

# Recommendations

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



II

III

IV

V

VI

APPENDICES

## 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 Credentialing 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

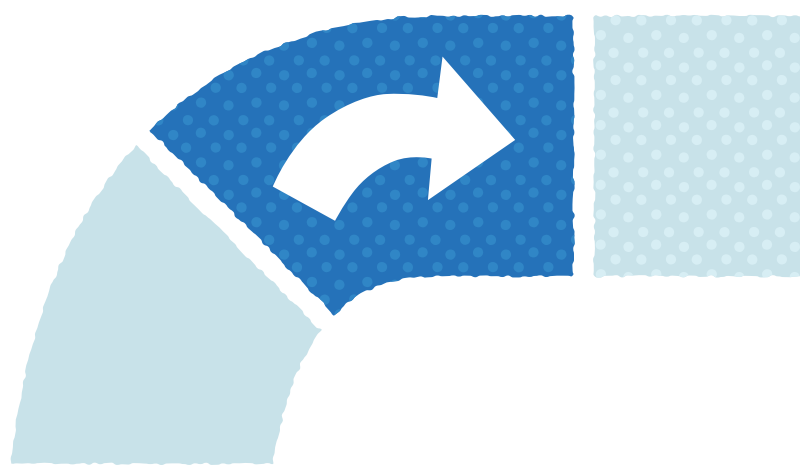
Taken together, these recommendations are intended to create a more coordinated, equitable, and effective children's mental health system in New Jersey. While the State has many strong programs and engaged partners, achieving meaningful improvement will require sustained investment, greater accountability,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

# Recommendations



**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<sup>115</sup> and workforce data centers in other states<sup>116</sup>. This effort could be housed within an existing structure such as the New Jersey Statewide Data System<sup>117</sup> 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.

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

<sup>116</sup> <https://www.oregon.gov/oha/hpa/analytics/pages/health-care-workforce-reporting.aspx>, [https://www.health.ny.gov/facilities/healthcare\\_workforce\\_innovation/](https://www.health.ny.gov/facilities/healthcare_workforce_innovation/)

<sup>117</sup> <https://njsds.nj.gov/about/>

I  
II  
III  
IV  
V  
RECOMMENDATIONS  
APPENDICES

## 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<sup>118</sup>, 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

<sup>118</sup> <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.<sup>119</sup>

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.

## 6 Improve Licensure and Credentialing Processes to Increase Access



### 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<sup>120</sup>, 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.

<sup>119</sup> <https://projectecho.rutgers.edu/>

<sup>120</sup> <https://www.govinfo.gov/content/pkg/PLAW-114publ255/pdf/PLAW-114publ255.pdf>

# Insurance Coverage and Access

## 7 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.

## 8 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.

- I
- II
- III
- IV
- V

RECOMMENDATIONS

APPENDICES





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.

- I
- II
- III
- IV
- V

RECOMMENDATIONS

APPENDICES



# 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.

- I
- II
- III
- IV
- V

RECOMMENDATIONS

APPENDICES



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.

- I
- II
- III
- IV
- V
- RECOMMENDATIONS
- APPENDICES

# 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.

- I
- II
- III
- IV
- V

RECOMMENDATIONS

APPENDICES



## 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.

- I
- II
- III
- IV
- V