certified Community Behavioral Health Clinics
State Fiscal Year



Source: NJ DMHAS Data Request
Data collection was discontinued as of July 2024.

Out-of-Home (OOH) Treatment Types and Utilization

Behavioral Health OOH Treatments include the following Intensity of Service (IOS) levels of care:

- Detention Alternative (DAP)
- Emergency Diagnostic Residential Unit (EDRU)
- Intensive Residential Treatment Service (IRTS)
- Group Home (GH)
- Psychiatric Comm Home (PCH)
- Residential Treatment Center (RTC)
- Specialty Bed (SPEC)
- Treatment Home (TH)

I/DD OOH Treatments include the following Intensity of Service (IOS) levels of care:

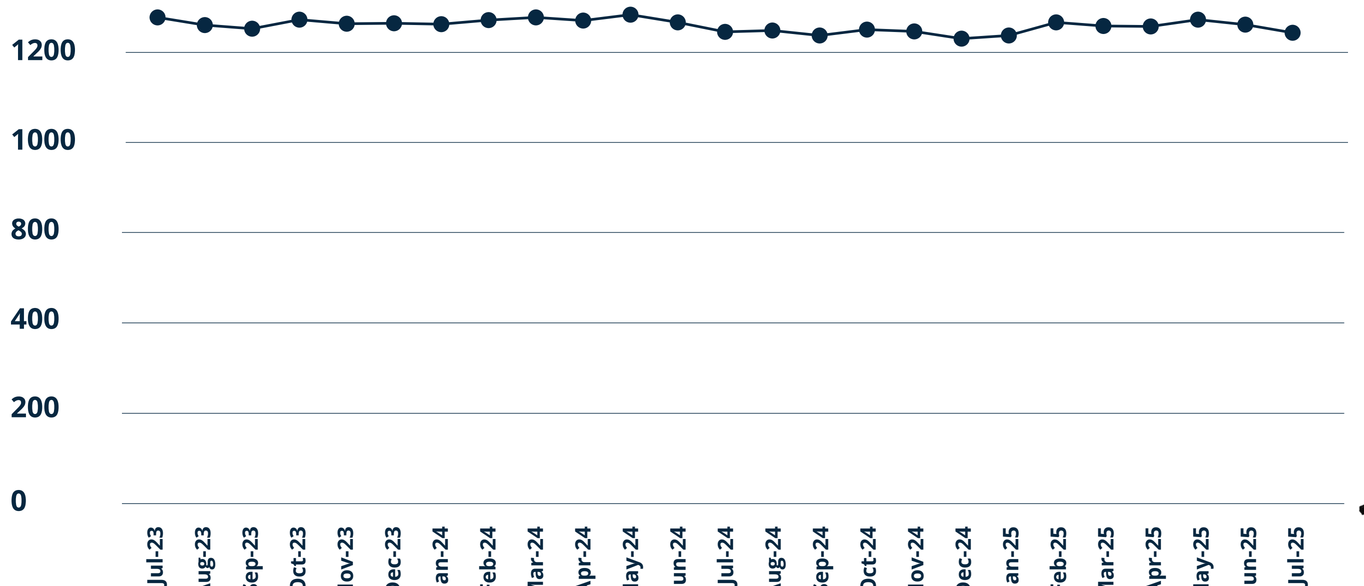
- Crisis Stabilization and Assessment for I/DD (CSAP-IDD)
- Group Home/Level 1 for I/DD (GH 1-IDD)
- Group Home/Level 2 for I/DD (GH 2-IDD)
- Intensive I/DD (INT-IDD)
- Intensive PCH for I/DD (IPCH-IDD)
- Out of State Residential for I/DD (ORT-IDD)
- Psychiatric Community Homes for I/DD (PCH-IDD)
- OOH IDD Respite (RESP-IDD)
- Residential Treatment Center - Co-Occurring BH/DD (RTC-BH/DD)
- Special Skill Homes for I/DD (SSH-IDD)

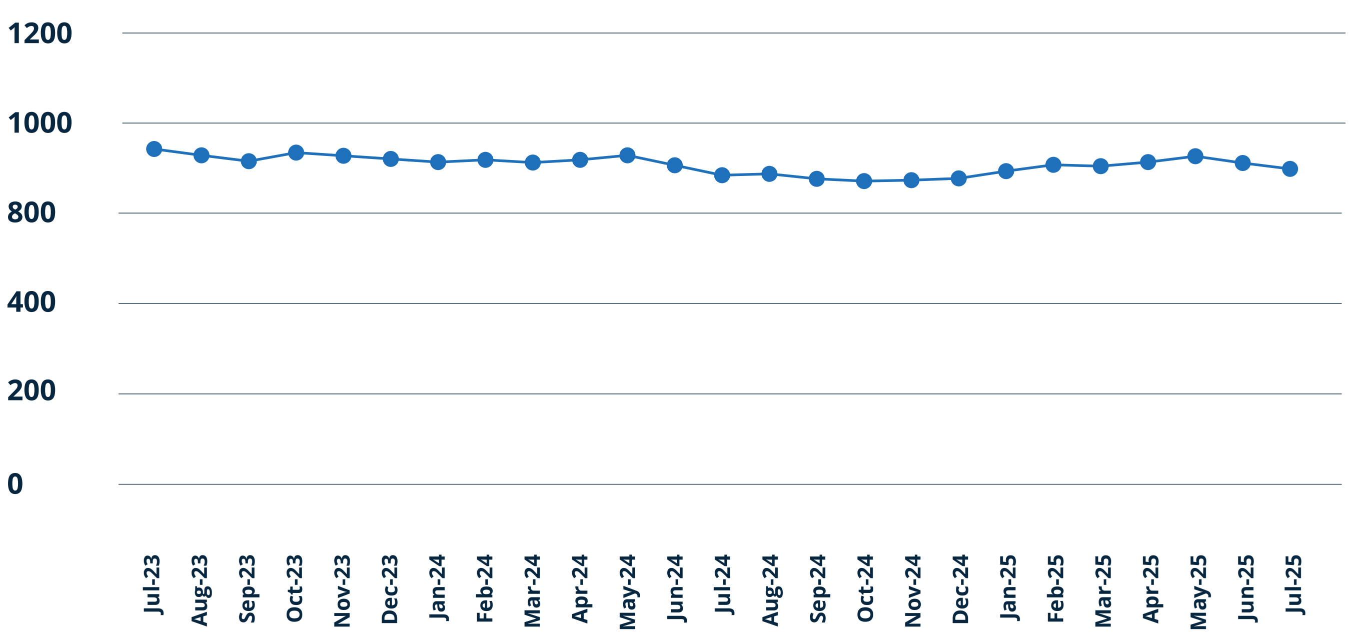
Substance Use OOH Treatments include the following Intensity of Service (IOS) levels of care:

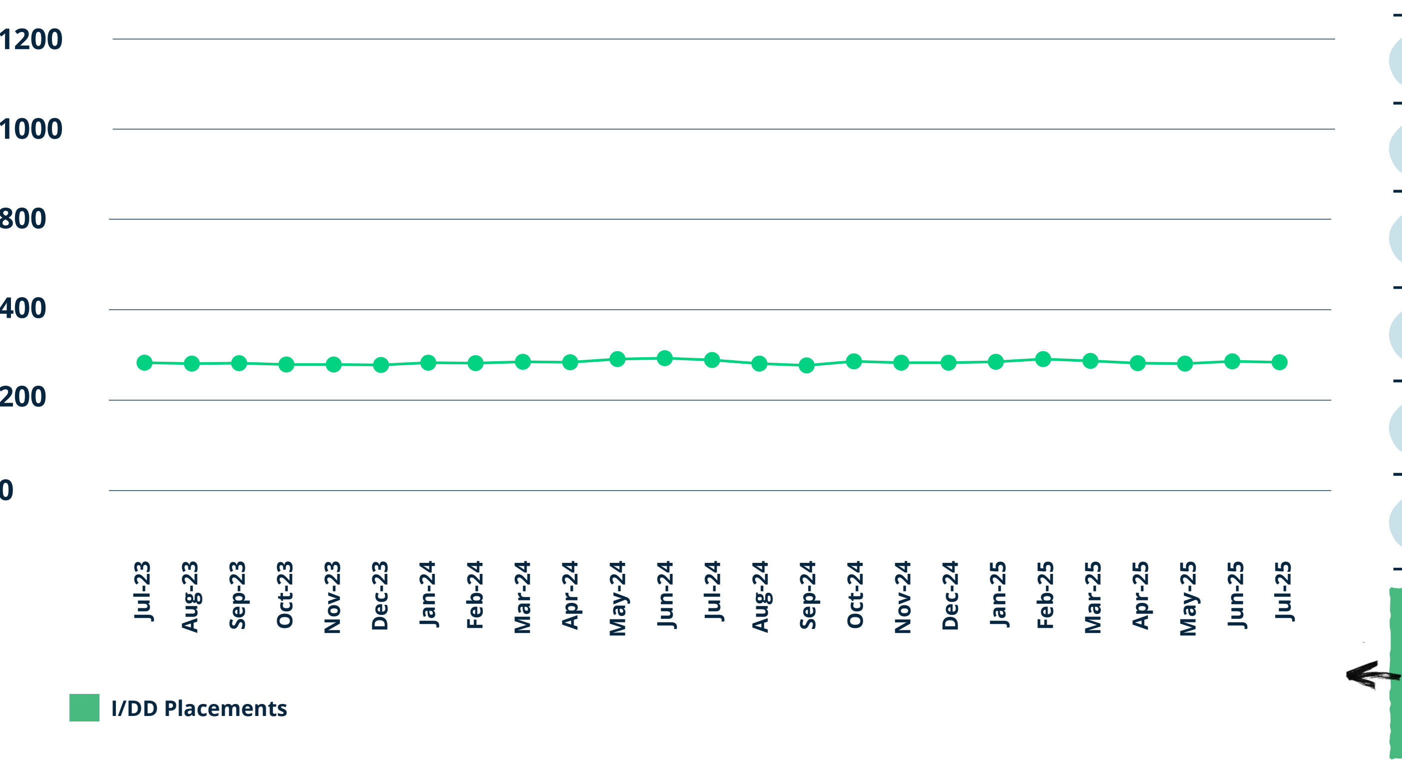
- Detox
- Residential Treatment Center - Co-Occurring BH/SU (RTC-BH/SU)
- Residential Treatment-Short Term SU (RTC-ST-SA)
- Residential Treatment-Short Term SJI (RTC-ST-SJI)

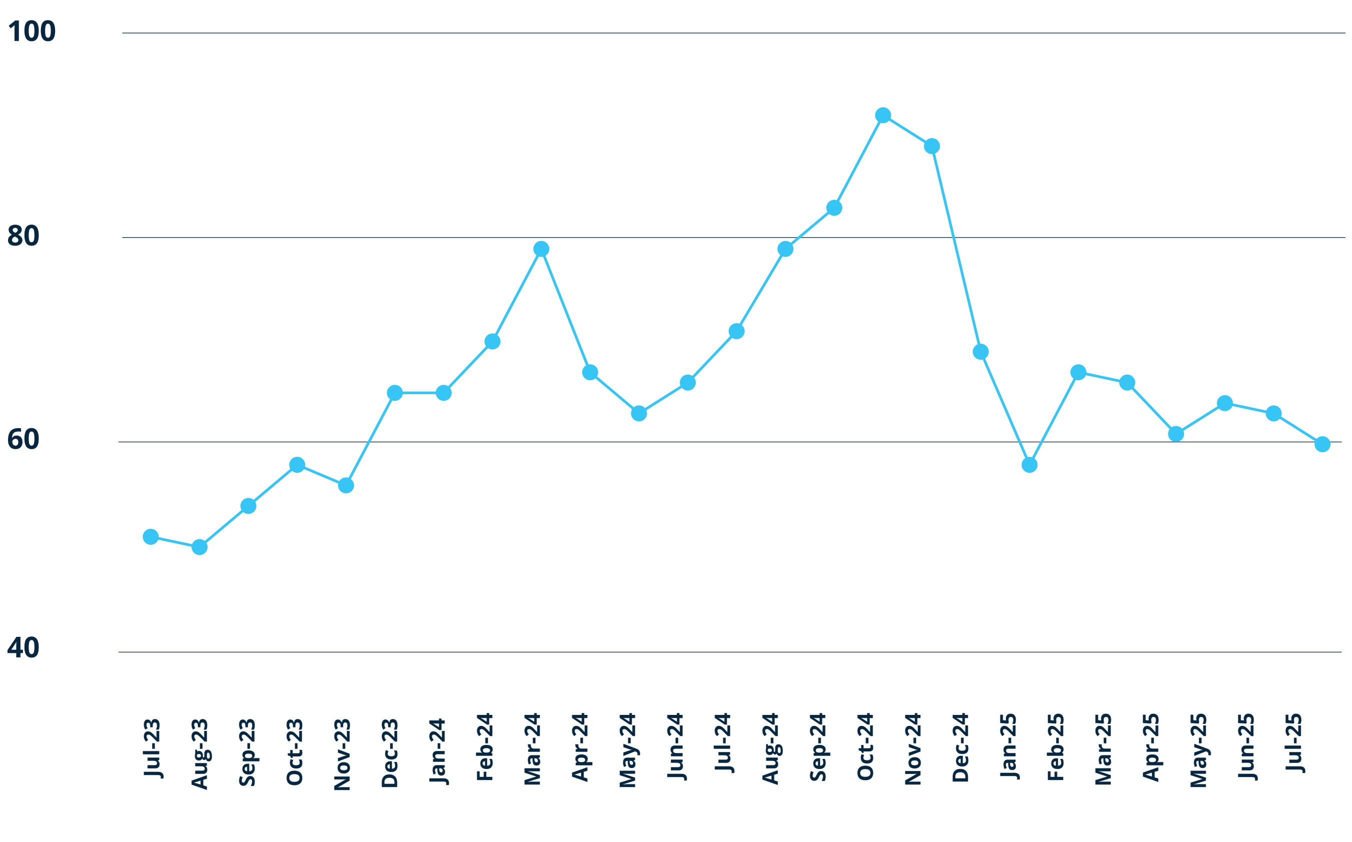
Figure J1

Youth in a CSOC Out-of-Home Treatment









Source: NJ DCF Data Request
Data was collected via monthly point-in-time counts. Youth defined as ages 0-20.

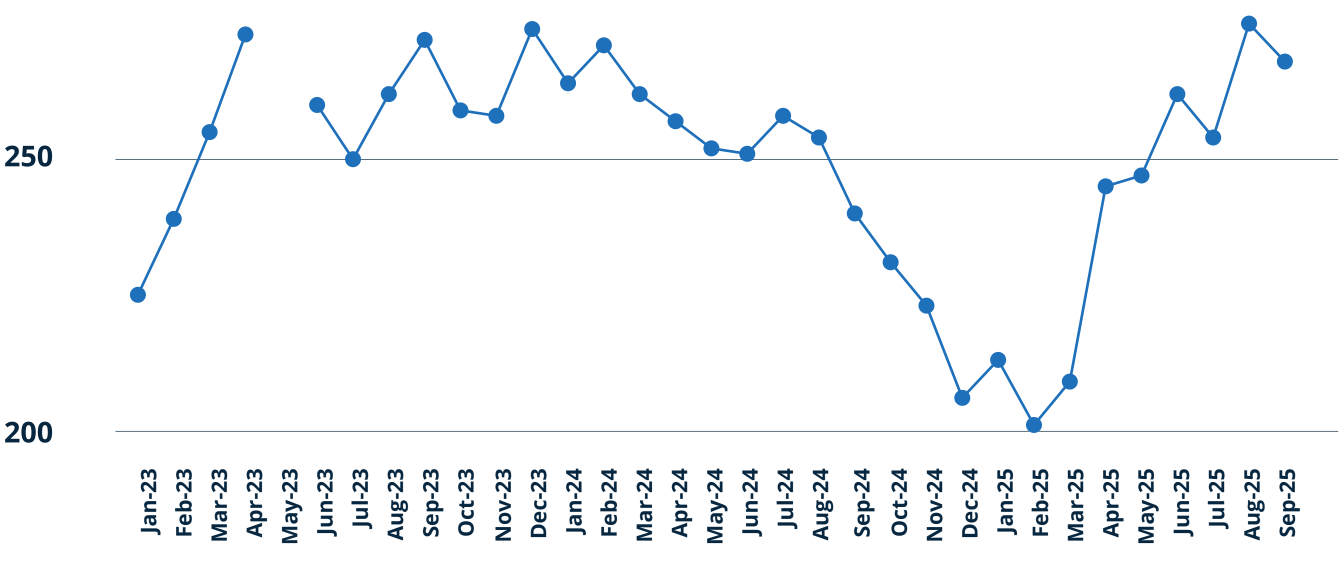
Figure J2

Youth on a Waiting List for CSOC OOH Treatment

400
200
300

Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24 Jan-25 Feb-25 Mar-25 Apr-25 May-25 Jun-25 Jul-25 Aug-25 Sep-25

All OOH Placements



I/DD Placements

Substance Use Placements

Source: NJ DCF Data Request
Data was collected via monthly point-in-time counts. Youth defined as ages 0-20.

Totals exclude the following levels of care:

Behavioral Health Treatments – Detention Alternative (DAP). I/DD Health Treatments - OOH IDD Respite. Substance Use Treatments - Detox, Residential Treatment-Short Term Substance Use, Residential Treatment-Short Term South Jersey Initiative (SJI).

Table J3

CSOC OOH Treatments by Level of Care

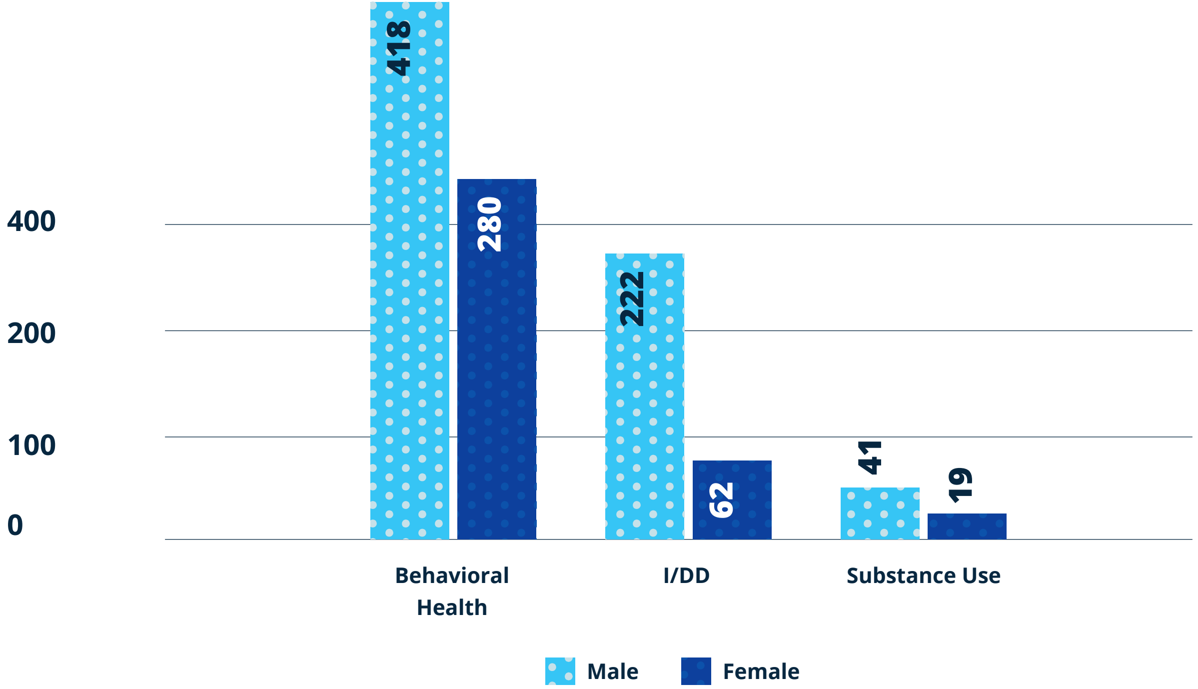
License Type	Contracted Beds	Admitted Youth	Admitted Youth - Average Days on Waitlist	Youth on Waiting List	Average Days on Waitlist	Maximum Days on Waitlist
Behavioral Health						
Emergency Diagnostic Residential Unit	20	15	-	-	-	-
Intensive Residential Treatment Services	55	38	-	-	-	-
Group Home	62	51	67	19	75	217
Psychiatric Community Home	176	132	98	70	111	554
Residential Treatment Center	231	174	86	84	67	430
Specialty Bed	212	172	72	59	74	385
Treatment Home	542	117	53	43	99	557
Totals	**1,298**	**699**	**-**	**275**	**-**	**-**
I/DD						
Group Home/Level 1 for I/DD	79	65	259	20	241	819
Group Home/Level 2 for I/DD	60	42	183	10	57	171
Intensive PCH for I/DD	15	14	352	7	426	822
Psychiatric Community Homes for I/DD	68	51	233	39	223	1,645
Special Skill Homes for I/DD	37	6	93	2	909	1,256
Special Programs for I/DD	0	0	0	1	506	506
CSAP-IDD	42	30	120	37	191	737
Intensive-IDD	15	13	223	16	233	821
Residential Treatment Center for BH/DD	15	14	279	15	187	829
Out-of-State Residential for I/DD	73	49	-	-	-	-
Totals	**404**	**284**	**-**	**147**	**-**	**-**

Substance Use						
Detox	4	2	-	-	-	-
Residential Treatment Center Behavioral Health/Substance Use	44	38	-	-	-	-
Residential Treatment-Short Term South Jersey Initiative	3	2	-	-	-	-
Residential Treatment-Short Term Substance Abuse	19	18	-	-	-	-
Totals	**70**	**60**	**-**	**-**	**-**	**-**
All OOH Treatment Beds	**1,772**	**1,043**				

Source: NJ DCF Data Request.
Data was accessed on July 31, 2025 capturing a point-in-time count. EDRU and IRTS are emergency services with no waitlist. Waitlists for Out-of-State Residential for I/DD and Substance Use placements were not reported. Special Programs for I/DD IOS level of care is no longer offered. Youth defined as ages 0-20.

Figure J4

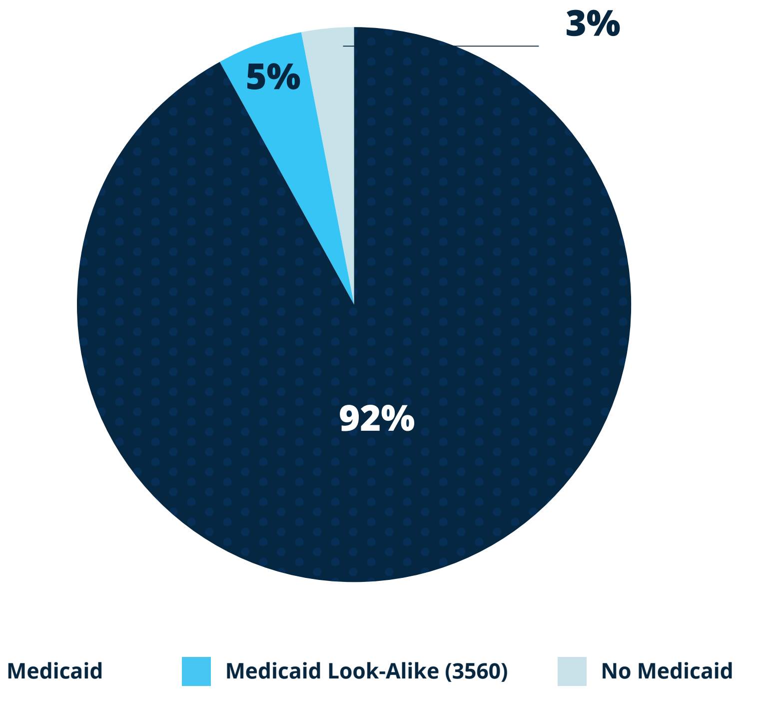
CSOC OOH Treatments by Gender



Source: NJ DCF Data Request.
Data was accessed on July 31, 2025 capturing a point-in-time count. For this report, gender is reported as a binary option of male or female. One youth's gender was unavailable. Youth defined as ages 0-20.

Figure J5

CSOC OOH Treatments by Payor

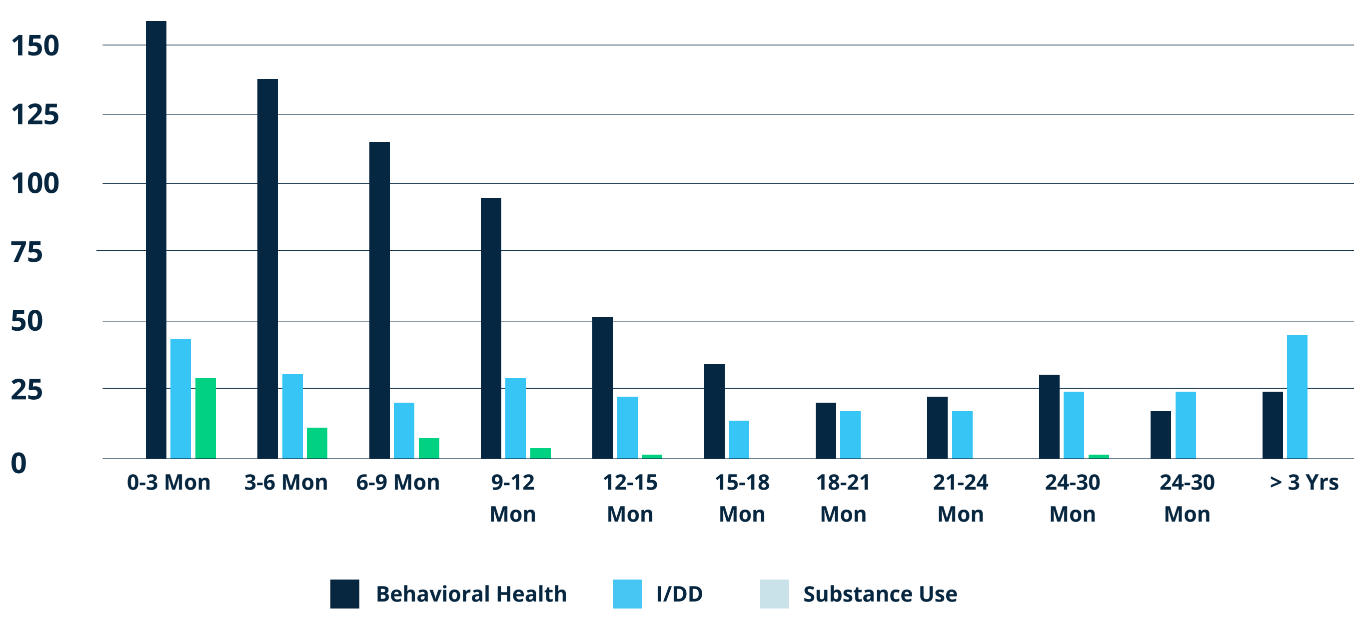


Medicaid   Medicaid Look-Alike (3560)   No Medicaid

Source: NJ DCF Data Request.
Data was accessed on July 31, 2025 capturing a point-in-time count. One youth's Medicaid status was unavailable. No longer offered. Youth defined as ages 0-20.

Figure J6

CSOC OOH Treatments by Length of Stay



Behavioral Health   I/DD   Substance Use

Source: NJ DCF Data Request.
Data includes youth with OOH placement activity between 7/1/2025 and 7/31/2025. Youth defined as ages 0-20.

Map J7

Children's System of Care Out-of-Home Treatment Contracted Beds

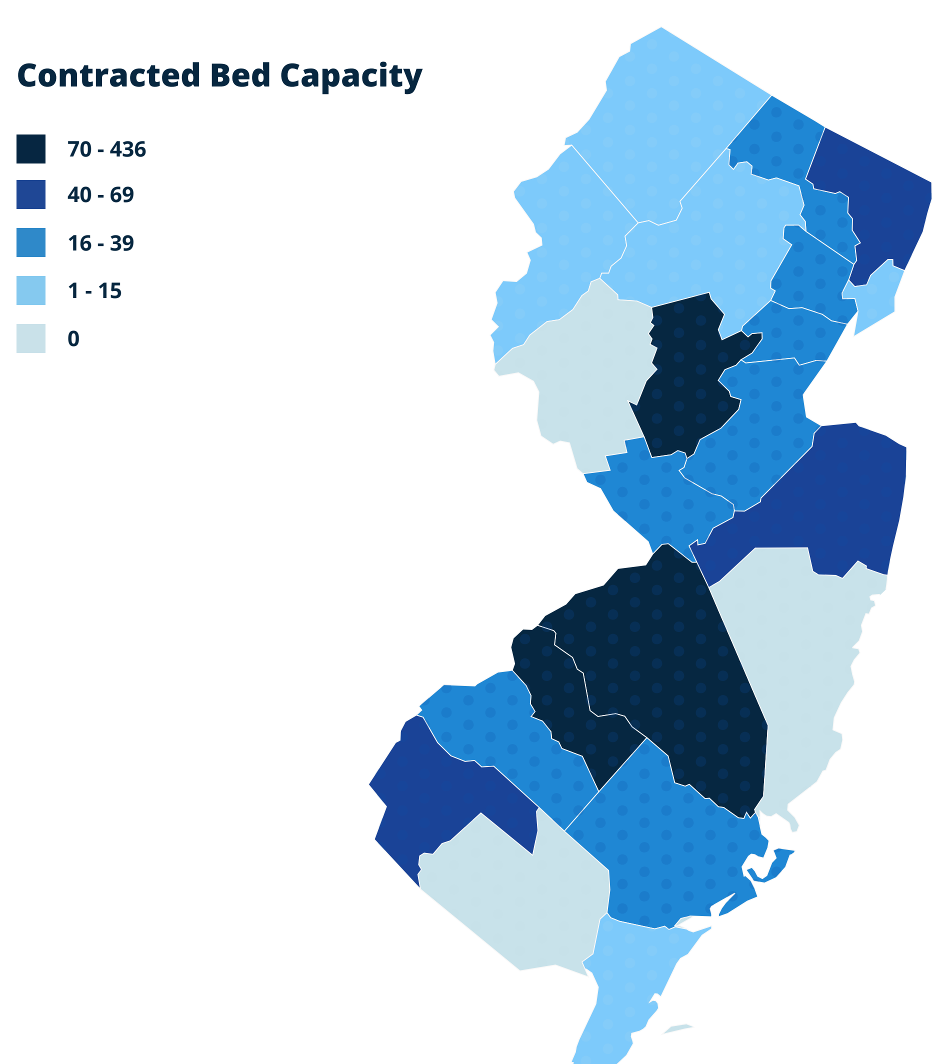


Table J8

Children's System of Care Out-of-Home Treatment Contracted Beds

County	Contracted Capacity
Atlantic	23
Bergen	69
Burlington	436
Camden	280
Cape May	5
Cumberland	0
Essex	32
Gloucester	35
Hudson	5
Hunterdon	0
Mercer	39
Middlesex	26
Monmouth	59
Morris	15
Ocean	0
Passaic	35
Salem	55
Somerset	267
Sussex	5
Union	20
Warren	5
Total	**1,411**

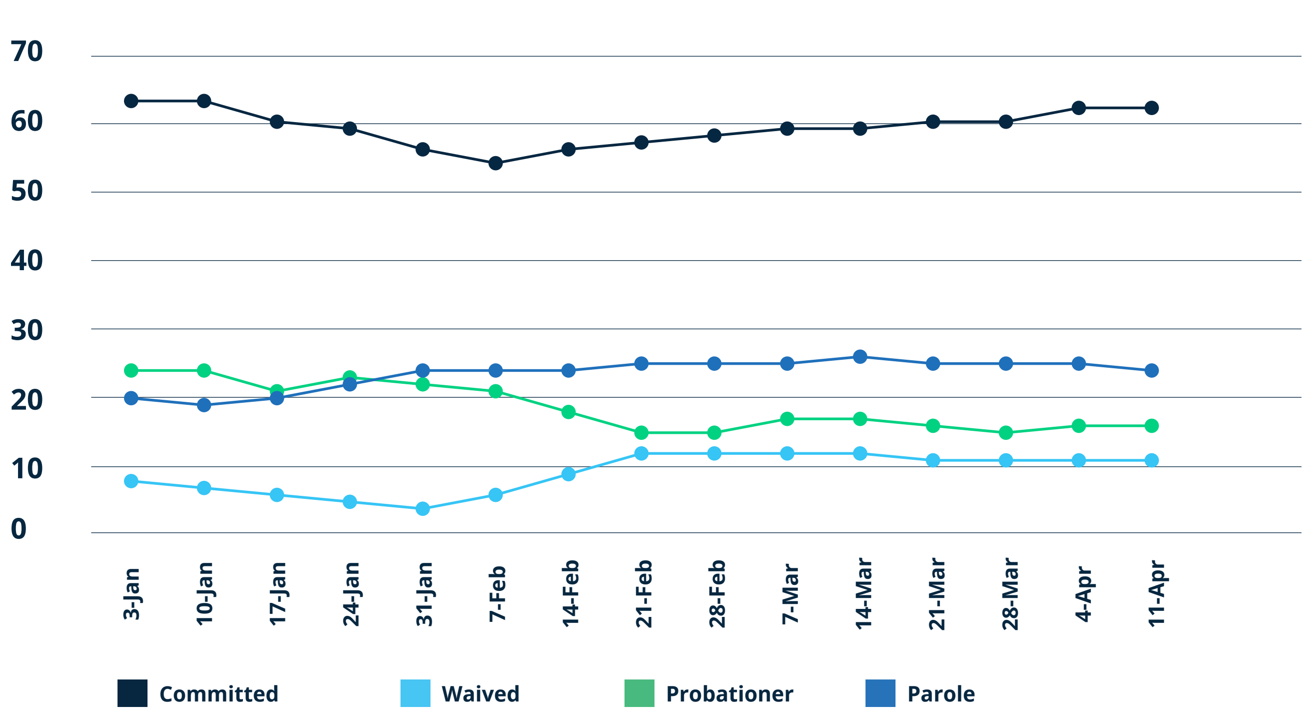
Source: DCF. Last Updated on January 5, 2026.

Children's System of Care (CSOC) contracted out-of-home (OOH) treatment beds. Contracted capacity may be higher than the actual number of beds available to youth due to constraints including staff, space, and resources available. Includes the following Intensity of Service (IOS) levels: Group Home/Level 1 for I/DD, Residential Treatment-Short Term South Jersey Initiative, Detox, Psychiatric Community Homes for I/DD, Psychiatric Community Home, Group Home/Level 2 for I/DD, Residential Treatment Center, Residential Treatment Center Behavioral Health/Substance Use, Group Home, Specialty Program, Residential Treatment Center for BH/DD, Treatment Home, Intensive PCH for I/DD, Intensive-IDD, Special Skill Homes for I/DD, and Residential Treatment-Short Term Substance Abuse.

Youth Justice Commission Data

Figure K1

2025 Youth Justice Commission Statistics
Youth Ages 0-17



Source: NJ Office of the Attorney General Juvenile Justice Commission. Accessed April 6, 2026. 2025 data unavailable past April 11, 2025.

APPENDIX L:

Hospital Volume and Utilization Data

Table L1

NJ Hospitals ED and Inpatient Admissions
For Youth Ages 0-17[1] with a Mental Health Diagnosis

		2023	2024
North Jersey[2]			
	Emergency Department - Primary Diagnosis[3]	8,978	7,679
	Emergency Department - Any Diagnosis[4]	18,528	19,462
	Inpatient Admission - Primary Diagnosis[3]	1,965	1,978
	Inpatient Admission - Any Diagnosis[4]	3,675	3,838
Central Jersey[2]			
	Emergency Department - Primary Diagnosis[3]	4,797	4,560
	Emergency Department - Any Diagnosis[4]	10,001	10,828
	Inpatient Admission - Primary Diagnosis[3]	630	580
	Inpatient Admission - Any Diagnosis[4]	1,718	1,778
South Jersey[2]			
	Emergency Department - Primary Diagnosis[3]	3,306	3,550
	Emergency Department - Any Diagnosis[4]	5,710	6,065
	Inpatient Admission - Primary Diagnosis[3]	836	920
	Inpatient Admission - Any Diagnosis[4]	1,312	1,411
Jersey Shore[2]			
	Emergency Department - Primary Diagnosis[3]	4,167	3,443
	Emergency Department - Any Diagnosis[4]	9,496	9,375
	Inpatient Admission - Primary Diagnosis[3]	740	705
	Inpatient Admission - Any Diagnosis[4]	1,384	1,377
Statewide			
	Emergency Department - Primary Diagnosis[3]	21,248	19,232
	Emergency Department - Any Diagnosis[4]	43,735	45,730
	Inpatient Admission - Primary Diagnosis[3]	4,171	4,183
	Inpatient Admission - Any Diagnosis[4]	8,089	8,404

Source: NJ DOH - New Jersey State Health Assessment Data. Accessed April 9, 2026.

[1] Youth is defined as 0-17 years of age at time of service.

[2] The county that service was provided in.
North Jersey Counties: Bergen, Essex, Hudson, Morris, Passaic, Sussex, Warren
Central Jersey Counties: Hunterdon, Mercer, Middlesex, Somerset, Union
South Jersey Counties: Burlington, Camden, Cumberland, Gloucester, Salem,
Jersey Shore Counties: Atlantic, Cape May, Monmouth, Ocean

[3] Primary diagnosis of mental and behavioral disorders (by ICD-10-CM Chapter).

[4] Any youth encounter with any DX code starting with F. The presence of a mental or behavioral health diagnosis in the record may vary across providers and hospital settings. Clinicians may differ in whether they document behavioral health conditions when those conditions are not central to the presenting complaint, and documentation may also depend on whether the condition is known to the provider or disclosed by the patient or family. As a result, the data may inconsistently capture mental and behavioral health comorbidity across otherwise similar encounters. These factors limit the precision of the measure and mean that reported counts should be interpreted as a broader indicator of hospital utilization among youth with documented mental or behavioral health conditions, rather than as a direct measure of visits primarily attributable to a behavioral health emergency.

Table L2

NJ Hospitals Service Volume
Unique Youth (Ages 0-17)[1]

		2023	2024	2025
North Jersey[2]				
	Mental Health Outpatient[3] (excluding PHP and IOP)	19,172	18,892	16,767
	Mental Health PHP or IOP program[4]	10,933	9,534	9,078
	Eating Disorder Diagnosis[5]	125	147	185
	I/DD Diagnosis[6]	119	165	170
	Substance Use Disorder Diagnosis[7]	538	511	586
Central Jersey[2]				
	Mental Health Outpatient[3] (excluding PHP and IOP)	30,104	28,212	18,808
	Mental Health PHP or IOP program[4]	698	464	5,439
	Eating Disorder Diagnosis[5]	1,120	646	931
	I/DD Diagnosis[6]	35	59	52
	Substance Use Disorder Diagnosis[7]	559	764	755
South Jersey[2]				
	Mental Health Outpatient[3] (excluding PHP and IOP)	278	251	221
	Mental Health PHP or IOP program[4]	125	114	118
	Eating Disorder Diagnosis[5]	3	3	1
	I/DD Diagnosis[6]	0	0	0
	Substance Use Disorder Diagnosis[7]	53	86	80

		2023	2024	2025
Jersey Shore[2]				
	Mental Health Outpatient[3] (excluding PHP and IOP)	2,591	3,359	3,834
	Mental Health PHP or IOP program[4]	276	286	281
	Eating Disorder Diagnosis[5]	38	42	58
	I/DD Diagnosis[6]	13	34	34
	Substance Use Disorder Diagnosis[7]	282	342	401
Statewide				
	Mental Health Outpatient[3] (excluding PHP and IOP)	52,145	50,714	39,630
	Mental Health PHP or IOP program[4]	12,032	10,398	14,916
	Eating Disorder Diagnosis[5]	1,286	838	1,175
	I/DD Diagnosis[6]	167	258	256
	Substance Use Disorder Diagnosis[7]	1,432	1,703	1,822

Source: Hospital Data Request. Data is not representative of all hospitals in NJ; only those that shared data.

[1] Youth is defined as 0-17 years of age at time of service.

[2] The county that service was provided in.
North Jersey Counties: Bergen, Essex, Hudson, Morris, Passaic, Sussex, Warren
Central Jersey Counties: Hunterdon, Mercer, Middlesex, Somerset, Union
South Jersey Counties: Burlington, Camden, Cumberland, Gloucester, Salem
Jersey Shore Counties: Atlantic, Cape May, Monmouth, Ocean

[3] Mental health outpatient services defined as the following CPT codes: 90791-90792, 90832-90834, 90836-90839, 90846, 90847, 90853, 90870, 90887, 99202-99205, 99211-99215, H0014, H0023, H0038, Rev Code 901, Rev Code 914-916, and Rev Code 919.

[4] Mental health Partial Hospitalization Program (PHP) or Intensive Outpatient Program (IOP) defined as the following CPT codes: Rev Code 912-913, H0035, A0120, Z0330, A0425, H0015, and H2036.

[5] Youth receiving any hospital care with a documented DX code F50, including any variation of the code groups listed (e.g., F50.XX).

[6] Youth receiving any hospital care with a documented DX code F70-79, including any variation of the code groups listed (e.g., F70.XX).

[7] Youth receiving any hospital care with a documented DX code F10-F19, including any variation of the code groups listed (e.g., F10.XX).

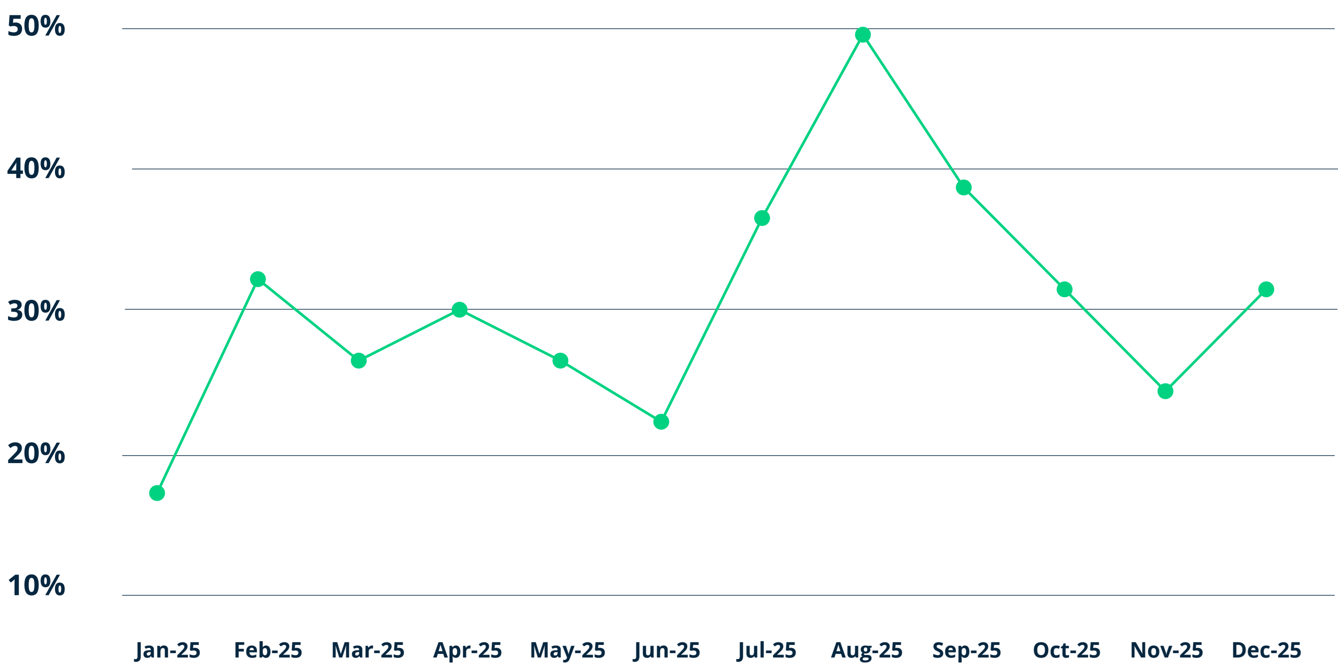
The presence of an eating disorder, I/DD, or substance use disorder diagnosis in the record may vary across providers and hospital settings. Clinicians may differ in whether they document behavioral health conditions when those conditions are not central to the presenting complaint, and documentation may also depend on whether the condition is known to the provider or disclosed by the patient or family. As a result, the data may inconsistently capture mental and behavioral health comorbidity across otherwise similar encounters. These factors limit the precision of the measure and mean that reported counts should be interpreted as a broader indicator of hospital utilization among youth with documented mental or behavioral health conditions, rather than as a direct measure of services primarily attributable to the diagnosis.

Table L3

2025 NJ Pediatric Psychiatric Bed Capacity - Licensed vs. Actual Availability	
	% of Licensed Beds Actually Available (on average)
North Jersey	26%
Central Jersey	23%
South Jersey and Jersey Shore	50%
Number of hospitals reporting no availability at point-in-time counts	2

Figure L4

Percentage of Licensed Pediatric Psychiatry Beds Available for Admission - by Month



Source: Hospital Data Request. Data was collected via monthly point-in-time counts throughout 2025. Data is not representative of all hospital in NJ; only those that shared data.

Available capacity represents beds that are available to accept patients - unoccupied, operational, and fully staffed (not merely licensed or physically open). Averages are calculated among participating hospitals' licensed capacity. Participating hospitals represented 47% of statewide licensed capacity. To protect data anonymity, the Shore and South Jersey regions are combined, and intermediate and acute levels of care are also reported in aggregate. Reports of no availability at the monthly point-in-time count excludes licensed but inactive pediatric psychiatric units.

North Jersey Counties: Bergen, Essex, Hudson, Morris, Passaic, Sussex, Warren
Central Jersey Counties: Hunterdon, Mercer, Middlesex, Somerset, Union
South Jersey and Jersey Shore Counties: Burlington, Camden, Cumberland, Gloucester, Salem, Atlantic, Cape May, Monmouth, Ocean

Table L5

Behavioral Health Care by Service Type at Children's Hospital of Philadelphia (CHOP)
Patients Served with Primary NJ Address at Time of Encounter
(January 2024-December 2025)

County	ED	Inpatient	Outpatient	PHP/IOP	Total
Atlantic	17	86	622	195	920
Bergen	1	20	120	0	141
Burlington	48	165	1,497	15	1,725
Camden	44	225	1,707	20	1,996
Cape May	6	26	183	29	244
Cumberland	5	26	188	0	219
Essex	0	32	116	0	148
Gloucester	33	108	828	8	977
Hudson	0	9	46	0	55
Hunterdon	4	16	96	0	116
Mercer	4	84	643	2	733
Middlesex	5	70	341	0	416
Monmouth	7	71	443	1	522
Morris	0	27	116	1	144
Ocean	6	129	484	6	625
Passaic	0	17	51	0	68
Salem	2	13	72	0	87
Somerset	2	25	181	2	210
Sussex	0	9	29	0	38
Union	1	41	129	1	172
Warren	1	12	37	0	50
Unknown County/Other	1	4	44	0	49
Total	**187**	**1,215**	**7,973**	**280**	**9,655**

Source: Children's Hospital of Philadelphia (CHOP) Data Request

Table L6

Behavioral Health Care by Diagnosis at Children's Hospital of Philadelphia
Patients Served with Primary NJ Address at Time of Encounter
(January 2024-December 2025)

County	Eating Disorder	I/DD	Substance Use Disorder	Other Categories	Total
Atlantic	30	20	6	862	918
Bergen	3	5	0	134	142
Burlington	86	35	16	1,628	1,765
Camden	109	43	30	1,879	2,061
Cape May	19	3	6	229	257
Cumberland	7	5	3	205	220
Essex	0	4	2	141	147
Gloucester	57	20	17	912	1,006
Hudson	1	0	0	53	54
Hunterdon	5	4	1	113	123
Mercer	41	20	7	709	777
Middlesex	16	6	4	398	424
Monmouth	17	16	3	494	530
Morris	9	2	0	137	148
Ocean	39	9	4	590	642
Passaic	2	1	0	64	67
Salem	6	2	2	84	94
Somerset	14	4	0	200	218
Sussex	1	2	1	36	40
Union	10	2	1	155	168
Warren	2	3	1	47	53
Unknown County/Other	3	1	0	49	53
Total	**477**	**207**	**104**	**9,119**	**9,907**

Source: Children's Hospital of Philadelphia (CHOP) Data Request

Table L7

Children's Hospital of Philadelphia - Distance Traveled for Behavioral Health Care
Unique Patients Served with Primary NJ Address at Time of Encounter
(January 2024-December 2025)

	NJ Patients	Percentage of NJ Patients
30 miles	4,788	52%
50 miles	2,664	29%
75 miles	424	5%
Total Youth with Zip Code Data	9,189	

Source: Children's Hospital of Philadelphia (CHOP) Data Request

Geospatial analysis was based on patient ZIP code of residence rather than exact address and may therefore underestimate actual travel distance, particularly in more rural or larger ZIP Code Tabulation Areas. Distance was calculated between CHOP's main building (3401 Civic Center Boulevard Philadelphia, PA, 19104) to patient address.

Secret Shopper Study - Commercial Insurance Network Adequacy

A Secret Shopper Review of a Commercial Insurance Network Directory Listings for Youth Mental Health Providers

In the absence of government oversight and independent audits to review, the Quality Institute created a secret shopper survey of commercial insurance networks to assess functional network access to youth mental health care. The Quality Institute engaged the Eagleton Center for Public Interest Polling at Rutgers University (Rutgers) to conduct the secret shopper calls and other checks of the Horizon Blue Cross Blue Shield NJ (Horizon BCBSNJ) OMNIA network, with advance notice to Horizon BCBSNJ. Horizon Omnia was selected as the Horizon product for review because it is a widely utilized commercial plan in New Jersey with broad provider participation and availability in the individual and employer markets. Initially, the commercial secret shopper methodology intended to include both Horizon and Aetna plans, as both insurers administer coverage through the State Health Benefits Program (SHBP) and maintain significant commercial market presence in New Jersey. However, due to legal language included in Aetna provider directory materials prohibiting use of the directory data for certain external review purposes and the inability to access directory data in a machine-readable format suitable for research use, the study ultimately proceeded with the Horizon commercial network analysis only.[124]

The secret shopper survey was designed to evaluate real-world access by assessing whether providers listed in the network directory could be reached, whether they were accurately represented as participating providers, and whether an adolescent with low-acuity mental health needs could obtain an in-person appointment within two weeks.

METHODOLOGY

The Quality Institute used a secret shopper methodology to evaluate Horizon BCBSNJ's Omnia commercial network for certain types of outpatient mental health providers for adolescents. This approach provides a more meaningful assessment of both directory accuracy and access than a review of provider listings alone. The calls were conducted between March 16 and March 27, 2026, by Rutgers on behalf of the Quality Institute.

The sample frame included all 881 therapy providers listed in the Horizon BCBSNJ Omnia directory who met the study criteria. Directory searches were limited to Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselor (LPCs), Psychologists, and Social Workers with NJ addresses. Additional filters restricted results to providers reported as accepting new patients, serving youth (13-17), and offering in-person care.   This resulting sample included 881 providers across all 21 counties. Nearly half offered scheduling through the Headway, LLC platform, while the remaining providers required scheduling by telephone.

[124] The Aetna Terms of Use contains the following warning language: "By using Provider Search, you acknowledge and agree that Provider Search and all of the data contained in Provider Search belongs exclusively to Aetna Inc. and is protected by copyright and other law. Provider Search is provided solely for the personal, non-commercial use of current and prospective Aetna members and providers. Use of any robot, spider or other intelligent agent to copy content from Provider Search, extract any portion of it or otherwise cause Provider Search to be burdened with unwarranted high access or transaction activity is strictly prohibited. Aetna reserves all rights to take appropriate civil, criminal or injunctive action to enforce these terms of use."

Aetna. (n.d.). *Print a provider directory*. [Data query system]. https://www.aetna.com/docfind/home.do?site_id=docfind&langpref=en&tabKey=tab5&fromDse=fromDse

- 881 Total Providers
    - 428 (49%) scheduled via Headway platform
    - 453 (51%) scheduled via telephone

To ensure representation across the state, this provider list was stratified by county. In counties with ten or fewer listed providers, all providers were included, with a random sample selected from counties with more than ten providers to select approximately 26% of the total list for the study sample.

- 231 Sampled Providers (26% of Total Providers)
    - 119 (52%) sampled via phone
    - 112 (48%) sampled via Headway online platform

For the providers who scheduled via telephone, researchers posed as a caregiver seeking an in-person mental health appointment for an adolescent (providers were asked to accept a 14-year old youth with low-acuity mental health needs) covered by Horizon BCBSNJ Omnia. Callers used a standardized script and asked whether:

- The provider accepted Horizon Omnia insurance
- The provider was currently practicing at the listed location
- The provider treated adolescents
- The provider was accepting new patients
- An in-person appointment was available within two weeks

Researchers contacted single-practice and small multi-provider practices by telephone. If no one answered a phone call, a voicemail message was left and any follow-up information/call-back was recorded by the researcher. Providers associated with Headway, LLC, were assessed on the same criteria as telephone calls, using the online scheduling platform. Providers who could not be located through Headway's website search tool were also searched for through Google and included if found.

Directory accuracy was defined as whether the provider could be reached and whether the listed information, including phone number, location, insurance participation, and specialty (ages served), was correct. Network adequacy was defined as whether an adolescent could obtain an in-person appointment within two weeks from an in-network provider.

Secret Shopper Findings

The secret shopper analysis found substantial gaps between the number of providers listed in Horizon BCBSNJ's Omnia directory and the number of providers who were available to deliver timely care to a 14-year-old youth. Of the 881 providers who met the study criteria, 231 were sampled. Among sampled providers, only 14.7% were able to offer in-network, in-person appointments within two weeks.

First, directory accuracy was a significant challenge. A notable share of listed providers could not be reached because phone numbers were disconnected or providers could not be identified through the directory or website. Approximately 15% of sampled provider phone calls failed due to a non-working number, incorrect number, or because the voicemail had not been set up. For providers associated with Headway, an online scheduling platform, information could not be located for 9% of providers.

Second, many providers listed in the directory did not accurately list the services they provide or their availability. Some providers did not see youth, some were not accepting new patients, some only offered virtual care, and some did not participate in the Horizon Omnia network.

Finally, of those that were in-network, treated youth, and were reachable, only a limited subset offered in-person appointments within two weeks. Although the directory suggested that almost 900 providers are available across New Jersey to accept new adolescent patients in-person, the number of providers who met all of these criteria was substantially smaller. As a result, families attempting to use the Horizon Omnia directory may experience significant delays, repeated calls, and difficulty finding timely in-network care.

The extent to which directory and appointment information could be confirmed varied across providers for several reasons. In some cases, the calls ended before all information could be collected; in others, the providers required intake forms that prevented reception staff from discussing availability; and, in some, the Headway provider pages were missing address information.

Among the 170 providers in the sample that were successfully contacted[125]:

- Network participation was reviewed for **140** providers:
  - In-Network – **132** (94%)
  - Out-of-Network – **8** (6%)
- Directory address accuracy was reviewed for 134 providers:
  - Correct Address – **88** (66%)
  - Incorrect Address – **46** (34%)
- Availability of in-person appointments was reviewed for 154 providers:
  - In-person availability within 2 weeks – **36** (23%)
  - No in-person availability within 2 weeks – **118** (77%)

Many in-person appointments could not be scheduled because some providers offered only telehealth services (a telehealth appointment within two weeks may have been available) or because the provider served only specific populations (e.g., adults over the age of 18).

- Offered telehealth appointments only – **62**
  - Phone calls – **19** (35% of all phone calls)
  - Headway searches[126] - **43** (43% of all Headway providers)
- Population Restrictions (e.g., age) – **12** (8%)

Overall, the findings suggest that the Horizon BCBSNJ Omnia directory overstates the practical availability of adolescent mental health services. The network may appear adequate on paper, but the real-world experience of families indicates meaningful deficiencies in both directory accuracy and timely access. The findings support the need for stronger standards for directory maintenance, regular verification of provider information, network adequacy requirements that measure whether adolescents can obtain an in-person appointment within a reasonable timeframe, and regulatory oversight and enforcement by DOBI.

[125] 61 providers were unable to be contacted due to unreturned voicemails or directory accuracy issues.

[126] Headway websites varied in reporting telehealth only availability, suggesting that telehealth-only offerings may be underestimated.

Table M1

Commercial Insurance Network Adequacy
Secret Shopper Results

	N	Percentage
Total NJ Providers on Horizion Omnia List	881	
Providers Scheduling via Headway	428	49%
Providers Scheduling via Telephone	453	51%
Male	179	20%
Female	702	80%
Social Worker	428	49%
Licensed Professional Counselor	358	41%
Psychologist	62	7%
Licensed Marriage and Family Therapist	24	3%
Multi-credentialed	9	1%
Total NJ Providers Sampled	231	26%
Headway Lookups	112	26%
Phone Calls	119	26%
Male	53	23%
Female	175	77%
Social Worker	115	50%
Licensed Professional Counselor	86	37%
Psychologist	15	6%
Licensed Marriage and Family Therapist	8	3%
Multi-credentialed	4	2%
Phone Calls	119	
Left Voicemails	43	
No Contact Made: Provider Did Not Call Back	32	74%
Provider Called Back and Left A Voicemail	11	26%
In-person Appointment Available	2	
In-Network	2	
Out-of-Network	0	
Network Not Confirmed	0	

Correct Address	1	
Incorrect Address	0	
Address Not Confirmed	1	
In-person Appointment Not Available	6	
In-Network	5	
Out-of-Network	0	
Network Not Confirmed	1	
Correct Address	3	
Incorrect Address	1	
Address Not Confirmed	2	
Telehealth Only[1]	3	
Not Accepting New Patients	3	
No Information Given	3	
Unable to Confirm	29	
No Contact Made: Non-working telephone/Incorrect Phone Number/No Voicemail Set Up	18	
No Contact Made: Call Blocked	1	
Contact Made: Administrative Barrier (e.g., practice reserved for patients with a specific PCP provider, intake required before discussing availability or insurance, etc.)	10	
In-Network	1	
Out-of-Network	0	
Network Not Confirmed	9	
Correct Address	0	
Incorrect Address	1	
Address Not Confirmed	9	
Contact Made: In-person Appointment Available	4	
In-Network	4	
Out-of-Network	0	
Network Not Confirmed	0	
Correct Address	2	
Incorrect Address	2	
Address Not Confirmed	0	

Contact Made: Provider Unavailable	43	
In-Network	28	
Out-of-Network	1	
Network Not Confirmed	14	
Incorrect Address	5	
Correct Address	18	
Address Not Confirmed	20	
Telehealth Only[1]	16	
Specific Population Exclusion (e.g., Adults Only)	5	
Not Accepting New Patients	16	
Provider No Longer Practicing at Listed Organization (Left practice, supervisory role, etc.)	6	
Headway Look Ups	109	25%
Provider Listed with Headway - No Listing	10	9%
Provider Listed with Headway - Listing	99	91%
In-Network	92	93%
Out-of-Network	7	7%
Network Not Confirmed	0	0%
Correct Address	64	65%
Incorrect Address	22	22%
Address Not Listed	13	13%
In-person appointment available within 2 weeks	30	30%
In-person appointment not available within 2 weeks	69	70%
Telehealth Only[1]	43	
Did Not Accept Adolescents	7	
Total Sample (Phone Calls and Headway)		
Network Participation Confirmed	140	
In-Network	132	94%
Out-of-Network	8	6%
Directory Address Confirmed	134	
Correct Address	88	66%
Incorrect Address	46	34%
In-person Appointment Availability Confirmed	154	
In-person apt. available within 2 weeks	36	23%

In-person apt. NOT available within 2 weeks	118	77%
Telehealth Only[1]	62	
Phone Calls	19	
Headway[2]	43	
Age or Specific Population Restrictions[3]	12	
In Network, In-person apt. available within 2 weeks	34	15%

Source: Data collection conducted by Eagleton Center for Public Interest Polling at Rutgers University on behalf of the Quality Institute.

[1] Telehealth appointments within 2 weeks may have been available.

[2] Headway websites varied in reporting telehealth-only availability, suggesting that telehealth-only offerings may be underestimated.

[3] Providers were asked to accept a 14-year old youth with low-acuity mental health needs.

Qualitative Interview Protocols

1 Stakeholder Interview Questions for Quality Institute (QI) and Central Jersey Family Health Consortium (CJFHC)

PROVIDER STAKEHOLDERS

1. What organization are you representing?
2. Describe the types of services your organization offers for youth and families.
3. What age group do you serve?
4. How does a child get referred to your services?
5. What are the options for treatment and services?
6. What organizations/services do you typically refer out to?
7. What is going well with the services you provide?
8. What are the most significant barriers and/or challenges you face in serving families?
9. What are the most significant gaps in services for the families you serve?
10. Have there been situations where children or families were denied services? If so, why?
11. Are there children or families you are unable to serve even after referral? What are the reasons?
12. From your perspective, how would you describe the overall quality of services available in your area?

COMMUNITY ORGANIZATION STAKEHOLDERS

1. What organization are you representing?
2. Describe the types of supports and services your organization offers for children and youth to mental/behavioral health.
3. What age groups do you primarily serve?
4. How do children typically connect with your organization or get referred to your services?
5. When a family comes to you with mental/behavioral health needs for their child, what kinds of services or resources are you most often connecting them to?
6. What mental/behavioral health organizations or services do you typically refer children out to?
7. From your perspective, what mental/behavioral health needs are you hearing about most often from families about their children in your community?
8. What aspects of your work supporting children's mental/behavioral health are going well?
9. What are the most significant barriers or challenges you face in helping children access mental/behavioral health services?
10. What do you see as the most significant gaps in mental/behavioral health services for the children you work with?

11. Have there been situations where children were unable to access the mental/behavioral health services they needed, even after referral? If so, why?

12. From your perspective, how would you describe the overall accessibility and quality of children's mental/behavioral health services available in your area?

13. Who else should we include in this conversation?

FAMILIES WITH LIVED EXPERIENCE STAKEHOLDERS

1. Where have you received mental health services?

2. Describe the types of services you have received (inpatient, outpatient, case management, medication management etc.)

3. Describe the process that led you to these services.

4. What went well when you were receiving services?

5. Was there anything that you wish had gone differently when you were receiving services?

6. Did you get all of the services you and your family needed?

7. Was there a time when you tried to get help but couldn't? What made it hard to get help?

8. Were you ever told you could not get a service you asked for? If so, what happened?

9. What, if anything, made it hard to get help?

10. How would you describe the quality of the services you received?

11. Is there anything else you'd like to share about your experience accessing mental health services?

2 Stakeholder Interview Questions for Social Emotional Learning for New Jersey (SEL4NJ)

School District Staff Interview Protocol

ORGANIZATIONAL CONTEXT (INTERNAL SUPPORTS)

1. What are the mental health needs of your school and students?
   a. [if needed] what are the mental health needs of your staff?
2. What types of internal supports are students accessing within your schools (Probe: PBIS, CST, Tier 1/2/3/ supports, specific programs, Rutgers Center for Emotional Wellness etc. - LEVEL: elementary, middle school, high school).
3. What staff have a direct role in offering mental wellbeing services and supports to students? (i.e. social workers, school counselors, SEL specialists, anti-bullying specialist or anti-bullying coordinator etc.)
4. What is the caseload for your counselors/social workers/SEL specialist, etc.?

PARTNERS AND COLLABORATION (EXTERNAL SUPPORTS)

1. What types of external youth mental health supports are students accessing within your schools? (Probe: SBYS, NJ4S, NJ Schools of Character - LEVEL: elementary, middle school, high school)
2. What community-based resources or personnel provide mental health supports in your schools?
3. In what ways do those supports meet the needs of your students?

FINANCIAL CONSIDERATIONS

1. How are your mental health supports funded (local, county, state, federal, private)
2. What kinds of funding streams have you used in the past?
3. How has funding changed over the last 5 years?
4. Do you anticipate your funding changing?
5. What are your funding needs moving forward?

COMMUNICATION

1. How do you communicate with external partners or referral agencies?
   a. What kinds of formal connections do you have with external agencies? (MOU, agreements, etc.)
   b. What kinds of informal connections do you have with external agencies?
2. Who do you typically communicate with at those agencies?

EFFECTIVENESS, DATA, IMPACT

1. What data do you collect related to your students' mental health needs?
2. How is that data used/reported?
3. How do you measure success?
4. What does success look like to you?
5. What impacts do you see as a result of this work?

CHALLENGES, GAPS, NEEDS

1. What types of challenges do you see in meeting the mental health needs of your students?
2. What types of supports do you need in your school to respond to student needs?
3. What groups of students or families that you see that need additional support? (race, age, language, ethnicity, religion, transportation, SES, etc.)
   a. What are the typical barriers for those groups?

FUTURE

1. What are your priorities related to school mental health for the next year?
2. What do you need in order to be successful supporting the mental health needs of school communities?
3. If you could do anything to meet the mental health needs of your school community, what would you do?

4. Is there anything I didn't ask you that you think is important for me to know about your work with schools related to youth mental health services?

State System and Community Organization Interview Protocol

ORGANIZATIONAL CONTEXT

1. Can you describe, in-general, the ways that you provide mental health services to kids in schools?
    a. Do you have staff based in schools, or is the work coordinated externally?
2. Describe [an example program]:
    a. How do schools connect with your services?
        i. How do schools self-select into [programming discussed]?
        ii. [if relevant] How do you define or identify high-need schools?
    b. What is the process for referral or intake related to school involvement?
    c. How is follow-up handled once a referral is made?
    d. What age groups are served with this service?

COMMUNICATION

1. How do you communicate and interact with schools?
    a. What kinds of agreements are in place to support the relationship? (i.e. MOU, formal agreement)
    b. What kinds of informal connections exist? (are there relationships developed where questions can be asked informally?)
2. Who in schools do you typically communicate with?
    c. What are the designated points of contact or roles that are most important?

PARTNERS AND COLLABORATION

1. Who are your primary partners in supporting youth mental health services in schools? (i.e. government agencies, community-based organizations, professional associations, philanthropic organizations, etc.)
2. Who informs and steers this work (is there an advisory board, administrative board, or something else that governs the direction of this work?)
    a. Who is involved and what roles do they play?
3. What are the opportunities for networking or professional development across organizations involved in school-based mental health services?

EFFECTIVENESS, DATA, IMPACT

1. What data do you collect related to your school-based work?
    a. How is that data used/reported?
2. How do you measure success?
    b. What does success look like to you?
3. What impacts do you see as a result of this work?

CHALLENGES, GAPS, NEEDS

1. What is going well with your work in schools?
2. What challenges are you experiencing?
3. What would you like to improve?
4. What gaps do you see in school-based youth mental health services?
5. What groups of kids or families that you see that need additional support? (race, age, language, ethnicity, religion, transportation, SES, etc.)
    a. What are the typical barriers for those groups?

FUTURE

1. What do you need in order to be successful supporting the mental health needs of school communities?
2. What are your priorities for the next year?
3. Is there anything I didn't ask you that you think is important for me to know about your work with schools related to youth mental health services?

Caregiver Interview Protocol

EXPERIENCES WITH MENTAL HEALTH SERVICES

1. Can you tell me about how you first interacted with youth mental health services for your child?
   a. What organizations/providers did you access?
   b. What role did your child's school play in that process?
2. Overall, was that a positive experience for your and your child?
   a. What went well? What could be improved?

SCHOOL INVOLVEMENT

1. How were your child's needs first identified or referred?
2. What was the referral process like for you as a caregiver?
3. How supported did you feel by the school during this process?
   a. Did anyone at the school guide you through what to expect?
4. How was follow-up handled after referral?
5. How was/is the school involved in supports for your child?

NAVIGATING THE SYSTEM

1. What was your experience navigating the mental health system overall?
   a. What was easy or helpful?
   b. What was difficult or confusing?
2. Did you interact with external partners like CSOC, DCF, NJ4S, or others?
   a. How did that experience connect (or not connect) back to the school?
3. If you could change something to improve how the system works for families what would it be?

FINANCIAL AND ACCESS CONSIDERATIONS

1. How did you pay for services?
   a. Insurance, out-of-pocket, other sources?
   b. How would you describe that process? (i.e. was it easy or were there some challenges? What were they?)
2. Were financial factors ever a challenge or barrier to accessing care?

CHALLENGES, GAPS, NEEDS

1. Looking back, what kinds of challenges or barriers do/did you face in trying to get mental health support for your child?
   a. Do you feel like you received appropriate supports from the school?
2. What gaps do you see in the mental health supports available for students and families?
3. What do you think schools and providers could do differently to better meet the needs of students and families?

ASSETS AND SUCCESSES

1. What went well for you and your child in this process?
2. Were there people, resources, or practices that made things easier or more supportive?
3. Are there examples you would want others to learn from or build on?
4. Is there anyone in your experience who was an asset for you through this process? What was their role?

FUTURE

1. What do you think families like yours need most to better support youth mental health?
2. Is there anything you would like to share about your experience that I did not ask?

APPENDIX O:

Department of Banking and Insurance Network Adequacy Reports

Table O1

Provider Directory Compliance with DOBI Regulations
Insurers in the Fully Insured Market

	Percentage of Plans Compliant in All Counties[1]	**Percentage of Plans Non-Compliant**[2] (all counties satisfying 0 of 2 requirements)	**Percentage of Plans Partially Compliant**[3] (satisfying 1 of 2 requirements)	**Average Number of Counties with Compliance Gaps** (Among Partially or Non - Compliant Reports)
10 Network Plans (Across 20 Reports)[4]				
Board Certified Behavior Analyst (BCBA)[5]	35%	35%	30%	12.7
Psychiatric - Mental Health Nurse (PMHN)	55%	30%	15%	14.8
Alcohol and Drug Counselor	65%	0%	35%	4.1
Social Worker (LCSW, LSW, CSW)	90%	0%	10%	2.5
All 20 Network Plans (Across 40 Reports)				
Pediatrics	13%	0%	88%	1.6
Residential Substance Abuse Treatment Center	60%	8%	33%	10.5
Inpatient Pediatric Psychiatric Facility	68%	0%	33%	1.7
Psychologist	75%	0%	25%	5.3
Primary Care Physicians	93%	8%	0%	1.0
Inpatient Substance Abuse Treatment Facility	93%	0%	8%	2.0
Outpatient Substance Abuse Treatment Facility	95%	0%	5%	1.5
Psychiatrist	95%	0%	5%	6.5

Source: NJ Department of Banking and Insurance (DOBI) Data Request.
The Quality Institute reviewed reports for insurers in the fully insured market (20 network plans) for Quarter 4 of 2024 and 2025 (a total of 40 reports) and an aggregate analysis of county-level compliance. DOBI monitors network directories quarterly to review whether insurers meet regulatory requirements based on listed providers. Carriers submit their provider network data to a third-party contractor retained by DOBI, which uses software and a sampling methodology to evaluate and monitor whether the network (on paper) satisfies network adequacy requirements. It does not assess whether directory information is accurate or whether providers are accepting new patients or have appointment availability. DOBI does not rely solely on the Quest Analytics reports to determine network adequacy, as there are limitations in the sampling and collection of that data. Results from DOBI's additional network adequacy verification checks, including to determine if providers are available in a particular region, and any internal agency corrections to the Quest Analytics reports, were not included in the analysis.

Insurers were analyzed on their performance on two required measures: a.) Minimum number of providers available within a county by specialty; and b.) Meeting the 90% time and distance access standard.

[1] Full compliance is defined as satisfying 2 of the 2 required measures in all serviced counties.

[2] Partial compliance is defined as meeting at least 1 of 2 required measures in some counties.

[3] Non-compliance is defined as satisfying 0 of the 2 required measures in all serviced counties.

[4] Ten of the twenty networks lease the following specialists from organized delivery systems (ODS), rather than contracting directly with the practitioners. Compliance data are not available for these specialists.

[5] Some BCBAs may offer in-home services, requiring the provider, rather than the family, to travel.

APPENDIX P:

Department of Health Program and License Data

Table P1

NJ Licensed Pediatric Psychiatric Beds

	County	Region	Acute Beds (Unspecified)	Acute Beds (Closed)	Acute Beds (Open)	Intermediate Beds	Total
Hackensack Meridian Health Carrier Clinic	Somerset	Central		30	6	6	36
Summit Oaks Hospital	Union	Central					22
Trinitas Regional Medical Center	Union	Central		13			40
University Behavioral Health Care	Middlesex	Central			30	30	40
Bergen New Bridge Medical Center	Bergen	North		17			17
Hoboken University Hospital	Hudson	North	19				19
Newark Beth Israel Medical Center	Essex	North		18			18
Saint Clare's Hospital - Boonton	Morris	North		28			28
St Joseph's University Medical Center Inc*	Passaic	North		10			10
Monmouth Medical Center	Monmouth	Shore		19			19
Hampton Hospital	Burlington	South		15			15
Inspira Medical Center Vineland	Cumberland	South		14			26
Jefferson Cherry Hill Hospital	Camden	South		14			14
Total			**19**	**178**	**36**	**36**	**304**

Source: NJ Department of Health, Accessed March 2026.

Closed units refer to units that are secure and/or locked and open units refer to units that are less restrictive environments.

Licensed beds reflect the maximum number of beds a hospital is authorized to operate under its state license as issued by DOH. Licensed capacity often is higher than the actual number of beds available to patients because hospitals can only use beds when they have the necessary staff, space, and resources available. The pediatric psychiatric unit at St. Joseph's University Medical Center and all intermediate beds at University Behavioral Health Care are licensed but inactive; additional licensed beds may also be inactive, but this could not be confirmed.

NJ regions are defined as:

North Jersey Counties: Bergen, Essex, Hudson, Morris, Passaic, Sussex, Warren; Central Jersey Counties: Hunterdon, Mercer, Somerset, Union; South Jersey Counties: Burlington, Camden, Cumberland, Gloucester, Salem; Jersey Shore Counties: Atlantic, Cape May, Monmouth, Ocean.

APPENDIX Q:

Licensed Board-Certified Behavior Analysts

Board Certified Behavior Analysts (BCBA) are graduate-degree professionals certified in behavior analysis.[127] In 2020, New Jersey established the State Board of Applied Behavior Analyst Examiners, which requires state licensure under the oversight of the Division of Consumer Affairs. Licensure is available for both Applied Behavior Analysts, who must hold a graduate degree and BCBA certification, and Assistant Applied Behavior Analysts, who must hold a bachelor's degree and Board-Certified Assistant Behavior Analyst (BCaBA) certification, each requiring renewal after two years. As of March 28, 2026, the NJ Division of Consumer Affairs reported 3,539 Applied Behavior Analysts and 30 Assistant Applied Behavior Analysts with active licenses.

Table Q1

NJ Board-Certified Behavior Analysts Active Licenses

License	Number of Individuals
Applied Behavior Analyst	3,538
Assistant Applied Behavior Analyst	30
Total	**3,568**

Source: NJ Div CA License Directory. Accessed March 28, 2026.

Assistant Applied Behavior Analyst must practice under supervision.

[127] Quinn, N. R. (2026, March 12). BCBA certification vs. ABA certification: What's the difference? AppliedBehaviorAnalysisEdu.org. https://www.appliedbehavioranalysisedu.org/bcba-vs-aba-certifications/

Monmouth County's Children's System Review Committee

Children's System Review Committee (CSRC)

PROGRAM DESCRIPTION

The Monmouth County Department of Health and Human Services, Division of Child and Youth Services runs the Children's System Review Committee (CSRC) which is a quarterly closed meeting specific to hospital crisis units. This Committee has shifted data collection to reflect the most useful information to identify gaps, trends, barriers etc. Data is submitted monthly by each crisis unit to the Division of Child and Youth Services Director, CSRC Chair and PESS Director; the data is maintained by the Division Director. The CSRC provides the opportunity to recognize and discuss children's crisis system issues for improvement, which may be brought to youth-related planning bodies to strategize solutions and areas for advocacy.

Table R1

Monthly Reporting Data Collection
I. VOLUME INDICATORS:
Total Volume (Adults & Children)
Total Youth Assessed
Age 0 to 4
Age 5 to 10
Age 11 to 15
Age 16 to 17
II. SERVICE INDICATORS:
a. Alcohol/Substance
b. Developmental Disability
c. Suicidal Ideation
d. Homicidal Ideation
III. HOLDS GREATER THAN 24 HOURS:
a. Waiting for CCIS Bed[1]
b. Held for Further Observation and stabilization
c. Held for Specialized Service, DDD[2]
TOTAL HOLDS greater than 24 Hours
IV. YOUTH ADMISSIONS DISCHARGED TO:
a. MMC CCIS[1,3]
b. Other CCIS[1]
TOTAL Psychiatric Hospitalizations (Items IVa. - IVc.)
V. TOTAL DISCHARGED TO COMMUNITY:
IV. REFERRAL SOURCES:
a. Parent/Guardian/Family Member
b. School District
c. Treatment Provider
d. Police
c. Other

Source: Monmouth County Department of Health and Human Services, Division of Child and Youth Services Data Request.

[1] CCIS refers to Children's Crisis Intervention Services.

[2] DDD refers to NJ Divison of Developmental Disabilities.

[3] MMC refers to Monmouth Medical Center.