APPENDIX

ADDITIONAL APPENDIX MATERIAL

SUBMITTED TO THE

JOINT COMMITTEE ON THE PUBLIC SCHOOLS

for the

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Submitted by

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SEL4NJ

Youth Mental Health in NJ: Starting the Discussion

December 2025

WRITTEN BY

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With Support from the Social Emotional Learning Alliance for New Jersey's Youth Mental Health Advocacy Collaborative (YMHAC):
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Introduction

YMHAC invited regional and statewide leaders to a statewide Youth Mental Health Summit in July 2025 to engage in information gathering and sharing to identify common themes related to needs and barriers across Statewide child and adolescent mental health systems in New Jersey. The Summit focused on identifying challenges, needs, gaps, partners, effective services, and improvements to youth mental health systems. The information below is intended to begin a discussion to build more proactive, coordinated, accessible, and effective youth mental health services, and is not intended as a list of recommendations. **A summary of findings from the Summit is included below.**

ACCESSIBILITY AND AVAILABILITY OF SERVICES

Families face long wait times, few providers (especially for tier 3 services), geographic and transportation barriers, and insurance/financial hurdles. Telehealth helps but does not fully bridge gaps.

Challenges: system access, long waits, cost barriers, lack of early intervention
Needs: fund timely service, expanded coverage, earlier intervention, targeted supports
Gaps: underserved youth, lack of continuity, medication management shortages, insufficient providers
Improvements: expansion of School-Based Youth Services, clearinghouse of services, portability of funding

SCHOOL AS A CENTRAL HUB

Schools are often the most direct and effective site for youth mental health supports, but they lack consistent resources and funding. School-Based Youth Services (SBYS) and community schools are valued and recommended for expansion.

Challenges: schools limited by Medicaid restrictions, privacy laws, and staffing shortages
Needs: tier 1 universal supports, training for school staff, SEL integration
Gaps: underdeveloped tier 2 interventions in schools, lack of resilience-building in education programs
Partners: schools as central but not fully supported collaborators
Effective Services: SBYS, community schools, coaching for staff, climate work
Improvements: expanding SBYS, mandating mental health programming in schools

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CROSS SYSTEM COLLABORATION AND COORDINATION

Systems are fragmented, siloed, and confusing to navigate. Families lack case management and system navigation tools. Schools, community organizations, healthcare, and state agencies must align better.

Challenges confusing, fragmented system, lack of navigation tools
Needs cross-system collaboration, case management, clear processes for coordination
Gaps lack of case management, continuity of care failures, siloed systems
Partners importance of schools, state agencies, but collaboration is inconsistent
Effective Services school-community partnerships, collaborative models like ESMHS, Clayton Model Pilot Program, NJ Pediatric Psychiatry Collaborative
Improvements clearinghouse for services, better information sharing, breaking silos

FUNDING AND POLICY BARRIERS

Current funding is insufficient, restrictive, and fragmented. Cuts to Medicaid or and mental health initiatives worsen disparities. Calls for more diversified funding, portability, and long-term sustainability.

Challenges: insurance coverage gaps, Medicaid restrictions, funding barriers in schools
Needs: expanded/diversified funding, private/public/philanthropic investments
Gaps: reliance on Medicaid, risk if reduced
Partners: state agencies and legislature critical for funding alignment
Improvements: policy reform i.e. Medicaid portability, lower consent age, universal mandates

UNDERSERVED POPULATIONS

Disparities between affluent and low-income families; insufficient support for younger (elementary age) children, foster youth, LGBTQIA+ youth, immigrant/undocumented families, and students with disabilities or co-occurring conditions. Cultural competence and bilingual services are essential.

Challenges: high- and low-SES family disparities, cultural stigma, immigrant family fears
Needs: culturally responsive systems, provider diversity, services for immigrant families
Gaps: youth with disabilities, foster care, juvenile justice, LGBTQ+, immigrant/undocumented
Effective Services: culturally responsive mentorship models, identity-affirming programs
Improvements: lowering consent age, universal programming, equitable service access

STIGMA AND CULTURAL BARRIERS

Mental health stigma in families and communities prevents care-seeking; cultural attitudes (e.g., immigrant and minority communities, young men, LGBTQ stigma) reinforce silence and avoidance.

Challenges: stigma at family, community, cultural, and political levels
Needs: culturally responsive systems to address stigma
Gaps: LGBTQIA+ youth, immigrant youth, marginalized communities facing stigma and exclusion
Effective Services: peer groups, mentoring, and culturally grounded programs reducing stigma

PROACTIVE, PREVENTATIVE, AND STRENGTHS-BASED APPROACHES

Too often, care is reactive (waiting until crisis). Participants stress prevention, resilience, mentoring, peer support, SEL, and building staff capacity to respond earlier and consistently.

Challenges: services often only accessed during crisis, early intervention gaps
Needs: strengths-based, resilience-building, prevention focus, SEL, staff training
Gaps: continuity of care missing, lack of skill-building in therapy, insufficient Tier 2
Effective Services: mentorship, SEL, school climate initiatives,
Improvements: peer empowerment, proactive universal programming, shift from reactive to proactive

CAREGIVER AND FAMILY ENGAGEMENT

Caregivers are critical partners but often overburdened by time, work schedules, and system complexity. Family stigma and lack of adult mental health support hinder youth access.

Challenges: caregiver bandwidth, HIPAA barriers, parental stigma
Needs: adult mental health support, parent training programs, evidence-based caregiver interventions
Gaps: lack of father-focused supports, insufficient parent education on social media effects
Effective Services: caregiver-focused training, family-based interventions
Improvements: training all adults in youth mental health, mentorship, peer/family supports

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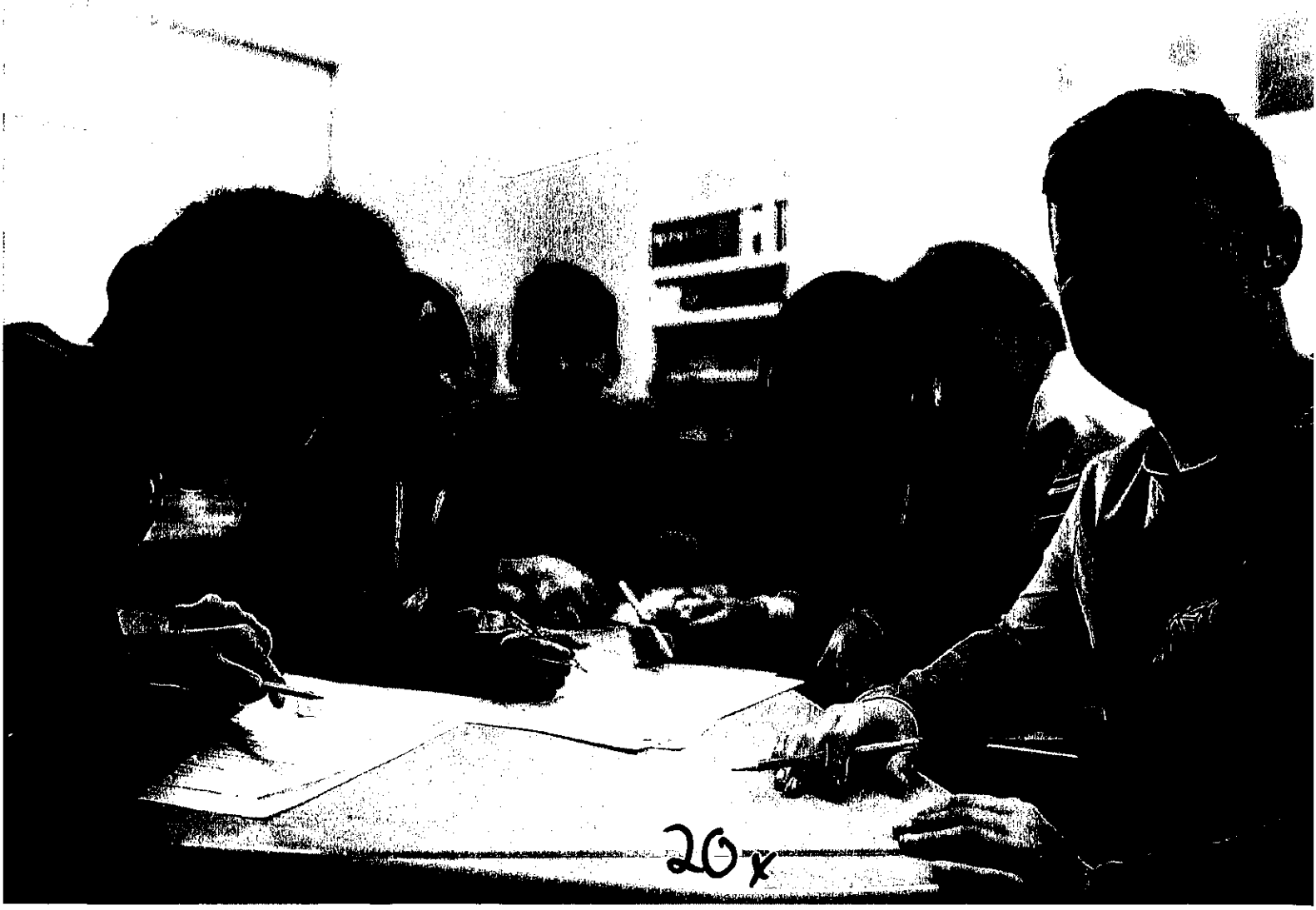
SEL4NJ

Perspectives on Youth Mental Health in New Jersey: Challenges, Gaps, Partners, Effective Services, and Improvements

December 2025



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Introduction

The Social Emotional Learning Alliance of New Jersey's (SEL4NJ) Youth Mental Health Advocacy Collaborative (YMHAC) hosted an initial information-gathering statewide Youth Mental Health Summit on July 9th, 2025 at the New Jersey Association of School Administrators in Trenton, New Jersey. Founded in 2023, YMHAC is a collaborative group of regional and statewide nonprofit, advocacy, and program partners interested in driving New Jersey policy and systems towards more proactive, coordinated, accessible, and effective youth mental health services. A full member list that is current as of the writing of this report is included on the title page above. The Youth Mental Health Summit invited regional and statewide leaders in youth mental health policy and practice to engage in structured small- and whole group discussions, information sharing and networking. This Summit focused on information gathering and sharing to identify common themes related to needs and barriers across Statewide child and adolescent mental health systems. A second more expansive Summit is planned for Fall 2025 that will focus on the identification of policy and practice changes to create more proactive, coordinated, accessible, and effective youth mental health systems in New Jersey. This report includes methods and reporting from the Summit, and primarily presents information to support systems improvement discussions.

METHODS

In Spring 2025 YMHAC members identified a need to convene regional and state leaders from across New Jersey to share information and breakdown silos related to youth mental health systems. Recognizing a need for a common understanding of youth mental health systems in New Jersey, YMHAC members identified a structured Summit as a format for sharing and documenting information across youth mental health systems in New Jersey.

Dr. Ross Whiting, Chair of YMHAC and President of Dogwood Consulting, an evaluation, organizational development, and advocacy organization, collaborated with YMHAC members to develop a Summit focused on convening leaders, gathering information, and creating networks across disparate youth mental health systems. YMHAC members used spider-web recruitment methods to identify participants in the Summit focusing first on their immediate networks for youth mental health professionals, then asking them to also identify and recruit Summit participants via email in June 2025. YMHAC members ultimately identified 87 participants to participate in the Summit with 37 participants ultimately attending the Summit. Graciously hosted by the New Jersey Association of School Administrators (NJASA) in Trenton, New Jersey, The Summit was held in the main

training and education room from 9:00am to 12:30pm at NJASA, with concerted, facilitated data collection and discussion taking place from 9:30am to 11:30am.

The YMHAC team developed an agenda that included facilitated discussion and note-taking focused on identifying challenges, needs, gaps, partners, effective services, and improvements to youth mental health systems across New Jersey. Participants self-divided into six small groups consisting of between 6-8 members each. Dr. Whiting facilitated the Summit with a presentation and prepared speaker's notes. The Summit included goals, guidelines for engagement, small- and whole-group discussion, opportunity for community building, and note-taking. Participants were informed that a report (this one) would be shared after the Summit, and would be used to inform a second phase Summit focused on solutions and action.

Dr. Whiting shared practical logistics including a desire for participants to prioritize their comfort, the timing of sharing and discussion, and the identification of a notetaker at each table. Notetakers included volunteers at each table during small-group discussions, and YMHAC members Kristy Ritvalsky, Deputy Director, and Stuart Luther, Senior Consultation and Training Specialist from the Center for Comprehensive School Mental Health at Rutgers University. Dr. Whiting reviewed the approach to discussion and information sharing within the Summit that focused on curiosity, collaboration, and brainstorming (the judgement-free building on the ideas of others) to share information within small- and whole-group discussions. Seven guiding questions were provided to participants in written form at each table then individually via the presentation in the sequence of discussion. Results from six of the seven questions are included in this report. The seventh question, focused on specific solutions to the current policy landscape in New Jersey, will be used in the next phase of organizing and is not included in this report. Questions can be found in Appendix A. Dr. Whiting gave short introductions of each question area, then provided structured time (~7 minutes of small group discussion and ~7 minutes of whole-group discussion) for participants to share in small groups, then as in whole group discussions. Many participants stayed after the formal facilitated session to share information and network.

Handwritten notes were digitized to text and combined with digital notes to form a single dataset. Data were organized into six youth mental health topic areas: challenges, needs, gaps, partners, effective services, and improvements. Open coding was applied at the phrase level to identify common themes across the data. Coding was conducted by Dr. Whiting with ATLAS.ti qualitative data analysis software. Results from data analysis are provided below.

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Results

Results are organized by each youth mental health topic area prioritized by consistency and depth of theme which are provided in each section below. All themes identified below were consistent enough to be identified across participants participating in the Summit. We encourage readers to take this report as *information to inform discussions* around improving youth mental health in New Jersey.

CHALLENGES

Participants were asked to describe the biggest challenges youth face when trying to access mental health support. Challenges identified included the accessibility, prevalence, and knowledge of mental health systems, mental health stigma, and caregiver bandwidth and involvement needed to access systems.

Mental Health System Accessibility

The most robust and consistent challenge participants reported during the Summit was access to youth mental health services. One of the most significant issues is the disparity in access between affluent families and those with limited resources. Families with higher incomes can often secure private mental health services, bypassing many of the barriers in the public or insurance-dependent system. In contrast, youth from lower-income households, especially those reliant on Medicaid, public insurance, or no insurance face long wait times, fewer provider options, and higher rates of care denial, since many mental health professionals do not accept Medicaid. Even when insurance is available, services may not be covered or may carry prohibitive co-pays, creating financial barriers that force families to forgo treatment entirely.

Participants reported that the lack of mental health resources for younger children, particularly in the elementary school years, means early-grade intervention opportunities are missed. Without adequate school-based support, students are more likely to struggle academically and emotionally, impacting their ability to pursue and succeed in higher education. This gap in early and ongoing care is evident at the college level, where students often leave school due to unmanaged anxiety, depression, and other mental health challenges that were never addressed earlier in life that are exacerbated by the increased rigor of post-secondary education and the loss of natural supports. The need for comprehensive college counseling and mental health education in the university and college setting is critical to improving student retention and long-term outcomes.

Structural and logistical obstacles compound the problem. Long wait times for appointments often result in care being delivered only when a youth is already in crisis, rather than through proactive or preventative interventions. Privacy laws, while important, can make follow-up care difficult, especially when youth transition between providers or care settings including schools. Additionally, telehealth cannot fully bridge the gap, as some families lack the necessary technology or stable internet access, and others prefer in-person interactions. For those who can access telehealth, quality and availability still vary significantly by provider and region.

The burden on families (and particularly caregivers) to find adequate mental health services is a crucial but under-discussed challenge. Caregivers often play a gatekeeping role in accessing services for minors, but those working multiple jobs or facing other responsibilities may lack the time or flexibility to attend appointments or facilitate treatment. Funding restrictions and Medicaid regulations can also limit the ability of schools to offer on-site services, further removing mental health care from the environments where youth spend most of their time. Together, these factors create a layered, interdependent web of challenges—financial, systemic, and practical—that disproportionately impacts vulnerable youth and leaves many without the support they need until a crisis emerges.

Prevalence and Knowledge of Mental Health Services

Participants emphasized the prevalence of services, with a specific focus on the need for staffing, mental health infrastructure, and professionals trained in the field. Long wait times for services emerged as a critical challenge with families often facing extended delays even for initial evaluations. These waitlists persist despite a family's readiness to engage in treatment, and the resulting gaps in service can escalate concerns from manageable issues to full-blown crises. Contributing to these delays is a shortage of qualified providers, infrastructure, and staffing, particularly for high-intensity tier 3 services that address the most severe mental health needs. The volume of demand overwhelms available resources, creating a system where access is not dictated by the urgency of need, but by the availability of scarce professionals and facilities.

A lack of clear, accessible information about youth mental health systems creates a major barrier to care, often leaving families feeling lost and unsupported. One participant stated "A lot of parents don't even know what is available." Navigating these systems is inherently complex, involving confusing referral processes, inconsistent guidance, and fragmented services that can delay access to needed support. This challenge is compounded for parents and caregivers who must juggle work, family responsibilities, and education while trying to secure care for their children. Many families simply do not know what services

exist or how to access them, and even those working within the system often struggle to fully understand its structure and processes, with another participant stating "Even people within the system don't understand the system."

Location and Transportation

Location and transportation present significant challenges to youth mental health service access, with barriers varying across rural, suburban, and urban settings. In many rural and some suburban areas, services simply do not exist within a reasonable distance, forcing families to travel long distances or forgo care altogether. Even in urban environments where providers may be more concentrated, access issues persist, particularly around obtaining necessary medications due to shortages, limited pharmacy hours, or other logistical hurdles. In suburban areas, while telehealth can bridge some gaps, many families still prefer in-person services, creating tension between available virtual options and the type of care they believe is most effective. Across all settings, transportation constraints further limit continuity of care and create additional barriers to consistent, timely treatment.

Mental Health Stigma

Stigma remains a powerful and persistent barrier to youth mental health care, shaping whether families seek help, how communities respond to mental health needs, and the willingness of schools and institutions to provide services. Cultural beliefs play a central role, with some communities viewing mental health challenges as personal weaknesses or moral failings rather than legitimate health concerns. These beliefs can lead to silence, denial, or blame, creating an environment where youth are discouraged from speaking openly about their struggles. In many immigrant communities, the stigma is compounded by cultural norms that prioritize privacy and self-reliance, making conversations about mental health particularly difficult without culturally competent and bilingual services.

Parental and family stigma often exerts the most direct influence on whether youth receive care. Families that do not believe mental health issues are real, or who attribute them solely to external factors like schools or peers, may resist seeking treatment. This resistance can be reinforced by generational trauma, where older generations who may have faced their own challenges without mental health supports minimize the value of therapy and/or psychiatric care. Such attitudes not only delay intervention but also make ongoing involvement in treatment more challenging, as family participation is often crucial for successful outcomes.

Some families avoid engaging with youth mental health systems out of fear, even when services are available and needed. For both documented and undocumented immigrant

families any service requiring personal documentation can feel risky, fueling concerns about immigration enforcement or legal repercussions. This fear can be strong enough to deter families from seeking care entirely, even in urgent situations. Beyond immigration-related concerns, some parents worry about stigma or disapproval from within their own circles, fearing that school staff, community members, or even extended family will judge their decision to pursue mental health support.

Community-level stigma amplifies these barriers, especially for certain populations. Young men frequently face societal pressures to appear strong, stoic, and emotionally unaffected, which can prevent them from seeking help or acknowledging distress. Political stigma also plays a role, as debates over which groups deserve services—such as LGBTQ youth—can result in some districts withholding support entirely. This not only leaves vulnerable groups without critical resources but also signals to the broader community that people with certain identities or experiences are less worthy of care.

Caregiver Bandwidth and Involvement

Caregiver involvement is critical for youth mental health care, yet many families face significant challenges in providing the time and attention needed to support treatment. Parents are often required to be directly involved in the process—attending appointments, providing consent, and coordinating with providers—but for those working multiple jobs or managing other demanding responsibilities, this level of engagement can be difficult to sustain. Long wait times for services further strain caregiver availability, as scheduling often requires taking time off work or rearranging responsibilities. Additionally, privacy regulations such as HIPAA, while designed to protect youth, can make it harder for schools and healthcare systems to track progress or stay fully informed about the youth's care, adding another layer of complexity.

NEEDS

Participants were asked to identify the biggest needs in youth mental health services right now including the types of supports needed, common or increasing needs, or funding streams needed to support youth mental health. Participants identified needs that include funding, focus on specific groups, strengths-based approaches, cross-system collaboration, culturally responsive systems, and information needed to meet needs.

Funding

Participants emphasized that sustainable youth mental health support in New Jersey requires expanded and diversified funding streams. Public sources alone cannot meet the scale of need, and a stronger reliance on private investment, philanthropy, and advocacy is essential. Stakeholders pointed to models such as Dalio Philanthropies' work on youth

disconnection and Massachusetts' framing of mental health as a strong "return on investment." Insurance systems also need to better support timely access to care, as reducing long wait times for tier 2 (small group) and tier 3 (individual) services remains a significant need. Gaps are especially acute for youth with co-occurring conditions, making the expansion of targeted funding for these populations critical.

Specific Areas of Need

The most commonly identified issues among youth included anxiety, depression, self-harm, and identity-related struggles, particularly for students in unsupportive environments. Stakeholders noted limited treatment options for eating disorders and substance use, despite increasing prevalence, as well as the need for earlier intervention for psychosis. Younger children, particularly those in elementary grades, often have no accessible mental health services. Participants also highlighted the mental health of adults including educators, staff, and caregivers as a direct factor in student wellbeing, stressing that "dysregulated adults can't offer the best support to students." Professional development for staff should be ongoing and integrated, not confined to one-off sessions. Evidence-based parenting programs such as Parent-Child Interaction Therapy (PCIT) and Trauma-Focused Cognitive Behavioral Therapy (TFCBT) were identified as underutilized tools for supporting both students and families.

Strengths-Based Approaches

Participants urged the adoption of resilience-building and prevention-oriented mental health strategies. This includes enhancing tier 1 (universal) supports like positive school climate, building help-seeking skills among students, and equipping faculty to respond effectively. A heavy emphasis on testing often results in social-emotional learning being deprioritized, despite its role in engagement and wellbeing. Rising rates of school avoidance and disengagement post-pandemic further underscore the need for consistent, proactive supports. Many participants advocated for empowering and training existing school staff, rather than relying on hiring additional personnel, to ensure mental health knowledge and skills are embedded in everyday practice.

Cross-System Collaboration

Effective youth mental health support requires strong case management and seamless coordination between schools, community providers, law enforcement, and other mental health systems. Participants stressed the need for clear operational processes for integrating mental health into school structures, improved inter-agency communication,

and strategies to break down existing silos. Enhanced tier 1 (universal) supports across all schools, coupled with coordinated care navigation for higher-need cases, would help ensure that every student receives the services they need. Stakeholders agreed that New Jersey must "double down" on its youth mental health efforts, making collaboration a central feature of the system.

Culturally Responsive Systems

Addressing stigma and ensuring access for all students, including those in immigrant and undocumented families, is essential. Services should be accessible without requiring documentation and should reflect the diversity of the populations they serve. This includes expanding the pool of Spanish-speaking therapists and increasing provider diversity across race, ethnicity, language, and sexual identity. Cultural competence was seen not as an optional skill but as a core component of effective care.

Information Needed to Meet Needs

Stakeholders called for better data and shared understanding of what youth mental health looks like in practice. Before crafting solutions, communities must clearly understand the trends, root causes, and actual experiences of students, recognizing, for example, that developmental norms for kindergarteners had already shifted before the pandemic. Clear, simplified language that can be understood by parents, educators, and students is necessary to demystify mental health and appropriate responses. Participants also stressed the importance of amplifying student voice to ensure interventions reflect actual needs and acceptability of interventions for youth, not just adult assumptions. System navigation tools, along with models of effective mental health care, are needed to guide decision-making at every level.

GAPS

Summit attendees were asked to identify the biggest gaps in mental health services for youth right now including groups of young people who are left out or not served well. Participants identified specific groups of youth who experience gaps in youth mental health services, approach to serving underrepresented groups, and resources.

Underserved Groups

Focus group participants identified multiple groups of young people in New Jersey who face persistent and often overlapping gaps in mental health services. Students with disabilities, particularly those with a dual diagnosis of developmental and mental health conditions, were described as among the most isolated and underserved. While some

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skills development and supports are provided within special education settings, schools lack universal strategies and common language that provide continuity schoolwide. This lack of consistency creates challenges for students who are classified as special and education and excludes general education students. Youth with intersecting marginalized identities, such as disabilities combined with racial, linguistic, or cultural differences, are particularly at risk of being overlooked.

Foster youth emerged as another group facing significant service gaps, especially those aging out of the system. These young people often lose access to structured supports just as they face the challenges of independent living. Youth returning from incarceration or the juvenile justice system encounter similar challenges in reentry, with insufficient mental health, educational, and social supports to help them transition successfully. Students who are placed out-of-district for educational services also frequently experience a lack of continuity in care and difficulty reintegrating into their home communities.

Participants also highlighted gaps for youth with both substance use disorders and mental health needs. This dual-diagnosis population often falls between systems, with addiction and mental health services failing to integrate treatment in ways that address both conditions effectively. Younger children, especially in elementary school, were described as an overlooked group, with most services focused on older youth despite clear early indicators of mental health needs.

LGBTQIA+ youth face unique challenges in accessing affirming, specialized care. Cuts to funding for diversity, equity, and inclusion (DEI) initiatives risk widening these gaps, particularly for students who may already be experiencing stigma or unsupportive environments. Similarly, undocumented and immigrant youth—some of whom are not attending school due to legal or systemic barriers—often lack access to even basic mental health services.

Finally, participants noted a lack of community-based support structures for both youth and their parents. Father-focused groups were cited as especially scarce, despite the potential benefits of engaging fathers in understanding their role in parenting and partnering in their children's mental health. The absence of such community supports leaves families without the resources and networks needed to help children thrive.

Approach

Youth Mental Health Summit participants emphasized that addressing gaps in youth mental health services in New Jersey requires a shift toward approaches that are sustained, inclusive, and community-centered. Participants noted that resilience should be taught consistently across all student populations, with teacher preparation programs placing a stronger emphasis on building resilience skills in the classroom. They said that the most effective organizations and schools are those that invest continually in community-building rather than treating it as a one-time effort. This focus on ongoing connection is seen as essential in countering the "society of rashness" mentality, where quick fixes are sought over long-term solutions.

Services also need to go beyond initial interventions and ensure continuity of care, including consistent access to medication management and follow-up supports. In parallel, many youth receiving long-term therapy are not gaining practical coping strategies for managing anxiety, depression, and related challenges. Participants stressed that services should prioritize equipping students with concrete skills to build healthy relationships, regulate emotions, and navigate stress effectively, rather than relying solely on clinical engagement without skill-building outcomes.

Parents and caregivers also need more education and support, particularly around the effects of social media on the developing brain. Understanding how social media both connects and isolates youth is seen as critical for helping families respond constructively to its influence. This includes providing tools for parents to foster digital literacy, emotional regulation, and boundaries in their children's online engagement.

Finally, participants called for significant improvements in cultural responsiveness among current and future mental health practitioners. Greater cultural humility and competence are needed to meet the needs of New Jersey's diverse communities. Tier 2 interventions, targeted supports for students who are not in crisis but need more than universal services, were identified as underdeveloped and unevenly implemented across schools and communities. Similarly, the transition from high school to college remains a period of vulnerability for many young people, with too few coordinated services in place to help them maintain mental health stability during this major life change.

Resources

Participants described significant gaps in mental health resources across New Jersey, with particular concern about the consequences if Medicaid funding is reduced. Medicaid serves as a critical lifeline for many families, and cuts would disproportionately impact those already struggling to access care, especially marginalized populations. Without this safety net, both preventive and ongoing mental health services would become even more

out of reach for youth who rely on public insurance for therapy, medication management, and crisis intervention.

A recurring theme was the shortage of case management services. Participants emphasized that even when care exists, navigating the system is complex and often overwhelming for families—especially those unfamiliar with mental health services or facing additional socioeconomic barriers. The lack of case managers leaves many youth without the coordinated support necessary to connect them to appropriate providers, follow up on referrals, and ensure continuity of care.

Statewide, the availability of mental health providers is insufficient to meet demand, leading to long wait times and limited options, particularly in rural and underserved areas. Systems are often inaccessible to those who need them most, compounding inequities for marginalized groups. Moreover, when youth do gain entry to services, supports too often focus on initial intervention without ensuring continued access to therapy, medication, or follow-up care. This fragmented approach fails to provide the consistent, sustained support needed for long-term mental health stability.

PARTNERS

Participants were asked who they saw as important partners in youth mental health, and how well they are working together right now. Discussion centered first on approach to collaboration, then local, regional, and New Jersey State governmental partners.

Approach to Collaboration

Focus group participants expressed that while there is growing recognition that youth mental health requires a team approach, collaboration among partners in New Jersey remains inconsistent and often hindered by structural and cultural barriers. Schools are viewed as central players, yet several stakeholders noted that they are not always treated as integral to the process, and building relationships with districts can be challenging. For example, "cold calling" schools to offer services was described as rarely effective, and private vendors reported difficulty accessing or connecting to state-level resources. When schools are required to select providers in procurement systems based solely on the lowest bid, quality can suffer, undermining the effectiveness of collaborative efforts.

Information sharing emerged as a critical element of successful partnerships, but many participants noted that communication between agencies, organizations, and schools is fragmented. At the state level, better coordination is needed to avoid duplicate projects and to maximize funding through strategies like braiding resources across programs. Partners stressed the importance of pooling strengths and referring out services they

cannot provide well, rather than competing or working in isolation. However, some organizations face real barriers to deeper engagement like limited staff capacity or unclear expectations about their role making sustained collaboration difficult.

Participants also emphasized that youth voices are rarely incorporated meaningfully into service planning, despite the fact that students themselves can offer insights into what approaches will work best. Without this input, services risk being mismatched to actual needs. Moreover, certain groups, such as homeschooled students, are often left out of mental health planning altogether, leaving unaddressed gaps in the broader system of care.

Local, Regional, and State Partners

Participants identified a range of key partners at the local level who play important roles in supporting youth mental health. Teachers, coaches, families, and peers are often the most immediate and consistent sources of support for young people, while first responders, libraries, and family success centers provide critical connections to information, resources, and safety. Community-based organizations such as the CIACC (County Interagency Coordinating Council) and faith leaders, especially youth ministers and faith-based groups, were recognized for their ability to reach youth in familiar, trusted settings. These leaders often have existing youth groups and are willing to dedicate time and space to mental health support if given proper training. The YMCA was noted for its dual role in providing direct services and connecting young people to other available resources across New Jersey. Hospitals, insurers, and both public and nonpublic schools also serve as critical local partners, though schools in particular are often expected to take on significant mental health responsibilities without adequate resources or systemic backing.

At the regional level, participants pointed to the importance of professional associations and collaborative networks for mental health practitioners, including the New Jersey Pediatric Psychiatry Collaborative, which connects pediatricians with mental health professionals to improve early identification and access to care, and the SEL4NJ Youth Mental Health Advocacy Collaborative that brings together organizational leaders across the State to advocate for improved youth mental health systems. These networks can help bridge gaps between local providers and statewide systems, ensuring that expertise and best practices are shared more broadly.

Key state partners include the Department of Children and Families and the Department of Education, both of which have direct influence over youth mental health policy, funding, and program implementation. The Governor's office and the state Legislature were recognized as essential in setting priorities, passing legislation, and allocating resources

that can either strengthen or weaken the statewide system of care. Participants emphasized that while hospitals, community organizations, and state agencies all have important roles, collaboration between these entities is often inconsistent, leaving opportunities for better alignment and shared strategy across New Jersey's mental health landscape.

EFFECTIVE SERVICES

Participants were asked to identify youth mental health services that are currently effective in New Jersey with a focus on proactive, coordinated, and accessible services, and an emphasis on what it might look like if services were even more effective. Summit attendees discussed approaches to providing services and specific programs that were effective, and effective school- and community-based services across the state.

Effective Mental Health Approaches

Participants highlighted a range of approaches to youth mental health supports and services that they considered effective, with an emphasis on mentorship, capacity-building, and sustained, community-connected interventions. Mentoring programs, including those using credible messengers who share lived experiences with youth, were seen as highly impactful. Male mentorship embedded within schools and grounded in purpose-driven work was cited as an important way to engage young men, foster connection, and provide role models. Culturally responsive models, such as the "I am my brother's keeper" approach, were noted for their ability to resonate with students and address both identity and wellbeing. Peer groups and youth mentorship programs within districts were also considered valuable for building trust, creating safe spaces for discussion, and reducing stigma.

Building the skills and confidence of school staff was another central recommendation. Rather than relying solely on traditional professional development sessions, participants stressed the importance of school-based coaching that is sustained over time. Coaching and team-based approaches allow teachers, coaches, and other school personnel to integrate mental health support into daily interactions, strengthening their role as trusted adults in students' lives. Initiatives like the Enhancing School Mental Health Services Project Model (ESMHS), which combines training with ongoing coaching, were seen as examples of how to ensure implementation actually improves outcomes. Similarly, when implemented effectively, school climate work was described as a foundation for both academic and emotional growth, with the potential to inspire other schools to adopt community-service-oriented and social-emotional learning (SEL) initiatives.

On the clinical side, participants emphasized the value of community-based mental health models and intensive outpatient programs that provide more accessible, flexible care options. These services, when connected to schools and community organizations, help bridge the gap between everyday support and specialized treatment. Caregiver-focused training, particularly on navigating hardship, was viewed as a complementary strategy to equip families with the skills needed to support youth mental health at home.

Finally, participants underscored the importance of investing in what already works. They called for the creation of a statewide directory of effective programs, as well as funding to expand proven initiatives. Participants emphasized a focus on building school and community capacity through sustained coaching, mentorship, and collaborative models, moving New Jersey away from fragmented, one-off interventions toward a more integrated and lasting system of youth mental health support.

School-Based Services

Participants identified several school-based approaches that have shown promise in supporting youth mental health when implemented effectively and consistently across New Jersey. School-Based Youth Services (SBYS) were repeatedly cited as an example of delivering *actual* on-site services that go beyond referral and screening, providing students with direct access to counseling, health care, and social supports within their school environment. Where SBYS programs exist, they are seen as a vital bridge between academic life and the broader system of care, reducing barriers to access and helping students receive timely, comprehensive support. SBYS was the most consistent and robust theme identified within the data. Similarly, community schools, when effectively implemented, were noted to correlate with improved student wellbeing by integrating academic, health, and social services under one coordinated framework.

Several specific initiatives were highlighted as valuable assets that could be expanded or strengthened. The Traumatic Loss Coalition, which exists in every county and is coordinated through Rutgers, provides schools with resources and crisis response following traumatic events. Participants felt that this structure offers a strong foundation that could be built upon to extend ongoing mental health supports, not just post-crisis intervention. The Pathways for Academic and Career Success and Exploration to Success (PACES) program and the Clayton Model Pilot Program, which focuses on serving younger children, were also identified as effective models for earlier intervention and prevention. Open Gym Nights in Camden were cited as an example of a low-barrier, community-connected approach that provides safe spaces for youth to gather, reducing isolation and fostering positive engagement.

The Enhancing School Mental Health Services Project Model (ESMHS) project by Rutgers' Center for Comprehensive School Mental Health (CCSMH) was recognized for its focus on building capacity through coaching support, rather than relying solely on one-time professional development. This coaching model ensures that training translates into practice, improving both the quality and sustainability of school mental health systems. Participants stressed that the success of these school-based programs lies in their ability to combine accessibility, trust, and integration, meeting students where they are while connecting them to a broader continuum of care.

Community-Based Services

Participants identified a range of community-based mental health services and organizations that play a critical role in supporting youth outside of school settings. Youth centers and Boys & Girls Clubs were highlighted as accessible, trusted spaces where young people can build relationships, develop life skills, and access supportive programming in a non-stigmatizing environment. These settings were seen as particularly important for reaching youth who may not seek out traditional clinical services. The YMCA was also recognized for its dual role in offering direct services and acting as a connector to other resources, helping families navigate the broader landscape of youth mental health supports.

Statewide and regional programs were also noted as essential infrastructure for community-based care. The New Jersey Statewide System of Supports (NJ4S) was cited for its potential to provide consistent, coordinated services across the state, though participants emphasized the importance of ensuring equitable access in all counties. PerformCare, the state's contracted service system administrator, plays a central role in connecting youth and families to care, but participants expressed a need for more uniform services across counties to reduce disparities in access and quality.

Several localized initiatives were pointed to as strong examples of community-based collaboration. The Center for Family Services in Camden was recognized for its comprehensive programming, which addresses mental health alongside other family and community needs. The Good Grief Network was valued for providing specialized support to youth coping with loss, helping them process grief in healthy ways. In Camden, police department social workers partnering with schools were seen as a promising model for integrating community safety and mental health support, enabling early intervention and stronger connections between youth, families, and local services.

IMPROVEMENTS

Participants were asked what changes they would make right now to improve both short- and long-term outcomes related to youth mental health. Four areas of focus were identified in participant responses including expanding or sustaining youth mental health resources, removing policy barriers, improving practices in existing systems, and how to approach improvement in youth mental health systems.

The primary immediate change participants identify was related to resources available to improve youth mental health. Participants emphasized maintaining support and funding for effective mental health programs and prioritizing effective operating programs rather than identifying new programs. The primary program identified for expansion was School Based Youth Services. Further, participants recognized the disconnect between knowledge of mental health systems and access, advocating for a state clearing house for mental health services that catalog existing services and connect potential users to services. The clearing house might also include effective practices like effective implementation of community schools initiatives, tier 1, 2, and 3 social, emotional, and mental wellbeing supports, and available local, regional, and state public and private mental health programming.

Participants also identified several policy barriers that might be adjusted to increase access to youth mental health supports. A lower age of consent for students to access mental health services without an adult was suggested to improve access to existing services and increase the speed at which youth might receive supports. Participants also suggested increasing the portability of mental health and Medicaid funding across service delivery systems to use funding across public and private service systems. Universal mental health programming was repeatedly identified as a need across school contexts; participants suggested mandating universal mental health programming in schools to ensure that all students have access and a basic understanding of mental health.

Practice improvements across existing systems were identified across participants. Participants identified a desire to create cell-phone-free schools and limit social media access during the day. Mentorship and peer empowerment were a primary focus as participants sought to create systems of peer support and mental health knowledge. Participants also identified a need for transparency, information sharing, and coordination across existing mental health systems with a clearinghouse identified as a primary method for sharing information and connecting disparate systems.

Improving youth mental health is contingent on a consistent, clear, and explicit approach to supporting youth mental health across New Jersey. Understanding and evaluating our existing systems was seen as important to participants as data should drive decision-making across the state. There was also a need to more explicitly make mental health a priority across the State through policy and funding support, and shift supports from reactive to proactive. Finally, participants also expressed a desire to provide more training to all adults across mental health and family systems to understand what mental health is and how to approach supporting it within their communities.

Conclusion

The findings from this Summit underscore the complexity and urgency of strengthening youth mental health services across New Jersey. Participants identified deep and interrelated challenges around accessibility, knowledge of systems, stigma, caregiver bandwidth, and structural barriers that make it difficult for youth to receive timely, appropriate support. The disparity between those with private means to access care and those reliant on public systems is a defining feature of the current landscape, leaving too many young people without adequate services until crises emerge. These challenges are amplified for youth in rural areas, immigrant families, LGBTQIA+ youth, foster youth, and those with co-occurring disabilities or substance use concerns. At their core, the issues reflect a fragmented system where availability, access, and quality vary widely, and where families are often left to navigate complex pathways with little guidance.

Participants identified a range of needs and opportunities that can inform strategic action moving forward. Expanded and sustainable funding streams are essential to address provider shortages, reduce long wait times, and build infrastructure for both early intervention and long-term care. Stakeholders called for culturally responsive systems, better navigation tools, and universal school-based programming to ensure youth across every community have equitable access to support. Participants also emphasized that meaningful cross-system collaboration, including schools, health care, community organizations, families, and state agencies, is critical to breaking down silos and ensuring services are coordinated, rather than isolated or duplicative. This collaborative approach must intentionally incorporate student voices and community strengths to ensure solutions reflect actual experiences, not just professional perspectives.

The Summit also highlighted what is working. Programs like School-Based Youth Services (SBYS), the Enhancing School Mental Health Services Project Model, the Clayton Model

Pilot Program, Traumatic Loss Coalitions, community schools, and youth mentorship initiatives demonstrate the power of accessible, embedded, and sustained support. Participants advocated for expanding proven models rather than creating entirely new programs, pointing to the importance of investing in what works. A statewide clearinghouse of programs and practices was repeatedly identified as a key tool to strengthen coordination, improve transparency, and help families, schools, and providers navigate the landscape more effectively.

Moving forward, the insights gathered here should serve as a foundation for action, not simply observation. Expanding youth mental health services in New Jersey will require coordinated policy, funding, and practice shifts that prioritize proactive care, prevention, and equity. This includes lowering structural barriers to access, diversifying the provider pipeline, embedding mental health literacy and tiered supports across schools, and ensuring Medicaid and other funding streams are flexible and portable across systems. Just as importantly, building a shared culture of mental health awareness that normalizes care-seeking and centers youth voice will be crucial to sustaining long-term impact.

This Summit represents not only a map of the current landscape but also a roadmap for future collaboration and innovation. By building on existing strengths, aligning systems, and centering equity and prevention, New Jersey has the opportunity to create a more responsive, accessible, and resilient mental health system for all young people.

For more information on this report or to join the Youth Mental Health Advocacy Collaborative contact Liz Hansen Warner (lwarner@sel4nj.org), President of SEL4NJ, or Dr. Ross Whiting (rosswhiting@dogwoodconsulting.org) chair of the Youth Mental Health Advocacy Collaborative.

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Perspectives on Youth Mental Health in New Jersey: Effective Processes across School, Healthcare, Community, and State Systems

April 2026

WRITTEN BY
Ross Whiting, Ph.D., YMHAC Chair and President, Dogwood Consulting

MISSION

The mission of **SEL4NJ** is to continuously build a network of organizations and individuals in New Jersey that are committed to the importance of developing students' social and emotional competencies, and through this collaboration, promote a systematic and intentional integration of SEL, as broadly defined, in schools and other organizations, including before and after school programming.

VISION

The vision of **SEL4NJ** is that all students in New Jersey have access to schools that provide a culture and climate that is respectful, caring, challenging, engaging, inspiring, safe and healthy. These schools are civic-minded and culturally responsive, promoting educational equity and helping students and adults build social-emotional competencies and developing positive relationships connecting them to the school, their community, and each other.

With Support from the Social Emotional Learning Alliance for New Jersey's Youth Mental Health Advocacy Collaborative (YMHAC):
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Introduction

The Social Emotional Learning Alliance of New Jersey's (SEL4NJ) Youth Mental Health Advocacy Collaborative (YMHAC) hosted a second information-gathering statewide Youth Mental Health Summit on December 17th, 2025 at the New Jersey Principals and Supervisors Association in Monroe Township, NJ. Founded in 2023, YMHAC is a collaborative group of regional and statewide nonprofit, advocacy, and program partners interested in driving New Jersey policy and systems towards more proactive, coordinated, accessible, and effective youth mental health services. An initial Summit was held on July 9th, 2025 focused on gaps, barriers, asset, challenges, and needs across youth mental health systems results from that Summit are available in a separate report. The second Youth Mental Health Summit invited regional and statewide leaders in youth mental health policy and practice to engage in structured small- and whole group discussions, information sharing and networking. This Summit focused on information gathering and sharing to identify common themes related to ideal youth mental health processes across school, healthcare, State, and community systems. This report includes methods and reporting from the Summit, and focuses primarily on the presentation of information to inform systemic and policy changes across youth mental health systems.

In Spring 2025 YMHAC members identified a need to convene regional and state leaders from across New Jersey to share information and breakdown silos related to youth mental health systems. Recognizing a need for a common understanding of youth mental health systems in New Jersey, YMHAC members identified multiple structured Summits as a format for sharing and documenting information across youth mental health systems in New Jersey. An initial Summit attended by 37 participants was held in July 2025 focused on gaps, barriers, assets, challenges, and needs. This report focuses on a second Summit held in December 2025 focused on the identification of ideal youth mental health processes across school, healthcare, State, and community systems.

Methods

Dr. Ross Whiting, Chair of YMHAC and President of Dogwood Consulting, an evaluation, organizational development, and advocacy organization, collaborated with YMHAC members to develop Summit structures focused on convening leaders, gathering information, and creating networks across disparate youth mental health systems. YMHAC members used spider-web recruitment methods to identify participants in the Summit focusing first on their immediate networks for youth mental health professionals, then asking them to also identify and recruit Summit participants via email. YMHAC members ultimately emailed over 200 partners who are youth mental health leaders across school districts, healthcare institutions, State agencies, and community-based organizations to attend the Summit, encouraging contacts to recommend people to attend the Summit within their own networks. 97 participants RSVP'd to attend the Summit, with 71 people

ultimately attending. Generously hosted by Karen Bingert at the New Jersey Principals and Supervisors Association in Monroe Township, New Jersey, the Summit was held from 8:30am to 12:30pm at NJPSA with concerted, facilitated data collection and discussion taking place from 9:30am to 11:30am.

The YMHAC team developed an agenda that included facilitated discussion and note-taking focused on developing ideal youth mental health systems across four contexts: school, healthcare, State-funded, and community-based systems. Participants were asked to self-organize into small groups focused on each of those four systems. Small groups consisted of 4-10 people at each table. A unique digital note-taking document was created and labeled for each group. A QR code and a list of links to note-taking documents were disseminated both in the room and digitally before the conference to facilitate collaborative group note-taking. Groups were given guidance on note-taking for the Summit and designated a note-taker within each group. Participants self-selected their context area of focus by selecting a note-taking document with a QR code linked to a shared note-taking document and moving to a table labeled and numbered with a group. Eight school groups, three State groups, three community-based groups, and one healthcare-focused group were formed.

Dr. Whiting facilitated the Summit with a presentation and prepared speaker's notes. The Summit introduction included goals, guidelines for engagement, a brief presentation of findings from the first Summit in July 2025, opportunities for community building, and note-taking guidance. Participants were informed that a report (the present report) would be shared after the Summit, and would be used to inform future Summits and make recommendations focused on solutions and action.

Dr. Whiting shared practical logistics including a desire for participants to prioritize their comfort, sharing and discussion timing, and the identification of a note-taker at each table. After each phase of small-group engagement, whole-group discussion was facilitated. Small group note-takers included volunteers at each table during small group discussions, and YMHAC members Kristy Ritvalsky, Deputy Director, and Stuart Luther, Senior Consultation and Training Specialist from the Center for Comprehensive School Mental Health at Rutgers University. Dr. Whiting reviewed the discussion and information sharing approach that focused on curiosity, collaboration, and brainstorming through judgement-free building on the ideas of others to share information within small- and whole-group discussions. Six guiding questions were provided via QR code or pre-distributed digital link. Dr. Whiting gave short introductions of each question area, then provided structured time (~10 minutes of small group discussion and ~5 minutes of whole-group discussion) for participants to brainstorm first in small, then with the whole group. Many participants stayed after the formal facilitated session to share information and network.

A template of the notetaking document with guiding questions is available in Appendix A. Dr. Whiting conducted data analysis using ATLAS.ti qualitative data analysis software using open-coding to identify themes across the data. Themes identified through data analysis were organized into six major areas with the most prevalent, strongest, and consistent themes presented at the beginning of each section.

Results

CROSS-SYSTEM COLLABORATION

Cross System Collaboration

The most dominant theme is the need for seamless, structured collaboration across systems, particularly between schools, community-based organizations, healthcare providers, and State systems. Participants repeatedly emphasized warm hand-offs, shared responsibility, and continuity of care so that youth and families do not experience gaps when moving between settings. Schools were consistently identified as a primary entry point into the mental health system, but not as a stand-alone solution; instead, respondents called for integrated referral pathways, shared portals or communication systems, regular cross-system meetings, and clearly defined roles (such system navigators) to ensure follow-through. Information sharing was viewed as essential to keeping "everyone on the same page," particularly during transitions such as hospital discharge, entry into community services, or re-entry to school. Privacy and confidentiality requirements were noted as constraining the ability to engage in such collaboration.

A second major sub-theme related to cross-system collaboration centers on trust-based relationships among organizational members and shared infrastructure to support collaboration. Across community, school, and State data, participants stressed that collaboration works best when it is grounded in long-term relationships, mutual accountability, and consistent funding structures. There were frequent calls for reduced competition for funding, multi-year investments, memoranda of understanding, and statewide uniformity in expectations, measures, and processes to create an environment more conducive for positive relationship development. Respondents highlighted the importance of engaging caregivers, leveraging trusted community organizations, and activating existing community networks including faith and justice partners to support a whole-child, healing-centered continuum of care. Without aligned incentives, stable funding, and common protocols, collaboration was described as fragmented and overly dependent on individual relationships rather than systems.

Finally, a less frequent but still meaningful sub-theme relates to State-level alignment and system stewardship. Participants identified disconnects among education, healthcare, and State systems of care, calling for clearer accountability, stronger data systems, and better integration of statewide access points and screening processes. There was a shared sense that the State has a critical role in convening partners, addressing data privacy barriers, and setting conditions that make collaboration the default rather than the exception. While mentioned less often than school-community dynamics, these State-level actions were framed as necessary to sustain and scale effective cross-system collaboration over time.

Communication and Information Sharing

Across the Summit data, the most prominent sub-theme related to communication is the need for consistent, streamlined, and bidirectional communication across systems. Participants repeatedly emphasized that communication must be intentional, timely, and embedded in day-to-day practice rather than dependent on individual effort. This included calls for warm hand-offs, shared portals, notification systems, and clearer feedback loops among schools, community providers, healthcare systems, and families. Breakdowns in communication (particularly during transitions such as hospital discharge or referrals to external services) were described as a major barrier to continuity of care. Respondents stressed that seamless communication is essential to ensuring youth do not fall through gaps and that families are not left to navigate systems alone, which participants worry leads to reduced service utilization.

Another major theme centers on communication grounded in relationships, trust, and shared responsibility. Across school and community settings, participants noted that effective communication depends on strong partnerships and mutual understanding of roles, rather than siloed or transactional exchanges. Open communication between academic and non-academic systems, schools and community providers, and service providers and caregivers were repeatedly identified as critical to expanding access and improving outcomes. Many participants highlighted the need for shared expectations, consent structures, and collaborative problem-solving when services are unavailable or systems become overwhelmed. Communication was framed not just as information exchange, but as an ongoing process that reinforces collaboration and shared ownership of youth mental health.

An additional sub-theme focused on balancing information sharing with privacy, consent, and role clarity. Participants frequently noted that legal and regulatory constraints, such as FERPA and HIPAA, create real barriers to communication, often leaving schools without access to critical clinical information. There were repeated calls for sensible, proactive consent processes and clearer protocols that define what information can be shared, with whom, and for what purpose. Importantly, respondents highlighted that information sharing must be paired with clear plans for action including guidance for educators to support students returning from treatment, to ensure meaningful support rather than confusion or inaction. One participant identified information sharing protocols similar to concussion protocols between healthcare systems and schools as a possible solution to this challenge.

Participants also pointed to structural and State-level communication challenges. These included disconnects between education systems and the broader system of care, limitations related to data access and consent, and the need for more efficient statewide communication pathways. Suggestions included clearer State guidance, improved infrastructure to support information sharing, and intentional inclusion of underutilized partners such as faith-based organizations. While discussed less often than school- and

community-level communication, these sub-themes highlight the role of the State in setting conditions that enable consistent, coordinated communication across all levels of the youth mental health system.

School-Healthcare Connect

Across the Summit data, the most prominent theme related to school–healthcare system connection is the need for seamless, bidirectional partnerships that support continuity of care for youth. Participants emphasized that schools and healthcare providers must be better aligned through streamlined referrals, shared communication pathways, and clearer expectations during key transition points such as hospital discharge and reentry to school. Respondents highlighted persistent gaps in information sharing, noting that schools are often not entitled to or able to access clinical information needed to support students effectively, while healthcare providers may lack insight into school-based supports. To address this, participants identified a need for shared portals, advanced consent processes, and sensible information-sharing protocols that ensure everyone including youth, families, healthcare providers, and school staff are on the same page and able to act on recommendations.

INTAKE AND IDENTIFICATION

Screening

Across the Summit data, the most common sub-theme related to screening systems is the strong consensus that universal, proactive screening is essential for early identification and prevention, particularly in school and pediatric settings. Participants repeatedly described schools as the most effective and equitable environment for identifying youth needs, given their regular contact with students, and emphasized the value of universal screeners administered once or twice a year. Screening was framed not only as a tool for identifying risk, but as a foundation for a tiered system of supports that shifts systems from reactive crisis response to proactive prevention. Respondents highlighted the importance of using both quantitative and qualitative data, tracking progress over time, and linking screening results to appropriate services and referrals.

A second major sub-theme centers on humanizing the screening process and ensuring it is supported by trained adults and clear pathways to care. Participants emphasized that screening must be developmentally appropriate, culturally responsive, and grounded in trust, rather than feeling punitive or purely clinical. Teachers, counselors, pediatricians, and other frontline staff were identified as critical observers, but many noted that training and capacity constraints (including high counselor case-loads) limit their ability to serve as effective screeners without additional support. Ongoing professional development, shared responsibility across school staff (including non-classroom teachers), and access to tools such as telehealth clinicians were seen as key to ensuring screening leads to timely, compassionate follow-up rather than unmet needs.

Less frequently, participants discussed system-level infrastructure and equity considerations related to screening. These included the use of technology to streamline data collection and referrals, integration of mental health indicators into health or academic records, and clearer processes for information sharing among schools, healthcare providers, and families. Respondents also raised concerns about obtaining universal screening consent, access for underserved populations, and ensuring that screening results translate into available services. Together, these insights underscore that effective screening systems require not only the right tools, but coordinated systems, sufficient capacity, and intentional safeguards to ensure screening improves outcomes rather than revealing needs systems cannot meet.

Referral Process

Across the Summit data, the most common sub-theme related to referral processes is the need for formalized, seamless referral pathways that move youth quickly from identification to appropriate support. Participants emphasized that referrals should be based on clear observations and documented standardized criteria, rather than ad hoc decision-making, and that schools and community organizations are critical entry points into the mental health system. Participants highlighted the importance of connecting youth to services not available in schools through well-defined handoffs to community- and State-based providers, with minimal burden on families. Timeliness was identified as a key concern, with repeated attention to how quickly referrals are made, how treatment plans are determined, and whether youth actually access services after a referral is initiated.

Participants also discussed ways to make mental health infrastructure and workforce supports that make referrals effective rather than symbolic. Participants noted the need for tracking systems to monitor referrals, follow-up, and outcomes, ensuring accountability across touchpoints. Ongoing training for staff across systems was identified as essential so educators, community providers, and first responders can recognize need and initiate appropriate referrals with confidence. Some participants also raised the idea of expanding referral pathways beyond traditional systems, such as integrating mental health response into emergency dispatch, underscoring a broader vision of referrals as part of a coordinated, responsive network rather than a single handoff between agencies.

Identification of Needs: School, Families and Self, and Healthcare

The most prominent sub-theme related to mental health need identification is the view that schools are the primary and most effective setting for early identification of youth mental health needs, particularly through universal screening and daily observation by trusted adults. Participants consistently emphasized that teachers, counselors, administrators, and other school staff are well positioned to notice early signs of distress because of their ongoing relationships with students. Universal screeners administered once or twice a year were frequently cited as a valuable tool for systematically identifying need, though participants also noted concerns related to implementation, capacity, and

follow-through. Closely tied to this was the emphasis on building educator capacity and mental health literacy, with repeated calls for training to help teachers recognize minor struggles, understand contributing factors, and feel more confident initiating referrals or conversations about mental health.

Self-identification and family-identification of mental health needs was identified as a sub-theme with a focus on family-centered approaches that make it safe and normal for families to recognize and share concerns about youth mental health. Participants emphasized that families are often the first to notice changes and are essential partners in both identification and intervention, but they need clear, welcoming pathways to disclose concerns and seek help. Creating environments where organizations feel safe, nonjudgmental, and responsive to families was described as critical to encouraging earlier identification. Family engagement was repeatedly framed not as an add-on, but as a core feature of effective youth mental health systems.

Another sub-theme focuses on the limits of youth self-identification and the need for supportive structures to help youth express their needs. Participants noted that many young people may not yet have the language or confidence to name what they are experiencing, which can delay help-seeking. Universal or simple surveys and check-ins were suggested as tools to help surface concerns that youth might not verbalize on their own. Less frequently, but still notably, participants referenced the role of counselors and shared processes that allow both students and families to raise concerns, underscoring that self- and family identification work best when supported by clear referral pathways and responsive adults.

Initial identification of mental health needs in healthcare settings was the final sub-theme related to identification of children's mental health needs. In this sub-theme there was recognition that pediatric and primary care settings are key partners in early identification, especially when paired with structured screening and cross-system information sharing. Participants highlighted universal screeners in pediatric or settings as an important mechanism for surfacing concerns early, and noted that pediatricians are often a trusted first point of contact for families.

Approach to Supports

Whole Child/Family

Whole-child and whole-family approaches were identified as a primary sub-theme within the data with a focus on a call for family-centered, relationship-driven systems that treat youth mental health in the context of their caregivers, schools, and communities. Participants consistently emphasized engaging families as partners through family therapy, family-centered care, and intentional strategies to build trust and buy-in. Families were viewed as essential to both identification and successful intervention, with repeated references to the need for strong communication and shared understanding among schools, providers, and caregivers. This reflects a shift away from child-only models

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toward approaches that recognize youth well-being as deeply connected to family support, safety, and stability.

A sub-theme highlights the importance of coordinated, team-based systems that wrap around the child and family. Respondents described follow-up and care as "concentric circles" of support, involving schools, community organizations, and providers working together through regular meetings, shared decision-making, and collective impact models. Teaming structures, liaisons, and shared portals were suggested to ensure consistent collaboration and progress monitoring. These ideas reinforce the belief that no single system can meet all needs and that alignment across partners is central to whole-child care.

Participants also discussed whole-child frameworks that consider social, emotional, and environmental factors alongside mental health symptoms. Concepts such as healing-centered engagement, social-emotional learning (SEL) lenses, and dual-factor models point to a broader understanding of youth well-being that includes strengths, relationships, and community context. Embedding these priorities into district and system-level goals was seen as a way to sustain whole-child and whole-family approaches over time.

Community Knowledge

Participants identified that effective youth mental health support depends on providers understanding the families, cultures, and everyday contexts of the communities they serve. Participants repeatedly emphasized knowing kids and their families, building relationships through family engagement, and creating welcoming spaces where families feel safe and respected. Activities like family nights, early parent engagement, and ongoing communication in multiple languages and formats were highlighted as ways providers can stay connected to real community needs. This reflects a belief that community knowledge is not secondary to clinical expertise, but foundational to trust, relevance, and early help-seeking.

Participants also discussed leveraging existing community networks and assets as part of care. Respondents noted that trusted community-building groups, local organizations, arts and sports programs, faith communities, and community schools all play important roles in youth well-being. Providers were encouraged to "hook into" these networks, recognize community gatekeepers, and partner with local organizations to pilot initiatives and expand reach. Rural communities were also noted as places where strong informal supports can be an asset. Participants conveyed that when providers are connected to community resources and relationships, they are better able to deliver culturally responsive, accessible, and sustained supports for youth and families.

Trust Building and Relationships

Across the Summit data, building trust with children and families was critical to intentionally create safe, relationship-centered environments where youth and caregivers feel respected, heard, and protected. Participants repeatedly emphasized family engagement, family-centered care, and communication grounded in trust as core strategies. Creating safe spaces for students to share personal experiences, using restorative practices, and hosting approachable events like family nights were all described as practical ways to build comfort and openness. Trust-building was framed as an ongoing process that requires time, consistency, and authentic relationship-building rather than one-time outreach. Many respondents also noted that when families view organizations as safe and supportive, they are more likely to seek help early and stay engaged in services.

A second sub-theme highlights barriers to trust and the importance of cultural and contextual responsiveness. Participants acknowledged that some families have low trust in formal systems, and that fear and uncertainty (particularly among vulnerable populations such as undocumented families) can limit engagement. This underscores the importance of safety, transparency, and partnerships with trusted community gatekeepers who already have strong relationships with families. Schools and providers were encouraged to meet families where they are, invest time in relationship-building, and collaborate closely with community partners. Trust was described as foundational: without it, even well-designed services may go unused, but with it, systems can better support youth and families in meaningful, sustained ways.

Strengths-Based Approaches

Summit participants identified strengths-based approaches with a focus on seeing and supporting the whole child by intentionally identifying and building on students' strengths alongside their challenges. Participants repeatedly highlighted strengths-based mindsets, the ability to enhance strengths, and the importance of both adults and students naming what youth do well. This approach was closely tied to creating non-stigmatizing environments where students feel safe sharing their experiences and developing confidence. A positive school climate and culture that values social and emotional learning was described as a key condition that allows strengths-based work to take hold, shifting the focus from deficits to growth and resilience. Less frequently, but still notably, participants connected strengths-based care to practical strategies such as training frontline staff to recognize assets and using Tier One practices like positive communication with families, reinforcing that strengths-based approaches are most effective when embedded in everyday interactions and system-wide culture.

Marginalized Groups

Prioritizing safety, accessibility, and trust for families who may fear or face barriers engaging systems was a prominent sub-theme within Summit data. Participants

highlighted that undocumented students and families often experience high levels of fear in institutional settings, making psychological and physical safety a prerequisite for any effective support. Closely related was the emphasis on language access, with repeated calls for free translation services and accessible hubs where families can receive support in their preferred language. Confidential processes for student and parent input were also noted as important for protecting privacy and encouraging honest engagement, particularly for those wary of systems.

A second sub-theme centers on structural inequities that shape access to care. Socioeconomic disparities were described as creating uneven access to services and supports, while rural communities were noted as sometimes having stronger informal supports but fewer formal resources. Participants also pointed to system-level constraints that limit how explicitly underserved groups can be targeted, suggesting a need for more flexible and equity-focused policies. The data reflect a consistent message that improving youth mental health systems requires intentional efforts to reduce language, economic, geographic, and documentation-related barriers so that marginalized families can safely and fully participate

SUPPORTS AND SERVICES

Education: Family/Caregivers

Education for families and caregivers was seen as the basis for effective supports and services as participants identified a need for accessible, ongoing learning opportunities that help caregivers understand youth mental health and how to navigate supports. Participants repeatedly emphasized that parents and caregivers need clear, practical information about available services, tiers of support, and how mental health systems work so they can make informed decisions for their children. This included calls for caregiver supports alongside child services, family therapy, and family-centered models that treat caregiver education as part of care rather than an add-on. Engagement at the elementary level was seen as critical so that knowledge and relationships are built proactively in early years.

Engagement strategies that make education meaningful and culturally responsive were seen as critical to caregiver and family education. Respondents highlighted that simply providing information is not enough; schools and providers must build trusting relationships with caregivers and present information in digestible, accessible ways. Cultural beliefs, stigma, and differing views on mental health were noted as important considerations, requiring sensitivity and adaptation in how information is shared. Funding and dedicated resources for family engagement were frequently mentioned as necessary to do this well. Data suggest that effective youth mental health systems depend on informed, empowered caregivers who are treated as partners in the process.

Tier 1: Universal Supports

Tier 1 supports were identified as the most important tier of supports as universal, preventative mental health systems were the foundation of effective youth mental health systems. Participants consistently described tier 1 as essential for all students, not just those identified as high need, framing it as prevention, mental wellness promotion, and skill-building that benefits every child. Social and emotional learning curricula across grade levels, leadership and SEL integration, and even mental health prevention as a standard class were highlighted as ways to normalize mental health and reduce stigma. Many respondents connected tier 1 to positive school climate, noting that safe, supportive environments and everyday practices including positive communication with families are core Tier One strategies. The idea that "all youth need mental health support" and that tier 1 should be continuous, proactive, and developmentally embedded was a repeated message. Participants also emphasized that high-quality tier 1 support requires trained staff, consistent delivery, and intentional design rather than one-off programs. Creative and artistic expression opportunities were also named as meaningful universal supports that foster belonging and well-being. Tracking movement across tiers and aligning tier 1 with broader tiered systems of care were seen as important for system coherence.

Tier 2: Small Group Supports

There is a clear need for clear, structured pathways that connect screening and identification to timely, targeted group interventions. Participants emphasized that effective tier 2 services depend on having screening processes that reliably identify which youth would benefit, as well as clear education for families and staff about what tier 2 is and when it is appropriate. Small group supports were described as a flexible middle layer that can respond to emerging needs before they escalate. Providing families with options and involving them in referral decisions was also highlighted, reinforcing that tier 2 works best when it is transparent and collaborative. Participants considered needs for small groups to run effectively including sufficient staffing to run groups, clarity around privacy regulations in group settings, and systems to track student movement across tiers to ensure the right level of support over time. Funding constraints were also mentioned as a barrier, with concerns that tier 2 (like tier 1) often lacks stable financial support.

Tier 3: Individual Supports

Effective tier 3 services require clear pathways to intensive, individualized, and crisis-responsive services supported by strong partnerships and clinical expertise. Participants emphasized that effective tier 3 requires trained clinicians, coordinated networks of support, and warm handoffs to ensure youth with the highest needs receive appropriate care. Screening and tiered frameworks were described as essential for identifying which students require this level of support, while matching the right professional to the student's needs was seen as critical for effectiveness. Respondents also highlighted the need to support students during transitions back to school after intensive services,

underscoring that tier 3 individual care extends beyond crisis response to include reintegration and continuity.

Needs Matching

Matching needs to available supports was most often described as requiring data-informed, structured decision-making to align the intensity and type of services with student and school needs. Participants emphasized using indicators, screening data, and systems-level analysis to determine best-fit supports, noting that some schools and communities face higher levels of need and should be resourced accordingly. Early identification (including attention to basic needs) was seen as critical so concerns can be addressed before they escalate, and respondents stressed matching staff roles and expertise to the level of student need while prioritizing significant mental health concerns when present. Less frequently, but importantly, participants noted that accurate matching is limited by system capacity: long waitlists, service shortages, and delayed access often prevent timely care. Effective matching depends on good data, early recognition of need, and a continuum of accessible services able to respond quickly.

Social Emotional Learning

SEL was identified as most effective when it is an intentional, system-wide mindset rather than a stand-alone program. The importance of shared training, common vocabulary, and a shared framework were seen as central to building consistency so that all adults understand their role in supporting students' social and emotional development. Participants repeatedly emphasized an SEL-minded approach across tiers, with proactive, ongoing supports embedded in daily practice and school culture. SEL was framed as something you build intentionally over time with leadership and systematic programming across grade levels reinforcing this preventative orientation. Participants also referenced dedicated spaces and centers that support connection and student well-being, suggesting that both mindset and infrastructure contribute to strong SEL implementation.

Education: Mental Wellbeing

There was a consistent call to embed mental health learning into regular educational experiences so it becomes a normal, preventive part of school life. Participants emphasized integral mental health and wellness into orientations, offering standard prevention-focused classes, and hosting strategic educational events that build awareness and skills before problems escalate. This reflects a shift toward normalization and early literacy, where students and families understand mental well-being as part of overall health. A second, related sub-theme is the need for adult capacity-building through professional development, ensuring educators and staff are prepared to deliver and reinforce mental health education.

EFFECTIVE PRACTICES

Training Identification

The most consistent sub-theme related to training needs is the call for broad-based mental health literacy and identification training for all adults who interact with youth. Participants repeatedly emphasized that teachers, pediatricians, frontline staff, counselors, and psychologists need stronger preparation to recognize early signs of distress, respond appropriately, and understand typical versus concerning age-related behavior. Training was seen as especially important for educators, including pre-service teachers, given their daily contact with students. Mental Health First Aid and similar foundational models were highlighted as useful for building a universal baseline of knowledge.

A second sub-theme centers on the need for shared frameworks, common language, and alignment across systems. Participants stressed training that builds a common vocabulary, shared understanding, and an SEL-informed mindset so that responses to student needs are consistent rather than fragmented. Professional development was described as needing to be ongoing so skills remain current and embedded in practice. Training in how to survey or screen students and how to interpret those results was also noted, linking training directly to early identification systems.

Systems Approach

Participants identified a need for a systems approach to care that includes intentional, coordinated structures that make youth mental health support consistent, proactive, and embedded in everyday practice rather than episodic or reactive. Participants repeatedly emphasized systematic SEL programming, tier 1 supports that are ongoing and preventive, and embedding mental health into school culture and climate. Universal screening and data-informed identification were viewed as core system functions that allow schools to act early and align supports to need. There was also a strong feeling that districts must set clear priorities for proactive identification and intervention so that mental health is treated as a core educational responsibility, not a peripheral service.

Participants identified a need for alignment and coherence across schools, counties, and State systems. Respondents described a need for greater uniformity and more cohesive guidance, including shared outcome measures and clearer structures that prevent communities from operating in isolation. The idea of "one system" appeared frequently, with suggestions for liaisons, cross-district collaboration, and closer coordination with community agencies. Collective impact approaches featuring shared goals, data, and decision-making were highlighted as models that can hold multiple partners together around common outcomes.

Participants emphasized the relational and operational infrastructure that sustains a systems approach. Dedicated teaming time, standardized processes, regular cross-partner meetings, and active family involvement were seen as necessary to make systems function in practice. The concept of a true continuum of care was identified as a unifying idea, requiring everyone to understand their role and stay connected across levels of support.

Staff Navigators

Across the Summit participants identified a need for dedicated people who help families move across complex systems and maintain continuity of care. Participants repeatedly emphasized navigator or liaison roles that support families between healthcare, school, and community settings, especially during transitions such as discharge from higher levels of care. Navigators were seen as a way to reduce confusion, prevent families from falling through gaps, and ensure warm handoffs between providers. The idea of a consistent point person or "champion" for the student or family was identified as particularly important, suggesting that relationships and reliability are central to effective navigation.

A second, related sub-theme highlights navigation as a shared function across systems rather than a single role. Schools, pediatricians, and community partners were all described as having a part to play, with some participants envisioning schools taking a more active coordinating role and others suggesting liaisons from community agencies. Training frontline staff to recognize needs and connect families to the right supports was also noted as a way to strengthen navigation capacity.

Barriers, Challenges, and Needs

Barrier: Confidentiality

Patient confidentiality was identified as the primary barrier (as well as a priority) in cross-system information sharing. Participants identified a tension between protecting child privacy and enabling effective coordination of care. Participants repeatedly described confidentiality rules as a barrier to collaboration, particularly when schools, healthcare providers, and community partners need to share information to support students. Confusion around when privacy laws apply and what can be shared created uncertainty that often led to less communication rather than careful communication. Many respondents called for clearer guidance, sensible information-sharing approaches, and practical protocols that allow teams to coordinate while still protecting student rights. There was also strong interest in structured solutions like secure portals, notification systems, and defined processes for sharing relevant information that could reduce ambiguity and support continuity of care.

A second sub-theme centers on consent and family engagement as the gateway to appropriate information sharing. Participants emphasized the need for clear, proactive consent processes, including advance permissions and ongoing home–school

communication agreements, so that collaboration is possible before crises arise. Parent knowledge and willingness to share information were seen as critical, yet sometimes limiting when families are hesitant. Suggestions such as memorandums of understanding, cross-system meetings, and defined disclosure pathways point to a desire for predictable structures that balance transparency, trust, and legal compliance. The data suggest that navigating confidentiality successfully requires clearer rules, stronger communication with families, and systems that make appropriate sharing easier rather than exceptional.

Need: Evaluation and Accountability

Evaluation was a major need identified by participants across the Summit. Participants identified a need for consistent, standardized measurement and data systems to understand impact and guide decisions. Participants repeatedly emphasized the need for shared outcome measures, common reporting requirements, and greater uniformity across providers and regions so results can be compared and learned from statewide. Tracking systems, annual screening data, and progress monitoring over time were viewed as essential to seeing the "whole picture" of student needs and system performance. Respondents also highlighted the value of evidence-based programs and clear standards of care, signaling a desire for evaluation to inform what is funded and sustained. There was strong agreement that without consistent data and evaluation structures, it is difficult to know what works or to scale effective practices.

A second major sub-theme centers on accountability, fidelity, and meaningful use of data. Participants raised questions about who is responsible for holding systems accountable and noted that disincentives for accountability can weaken evaluation efforts. Measuring whether services are true interventions, ensuring fidelity of implementation, and identifying general success metrics were described as critical components of quality evaluation. Both quantitative and qualitative approaches were mentioned, with anecdotal and formal data collection seen as complementary. Teaming processes were also linked to evaluation, as they support intentional progress monitoring and shared review of data.

Less frequently, but notably, participants pointed to capacity and literacy challenges related to evaluation. Some noted that many practitioners need stronger data literacy to interpret and use findings, and that data collection systems should be streamlined so they do not overburden staff. Questions about whether programs provide useful aggregated data further reflect a desire for evaluation that is practical and actionable. Stakeholders see evaluation as central to improvement, but only if it is standardized, supported, and meaningfully connected to decision-making.

Need: Funding

Three sub-themes related to funding were identified within the data. The most prominent sub-theme related to funding is the need for stable, sustainable, and predictable financing that allows youth mental health supports to be maintained over time rather than built and lost in cycles. Participants repeatedly stressed sustainability, noting that external or short-

term grants require clear long-term plans and that programs should not depend on changing political leadership. Schools and community organizations highlighted that funding greatly limits the amount and type of services they can provide, with particular gaps for tier 1 and tier 2 prevention. There were frequent calls for consistent state support, operating-budget prioritization, and multi-year funding so that staffing, programming, and relationships can be sustained.

A second sub-theme centers on how funding flows and what it covers. Respondents emphasized that funding must support operational and staff costs, not just program ideas, and that allocation decisions matter as much as total dollars. Several participants pointed to inequities driven by socioeconomic disparities, where communities with fewer resources struggle to access or match funds. Private providers and contracted services were sometimes described as financially unsustainable, reinforcing the need for smarter allocation and system-level planning. Family engagement and collaboration efforts were also named as areas needing dedicated funding, suggesting that relational work requires financial backing.

Participants also discussed leveraging insurance and cross-sector funding mechanisms. Ideas included billing Medicaid or private insurance for school-based services, partnering healthcare systems with schools, and improving knowledge of available funding sources. Some also referenced broader structural solutions such as universal coverage concepts, insurance alignment, and flexibility in funding thresholds. Effective youth mental health systems depend not only on more funding, but on sustainable, flexible, and well-coordinated financing that supports prevention, early intervention, and intensive care across settings.

Barrier: Policy

The disconnect between policymakers and policy was noted amongst Summit participants. Participants identified a misalignment between policy design and on-the-ground realities. Participants suggested that decision makers are often too far removed from practice, leading to policies that do not reflect school and community conditions. References to legislators needing closer connection to communities, keeping politics out of youth mental health, and making funding decisions more informed by lived experience all point to this gap. Administrative turnover and shifting priorities were also seen as undermining continuity. Respondents raised workforce-related policy issues such as staffing ratios, role overload, and age thresholds for services that can limit early intervention.

Barrier: Stigma

Across the Summit data, the most prominent sub-theme related to reducing stigma is the need to normalize mental health as part of everyday wellness and prevention rather than something associated only with crisis or treatment. Summit attendees repeatedly emphasized normalizing mental health conversations, embedding wellness into school

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orientations, and using proactive screening and prevention models so support feels routine and universal. Broad tier 1 framing and social-emotional learning for all students were seen as powerful stigma-reduction strategies because they position mental health as "basic nutrition" for everyone, not a signal that something is wrong. Creating safe, non-stigmatizing environments where schools see and support the whole child was also central, reinforcing that climate and messaging matter as much as services.

A second major sub-theme focuses on family and cultural influences on stigma. Participants noted that families are essential partners in identification and intervention, but stigma (which is shaped by cultural beliefs, fear, or mistrust) can delay help-seeking. Addressing cultural differences in how mental health is understood, engaging families early, and making conversations accessible and respectful were described as key to reducing stigma. Concerns about confidentiality and consent also intersected with stigma, as some families hesitate to share information or accept services due to fear of labeling or exposure.

Less frequently, but notably, participants highlighted structural stigma and fear among vulnerable groups. Undocumented families and underserved communities may avoid services due to fear or perceived risk, and the label of "being in treatment" itself can be a barrier. Respondents identified a need to reduce these barriers through inclusive messaging, warm handoffs, and universal supports that make seeking help feel safe and typical. The data suggest that stigma is reduced when mental health is normalized, culturally responsive, and embedded in universal systems rather than isolated as a specialized service.

Barrier: Ongoing Care

Ongoing care was identified as a primary theme as participants recognize that youth mental health support must be continuous and well-coordinated over time, yet systems often operate in fragmented, short-term ways. Attendees reported that care cannot be "one and done," pointing to delays in initial connections, unclear follow-through when providers are unavailable, and situations where schools believe supports are in place when they are not. Transparency about service availability and clear processes for what happens next when a referral cannot be met were seen as critical to maintaining continuity. Respondents also highlighted the importance of thoughtfully managing the duration of services and planning how to fade supports without abruptly ending care, reinforcing that transitions require as much attention as entry into services. High staff turnover in community agencies, unstable funding, and disconnects between state systems and education settings were described as major contributors to inconsistency. Access points such as County or wellness hubs and tiered approaches that build supportive climates were mentioned as ways to stabilize care. Participants identified that coordination, stability, and long-term commitment were critical to implementing ongoing care.

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Barrier: Waitlists

Across the Summit data, the most prominent theme related to provider bandwidth and waitlists is the reality that current staffing levels and caseloads are too high to meet student needs in a timely way. Participants repeatedly pointed to school psychologists and counselors carrying heavy caseloads that limit their ability to serve as front-line identifiers or provide ongoing care. Time constraints and competing responsibilities were described as major barriers, with calls to free mental health staff from non-core duties so they can focus on student support. Universal screening was often viewed as valuable in theory, but difficult to implement well when staff lack the time and capacity to respond to identified needs. Respondents conveyed that identification without sufficient provider bandwidth can overwhelm systems rather than help students.

Participants identified that access delays and workaround signal insufficient system capacity. Long waitlists, slow initial connections to services, and roadblocks in referral pathways were common concerns. Some participants noted that families and schools sometimes turn to private vendors because they are faster, even if that creates inequities in access. Greater transparency about service availability and offering families multiple referral options were suggested as partial solutions, but these do not replace the need for more provider capacity. The data suggestion that reducing waitlists requires both increasing workforce capacity and redesigning workloads so providers have the time and focus needed to deliver care

Need: Language Accessibility

Language accessibility was identified by participants as a primary need. Participants identified a need for clear, culturally and linguistically accessible communication so families can understand, trust, and use mental health supports. Participants repeatedly emphasized that language access is foundational to equity, with calls for free translation services in schools, community hubs where families can receive interpretation, and materials available in multiple languages. Respondents also noted that accessibility is not only about translation but about clarity including using digestible, jargon-free language so results, referrals, and service information are understandable to caregivers. When information does not reach families in an accessible way, engagement and follow-through suffer.

Need: Early Grades/Years

Participants identified a need to start identification and support as early as possible, particularly in early childhood and elementary settings. Participants repeatedly emphasized that waiting until middle school misses key opportunities for prevention and early intervention, noting that elementary teachers are often well positioned to recognize emerging needs. Early supports were framed as both developmental and preventative, with suggestions to begin programming in the elementary years and to provide help in the

environments where challenges naturally appear, such as classrooms and daily school contexts.

Conclusion

Across the Summit findings, a clear and consistent message was identified: youth mental health systems must move from fragmented, reactive efforts to coordinated, preventive, and relationship-centered systems of care. The most consistent themes including cross-system collaboration, strong communication and information sharing, universal prevention and early identification, and whole-child and whole-family approaches point to a shared vision where schools, healthcare, community organizations, State systems, and families operate as one connected system. Participants repeatedly emphasized that youth mental health is not the responsibility of any single system and that schools, while a critical entry point, cannot succeed alone. Trust, cultural responsiveness, strengths-based mindsets, and community knowledge were identified as foundational conditions that make services usable and meaningful for families. At the same time, persistent barriers including confidentiality confusion, unstable funding, policy misalignment, stigma, workforce shortages, and long waitlists continue to prevent systems from functioning as intended.

The findings also highlight that prevention and early intervention must be the backbone of the system. Tier 1 universal supports, social-emotional learning, early screening, and mental health education for students and families were consistently named as high-impact strategies that normalize mental health and reduce stigma. Participants underscored that identification without follow-through capacity can do harm, reinforcing the need to pair screening with referral pathways, provider bandwidth, and ongoing care. Evaluation and accountability were identified as critical levers for improvement, with calls for shared metrics, standardized reporting, and data systems that inform decisions rather than burden practitioners. Likewise, families must be treated as partners through education, navigation support, and accessible, culturally and linguistically responsive communication.

New Jersey State and its local communities must intentionally build integrated, sustainable youth mental health systems rather than isolated programs. This includes investing in cross-system infrastructure, stable multi-year funding, and workforce capacity, clarifying confidentiality and consent processes to enable responsible information sharing, and embedding mental health into everyday school and community life from the earliest grades. Policymakers and system leaders must align policies with practice realities, center youth and family voices, and prioritize prevention as much as crisis response. When collaboration is structured, funding is stable, data guides decisions, and families are true partners, youth mental health systems can become accessible, effective, and equitable. The Summit's collective engagement signals a readiness for this shift; the next step is coordinated action to make it real.

Appendix A

1. **Identification of youth who need supports**
    a. What would an ideal process look like for **identifying which youth with mental health needs** who are served in this context and for ensuring early and accurate identification of needs particularly among underserved groups (i.e. elementary age children, LGBTQIA+ youth, multilingual families and youth, foster youth, and youth with disabilities). Think **where, who identifies, and how needs are identified.**

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2. **Intake and service matching**
    a. What would an ideal process look like for collaboration and communication with caregivers and the identification of appropriate supports and services for identified youth? Think **communication methods, education, format and accessibility, and collaboration.**

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3. **Types of services and services provided**
    a. If we were designing a system from scratch, what services should be offered in or by this context? What services should *not* be offered? Think **tiers of services** (1-universal, 2-small group, and 3-individual), **level of service** (proactive, responsive, urgent, or crisis), **duration** (short-term: one or a few sessions, medium term: ongoing sessions over several weeks or months, or long-term: ongoing sessions over months or years) and **types of services** (counselling, SEL, behavior modification and management,

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4. **Monitoring, follow-up, and reporting**

a. What would an effective process look like for monitoring youth progress, ensuring continuity of care across contexts, and sharing information responsibility so no youth "fall through the cracks" and kids' circles of adult support stay informed within privacy constraints? Think **personal growth tracking, outcomes tracking, and reporting formats and audiences.**

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5. **Collaboration with external partners**
    a. What would a seamless process look like for coordinating across schools, community, providers, healthcare systems, state agencies, and other partners so families experience greater continuity of care and support rather than silos of care? Think **communication and information sharing, and reduction in redundant/increase in service efficiency.**

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6. **Funding, accessibility, and service format**
    a. Review your answers above; through the lens of your context, what tweaks to these processes would ensure **accessibility** (financially, geographically, linguistically), **sustainable funding** (types of funding), **multiple-formats** (in-person, school-based, telehealth, community-based), and **responsiveness to community needs.**

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SEL4NJ

Technical Summary

Perspectives on Youth Mental Health in New Jersey: Effective Processes across School, Healthcare, Community, and State Systems - April 2026

WRITTEN BY
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MISSION

The mission of **SEL4NJ** is to continuously build a network of organizations and individuals in New Jersey that are committed to the importance of developing students' social and emotional competencies, and through this collaboration, promote a systematic and intentional integration of SEL, as broadly defined, in schools and other organizations, including before and after school programming.

VISION

The vision of **SEL4NJ** is that all students in New Jersey have access to schools that provide a culture and climate that is respectful, caring, challenging, engaging, inspiring, safe and healthy. These schools are civic-minded and culturally responsive, promoting educational equity and helping students and adults build social-emotional competencies and developing positive relationships connecting them to the school, their community, and each other.

With Support from the Social Emotional Learning Alliance for New Jersey's Youth Mental Health Advocacy Collaborative (YMHAC):
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Introduction

The Social Emotional Learning Alliance of New Jersey's (SEL4NJ) Youth Mental Health Advocacy Collaborative (YMHAC) hosted a second information-gathering statewide Youth Mental Health Summit on December 17th, 2025 at the New Jersey Principals and Supervisors Association in Monroe Township, NJ. Founded in 2023, YMHAC is a collaborative group of regional and statewide nonprofit, advocacy, and program partners interested in driving New Jersey policy and systems towards more proactive, coordinated, accessible, and effective youth mental health services. An initial Summit was held on July 9th, 2025 focused on gaps, barriers, assets, challenges, and needs across youth mental health systems. Results from that Summit are available in a separate report. The second Youth Mental Health Summit invited regional and statewide leaders in youth mental health policy and practice to engage in structured small- and whole group discussions, information sharing, and networking. 81 Statewide leaders attended this Summit which focused on information gathering and sharing to identify common themes related to ideal youth mental health processes across school, healthcare, State, and community systems.

This report is intended to guide discussions to create more proactive, coordinated, accessible, and effective youth mental health systems across New Jersey. **A summary of findings from the Summit is included below.**

SYSTEM AND SUPPORT COLLABORATION

- **Seamless cross-system collaboration** across schools, community organizations, healthcare, and State systems is foundational, with schools as key entry points within integrated, shared-responsibility models.
- **Coordinated, team-based structures** are required to deliver wraparound supports, emphasizing shared decision-making, consistent communication, and aligned care processes.
- **A system-wide, proactive approach** embedding mental health into school culture and leveraging data-informed practices is essential for consistent identification and intervention.
- **Stronger State-level evaluation and accountability** are needed to ensure alignment, integration, and the institutionalization of collaboration across systems.
- **Comprehensive, ongoing training and shared frameworks** support mental health literacy, consistent responses, and early identification across youth-serving professionals.
- **Sustained infrastructure for collaboration** including teaming structures, shared goals, and family engagement is necessary to maintain an integrated continuum of care across school, community, healthcare, and State systems.

IDENTIFICATION, REFERRAL, AND CONTINUITY OF CARE

- **Universal, proactive screening across schools and healthcare settings** is foundational for early identification and prevention, with schools serving as the primary access point.
- **Clear, documented referral pathways with accountability mechanisms** are essential to ensure identified needs lead to timely, appropriate services.
- **Continuity of care through warm hand-offs and coordinated transitions** including hospital discharge and school reentry is critical to prevent gaps in support.
- **Multi-source identification** including engaging schools, families, youth, and healthcare providers strengthens early detection and response.
- **Dedicated and shared navigation supports** improve access, guide families through systems, and sustain continuity across service.

SUPPORTS AND SUPPORT APPROACHES

- **Tiered systems of support (Tiers 1–3)** provide a structured continuum, with universal prevention (Tier 1), targeted group and brief interventions (Tier 2), and intensive individualized care (Tier 3) all requiring clear pathways, coordination, and sustained resources.
- **Social-emotional learning as a system-wide approach** requires shared frameworks, consistent training, and integration across school culture rather than stand-alone programming.
- **Whole-child and whole-family approaches** are central, emphasizing family-centered, relationship-driven care that integrates youth mental health with family, school, and community contexts.
- **Strengths-based approaches** promote resilience and reduce stigma by focusing on youth assets, positive school climate, and embedding social-emotional learning into everyday practice.
- **Equity-focused supports for marginalized groups** are essential, addressing barriers related to language, immigration status, socioeconomic disparities, and access to ensure safe, inclusive participation in services.

TRAINING AND EDUCATION

- **Effective identification requires trained, supported adults and sufficient system capacity,** ensuring screening is human-centered and leads to timely follow-up.
- **Caregiver education and engagement** are foundational, requiring accessible, culturally responsive learning opportunities that empower families to understand mental health and navigate supports as active partners.
- **Mental health education and literacy** should be embedded across school experiences for both students and adults to normalize mental wellness and support early intervention.

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COMMUNICATION AND INFORMATION SHARING

- **Shared infrastructure and communication systems** including referral pathways, data platforms, and defined roles are needed to support consistent, real-time collaboration are needed to support screening, referrals and equitable access to care.
- **Privacy, consent, and data-sharing barriers** limit coordination and require clearer protocols and solutions.

RELATIONSHIP AND TRUST BUILDING

- **Family and community engagement** and **community-informed care** are essential components of a coordinated, whole-child mental health system as providers seek to understand and engage with local cultures, families, and existing community networks to ensure relevance, trust, and accessibility.
- **Trust-building and strong relationships** are foundational, with sustained engagement, safe environments, and culturally responsive practices necessary for families to access and remain in care.

GAPS, BARRIERS, AND NEEDS

- **Confidentiality and consent barriers** limit cross-system communication, with unclear guidance and privacy concerns hindering coordinated care and information sharing.
- **Lack of standardized evaluation and accountability systems** creates challenges in measuring impact, ensuring fidelity, and using data effectively for decision-making and scaling.
- **Insufficient, unstable, and inequitable funding** constrains service availability, workforce capacity, and sustainability, particularly for prevention and early intervention.
- **Policy misalignment and system disconnects** between decision-makers and on-the-ground realities hinder effective implementation, continuity, and workforce support.
- **Stigma and cultural barriers** reduce help-seeking, particularly among families and marginalized groups, requiring normalization and culturally responsive approaches.
- **Fragmented and inconsistent ongoing care** limits continuity, with gaps in follow-through, transitions, and coordination across systems.
- **Workforce shortages and high caseloads** contribute to long waitlists, delayed access to services, and limited capacity to respond to identified needs.
- **Language and communication barriers** reduce accessibility and engagement, highlighting the need for culturally and linguistically appropriate information and supports.
- **Delayed identification and intervention**, particularly in early childhood, limit opportunities for prevention and timely support.

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NJPSA
NEW JERSEY PRINCIPALS AND SUPERVISORS ASSOCIATION

NJPSA Survey Results on Student Mental Health/NJ4S Services

In anticipation of proposed changes to the state's delivery of student mental health services in New Jersey by the Sherrill administration, the NJ Principals and Supervisors Association (NJPSA) conducted a member survey between March 27, 2026 and April 14, 2026. The focus of the survey is student mental health needs in New Jersey, the provision of mental health services in and outside of school, and our members' experiences with NJ4S, the NJ Statewide Student Support Services program offered by the NJ Department of Children and Families. The following is a summary of the Survey results.

Survey Respondent Demographics

NJPSA's Student Mental Health/NJ4S Survey was completed by 201 respondents serving in a broad range of school leadership roles including principals, assistant principals, directors, assistant superintendents, counselors, and supervisors. Respondents work in schools across all regions of the state and serve a diverse population of students. Respondents also represent all grade levels and grade bands including PreK-2, grades 3-5, middle level, high school and districtwide.

Survey Framework

The NJPSA Survey is organized into four sections, Section I, respondent demographic information, Section II, student mental health needs in schools, Section III, NJPSA member experiences with NJ4S and Section IV, NJPSA member recommendations. At the end of Section II, members were asked if they had experience with the NJ4S program. If a member answers "yes", the member is directed to Section III of the survey which contains 18 questions on their experience working with the NJ4S program. Out of the 201 total respondents, 165 members completed the NJ4S Section III. If a member answers "no", he/she is directed to the Section IV recommendations section which contains four additional substantive questions. All respondents were directed to Section IV. Key questions provided an opportunity for a member to comment.

Executive Summary

New Jersey school leaders report a systemic and escalating student mental health crisis that schools are increasingly unable to manage with existing resources;

Over 90% of respondents identify anxiety as a primary issue, with depression, trauma, and home-related stress also widespread;

Up to 40%+ of students in many districts are experiencing mental health challenges;

Schools are functioning as a primary mental health provider, due to failures in access to community-based care; however staffing challenges, the lack of licensed mental health staff in many schools, and insufficient mental health training limit schools ability to respond to overwhelming student needs;

School leaders identify a variety of local resource gaps that impact their ability to respond including insufficient funding, a lack of resource support at the elementary levels, language barriers that impact service delivery and communications with parents, insurance barriers, and regional service gaps.

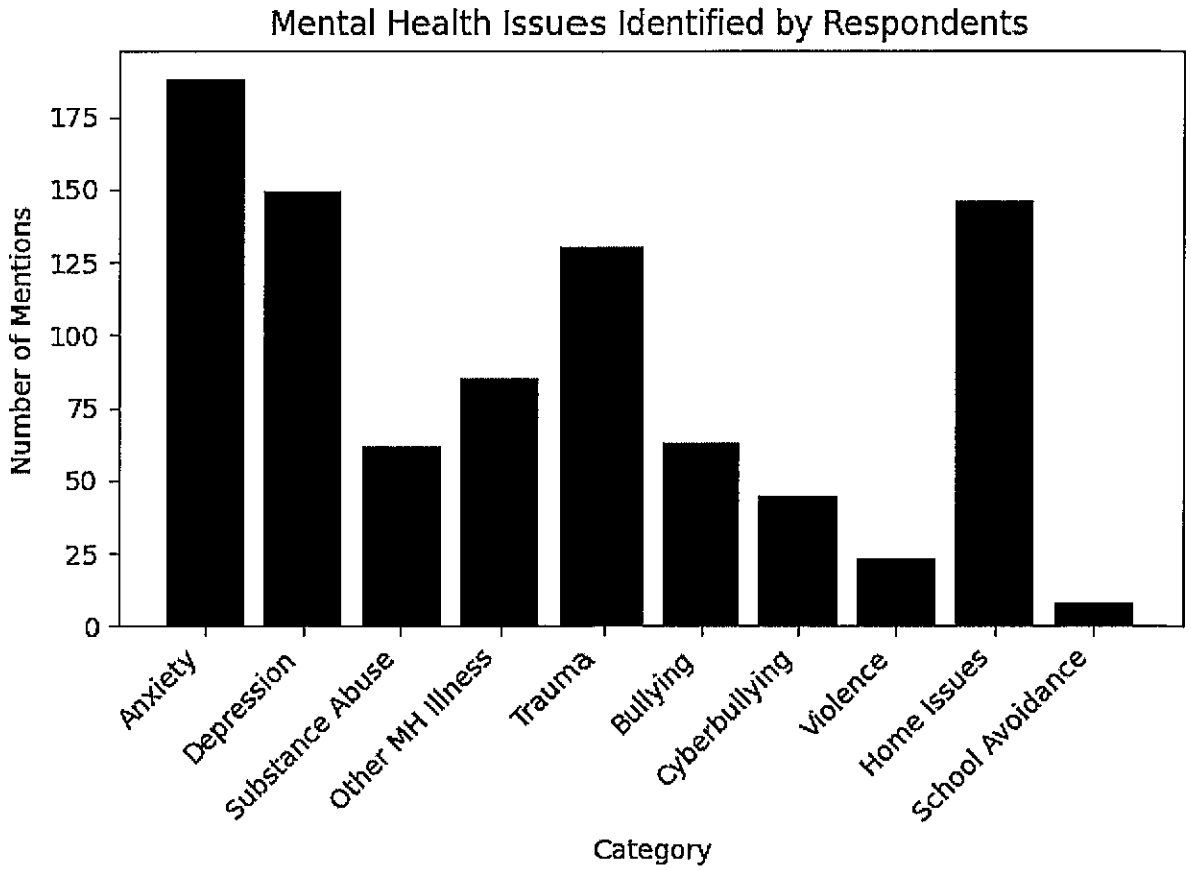
The most urgent need is increased in-school clinical capacity, supported by sustainable state funding and stronger integration with external services. Without intervention, districts warn of continued increases in crisis events, school avoidance, and unmet student needs.

School leaders also strongly value the services currently provided by the NJ Statewide Student Support Network (NJ4S) noting that this program has had a critical impact on their neediest students, has removed important barriers to mental health access (insurance and transportation) through on-site services, and has empowered staff through specialized training. **They urge continued funding of NJ4S in FY 2027, coordination of agency roles, and stakeholder engagement in the development of SPARK to avoid the disruption of student services and to build upon what works in schools.**

74x

Section II Student Mental Health Needs in School - Taking the Pulse
Section II focuses on the range of mental health needs our members are experiencing with their local student populations, the types of resources schools need to meet these needs, barriers to providing services and member priorities.

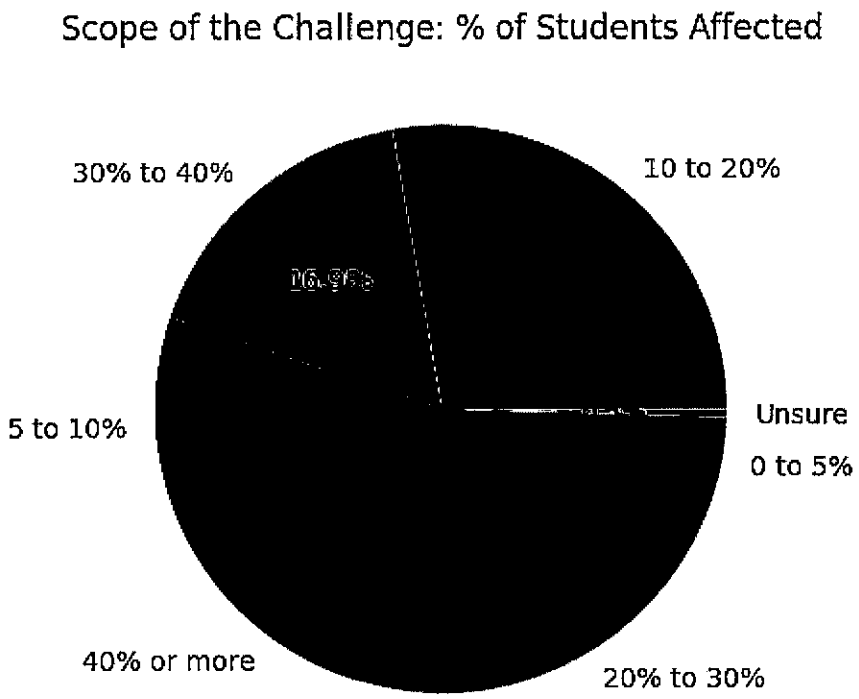
Most Pressing Mental Health or Behavioral Issues
Respondents were asked to indicate all areas that applied in their schools and had the opportunity to comment. The top mental health issues our members are experiencing include student anxiety (89.9% of respondents), depression (70.2%), issues at home (69.7%) and trauma (61.8%).



Scope of the Challenge
Respondents estimated the percentage of their student bodies currently experiencing one or more mental health issues:

75x

- Student mental health needs are widespread, with a majority of respondents reporting that at least 10% - 30% of their student population is impacted.
- Nearly half (49%) report moderate to high prevalence, estimating that 20% to 40% of students are experiencing mental health challenges.
- More than 1 in 3 respondents indicate high-impact environments where 30% or more of students are affected.
- The largest group of respondents (27.9%) report 10-20% of students with challenges.
- Findings also show that extreme levels of need, identified as 40% or more of the student populations, exist in some districts.
- Only a small minority of school leaders report low prevalence (under 10%).

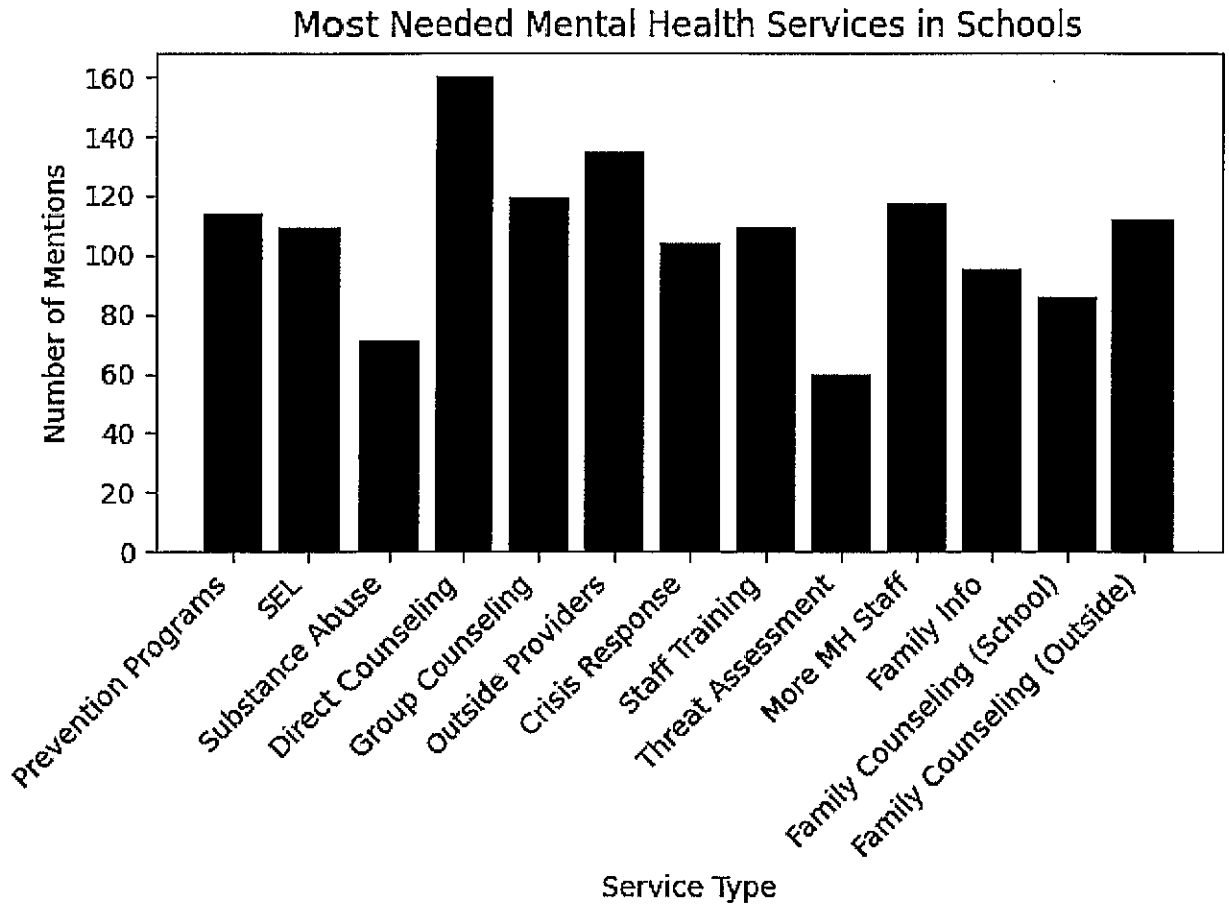


Most Needed Mental Health Services

Survey respondents strongly identified direct student counseling services at school (79.6%) as the top need in their schools. Other critical services identified include access to outside mental health professional services, group counseling in school, family counseling options and prevention programs.

76x

- Direct, in-school counseling is the top priority (79.6%), reinforcing that schools need immediate, on-site clinical capacity to meet student demand.
- Access to external mental health providers remains a critical gap (67.2%), highlighting ongoing barriers beyond the school system, including cost, availability, insurance restrictions, and coordination.
- Schools are seeking a multi-tiered support model, with strong demand for group counseling (59.2%), prevention programs (56.2%), and social-emotional learning (54.2%)
- Family engagement is a key component of effective care, with significant demand for family counseling (42.8%–55.2%) and family information programs (46.8%).
- Training and crisis response capacity are essential but insufficient, as over half of respondents identify the need for staff training (54.2%) and crisis response services (51.2%).

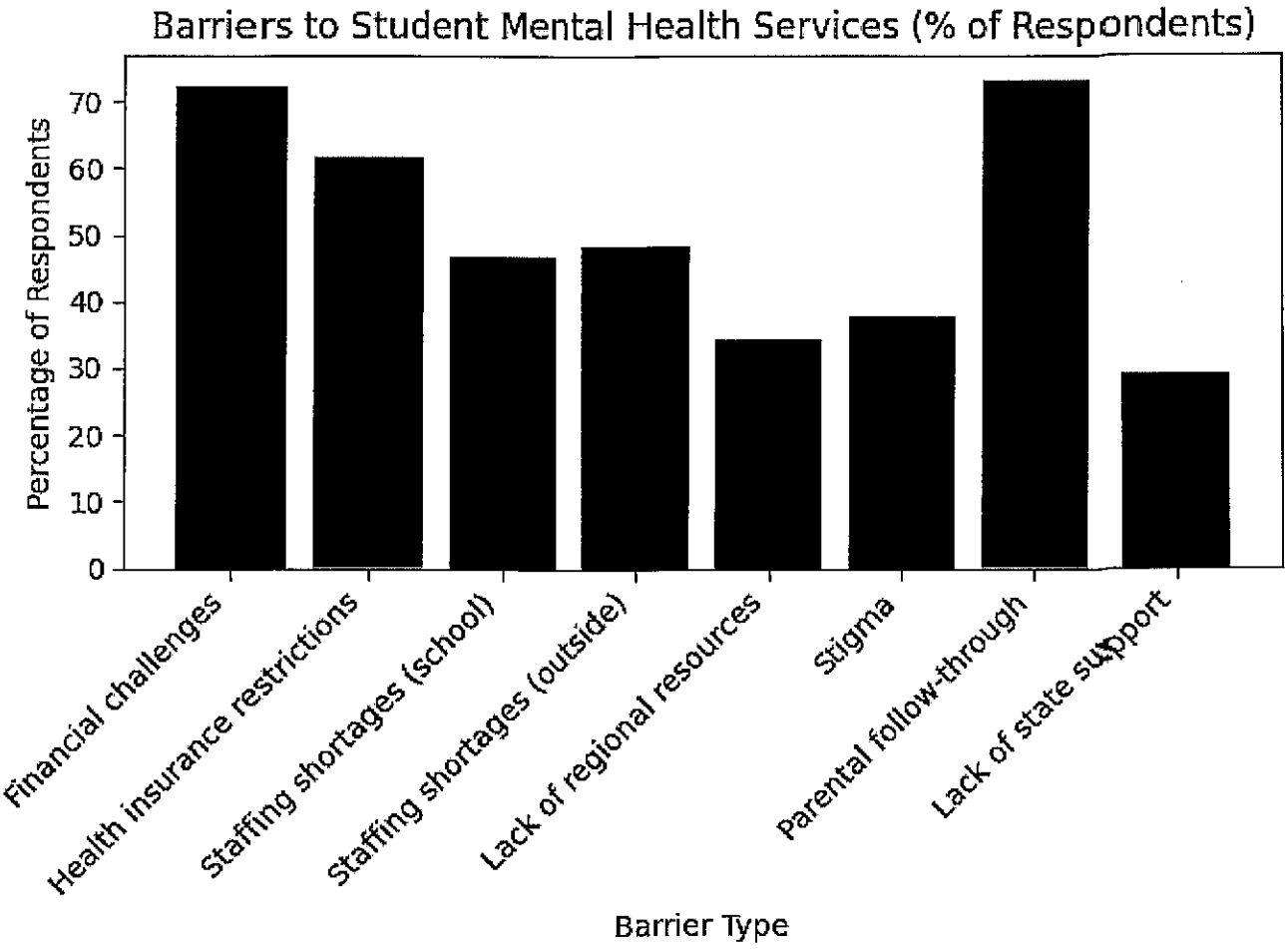


77x

Primary Access Barriers to Mental Health Services
Survey respondents reported that the top barriers are:

- Lack of Parental Follow-Through (73.1%) (pink bar)
- Financial Challenges (72.1%) (blue bar)
- Insurance restrictions

While often minimalized, it is clear that better communication and resources for parents are critically important issues that need to be addressed.



78x

Identified Mental Health Resource Gaps in Districts
Survey respondents answered an open-ended question (Question 10) asking them to share what mental health services resource gaps existed in their district. The 201 respondents answered this question with the following trends emerging in their responses:

- **Insufficient In-School Staffing and Resources:** Districts lack sufficient mental health professionals (counselors, social workers, clinicians) in schools, resulting in high student-to-counselor ratios (e.g., 450-to-1), shared counselors across buildings, and limited capacity for individual, small group, and long-term counseling, particularly at the elementary level. Many feel the need for more dedicated mental health staff to move beyond triaging and focus on consistent, preventative programs.

- **Barriers to Accessing Outside Services:** Families frequently struggle to secure mental health support outside of school due to issues with insurance (including lack of coverage or few providers accepting Medicaid/NJ FamilyCare), affordability, transportation challenges (especially in rural areas), and long waitlists for external providers, including partial hospitalization programs (PHPs) and intensive outpatient programs (IOPs).

- **Need for Tiered and Specialized Support:** There is a significant gap in providing consistent Tier 2 and Tier 3 interventions, including individualized counseling and specialized behavioral therapies. There is also an urgent need for community-based, after-hours care, as school staff cannot provide 24/7 crisis support.

- **NJ4S is Currently Filling Key Gaps:** Multiple districts explicitly state that NJ4S has been "successful" and "invaluable" in bridging resource gaps by providing student counseling and connecting families to outside services, especially for students whose parents cannot afford or access external therapy, or for those needing individual counseling in school. **There was a widespread sentiment expressed that the potential loss of NJ4S would create significant new resource gaps.**

- **Gaps in Training, Family Engagement, and Language Accessibility:** Districts report a need for more free or low-cost staff training options in trauma-informed practices, de-escalation, and mental health awareness. Additionally, there is a recurring gap in engaging families, with many noting difficulty in obtaining "parent buy-in" and follow-through with outside referrals. There is a critical shortage of bilingual/Spanish-speaking mental health professionals, which limits equitable care for multilingual learners and engagement with Spanish-speaking families.

Representative Member Comments for Question 10
"Students are not able to access quality mental health services due to insurance, transportation, affordability, quality and availability issues. Crisis resource options are poor." - School Administrator
"The gaps largely center on limited access, insufficient staffing and lack of preventative supports. Our schools have overburdened counselors and no licensed mental health professionals. Additionally, stigma, low awareness, and limited trust among families reduce student engagement with available supports. The community faces gaps in early intervention and consistent, equitable delivery of mental health services." - Director
"The biggest mental health gap is access to mental health services outside of school for young students (under 10) who need intense therapy/need a therapeutic setting. There is a group of students whose needs go beyond the services of school-based counseling, Perform Care, UBHC and /or CHAT." - Instructional Dean
"NJ4S fills some gaps since health insurance is not required." -Director
"There are very few services for children and adolescents and the ones out there are overburdened so they are very selective on who they accept and approve for services. They also do not serve a lot of families without insurance. Access to bilingual services is also a major roadblock." -Principal

Key Change/Resources Needed for Improved Mental Health Outcomes

Survey respondents answered this open-ended question with the following themes and trends in many comments.

- **Increased Staffing and Direct In-School Counseling:** The most frequently cited need is increased funding for, and hiring of, dedicated mental health professionals (school counselors, social workers, psychologists, and clinicians) who can provide direct, consistent, one-on-one, and group therapeutic counseling services during the school day. This is crucial for immediate access, crisis evaluation, reducing caseloads, and providing Tier 2 and Tier 3 supports, especially at the elementary level.

80x

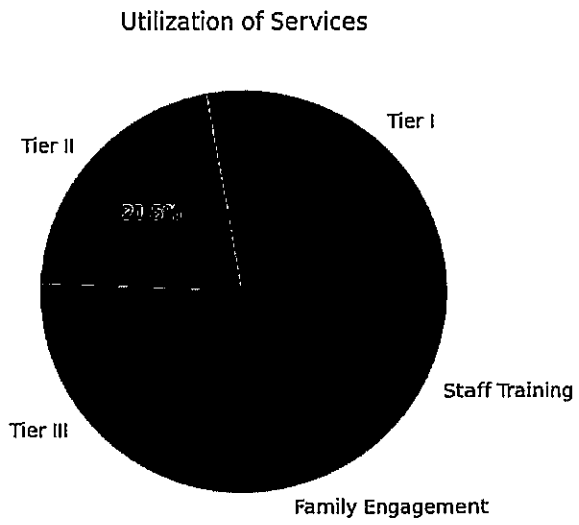
- **Improved Access and Reduced Financial/Systemic Barriers:** Respondents repeatedly called for more access to low-cost or free mental health resources for students and families, particularly those that eliminate significant barriers such as long waitlists, complex paperwork, insurance limitations, and financial burdens. This includes establishing a formal clinical bridge between school and community care, regardless of insurance carrier.
- **Enhanced Family Engagement and Outside Resources:** A critical need is for stronger connections and collaboration with external mental health providers, as schools are often overburdened. This includes providing in-home family support, parent education, offering services after school hours, and ensuring parental follow-through in treatment plans.
- **Funding and Program Sustainability:** Maintaining and increasing state funding is essential, with many responses specifically mentioning the importance of continuing the NJ4S program, while also expanding programs to earlier grades (primary/elementary) and ensuring long-term sustainability against rising costs.
- **Specialized and Crisis Services: T**here is a need for specialized, mid-level resources for mental health crises that are more than a school counselor but less than an overwhelmed emergency room.

Section III: NJ4S Review

Section III focuses on school leaders' experiences working with the NJ Statewide Student Support System (NJ4S). Respondents were asked to identify what NJ4S services they have utilized, to rate the effectiveness of each tier of services utilized, to rate the responsiveness of the program and its providers, and to provide input and recommendations for the future. Of the 201 respondents, 64.2% (165) have utilized NJ4S services in their school, 17.9% were unsure of district participation and 17.9 % had not used NJ4S services.

Respondents who answered "no" to this question moved on to Section IV. Respondents (36) who indicated that they have not utilized NJ4S services cited a lack of awareness of NJ4S services; the availability of certain services in-house, no outreach from NJ4S and concerns with the quality of services available.

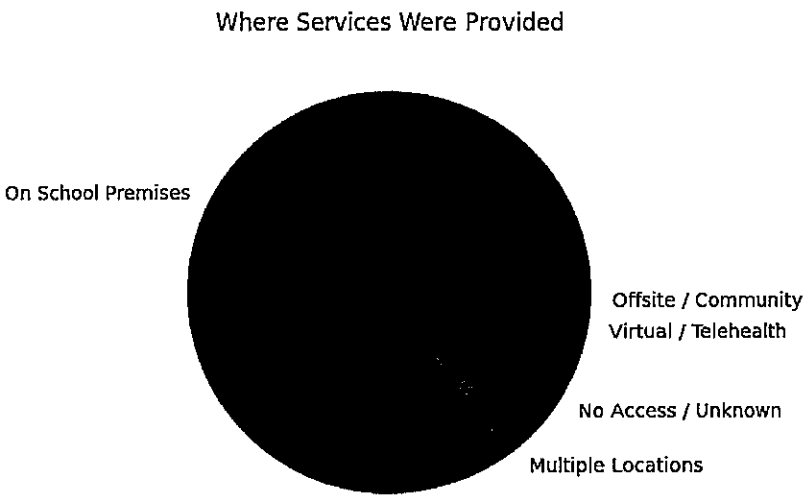
Services Utilization



While Tier I to Tier III services show strong utilization, lower engagement in family and staff supports highlights a critical gap in system-wide impact.

- Tier I (27.8%) → largest share (broadest reach)
- Tier III (22.8%) and Tier II (21.5%) → strong clinical and targeted usage
- Gap areas:
    - Staff Training (14.7%)
    - Family Engagement (13.2%)

Service Location is Critical



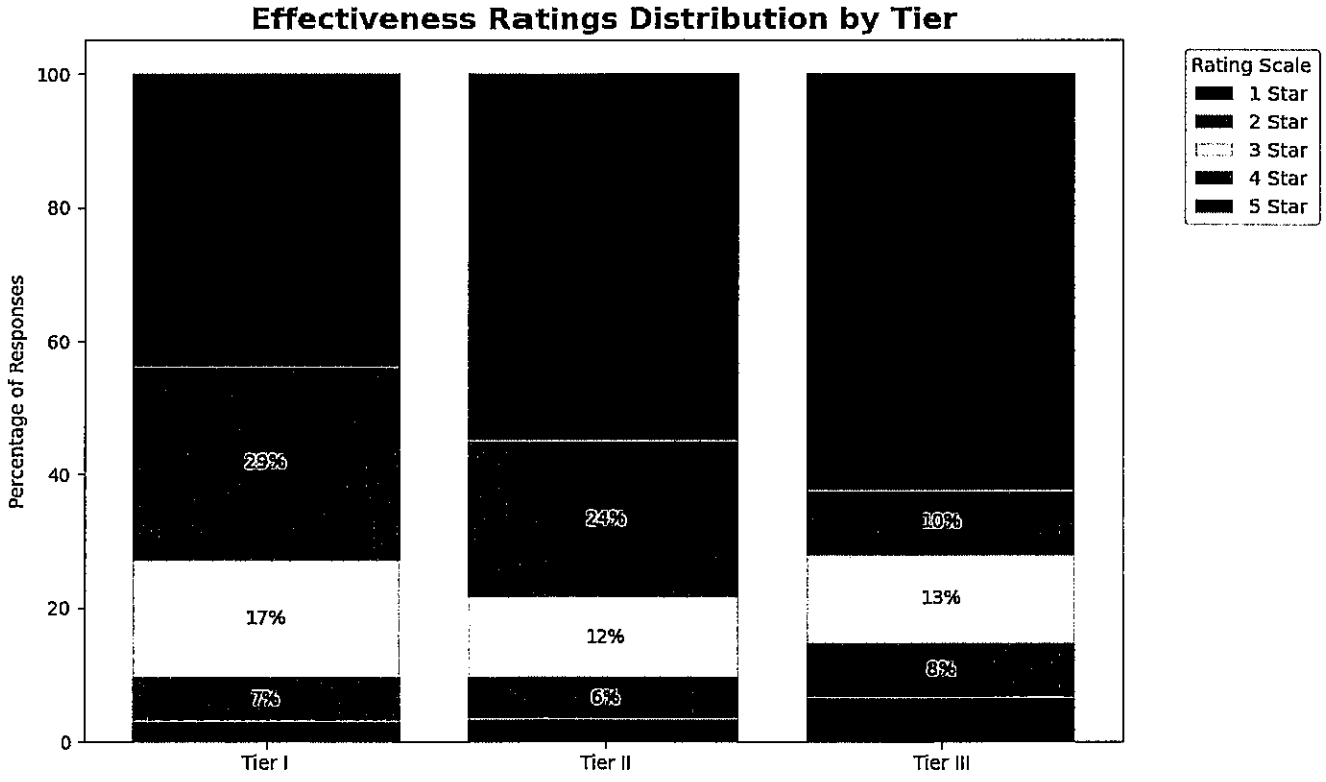
Respondents indicate that school-based access is not optional - it is essential, reflecting the central role schools play in delivering mental health services. Respondents overwhelmingly agreed that providing the mental health services students need **at the school facility** is of the utmost importance.

82x

Effectiveness Ratings for NJ4S Tiered Services

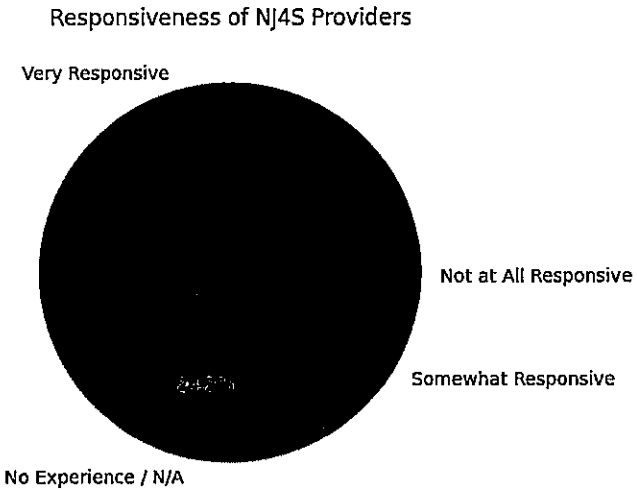
School leaders rated the effectiveness of each tier of service provided by NJ4S on a scale of one to five with one being ineffective and five being most effective.

- Tier III stood out among respondents with the highest concentration of "5 (extremely effective)" ratings
- Tier II is strong and well-balanced, with a large share of 4s and 5s
- Tier I shows more spread, with a noticeable mix across 3–5 and slightly more lower ratings than the others
- Across all tiers, negative ratings (1–2) are minimal, reinforcing overall program effectiveness



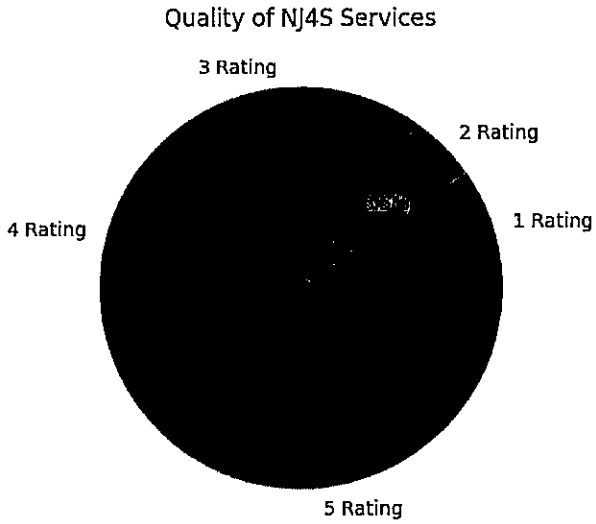
83x

Responsiveness of NJ4S Providers



59.4% of survey respondents reported that providers are "Very Responsive", while just 15.8% of survey respondents reported that providers are "Somewhat Responsive"

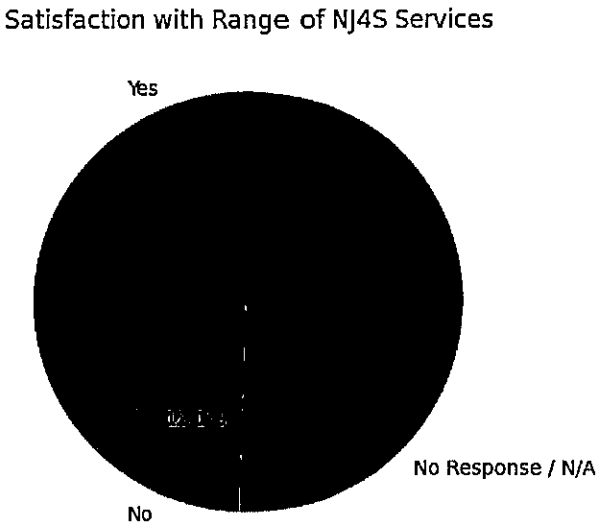
Quality of Services provided by NJ4S Providers



While we did see lower ratings more present here than in other metrics, 46.7% of survey respondents rated services as "5 Extremely Effective" and 15.2% rated a 4 "Effective".

34x

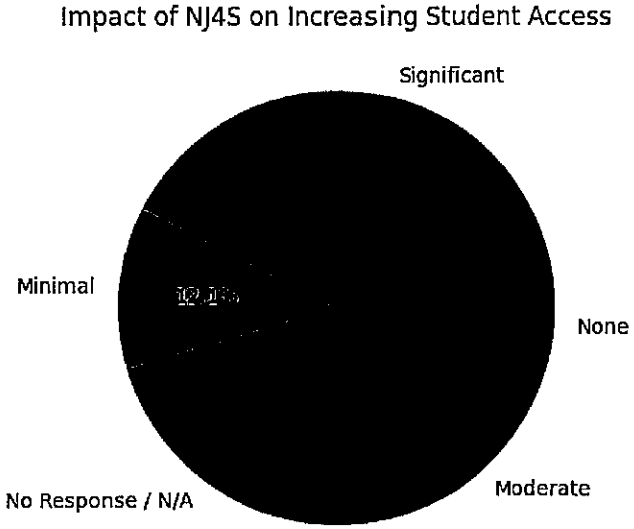
Satisfaction with Range of Services offered by NJ4S



Nearly two-thirds of respondents report satisfaction with the range of NJ4S services

- 62.4% are satisfied (Yes)
- 12.1% are not satisfied (No)

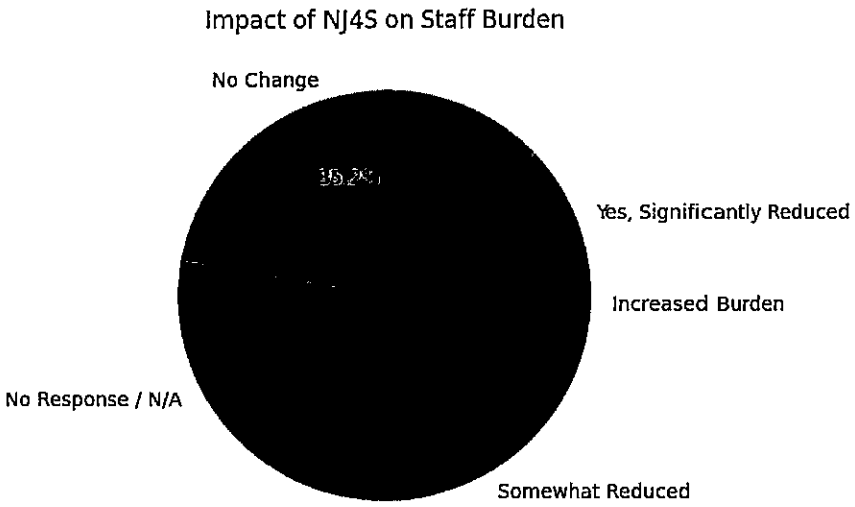
Overall Assessment of the Impact of NJ4S Increasing Student Access to Mental Health Supports



- NJ4S is expanding student access to mental health supports across the state
- 42.4% of survey respondents report a **significant** impact
- 22.4% of survey respondents report a **moderate** impact

35x

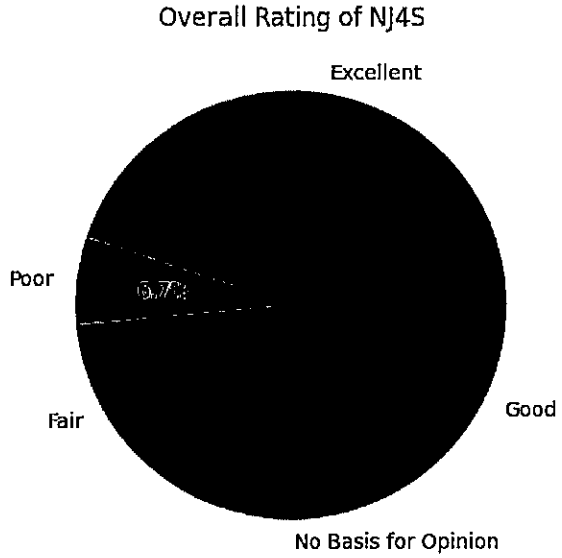
Impact of NJ4S on Staff Burden



NJ4S is reducing staff burdens for many schools, but impact Is not yet universal.

- While over 40% report reduced burden, the largest group still sees no change in staff workload.
- 12.1% say it has significantly reduced burden
- 30.9% say NJ4S has somewhat reduced staff burden

Survey Respondents' Overall Rating of NJ4S



- Strong positive perception overall, however, 1 in 5 lack enough exposure to have provided a rating here.
- 44.8% of survey respondents rate NJ4S as **excellent**
- 14.5% of survey respondents rate it **good**

86x

School Leaders Comments on NJ4S

The 165 respondents who answered Section III took the time to submit detailed comments on their experiences with the NJ4S program and the need to continue funding for this program. The following themes crossed many of the comments of school leaders:

- **Positive Impact and Clinician Quality:** NJ4S has been an extremely beneficial and vital resource, providing essential one-on-one clinical care and group therapy for students with complex mental health challenges (including anxiety, depression, suicidal ideation, and trauma), particularly for at-risk and underinsured students. Clinicians are frequently described as outstanding, professional, responsive, flexible, and essential in connecting families to outside, long-term therapeutic resources although some commenters experienced varying levels of quality in the clinicians or presenters provided.
- **Accessibility and Barriers Reduced:** The program's greatest strength is its accessibility; providing services directly in schools removes common barriers such as insurance requirements, transportation, and long waitlists, ensuring students receive timely and consistent professional help. Many school leaders positively commented that student access to mental health assistance had significantly and positively expanded through NJ4S.
- **Areas for Improvement:** A significant number of comments stated that some barriers continue to exist. A common thread criticized the grade level restrictions on service eligibility with many advocating for services beginning before 6th grade. Others noted that the 6–8 week window of services is too short with a need for longer services for their students. Others experienced difficultties in accessing Tier 3 services, sometimes leading to long wait times for students with high acuity needs.
- **Tiered Support and Program Offerings**: NJ4S provides support across all three tiers of intervention, including Tier 1 awareness workshops, assemblies, and staff/parent training, which are often well-received and engaging. While many districts utilize Tier 1 supports effectively, some feel the focus on "prevention" is inadequate for high-acuity needs, and many districts, even those with school-based youth services—wish to increase their utilization of Tier 2 and Tier 3 services.
- **Operational Challenges and Need for More Support:** Although many find the referral process simple, initial access was sometimes difficult. Challenges include disorganized service delivery, inconsistent follow-through on Tier 1 and 2 promises, difficulty staffing in-school programs, and a need for more consistent providers. Leaders also seek greater funding to meet the high demand, as some districts have wait lists for services. Respondents did note that the program is still evolving and improving, noting their reliance on the services provided.

87x

Representative Member Comments on NJ4S Experiences
Overall Impacts
"NJ4S has had a critical impact on our neediest students through individual and group therapy. The program has also empowered our educators, fundamentally improving how our school operates through specialized staff training on student crisis intervention, among other topics, allowing our educators to feel confident in their ability to handle student distress. Another of NJ4S' greatest strengths is its accessibility. The program removes two of the most common barriers to mental health care—insurance requirements and transportation. Because services are provided directly in schools, students who might otherwise go without support are able to receive timely help. The efficiency of the program has also been remarkable. The referral process is simple and quick, and services begin soon after a student is referred, often preventing challenges from escalating into larger crises."
"My experience with this organization has been overwhelmingly positive. They serve as a crucial partner to our school district, providing students with essential one-on-one clinical care for complex challenges such as anxiety, depression, suicidal ideation, trauma, and school avoidance. Beyond providing direct counseling, they successfully connect families with long-term external therapeutic resources. Furthermore, offering these clinical services on-site has resulted in exceptionally high compliance. Meeting in a familiar school environment eliminates the logistical barriers that typically cause missed appointments, ensuring students consistently receive the professional support they need."
Student Impacts
"Our experience with New Jersey Statewide Student Support Services (NJ4S) has been overwhelmingly positive, as it has significantly expanded access to mental health supports for our students in a meaningful and engaging way. Programs like Mental-Hop have been especially impactful in normalizing conversations around mental health, building student trust, and addressing real-life challenges such as stress, boundaries, and emotional regulation. NJ4S has also been a strong partner in collaboration, consistently responsive and willing to adapt to our school's needs. While there is still a need for increased capacity and more individualized services, NJ4S has played a critical role in

strengthening our overall support system and enhancing the well-being of our students."
"NJ4S has had a critical impact on our neediest students through individual and group therapy. In our district, NJ4S has become an indispensable extension of our student support system. In addition to providing individual therapeutic services, the NJ4S team has implemented targeted group counseling sessions that address the needs of our diverse and historically underserved student populations, students who are often the least likely to access external mental health services. They have also provided Tier I supports to our faculty and school community, strengthening our collective ability to respond to student needs. Without NJ4S, many of our students would not have access to this level of comprehensive, school-based mental health support."
Staff Impacts
"Having NJ4S staff support our schools has been extremely beneficial in light of the challenges this district faces with school staff already assisting in these capacities. The various tiers directly addressed the needs of specific students affected by a lack of personnel helping to meet the higher demands of their specific individualized supports. These professionals came in and were embedded directly within multiple school locations, helping to minimize the barriers faced by students once they leave our building, including transportation needs or appointment-making/waiting."
"NJ4S was utilized for crisis management and beyond that will help minimize the severity of mental health issues through quick and early supports. These tiered services helped teachers because they were able to send the students and know that students were being helped, expanding their ability to focus on instruction and not worry about their student's mental health. Our guidance and Child Study Team staff were relieved to have collaborative efforts in managing sometimes complex needs. This partnership is a huge support!"
"NJ4S has been a tremendous asset to our district. We have a wait list of students as we only have one clinician assigned to our school who shares her services with another district. NJ4S has done wonders for our student's mental health. We were devastated to learn this program was going to be taken away. Students need support."

89x

Need for Elementary Services
"Mental health issues begin prior to grade 6. It is concerning that this fact is not recognized with the number of suicides that are occurring at younger ages."
"Waiting until sixth grade to help our students is often too late."
"NJ4S was a great resource for our district. The only complaint was that many of our younger students would have also benefitted from Tier II and Tier III services."
Areas for Improvement
"Most of what NJ4S delivers is "Tier 1" support- assemblies, staff training, and "awareness" workshops. While education is fine, it does not help a child having a panic attack in the hallway or a family dealing with suicidal ideation at 9:00 p.m. Unlike the old school-based clinics where a kid could walk in, NJ4S requires schools to apply for services through a portal. This creates a bureaucratic barrier that delays actual clinical action. NJ4S is explicitly branded as a prevention program. For a county like mine, where the "broken" system has already led to high-acuity suffering, "prevention" feels like too little, too late."
"My experience with NJ4S services has been positive overall. The services are approachable and youth-centered, and it is reassuring to know that mental health supports are available in a way that feels accessible and non-stigmatizing. NJ4S does a good job promoting awareness of mental health resources and offering programming that supports prevention, early intervention, and emotional well-being. Continued expansion of outreach, clearer communication about how to access services, and increased availability of staff - especially during high-stress periods - would help ensure even more students are able to benefit from these supports."
"We have found NJ4S services to be a valuable support for our students, particularly in providing access to mental health resources and crisis response. However, we would benefit from more consistent on-site presence and faster response times, as well as stronger alignment with our school-based initiatives, such as restorative practices and our House System. Expanding preventative supports and increasing opportunities for small group counseling would further enhance the impact of NJ4S services on student well-being and school climate."

90x

Recommendations and Conclusion

The final section of the survey asked respondents to share their final thoughts and experiences on NJ4S with Governor Sherril and the State Legislature, and to outline considerations they believe should be incorporated into the development of any supplemental or replacement program. School leaders provided extensive comments in this area reflected in the following recommendations for future policy making:

1. School leaders strongly value the support and programming services they have experienced through NJ4S. Although there are areas for improvement and some inconsistency in the delivery of services in different regions of the state, **they ask that there be no break in the delivery of NJ4S services next school year.** They believe that the abrupt ending of NJ4S will result in a quick and direct loss of student access to services, increased burdens on school staff, increased wait times for treatment, and likely increases in student behavioral issues, absenteeism and family strife.

2. As this member survey demonstrates, student needs for mental health interventions far exceeds the availability of services statewide. **For this reason, NJPSA recommends flat funding of NJ4S at the FY 2026 levels in the FY 2027 budget.** The $38 million proposed for the proposed SPARK program does not meet the $45 million spent on NJ4S in the current school year. School leaders fear a loss in services will significantly hurt students experiencing mental health challenges.

3. **School leaders stress the need to thoughtfully transition to any new system that provides direct mental health services to students.** School leaders expressed their passionate dedication to assisting their students with mental health needs and their wish to be a part of the discussion of developments in state programming in this area. **We recommend a stakeholder engagement process with agencies, school leaders and other stakeholders, and experts collaborating on the development of new approaches to student mental health.** NJPSA is happy to facilitate this engagement in any way we can.

4. School leaders understand that for many students, school is their safe place where they feel most comfortable sharing their feelings, thoughts and needs. The need for expanded in-school resources and staffing is critical to meet students where they are. Recognizing that schools cannot do it all however, they seek supplemental support, a focus on higher levels of student interventions, and direct local financial support as proposed in concept in the SPARKS program.

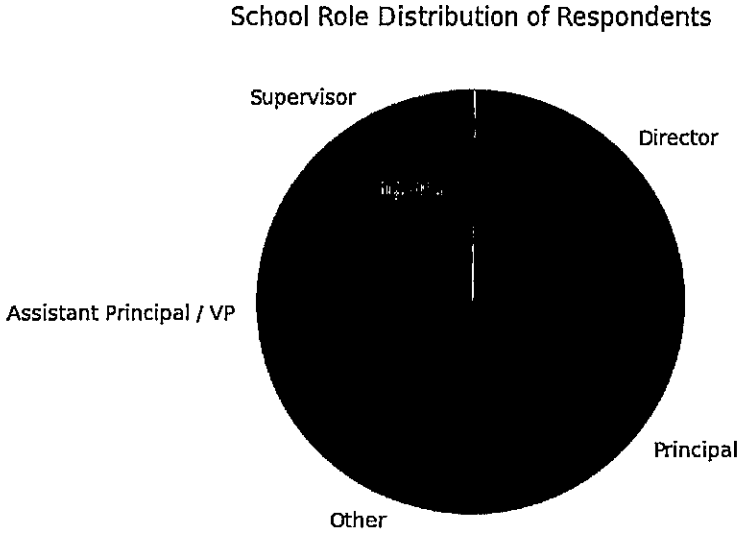
5. In the context of a difficult budget year, it is important to coordinate inter-agency resources related to student mental health to promote breadth of services, accessibility and tiered interventions without duplicating resources or creating confusion in the field.

In closing, NJPSA applauds the necessary focus on student mental health in New Jersey by Governor Sherrill and the State Legislature. NJPSA stands ready to engage on this critical issue and share the experiences and recommendations of school leaders responsible for leading this important school-based support. For more information, please contact Debra Bradley, Esq. NJPSA Director of Government Relations and Assistant Directors Jennie Lamon and Chris Nelson. Thank you for your consideration.

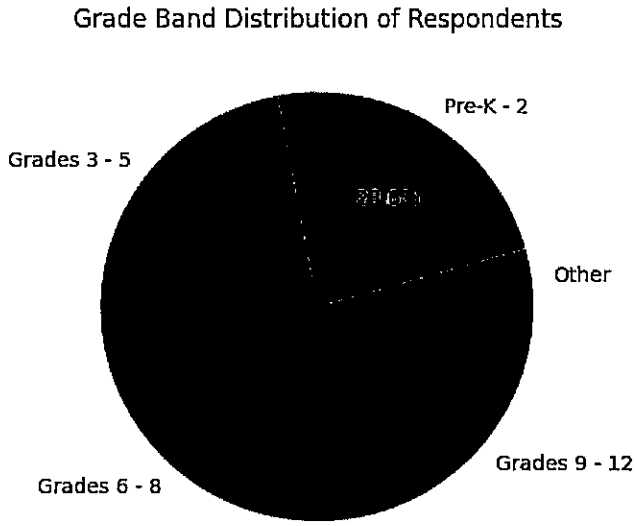
April 16, 2026

Appendix A: NJPSA Survey Results on Student Mental Health/NJ4S - Survey Respondent Demographics

School Roles



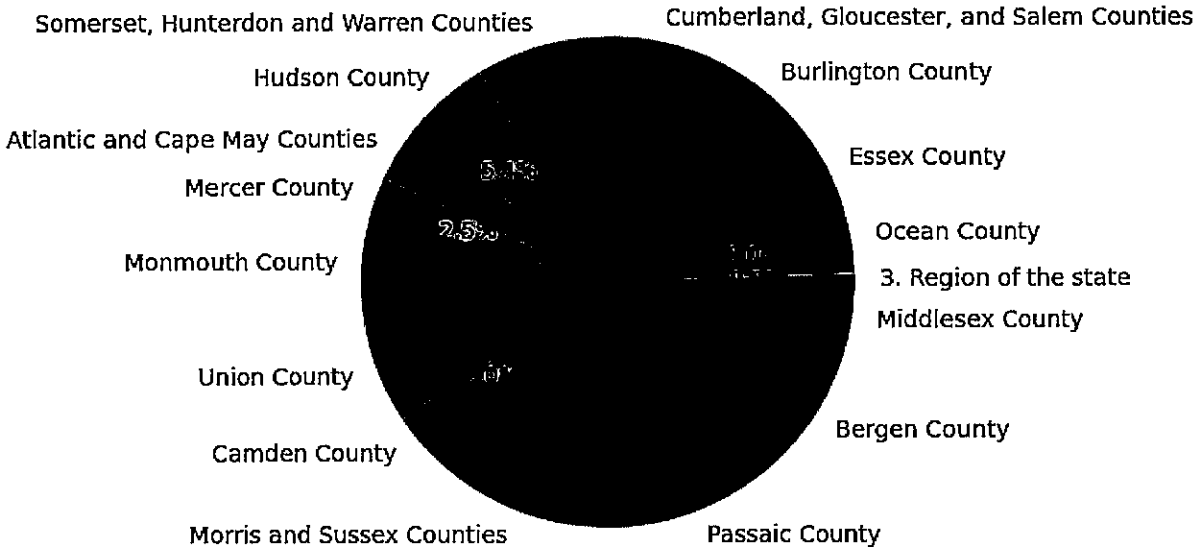
Grade band(s)



Region of the State

Survey Responses Reflect Broad Geographic Representation Across New Jersey

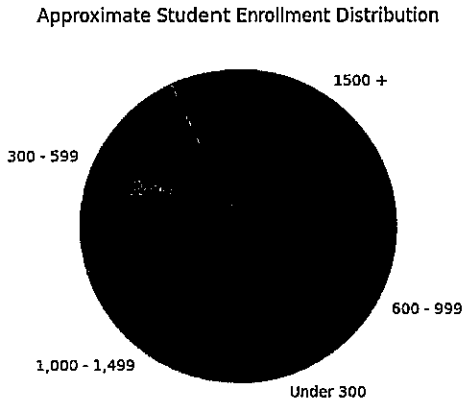
Regional Distribution of Respondents (NJ4S)



Approximate student enrollment

Survey Responses Skew Toward Larger School Districts

- 31.8% -1500+ students (largest segment)
- 22.9% - 300–599 students
- 20.4% -1,000–1,499 students
- 15.9% - 600–999 students
- 9.0% - Under 300 students

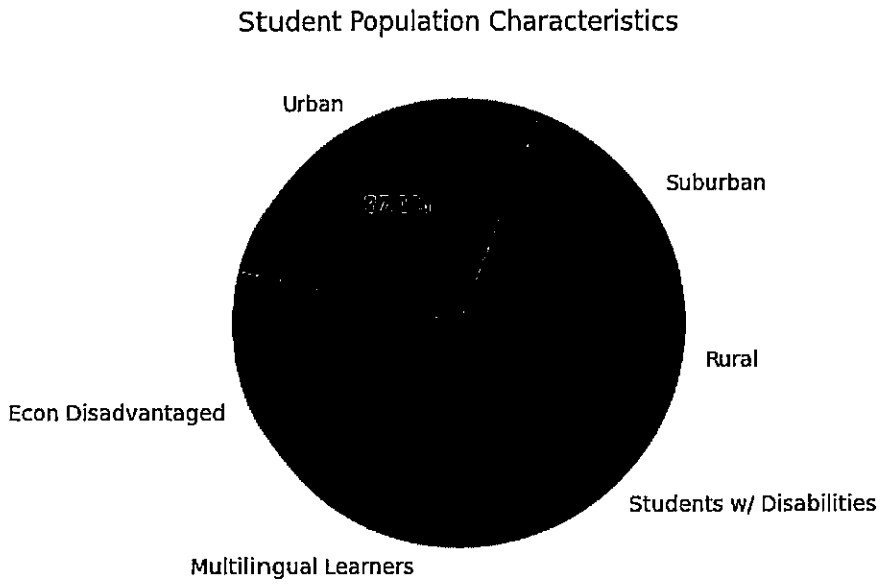


94x

Student population characteristics

Survey respondents reflect high-need student populations across diverse communities

- Urban: 27.1% (largest segment)
- Suburban: 19.2%
- High % Economically Disadvantaged: 19.2%
- Students with Disabilities: 16.7%
- Multilingual Learners: 13.2%
- Rural: 4.6%



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Annual Program Report

NJ4S Services

Supporting youth mental wellness in New Jersey

2024-2025 School Year

NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES

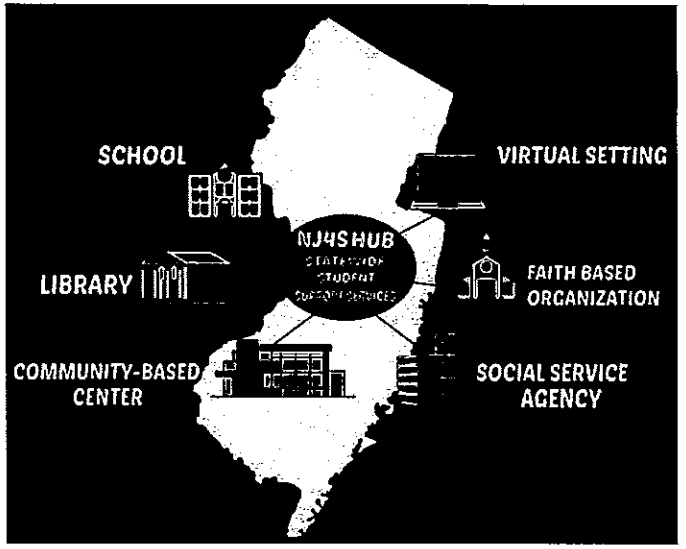
What is NJ4S?

Youth are facing unprecedented mental health challenges. In 2023, four in ten surveyed New Jersey high school students reported feeling sad or hopeless and one in six reported a major depressive episode, while one in nine reported suicidal ideation.[1]

The NJ Statewide Student Support Services (NJ4S) network was launched in the 2023-2024 school year to address the youth mental health crisis in NJ. Utilizing an innovative hub-and-spoke network design model to leverage limited resources to maximize reach, NJ4S is the first initiative to extend mental wellness and wellbeing programs to the entire state, with universal supports offered in the community, and specialized prevention and brief clinical intervention offered to students, caregivers, and educations in public middle and high schools.

Regional hubs are contracted from well-established provider agencies, with staff who meet youth where they are, in-school or in trusted locations in the community. NJ4S programming addresses a number of topics, including: coping strategies for stress, anxiety, and depression; healthy relationships; life skills; substance use prevention; and bullying. Now in its third year, evaluators have found that NJ4S is making a difference in the lives of youth

Why NJ4S? As an upstream, prevention-based program, NJ4S proactively identifies issues *before* they become crises. Preventative strategies are shown to reduce the need for long-term intervention, minimize the harmful effects of stigma, support wellbeing, and elevate school climate.[2]



Executive Summary: SCHOOL YEAR 2024-2025

What we learned after *two school years* of implementation:

NJ4S has grown significantly in school engagement, service delivery, and community partner referrals in just 2 years

- There was a **35% increase** (n=395) from the 2023-24 school year in the number of schools that *received* services.
- There was a **178% increase** (n=770) in Tier 2 prevention programs and a **137% increase** (n=2051) in Tier 3 interventions delivered to students, caregivers and educators from the 2023-24 school year.
- There was a **151% increase** (n=1,779) from the 2023-24 school year in referrals provided. **Most students were successfully connected to mental health resources** to meet additional ongoing needs.

NJ4S has expanded delivery of evidence-based programming and shown positive outcomes for Tier 2 service groups

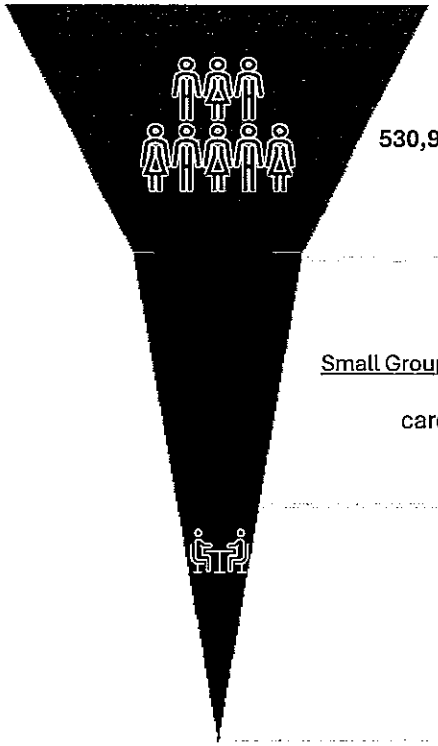
- There was a **16% increase** in provision of evidence-based Tier 2 services (81%) from the 2023-24 school year.
- Among Tier 2 participant groups, 66% demonstrated improved post-programming evaluation scores. The greatest shift in scores occurred in **the attitudes around substance use and healthy relationships,** and in the **social emotional life skills categories.**

NJ4S benefits can outweigh program costs

- Cost comparisons show that **the benefits of NJ4S prevention** and intervention services likely **outweigh the costs** of program implementation, especially for youth struggling with mental health and substance use.

558,044

Total participants were served



Tier 1

Universal Supports

530,964 students, caregivers and staff attended

*(**122% growth** from 2024)*

Tier 2

Small Group Prevention Programming

24,807 students, caregivers and staff served

*(**62% growth** from 2024)*

Tier 3

Brief Clinical Intervention

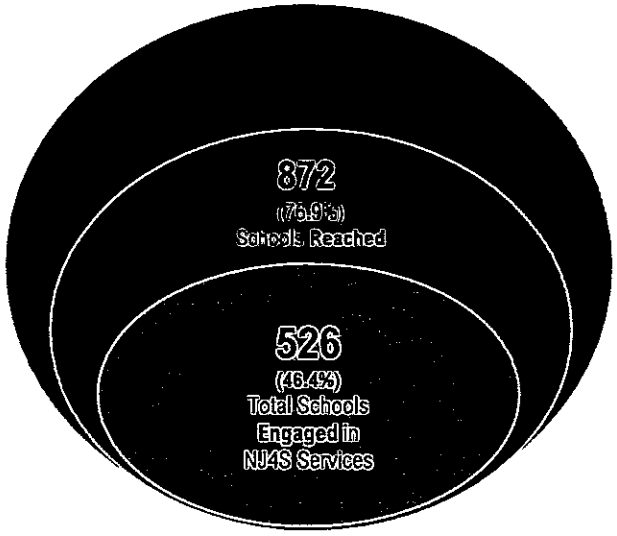
2,273 students and caregivers served

*(**103% growth** from 2024)*

Reach & Engagement:
Process for Reaching Schools

Over one thousand schools, and nearly 600 school districts in New Jersey are eligible for NJ4S ***Tier 2 and Tier 3*** services. The program proactively outreaches schools and communities—particularly ones with the highest identified needs—to register them for, and engage them in, service delivery.

From inception through the 2024-2025 school year, NJ4S has engaged with schools in 52% (310) of all NJ school districts.

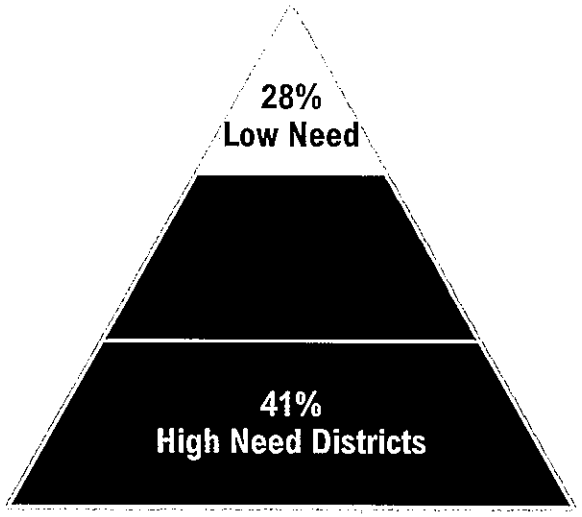


Targeting and Prioritizing Program Delivery:
School Needs Index

- The School District Needs Index (SDNI) uses specialized criteria and evidence to identify the level of need in school districts and charter schools within New Jersey.
- The index combines school district and community level indicators to create one composite "needs score" for an NJ4S eligible school in each district.

> **"...[They] used to say, 'OK, these are the only four communities that are most at risk.' So you can only write this grant for those four communities...The state has broken that barrier."**
>
> *-NJ4S Hub Leadership*

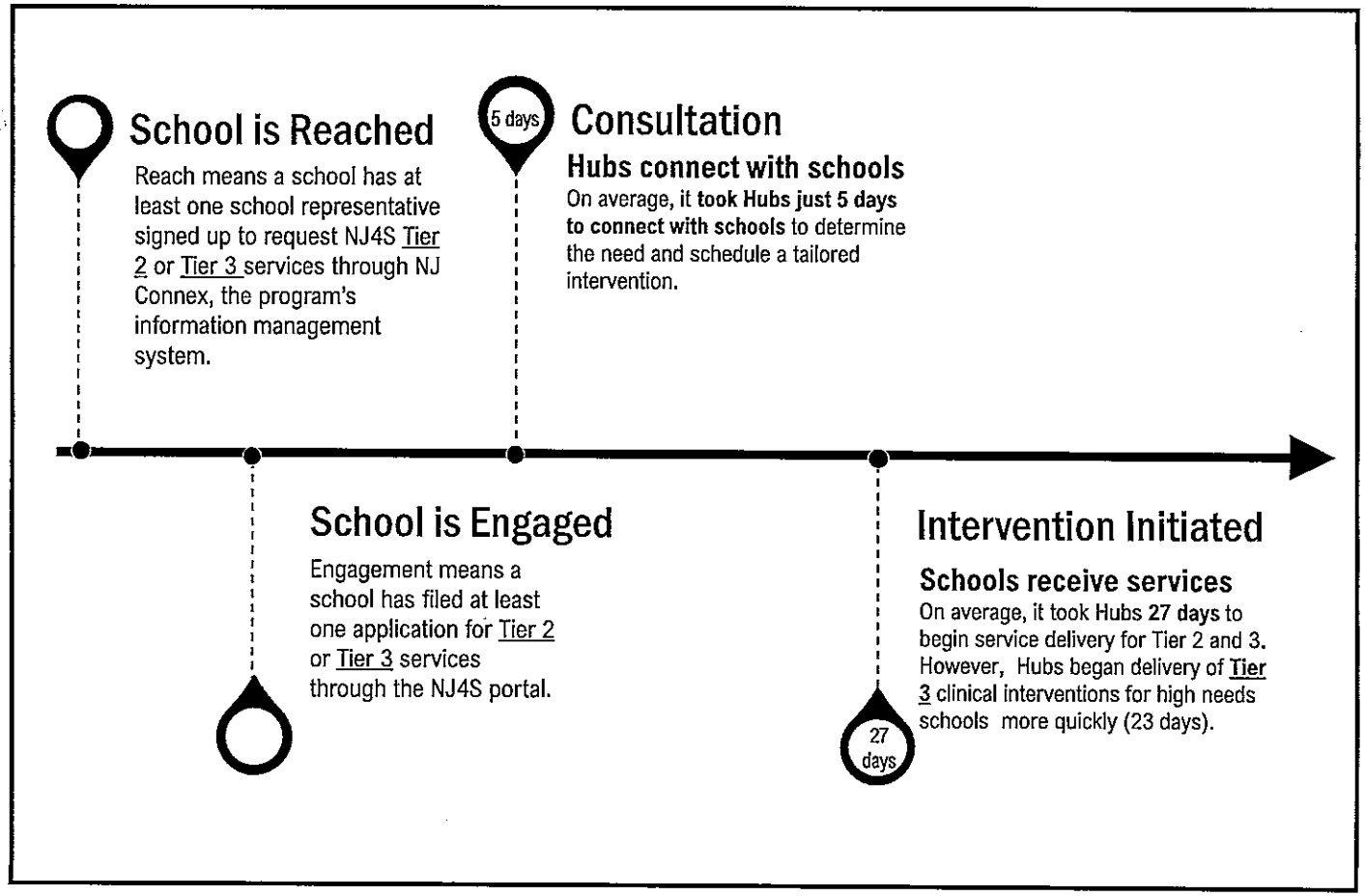
- Out of the **597** New Jersey School Districts, from inception through the 2024-2025 school year, NJ4S reached:



Reach & Engagement:
Process for Schools to Receive NJ4S Services

Hubs met nearly 97% of requested needs

Average wait times in 2022 for an outpatient mental health treatment intake in New Jersey ranged from **28 to 42 days (4 to 6 weeks)** and the wait times thereafter to then receive counseling/therapy varied from **14 to 35 days (2 to 5 weeks).**[3]



Prevention Services and Interventions Delivered

Hubs are administrative and organizational centers that mobilize prevention specialists and mental health clinicians to provide targeted, tiered services locally. The services include public events, small group preventative programming and brief clinical interventions focused on mental health, substance use prevention, social connections, positive relationships and anti-bullying/violence prevention.

TIER 1: *UNIVERSAL SUPPORTS*

Universal (Tier 1) supports include virtual and in-person workshops, webinars, assemblies and training. They are available to students (grades Pre-K through 12), their families, school staff, and community members.

TIER 2: *SMALL GROUP PREVENTION PROGRAMMING*

Small Group Programming (Tier 2) includes early identification and focused prevention services. It can be delivered through small group or individualized prevention programs, mentoring, or low-intensity classroom support to students identified as at-risk. Tier 2 services are often Evidence Based Programs (EBPs) and also include linkages to existing community programming and resources.

TIER 3: *BRIEF CLINICAL INTERVENTION*

Brief Clinical Interventions (Tier 3) include assessment and brief individualized therapeutic interventions for youth while they are being referred and connected to a community provider to support ongoing mental health needs.

"It was good. I think **I got a lot of stuff out** during the sessions **and learned a lot more problem solving.** I have problems with not solving my problems, so **it was good to figure out** a way to solve them."

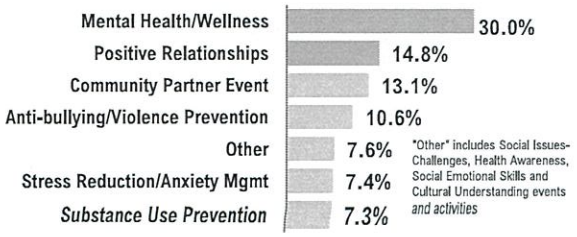
-NJ4S Student

6,687 **Tier 1** services provided

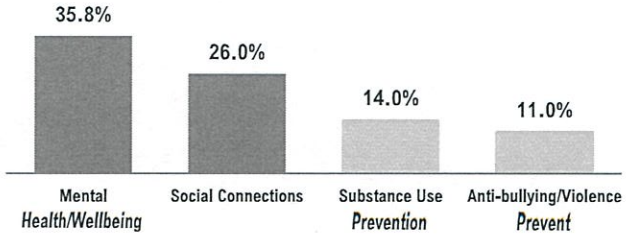
770 **Tier 2** programs provided

2,051 **Tier 3** interventions provided

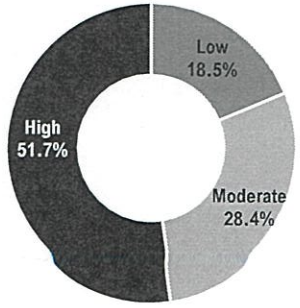
Most **Tier 1** services focused on **mental health/wellness and positive relationships.**



Most **Tier 2** programs focused on **mental health/wellness and social connections.**

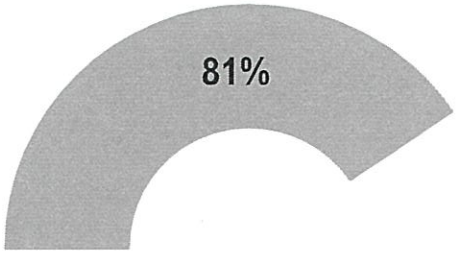


Most students who accessed **Tier 3** supports were from **high needs** school districts.



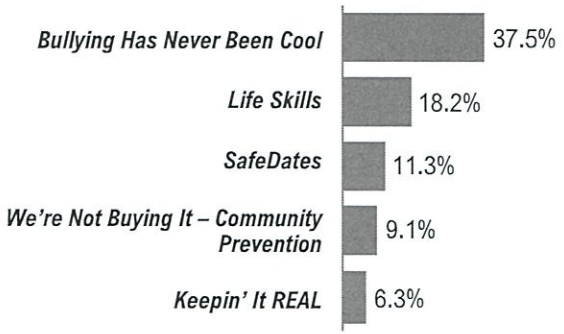
Tier 2: Evidence-Based Services and Outcomes

Hubs prioritize implementation of **evidence-based** services in schools and assess the effectiveness with a pre-test administered to participants prior to the programming and a post-test after completion.



The majority of **Tier 2** prevention programs were **evidence based**.

Top Evidence Based Services Delivered

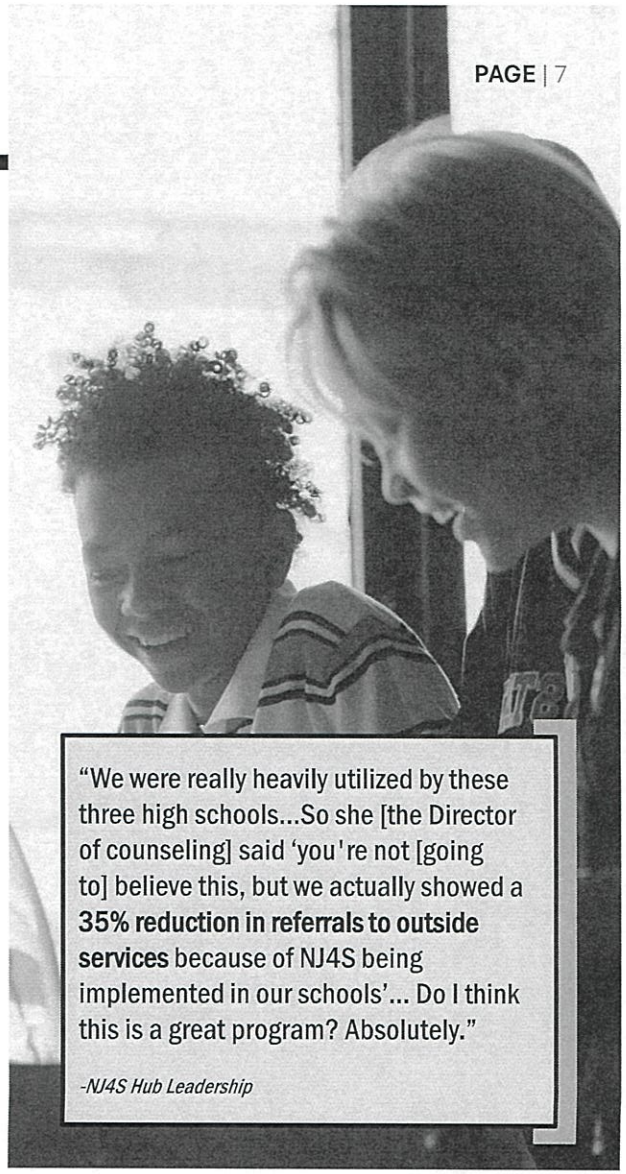


Positive Outcomes

Two out of three **Tier 2 evidence-based participant groups' scores improved after engaging in prevention programming.**

Among these groups **with increased scores**, the largest improvements were in…

- Attitudes towards resisting drugs and building healthy relationships
- Social emotional life skills
- Knowledge about resisting drugs, healthy relationships, mental health and college readiness
- Reducing depression and anxiety



"We were really heavily utilized by these three high schools…So she [the Director of counseling] said 'you're not [going to] believe this, but we actually showed a **35% reduction in referrals to outside services** because of NJ4S being implemented in our schools'… Do I think this is a great program? Absolutely."

-NJ4S Hub Leadership

Hub and Spoke Model in Action:
NJ4S Community Referrals

1,779 referrals were made in school year 2024.

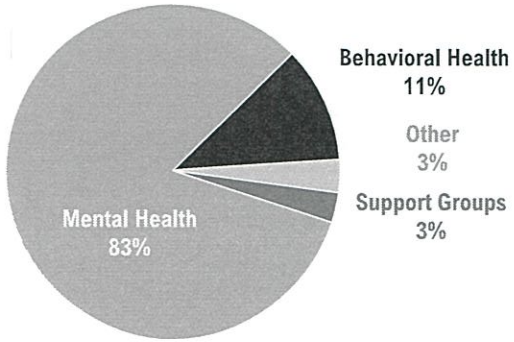
61% of students referred were from **High Need** school districts	27% Moderate Need	10% Low Need

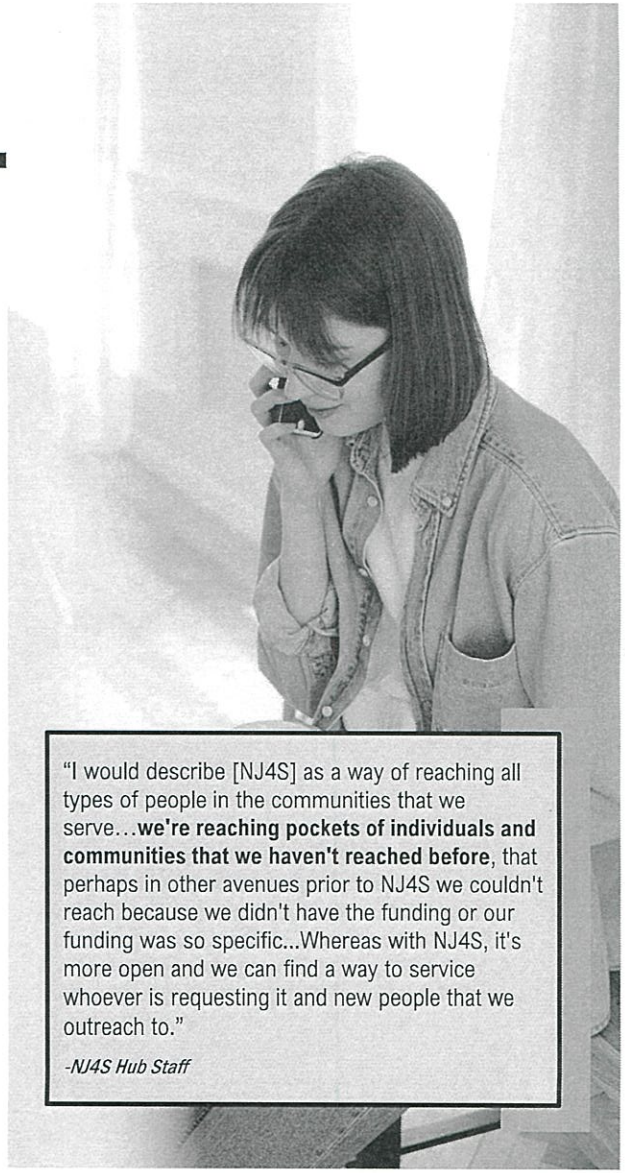
What happens if students need supplemental services?

NJ4S works in partnership with communities and leverages local resources to avoid duplicating existing services. Students may be referred to community providers if requested interventions already exist, rather than NJ4S duplicating community services. Students may also be referred if there is a need that NJ4S cannot meet, or to provide continuing services after NJ4S interventions are complete.

70% of students referred for mental health services in the community successfully accessed the resource.

Top Referral Reasons Included:





"I would describe [NJ4S] as a way of reaching all types of people in the communities that we serve…**we're reaching pockets of individuals and communities that we haven't reached before**, that perhaps in other avenues prior to NJ4S we couldn't reach because we didn't have the funding or our funding was so specific...Whereas with NJ4S, it's more open and we can find a way to service whoever is requesting it and new people that we outreach to."

-NJ4S Hub Staff

Costs and Benefits of Prevention

Research consistently finds that **preventive and promotive mental health interventions are cost-effective, resulting in reduced medical costs,** improved academic progress, and lifetime increased earnings.[4]

The annual cost of NJ4S is *$48,000,000*

National statistics show that among youth aged 12 to 17 years in 2024, **nearly 29% received mental health treatment** and **over 10% had serious thoughts of suicide,** while over **9% needed substance use treatment.**[5]

Nationally, the average cost of one youth having a mental health hospitalization is **$15,540.**[6]

In New Jersey, the average cost of one youth receiving a Children's System of Care mental health mobile crisis response is **$1,913.**[7]

Nationally, the median cost of one youth going to inpatient substance use treatment is **$52,706.**[8]

The potential benefits of NJ4S services can outweigh costs if it prevents...

3089 **inpatient youth mental health hospitalizations**

22,478 **mobile crisis calls**

815 **inpatient youth substance use treatments**

Deeper Dive: STUDENTS SERVED AND REFERRALS

*In its second year of implementation, NJ4S continues efforts to increase demographic data collection and improve data quality. The goal is to ensure that participants are better represented in program evaluation.

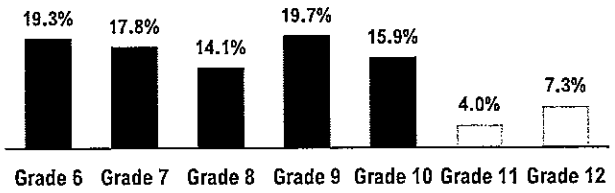
NJ4S provides programs and services for youth (public middle and high school students), their **caregivers, and educators.** NJ4S **serves diverse students from across the state of New Jersey.** Participants were primarily students, grades 6 through 9, who identified their race as Latino/a/x/Hispanic or White, gender as female, their sexual orientation as heterosexual, and spoke English.

24,121

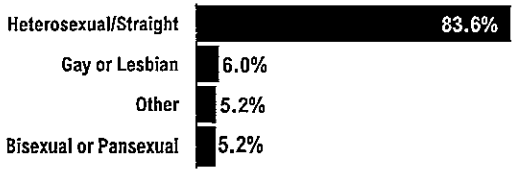
students were engaged in an NJ4S Tier 2 or 3 service.

27,080 total participants (including students, caregivers and educators) received services.

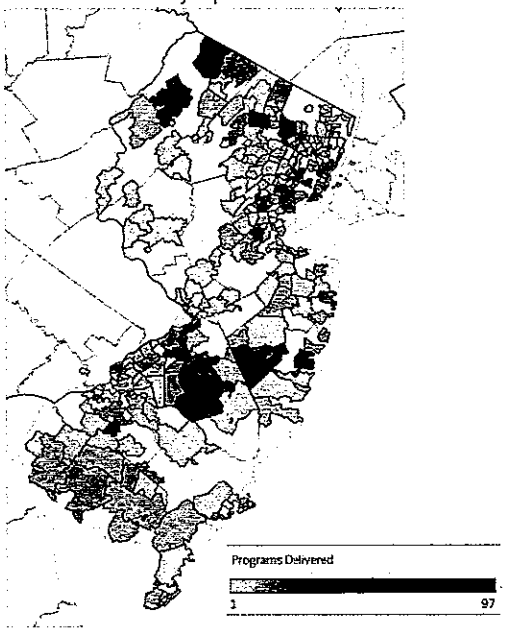
Most participants were **in grades 6 through 10** (n=19,646).

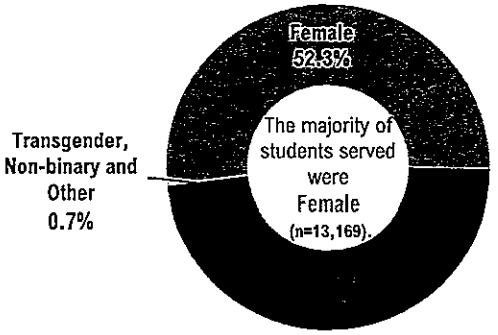


Most participants identified as heterosexual (n=5763).

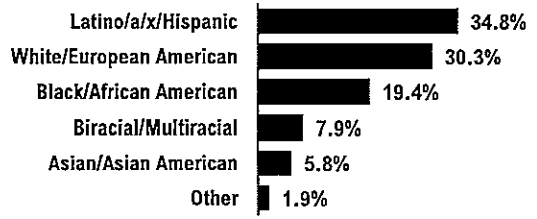


Programs Delivered
by Zip Code

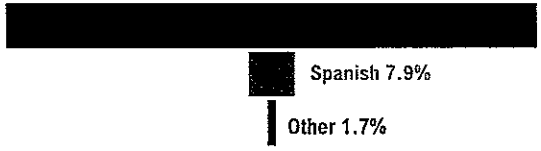




Most participants identified as **Latino/a/ Hispanic or White/Caucasian** (n=11,258).



Most participants **spoke English** at home (n=2643).



Evaluating NJ4S

Multi-Phased Evaluation Plan and Methods

NJ DCF is undertaking a collaborative, multi-year, phased evaluation of the program using a mixed-methods approach to evaluating NJ4S during the first years of implementation.

This brief reports on findings from quantitative program data collected from September 2024 to August 2025 through NJ Connex, the program's information management system. Data were analyzed for frequencies, portions and overtime. Qualitative data were collected through ethnographic observations, interviews and focus group discussions with students, caregivers, Hub staff and leadership as well as community stakeholders (NJ4S Formative Brief).

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[3] Mental Health Association in New Jersey, Inc. (2022). Wait Times for Outpatient Mental Health Treatment in New Jersey. Accessed online at: https://www.mhanj.org/content/uploads/2022/08/Wait-Time-Study-March-15-2022.pdf

[4] Kumar, T. (2025). The cost-benefit analysis of preventive mental health interventions in adolescent populations. *Research Archive of Rising Scholars*. https://research-archive.org/index.php/rars/preprint/view/2603/3664

[5] Substance Abuse and Mental Health Services Administration. (2025). *Key substance use and mental health indicators in the United States: Results from the 2024 National Survey on Drug Use and Health* (HHS Publication No. PEP25-07-007, NSDUH Series H-60). Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases

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[7] New Jersey Legislature Assembly Budget Committee (2025). *Department of Children and Families hearing before the Assembly Budget Committee written response*. dcf_follow_up_response_abu.pdf

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Questions?

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NJ4S: Growth Over Time

School Year 2023-2024 (September 1, 2023, to August 31, 2024) to School Year 2025-2026 to date (September 1, 2025, to *February 1*, 2026)

Key Findings

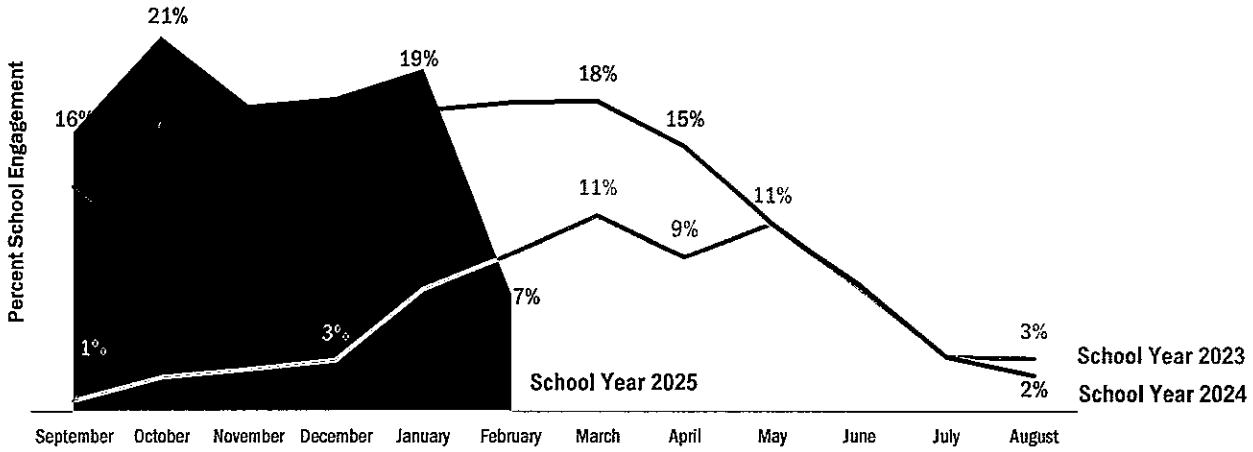
With six months left in the 2025-2026 school year, school engagement in NJ4S is tracking to be greater than or equal to the 2024-2025 school year.

With 466 NJ schools engaged, NJ4S has **grown 59.6%** from the 2023-2024 School Year (292).

NJ4S retained all participating schools from last year, and school engagement grew in **19 of 21** NJ counties, during the 2024-2025 school year.

NJ4S School Engagement

School Year 2023, 2024, & 2025 to date



% Growth in Schools Engaged

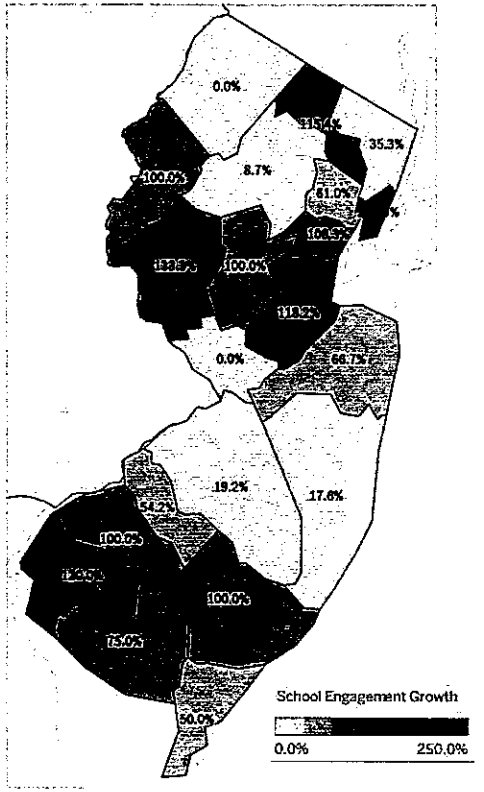


Figure Note: Lighter shades indicate lower growth, and darker shades indicate higher growth. The range of values is from 0% to 250%.

NJ4S: Growth Over Time

School Year 2024-2025 (September 1, 2024 to August 31, 2025) to School Year 2025-2026, to date (September 1, 2025 to *April 1,* 2026)

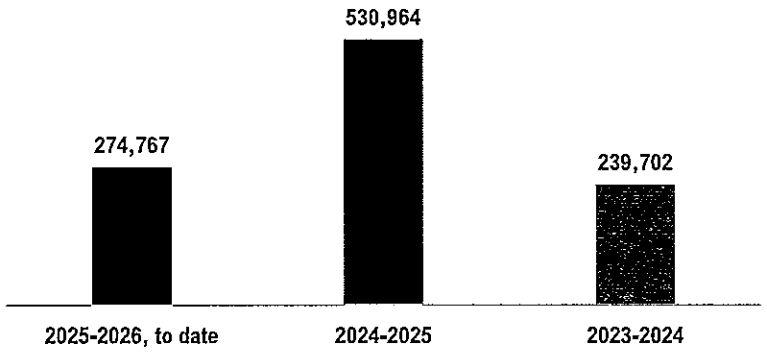
Key Findings

With six months left in the 2025-2026 school year, participation in NJ4S is tracking to be greater than or equal to the 2024-2025 school year.

Direct Year-to-Year comparisons:

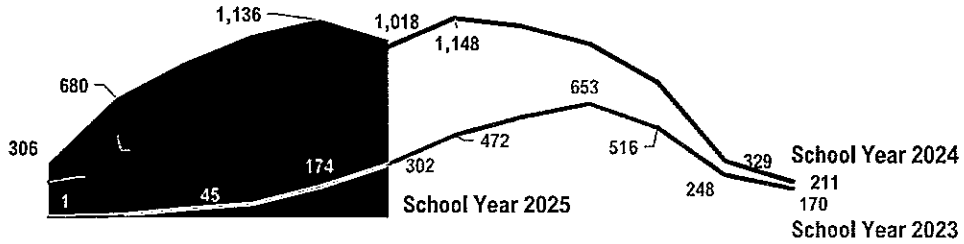
- The number of students, caregivers and staff receiving Tier 1 services grew from **531K** in the 2024-2025 School Year, up from **240K** to in the 2023-2024 school year.
- **770** Tier 2 services have been delivered in the 2024-2025 school year, up from **285** in the 2023-2024 school year.
- **2,051** Tier 3 interventions have been delivered in the 2024-2025 school year, up from **869** in the 2023-2024 school year.

Total Number of Attendees Receiving Tier 1 Services By School Year



Total Number of Services by Month

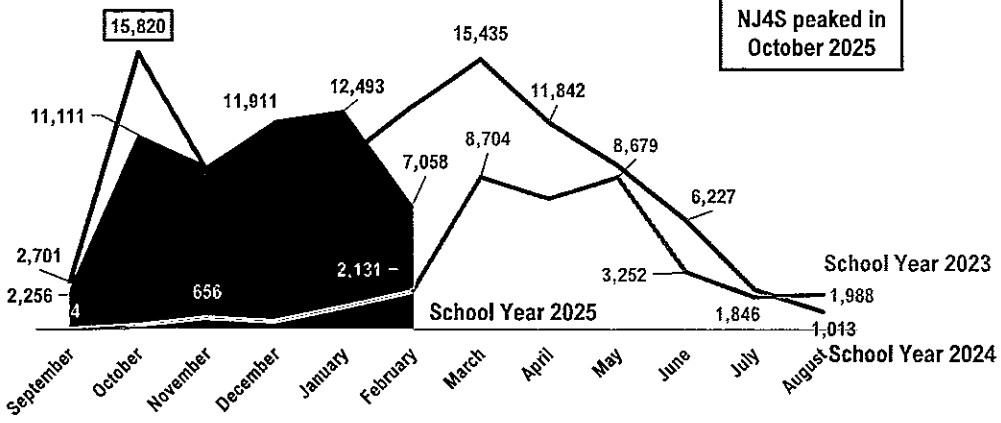
Tier 2 and 3 Services
School Year 2023, 2024, & 2025 to date



Total Number of Attendees Receiving Services by Month

Tier 2 and 3 Services
School Year 2023, 2024, & 2025 to date

Attendance in NJ4S peaked in October 2025



Dear Governor Sherrill, Members of Your Administration, and Esteemed Legislators,

I am writing to respectfully urge your administration to meaningfully involve school counseling professionals and school-based mental health practitioners in the development and implementation of the proposed SPARK initiative as New Jersey transitions away from the NJ4S model.

New Jersey has made a substantial investment in youth mental health services over the past several years. While the NJ4S initiative brought needed attention and funding to student mental health, many educators, school counselors, and district leaders observed significant inconsistencies in implementation, duplication of services, and administrative inefficiencies that limited the impact of those investments at the local level. As the State considers a transition to the SPARK program, there is a critical opportunity to build a more coordinated, sustainable, and effective framework rooted in the realities of how schools function and how students actually access care.

The voices of school counseling professionals must be central to this process. School counselors are uniquely positioned to understand both the educational and mental health needs of children and adolescents. These professionals work daily at the intersection of academic performance, attendance, behavior, crisis intervention, family engagement, social-emotional development, and access to outside care. They are often the first adults to identify emerging concerns and the professionals most responsible for maintaining continuity of care within school settings. We are also the only professionals working in schools who serve **all** students, plus their families and caretakers, and the staff. In most cases, our school social workers and school psychologists only serve a small percentage of students and because they are generally tied to case management services, do not have the time or bandwidth to service all students at the tier one or tier two level.

Recent statewide findings from the Social Emotional Learning Alliance for New Jersey's Youth Mental Health Advocacy Collaborative reinforce this point. The April 2026 statewide summit report emphasized that schools serve as the primary and most equitable entry point into youth mental health systems, and that effective systems depend on seamless collaboration across schools, healthcare providers, community organizations, and State agencies. The report also highlighted the importance of tiered systems of support, universal prevention, coordinated referrals, family engagement, and sustainable funding structures. I was fortunate enough to be a participant in the statewide summit where I expressed the following:

- We must look critically at the services that schools can provide given the restrictions on NJDOE certificated staff. The intersection of licensure and insurance requirements with DOE certification requirements ties the hands of individuals qualified to provide mental health assistance to students.
- School Counselors are trained as clinical mental health clinicians. If you need evidence of that fact, I encourage you to read the CACREP requirements for a masters degree in Counseling here. We need to create a pathway through partnership with the Division of

Consumer Affairs and the New Jersey Department of Education to strengthen the pipeline of available mental health professionals ready to work with youth in schools. The lack of understanding of a myriad of stakeholders as to the training and expertise of school counselors is deep and cuts across multiple state agencies.

As New Jersey evaluates how to improve youth mental health services moving forward, I respectfully ask the administration to consider several core recommendations:

1. Preserve Funding for Existing School-Based Programs That Are Demonstrably Working

Where districts, counties, or community partnerships have developed effective school-based mental health systems, those programs should not be dismantled solely because of a statewide structural transition.

Many schools have spent years building trusted relationships, referral pathways, crisis response protocols, prevention programming, and collaborative systems with local providers. In communities where school-based mental health programming is functioning effectively, continuity and stability should be prioritized. Abruptly removing funding or replacing established systems with entirely new administrative structures risks disrupting services for students and families who already face barriers to care.

The State should instead identify and preserve effective local models while using evaluation data, stakeholder feedback, and measurable outcomes to guide future improvements.

2. Re-center School-Based Mental Health Around a True Tiered System of Supports

The transition to SPARK presents an opportunity to better clarify the distinct roles of schools, community providers, and healthcare systems within a comprehensive continuum of care.

A sustainable and educationally appropriate model should recognize that:

- Tier 1 supports (universal prevention, school climate, social-emotional learning, mental health literacy, relationship-building, and wellness promotion) are most effective when led by school district personnel embedded in the daily life of the school community. *This is something that schools know how to do very well.* Money would be well spent in tier 1 providing training to school personnel to turnkey programming to their local staff and community. The partnerships and available training from Rutgers University have been tremendously helpful over the past several years.
- Tier 2 supports (targeted small-group interventions, brief counseling, early intervention, and skill-building supports) are also most effective when coordinated by trained school-based professionals who understand student schedules, educational impacts, family dynamics, and school culture. This is an area that has been identified as lacking with the NJ4S in many vicinages. Here again, there is much "red tape" around who can come into a school building to provide these services, as well as privacy and parental permission concerns. These factors made it significantly more difficult for the outside

providers (the "hubs") to provide consistent services in our schools. **School Counselors** are trained to provide these tier 2 supports.

- Tier 3 services represent intensive clinical mental health treatment and should be recognized as healthcare services requiring appropriate clinical oversight, licensure, coordination with healthcare systems, and continuity-of-care protocols. Tier 3 services are the area that will most certainly require coordination between DCA, NJ DOE, and other agencies. We must remember that when our students need crisis intervention, mental health stabilization, and intensive outpatient or inpatient mental health services, they need **healthcare**, not social-emotional learning.

The statewide summit findings strongly supported this distinction, identifying Tier 1 prevention and universal supports as foundational to effective youth mental health systems and emphasizing that schools are uniquely positioned to provide early identification, prevention, and coordinated intervention. This framework would allow New Jersey to better align educational systems with healthcare systems while reducing duplication, clarifying responsibilities, and improving efficiency.

3. Ensure NJDOE Provides Clear Guidance to Districts on Effective and Efficient Use of Funding

One of the major concerns raised by educators and school leaders during the NJ4S rollout was the lack of clarity regarding how funding should be structured, implemented, evaluated, and integrated into existing district systems.

Many districts experienced:

- Significant administrative overhead;
- Duplication of services already being provided by district staff;
- Fragmented referral systems;
- Inconsistent communication between providers and schools;
- Unclear expectations regarding accountability and outcomes;
- Limited flexibility to tailor services to local needs.

In some cases, large amounts of funding appeared to be absorbed into administrative infrastructure rather than direct student services.

As SPARK is developed, the New Jersey Department of Education should provide districts with:

- Clear implementation guidance;
- Evidence-based frameworks for tiered supports;
- Expectations for collaboration between schools and outside providers;
- Accountability measures tied to student outcomes and access;
- Guidance on sustainable staffing structures;
- Technical assistance on integrating prevention, intervention, and clinical services. *Note: Mental health professionals **must** be involved in this process.*

Districts should not be expected to independently navigate complex mental health systems without coordinated State support. And the State must help districts by employing or contracting with qualified professionals who understand the complexities of the mental health care system.

4. Prioritize Workforce Expertise and School-Based Mental Health Capacity

New Jersey should leverage and strengthen the expertise that already exists within school systems.

School Counselors are trained in prevention, crisis response, developmental counseling, family engagement, school systems, and multi-tiered systems of support. Yet too often, policy discussions occur without adequate representation from those professionals most directly responsible for implementation.

Future planning for SPARK should include:

- School Counselors;
- Student Assistance Coordinators;
- School Psychologists & School Social Workers (specifically excluded from case management and testing responsibilities)
- Directors of School Counseling and Student Services;
- District administrators with expertise in school mental health systems;
- Community school leaders;
- Families and students.

The State should also carefully examine how clinical mental health services delivered in schools are supervised, coordinated, and integrated with educational systems, particularly when outside agencies are involved.

5. Create Shared-Service and Flexible Contracting Pathways for Crisis Screenings, Risk Assessments, and Return-to-School Clearances

SPARK should directly address one of the most urgent and inefficient problems facing school districts: access to qualified mental health professionals when a student presents with suicidal ideation, self-harm concerns, or other acute risk.

Current regulatory expectations, legal obligations, and local district policies often require schools to take immediate action when a student may be at risk of harm to self or others. In practice, many districts require some form of medical or psychiatric clearance before a student returns to school. When a district does not employ or have direct access to a qualified mental health clinician, the default option is often referral to a hospital emergency department.

This approach can be costly, time-consuming, and potentially traumatic for students and families. Emergency rooms are essential for true medical or psychiatric emergencies, but they

should not become the only available pathway because schools lack access to timely, school-linked clinical screening.

New Jersey should make it easier for districts to use shared services and flexible contracts for crisis/risk assessment and return-to-school clearance. This could include:

- Regional or county-based shared-service agreements allowing districts to access qualified clinicians employed by another district, county agency, educational services commission, university partner, hospital system, or community provider;
- Fee-for-service arrangements so a district without its own clinician can obtain timely access to a licensed mental health professional when a student is in crisis;
- Contracts with smaller community agencies and private practices to provide clinical services, crisis/risk assessments, and return-to-school clearance documentation when clinically appropriate;
- Regional clinician pools that include licensed clinical social workers, licensed professional counselors, licensed psychologists, psychiatric advanced practice nurses, psychiatrists, and appropriately supervised clinicians working within the scope of New Jersey law and professional licensure requirements;
- Clear State guidance on documentation, parent consent, confidentiality, liability, information sharing, and coordination between the clinician, family, district, and school physician or school nurse;
- A mechanism for districts to select providers that meet local needs rather than relying only on a single large regional provider.

This is especially important because NJ4S was structured around large regional hubs. While regional coordination has value, a one-provider-per-vicinage approach does not reflect the significant variation in local resources, geography, transportation barriers, workforce availability, and community relationships across New Jersey. In many areas, smaller agencies and private practices may be better positioned to provide timely, trusted, and clinically appropriate services to schools and families.

SPARK should therefore allow districts to braid funding with shared-service agreements, county or regional partnerships, and approved local provider contracts. Doing so would create a wider and deeper pipeline of mental health support, reduce unnecessary emergency room referrals, preserve hospital capacity for true emergencies, and help students return to school safely and quickly with appropriate supports in place. I probably sound very redundant at this point, however, I must stress that in order for any of these suggestions to be implemented with fidelity, we **must** prioritize having a representative (ideally multiple) in planning meeting, decision making, and assisting school districts who have knowledge of both the landscape of mental health services and our educational system.

6. Build a Sustainable, Coordinated, and Prevention-Focused System

The statewide summit findings repeatedly emphasized that New Jersey must move from fragmented and reactive systems toward coordinated, preventive, relationship-centered systems of care.

This means building systems that:

- Prioritize prevention and early intervention;
- Reduce fragmentation between schools and providers;
- Improve continuity of care;
- Support warm handoffs and coordinated referrals;
- Reduce waitlists and barriers to access;
- Strengthen family engagement;
- Use data responsibly to guide improvement;
- Invest in sustainable staffing and infrastructure rather than temporary programming.

Schools cannot function as isolated mental health providers, nor should they be excluded from shaping youth mental health policy. The most effective system will be one where schools, healthcare providers, families, and community organizations operate as coordinated partners with clearly defined roles.

New Jersey has an opportunity to lead the nation in building a thoughtful, integrated model of school-linked youth mental health care. Achieving that vision will require listening carefully to the professionals working directly with students every day and ensuring that funding decisions prioritize sustainable, student-centered services over administrative expansion.

I welcome the opportunity to partner with your staff and any other stakeholders and decision makers to discuss the points made in my letter. On behalf of the New Jersey School Counselors Association, as a 24 year veteran School Counselor and Director of Counseling, and as an 18 year Licensed Professional Counselor, thank you for your attention to this critically important issue and for your continued commitment to the mental health and well-being of New Jersey's children and adolescents. I can be reached by phone at (, - - - via email at aed@njsca.org.

Sincerely,

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