

Integrated Case Management Service Essex, Morris and Passaic

Description

Integrated Case Management is an assertive outreach program that emphasizes assessment, advocacy, empowerment, referral, linkage, and supportive counseling. This voluntary program is designed to assist individuals in their recovery based on their unique needs and interests. Case management has four primary goals: (1) to engage and provide referrals, linkages and support to individuals with mental illness or co-occurring disorders; (2) to enable a smooth transition through all phases of illness and recovery; (3) to empower persons with mental illness or co-occurring disorders to independently manage their own lives in the way they choose; and (4) to address the specific needs of each person and assist in service procurement, delivery, coordination, and integration.

Services are designed to help adults in their recovery by facilitating access to necessary medical, social, educational, housing and other services and resources. These services are consumer-centered and provided predominantly off-site in the consumer's natural environment.

Personnel

ICMS is comprised of three teams serving the counties of Essex, Morris and Passaic, with each team based out of a satellite office in their respective county. Program staffing includes two Program Directors, three Program Coordinators, 4 Senior Case Managers, 22 Case Managers, and 3 administrative staff. This experienced group collectively brings many years of outreach expertise and remains culturally diverse and representative of the persons served. ICMS staff includes bilingual Case Managers fluent in Spanish and Kru, with half the ICMS Passaic staff being bilingual in Spanish. Several staff members are pursuing continuing education and additional licensure to support professional and personal growth.

Caseload

ICMS serves adult individuals diagnosed with a serious and persistent mental illness, primarily under two main disorder categories: psychotic disorders (Schizophrenia, Schizoaffective Disorder, and Delusional Disorder) and mood disorders (Bipolar Disorder and Major Depressive Disorder). Case management services are initially offered for 12 months to individuals referred from a state or county hospital, and six months for all others. An individual's length of program stay is reassessed during service planning and may be extended if justified. The current average length of stay is two years. As of June 30, 2025, the ICMS caseload totaled 878 consumers.

- Admissions/Referrals are received from various sources, including state and county hospitals, Short Term Care Facilities (STCF), voluntary psychiatric inpatient units, community treatment providers, families, and consumers themselves. ICMS served 316 enrolled individuals in community hospitals.

- Discharge/Graduation primarily occurs once an individual has achieved their individualized goals and has been linked to appropriate services. Other reasons for discharge include moving out of the county, referral to more suitable services such as PACT, CSS, or other mental health residential programs, requiring hospitalization for more than six months, declining services, or inability to establish contact. All ICMS discharges must be approved by DMHAS through a web-based portal. During this reporting year, ICMS discharged 318 consumers.
- Units of service are defined as continuous face-to-face contact with or on behalf of an enrolled individual, lasting 15 minutes, excluding travel time. For this reporting year, total units of service—including both face-to-face and telecommunication contacts—amounted to 79,851 units, representing approximately 19,962 hours of contact.
- Risk category refers to the three levels of case management involvement, based on assessed risk of hospitalization, functional level, and willingness or ability to access needed services. The categories are: high-risk or intensive case management; at-risk or supportive case management; and low-risk or maintenance level case management. This risk assessment is routinely completed alongside the consumer's service plan, with services tailored accordingly.

Demographics

The MHA ICMS program effectively serves a broad geographic area, reaching individuals across 85 municipalities in Essex, Morris, and Passaic counties. The program's client base is most heavily concentrated in the most populous municipalities of each county. Within Essex County, East Orange has the largest number of residents served with 106, closely followed by Newark with 101 and Irvington with 37. In Passaic County, Paterson is the most populous with 103 residents, while Morristown is the most populous in Morris County with 23 residents served. The top 15 municipalities by residency show a significant presence in urban and suburban areas, demonstrating the program's wide-ranging reach and ability to support individuals in diverse communities across the three counties. In total, 85 different municipalities were served during this fiscal year.

The current ICMS census ranges from age 18 to 77, with an average age of 42. Gender identity is reported as 67% female, 32% male, and 1% gender conforming. Self-reported races of enrolled consumers are as follows: White/Caucasian (43%), Black or African-American (31%), Asian (1%), American Indian or Alaskan Native (0%), other (11%), multi-racial (13%), and declined to specify (1%). The primary spoken language of consumers is predominantly English; however, ICMS is able to serve all consumers with assistance from bilingual staff, family members, and paid translation services when needed. Spoken consumer languages are as follows: English (85%), Spanish (13%), Creole (1%), and French, Russian, Polish, Portuguese, Arabic, and other (1%).

Performance Outcomes

Performance outcomes are measured and monitored through MHA's Quality Assurance Committee (QA). Performance indicators specific to ICMS measure effectiveness and access: hospitalization recidivism rates, employment rates, and contact rates.

- **Hospitalization Recidivism (effectiveness):** The MHA ICMS program demonstrates strong effectiveness in preventing hospitalization recidivism, as evidenced by its consistently low rates across the three counties it serves. The program achieved a 0% rate for state and county hospitalizations in both Essex and Morris counties, and a very low 1% in Passaic County. When acute care was necessary, it was typically of a short-term nature, with rates for Short Term Care Facilities at 4% in Essex and 1% in both Morris and Passaic. Additionally, voluntary hospitalizations were minimal, with rates of 1% in Essex and Morris and 2% in Passaic. This data underscores the program's success in stabilizing clients, managing symptoms, and providing a level of care that prevents the need for more intensive, long-term institutionalization.

Employment Rates (effectiveness): MHA ICMS collaborates with both internal and external county-based Supported Employment Services (SES) to increase employment rates and opportunities for individuals with severe mental illness. In fiscal year 2025, Passaic ICMS identified an average of 19% of the active caseload as employed, Essex ICMS identified 16%, and Morris ICMS identified 7%.

Contact within 72 hours (access): Access was evaluated based on the time interval between a person's discharge from a state or county hospital and their initial contact with a case manager. The goal for this indicator is that over 80% of consumers enrolled in ICMS are engaged within 72 hours of hospital discharge. In this fiscal year, 100% of individuals were enrolled within 72 hours following discharge from County or State hospitals.

Consumer Satisfaction Surveys

The MHA ICMS program's recent survey data reveals a strong and positive client experience. The results indicate that a vast majority of clients feel that staff are not only responsive and respectful but also deeply committed to a client-centered approach. A remarkable 95% of clients reported overall satisfaction, with a similar 97% feeling they are treated with dignity and respect. Furthermore, the program is highly effective at fostering client empowerment, as 96% of individuals are encouraged to make their own decisions regarding their services. The survey also highlights strong communication and collaboration, with 97% of clients feeling they can freely voice concerns and 93% actively participating in their service plans. While the data is overwhelmingly positive, there is a minor opportunity for enhancement regarding one-on-one time, as a small percentage of clients expressed neutral or negative feedback about the time their case managers spend with them on visits.

Program Highlights

ICMS continued its commitment to supporting ICMS individuals through several meaningful initiatives throughout the year. Over 150 winter coats, along with hats and gloves were purchased and distributed to individuals. This annual effort recognizes that some individuals may lack the means or ability to obtain essential items for navigating New Jersey's harsh winter months.

In addition to winter gear, food donations were received and distributed to both individuals and families. “Wellness boxes” filled with items that promote self-care and well-being were also provided.

Individuals had opportunities to participate in various agency-hosted social events, including Operation Holiday, Gifts for the Season, and the Holiday Express party. These donor-supported events provided gifts such as clothing, personal care products, and toys helping to bring joy and comfort to individuals and families during the holiday season. ICMS also provided blankets, sheets and other hygiene products to consumers throughout the year.

In June 2025, MHA proudly hosted the Annual Consumer Picnic at two locations—Eagle Rock Reservation in Essex County and Hedden Park in Morris County. Consumers from all three counties came together to enjoy beautiful weather, delicious food, and uplifting social connection with their peers.

Advocacy Activities

ICMS participated on the following committees, boards, and task forces, during the past year:

- ***Essex, Morris and Passaic Systems Review Committees (SRC)*** - This monthly meeting is convened by the Mental Health Administrator and Screening Center of the respective county. The purpose of these meetings is to identify countywide gaps in services and breakdowns in services between providers and/or mental health treatment systems. The Committees provide education and advocacy to the community, mental health providers, consumers of mental health services and their families and provides advocacy on the needs of the mental health system in the county.
- ***Essex Children Systems Review Committee (CSRC)*** - ICMS participates in these monthly meetings convened by the Mental Health Administrator of Essex County. The purpose of these meetings is to identify countywide gaps of consumers transitioning or aging out of services of Department of Child Protection and Permanency and identify breakdowns in services between providers and/or mental health treatment systems. The Committee provides education and advocacy to mental health providers, consumers of mental health services and their families on systems in the county.
- ***ICMS Statewide Quarterly Meeting (NRQM)*** – This leadership meeting is scheduled on a quarterly or as needed basis by the DMHAS ICMS Coordinator for the purpose to discuss any system issues, identify service gaps and for DMHAS to provide support and guidance to the ICMS programs statewide.
- ***Essex, Morris and Passaic Professional Advisory Committee (PAC), Mentally Ill Chemical Abuser/MICA Task Force Meeting*** - ICMS/Agency leadership participates in a monthly meeting with the Counties Drug and Alcohol Task Force to develop ways in which community providers can serve individuals with mental health, addictions and co-occurring mental health and addictions disorders in a unified manner.
- ***Essex, Morris and Passaic Residential Meeting*** - ICMS participates in a monthly meeting along with DMHAS, County Administrator and hospital and residential housing professionals to collaborate on safe and appropriate discharge planning for persons primarily in state and county psychiatric facilities.

- ***Passaic County Behavioral Health/Opioid Task Force*** – The Task Force was established by the Passaic County Collective Impact Council to undertake a process of designing and implementing an organized system of services for individuals and families, including strategies for enhancing prevention, early intervention, and aftercare services, in addition to crisis-based services. Monthly virtual meetings are attended by the Passaic ICMS Director.
- ***Passaic County Crisis Intervention Training Board***- The task force was established by Passaic County in order to provide training to police officers in Crisis Intervention Training.
- ***Passaic County Overdose Fatality Committee*** - The Passaic County OFRT meets monthly and through the decedent cases we receive, review factors, trends, gaps, and barriers that cause or play a role with fatal overdoses. From there we identify any and all gaps or barriers to services, promote and engage in cross sector coordination and collaboration, engage in thorough discussions, and develop then provide recommendations and implementations for change that will support the Team’s ultimate goal in reducing fatal overdoses in Passaic County and saving lives. ICMS Director participates in Resource Subcommittee.

FY 2026 Goals

1. **Enhance Service Quality and Outcomes:** Continuously improve the quality of case management services to support recovery, independence, and improved quality of life for consumers.
2. **Improve Documentation:** Strengthen documentation practices through regular audits and training to ensure compliance and support quality care.
3. **Expand Community Partnerships:** Develop and sustain collaborations with healthcare providers, and community organizations to facilitate seamless service delivery and increase referrals.
4. **Promote Cultural Competency:** Enhance staff training on cultural competence and bilingual services to better serve diverse populations.
5. **Support Staff Development:** Provide ongoing training and professional development opportunities to ensure staff remain informed about best practices and emerging trends in mental health services.
6. **Foster Person-Centered Care:** Ensure services are individualized, recovery-oriented, and empowering, respecting individual preferences and goals.

ASSISTED OUTPATIENT TREATMENT (AOT)

Description

The mission of Assisted Outpatient Treatment (AOT), also known as Involuntary Outpatient Commitment (IOC), is to provide court-ordered mental health treatment, intensive case management, and assistance to a select group of mental health consumers who have been resistant to treatment and have difficulty engaging in outpatient treatment. AOT helps these consumers live safely in the community, avoid repeated inpatient hospitalizations, arrests or incarcerations, and ensures they have access to comprehensive outpatient services. By adherence to a court-ordered treatment plan, consumers have the opportunity to engage more consistently in ongoing treatment and, ultimately, to graduate to less restrictive mental health services.

Personnel

The AOT staff is culturally diverse and is representative of the population served.

- AOT Essex is currently staffed by one full-time Licensed Program Director, three full-time Master's Level Case Managers, one part-time Psychiatrist, and one part-time Administrative Assistant.
- One full-time Licensed Program Director oversee:
 - AOT Sussex which is currently staffed by one full time Bachelor's Level Case Manager and one part-time Psychiatrist.
 - AOT Morris which is currently staffed by one full- time Program Director, one fill-time Master's Level Case Manager, one full time Bachelor's Level Case Manager, and one part-time Psychiatrist.

Caseload

Essex: As of June 30, 2025, there were 40 active cases. During FY 2025, 51 referrals were enrolled into the AOT program; 73% of the referrals were made through Short Term Care Facilities (STCF) and/or private hospitals via conversion or amended hearings; 27% were made through conversion hearings at long-term care facilities, such as Essex County Hospital Center (ECHC) and/or state hospitals.

Sussex: As of June 30, 2025, there were 14 active cases. During FY 2025, the program served 32 unduplicated individuals; 72% of the referrals were made through Short Term Care Facilities (STCF) and/or private hospitals via conversion or amended hearings; 11% were made through conversion hearings at long-term care facilities, such as state hospitals. There were 11% referrals enrolled through the designated screening centers.

Morris: As of June 30, 2025, there were 21 active cases. During FY 2025, the program served 41 unduplicated individuals; 52% of the referrals were made through Short Term Care Facilities (STCF) and/or private hospitals via conversion or amended hearings; 36% were made through conversion hearings at long-term care facilities, such as state hospitals.

Demographics

MHA's AOT programs provide services to residents of Essex, Sussex, and Morris counties who are 18 years of age and older, diagnosed with a serious and persistent mental illness (SPMI) and have a history of treatment non-compliance.

Gender: At the end of the fiscal year, the self-reported gender for individuals served in AOT Essex was 38% female, 57% male, and 5% undisclosed; for Sussex was 53.2% male and 37.5% female, 3.1% individual refused, 3.1% data was not collected, and 3.1% trans-male; and for Morris, it was 42.5% female and 55.0% male and 2.5 % individual declined to answer.

Ethnicity: During Fiscal Year 2025, AOT Essex provided services to individuals who self-reported the following races and ethnicities: 54% African-American, 9% Hispanic/Latino, 3% Asian or Asian-American, 16% Caucasian, 11% unknown or refused to disclose, and 7% individuals who identified as multiracial. AOT Sussex provided services to individuals who self-reported the following races and ethnicities: American Indian or Alaskan Native 3.1%, Asian 3.1%, Black or African-American 6.4%, Multi-Racial 3.1%, Other 6.3% White 74.9%, and 3.1% data was not collected. AOT Morris provided services to individuals who self-reported the following races and ethnicities: White 65%, Unknown 5.0%, Other 2.5%, Black or African-American, White 2.5%, Black or African-American 10%, Both and Black or African-American 2.5%, Asian 10%, No Data Collected 2.5%.

Age: AOT Essex provided services to 46% of individuals between the ages of 18-29, 22% between the ages of 30-39, 14% between the ages of 40-49, 8% between the ages of 50-59, and 10% above the age of 60. AOT Sussex provided services to 6.3% of individuals are ages of 18 to 20, 15.6% are between 21 and 30 years old, and another 15.6% fall within the 31 to 40 age range. Those aged 41 to 50 make up 25.0%, while the 51 to 60 group represents 28.1%. Lastly, 9.4% of the population is between 61 and 70 years old. AOT Morris provided services to 21–30 age range, making up 27.5% of the total. This is followed by those aged 31–40 at 25.0%, and 61–70 at 20.0%. Individuals aged 41–50 represent 15.0%, while those aged 51–60 account for 10.0%. The smallest group is those aged 71 and older, comprising 2.5% of the population.

Performance Outcomes

All AOT consumers have a history of frequent inpatient hospitalizations and emergency room visits. AOT closely monitored these indicators and established baselines to measure the access, efficiency, and effectiveness of the program. During this past fiscal year, AOT has clearly demonstrated progress, as

evidenced by the reduction in emergency room screenings, long-term care admissions, arrests, incarcerations, voluntary and involuntary hospitalizations, and homelessness among consumers.

AOT ensures easy access and availability for referral via screening, Short Term Care Facility (STCF) and/or Long-Term Care (LTC) in order to assess consumers for appropriateness to AOT services. AOT staff is available 24 hours a day, 7 days a week, via on-call if a referral needs to be seen outside regular hours. This year, AOT collectively received 2 referrals from local screening centers, 63 STCF referrals and 25 LTC referrals.

The use of the AWARDS clinical database allows for efficient and organized clinical record keeping. With multiple report modules, we are able to better track staff interventions and crises.

AOT monitors recidivism rates monthly to evaluate service quality and outcomes, with annual calculations to assess overall effectiveness. Recidivism includes any hospitalization or emergency room visit, psychiatric admissions (voluntary, involuntary, or long-term care), arrests, incarcerations, and episodes of homelessness. The programs have successfully met or exceeded all benchmark expectations across the counties.

Consumer Satisfaction Surveys

MHA is continuously refining services based on consumer input. This is received through various methods, including the annual Consumer Satisfaction Survey. Consumers completed the survey via web link, QR code, or hard copy. The results were analyzed by the Director of Quality Assurance and provided to the Program Directors for review. Approximately 20 surveys were delivered to consumers in Essex, Morris, and Sussex counties. This accounts for a response rate of 19%, 29% and 36% respectively.

Program Highlights

Program Success: The Assisted Outpatient Treatment programs continue to demonstrate meaningful impact, with a total of 37 consumers successfully graduating this year. These individuals have met their treatment goals, maintained stability, and demonstrated readiness to transition out of the program, underscoring the effectiveness of the supportive and collaborative care model.

Consumer-Centered Approach: AOT provided individual psychoeducation for consumers transitioning or approaching graduation from AOT, focusing on increasing their self-awareness regarding emotions, identifying and establishing social supports outside of AOT, and education on the importance of medication adherence.

Strengthened Partnerships: AOT continued to collaborate with and educate staff at Screening Centers, Short Term Care Facilities, Essex County Hospital Center (ECHC), state psychiatric institutions, and private hospitals. These strengthened relationships have enhanced continuity of care, improved coordination during transitions from inpatient to outpatient services, and supported more timely and appropriate interventions for consumers in crisis.

Community Engagement and Social Integration: AOT consumers have actively participated in community-building events, such as holiday celebrations, achievement awards, and a summer picnic. These gatherings foster social connection, reduce isolation, and promote recovery-oriented values by encouraging inclusion, engagement, and empowerment outside of clinical settings.

Giving Back: With community donations, AOT was able to provide assistance to several consumers in obtaining daily household items, toiletries, clothing, and county, state, or drivers' identification.

Advocacy Activities

AOT staff work closely with consumers to assist them in developing self-advocacy skills by maintain an open dialogue about various ways they can become involved in different levels of advocacy. All counties participate in the Statewide IOC Directors' meeting convened by the Department of Health and Addiction Services (DMHAS). The purpose of these meetings is to collaborate with counterparts in other counties to discuss ways to increase program effectiveness, review service delivery concerns, and to obtain needed updates on practices and protocols of the IOC programs.

AOT also participates in the following county specific meetings, task forces, and committees:

Acute Care/System Review Committee is a monthly meeting. The purpose of these meetings is to identify countywide gaps in services and gaps in services between providers and/or mental health treatment systems. The committee provides education and advocacy to the community, mental health providers, consumers of mental health services and their families, and provides advocacy on the needs of the mental health system in the county.

Behavioral Health Providers Meeting, formerly Professional Advisory Committee (PAC), is a bimonthly meeting convened by the County Mental Health Administrator. The purpose of these meetings is to identify and address the current mental health service needs, trends and priorities of the County.

Sussex County Enhancement is a monthly meeting directed by the Team Mental Health Technology and Training Center of Rutgers University aimed at reducing transfer wait times for individuals utilizing psychiatric screening services. The team reviewed and evaluated current county needs and challenges and developed strategies to improve the use of county resources for consumers.

FY 2026 Goals

The Assisted Outpatient Treatment (AOT) program remains committed to continuous improvement and expanding its impact. Looking ahead, the program has outlined several strategic goals to enhance service delivery, increase consumer success, and strengthen collaboration across systems of care.

- 1. Increase Consumer and Provider Contact:** AOT staff will work on increasing the overall number of meaningful contacts with consumers, their families, and associated service providers. This

enhanced communication aims to strengthen relationships, improve coordination of care, and foster a more consistent and responsive support system.

- 2. Strengthen Collaboration with the Public Defender's Office:** AOT will continue to work closely with the Public Defender's Office to ensure legal and clinical coordination that supports consumer success. This collaboration is vital in aligning legal processes with therapeutic goals, reducing barriers to care, and promoting individual recovery outcomes.
- 3. Collaborate with DMHAS and Community Partners on AOT Development:** AOT will continue to work in close partnership with the DMHAS and local community providers to refine the process and legislative framework for AOT. The goal is to improve clarity, efficiency, and alignment of practices across all stakeholders involved.
- 4. Empower Consumers to Achieve Personal Goals and Program Graduation:** Empowering consumers to take an active role in their recovery remains central to AOT's mission. The program will continue to support individuals in identifying and working toward their personal goals—whether related to health, relationships, education, or employment—with the aim of preparing them for successful program graduation and long-term independence.
- 5. Enhance Community Integration and Social Inclusion:** Building on past successes, AOT will further promote community engagement through structured group activities, events, and opportunities for social interaction. These efforts help reduce isolation and support consumers in developing social skills and natural supports.

Co-Response

Description

Co-Response delivers crisis response in collaboration with local police departments, ensuring that individuals in a mental health related crisis feel safe and receive the support they need in order to stabilize. Co-Response is an interactive approach to emergency response and crisis intervention that involves both law enforcement officers and mental health professionals working together to address situations involving individuals experiencing mental health crises or emotional distress. This model recognizes that traditional law enforcement responses may not always be the most appropriate or effective way to handle such situations, especially when mental health issues are involved.

In a co-response model, specially trained mental health professionals called clinical co-responders are paired with law enforcement officers to jointly respond to calls involving individuals in crisis. The clinical co-responders bring expertise in de-escalation techniques, crisis intervention, and mental health assessment, while law enforcement officers ensure safety and security during the encounter. Overall, co-response represents a proactive and compassionate approach to addressing mental health crises, emphasizing collaboration, empathy, and the prioritization of individual well-being.

MHA Co-Response programs are located in Essex County, in West Orange Township and South Orange Township, as well as in Middlesex County in the City of Perth Amboy. As of March 2025, Co-Response services are also available in Morris County, in Mount Olive Township.

Beginning March 2024, the Mental Health Association partnered with police departments in Morris County to implement the ARRIVE (Alternative Responses to Reduce Instances of Violence & Escalation) Together program. This initiative was initially introduced by the New Jersey State Police to deploy the Close in Time/Follow-up response program. Through this delivery system, a Crisis Intervention Team (CIT) trained law enforcement officer (when available) and a mental health specialist respond to emergency service calls and/or follow-up visits related to a behavioral health crisis, traveling in separate vehicles. The response may be simultaneous or there may be a short delay in the mental health specialist's arrival, generally within 30 minutes of the law enforcement encounter. In some cases, the mental health specialist may stage before arriving at the scene alongside law enforcement. response may also require staging before arrival at the scene with law enforcement. The mental health specialist provides social and mental health services as appropriate and arranges for follow-up care as deemed necessary.

Personnel

MHA has nine clinical co-responders across Essex, Morris, and Middlesex counties who are stationed within the assigned police departments Monday to Friday.

Caseload

MHA Co-Responders responded to mental health related and crisis calls in the community. Upon receiving calls from dispatch, MHA reported to the designated scene or incident. Throughout the fiscal year, MHA

was able to provide practical support to officers responding to mental health-related crises. As a result of this collaboration, all parties were able to ensure that the individuals received the appropriate level of care, promoting treatment and recovery while helping to prevent involvement in the criminal justice system. During FY2025, MHA co-responded to 928 incidents in 13 municipalities.

From July 1, 2024 to June 30, 2025, Co-Response Programs serviced a total 1651 individuals.

Performance Outcomes

During FY2025, across 13 municipalities, MHA co-responded to 928 incidents and 1825 referrals were received for follow up. In addition, the following outcomes were measured:

- For Co-Response Program, 195 of 373 Co-Responses required transport to the hospital.
 - 35 involuntary hospital transports
 - 160 voluntary hospital transports
 - 173 Co-Responses were resolved at scene
- For ARRIVE, 667 of 1,496 Co-Responses/Follow Ups required transport to the hospital.
 - 92 involuntary hospital transports
 - 575 voluntary hospital transports
- 848 linkages (i.e., mental health services, substance services, community resources) were made in the community.

As evidenced by outcomes, Co-Response Programs has allowed for an increase in the success rate of appropriate dispositions and interactions with individuals in the community living with mental illness. Through mental health awareness training, recommendations and analysis, and real-time Co-Response support, MHA has assisted police departments with the important process of utilizing community resources in an effort to promote options of prevention, intervention, treatment, and overall wellness and recovery.

Program Highlights

Co-response is a collaborative approach to emergency response that involves both law enforcement officers and mental health professionals working together to address situations involving individuals experiencing mental health crises or emotional distress. Some highlights and activity from this year includes:

- Completed first year of co-response program with South Orange Police Department.
- During the fiscal year, MHA was able to provide over 40 trainings to police departments and dispatch.
- In August 2024, Co-Response Programs participated in several municipalities for their annual National Night Out.

- In October 2024, 2 additional municipalities in Morris County (Randolph, Hanover) began participating in the ARRIVE program.
- ARRIVE Director participated in the Morris Plains Mental Health Symposium in September 2024.
- ARRIVE staff participated in Bottle Hill Day with Madison Police Department in October 2024.
- Staff provided multiple trainings on de-escalation to multiple police departments.
- Staff participated in multiple Coffee with a Cop events throughout Morris County.
- Program Director and Morris County Prosecutors Office provided 160 hours of Crisis Intervention Team (CIT) training to approximately 132 law enforcement officers.
- In August 2024, program Director attended the CIT International Conference held in Indianapolis, Indiana. The purpose of the conference is to bring together law enforcement, mental health professionals, advocates and public safety leaders.
- In September 2024, Co-Responders attended South Orange and Maplewood's Community Day and Health Fair in September 2024 to promote mental health resources and connect with local service providers.
- In November 2024, Co-Responders participated in the South Orange PBA Turkey Drive in November 2024 to help distribute Thanksgiving turkeys and strengthen community partnerships.
- March 2025, ARRIVE staff participated in the county-wide Law Enforcement Night.
- In March 2025, Co-Responders participated in Read Across America in the City of Perth Amboy
- In March 2025, Program Director participated in a video highlighting ARRIVE program for the New Jersey Office of Attorney General.
- In February 2025, Program Director participated in the 2025 Winter Summit panel for the New Jersey Conference of Mayors with the New Jersey Office of Attorney General. The summit highlighted the ARRIVE program and the partnerships with local law enforcement entities.
- In March 2025, MHA implemented Co-Response in partnership with Mt. Olive Police Department (MOPD) through the Connect and Protect grant through the BJA. The partnership allows MHA to provide Co-Response and follow up to individuals in crisis, as well as mental health related trainings to the MOPD. The program consists of two staff coverage Monday to Friday 7am to 11pm.
- In April 2025, Co-Response attended West Orange Police Department's Senior Citizen Police Academy.
- In June 2025, the ARRIVE program expanded to an addition 25 municipalities, resulting in county-wide coverage.
- In June 2025, Co-Response attended West Orange Police Department's Touch a Truck event for individuals ages 2-7 with a diagnosis of autism spectrum disorder.
- In May 2025, the program partnered with Morris County Prosecutor's Office to implement the ARRIVE Critical Incident Model. The Critical Incident Model ensures that a mental health professional is available to respond 24/7, 365 days a year to incident involving barricaded individuals who appear to be in need of medical or mental health intervention.

Advocacy Activities

- The program participates as a member of the Morris Crisis Intervention Team (CIT) Steering Committee, and the NJ State CIT Committee.
- Co-Responders attended South Orange and Maplewood's Public Health and Safety Meeting which included local stakeholders with the goal of discussing public health initiatives.

FY 2026 Goals

Looking ahead, the future goals of the co-response program include expanding its reach to more communities and increasing the number of trained mental health professionals available to respond to crises. Enhancing collaboration with additional community partners, such as hospitals, social service agencies, and advocacy groups, is also a priority to ensure comprehensive support for individuals in crisis. The programs aim to incorporate data-driven practices to continually assess and improve response outcomes, fostering more effective and timely interventions. Additionally, there is a focus on increasing public awareness and education around mental health and crisis response to reduce stigma and promote community engagement. Investing in ongoing training and professional development for co-responders will be essential to keep pace with best practices and emerging needs. Ultimately, the goal is to create a seamless, community-centered crisis response system that prioritizes recovery, reduces unnecessary hospitalizations, and promotes long-term wellness and resilience.

Projects for Assistance in Transition from Homelessness (PATH)

Description

The PATH program includes the following programs and services:

The PATH program provides outreach, intensive case management, and housing support to adults 18 and over who are homeless or at risk of homelessness, and who have serious mental illness and co-occurring substance use disorders. Its goal is to engage individuals in community-based services, improve health outcomes, and expand access to permanent, affordable housing. PATH specifically targets those who lack access to traditional services and have minimum community support, meeting them wherever they are—on the streets, train stations, or under bridges—in Essex and Morris counties. The program offers flexible, wellness-based support and works within the counties' Coordinated Entry System to strategically allocate resources and promote a Housing First approach, helping individuals achieve stability and a higher quality of life.

Edna's Haven Resource Center offers temporary relief from the pressures of homelessness and poverty and to provide companionship and constant inspiration. We use positive encouragement and existing community resources to provide a safe and welcoming daytime refuge for all, foster self-sufficiency, renew hope, provide comfort, and enrich lives.

Homeless Diversion is a proactive approach aimed at preventing individuals and families from entering the shelter or housing system by quickly identifying and addressing their immediate needs. It involves connecting people to alternative resources to help them resolve housing crises and maintain stability without entering emergency shelters or becoming homeless. The goal of diversion is to reduce homelessness by providing timely, tailored solutions that keep people safely housed and engaged in the community.

Personnel

Essex PATH services are provided by one Director, one Master's Level Coordinator, one Co-Occurring Counselor, three Outreach Case Managers, one Peer Outreach Case Manager, one part-time RN. Morris PATH services are provided by one Director, one Master's Level PATH Intake Coordinator, one full-time PATH Outreach Case Manager, one full-time Outreach Case Manager (County), one part-time Outreach Case Worker and one part-time Housing Navigator for Coordinated Entry. PATH has 2 staff members fluent in Spanish. Edna's Haven services are provided by one part time case manager and one part time Resource Navigator who is fluent in Spanish. Homeless Diversion services are provided by 2 bachelor level case managers. In all programs, staff are culturally diverse and represent the consumers served.

Caseload

During fiscal year 2025, PATH has outreached 671 homeless individuals and those at imminent risk of homelessness throughout Essex and Morris counties. Of these, 351 consumers received case management services through the PATH Program. The program conducts weekly outreach in various

community locations such as Newark International Airport, Newark Penn Station, Morristown and Dover train stations, local drop-in centers such as Salvation Army Montclair, NJCRI, Edna's Haven, Our Promise, Community Soup Kitchen, Dover Faith Kitchen, as well as other churches and community kitchens.

Referrals were received from all local Short Term Care Units, including Newark Beth Israel, East Orange General Hospital, University Hospital, Saint Michael's Medical Center, Morristown Medical Center, Saint Clare's Hospital, Summit Oaks, Bergen Regional, Chilton Hospital, as well as outpatient treatment centers. Additionally, referrals came from local police departments such as Montclair, East Orange, West Orange, Orange, Irvington, Maplewood, Caldwell, Verona, Nutley, Essex County Sheriff, NJ Transit Police, NJ/NY Port Authority Police, Morristown Police, Dover, Jefferson, Parsippany, Budd Lake, Netcong, Lake Hiawatha, and other municipalities that report homeless individuals. Other social service providers also provided referrals, and some are obtained through the Coordinated Entry waitlist.

Edna's Haven operates using a drop-in center model without maintaining a formal caseload. However, 261 individuals received various resources, linkages, and services through this program.

Homeless Diversion successfully diverted 86 households from experiencing homelessness during fiscal year 2025.

Demographics

As of June 30, 2025, Essex and Morris PATH served a total of 351 individuals. Among them, 186 were male (53%), 163 female (46%), and 2 identified as transgender (1%). The self-reported ethnicities were 48 Hispanic/Latino (14%) and 303 non-Hispanic/Latino (86%). Regarding race, the self-reported data showed 33 individuals of multiple races (9%), 95 Caucasian (27%), 219 African American (62%), 3 Asian (1%), no Native Hawaiian or Other Pacific Islander (0.5%), 1 American Indian or Alaska Native (1%), and no individuals identifying as Middle Eastern (0%). Some individuals chose not to disclose their race or ethnicity.

The following reflects the municipalities in Essex and Morris Counties where consumers reported sleeping the night before being outreached by PATH: Belleville (1), Morristown (22), Bloomfield (3), Mine Hill (1), Boonton (5), Newark (118), Budd Lake (14), Nutley (1), Dover (10), Orange (8), East Orange (20), Parsippany (12), Lake Hiawatha (3), Randolph (2), Ledgewood (3), Rockaway (4), Lake Hopatcong (1), Livingston (1), Irvington (9), West Orange (3), Montclair (20), Whippany (14), Morris Plains (14), and South Orange (1).

Consumers outreached by the PATH Program reported sleeping in the following locations the night before engagement: 44 on the street or in places not meant for human habitation (12%), 57 in emergency shelters, including motels paid with emergency assistance (16%), 70 couch surfing (20%), 9 in incarceration (3%), 12 in substance use disorder treatment facilities, detox centers, or halfway houses (3%), 4 in inpatient hospitals (1%), and 36 with eviction pending (36%). Some individuals chose not to provide this information. Among enrolled consumers, 149 (42%) met the Department of Housing and Urban Development (HUD) definition of "chronically homeless," which includes being homeless for one year or more or experiencing four or more periods of homelessness within the past three years, totaling at least 12 months.

Homeless Diversion provided services to 86 households, with the head of household consisting of 75% females and 25% males.

Performance Outcomes

PATH participates in the agency-wide Quality Assurance Committee (QA), which holds monthly meetings to collect and analyze data on the utilization and quality of services provided by each MHA program. During this fiscal year, Essex and Morris PATH outreached 671 individuals and served 351, exceeding the contract commitment by 140%. PATH successfully connected 141 individuals to Community Mental Health, 22 to substance abuse treatment, 109 to financial benefits, 86 to temporary housing, 96 to permanent housing, 45 to medical or dental services, and 49 to rehabilitation or habilitation programs. Furthermore, 100% of PATH enrollees in Essex and Morris Counties received education on “Summer Heat and Sun Risks” and were provided, at least quarterly, medication education.

The average time to resolution for Homeless Diversion cases was 12 days, with a 0% recidivism rate. Of these cases, 46 individuals remained in their current housing, 12 were reunited with family, and 28 were successfully relocated.

Consumer Satisfaction Surveys

Approximately 35 satisfaction surveys were completed by consumers enrolled in the PATH Program. The feedback from these surveys indicated a high level of satisfaction, with 99% of respondents expressing that they were pleased with the services received. Consumers reported that the PATH Program effectively met their needs, provided compassionate and respectful support, and helped them access essential resources and services. This overwhelmingly positive feedback reflects the program’s commitment to client-centered care and highlights its success in fostering trust and engagement among participants. The high satisfaction rates also suggest that the program continues to be a valuable resource for individuals experiencing homelessness and those with complex mental health and substance use challenges.

Program Highlights

This year, PATH’s greatest achievement was securing permanent housing for ninety-six individuals experiencing chronic homelessness, many of whom have severe and persistent mental illnesses along with co-occurring substance use disorders.

The PATH Morris Director organized and led the Morris County Project Homeless Connect, which served 116 attendees through over 40 agencies. The event included distributing 46 Narcan kits, HIV testing for 50 individuals, glucose and cholesterol checks for 20, and 7 flu vaccinations. Over 130 hygiene bags and 50 coats were donated and distributed. Additionally, two barbers provided more than 30 haircuts during the event. In addition, PATH Essex staff participated in Essex County’s Project Homeless Connect, engaging with homeless individuals and distributing care packages that included toiletries, snacks, and bus tickets to provide support.

PATH Essex and Morris staff participated in the HUD mandated Point-In-Time Count which a census of shelter and unsheltered homeless individuals conduct on a single night.

PATH Essex Director organized monthly events with Division of Family Assistance and Benefits (DFAB) who provided individuals with NJ SNAP (formally Food Stamps and Work First NJ (Cash Assistance).

PATH organized 3 events with New Jersey Motor Vehicle Commission for their mobile van to provide individuals with services such as drivers licenses and non-drivers state identification.

Homeward Bound continued operations at Newark International Airport. Homeward Bound is a 24-hour, 7 day a week program contracted by The Port Authority of New York & New Jersey to provide homeless outreach to individuals residing at Newark International Airport. One hundred and seventy individuals were outreached throughout the year.

PATH Morris Director continues to serve as a Code Blue Provider Participant with the Office of Temporary Assistance and The Office of Emergency Management in Morris County.

PATH Morris continued to operate the part-time Coordinated Entry Housing Navigator position funded by NJ 211. Meanwhile, PATH Essex hosted Coordinated Entry staff in the office three days a week to conduct intakes for the permanent supportive housing waitlist.

Edna's Haven hosted quarterly HIV and Hepatitis C testing in collaboration with the Atlantic Health Care Group. It also established strong relationships with local organizations such as Zufall and Hope House, which attend Edna's Haven quarterly to provide resources and educational information to individuals on site. Additionally, Edna's Haven hosted the CARES substance and support group every Friday, offering a supportive environment for those in need. Edna's Haven also held regular community events, including Pizza Tuesdays, to foster engagement and connection among attendees.

Advocacy Activities

PATH Essex and Morris Directors are voting members for their respective counties Continuum of Care (CoC) as well as sit on various subcommittees with the goal to advocate and achieve better housing outcome for homeless individuals.

PATH actively participates in monthly DMHAS Systems Review Committee (SRC) meetings. The purpose of the committee is to identify countywide gaps in service delivery.

PATH Director participates in Montclair Unhoused Collaborative meetings to end homelessness in Montclair.

FY 2026 Goals

The primary goals for PATH are to increase access to permanent housing for individuals experiencing chronic homelessness by exploring housing options and improving placement outcomes. Additionally, PATH aims to enhance outreach and engagement efforts to identify and connect with more individuals in need, especially those who are hard to reach or experiencing persistent mental health and substance use challenges. Another key goal is to improve client satisfaction and overall outcomes through continuous program evaluation and feedback, fostering a client-centered approach. Providing ongoing staff training on trauma-informed and culturally competent care is also essential to delivering effective support.