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

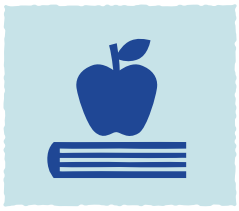
New Jersey, like the nation, faces a shortage of child-serving mental health professionals across nearly every discipline, including child psychiatrists, developmental pediatricians, therapists, psychologists, behavioral health staff in schools, and providers trained to serve youth with co-occurring 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.

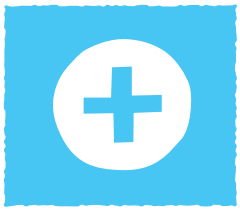
FAMILY NAVIGATION AND COORDINATION

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.

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:

1. **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.

2. **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.

3. **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

1. **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.

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

3. **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.

4. **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.

5. **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:

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

2. **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.

3. **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.

4. **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:

1. **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.

2. **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.

3. **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.

4. **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

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.

Key Findings

1. **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.**

2. **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.**

3. **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.**

4. **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

1. **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.

2. **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.

3. **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.

4. **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:

1 **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.

2 **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

1. **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.

2. **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.

3. **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.