

Mental Health Association Management Report Fiscal Year 2026

Inspiring Hope and Healing

20,000+
individuals served

40+
mental health and
addiction programs
offered

250+
yearly community
presentations on
mental health and
addiction topics

Mental Health Association

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Introduction

The Mental Health Association (MHA) continued its strong focus on the recovery, safety and mental health and substance use disorder needs of consumers and their families in fiscal year 2026. MHA exceeded its service and quality expectations while remaining in a strong financial position. The agency operated in a financially sound manner while advancing its mission of providing services to individuals and their families regardless of their ability to pay.

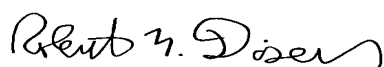
MHA continued to focus on innovative service delivery, emphasizing wellness and recovery:

- MHA maintains a 76-year legacy of advocacy, treatment, policy and caring.
- MHA completed implementation of the 988 Mobile Crisis Response Teams for Essex and Hudson County. MHA now provides services in 6 counties, Essex, Morris, Passaic, Sussex, Hudson and Middlesex.
- MHA completed the implementation of 2 grants to provide Community Wellness Centers (Drop-in programs) in Morris and Sussex Counties.
- MHA continues to benefit from strong support from local foundations as evidenced by continued significant financial support from the Healthcare Foundation of the Oranges, F.M. Kirby Foundation and the Partners for Health.
- MHA met the service needs of the community via its counseling, case management, partial hospitalization, primary care, supported employment, criminal justice, educational, supportive housing, therapeutic jurisprudence, faith-based, consumer advocacy, school-based, suicide prevention services and family and children's programs. All services are evidenced based and recovery focused, culturally competent to the diverse communities we serve with an emphasis on the underserved and marginalized persons with health disparities.
- MHA led a successful advocacy campaign to restore funding for the statewide NJ4S program, and MHA's Morris and Sussex County NJ4S program specifically.
- MHA received CARF Accreditation at the highest level as a result of their significantly successful triennial survey.

Raising mental health awareness was the centerpiece of MHA's performance for fiscal year 2025. MHA provided over 250 community presentations on a range of mental health and addiction recovery topics throughout Northern New Jersey. Suicide Prevention and adolescence mental health were the most common raising awareness activity with presentations to schools, colleges, community groups and houses of worship. MHA staff appeared on NJTV, NEWS 12, WPIX and were quoted numerous times on several online outlets, including the Daily Record and NJ. Com/Star-Ledger.

Advocacy, on behalf of individuals with mental illness and their families, was a continued interest in fiscal year 2026. Led by the Board's Advocacy Committee and senior staff, the agency was instrumental (working with other community partners) in maintaining funding in the State Budget for FY 2027. The agency advocated strenuously for improving the conditions at Greystone Park Psychiatric Hospital. MHA advanced its advocacy efforts with two Legislative Breakfasts attended by over 500 people and broadcast live via the internet. Participants included numerous elected officials from the Federal, State and County level. Staff and Board advocated in Newark, Trenton and Washington, D.C. for legislation, mental health funding and the care of individuals with mental illness and those with addictions.

The environment of care is in excellent condition. The agency continues to replace vehicles, as needed, and appropriately maintain the physical plant. Consumer, family and provider satisfaction surveys indicate a high level of satisfaction with MHA and its services.



Robert N. Davison, Chief Executive Officer

Agency Strategic Goals

1. Expand advocacy and reduce stigma: MHA's goal is to create a more supportive and inclusive community for individuals with mental illness and addiction.
2. Focus on broader societal mental health and addiction challenges: MHA champions a society where those in need have access to the mental health and addiction services, and where mental wellness is valued and prioritized.
3. Broaden MHA's name recognition while concurrently seeking new funding sources: In doing so, MHA can ultimately expand its impact on the community.
4. Improve person's served long-term prospects, and personal independence and autonomy: MHA emphasizes overall wellness through the integration of physical health and social interaction, in conjunction with traditional mental health services, in all MHA programs.
5. Enhance the financial strength of the agency: MHA will continue to maintain a strong financial foundation that supports its mission and ensures its long-term sustainability.
6. Fortify MHA's workforce: MHA recognizes building a strong and dedicated workforce is essential for the agency's success and the well-being of the individuals it serves.

Chief Executive Officer Goals & Objectives July 1, 2026 – June 30, 2027

GOAL	OBJECTIVE/OUTCOME MEASURE
1. Increase public awareness of mental health and addiction recovery and awareness of MHA. <i>Ref: Strategic Goals # 3</i>	a. Work with Board of Directors, the Advocacy Committee, Director of Development and Marketing and Program Directors to continue raising awareness. Specifically, areas as described in the Strategic Plan. Outcome Measure - High impact media drops at least quarterly (e.g., MHA's email blast, newspaper and cyber press releases, Op/Eds, podcast, etc.), paid media campaigns (social media, TV commercials), and community trainings (e.g., Suicide Prevention and Mental Health First Aid Trainings) Target Date: Ongoing
2. Continue Advocacy efforts at MHA. <i>Ref: Strategic Goals # 1</i>	a. Organize Legislative Breakfast(s) (Essex & Morris) – advocate for the following: • Increase elected officials' awareness of Mental Health and Addiction Recovery needs and services • Improve access to Mental Health and Addiction Recovery services • Improve conditions at State Psychiatric Hospitals • Suicide Prevention Outcome Measure – Hold well attended Legislative Breakfasts with meaningful representation from elected officials. b. Meet with Office of the Governor, State Senators and Assemblymen/women about the above-mentioned issues. Outcome Measure – Meet with 10 elected officials. Quantitative action concerning the above advocacy items. c. Meet with federal elected officials (senators, congressional representatives) about federal issues, e.g., regulations, mental health funding, etc. Outcome Measure – Meet with one senator or staffer and three congressional representatives.

	d. Involve Board members and community supporters in advocacy efforts, e.g., legislative visits, Town Halls, letter writing, Mental Health Awareness Campaign, etc. Outcome Measure – 100% Board involvement in at least one aspect of advocacy and/or public awareness. e. Working with COO develop Advocacy Skills of Senior Management Team Outcome Measure- Placing COO and others in more forward-facing advocacy opportunities Target Date: June 30, 2027
3. Advocate nationally as a Board member of Mental Health America, Washington DC. <i>Ref: Strategic Goal # 1</i>	a. Participate as an active Board member and Chair of the Public Policy Committee. Outcome Measure - Evidence of contributions in National MHA policy Target Date: Ongoing
4. Deploy AI-driven clinical tools: Implement AI-assisted documentation software to reduce direct care worker administrative burdens. Consider AI-driven assisted accounting and human resources software to reduce support staff administrative burdens. <i>Ref: Strategic Goal # 1, 2, 3, 4, 5, 6</i>	a. Work with Chief Operating Officer, Chief Information Officer, Director of Quality Assurance and other management staff to implement software solutions and reduce time taken to achieve tasks. b. Work with Chief Operating Office, Chief Information Officer, Director of Quality Assurance and other management staff to implement MHA's own AI software. Outcome Measure – Reduce time taken to document clinical and administrative burdens by 10%. Target Date: May 31, 2027
5. Emphasize the integration of physical and mental health in all MHA services with an emphasis on the underserved and marginalized people with health disparities. <i>Ref: Strategic Goal # 2, 4</i>	a. Ensure appropriate education for all staff. b. Ensure consistent access to medical services for our consumers through Prospect Primary Care and partnerships with healthcare providers e.g., FQHCs, coordinate on-site mobile outreach services e.g., Zufall medical and dental mobile van, Edge (LGBTQ+ mobile HIV testing and Hepatitis screening. Outcome Measure – Evidence of coordinated medical care in 95% of MHA's consumers charts.

	Target Date: Ongoing
6. Keep informed of industry-wide standards, dynamics and changes. <i>Ref: Strategic Goals # 1, 2, 3, 4, 5, 6</i>	a. Attend Continuing Education programs and Leadership Training, provide monthly trainings to staff Outcome Measure – As evidenced by attendance at appropriate trainings and continuing education opportunities. Target Date: Ongoing

7. Raise money for MHA. Coordinate a successful Presidents Giving Society, Annual Appeal, Major Gift Solicitation and Fashion is Art Spring Event. <i>Ref: Strategic Goal # 3, 4</i>	a. Working with Development Committee, Board, Director of Development and Marketing and Development and Marketing Manager to develop fundraising as well as other potential opportunities. Outcome Measure – Exceed MHA budget of \$225,000 for fundraising and \$50,000 for major gifts. Target Date: June 30, 2027
8. Secure foundation and corporate support of agency. <i>Ref: Strategic Goals # 3, 4</i>	a. Work with Director of Development and Marketing and senior staff to secure \$100,000 of new grants/support for FY 2027. Outcome Measure – Successfully secure \$100,000 of grants/support. b. Work with Board/community members to identify “known contacts” at various foundations/government/companies. Outcome Measure – Board/community members making contacts that result in successfully funded grants. Target Date: June 30, 2027
9. Secure additional public grant for mental health and addiction recovery services.	a. Working with Chief Operating Officer, Senior Director of Programs and senior staff to successfully secure public support for mental health and addiction recovery initiatives, e.g., CCBHCs, Morris County grants, Riskin Children’s Center, Raising Awareness, Suicide Prevention, SURE program, etc. Outcome Measure – secure \$250,000 of public funding. Target Date: June 30, 2027

<i>Ref: Strategic Goal # 5</i>	
10. Secure funds to continue vehicle replacement and maintain owned facilities (1160 Parsippany, 33 So. Fullerton, Prospect House, Supportive Living Services sites). <i>Ref: Strategic Goal # 5</i>	a. Working with Director of Operations to replace five vehicles and make necessary capital improvements. Outcome Measure – Secure County/state grant and private funding to purchase new cars and make necessary capital improvements. Target Date: June 30, 2027
11. Contain Medical Benefit Plan Costs. <i>Ref: Strategic Goal # 5, 6</i>	a. Review, in conjunction with Director of Human Resources, CFO and Board, medical benefit plan and remain within budget. Outcome Measure – Improved Plan (within budgetary restrictions) while maintaining quality. Target Date: September 30, 2027
12. Maintain fiscal stability and maintain financial position. <i>Ref: Strategic Goal # 5</i>	a. Work with Board, Finance Committee, COO, CFO and Investment Advisor to ensure sound, organizational investments. Outcome Measure – Growth in investments relative to the market. Target Date: Ongoing b. Finish FY 2027 on budget or better, e.g., no operational deficit. Target Date: June 30, 2027 c. Working with Finance Committee, CFO and key staff, develop fiscally sound budget for FY 2028, approved by the Board and accepted by the State. Target Date: June 30, 2027
13. Educate the Board of Directors on topics related to their roles and responsibilities. <i>Ref: Strategic Goals # 1, 2, 3, 4, 5, 6</i>	a. Coordinating with Board President, provide short, high impact presentations on development and networking concepts at Board meetings and special training sessions. b. Provide ongoing information concerning the mental health and addiction recovery industry. Outcome Measure – Informed Board of Directors.

	Target Date: Ongoing
14. Recruit new members to the Board of Directors. <i>Ref: Strategic Goal # 5</i>	a. Working with the Board, Board President and Nominating Committee Chair to recruit 2-3 new and diverse Board members for FY 2026. b. <i>Work with Governance Committee to review eligibility status of Board Officers completing their terms.</i> Outcome Measure – 2-3 new Board members. Target Date: June 30, 2027
15. Work with Director of Human Resources and entire management team to recruit and maintain high quality staff. <i>Ref: Strategic Goals # 1, 2, 3, 4, 5, 6</i>	a. Foster an environment and work culture that supports employees through engagement in the mission, future opportunities and fair pay (relative to the industry). Outcome Measure: Hire and maintain 90% of budgeted positions and increase average tenure. Target Date: Ongoing

Strategic Plan of the Mental Health Association

July 1, 2025 - June 30, 2028

Mission

MHA promotes mental health and total wellness for individuals facing challenges associated with mental illness and addiction recovery.

We increase community awareness while enhancing mental well-being through advocacy, education, prevention, treatment, and services.

Vision

We envision a society where individuals with mental illness and addiction can readily access services and live with hope.

Values

A Strategic Plan must be consistent with the core beliefs and values of the organization. Those values determine the philosophy and guiding principles by which the organization operates.

These are the core values to which MHA is committed:

- **Integrity:** Conducting operations honestly, ethically and transparently while treating ALL people with respect.
- **Access / Accessibility:** Actively working to create a low barrier environment so that everyone, regardless of their ability or financial resources, can fully engage in MHA's programs and services.
- **Compassion:** The desire to help relieve suffering, through empathy and understanding.
- **Diversity:** A qualified staff with a variety of skills, education, and backgrounds and a wide range of programming better serves the needs of our community.
- **Advocacy:** A commitment to actively speak up and work towards systemic change on behalf of those we serve.
- **Collaboration:** Involve professionals throughout the agency to improve care and actively seek partnerships with organizations, community groups or persons served to enhance our mission.
- **Sustainability:** Prioritizing long-term viability through diverse funding sources, responsible operations, financial stability and a focus on creating a lasting impact.

Long Term Goals

1. **Expand** advocacy and reduce stigma: MHA's goal is to create a more supportive and inclusive community for individuals with mental illness and addiction.
2. **Focus** on broader societal mental health and addiction challenges: MHA champions a society where those in need have access to the mental health and addiction services, and where mental wellness is valued and prioritized.
3. **Broaden** MHA's name recognition while concurrently seeking new funding sources: In doing so, MHA can ultimately expand its impact on the community.
4. **Improve** person's served long-term prospects, and personal independence and autonomy: MHA emphasizes overall wellness through the integration of physical health and social interaction, in conjunction with traditional mental health services, in all MHA programs.

5. **Enhance** the financial strength of the agency: MHA will continue to maintain a strong financial foundation that supports its mission and ensures its long-term sustainability.
6. **Fortify** MHA's workforce: MHA recognizes building a strong and dedicated workforce is essential for the agency's success and the well-being of the individuals it serves.

In all aspects of this Three-Year Plan, proceeding in ways and through means that acknowledge (A) the capabilities of the MHA (must have or be able to acquire the appropriate knowledge base and expertise to perform the work); (B) agency infrastructure (must be able to operate the program without undue burden to its personnel); and which are (C) financially responsible and supportable in both the short- and long-term.

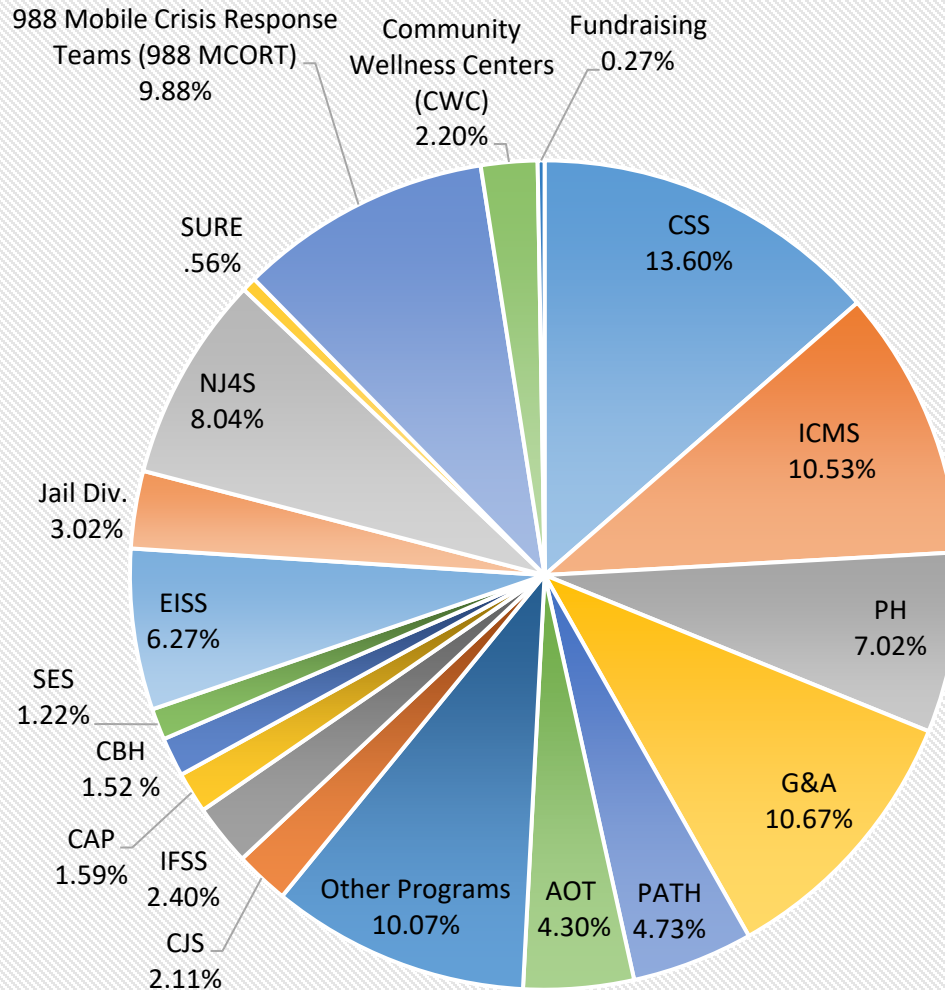
This Strategic Plan was formulated with the input of internal and external stakeholders, including but not limited to; Persons Served, their Families, the Strategic Planning Committee, the Board of Directors, Staff, Public funding sources, Private funding sources, Public oversight entities and Community partners.

Finance

For the fiscal year ended June 30, 2026 the Agency maintained a strong financial position, as evidenced by an average operational surplus of \$164,000. In addition, the Agency reported an average current ratio was 1.73 indicating the ability to meet current obligations. These results reflect financial stability and prudent fiscal management throughout the fiscal year. In 2026, the Agency completed the implementation of two new programs: Community Wellness Centers in Morris and Sussex counties and 988 Mobile Crisis Outreach Response Teams in Essex and Hudson counties. Financial highlights for the fiscal year ended June 30, 2026 are as follows:

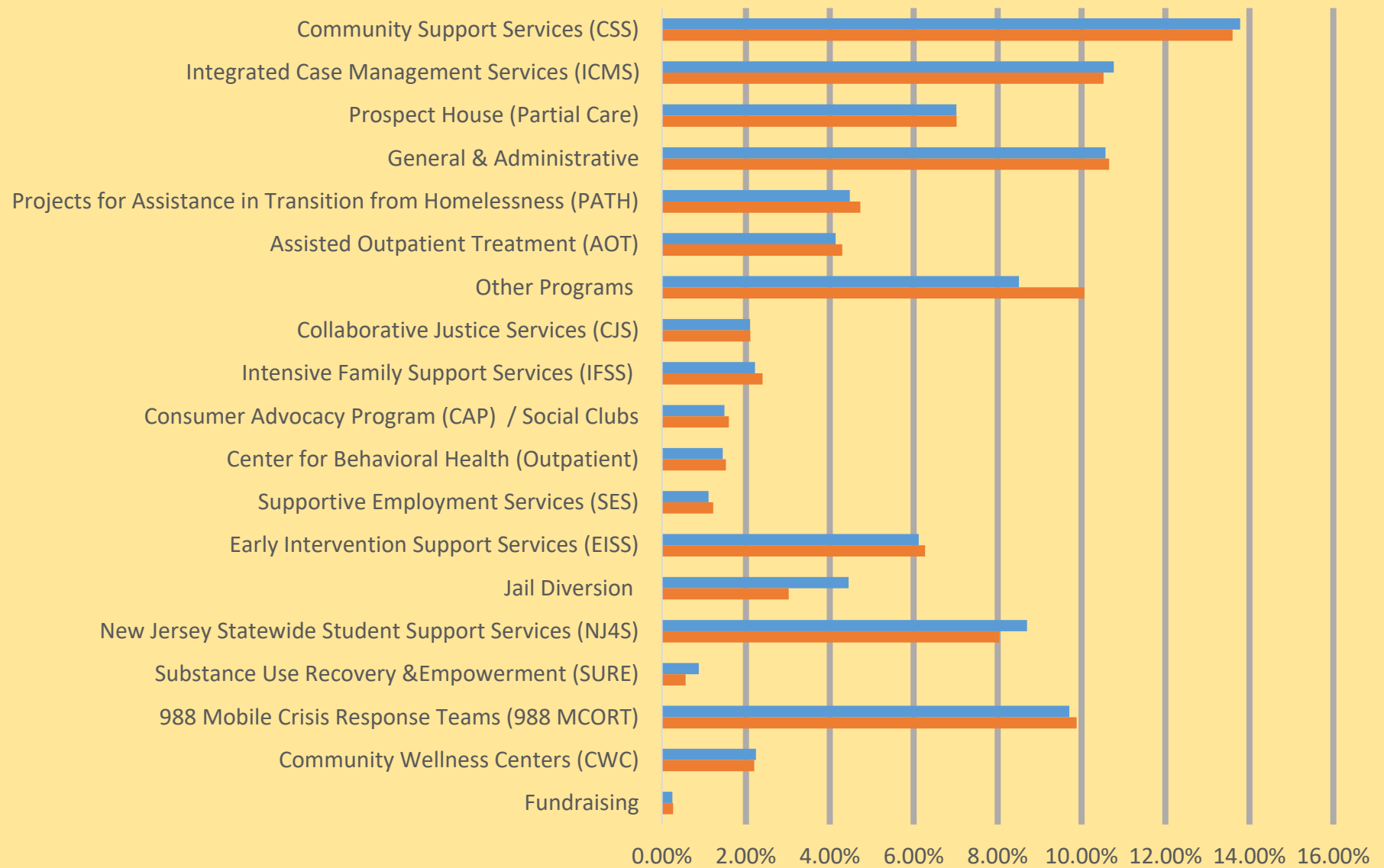
- The Agency made a one-time 6% discretionary 401(k) contribution in the amount of \$600,470. Over a three-year period, the Agency on average contributed 6% per year as a discretionary 401(k) contribution.
- The Agency's available line of credit amounts to \$1,250,000 and did not have an outstanding balance as of June 30, 2026.
- The Agency added four new vehicles to the fleet of which two are replacements. The Agency has approximately 112 vehicles in the fleet. The Agency continues to maintain and review the fleet of vehicles to keep the vehicles under ten years old.
- The Agency's property and casualty insurance renewed with a 16% increase on July 1, 2025.
- The fiscal June 30, 2026 medical insurance was renewed with Horizon Blue Cross with a 4.5% increase.
- The Agency's services based upon the budget for 6-30-2027 are made up of Assisted Outpatient Treatment (AOT) 4.30%, Center for Behavioral Health (Outpatient) 1.52%, Partial Care (PH) 7.02%, Community Support Services (CSS) 13.60%, Consumer Advocacy Program (CAP) / Social Clubs 1.59%, Integrated Case Management Services (ICMS) 10.53%, Projects for Assistance in Transition for Homelessness (PATH) 4.73%, Supported Employment Services (SES) 1.22%, Intensive Family Support Services (IFSS) 2.40%, Collaborative Justice Services (CJS) 2.11%, Early Intervention Support Services (EISS) 6.27%, Judicial Diversion 3.02%, New Jersey Statewide Student Support Services (NJ4S) 8.04%, Substance Use Recovery & Empowerment (SURE) .56% , 988 Mobile Crisis Response Teams (988 MCORT) 9.88%, Community Wellness Centers (CWC) 2.20% and Other Programs 10.07%.
- Based upon the budget for 6-30-2027 general and administrative expenses are 10.67% while fundraising expenses represent .27%.

Program Composition based on
FY27
Budget



- Community Support Services (CSS)
- Integrated Case Management Services (ICMS)
- Prospect House (Partial Care)
- General & Administrative
- Projects for Assistance in Transition from Homelessness (PATH)
- Assisted Outpatient Treatment (AOT)
- Other Programs
- Collaborative Justice Services (CJS)
- Intensive Family Support Services (IFSS)
- Consumer Advocacy Program (CAP) / Social Clubs
- Center for Behavioral Health (Outpatient)
- Supported Employment Services (SES)
- Early Intervention Support Services (EISS)
- Jail Diversion
- New Jersey Statewide Student Support Services (NJ4S)
- Substance Use Recovery & Empowerment (SURE)
- 988 Mobile Crisis Response Teams (988 MCORT)

Program Composition Based on FY26 & FY27 Budget



Corporate Compliance

Mental Health Association (MHA) is dedicated to the delivery of behavioral health care in an environment characterized by strict conformance with the highest standards of accountability for administration, clinical, business, marketing and financial management. MHA's leadership is fully committed to the need to prevent and detect fraud, fiscal mismanagement and misappropriation of funds and therefore, to the development of a formal corporate compliance program to ensure ongoing monitoring and conformance with all legal and regulatory requirements. Furthermore, the organization is committed to the establishment, implementation, and maintenance of a corporate compliance program that emphasizes (1) prevention of wrong doing, whether intentional or unintentional, (2) immediate reporting an investigation of questionable activities and practices without consequences to the reporting party and (3) timely correction of any situation which puts the organization, its leadership or staff, or funding sources at risk.

The Corporate Compliance Committee assembles quarterly to review and ensure the agency's operations are compliant with regard to all fiscal activities and clinical services.

Program Highlights

- MHA sustained strong compliance across all major program areas throughout the fiscal year, spanning July 1, 2025 through June 30, 2026. The Corporate Compliance Committee convened four times during this period, consistent with its quarterly meeting cycle. The Committee identified no material compliance violations during the reporting period and confirmed that all recommendations from prior meetings had been implemented on schedule.
- Medicaid compliance reviews encompassed twelve scheduled audits across the agency's three Integrated Case Management Services (ICMS) teams serving Passaic, Essex, and Morris Counties, as well as the Prospect House partial care program. Of the approximately \$3.9 million billed to NJ Medicaid and Managed Care Organizations across these programs in FY26, only \$69.44 was identified for recoupment — a variance of less than 0.01%. Separately, NJMHAPP billing activity totaled approximately \$2.2 million across the three ICMS teams, CBH, and Prospect House, of which approximately \$28,000 (1.27%) required return (below industry norm); all returned claims were processed in a timely manner and resubmitted to NJ Medicaid for reimbursement at a higher rate.
- Program-specific reviews further affirmed the agency's compliance standing across multiple service lines. A case review conducted by a DMHAS Program Analyst in response to a client concern found Community Support Services (CSS) Morris records to be complete and properly documented, with all rendered services accurately reflected. Reviews of the Morris County Mental Health First Aid, Hope One, and SURE programs confirmed DMHAS satisfaction with current operations, notwithstanding a 50% reduction in Mental Health First Aid funding resulting from budget cuts. DMHAS similarly expressed satisfaction with program operations during its review of Sussex EISS and AOT. Additionally, site reviews conducted for NJ4S (New Jersey Department of Children and Families, April 2026), Senior in Home (county pre-site review, May 2026), and CSS Morris and Essex (HUD/Continuum of Care) were each completed successfully, with no findings identified.

- The Annual External Financial Audit was completed with an unqualified opinion and no findings, the highest possible outcome, with final audit figures matching internal reports precisely, underscoring the strength of MHA's internal financial controls.
- The 401(k) plan audit for the year ending December 31, 2025 was completed with no findings.
- MHA met all applicable federal tax and reporting deadlines: 1099s and W-2s were distributed to staff and recipients; the 2025 annual tax returns were filed; and Form 5500 for employee health and welfare benefits was completed and submitted.
- The Human Resources department maintained a comprehensive schedule of compliance activity throughout the fiscal year. Monthly debarment checks were performed consistently, with no adverse findings reported, and annual driver's license, professional license, and criminal background verifications were completed as scheduled. A formal review meeting with the agency's workers' compensation carrier confirmed timely reporting across all open cases.
- Human Resources also advanced several policy and benefits initiatives during the fiscal year. A revised Employee Handbook was prepared for legal review, approved by the Board of Directors, and distributed to all staff. Salary ranges were added to all internal and external job postings in compliance with New Jersey salary transparency requirements, and staff were notified of new IRS 401(k) catch-up contribution rules effective January 1, 2026. Additionally, the annual 401(k) census was submitted to Alaris, the fiscal custodian. ACA and termination compliance filings were completed with the appropriate state and federal entities, and job descriptions were updated for all positions in advance of annual performance evaluations.
- The Information Technology department advanced multi-factor authentication for AI software without incident and launched a comprehensive, agency-wide Cybersecurity Awareness Training program in March 2026, achieving 100% completion among active employees. The Chief Information Officer attended an external cybersecurity conference in December 2025, incorporating key insights into ongoing IT operations planning.
- MHA's Electronic Health Record (EHR) system remained in full compliance throughout the fiscal year, with the Information Technology department continuing to monitor EHR-related billing and documentation on an ongoing basis.
- All staff received the agency's biannual Corporate Compliance Memo, which identifies MHA's Corporate Compliance Officer and outlines the responsibilities of the position. No reportable Corporate Compliance incidents or sentinel events, defined as serious, unexpected occurrences on agency property involving loss of life, serious injury, or harm caused by personnel, were recorded during the reporting period.
- MHA achieved full compliance with amended Substance Use Disorder (SUD) confidentiality regulations under 42 CFR Part 2. These changes, effective April 16, 2024 with a compliance deadline of February 26, 2026, more closely align Part 2 requirements with HIPAA. Agency documentation was fully updated by the deadline to reflect the revised requirements.
- In April 2026, MHA underwent a CARF (Commission on Accreditation of Rehabilitation Facilities) accreditation review and achieved a three-year accreditation, the highest level CARF awards. The review yielded strong, positive results that reflect the agency's continued commitment to delivering high-quality services in accordance with CARF standards. This outcome was made possible by the contributions of every department across the agency, and program directors remain committed to regularly reviewing and updating policies and procedures to ensure MHA continues to meet and exceed accreditation standards moving forward.

FY 2027 Goals

Corporate Compliance will continue prioritizing adherence to all applicable laws, regulations, and ethical standards in support of safe, ethical, high-quality care. This includes maintaining comprehensive policies and procedures aligned with regulatory requirements, delivering ongoing staff training to build awareness and understanding of compliance obligations, and sustaining effective monitoring and auditing systems that identify and address potential violations early. Protecting confidentiality, safeguarding client rights, and ensuring accurate documentation remain core objectives as well. Ultimately, these efforts are aimed at reducing legal and financial risk, preserving public trust, and advancing MHA's broader mission.

Development and Marketing

Description

The Development and Marketing Department at the Mental Health Association is responsible for advancing the organization's mission through strategic fundraising, donor engagement, and effective communication. The department cultivates relationships with individual donors, foundations, corporate partners, and community stakeholders to secure essential funding that supports MHA's wide range of programs and services.

On the marketing side, the department manages all internal and external communications including branding, social media, email campaigns, newsletters, media relations, and website content. By promoting awareness, advocacy, and community involvement, the department plays a key role in highlighting the impact of MHA's work and expanding its reach.

Together, the development and marketing functions ensure that MHA remains visible, financially sustainable, and connected to the community it serves.

Fundraising and Development

Giving Tuesday was on December 2, 2025. A total of \$1,875 was raised from that campaign.

MHA's President's Giving Society raised a total of \$79,020 from 79 donors. The letter featured a story about a consumer whose life was changed because of Prospect House. The giving levels range from \$100 to \$10,000. A thank you reception was held on January 22nd at The Wilshire Grand in West Orange with approximately 80 people in attendance.

An annual appeal letter was mailed out to the donor database. This year's story focused on two consumers' lives who were forever changed because of the PATH and CSS program. A total of \$9,700 was raised.

Derby Day with MHA was held on May 2, 2026 at the Yogi Berra Museum in Montclair. The event raised a total of \$85,575. During the event, guests enjoyed delicious food, drinks and watched the Kentucky Derby live. Over 100 people were in attendance. The total expenses were approximately \$15,000 for a net of approximately \$70,000.

Marketing

NJ Transit partnered with MCORT 988 to create a digital campaign at Newark Penn Station that ran from November 17-January 11, 2026. MCORT 988 static images were displayed on the advertising digital screens throughout the station during these 7 weeks to help raise awareness of the program.

The sponsorship of the Seton Hall University Men's Basketball program was renewed to help continue to raise awareness for the agency. MHA received visibility at each of the home games with prime logo placement throughout the arena, an ad in the digital program and a 30 second commercial that was played during each of the home games. This year they also included a 3-day website takeover from January 28-January 30th. Deanna Ackerman, Director of the Veterans/Family Support program was interviewed at half-time by Seton Hall commentator, Dave Popkin. Arielle Scarpelli, Director of MCORT was interviewed by Dave Popkin for a podcast that was released on July 12th.

On May 7th, MHA was honored at New Bridge's Legacy of Hope Gala. The MHA logo was on the ad journal, signage, on the event website and the agency received an award for their commitment to the community. MHA was a sponsor of the 2-mile Fun/Run for the 43rd Annual YMCA of Montclair Run on June 10th. The Montclair Run supports the YMCA's Community Health Program Fund which helps our neighbors live healthier lives.

Advocacy

The 25th Annual Essex County Mental Health & Addictions Coalition Legislative Breakfast was held on October 3rd at the Wilshire Grand Hotel in West Orange. The sold-out breakfast event featured more than 340 elected officials, executives, stakeholders and community members who spoke on issues pertaining to mental health, as well as opportunities to address ongoing developments, and current challenges facing the field. The keynote speaker was Robbie Parker, author of "A Father's Fight." In his discussion, he spoke about losing his daughter Emilie in the Sandy Hook tragedy and his journey through grief, resilience, and a fight for truth and justice against the conspiracy theories spread by Alex Jones.

The 7th Annual Morris County Mental Health & Addictions Coalition Legislative Breakfast was held on October 10th at the Park Avenue Club in Florham Park. Over 240 elected officials, executives, stakeholders and community members spoke on issues pertaining to mental health, as well as opportunities to address ongoing developments, and current challenges facing the field. The keynote speaker of the event Alison Malmon, CEO of Active Minds. She discussed changing the culture around mental health to empower young people to speak openly, seek support, and help end the stigma surrounding mental illness.

Grants

MHA received a total of \$43,000 in grants from the Health Care Foundation of the Oranges for Prospect House and Riskin Children's Center. The agency received \$15,000 from Partners for Health Foundation for ICMS Essex. F.M. Kirby awarded MHA \$40,000 for all Morris County program. The SURE program was granted \$5,000 from the Morristown Medical Community Advisory Board. The total amount of private foundation grants awarded was \$103,000.

FY27 Goals

The goals of MHA's Marketing and Development Department are centered on expanding outreach, reducing stigma, enhancing service accessibility, and increasing philanthropic support. By leveraging innovative digital marketing strategies such as social media campaigns, targeted advertising, and community engagement initiatives, MHA raises awareness about mental health issues and available resources. Emphasizing culturally competent and inclusive messaging helps reach diverse populations and foster trust within underserved communities. These efforts not only promote mental well-being but also support fundraising initiatives by strengthening donor engagement, broadening community support, and ensuring the sustainability of MHA's programs and services.

HUMAN RESOURCES

MHA's Human Resources Department plays a vital role in supporting the mission and values of the organization. It ensures that the organization attracts, retains, develops and supports a compassionate, skilled and mission-driven workforce, while maintaining compliance with employment laws and fostering a positive workplace culture.

292 Active Employees	+5% Staff Growth YoY	27% Annual Turnover	94% Staff Satisfaction
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Workforce Composition and Stability

MHA's workforce reflects a multidisciplinary group of professionals whose expertise and credentials reinforce the organization's mission and culture. Equal employment opportunity guides every stage of MHA's operations, with hiring and advancement decisions grounded in each candidate's knowledge, skills, abilities, and talent. MHA remains dedicated to building a workforce whose diversity mirrors and strengthens its capacity to serve the communities of Northern and Central New Jersey.

Staff levels grew 5% over the prior fiscal year, though 24 positions remained open as of June 30, 2026, bringing MHA's active headcount to 292. Voluntary turnover for FY2026 totaled 27% on an annual basis, equating to an average monthly rate of approximately 2%. Notably, voluntary turnover declined, signifying that MHA's growth and promotion pathways are helping the organization hold on to its strongest performers. Recognizing excellence with real opportunities for advancement remains central to that effort.

Workforce Engagement

Each year, MHA fields an Employee Opinion Survey as part of its ongoing commitment to self-examination. The survey assists MHA in determining how well the organization communicates its long-term direction and purpose, and how closely management practices align with strategy, mission, and vision. MHA views staff satisfaction as central to retention, making the survey a key barometer of organizational health.

An incentive introduced in FY2024 to encourage survey participation was continued in FY2026 given its strong results. The anonymous survey, conducted via SurveyMonkey in June 2026, drew responses from 193 employees (85% of the FT workforce).

Selected Results

- 97% are satisfied with the technology provided, enabling them to perform their job duties more efficiently
- 98% report feeling well-informed about their employee benefits following onboarding or open enrollment
- 96% of staff report that their supervisors welcome team input and cultivate a collaborative work environment
- 97% would recommend MHA as a good place to work - citing potential for growth, mission alignment, fringe benefits, team culture, and feeling valued

Suggestions, criticisms and compliments are reviewed by management and the Quality Assurance Committee, with outcomes communicated to staff through memos and Quarterly Staff Meetings.

Workforce Planning and Recruitment

MHA formally posts all job openings internally, giving current staff full visibility into available positions. This approach promotes equity in hiring and encourages employees to pursue new roles within the organization.

For external recruiting, the JAZZ HR applicant tracking system continues to streamline sourcing and simplify the hiring process. MHA also takes a grassroots approach through in-person job fairs at local universities, building relationships with emerging talent and strengthening its community presence.

MHA continues to sponsor interns each semester, giving students hands-on experience in the mental health field and academic credit, while supervising pre-licensure candidates toward licensure hours. Many interns go on to join MHA as employees after graduation.

Retention incentives remain in place: \$1,000 for full-time candidates, and \$2,000 for Clinical, Medical, or Master's-level professionally licensed candidates, paid upon successful completion of the six-month introductory period.

In FY2026, 31 staff members were recognized for earning additional degrees, obtaining professional licenses, or advancing their careers at MHA.

Compliance Screening

The HR Department conducts required background and compliance checks, including:

- NJ State Criminal Background checks
- Central Registry of Offenders Against Individuals with Developmental Disabilities (N.J.A.C. 10:44D)
- Motor Vehicle Abstracts
- Degree and Professional License Verification
- Pre-employment Drug Screening
- CARI background checks (N.J.S.A. 9:6-8.10f)
- State-level Criminal History Record Information (CHRI) checks via fingerprinting, for certain staff and interns based on program assignment
- FASCIS Level III checks, upon hire and monthly (implemented FY2024)

Workforce Training and Development

FY2026 marked the thirteenth year MHA has conducted annual and introductory performance evaluations electronically through Trakstar Perform, incorporating staff self-evaluations alongside supervisor feedback across all assigned competencies.

Online training for all staff is delivered through Relias Learning, which tracks required online, hands-on, and classroom training, along with conferences and events. Program Directors and Human Resources jointly monitor completion, and training transcripts are retained in the learning management system.

In-Person Trainings Conducted

- Safety in the Workplace — quarterly, for new staff; covers workplace violence, warning signs, early intervention, and safety measures
- Psychopharmacology — annual training led by Health Home Director Jessica Velasquez, RN, covering mental health disorders, common medications, side effects, and antipsychotic medication risks related to heat and sun exposure; completed by all direct care staff in April
- Trauma Informed Care — provided to all direct care staff upon hire by Barbara Maurer, MA, LPC, CTS, covering trauma prevalence, assessment, and psychoeducation tools
- CPR / First Aid / AED — fifteenth consecutive year with a third-party certified instructor, and sixth consecutive year offering in-house certification through American Heart Association certified staff, enabling faster training turnaround for newly hired staff

Workforce Support Offerings

Effective October 1, 2025, MHA renewed its medical plans with Horizon Blue Cross Blue Shield of New Jersey and its dental plans with Principal Dental. To support a smooth enrollment experience and continuous access to information, beginning in September 2025, the HR Department introduced monthly virtual office hours.

These monthly sessions were designed to encourage staff to ask questions, and share suggestions regarding their benefits. This recurring forum promotes an open and active line of communication between HR and staff and provides employees with an additional opportunity to receive benefits-related support. MHA's Benefits Administrator remains available during regular business hours to assist employees, while benefits information and resources continue to be accessible year-round through the employee portal.

Medical and Vision

Horizon BCBS of NJ provides medical coverage through OMNIA 2 Tier, Exclusive Provider Organization, and Direct Access plans, plus the Panorama Vision plan. MHA pays the full monthly premium for single enrollments on the OMNIA plan, with an equivalent benefit applied across all medical plan selections.

Dental

Principal Dental offers two cost-effective plan options for benefits-eligible employees and their families.

Group Term Life, AD&D, and LTD

MHA provides complimentary Group Term Life, Accidental Death & Dismemberment, and Long-Term Disability coverage through USAble after 90 days of active full-time employment, fully paid by the organization.

Retirement Planning

The 401(k) Safe Harbor Plan, administered by Alerus Retirement and Benefits, reached 215 active participants in FY2026, with 198 actively contributing to the Plan. Since introducing automatic 3% contributions enrollment for new participants in FY2025 - with opt-out and change options available - the number of staff actively contributing to the Plan has increased by 6.5%, growing from 186 to 198 participants.

The Plan is paired with a Safe Harbor matching contribution: 100% of deferrals up to 3% of compensation, plus 50% of deferrals between 3% and 5%. All matching contributions are 100% vested.

Time Off and Holidays

Vacation, personal, and sick time begin accruing on the first day of employment, and full-time staff are eligible for paid observed holidays upon hire. MHA believes this to be a key factor in employee satisfaction with the organization.

Tuition Reimbursement

MHA funded tuition reimbursement for 8 staff members in FY2026, totaling \$16,000 (\$2,000 per employee/per each year). This investment in staff supports professional development, career advancement, and retention of top talent.

Employee Assistance Program

Offered through RWJ Barnabas Health's One Source EAP at no cost to employees regardless of benefits eligibility, providing confidential assessment, counseling, and referral for family concerns, anxiety/depression, domestic violence, lifestyle changes, relationship issues, substance use, work performance, and grief.

Supplemental Disability Benefit

Employees with more than five years of tenure receiving temporary disability are eligible for supplemental income, administered alongside the NJ Temporary Disability Benefits program.

Additional Offerings

Aflac, Colonial Life, New York Life, Liberty Mutual, Verizon Wireless Employee Discount, College America 529 Savings Plan, and a pre-tax Commuter Benefit plan (via Gente Employee Benefits and HR Solutions), along with LifeMart and Plum Benefits entertainment and travel discounts.

Wellness

A monthly Wellness Newsletter, produced in collaboration with Horizon BCBS of NJ, shares nutrition and fitness resources. Staff continue to engage with the HorizonBFit incentive program, which rewards enrolled members up to \$20 per month for prioritizing their health.

Worker's Compensation

Key Risk Insurance was the provider of MHA's Worker's Compensation coverage in FY2026. The organization recorded nine workers' compensation claims in FY2026.

Highlights from the Human Resources Department

The HR Department hosted several well-received employee events in FY2026, reflecting MHA's ongoing commitment to a culture of teamwork and appreciation.

"Keep It Cool Friday" Tradition

Continuing an MHA tradition, staff enjoyed cool summer treats each Friday throughout the summer months, available for pickup at the kitchen or conference room at each work location. In-community staff were able to pick up their treat upon returning to the office, ensuring everyone could take part in the seasonal perk. This small weekly gesture added a fun, refreshing touch to the summer months and reflects MHA's continued focus on staff morale and appreciation.

Employee Appreciation Breakfasts

In September, Employee Appreciation Breakfasts were held on-site at each location to kick off the season of gratitude and honor staff dedication and hard work. Small branded gifts are given to each staff member during this event. The breakfasts created a relaxed, uplifting atmosphere for coworkers to connect, recharge, and feel valued.

Winter Holiday Celebration

In December, MHA leadership hosted its annual winter holiday celebration dinner, drawing 120 staff members from programs across every county. The evening gave the team a well-earned chance to unwind together after hours, with great food, music, and dancing rounding out the celebration.

FY2027 Goals

Management will continue to use Human Resources data and employee feedback findings to identify trends and guide workforce-related decisions. Progress toward these goals will be reviewed routinely, with corrective actions and improvement strategies implemented when identified outcomes are not achieved. These efforts are intended to support workforce stability, staff competency, employee well-being, and ultimately the quality and continuity of services provided to individuals served.

Information Technology

Mission Statement

The mission of the Mental Health Association of Essex and Morris (MHA) Information Technology (IT) department is to develop and maintain a reliable, secure, effective and efficient network system that supports the mission and goals of the agency. We strive to provide a system that enables departments to share data and reduce the duplication of information. Our goal is to minimize time spent on administrative tasks and procedures while increasing time dedicated to direct care services for our consumers.

Highlights

During the 2025–2026 fiscal year, the MHA Information Technology Department continued to strengthen the agency's technology infrastructure, cybersecurity posture, business systems, and operational capabilities. Major initiatives included successful CARF accreditation compliance, modernization of the agency's backup infrastructure, agency-wide Windows 11 migration, cybersecurity awareness training, expansion of AI-assisted clinical documentation, improvements to EHR and Medicaid billing systems, and implementation of technology solutions supporting new and existing programs.

The IT Department also continued to provide critical day-to-day technology support across the agency while working closely with program leadership, Accounting, Billing, Human Resources, and other departments to address evolving operational and regulatory requirements.

CARF Accreditation and IT Compliance

- Conducted a comprehensive review and update of agency IT policies in preparation for MHA's triennial CARF accreditation survey, ensuring alignment with applicable CARF standards and requirements.
- Met directly with the lead CARF surveyor to review IT-related standards, policies, security practices, and technology operations.
- Successfully demonstrated the IT Department's compliance with CARF requirements. The department completed the accreditation review with no IT-related recommendations or deficiencies.

Cloud Backup and Disaster Recovery

- Conducted extensive research, testing, and evaluation of multiple cloud backup and storage solutions as part of the agency's initiative to modernize its backup infrastructure.
- Selected Comet Backup and Wasabi Technologies as the agency's cloud backup and storage solutions following technical, operational, and cost evaluations.
- Successfully implemented the new cloud-based backup infrastructure across agency servers, providing secure daily cloud backups and strengthening the agency's disaster recovery capabilities.
- Improved backup redundancy and reduced the agency's dependence on locally stored backup infrastructure.

IT Infrastructure and Systems Modernization

- Upgraded the agency's IT asset inventory and software deployment environment using PDQ Deploy and PDQ Inventory, improving device tracking, software deployment, and centralized IT management.
- Coordinated the replacement of aging agency servers to improve infrastructure reliability, performance, and operational continuity.
- Led the agency-wide Windows 11 migration, identifying compatible systems, upgrading eligible computers, and replacing devices that did not meet Windows 11 hardware requirements.
- Successfully completed the Windows 11 migration before Microsoft's Windows 10 end-of-support deadline with minimal disruption to agency operations.
- Continued evaluating opportunities to modernize the agency's IT infrastructure and improve the security, reliability, and manageability of critical systems.

Cybersecurity and Security Awareness

- Continued strengthening the agency's cybersecurity program in response to the increasing frequency and sophistication of cyber threats affecting healthcare and other organizations.
- Researched and evaluated multiple cybersecurity awareness and employee training platforms to establish a formal agency-wide security awareness program.
- Selected Adaptive Security as the agency's cybersecurity awareness training platform following product evaluations and testing.
- Collaborated with the Adaptive Security implementation team to configure and deploy the platform across the agency.
- Successfully launched the cybersecurity awareness program to agency staff, providing employees with ongoing education on phishing, social engineering, cybersecurity threats, and safe technology practices.
- The program has received highly positive feedback from staff and provides an additional layer of protection by strengthening the human component of the agency's cybersecurity strategy.

MCORT Technology and Operational Support

- Researched and evaluated multiple workforce scheduling platforms to support the complex staffing requirements of the agency's 24/7 MCORT operations.
- Conducted vendor evaluations and extensive system testing and selected Humanity as the preferred workforce scheduling solution.
- Collaborated with the Humanity implementation team and MCORT leadership to configure and successfully deploy the platform for both full-time and part-time staff.
- The new scheduling platform has significantly improved staff scheduling, workforce visibility, and overall management of MCORT's 24/7 operations.
- Responded to State of New Jersey Medicaid billing requirements for MCORT services by coordinating the necessary EHR system changes and billing configurations.
- Configured and tested MCORT Medicaid billing rules within the agency's Electronic Health Record system to support accurate claim generation and submission.
- Successfully implemented electronic Medicaid billing for the MCORT program, enabling claims to be submitted through the agency's existing billing infrastructure.

Electronic Health Record (EHR) and Billing System Enhancements

- Completed numerous EHR configuration changes, billing updates, and workflow enhancements throughout the fiscal year to support changing agency, program, Medicaid, and operational requirements.
- Created and configured new programs within the EHR system as new agency services and initiatives were launched.
- Continued working with program, billing, and administrative staff to identify workflow improvements and resolve EHR-related operational issues.
- Maintained and enhanced billing configurations to support accurate and efficient electronic claim processing.

AI-Assisted Clinical Documentation Expansion

- Continued expanding the agency's use of Blueprint AI for AI-assisted clinical documentation.
- Collaborated with the Blueprint AI team to configure additional agency forms and documentation workflows within the platform.
- Conducted testing and coordinated deployment of newly configured documentation capabilities.
- Expanded the range of clinical and program documentation that staff can complete using AI-assisted workflows.
- Continued evaluating opportunities to use AI responsibly to improve staff efficiency, reduce administrative burden, and support documentation quality.

West Orange Conference Center Technology Implementation

- Supported the launch of the agency's new West Orange Conference Center by planning and deploying the required IT infrastructure.
- Installed wired and wireless networking and integrated the conference center with the existing office network.
- Deployed Zoom Rooms technology to support meetings, training, presentations, and hybrid collaboration.

Accounting System Support

- Assisted the Accounting Department with troubleshooting issues involving budget and return-on-investment reporting within the agency's accounting system.
- Worked directly with the Traverse support team to investigate the reporting problems and identify their underlying causes.
- Provided technical coordination and support to help resolve the issues and improve reporting reliability.

Agency-Wide IT Operations and Staff Support

- Continued providing comprehensive technical support to agency staff across departments, programs, and office locations.
- Supported hardware, software, networking, telecommunications, EHR, mobile devices, conferencing systems, and other technology used in daily agency operations.
- Worked proactively with staff and department leadership to troubleshoot technology issues and minimize operational downtime.

- Continued maintaining and improving the agency's technology environment to support reliable and secure delivery of services.

Summary

Fiscal Year 2026 represented another year of significant technology modernization and operational improvement for MHA. Major accomplishments included achieving CARF compliance with no IT-related deficiencies, implementing a secure cloud-based backup environment, completing the agency-wide Windows 11 migration, replacing aging server infrastructure, strengthening cybersecurity through a formal employee awareness program, improving MCORT workforce scheduling and Medicaid billing capabilities, and expanding the agency's use of AI-assisted clinical documentation.

These initiatives strengthened the security, reliability, resiliency, and efficiency of MHA's technology environment while supporting the continued growth and changing operational needs of the agency.

Information Technology Goals – Fiscal Year 2027

Cloud-Based Endpoint and Device Management

- Research and evaluate cloud-based endpoint and device management solutions to replace the agency's existing on-premises management systems.
- Implement the selected platform to improve centralized management, remote administration, security, scalability, and overall IT operational efficiency.

Enterprise AI Evaluation and Implementation

- Research and evaluate enterprise AI platforms that can securely support staff across the agency and integrate with existing technology and business workflows.
- Evaluate solutions based on security, HIPAA compliance, data privacy, functionality, integration capabilities, cost, and administrative controls.
- Select and implement an enterprise AI solution to help staff improve productivity, streamline routine tasks, assist with research and information management, and reduce administrative workload.
- Develop appropriate governance, security controls, policies, and staff training to ensure the responsible and secure use of AI across the agency.

QUALITY ASSURANCE ANALYSIS

Description

Mental Health Association (MHA) strives to provide the highest quality behavioral health services to those who live or work in Essex, Morris, Passaic, Sussex, Hudson and Middlesex Counties. Services are provided in a competent, respectful and timely manner which reduce risk and maximize outcomes. MHA is committed to continuously improving the performance of the activities and functions which are related to outcomes for individuals served.

Quality Assurance Committee and Plan

The Quality Assurance Committee (QAC) provides oversight and monitoring to ensure agency and programmatic goals and objectives are met. QAC meets on a monthly basis and is chaired by the Director of Quality Assurance. The committee members consist of the Chief Operating Officer, all MHA Program Directors, Director of Operations, Director of Human Resources and the Director of Information and Technology. The Medical Director serves as a consultant and the Chief Executive Officer is an ex officio member.

MHA programs gather demographic, service and outcome data through our Management Information Systems department (MIS). This data is presented to QAC to review and analyze for quality issues, and to implement problem-solving measures. QAC monitors all quality assurance processes within MHA to ensure that programs address individual needs in a systematic manner. These procedures include: (1) monitoring of performance indicators; (2) updating indicators to include new ones as needed, to measure and track performance improvement; (3) satisfaction surveys: (a) individuals served satisfaction with MHA services; (b) staff satisfaction with MHA employment, including the quality of work environment, supervisory and management support, and related employment factors; and (c) the satisfaction of referral sources and other community providers with MHA's responsiveness as a partner. Quality Assurance Prescriber Reviews are periodically conducted for psychiatric records, as well as monthly record reviews of service delivery issues and unusual incidents to analyze program trends and take corrective action as needed. This may include tracking additional performance indicators, modifying service approaches, training/ retraining staff, among other corrective actions to ensure compliance and delivery of quality service.

MHA believes complete and accurate data is essential, as only then can we improve service provisions for individuals served. Data and information flow into QAC through numerous sources: each program element funnels program specific data regarding thresholds and outcomes; input from MHA employees who have identified issues and problems; feedback including complaints and grievances received by supervisory personnel; and suggestion boxes which are located at every MHA site. Data is also collected and analyzed for trends in areas of agency access, effectiveness, satisfaction and efficiency. MHA's comprehensive data collection begins at the time of an individual referral and continues through sixty days post discharge of programs. MHA maintains a robust and accessible client feedback and grievance system, reflecting its commitment to addressing concerns effectively. In FY26, MHA logged five complaints across four programs, with no formal grievances filed. Issues included dissatisfaction with staff, a discrimination claim, housing concerns, and a communication gap after a client relocated. All were reviewed by program leadership and resolved within a few weeks, though one consumer remained unsatisfied with the outcome. Individuals served are thoroughly informed of their rights through clear documentation at admission and annually, as well as through prominent postings throughout MHA sites.

A tiered approach encourages resolution at the primary worker or supervisory level, with an accessible agency ombudsperson available for additional support. The absence of any clear trend among reported complaints, combined with a strong rate of resolution consistent with agency policy, reflects MHA's effective and responsive approach to client relations.

Analyzed and summarized data flow from QAC to MHA's Chief Executive Officer, the MHA Board of Directors, senior management, staff, consumers and other stakeholders through respective meetings. Aggregated materials from QAC, Risk Management and Safety, and incident reporting are also posted in public areas of each program site and on MHA's website. The detailed Quality Assurance Tracking Calendars are included in the full Management Report.

QAC includes a Task Force which reviews and approves all policies and procedures, prepares for accreditation and licensing reviews and develops and revises documentation, forms and standards.

Sub-committees established for areas of oversight that also report to QAC:

- Risk Management and Safety Committee: includes clinical and non-clinical staff that review and monitor all issues related to the care of environment, accessibility, infection control, vehicle safety and maintenance, potential liability and loss control, incidents, complaints or grievances, and safety and security. This sub-committee meets six times per year.
- Cultural Competency, Diversity and Inclusion Committee: composed of interested, designated multi-ethnic and bi-cultural staff members who reflect persons served and who represent all programs and all levels of employees. This committee is responsible to ensure cultural diversity, sensitivity and competence among staff, monitoring of trainings and education regarding cultural diversity, and for the upkeep and distribution of an agency wide staff list who are able to interpret in a host of languages when needed to aid quality services. This sub-committee meets four times per year.
- Member-Specific Performance Improvement Committee at Prospect House (MHA's day treatment program): made up of PH members with the overall goal to address programmatic areas of concern. QAC also reviews suggestions from the suggestion box, safety issues and discusses ways to enhance services at Prospect House. This sub-committee meets six times per year.
- Trauma Informed Care Committee: composed of clinical staff with the purpose to identify, evaluate, and make recommendations regarding the agency's response to providing trauma informed practices. This sub-committee meets four times per year.

Strengths of the Quality Assurance Plan

- A team of highly engaged professionals whose consistent and committed involvement profoundly reflects their dedication to MHA's mission.
- A diverse staff membership, which effectively represents all facets of our programs and operations, fostering a holistic organizational perspective.
- MHA's comprehensive communication strategy ensures transparency and engagement across all levels, utilizing channels such as the QAC bulletin board, various staff and member meetings, year-end reports, and satisfaction surveys. Additionally, the QAC Chairperson regularly reports key findings directly to the CEO, Board of Directors, and staff.
- A systematic approach to quality assurance and utilization, driven by focused audits and comprehensive data reporting.
- Robust and effective tracking format for performance indicators, which facilitates accurate measurement and strategic decision-making.

- Utilizing up to date technology advancements enhancing overall care quality and workflow efficiency.
- MHA's consistent, agency-wide commitment to professional development — including a strong year-round in-service training program — stands as a clear strength, keeping staff current, skilled, and set up for success.

Program Highlights and Analysis

- MHA's achievement of a 3-year accreditation this fiscal year, the highest level awarded by CARF (Commission on Accreditation of Rehabilitation Facilities), is a testament to the agency's commitment to excellence in its programs and services. This accreditation reflects MHA's dedication to meeting internationally recognized standards of quality, giving staff, clients, and stakeholders confidence in the agency's performance.
- MHA continued to be fully licensed for all required programs.
- At admission, individuals are provided access to a patient portal, giving them easy, secure access to their records and supporting greater transparency and engagement in their own care.
- All outreach case managers are provided a laptop or tablet and an agency cell phone to utilize in the field. This allows for increased mobility in the community to better serve the consumer in-vivo and assist with completing treatment/service plans and enhancing services. Agency cell phones increase communication through video call and text and enables prompt scheduling through various applications.
- MHA's website and social media platforms, including Facebook, Twitter, and Instagram, are easily accessible and regularly updated. MHA's Information & Technology and Marketing & Development teams continue to collaborate to improve services through the use of technology.
- MHA continued to provide care coordination ensuring a holistic service approach. All treatment is individualized to meet the needs of each person served. Individuals are encouraged to include a health goal in their treatment/service plan and are encouraged to schedule annual physicals.
- MHA remains committed to providing benefits assistance, helping individuals navigate the application process and access the benefits they're eligible for. The agency has increased its number of trained Presumptive Eligibility Counselors to 13 and is a designated Presumptive Eligibility site; these counselors provide quick access to temporary Medicaid for approximately one month while eligibility for NJ FamilyCare is being determined. MHA has also grown its team of Healthcare Assistors to 8 (up from 6 last year), providing additional support to staff in helping consumers apply for affordable health care.
- MHA understands the importance of ongoing education and training; therefore, in-services are conducted throughout the year. Such trainings include, but are not limited to: Ethics and Legal Issues, Motivational Interviewing, Psychopharmacology, Safety in the Community and CPR, First Aid and AED training. Other trainings which are program specific are provided through our Relias Learning which is a web-based training program
- A key strength of MHA is its proactive and continuous investment in advanced staff training to enhance the quality of client care. The agency is committed to providing cutting-edge, evidence-based services through two significant initiatives. First, MHA has 8 clinicians certified in Dialectical Behavioral Therapy (DBT). This highly effective, evidence-based modality teaches clients skills for managing intense emotions and improving relationships. In a further commitment to this approach, these trained clinicians have developed an agency-wide skills group to make this valuable therapy accessible to a broader range of clients. Second, 8 MHA staff members were certified to provide Motivational Interviewing (MI) training to other staff agency-wide. These trainings are offered on a quarterly basis and are supported by a learning community and office

hours, ensuring that the skills are effectively implemented in practice. This dual focus on advanced training demonstrates MHA's dedication to professional development and providing the best possible care.

- A Staff Development/ Mentoring Program was initiated in FY25 and continued throughout FY26; a designated management staff or supervisor hosts a one-hour, virtual discussion focused on a topic to promote professional growth both within the agency and one's long-term career. This newer program is voluntary and open to all staff; 11 sessions were offered this year.
- MHA currently has 16 staff certified as Mental Health First Aid (MHFA) Instructors for both youth and adults. The MHFA instructors educate the public on risk factors and warning signs regarding mental health and addiction concerns. Participants are educated on strategies to help someone in both crisis and non-crisis situations, and provides community resources. This year, MHA trained individuals who included clinical and non-clinical mental health staff, graduate students, local deacons of worship, family members and other community members. A total of 18 MHFA trainings were delivered to 104 individuals.
- MHA provided tuition reimbursement to 15 eligible staff for coursework directly related to the agency's mission and the employee's job responsibilities, supporting continued growth and professional development within the organization.
- MHA's Annual Community Provider Survey gathered feedback from 76 community partners who refer to, collaborate with, or rely on Mental Health Association (MHA) programs. Distributed to over 400 community partners, the survey yielded 76 completed responses, a 19% response rate, from a broad cross-section of the service network, including hospitals and health centers, law enforcement, schools, YMCAs, county and municipal offices, universities, faith-based groups, and nonprofit providers. The survey combined program-usage questions, a 17-item agreement scale on partnership and service quality, and five open-ended questions, and yielded a 93% satisfaction rate.
- MHA's Annual Persons Served Satisfaction Survey was distributed to over 2,000 service recipients across the agency's programs, yielding more than 700 responses, a 32% response rate, and an overall satisfaction rate of 91%. Individual surveys are tailored in length and content to each program, ensuring the feedback gathered reflects the specific services and experiences of the individuals served.
- MHA's Strategic Plan ensures the agency remains strategically positioned to fulfill its mission. The plan is reviewed and revised every 3 years by the Board of Directors, with input from staff, consumer and family focus groups, County Administrators, and other stakeholders. An updated Strategic Plan was approved and implemented during FY25, and progress against the plan was reviewed for FY26.
- MHA continues to utilize its electronic clinical records system, AWARDS, which offers several key benefits: improved access to complete and accurate client information, the ability to update records in real time, and the production of data analysis to help identify needs and trends across the agency.
- This year, MHA continued utilizing two newer software programs to support staff in their respective roles, enhancing overall care quality and workflow efficiency. Blueprint is an AI assistant designed specifically for mental health professionals to automate clinical documentation, reducing documentation time and allowing staff to focus more on individuals' care while ensuring compliance with standards. Inovalon is an insurance eligibility verification platform that streamlines billing workflows and claims processing by enabling staff to assign and prioritize tasks during eligibility verification; it provides up-to-date, accurate insurance data that

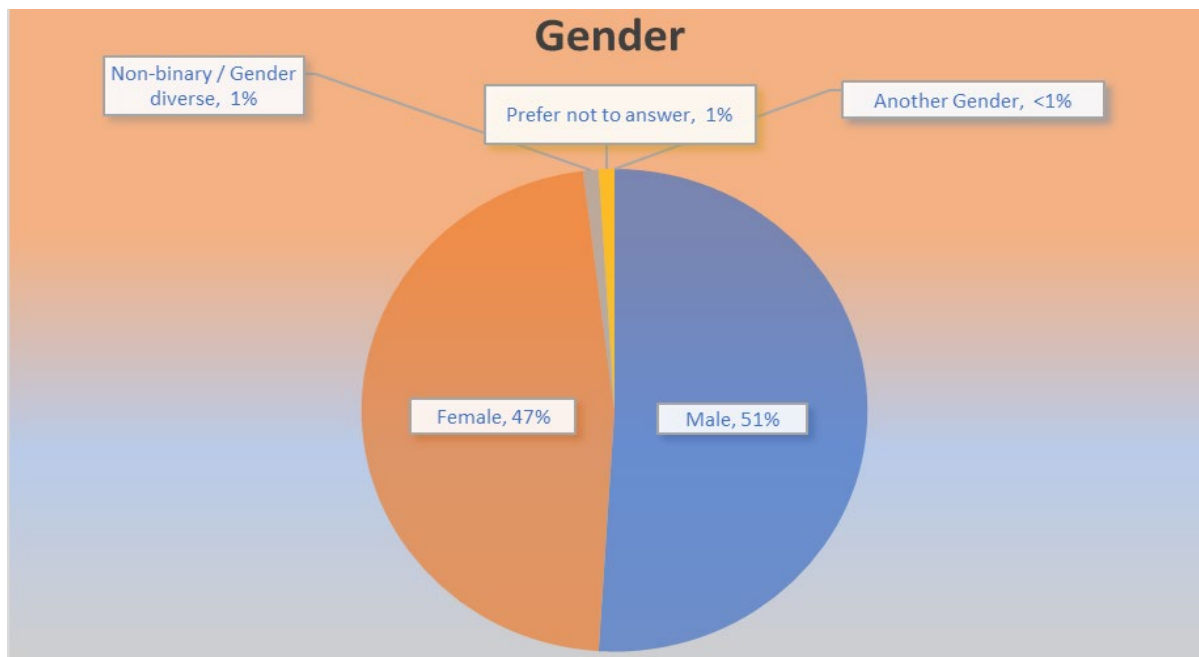
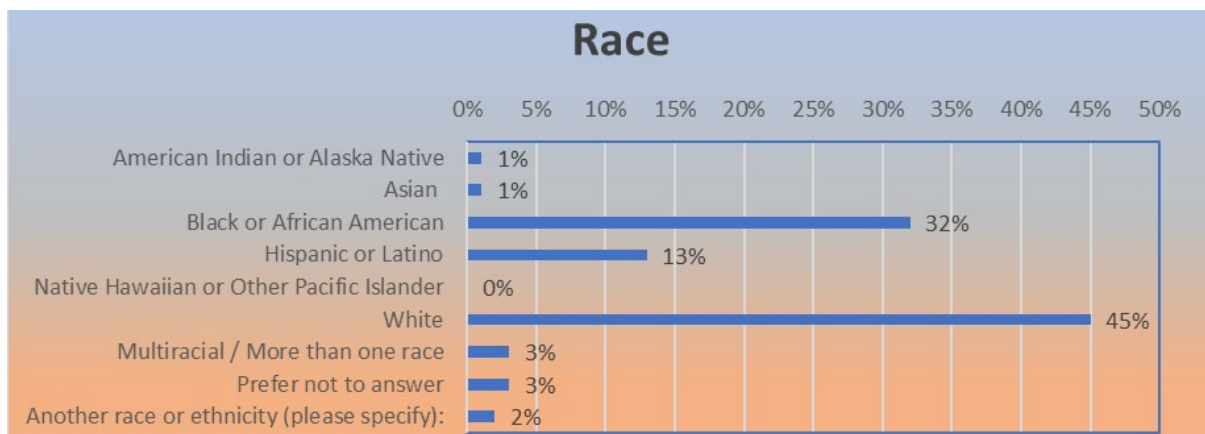
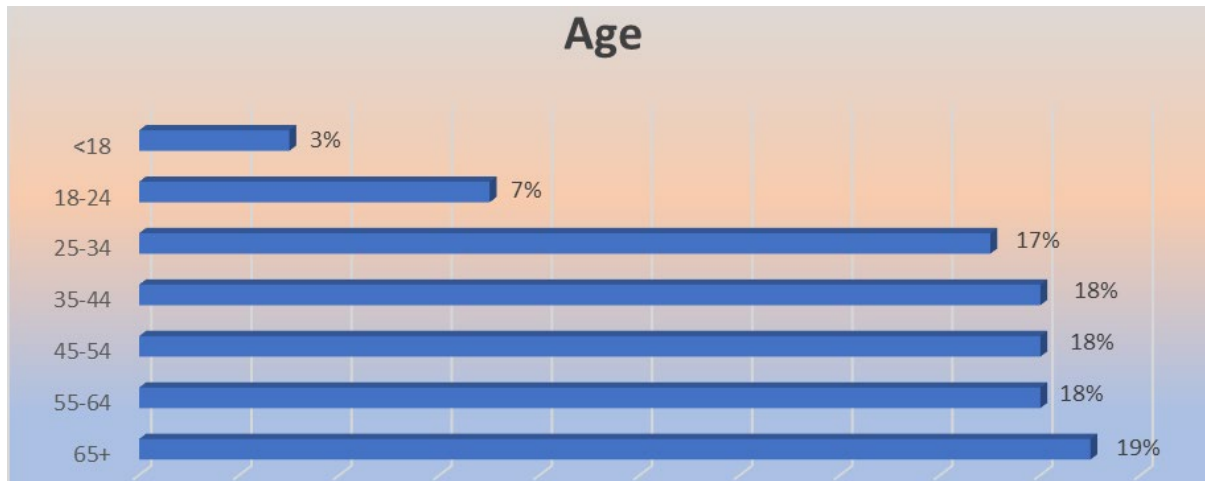
allows staff to take more immediate action when a person may have unknowingly lost or changed coverage.

- Agency-wide quarterly staff meetings are held to provide staff with up-to-date information. This year, meetings were held outdoors at Eagle Rock Reservation (weather permitting) or virtually otherwise, fostering agency cohesiveness and connection among staff.
- Education on Summer Heat and Sun Risk was provided to 100% of the agency-wide active caseload, helping ensure that all individuals served were equipped with the knowledge needed to recognize warning signs and protect themselves during periods of extreme heat. This initiative reflects MHA's ongoing commitment to proactive health and safety education as part of comprehensive care.
- MHA reviews and revises its Accessibility Plan annually, ensuring that physical spaces, communication methods, and service delivery continue to meet the needs of all individuals served. This ongoing commitment reflects MHA's dedication to removing barriers to care and ensuring equitable access to services for everyone.

FY 2027 Goals

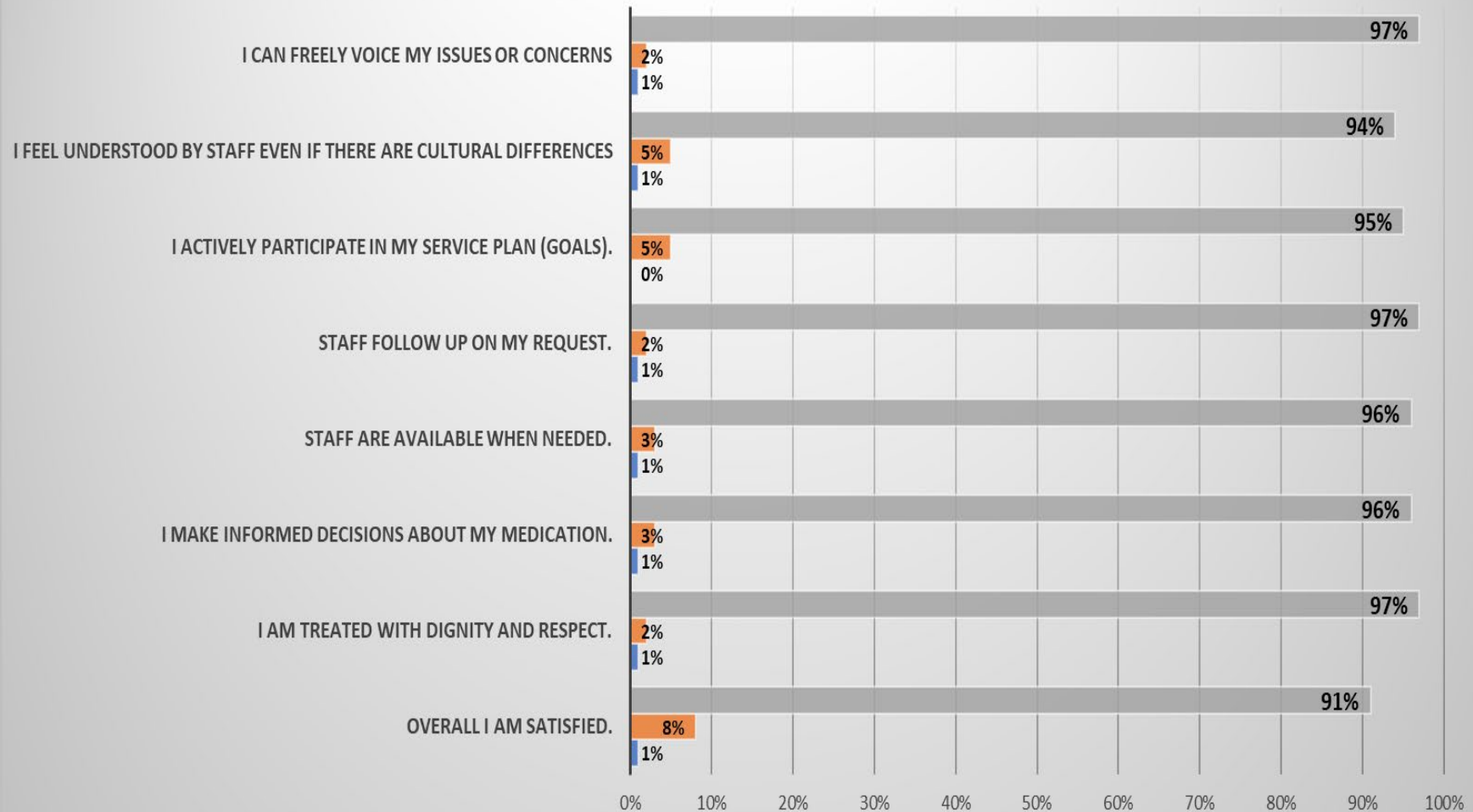
Quality Assurance will continue ensuring the delivery of safe, effective, and equitable care to all consumers. These goals include continuously monitoring and evaluating clinical practices to maintain high standards, identifying areas for improvement, and implementing evidence-based interventions. Another key objective is to enhance consumer satisfaction and engagement by promoting a consumer-centered approach that respects individual needs and preferences. Additionally, quality assurance aims to ensure compliance with regulatory requirements and industry standards, fostering a culture of accountability and transparency. By leveraging data and feedback, MHA will improve treatment outcomes, reduce disparities, and create a supportive environment that promotes mental well-being and recovery for every client.

2026 Person Served Satisfaction Survey Demographics and Results Summary

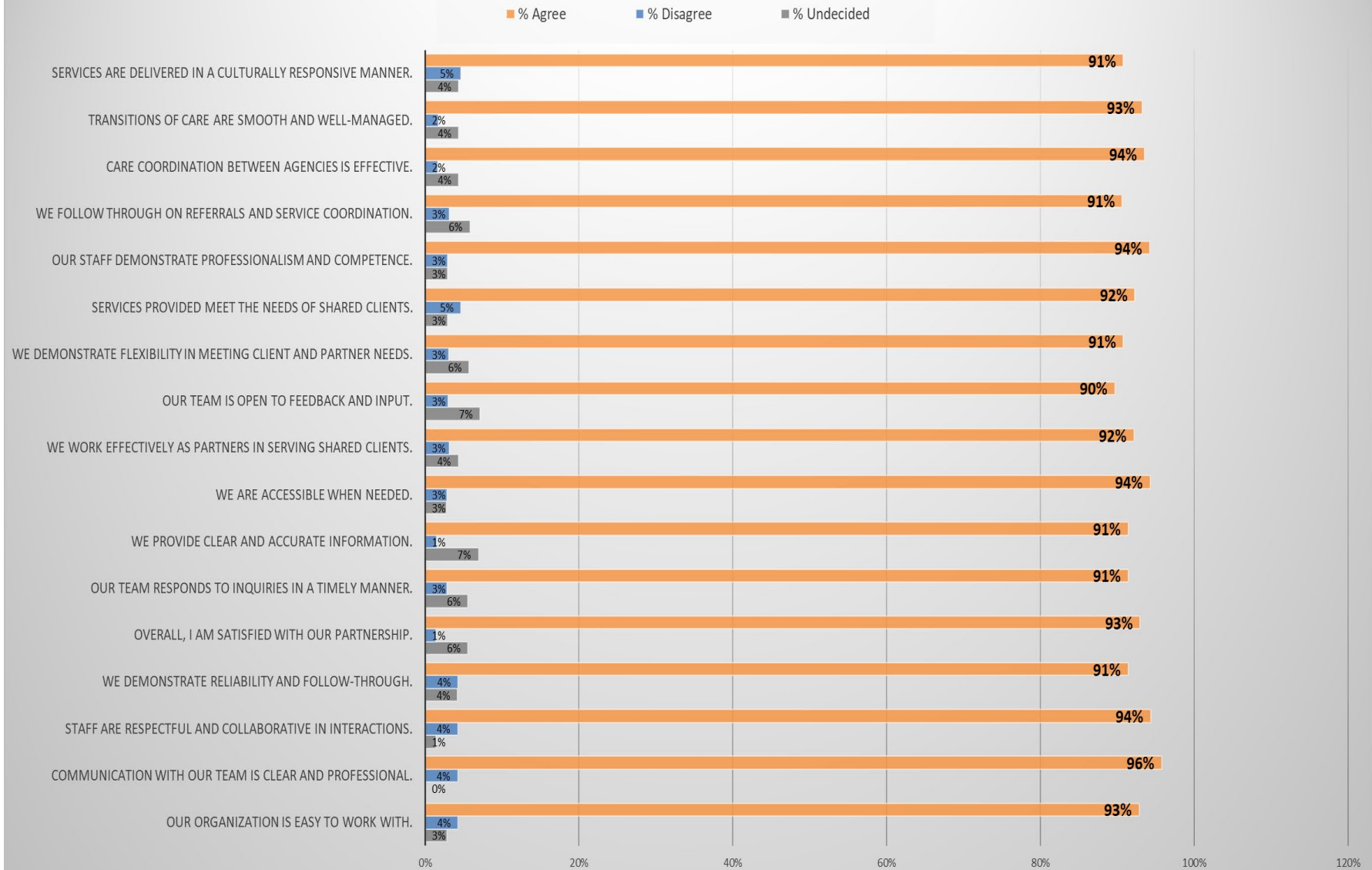


Agency Wide Satisfaction Results

■ Agree ■ Neither Agree or Disagree ■ Disagree



FY 26 Community Provider Satisfaction Survey Results



Assisted Outpatient Treatment (AOT) - Essex

Mental Health Association																	
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																	
Fiscal Year: 2026			2025						2026								
Topic/Issue Requesting Follow up																	
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%	
TECHNICAL AUDITS	Quarterly	80%	93%	98%	98%	90%	93%	80%	89%	92%	100%	100%	85%	86%	NA	92%	
Service Access:																	
Wait for service (days)	Monthly	3	4	2	2	3	4	2	3	2	3	3	3	3	3	3	NA
Community/ Screening referrals	Quarterly	1	NA	NA	0	NA	NA	4	NA	NA	1	NA	NA	0	1	125%	
Inpatient referrals	Monthly	4	9	9	4	9	7	8	13	10	7	8	5	7	96	200%	
Long Term Care (LTC) referrals	Monthly	2	2	0	1	2	1	0	0	0	4	5	3	2	20	83%	
Number of transport orders	Monthly	<2	1	1	0	0	0	0	2	0	0	0	1	0	0	NA	
Linked to Medical Services	Quarterly	80%	NA	NA	100%	NA	NA	100%	NA	NA	100%	NA	NA	100%	NA	100%	
60 day discharge follow up	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%	
Program Census	Monthly	Baseline	46	42	44	49	50	50	47	45	44	49	48	45	47	NA	
Hospitalizations (Medical)	Monthly	<5%	0%	0%	0%	0%	2%	0%	2%	0%	0%	0%	4%	2%	NA	0.8%	
Hospitalizations (Psychiatric)	Monthly	<10%	17%	5%	2%	4%	8%	8%	8%	11%	6%	4%	13%	8%	NA	8%	
Indicators:																	
ER (screening)	Monthly	<5	1	0	0	1	2	1	2	0	0	0	2	1	1	NA	
# Voluntary admissions	Monthly	Baseline	1	0	0	0	0	1	4	2	0	0	0	2	10	NA	
# Involuntary admissions	Monthly	Baseline	7	2	1	2	4	3	0	3	3	2	4	2	33	NA	
# Long Term Care	Monthly	Baseline	0	0	0	0	0	0	0	0	0	0	2	0	2	NA	
# medical hospitalization	Monthly	Baseline	0	0	0	0	1	0	1	0	0	0	2	1	5	NA	
Arrests	Monthly	<3	0	0	0	0	1	0	1	1	2	0	0	1	1	NA	
Incarceration	Monthly	<3	0	0	0	0	0	0	1	1	1	1	1	2	1	NA	
Homelessness	Monthly	<3	0	0	0	0	0	0	0	0	0	0	0	0	0	NA	
Education Enrollment	Monthly	>4%	2%	2%	0%	0%	0%	0%	0%	4%	4%	2%	2%	0.02	0	NA	
Client Employment	Monthly	>4%	4%	7%	7%	10%	4%	0%	0%	2%	6%	4%	2%	0.04	0	4%	
Satisfaction Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	100%	
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%	
Sun Risk Education	Annually	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	NA	100%	

The Gathering Place - Community Wellness Center (Sussex)

Mental Health Association																	
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																	
Fiscal Year: 2026			2025						2026								
Topic/Issue Requesting Follow up																	
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%	
# of unduplicated consumers served	Monthly	19	x	x	134	x	x	143	x	x	136	x	x	146	559	248%	
# of new consumer attendees served	Monthly	19	x	x	134	x	x	58	x	x	38	x	x	38	268	119%	
# of participants in peer support activities	Monthly	813	x	x	452	x	x	1536	x	x	1795	x	x	1633	5416	56%	
# of participants in Wellness/Recovery activities	Monthly	260	x	x	341	x	x	431	x	x	1070	x	x	1210	3052	98%	
# of Community Outreach Activities	Monthly	114	x	x	296	x	x	321	x	x	115	x	x	134	866	63%	
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%	

Criminal Justice Reform (CJR)																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
TECHNICAL AUDIT	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Focused:																
Quarterly Progress with Measurable Objectives	Quarterly	85%	88%	98%	96%	90%	89%	90%	86%	92%	100%	94%	100%	100%	NA	94%
Medication Education	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Discharge Follow Up 60 Days	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Closed Chart Audits	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Linked to Medical Services	Monthly	100%	2%	4%	4%	4%	0%	0%	6%	15%	12%	3%	0%	0%	NA	4%
Wait for services	Monthly	<24 hrs.	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Hospitalizations (Psychiatric)	Monthly	<10%	0%	0%	0%	2%	2%	0%	0%	0%	3%	0%	0%	0%	NA	1%
Hospitalizations (Medical)	Monthly	<5%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	3%	0%	NA	0.3%
Indicators:																
Employment (client #)	Monthly	0	37%	35%	33%	36%	25%	25%	28%	31%	27%	28%	33%	37%	0	NA
Community Linkages	Annually	116	3	5	7	12	4	2	4	6	6	7	7	6	69	59%
# of Dismissals	Annually	15	1	0	2	0	0	3	2	0	1	2	1	3	15	100%
Recidivism to jail within 30 days	Annually	<3	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Recidivism to jail within 60 days	Annually	<3	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Recidivism to jail within 90 days	Annually	<3	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Recidivism to jail within 120 days	Annually	<3	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Satisfaction Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	100%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%
Sun Risk Education	Annually	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	NA	100%

Senior In Home Therapy																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
CALENDAR YEAR: 2025			2026						2025							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEP	OCT	NOV	DEC	TOTALS	%
TECHNICAL AUDIT	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Focused:																
New enrolleess	Monthly	8	0	0	1	0	0	0	0	0	1	0	0	0	2	25%
Annual Consumers Served	Annually	32	17	0	18	16	16	16	0	0	1	0	0	0	84	263%
Medication Education	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Closed Chart Audits	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Wait for services (# of days)	Monthly	Baseline	0	0	30	0	0	0	0	0	120	0	0	0	13	NA
Indicators:																
MHQOL Survey completed q120 days	Monthly	11	3	3	0	1	0	0	5	2	2	3	0	6	25	NA
APC Contact Units (full year 742)	Monthly	742	51	64	65.5	76.5	66.5	58.5	88	67	108	94	66	70	875	118%
MC Contact Units (full year 78)	Monthly	78	12	11	13.5	10.5	13.5	9	10.5	11	13.5	13.5	8	11	137	176%
Mental Health Counseling	Quarterly	1256	NA	NA	216.75	NA	NA	235	NA	NA	298.5	NA	NA	273.5	1024	82%
Goal attainment	Quarterly	90%	NA	NA	100%	NA	NA	97%	NA	NA	92%	NA	NA	93%	NA	96%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	93%	NA	NA	NA	NA	NA	NA	NA	93%
Satisfaction Survey	Annually	80%	NA	NA	NA	NA	100%	NA	NA	NA	NA	NA	NA	NA	NA	100%
Sun Risk Education	Annually	100%	NA	NA	NA	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%
Riskin's Children Center (RCC)																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
TECHNICAL AUDIT	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Focused:																
Medication Education	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Progress Notes	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Wait for intake	Monthly	≤5	8	0	9	4	5	6	9	3	7	0	0	7	5	NA
Wait for assignment	Monthly	≤5	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Informed Consent	Monthly	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Service Plans	Monthly	85%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Closed Chart Audits	Quarterly	80%	x	x	100%	100%	x	x	x	100%	x	x	x	100%	NA	100%
Number of individuals linked to pediatrician	Quarterly	80%	100%	x	x	x	x	100%	100%	x	x	x	100%	100%	NA	100%
Indicators:																
Hospitalizations (Medical)	Monthly	<10%	0%	0%	0%	0%	5%	0%	0%	0%	0%	0%	0%	0%	NA	0%
Hospitalizations (Psychiatric)	Monthly	<10%	0%	4%	0%	0%	0%	4%	4%	0%	0%	0%	4%	12%	NA	2%
Child/Youth Symptom Check List	Semi-Annual	80%	x	x	x	x	x	85%	x	x	x	95%	x	x	NA	90%
Satisfaction Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	100%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%
Sun Risk Education	Annually	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	NA	100%

Projects for Assistance in Transition from Homelessness (PATH) - Essex																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
TECHNICAL AUDIT	Monthly	80%	97%	98%	98%	95%	90%	96%	95%	98%	96%	86%	85%	90%	NA	94%
Focused:																
Medication Education	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Client Consent	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Goal Attainment	Monthly	80%	30%	70%	83%	62%	73%	26%	90%	63%	74%	87%	75%	81%	NA	68%
Hospitalizations (P)	Monthly	<10%	2%	2%	5%	1%	0%	0%	0%	0%	1%	0%	0%	1%	NA	1%
Hospitalizations (M)	Monthly	<10%	1%	1%	5%	1%	0%	1%	1%	4%	2%	1%	4%	3%	NA	2%
Indicators:																
Number of outreaches	Annually	500	36	40	51	31	35	27	37	34	37	20	44	47	439	88%
Total Individuals Served	Annually	200	14	13	3	18	9	12	7	9	16	10	9	11	131	66%
Linked to own MHA CMH services	Annually	9	0	2	0	1	1	0	1	1	0	1	0	0	7	78%
Linked to Non- MHA CMH services	Annually	132	6	8	3	10	6	7	5	6	4	5	4	3	67	51%
Linked to financial benefits	Annually	40	7	4	2	1	0	4	5	13	7	6	4	0	53	133%
Linked to permanent housing	Annually	40	5	5	5	4	5	6	4	3	3	2	8	3	53	133%
Linked to rental by client, no ongoing subsidy	Annually	6	3	3	0	0	4	3	1	2	2	1	3	1	23	383%
Linked to rental by client, with HCV voucher	Annually	22	0	2	0	0	0	0	0	0	0	0	0	0	2	9%
Linked to rental by client with other ongoing housing subsidy	Annually	24	1	0	1	1	0	0	1	0	0	1	4	0	9	38%
Linked to Rental by client in a public housing unit	Annually	3	1	0	3	2	0	1	1	0	0	0	0	1	9	300%
Linked to residential project or halfway house with no homeless criteria	Annually	2	0	0	0	0	0	0	0	1	0	0	0	0	1	50%
Linked to staying or living with Family/friends permanent tenure	Annually	2	0	0	0	0	0	0	0	0	0	0	0	1	1	50%
Linked to "other" permanent housing	Annually	8	0	0	1	1	1	2	1	0	1	0	1	0	8	8
Linked to temporary housing	Annually	35	5	3	2	3	1	3	7	2	2	2	2	1	33	94%
Linked to substance use Tx. services	Annually	35	1	0	0	1	0	0	1	1	0	1	0	0	5	14%
Linked to medical/dental services	Annually	30	1	4	1	1	0	0	1	2	0	2	1	0	13	43%
Linked to rehabilitation services	Annually	10	2	1	3	5	1	0	4	8	2	2	7	3	38	380%
Linked to identification	Annually	50	3	3	1	1	1	3	2	2	4	4	2	1	27	54%
Satisfaction Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	100%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%
Sun Risk Education	Annually	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	NA	100%

Community Support Services (CSS) - Essex																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
Focused:																
Medication Education	Quarterly	80%	x	x	100%	x	x	100%	x	x	100%	x	x	100%	NA	100%
Client Consent	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Psychiatric Advance Directives	Monthly	90%	100%	100%	90%	90%	95%	90%	90%	95%	97%	90%	90%	90%	NA	93%
Hospitalizations (Psychiatric)	Monthly	<10%	2%	2%	4%	2%	2%	1%	0%	0%	1%	2%	2%	2%	NA	2%
Hospitalizations (Medical)	Monthly	<5%	1%	4%	2%	2%	2%	2%	2%	2%	1%	3%	2%	3%	NA	2%
Linked to Medical Services	Monthly	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Objectives/interventions linked to notes	Monthly	75%	100%	100%	100%	100%	90%	90%	90%	95%	96%	97%	96%	98%	NA	96%
Closed Chart Audits	Quarterly	80%	x	x	80%	x	x	80%	x	x	85%	x	x	80%	NA	81%
Wait for service (# of Days)	Monthly	1	1	1	1	1	1	1	1	1	1	1	1	1	1	NA
Indicators:																
Employment	Quarterly	≥10%	11%	11%	11%	12%	11%	10%	10%	11%	11%	14%	14%	14%	NA	12%
Recidivism to County/State	Monthly	≤20%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	NA	0.0%
Recidivism to STCF	Monthly	≤20%	2%	2%	4%	2%	1%	1%	1%	1%	0%	2%	2%	2%	NA	2%
Nursing Assessments	Monthly	≥90%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	NA	0.0%
Permanent Housing	Quarterly	80%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	NA	99%
Linked to benefits	Monthly	90%	90%	90%	90%	90%	90%	90%	90%	95%	95%	95%	95%	95%	NA	92%
Linked to Natural Community social supports	Monthly	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
IRP within 14 days of admission	Monthly	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Satisfaction Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	100%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%
Sun Risk Education	Annually	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	NA	100%
Community Advocacy/ POST																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
Focused:																
Active Clients Enrolled	Annually	106	x	x	282	x	x	334	x	x	357	x	x	365	1338	1262%
Total new enrolled/ client volunteers	Annually	10	x	x	4	x	x	52	x	x	23	x	x	8	87	870%
Total Units Served	Annually	21160	x	x	5796	x	x	5158	x	x	5197	x	x	7379	23530	111%
Satisfaction Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	100%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%
Sun Risk Education	Annually	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	NA	100%

Community Support Services (CSS) - Morris																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
Focused:																
Medication Education	Quarterly	80%			100%			100%			100%			100%	NA	100%
Client Consent	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Psychiatric Advance Directives	Monthly	90%	90%	90%	90%	90%	90%	90%	95%	95%	98%	90%	90%	90%	NA	92%
Hospitalizations (Medical)	Monthly	<10%	5%	5%	5%	2%	0%	0%	1%	1%	0%	3%	4%	3%	NA	2%
Hospitalizations (Psychiatric)	Monthly	<5%	5%	5%	5%	4%	1%	1%	1%	1%	1%	2%	3%	3%	NA	3%
Linked to Medical Services	Monthly	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Objectives/interventions linked to notes	Monthly	75%	70%	70%	75%	80%	80%	85%	90%	95%	97%	97%	97%	97%	NA	86%
Closed Chart Audits	Quarterly	80%			80%			80%			90%			80%	NA	83%
Wait for service (# of days)	Monthly	1	1	1	1	1	1	1	1	1	1	1	1	1	1	NA
Indicators:																
Employment	Quarterly	≥10%	15%	15%	15%	14%	14%	14%	13%	13%	10%	15%	15%	15%	NA	14%
Recidivism to County/State	Monthly	≤20%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	NA	0%
Recidivism to STCF	Monthly	≤20%	5%	5%	5%	4%	1%	1%	0%	1%	1%	3%	3%	3%	NA	3%
Nursing Assessments	Monthly	≥90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	NA	NA
Permanent Housing	Quarterly	80%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	NA	98%
Linked to benefits	Monthly	90%	90%	90%	90%	90%	90%	90%	95%	95%	95%	95%	95%	95%	NA	93%
Linked to Natural Community social supports	Monthly	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Individualized rehabilitation plan within 14 days of admission	Monthly	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Satisfaction Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	96%	NA	NA	96%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%
Sun Risk Education	Annually	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	NA	100%
Teen Connect																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
Focused:																
Number of calls	Annually	15	0	1	2	4	2	0	6	2	8	7	11	34	77	513%
Number of texts	Annually	35	1	6	1	2	3	7	11	13	9	4	9	14	80	229%
New callers/texters	Annually	25	0	5	1	5	1	7	10	11	9	7	16	11	83	332%
Hours of operation	Annually	2350	230	210	220	230	200	230	220	200	220	220	210	220	2610	111%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%

Integrated Case Management Services (ICMS) - Passaic																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
TECHNICAL AUDITS	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Focused:																
Quarterly Progress/w goal attainment	Quarterly	84%	x	x	82%	x	x	88%	x	x	78%	x	x	88%	NA	84%
Medication Education	Monthly	85%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Linked to Medical Services	Monthly	74%	86%	82%	88%	85%	84%	88%	87%	80%	82%	80%	85%	88%	NA	85%
Wait for service	Monthly	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	NA	0%
60 day discharge follow up	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Justified Continued Stay	Quarterly	100%	x	x	100%	x	x	100%	x	x	100%	x	x	100%	NA	100%
Medicaid Justification	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Closed Chart Audits	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Hospitalizations (Psychiatric)	Monthly	<10%	2%	2%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	NA	1%
Hospitalizations (Medical)	Monthly	<5%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	NA	1%
Indicators:																
County/State discharges seen within 72 hours	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Short Term Care Facility Recidivism	Monthly	<10%	1%	3%	1%	2%	1%	1%	1%	1%	1%	0%	1%	1%	NA	1%
County or State Hospitals Recidivism	Monthly		0%	1%	0%	0%	0%	0%	0%	0%	0%	1%	0%	0%	NA	0%
Voluntary Recidivism	Monthly		1%	1%	0%	0%	0%	1%	1%	0%	1%	1%	1%	1%	NA	1%
Client Employment	Quarterly	17%	16%	15%	14%	15%	12%	13%	14%	12%	12%	12%	14%	15%	NA	14%
Satisfaction Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	100%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%
Sun Risk Education	Annually	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	NA	100%
External Audits	Annually	COMPLETE				x						x			NA	COMPLETE
Peer to Peer Line																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
Focused:																
Number of calls	Annually	2537	570	571	564	544	551	616	562	514	582	569	632	604	6879	271%
New callers	Annually	80	14	10	15	14	15	9	11	13	24	10	14	11	160	200%
Staff Satisfaction Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	100%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%

Integrated Case Management Services (ICMS) - Essex																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
TECHNICAL AUDIT	Monthly	85%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Focused:																
Quarterly Progress with goal attainment	Quarterly	80%	x	x	82%	x	x	88%	x	x	78%	x	x	88%	NA	84%
Medication Education	Monthly	80%	82%	80%	80%	76%	82%	83%	88%	87%	88%	85%	82%	79%	NA	83%
Linked to Medical Services	Monthly	33	15	16	15	20	33	29	23	20	33	22	23	21	270	818%
Wait for service	Monthly	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
60 day discharge follow up	Monthly	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Justified Continued Stay	Monthly	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Medicaid Justification	Quarterly	90%	x	x	100%	x	x	100%	x	x	100%	x	x	100%	NA	100%
Closed Chart Audits	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Hospitalizations (Psychiatric)	Monthly	<10%	2%	3%	3%	3%	5%	6%	5%	2%	2%	2%	2%	2%	NA	3%
Hospitalizations (Medical)	Monthly	<5%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	2%	NA	1%
Indicators:																
County/State discharges seen within 72 hours	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Short Term Care Facility Recidivism	Monthly	<10%	3%	1%	0%	0%	1%	0%	1%	1%	1%	2%	1%	1%	NA	1%
County or State Hospitals Recidivism	Monthly		2%	2%	0%	2%	4%	2%	2%	1%	1%	1%	1%	1%	NA	2%
Voluntary Recidivism	Monthly		2%	1%	1%	0%	0%	2%	1%	1%	1%	1%	1%	1%	NA	1%
Client Employment (% of census)	Quarterly	0	x	x	13%	x	x	14%	x	x	14%	x	x	13%	NA	14%
Satisfaction Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	98%	NA	NA	98%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%
Sun Risk Education	Annually	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	NA	100%
External Audits	Annually	COMPLETE	x												NA	COMPLETE

Intensive Family Support Services (IFSS) - Essex																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
IFSS TECHNICAL CHART AUDITS	Monthly	85%	94%	90%	94%	94%	85%	92%	87%	93%	98%	98%	94%	93%	NA	93%
Intake Assessment completed	Monthly	85%	100%	90%	90%	100%	100%	100%	90%	100%	100%	90%	100%	100%	NA	97%
Service Pref Form Completed-Intake, 6mo, yearly	Monthly	85%	100%	90%	100%	90%	100%	100%	90%	90%	90%	100%	90%	90%	NA	94%
Family Concern Survey (Intake, 6mo, yearly)	Monthly	85%	100%	100%	100%	100%	100%	100%	100%	100%	90%	100%	90%	90%	NA	98%
Closed Chart Audits	Quarterly	80%	NA	NA	100%	NA	NA	100%	NA	NA	100%	NA	NA	100%	NA	100%
Service Accessibility:																
IFSS Wait for Service	Quarterly	≤5 days	NA	NA	1	NA	NA	2	NA	NA	2	n/a	NA	1	2	250%
IFSS Wait for Intake	Quarterly	≤5 days	NA	NA	5	NA	NA	5	NA	NA	4	n/a	NA	2	4	125%
Project FERST Accessibility- response time	Quarterly	≤2 days	NA	NA	1	NA	NA	2	NA	NA	2	n/a	NA	2	2	100%
Indicators:																
IFSS Family Concerns Scale	Semi-Annual	↓ Reduction	NA	NA	NA	NA	NA	-6%	NA	NA	NA	NA	NA	-28%	-28%	-28%
IFSS Discharge Follow Up	Semi-Annual	90%	NA	NA	NA	NA	NA	33%	NA	NA	NA	NA	NA	100%	NA	67%
IFSS Family Satisfaction Survey	Annually	90%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	100%
Project FERST-Family Satisfaction Survey	Annually	85%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	100%
IFSS Sun Risk Education	Annually	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	NA	100%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%
MHA Agency-wide																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
Indicators:																
Staff Voluntary Turnover	Monthly	≤30%	2%	2%	2%	1%	1%	1%	2%	3%	2%	1%	2%	1%	NA	2%
Staff Satisfaction	Annually	↑ satisfaction	x	x	x	x	x	x	x	x	x	x	x	94%	NA	94%
		↑ response	x	x	x	x	x	x	x	x	x	x	x	85%	NA	85%
90 day New Hire Survey Satisfaction	Quarterly	75% Satisfaction	x	x	92%	x	x	83%	x	x	94%	x	x	95%	NA	91%
Voluntary Resignations Only	Monthly		6	6	6	3	6	4	4	2	5	3	4	5	54	4.5
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%
Safety First Calls	Monthly	<20	6	2	4	2	0	3	3	4	2	2	0	2	30	NA
Suggestions	Monthly	NA	0	0	0	0	0	0	0	0	0	1	0	1	2	NA
Grievances	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Complaints	Monthly	0	1	1	1	0	0	1	0	0	0	1	0	0	5	NA
Corporate Compliance	Quarterly	Completed	NA	NA	x	NA	NA	x	NA	NA	x	NA	NA	x	NA	Completed
External Financial Audit	Annually	Completed	NA	NA	x	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	Completed
Psychiatrist Peer Review	Quarterly	Completed	NA	NA	NA	x	NA	NA	NA	NA	NA	NA	NA	x	NA	Completed
Medication Errors	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Adverse Reactions to Medications	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0	NA

Substance Use Recovery and Empowerment (SURE)																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
TECHNICAL AUDITS	Monthly	80%	85%	90%	85%	80%	95%	80%	90%	95%	100%	90%	95%	100%	NA	90%
Focused:																
Service plans with Measurable Objectives	Quarterly	80%	100%	NA	NA	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Goal Attainment	Quarterly	80%	100%	NA	NA	100%	95%	95%	90%	80%	95%	90%	90%	90%	NA	93%
Informed Consent for medications	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Linked to Medical Services	Monthly	80%	80%	80%	80%	80%	100%	100%	100%	100%	100%	100%	100%	100%	NA	93%
Client consents	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Closed Chart Audits	Monthly	80%	80%	80%	80%	80%	85%	80%	95%	90%	95%	80%	80%	80%	NA	84%
Medication Education	Quarterly	80%	100%	NA	NA	100%	80%	80%	100%	100%	100%	100%	100%	100%	NA	96%
Referred to Medical Provider	Quarterly	80%	100%	NA	NA	100%	80%	80%	100%	100%	100%	100%	100%	100%	NA	96%
Service Access:																
Wait for Intake (within 48 hours)	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0	100%
Internal referrals	Annually	60	11	9	14	11	5	8	10	2	6	2	3	2	83	138%
External referrals	Monthly	50	25	10	21	20	13	7	15	8	9	11	8	16	163	326%
Indicators:																
Hospitalized (Medical)	Monthly	<5%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	NA	100%
Hospitalized (Psychiatric)	Monthly	<10%	0%	0%	1%	1%	0%	0%	0%	0%	0%	0%	0%	0%	NA	100%
Admitted/referred to Withdrawal Management	Monthly	4	0	1	1	0	0	1	1	0	0	0	1	0	5	125%
Admitted/referred to higher level of care.	Monthly	7	0	0	0	1	0	0	0	0	1	1	1	1	5	71%
Referred to Mental Health Treatment	Monthly	4	0	0	0	0	1	0	0	0	0	0	0	1	2	50%
Administrative Discharge (Noncompliance with Tx.)	Monthly	14	0	0	1	1	1	1	1	1	1	1	0	0	8	57%
Scheduled SA Intake Assessments	Monthly	85	18	17	22	21	18	15	20	10	14	13	11	18	197	232%
Client Admissions	Monthly	52	11	7	8	15	7	12	6	6	8	5	6	6	97	187%
Discharge Follow Up	Quarterly	100%	80%	NA	NA	80%	80%	80%	100%	100%	100%	80%	80%	80%	NA	86%
Satisfaction Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	NA	100%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%
Sun Risk Education	Annually	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	NA	100%
Information Technology																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
Focused:																
System Upgrades	Monthly	Completed	7	8	7	6	5	4	5	3	5	6	5	4	65	NA
Trouble Ticket Response	Monthly	≤5 days	1	1	1	1	1	1	1	1	1	1	1	1	1	NA
Trouble Ticket Received	Monthly	≤200	7	6	4	7	5	6	7	5	4	6	7	5	69	NA
Hardware Inventory	Annually	90%	x	x	x	x	x	x	x	x	x	x	98%	x	NA	98%
Software Inventory	Annually	90%	x	x	x	x	x	x	x	x	x	96%	x	x	NA	96%

Projects for Assistance in Transition from Homelessness (PATH) - Morris																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
TECHNICAL AUDIT	Monthly	80%	100%	100%	100%	100%	98%	100%	99%	100%	99%	100%	100%	100%	NA	100%
Focused:																
Medication Education	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Client Consent	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Hospitalizations (P)	Monthly	<10%	3%	1%	0%	0%	1%	3%	3%	2%	3%	1%	0%	2%	NA	2%
Hospitalizations (M)	Monthly	<5%	0%	0%	1%	1%	0%	1%	2%	2%	2%	1%	3%	3%	NA	1%
Indicators:																
Goal Attainment	Monthly	80%	99%	98%	98%	99%	99%	99%	98%	100%	99%	100%	98%	100%	NA	99%
Number of outreaches	Annually	200	17	13	11	16	14	13	17	19	21	14	14	20	189	95%
Number of individuals enrolled	Annually	100	51	7	7	6	5	3	3	5	3	3	1	2	96	96%
Linked to Community MH services	Annually	50	7	0	9	0	1	8	0	2	3	2	7	16	55	110%
Linked to financial benefits	Annually	40	2	2	4	3	8	3	0	5	1	0	5	16	49	123%
Linked to permanent housing	Annually	15	4	1	3	2	3	3	6	0	5	3	4	2	36	240%
Linked to temporary housing	Annually	25	0	0	9	1	1	2	0	3	4	0	3	6	29	116%
Linked to substance abuse treatment services	Annually	10	2	2	0	0	0	0	0	1	0	1	2	2	10	100%
Linked to Medical Services	Annually	16	1	0	8	2	0	3	0	2	3	0	4	10	33	206%
Linked to vocational/educational services	Annually	8	3	1	1	0	1	4	0	2	0	0	0	3	15	188%
Satisfaction Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	100%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%
Sun Risk Education	Annually	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	NA	100%

Collaborative Justice Services- Expansion Program - Morris																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
TECHNICAL AUDIT	Monthly	80%	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%	100%	100%	NA	100%
Focused:																
Quarterly Progress with Measurable Objectives	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Medication Education	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Discharge Follow Up 60 Days	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Closed Chart Audits	Monthly	80%	100%	100%	100%	97%	100%	100%	100%	97%	97%	100%	100%	100%	NA	99%
Linked to Medical Services	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Wait for services (# of days)	Monthly	3	3	3	3	3	3	3	3	3	3	3	3	2	3	NA
Hospitalizations (Psychiatric)	Monthly	<10%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	3%	NA	0%
Hospitalizations (Medical)	Monthly	<5%	4%	0%	0%	0%	0%	0%	3%	0%	0%	0%	0%	0%	NA	1%
Indicators:																
Employment (census %)	Annually	24%	29%	29%	25%	25%	25%	25%	31%	31%	25%	25%	25%	30%	0	113%
Number of days ↓ county jail time	Annually	1000	0	0	0	0	0	0	0	0	0	0	0	0	0	0%
Number of days ↓ state time	Annually	10,000	0	3,640	3,650	7,300	1,825	1,825	2,190	3285	0	0	7,300	14600	45615	456%
Consumers Served	Annually	70	25	4	2	1	1	1	1	0	1	0	2	2	40	57%
Referrals from Community Connections	Monthly	8	0	0	3	0	0	0	1	1	0	0	0	0	5	63%
Linkage to MH Prosecutors Diversion Pro.	Annually	10	0	2	1	4	1	1	2	3	0	0	2	4	20	200%
Community Linkages	Annually	60	11	17	19	15	13	19	13	19	14	9	12	9	170	283%
Recidivism to jail within 30 days	Annually	<5 clients	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Recidivism to jail within 60 days	Annually	<10 clients	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Recidivism to jail within 90 days	Annually	<5 clients	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Recidivism to jail within 120 days	Annually	<10 clients	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Satisfaction Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	100%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%
Sun Risk Education	Annually	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	NA	100%

Collaborative Justice Services - Morris																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
TECHNICAL AUDIT	Monthly	80%	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%	100%	100%	NA	100%
Focused:																
Quarterly Progress with Measurable Objectives	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Medication Education	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Discharge Follow Up 60 Days	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Closed Chart Audits	Monthly	80%	100%	100%	100%	100%	100%	100%	97%	97%	97%	100%	100%	100%	NA	99%
Linked to Medical Services	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Wait for services (# of days)	Monthly	3	3	3	3	3	3	3	3	3	3	3	3	3	3	NA
Hospitalizations (Psychiatric)	Monthly	<10%	0%	0%	0%	0%	0%	0%	0%	0%	0%	14%	0%	6%	NA	2%
Hospitalizations (Medical)	Monthly	<5%	6%	0%	4%	6%	6%	0%	11%	0%	13%	0%	0%	0%	NA	4%
Indicators:																
Employment (census %)	Annually	30%	36%	36%	33%	33%	33%	33%	33%	33%	33%	21%	21%	33%	0	105%
Number of days ↓ county jail time	Annually	1000	0	0	0	0	0	0	0	0	0	0	0	364	364	36%
Number of days ↓ state time	Annually	10,000	0	0	0	0	0	0	0	0	0	0	0	0	0	0%
Linkage to MH Prosecutors Program	Annually	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0%
Community Linkages	Annually	60	11	0	3	2	3	7	7	5	6	14	8	15	81	135%
Recidivism to jail within 30 days	Annually	<5 clients	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Recidivism to jail within 60 days	Annually	<10 clients	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Recidivism to jail within 90 days	Annually	<5 clients	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Recidivism to jail within 120 days	Annually	<10 clients	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Satisfaction Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	100%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%
Sun Risk Education	Annually	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	NA	100%

Integrated Case Management Services (ICMS) - Morris																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
TECHNICAL AUDIT	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Focused:																
Quarterly Progress with goal attainment	Quarterly	80%	NA	NA	97%	NA	NA	97%	NA	NA	100%	NA	NA	95%	NA	97%
Medication Education	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Linked to Medical Services	Monthly	33	16	6	12	17	1	0	1	4	4	5	1	0	67	203%
Wait for service	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
60 day discharge follow up	Monthly	90%	100%	100%	100%	99%	97%	98%	95%	90%	93%	89%	100%	100%	NA	97%
Justified Continued Stay	Monthly	90%	94%	97%	98%	98%	95%	100%	100%	97%	95%	97%	97%	100%	NA	97%
Medicaid Justification	Monthly	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Closed Chart Audits	Monthly	80%	100%	100%	100%	84%	92%	100%	100%	94%	94%	95%	92%	100%	NA	96%
Hospitalizations (Psychiatric)	Monthly	<10%	8%	10%	3%	6%	5%	5%	6%	9%	14%	6%	9%	12%	NA	8%
Hospitalizations (Medical)	Monthly	<5%	5%	4%	5%	3%	0%	4%	7%	0%	7%	6%	5%	5%	NA	4%
Indicators:																
County/State discharges seen within 72 hours	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Short Term Care Facility Recidivism	Monthly	<10%	0%	0%	0%	0%	0%	0%	1%	0%	0%	1%	0%	0%	NA	0%
County or State Hospitals Recidivism	Monthly		0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	NA	0%
Voluntary Recidivism	Monthly		0%	0%	1%	0%	0%	1%	1%	0%	3%	2%	0%	0%	NA	1%
Client Employment (census %)	Quarterly	6%	NA	NA	15%	NA	NA	3%	NA	NA	6%	NA	NA	2%	NA	7%
Satisfaction Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	16%	NA	NA	16%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%
Sun Risk Education	Annually	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	NA	100%
External Audits	Annually	COMPLETE	NA	Medicaid	NA	NA	NA	NA	Medicaid	NA	NA	Medicaid	NA	NA	NA	COMPLETE

Collaborative Justice Services (CJS) - Essex																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
TECHNICAL AUDIT	Monthly	85%	85%	87%	87%	87%	90%	85%	90%	90%	89%	90%	90%	100%	NA	89%
Focused:																
Quarterly Progress with Measurable Objectives	Quarterly	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	100%	1	82%
Medication Education	Quarterly	80%	80%	80%	80%	80%	80%	80%	80%	80%	100%	100%	100%	100%	1	87%
Discharge Follow Up 60 Days	Quarterly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	1	100%
Closed Chart Audits	Quarterly	80%	80%	80%	80%	80%	80%	80%	80%	80%	100%	100%	100%	100%	1	87%
Linked to Medical Services	Annually	25	4	10	5	2	3	3	4	0	2	1	2	6	42	168%
Wait for Service	Monthly	<7	2	2	2	3	3	3	2	5	5	3	5	3	3	NA
Hospitalizations (Medical)	Monthly	<3	2	2	2	1	3	0	0	4	0	1	2	0	1	NA
Hospitalizations (Psychiatric)	Monthly	<3	1	1	1	3	0	0	4	2	0	1	1	1	1	NA
Indicators:																
Employment (client #)	Annually	40	5	7	8	4	6	8	5	0	3	2	5	6	59	148%
Number of days ↓ county jail time	Annually	1000	0	0	0	0	364	364	730	1,092	728	728	0	0	4006	401%
Number of days ↓ state time	Annually	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Divert/Pre-Adjudication	Annually	15	0	0	0	0	0	0	0	0	0	0	0	0	0	0%
Community Linkages	Annually	75	23	22	15	21	13	16	17	35	14	10	3	28	217	289%
Recidivism to jail within 30 days	Annually	≤25 clients	0	1	1	1	4	1	0	0	0	0	1	1	10	NA
Recidivism to jail within 60 days	Annually	≤50 clients	0	0	0	0	0	0	0	0	0	0	0	1	1	NA
Recidivism to jail within 90 days	Annually	≤25 clients	0	0	1	0	0	0	0	0	0	0	0	1	2	NA
Recidivism to jail within 120 days	Annually	≤50 clients	1	2	1	0	0	0	0	0	0	0	0	0	4	NA
Satisfaction Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	100%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	100%
Sun Risk Education	Annually	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	NA	100%

Assisted Outpatient Services (AOT) - Morris																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
TECHNICAL AUDITS	Monthly	80%	80%	76%	80%	84%	80%	80%	80%	80%	80%	80%	80%	80%	NA	80%
Focused:																
Wait for service	Monthly	3 days	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Screening referrals	Monthly	1 consumer	0	0	0	0	0	0	0	0	0	0	0	0	0	0%
Inpatient (STCF) referrals	Monthly	7	1	3	1	1	2	3	4	1	1	1	2	3	23	2%
Long Term Care (LTC) referrals	Monthly	3	1	1	1	4	0	0	1	2	2	2	1	4	19	4%
Number of transport orders	Monthly	<3 transport orders	0	1	1	3	1	0	0	1	4	0	0	0	1	NA
Linked to Medical Services	Quarterly	80%	0	0	0%	0	0	0%	0	0	0%	0	0	0%	0	0%
60 day discharge follow up	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Hospitalizations (Psychiatric)	Monthly	<10%	13%	12%	10%	15%	9%	8%	10%	13%	33%	4%	4%	3%	NA	11%
Hospitalizations (Medical)	Monthly	<5%	4%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	NA	0%
Indicators:																
ER (screening)	Monthly	< 4	0	1	2	4	2	0	3	2	5	1	0	1	2	NA
Voluntary admissions	Monthly	≤ 2	3	0	1	2	0	1	0	3	3	0	1	0	1	NA
Involuntary admissions	Monthly	≤ 2	0	3	1	3	2	1	3	0	6	1	0	1	2	NA
Long Term Care	Monthly	≤ 2	0	0	2	0	1	1	0	0	0	1	0	0	0	NA
Arrests	Monthly	≤ 2	0	0	0	0	0	0	0	0	1	0	0	0	0	NA
Incarceration	Monthly	≤ 2	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Homelessness	Monthly	≤ 2	0	0	0	0	1	1	1	1	1	0	0	0	0	NA
Satisfaction Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	100%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%
Sun Risk Education	Annually	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	NA	100%

Assisted Outpatient Services (AOT) - Sussex																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
TECHNICAL AUDITS	Monthly	80%	80%	88%	90%	97%	80%	80%	80%	80%	80%	80%	80%	80%	NA	83%
Service Access:																
Wait for service	Monthly	3 days	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Screening referrals	Monthly	1 consumer	0	0	0	0	0	0	0	0	0	0	0	1	1	8%
Inpatient referrals	Monthly	7 consumers	4	3	2	0	1	2	1	1	0	2	1	1	18	2%
Long Term Care (LTC) referrals	Monthly	3 consumers	0	0	0	1	0	0	0	1	0	0	0	1	3	0.7%
Number of transport orders	Monthly	<3 transport orders	1	0	0	1	0	1	2	1	1	0	0	0	1	NA
Linked to Medical Services	Quarterly	80%	0	0	0%	0	0	0%	0	0	1	0	0	0%	NA	8%
60 day discharge follow up	Monthly	90%	100%	100%	100%	NA	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Hospitalizations (Medical)	Monthly	≤5%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0.0%	11%	11%	NA	2%
Hospitalizations (Psychiatric)	Monthly	≤10%	13%	0%	23%	0%	6%	6%	13%	21%	10%	11%	11%	11%	NA	10%
Indicators:																
ER (screening)	Monthly	≤ 3	0	0	3	1	1	1	2	3	1	1	1	1	1	NA
Voluntary admissions	Monthly	≤ 1	1	0	0	0	0	0	0	1	0	1	0	0	0	NA
Involuntary admissions	Monthly	≤ 1	1	0	4	0	1	1	2	2	1	0	1	1	1	NA
Long Term Care	Monthly	≤ 2	0	0	0	0	0	0	1	0	1	0	0	0	0	NA
Arrests	Monthly	≤ 1	0	1	0	1	0	0	0	0	0	0	0	0	0	NA
Incarceration	Monthly	≤1	0	0	0	1	0	0	0	0	0	0	0	0	0	NA
Homelessness	Monthly	≤ 1	1	2	2	1	0	0	0	0	0	0	0	0	1	NA
Satisfaction Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	100%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%
Sun Risk Education	Annually	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	NA	100%
NJ Statewide Student Support Services (NJ4S)																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
Contracted MLOS	Monthly	124	10	2	606	176	45	138	218	69	93	38	90	1	1486	100%
Tier 1 services – Community Events	Quarterly	60	50	39	34	39	22	37	23	23	54	43	43	43	450	188%
Tier 2 services – Applications received for Evidence Based Programming	Quarterly	20	6	0	10	13	5	6	8	51	6	1	0	0	106	133%
Tier 3 services – Applications received for individual counseling	Quarterly	25	2	1	19	25	21	20	20	26	22	47	10	1	214	214%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%

Supportive Employment Services (SES)																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
TECHNICAL AUDITS	Monthly	80%	97%	90%	89%	84%	93%	97%	95%	98%	84%	93%	92%	100%	NA	93%
Focused:																
Comprehensive Intake Assessment w/Strengths Needs Abilities Preferences	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Treatment Plans: update/measurable	Monthly	80%	99%	100%	100%	85%	80%	100%	100%	100%	96%	99%	100%	100%	NA	97%
Support Plan	Quarterly	80%	NA	NA	100%	NA	NA	100%	NA	NA	100%	NA	NA	100%	NA	100%
Closed Chart Audits	Quarterly	80%	NA	NA	100%	NA	NA	100%	NA	NA	100%	NA	NA	100%	NA	100%
Progress on Goal attainment	Quarterly	80%	NA	NA	78%	NA	NA	74%	NA	NA	80%	NA	NA	79%	NA	78%
Linked to Medical Services	Quarterly	80%	NA	NA	100%	NA	NA	100%	NA	NA	99%	NA	NA	100%	NA	100%
Wait for service (# of days)	Monthly	3	6	0	2	7	10	2	3	2	2	2	1	1	3	NA
Hospitalizations (Psychiatric)	Monthly	<5%	0	1%	0	2	1	2	1	1	1%	0	3	1	NA	91.8%
Hospitalizations (Medical)	Monthly	<3%	2	0	0	0	0	0	2	0	2	1	2	0	NA	75%
Indicators:																
Linked to Community Service	Quarterly	80%	NA	NA	3%	NA	NA	2%	NA	NA	5%	NA	NA	1%	NA	3%
Interviews	Quarterly	60	NA	NA	36	NA	NA	36	NA	NA	38	NA	NA	25	135	225%
Placed within 4 months of admission	Quarterly	30%	NA	NA	32%	NA	NA	42%	NA	NA	32%	NA	NA	47%	NA	38%
Discharge Follow Up 90 Days	Quarterly	80%	NA	NA	100%	NA	NA	100%	NA	NA	100%	NA	NA	100%	NA	100%
Job retention > 3 months	Quarterly	80%	NA	NA	23%	NA	NA	24%	NA	NA	75%	NA	NA	50%	NA	43%
Satisfaction Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	92%	NA	92%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%
Sun Risk Education	Annually	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	100%
Education																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
Focused:																
Number of Participants	Annually	50	x	x	27	x	x	90	x	x	79	x	x	33	229	458%
Number of MHFA	Annually	16	x	x	3	x	x	6	x	x	5	x	x	4	18	113%
Satisfaction Survey	Quarterly	80%	x	x	100%	x	x	99%	x	x	99%	x	x	98%	NA	99%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%

Health Home																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
Focused:																
AIMS Completed	Annually	14	0	3	0	16	7	11	9	4	5	3	2	0	NA	429%
Blood pressure <140/90	Annually	80%	33%	50%	75%	33%	33%	45%	41%	75%	58%	18%	50%	80%	NA	49%
Nursing Meetings	Annually	6	NA	NA	1	1	1	1	1	1	1	1	1	1	NA	42%
Health Group Attendees	Annually	680	32	22	4	56	37	40	31	60	53	13	32	34	NA	61%
Nursing Visits	Annually	388	30	53	55	103	94	121	128	121	130	125	109	163	NA	318%
Nursing Assessments Completed	Annually	28	0	3	3	27	18	28	23	16	14	15	8	7	NA	579%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%
MHAS - Arrive																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
Co-Response Outreach (Law Enf. & MHA)																
Number of face to face co-responses	Monthly	45	21	8	17	24	17	4	1	10	7	14	8	8	139	309%
Hours Co-Responding	Monthly	35	14.39	7.33	11.92	14.41	10.25	2.58	2.25	10.08	8.08	12.67	14.33	7.76	116	332%
Number of homeless outreaches	Monthly	18	0	3	1	3	3	1	0	1	0	0	1	0	13	72%
Number of referrals received for follow up	Monthly	260	27	35	27	16	20	23	9	16	24	16	26	22	261	100%
Co-Response/Follow Up Outcomes																
Arrest	Monthly	<5	6	0	0	0	0	0	1	1	0	0	2	0	10	NA
Involuntary Transport to Hospital	Monthly	50	2	3	3	2	0	0	2	3	7	2	9	8	41	82%
Voluntary Transport to Hospital	Monthly	118	11	11	12	18	15	11	2	12	10	11	8	7	128	108%
Resolved without Incident	Monthly	125	29	26	28	17	19	15	5	9	14	17	14	15	208	166%
Co-Response/Follow Up Linkage Outcomes																
Declined linkages or future follow up	Monthly	<5	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Linked to MHA services	Monthly	18	0	0	0	0	0	0	0	0	0	0	0	0	0	0%
Linked to non-MHA mental health services	Monthly	15	2	2	0	1	9	4	0	5	9	3	2	1	38	253%
Linked to other services	Monthly	25	2	1	1	1	2	2	0	7	5	3	3	5	32	128%
Follow Up Outreach																
# People outreached to	Monthly	165	47	49	58	52	49	52	18	33	44	45	45	47	539	327%
Duration outreaches (hours)	Monthly	68	19.06	20.06	20.54	23.47	15.07	15.47	2.31	16.5	16.1	15.53	18.69	18.62	201	296%
# Outreaches	Monthly	250	97	81	84	79	81	75	21	71	91	88	90	78	936	374%
Indicators																
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%

Veterans Program																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Year: 2025			2026						2025							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEP	OCT	NOV	DEC	TOTALS	%
TECHNICAL AUDIT	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Focused:																
New enrolleess	Annually	30	29	1	3	0	0	1	0	0	0	1	0	0	35	116%
Medication Education	Monthly	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Wait for services (# of days)	Monthly	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
Indicators:																
Mental Health Counseling	Quarterly	100 hours	8.5	10.5	13.75	17.25	11.25	19.75	23.25	7.75	2.5	3.75	0.75	15	134	34%
Psycho Edu Group	Quarterly	3 sessions	1	1	1	1	1	1	2	1	1	2	1	1	14	117%
Veterans Support Group	Quarterly	8 sessions	3	2	3	3	3	3	2	2	2	3	1	2	29	91%
Case Management	Quarterly	18 units	1	2	22	25	13	3	0	0	1	0	1	2	70	114%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	93%	NA	NA	NA	NA	NA	NA	NA	93%
Satisfaction Survey	Annually	80%	NA	NA	NA	NA	100%	NA	NA	NA	NA	NA	NA	NA	NA	100%
Sun Risk Education	Annually	100%	NA	NA	NA	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%
Mt Olive Police Department Collaboration																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
Training																
Number of trainings provided	Annually	Baseline	0	0	0	2	1	1	1	1	4	1	1	1	13	NA
Training hours (enter minutes)	Annually	Baseline	0	0	0	480	20	20	40	40	80	20	20	20	740	NA
Co-Response Outreach																
Total number of calls	Annually	Baseline	50	35	45	43	35	63	47	54	56	51	51	69	599	NA
Number of face to face co-responses	Annually	Baseline	21	9	7	10	13	14	26	29	25	27	32	40	253	NA
# of referrals received	Annually	Baseline	29	26	38	33	22	49	21	25	31	24	19	29	346	NA
Co-Response Outcomes																
Arrest	Annually	Baseline	2	1	3	1	0	1	1	1	4	1	1	1	17	NA
Involuntary Transport to Hospital	Annually	Baseline	4	2	3	6	3	6	3	3	0	3	3	7	43	NA
Voluntary Transport to Hospital	Annually	Baseline	13	9	10	12	11	24	11	20	9	15	22	18	174	NA
Resolved without Incident	Annually	Baseline	31	23	29	24	21	32	32	30	43	32	25	43	365	NA
Co-Response Linkage Outcomes																
# of linkages/ referrals provided	Annually	Baseline	23	19	14	14	13	17	17	10	21	12	18	23	201	NA
Co-Responder Outreach																
# of responses involving substance use/ alcohol	Annually	Baseline	16	8	17	13	11	12	9	15	15	16	14	19	165	NA
# of responses involving duplicate individuals	Annually	Baseline	14	13	22	10	13	26	20	22	21	17	15	23	216	NA
Indicators																
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%

Intensive Family Support Services (IFSS) - Sussex																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
TECHNICAL CHART AUDITS	Monthly	85%	93%	98%	87%	89%	98%	94%	97%	99%	97%	97%	99%	94%	NA	95%
Focused:																
Intake Assessment completed	Monthly	85%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Service Preference Form Completed-Intake, 6mo, yearly	Monthly	85%	93%	100%	100%	100%	100%	89%	100%	100%	97%	100%	100%	88%	NA	97%
Family Concern Survey (Intake, 6 months, yearly)	Monthly	85%	93%	88%	88%	100%	100%	89%	100%	100%	100%	89%	88%	88%	NA	94%
Closed Chart Audits	Quarterly	85%	x	x	100%	x	x	100%	x	x	100%	x	x	100%	NA	100%
Service Accessibility:																
IFSS Wait for Service	Quarterly	≤5 days	x	x	0	x	x	0	x	x	0	x	x	0	0	500%
IFSS Wait for Intake	Quarterly	≤5 days	x	x	1	x	x	2	x	x	1	x	x	1	1	400%
Indicators:																
IFSS Family Concerns Scale	Semi-Annual	↓ Reduction	x	x	x	x	x	-17%	x	x	x	x	x	-9%	NA	-13%
IFSS Family Satisfaction Survey	Annually	85%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	100%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%
Sun Risk Education	Annually	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	NA	100%
Prospect House																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
TECHNICAL AUDITS	Monthly	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	NA	85%
Focused:																
Height, Weight, & Blood Pressure	Monthly	85%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	NA	90%
Initial Psych Evals completed within 2 weeks of admission	Monthly	90%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	NA	80%
6 Month Psych	Monthly	100%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	NA	90%
Consent Forms	Monthly	85%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Comp Assess. completed w/in 1 month of adm. into prgrm	Monthly	90%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	NA	0%
Informed Consent for medications	Quarterly	100%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	NA	90%
Wait for service	Monthly	<2	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Hospitalizations (Medical)	Monthly	<5%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Hospitalizations (Psychiatric)	Monthly	<10%	2%	2%	3%	3%	3%	3%	3%	2%	3%	3%	3%	3%	NA	3%
Nutritional Screenings completed.	Monthly	100%	NA	NA	6%	6%	6%	6%	6%	6%	6%	6%	6%	6%	NA	6%
Indicators:																
Employment (census %)	Quarterly	5%	NA	NA	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	0	NA
Satisfaction Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	95%	NA	NA	95%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%
Sun Risk Education	Annually	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	NA	100%
External Audits	Annually	Completed	x			x			x			x			NA	Completed

Suicide Prevention																	
Mental Health Association																	
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																	
Fiscal Year: 2026			2025						2026								
Topic/Issue Requesting Follow up																	
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%	
Focused:																	
Participants under 18	Monthly	1990	26	195	29	97	48	87	89	57	399	25	48	91	1191	60%	
Participants over 18	Monthly	1750	34	370	177	186	39	74	39	99	115	83	207	68	1491	85%	
Training Hours	Monthly	225	9	19	16	31	9	15	8	21	21	17	19	14	199	88%	
Presentations	Monthly	100	6	10	9	13	7	9	5	9	9	9	10	9	105	105%	
# of Law Enforcement Trained	Annually	Baseline	0	0	2	0	0	0	0	0	0	0	34	0	36	NA	
# of Students Trained	Annually	2065	26	195	29	97	48	87	89	57	399	25	48	91	1191	58%	
# of Teachers Trained	Annually	120	0	0	0	1	6	6	6	6	3	1	2	11	42	35%	
# of Others Trained	Annually	1635	34	370	175	185	33	68	33	93	112	82	171	57	1413	86%	
Mindfulness Art-Based Activity post survey- better understanding of how to manage mental and emotional health.	Quarterly	Baseline	NA	NA	3.9	NA	NA	NA	NA	NA	NA	NA	NA	NA	4	NA	
Satisfaction Surveys	Quarterly	80%	NA	NA	100%	NA	NA	93%	NA	NA	NA	NA	NA	93%	NA	95%	
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%	
The Wellness Hub/ Early Intervention Support Services (EISS) - Sussex																	
Mental Health Association																	
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																	
Fiscal Year: 2026			2025						2026								
Topic/Issue Requesting Follow up																	
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%	
TECHNICAL AUDITS	Monthly	80%	85%	90%	90%	90%	80%	90%	90%	95%	98%	95%	96%	98%	NA	91%	
Focused:																	
Goal Attainment at Discharge	Quarterly	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%	100%	100%	NA	100%	
Medication Education	Monthly	80%	90%	95%	95%	100%	95%	95%	95%	90%	90%	100%	100%	95%	NA	95%	
Linked to Medical Services	Monthly	90%	80%	90%	95%	80%	85%	90%	100%	100%	95%	100%	90%	95%	NA	92%	
Wait for service (days)	Monthly	0	0	0	0	0	0	0	0	0	0	0	0	0	0	NA	
60 day discharge follow up	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%	
Justified Continued Stay	Quarterly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%	
Closed Chart Audits	Monthly	100%	100%	100.00%	100%	100%	100%	100%	100%	100%	100%	95%	100%	100%	NA	100%	
Indicators:																	
New Enrollees: OFFERED MH Professional w/in 24 hrs.	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%	
New Enrollees: F2F access with MH Professional w/in 24 hrs.	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%	
New Enrollees: OFFERED access to Prescriber w/in 24 hrs.	Monthly	90%	100%	100%	100%	92%	97%	100%	100%	98%	99%	98%	100%	98%	NA	98%	
New Enrollees: F2F access with Prescriber w/in 24 hrs.	Monthly	90%	90%	93%	86%	84%	90%	90%	97%	90%	89%	97%	94%	85%	NA	90%	
Consumers referred to Screening	Monthly	<5%	0%	1%	0%	0%	1%	1%	0%	1%	1%	0%	0%	1%	1%	400%	
Satisfaction Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	100%	
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%	
Sun Risk Education	Annually	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	NA	100%	

Social Club																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
Focused:																
Number of Openings	Annually	16	x	x	4	x	x	32	x	x	6	x	x	56	98	613%
Number of Attendees	Annually	560	x	x	114	x	x	479	x	x	409	x	x	1139	2141	382%
Activities	Annually	90	x	x	31	x	x	32	x	x	33	x	x	36	132	147%
Units of Service	Annually	4384	x	x	1294	x	x	1437	x	x	1208	x	x	2720	6659	152%
Satisfaction Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	100%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%
Sun Risk Education	Annually	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	NA	100%
"The Core 4" Arrive Together Collaboration																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
Co-Response Outreach (Law Enf. & MHA)																
Number of face to face co-responses	Monthly	Baseline	37	26	22	22	21	17	16	20	28	14	11	6	240	NA
Hours Co-Responding	Monthly	Baseline	44.25	24	29.42	25.5	25.5	22.25	28	23.75	29.5	10	9.83	5.33	277	NA
Number of homeless outreaches	Monthly	Baseline	5	3	3	5	6	3	4	0	4	4	0	0	37	NA
Number of referrals received for follow up	Monthly	Baseline	62	33	46	53	47	42	62	33	48	50	45	50	571	NA
Co-Response/Follow Up Outcomes																
Arrest	Monthly	Baseline	1	3	5	0	1	3	1	2	1	2	4	1	24	NA
Involuntary Transport to Hospital	Monthly	Baseline	9	3	2	6	5	2	1	4	7	4	0	5	48	NA
Voluntary Transport to Hospital	Monthly	Baseline	28	14	17	26	25	24	26	21	27	21	17	18	264	NA
Resolved without Incident	Monthly	Baseline	56	36	41	38	31	27	46	26	37	34	35	32	439	NA
Co-Response/Follow Up Linkage Outcomes																
Declined linkages or future follow up	Monthly	Baseline	0	0	0	5	0	0	1	0	0	0	0	0	6	NA
Linked to MHA services	Monthly	Baseline	0	0	0	3	5	4	0	2	0	1	2	1	18	NA
Linked to non-MHA mental health services	Monthly	Baseline	0	3	25	16	11	7	15	10	3	10	0	2	102	NA
Linked to other services	Monthly	Baseline	2	3	26	14	23	20	10	17	6	18	1	2	142	NA
Follow Up Outreach																
# People outreached to	Monthly	Baseline	80	83	68	85	64	70	77	74	64	41	25	20	751	NA
Duration outreaches (hours)	Monthly	Baseline	46.24	39.6	36.35	39.97	37.01	41.47	37.68	55.86	40.84	33.37	8.72	10.15	427	NA
# Outreaches	Monthly	Baseline	162	170	143	186	142	174	154	223	144	84	36	26	1644	NA
Indicators																
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%

Center for Behavioral Health (CBH)																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
TECHNICAL AUDITS	Quarterly	90%	x	100%	x	100%	x	x	x	x	90%	x	100%	x	NA	98%
Focused:																
Service Plans	Monthly	85%	91%	85%	87%	92%	91%	91%	92%	88%	88%	88%	91%	92%	NA	90%
Progress Notes	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
AIMS	Semi-Annual	80%	x	x	x	x	x	x	100%	x	x	x	x	100%	NA	100%
Medication Sheet	Monthly	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Informed Consent	Monthly	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	NA	100%
Closed Chart Audits	Quarterly	80%	x	x	100%	100%	x	x	x	x	85%	x	x	85%	NA	93%
Medication Inventory	Quarterly	Completed	x	Completed	x	x	x	x	x	Completed	x	x	x	x	NA	Completed
Referred to Medical Provider	Quarterly	90%	92%	x	x	x	x	95%	x	x	93%	x	x	100%	NA	95%
Service Access:																
Wait for Intake	Monthly	≤7 Days	0	3	5.4	3.8	2.75	7	4	5	5	0	5.5	2	4	NA
Wait for Assignment	Monthly	≤5Days	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Indicators:																
Hospitalized (Medical)	Monthly	<10%	2%	3%	2%	2%	3%	4%	6%	2%	4%	3%	3%	2%	0	3%
Hospitalized (Psychiatric)	Monthly	<10%	1.53%	2%	2.00%	2.10%	2%	0.01%	0.70%	0.69%	0.70%	0.70%	0%	0%	0	1%
DASS-21	Monthly	↑functioning	5	5	8	10	8	10	10	8	10	10	30	5	10	NA
Discharge Follow Up	Semi-Annual	95%	x	x	x	100%	x	x	x	x	100%	x	x	x	1	100%
Satisfaction Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	95%	NA	NA	95%
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%
Sun Risk Education	Annually	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	NA	NA	NA	100%

Perth Amboy Police Department Collaboration																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
Training																
Number of training videos provided	Annually	12	1	1	1	1	1	1	1	1	1	1	1	1	12	100%
Training hours (enter minutes)	Annually	340	24	26	24	23	25	24	22	23	25	22	25	24	287	84%
Co-Response Outreach (WOPD & MHAEM)																
Number of face to face co-responses	Annually	180	16	8	11	8	10	10	8	7	10	7	7	8	110	61%
Hours Co-Responding	Annually	110	16.25	6.41	8.9	8.25	8.9	7.8	8.8	5.3	6.75	5.3	5.6	7.3	96	87%
Co-Responses Requiring Spanish	Annually	62	2	1	0	2	0	0	1	0	1	3	0	1	11	18%
Number of homeless outreaches (PAPD request)	Annually	10	3	2	0	0	0	0	0	0	1	1	1	0	8	80%
Number of referrals received	Annually	Baseline	NA	NA	NA	NA	NA	NA	NA	NA	NA	48	52	49	149	NA
Co-Response Outcomes																
Arrest	Annually	1	0	0	0	0	1	1	0	0	0	0	0	0	2	2.0
Involuntary Transport to Hospital	Annually	15	3	0	1	0	1	1	2	1	0	1	0	0	10	67%
Voluntary Transport to Hospital	Annually	50	6	4	6	4	5	4	4	6	4	4	3	1	51	102%
Resolved without Incident	Annually	40	7	4	4	4	3	4	2	0	6	2	4	7	47	118%
Co-Response Linkage Outcomes																
Accepted linkages	Annually	67	5	2	4	3	3	2	2	3	2	4	3	8	41	61%
Declined linkages or future follow up	Annually	31	11	6	7	5	7	8	6	4	8	3	4	0	69	223%
Linked to MHA mental health services	Annually	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0%
Linked to non-MHA mental health services	Annually	25	1	0	3	3	4	1	0	2	1	3	3	2	23	92%
Linked to other services	Annually	68	4	2	3	2	0	1	2	1	1	1	0	6	23	34%
Co-Responder Outreach																
# people outreaches were attempted to	Annually	180	44	35	54	22	29	24	27	28	36	33	24	36	392	218%
# People outreached to	Annually	122	21	15	24	9	14	13	15	11	22	18	13	10	185	152%
# People accepted linkages during outreach	Annually	110	15	14	19	9	14	14	15	15	21	15	10	21	182	165%
Duration outreaches (hours)	Annually	92	6.9	9.75	9.3	7.25	12.25	15.3	6.25	11.75	9	11.2	8.7	5.7	113	123%
Total # Outreaches (times connecting with clients)	Annually	141	38	23	32	22	29	26	28	16	43	36	18	25	336	238%
Indicators																
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%

South Orange Police Department Collaboration																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
Training																
Number of training videos provided	Annually	12	1	1	1	1	0	0	0	0	0	1	1	1	7	58%
Training hours (enter minutes)	Annually	340	20	24	25	24	0	0	0	0	0	40	35	25	193	57%
Co-Response Outreach																
Number of face to face co-responses	Annually	180	3	1	4	1	0	0	0	0	5	6	13	6	39	22%
Hours Co-Responding	Annually	110	3.1	0.75	4	1	0	0	0	0	4.1	4.6	12.83	7.3	38	34%
Co-Responses Requiring Spanish	Annually	Baseline	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Number of homeless outreaches (SOPD request)	Annually	10	1	0	0	0	0	0	0	0	0	2	1	0	4	40%
Number of referrals received	Annually	Baseline	NA	NA	NA	NA	NA	NA	NA	NA	NA	27	9	12	48	NA
Co-Response Outcomes																
Arrest	Annually	1	0	0	0	0	0	0	0	0	0	2	0	0	2	2.0
Involuntary Transport to Hospital	Annually	15	0	0	0	0	0	0	0	0	0	1	1	0	2	13%
Voluntary Transport to Hospital	Annually	50	1	1	3	0	0	0	0	0	1	3	1	0	10	20%
Resolved without Incident	Annually	40	2	0	1	1	0	0	0	0	4	0	11	6	25	63%
Co-Response Notification																
# of co-responses initiated by dispatch	Annually	55	3	1	4	1	0	0	0	0	3	4	10	5	31	56%
# of co-responses initiated by self-initiated by officer	Annually	Baseline	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
# of co-responses initiated by co-responder listening to radio	Annually	Baseline	0	0	0	0	0	0	0	0	1	2	2	0	5	NA
# of co-responses initiated by "other"	Annually	15	0	0	0	0	0	0	0	0	1	0	0	1	2	13%
Co-Response Linkage Outcomes																
Accepted linkages	Annually	32	2	1	3	1	0	0	0	0	3	3	8	6	27	84%
Declined linkages or future follow up	Annually	40	1	0	1	0	0	0	0	0	2	3	5	0	12	30%
Linked to MHA mental health services	Annually	5	1	0	1	1	0	0	0	0	0	2	3	3	11	220%
Linked to non-MHA mental health services	Annually	25	0	0	1	0	0	0	0	0	2	1	2	2	8	32%
Linked to other services	Annually	10	1	1	1	1	0	0	0	0	1	1	3	2	11	110%
Co-Responder Outreach																
# people outreaches were attempted to	Annually	130	15	17	13	1	3	1	7	1	23	27	41	33	182	140%
# People outreached to in the community	Annually	80	11	6	10	1	1	1	3	0	16	15	36	14	114	143%
# People outreached to individuals detained	Annually	Baseline	0	0	0	0	0	0	0	0	3	1	0	0	4	NA
# People accepted linkages during outreach	Annually	Baseline	10	5	9	1	1	1	3	0	13	1	26	14	0	84
Duration outreaches (hours)	Annually	65	12.7	10.6	8.7	0.25	0.25	0.25	1.8	0	9.75	7.6	25.7	5.7	83	128%
Total # Outreaches (times connecting with clients)	Annually	125	22	8	18	1	1	1	3	0	30	25	72	30	211	169%
Indicators																
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%

West Orange Police Department Collaboration																	
Mental Health Association																	
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																	
Fiscal Year: 2026			2025						2026								
Topic/Issue Requesting Follow up																	
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%	
Training																	
Number of training videos provided	Annually	12	1	1	1	1	1	1	1	1	1	1	1	1	12	100%	
Training hours (enter minutes)	Annually	340	24	25	23	24	22	23	24	25	27	25	25	24	291	86%	
Pre-Test Average Score	Annually	Baseline	NA	50%	90%	92%	92%	NA	70%	83%	90%	100%	NA	NA	NA	88%	
Post-Test Average Score	Annually	Baseline	NA	97%	100%	100%	100%	NA	93%	92%	90%	100%	NA	NA	NA	96%	
Body Camera After-Action Review																	
Number of videos reviewed	Annually	50	12	0	14	6	4	4	3	3	3	12	4	7	72	144%	
Number of videos with recommendations	Annually	5	0	0	1	0	0	0	0	0	0	0	0	0	1	20%	
Number of videos with no recommendations	Annually	45	12	0	13	6	4	4	3	3	3	12	4	7	71	158%	
Number of videos Co-Response were present for	Annually	15	3	0	2	2	1	0	0	1	1	2	2	4	18	NA	
Co-Response Outreach (WOPD & MHAEM)																	
Number of face to face co-responses	Annually	180	16	4	13	31	13	17	17	13	32	24	22	37	239	133%	
Hours Co-Responding	Annually	110	9.6	3.25	8	15.42	4.8	7.75	9.1	7.1	18.4	14	10	17.1	125	113%	
Number of homeless outreaches (WOPD request)	Annually	10	0	0	0	0	0	0	1	0	0	2	1	0	4	40%	
Number of referrals received	Annually	Baseline	20	31	21	37	28	23	23	19	27	15	23	14	281	NA	
Co-Response Outcomes																	
Arrest	Annually	1	0	0	0	0	0	0	0	0	1	0	0	0	1	1.0	
Involuntary Transport to Hospital	Annually	15	1	0	0	1	1	1	0	2	1	3	5	3	18	120%	
Voluntary Transport to Hospital	Annually	50	4	3	6	12	6	10	7	5	16	13	11	21	114	228%	
Resolved without Incident	Annually	40	11	1	7	18	5	6	10	6	14	8	6	13	105	263%	
Co-Response Notification																	
# of co-responses initiated by dispatch	Annually	120	11	3	13	30	13	17	17	13	32	24	22	37	232	193%	
# of co-responses initiated by self-initiated by officer	Annually	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0%	
# of co-responses initiated by co-responder listening to radio	Annually	2	5	1	0	1	0	0	0	0	0	0	0	0	7	350%	
# of co-responses initiated by "other"	Annually	14	0	0	0	0	0	0	0	0	0	0	0	0	0	0%	
Co-Response Linkage Outcomes																	
Accepted linkages	Annually	30	6	0	4	9	1	4	5	2	10	6	7	9	63	210%	
Declined linkages or future follow up	Annually	48	5	1	7	0	0	3	3	5	6	0	0	4	34	71%	
Unable to refer	Annually	60	5	3	2	22	12	10	9	6	16	18	15	24	142	237%	
Linked to MHA mental health services	Annually	5	1	0	2	4	0	0	0	0	0	2	3	2	14	280%	
Linked to non-MHA mental health services	Annually	25	3	0	2	3	0	2	4	2	5	4	3	7	35	140%	
Linked to other services	Annually	22	3	0	3	2	1	2	1	0	1	0	1	0	14	64%	
Co-Responder Outreach																	
# people outreaches were attempted to	Annually	312	37	30	18	32	25	21	33	16	22	19	37	29	319	102%	
# People outreached to	Annually	136	17	14	14	15	17	16	16	10	12	13	18	24	186	137%	
# People accepted linkages during outreach	Annually	70	8	3	5	4	3	7	5	3	2	4	10	6	60	86%	
Duration outreaches (hours)	Annually	95	5.4	6.8	3.3	6.3	6.6	4.8	6.5	13.8	5.2	4.25	6.75	6.7	76	80%	
Total # Outreaches (times connecting w/ clients)	Annually	340	27	19	21	17	19	16	17	12	12	13	20	25	218	64%	
Indicators																	
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%	

"4M's" Arrive Together Collaboration																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
Co-Response Outreach (Law Enf. & MHAEM)																
Number of face to face co-responses	Monthly	80	43	40	39	52	33	48	16	31	48	32	35	33	450	563%
Hours Co-Responding	Monthly	68	37.25	31	30.25	55.25	26.5	31.75	13	24.75	44.5	30.5	29	33.5	387	569%
Number of homeless outreaches	Monthly	50	12	1	0	0	0	0	0	0	0	0	1	2	16	32%
Number of referrals received for follow up	Monthly	360	46	45	47	39	39	43	40	30	40	48	34	39	490	136%
Co-Response/Follow Up Outcomes																
Arrest	Monthly	5	1	2	4	1	0	1	1	0	1	1	1	1	14	280%
Involuntary Transport to Hospital	Monthly	15	6	4	6	5	2	5	5	5	9	8	5	9	69	460%
Voluntary Transport to Hospital	Monthly	20	32	35	37	39	33	38	28	29	37	37	31	33	409	2045%
Resolved without Incident	Monthly	40	38	43	39	45	37	47	22	27	41	24	31	27	421	1053%
Co-Response/Follow Up Linkage Outcomes																
Declined linkages or future follow up	Monthly	<5	0	0	1	0	0	0	0	0	0	0	0	0	1	NA
Linked to MHA services	Monthly	20	0	3	1	4	1	1	1	2	2	2	2	0	19	95%
Linked to non-MHA mental health services	Monthly	10	0	5	3	10	9	12	4	2	2	4	6	2	59	590%
Linked to other services	Monthly	30	0	12	4	8	8	8	3	2	7	7	10	5	74	247%
Follow Up Outreach																
# People outreached to	Monthly	280	66	56	65	84	62	84	55	61	63	67	76	70	809	289%
Duration outreaches (hours)	Monthly	60	32.87	28.6	37.66	41.38	27.18	29.97	31.86	25.9	26.23	25.93	33.04	23.04	364	606%
# Outreaches	Monthly	450	103	85	110	138	126	135	112	102	104	109	134	121	1379	306%
Indicators																
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%

MHA4 - Arrive																	
Mental Health Association																	
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																	
Fiscal Year: 2026			2025						2026								
Topic/Issue Requesting Follow up																	
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%	
Co-Response Outreach (Law Enf. & MHAEM)																	
Number of face to face co-responses	Monthly	Baseline	8	5	9	10	6	7	6	8	6	8	4	6	83	NA	
Hours Co-Responding	Monthly	Baseline	9	5.75	9	9.92	6.75	10.25	6.5	11.75	12	15.75	5.75	10.25	113	NA	
Number of homeless outreaches	Monthly	Baseline	1	1	0	1	0	0	0	0	1	1	0	0	5	NA	
Number of referrals received for follow up	Monthly	Baseline	41	39	52	40	42	20	29	38	32	47	28	27	435	NA	
Co-Response/Follow Up Outcomes																	
Arrest	Monthly	Baseline	1	2	1	2	2	0	0	0	1	0	1	0	10	NA	
Involuntary Transport to Hospital	Monthly	Baseline	4	4	10	8	7	3	4	3	4	4	0	3	54	NA	
Voluntary Transport to Hospital	Monthly	Baseline	21	18	22	24	29	23	19	31	20	27	16	21	271	NA	
Resolved without Incident	Monthly	Baseline	22	19	24	15	14	20	12	12	12	23	15	12	200	NA	
Co-Response/Follow Up Linkage Outcomes																	
Declined linkages or future follow up	Monthly	Baseline	0	0	0	0	0	0	0	0	0	0	0	0	0	NA	
Linked to MHA services	Monthly	Baseline	2	0	0	0	1	0	0	0	1	0	0	0	4	NA	
Linked to non-MHA mental health services	Monthly	Baseline	5	3	1	3	3	2	1	1	1	1	4	0	25	NA	
Linked to other services	Monthly	Baseline	8	2	1	6	5	3	2	2	3	3	4	1	40	NA	
Follow Up Outreach																	
# People outreached to	Monthly	Baseline	48	56	42	71	54	54	51	52	45	56	45	27	601	NA	
Duration outreaches (hours)	Monthly	Baseline	21.07	26.38	14.46	31.4	15.48	19.22	20.34	19.56	27.65	24.12	23.88	11.8	255	NA	
# Outreaches	Monthly	Baseline	79	102	54	115	96	88	91	78	83	93	87	49	1015	NA	
Indicators																	
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%	
The Gathering Place - Community Wellness Center (Morris)																	
Mental Health Association																	
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																	
Fiscal Year: 2026			2025						2026								
Topic/Issue Requesting Follow up																	
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%	
# of unduplicated consumers served	Monthly	19	x	x	169	x	x	197	x	x	242	x	x	272	880	391%	
# of new consumer attendees served	Monthly	19	x	x	15	x	x	27	x	x	46	x	x	55	143	64%	
# of participants in peer support activities	Monthly	1016	x	x	154	x	x	110	x	x	147	x	x	1380	1791	15%	
# of participants in Wellness/Recovery activities	Monthly	325	x	x	137	x	x	212	x	x	272	x	x	880	1501	38%	
# of Community Outreach Activities	Monthly	114	x	x	29	x	x	59	x	x	66	x	x	82	236	17%	
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%	

Mobile Crisis Outreach Response Teams (MCORT) - Hudson																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
Dispatches																
Total number of dispatches received	Monthly	35	2	9	3	3	5	5	3	6	8	2	13	15	74	211%
Number of dispatches completed	Monthly	30	2	8	2	2	3	4	3	6	5	2	10	14	61	203%
Number of dispatches arrived within 1-hour	Monthly	35	2	9	3	3	4	5	2	6	4	2	9	13	62	177%
Number of dispatches arrived between 2-hours	Monthly	Baseline	0	0	0	0	1	0	1	0	1	0	1	1	5	NA
Number of dispatches arrived after 2-hours	Monthly	Baseline	0	0	0	0	0	0	0	0	0	0	0	0	0	NA
Number of dispatches during day shift	Monthly	12	1	4	1	3	2	1	2	2	2	1	3	8	30	250%
Number of dispatches during evening shift	Monthly	12	1	5	2	0	2	2	1	3	3	0	9	6	34	283%
Number of dispatches during overnight shift	Monthly	12	0	0	0	0	1	2	0	1	0	1	1	0	6	50%
Linkages/ Outcomes																
Number of referrals/linkages	Monthly	27	2	7	5	2	5	6	7	7	10	2	17	28	98	363%
Number of warm transfers	Monthly	20	1	5	5	2	5	6	7	6	10	1	16	24	88	440%
Number of dispatches resolved on site by MCORT	Monthly	30	2	8	3	2	3	5	3	6	5	1	10	14	62	207%
Number of dispatches requiring emergency services involvement	Monthly	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0%
Total number of individuals requiring transport	Monthly	5	0	0	1	2	1	0	1	1	3	1	4	3	17	340%
Follow up																
Total number of contacts requiring follow-up	Monthly	30	2	8	2	2	3	4	3	6	5	2	10	14	61	203%
Number of follow-up contacts attempted by phone	Monthly	20	7	16	3	4	7	12	37	32	38	8	69	86	319	1595%
Number of follow-up contacts achieved by phone	Monthly	13	4	13	3	3	7	7	33	27	33	3	54	58	245	1885%
Number of follow-up contacts attempted in-person	Monthly	25	2	6	4	1	6	7	9	10	11	0	22	13	91	364%
Number of follow-up contacts achieved in-person	Monthly	20	2	6	4	1	6	7	9	10	10	0	21	12	88	440%
Persons served																
Number of individuals served out of agency's designated region	Monthly	Baseline	0	0	0	0	0	0	0	1	0	0	0	0	1	NA
Average number of individuals served per 8-hour shift	Monthly	0.05	0.05	0.1	0.03	0.03	0.05	0.05	0.03	0.07	0.05	0.02	0.14	0.16	0	130%
Number of unique (unduplicated) consumers visited	Monthly	32	2	8	3	2	3	4	3	6	5	2	10	14	62	194%
Number of dispatches requiring consultation from a Master's Level Supervisor	Monthly	5	1	0	0	0	0	1	1	1	0	1	1	2	8	160%
Number of dispatches resulting in higher level of service within 72 hours after the initial MCORT contact	Monthly	3	0	0	0	0	0	0	1	1	0	1	1	2	6	200%
Indicators																
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	93%

Mobile Crisis Outreach Response Teams (MCORT) - Essex																
Mental Health Association																
MASTER UTILIZATION REVIEW/QUALITY ASSURANCE TRACKING CALENDAR																
Fiscal Year: 2026			2025						2026							
Topic/Issue Requesting Follow up																
	Monitoring	Threshold	JULY	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	TOTALS	%
Dispatches																
Total number of dispatches received	Monthly	35	5	12	15	5	9	14	8	10	16	20	19	17	150	429%
Number of dispatches completed	Monthly	35	4	9	10	5	8	14	8	9	15	19	15	17	133	380%
Number of dispatches arrived within 1-hour	Monthly	35	5	12	13	5	7	13	8	8	14	19	13	14	131	374%
Number of dispatches arrived between 2-hours	Monthly	Baseline	0	0	0	0	2	1	0	1	1	0	2	3	10	NA
Number of dispatches arrived after 2-hours	Monthly	Baseline	0	0	1	0	0	0	0	0	0	0	0	0	1	NA
Number of dispatches during day shift	Monthly	32	3	7	7	2	2	7	4	6	8	8	9	7	70	219%
Number of dispatches during evening shift	Monthly	3	1	3	2	1	1	5	3	4	7	9	8	9	53	1767%
Number of dispatches during overnight shift	Monthly	Baseline	1	0	7	2	6	2	1	0	0	2	2	1	24	NA
Linkages/ Outcomes																
Number of referrals/linkages	Monthly	32	4	9	16	8	17	25	16	11	22	31	22	26	207	647%
Number of warm transfers	Monthly	32	3	6	13	6	13	25	15	10	21	30	19	25	186	581%
Number of dispatches resolved on site by MCORT	Monthly	30	4	9	10	5	8	14	8	10	14	1	15	17	115	383%
Number of dispatches requiring emergency services involvement	Monthly	3	0	0	0	0	0	0	0	0	1	0	0	0	1	33%
Total number of individuals requiring transport	Monthly	5	2	3	3	1	0	1	1	1	1	2	3	3	21	420%
Follow up																
Total number of contacts requiring follow-up	Monthly	32	4	9	10	5	8	14	8	9	15	19	15	17	133	416%
Number of follow-up contacts attempted by phone	Monthly	16	12	34	22	10	33	37	48	35	46	64	56	77	474	2963%
Number of follow-up contacts achieved by phone	Monthly	20	6	21	14	10	26	34	36	29	31	44	34	56	341	1705%
Number of follow-up contacts attempted in-person	Monthly	25	6	6	10	6	9	19	15	6	15	28	16	22	158	632%
Number of follow-up contacts achieved in-person	Monthly	27	6	6	9	5	8	18	12	6	13	26	15	22	146	541%
Persons served																
Number of individuals served out of agency's designated region	Monthly	3	0	0	1	1	1	1	2	1	6	5	6	5	29	967%
Average number of individuals served per 8-hour shift	Monthly	0.15	0.05	0.1	0.17	0.05	0.1	0.15	0.09	0.12	0.16	0.21	0.2	0.19	0	88%
Number of unique (unduplicated) consumers visited	Monthly	35	4	9	13	5	8	14	8	9	15	19	14	16	134	383%
Number of dispatches requiring consultation from a Master's Level Supervisor	Monthly	5	0	0	1	1	0	1	1	0	1	4	3	2	14	280%
Number of dispatches resulting in higher level of service within 72 hours after the initial MCORT contact	Monthly	Baseline	0	0	0	0	0	0	1	0	0	4	3	2	10	NA
Indicators																
Community Provider Survey	Annually	80%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93%	NA	93%

MENTAL HEALTH ASSOCIATION
PERFORMANCE INDICATORS: FY 2026

PLAN FOR OUTCOME MEASURES
July 1, 2025 – June 30, 2026

PROGRAMS AND INDICATORS:

AGENCY-WIDE	OUTCOMES: FY2025
<u>Efficiency:</u> Staff turnover is monitored. This agency is committed to reducing turnover and increasing staff retention through staff recognition, staff development, communication, organizational culture, and improvements of working conditions and benefits. The Director of Human Resources tracks voluntary turnover rates monthly per program and in the aggregate. FY2025: 2.0% average monthly turnover rate	<u>Annually:</u> voluntary staff turnover ≤ 25% 27% annual voluntary turnover rate 2.0% average monthly turnover rate
<u>Staff Satisfaction:</u> Annually, staff completes a Satisfaction Survey in June. MHA believes that staff satisfaction correlates with staff turnover. Expected measures of this indicator include an increased number of respondents and maintained or increased levels of satisfaction. FY2025: 96% satisfaction and response rate of 81%	<u>Annually:</u> satisfaction rate ≥90%; percentage of staff respondents 40% 94% satisfaction and response rate of 85%
<u>Community Agency Satisfaction:</u> Annually, this agency conducts a survey of community providers who refer clients, collaborate with staff, or to whom staff refer clients and collaborate. Results of this survey provide information regarding community needs, service assessment and collaborative efforts, marketing needs, professional reputation and relationship to providers. FY2025: 98% satisfaction rate	83% satisfaction and increased response rate: annual: 98% satisfaction rate
<u>Access:</u> MHA has programs throughout Essex, Morris, Sussex and Passaic counties. The agency provides Community Support Services throughout Essex and Morris counties. Staff deliver services in Montclair schools and the surrounding areas. The agency has offered Psycho-Ed sessions throughout Essex, Morris, Sussex and Passaic counties. FY2025: over 20,000 consumers received services from MHA	MHA will provide services to 5000 consumers annually Over 20,000 consumers received services from MHA
<u>Effectiveness:</u> MHA is contracted with the NJDMHAS to provide service commitments annually for deficit funded programs, with a 90% commitment achievement rate. FY2025: 54% was the lowest number achieved	90% commitment achievement rate for all programs contracted with NJDMHAS: quarterly: 78% was the lowest number achieved

MENTAL HEALTH ASSOCIATION

PERFORMANCE INDICATORS: FY 2026

PLAN FOR OUTCOME MEASURES

July 1, 2025 – June 30, 2026

PROGRAMS AND INDICATORS:

ASSISTED OUTPATIENT TREATMENT (AOT)

OUTCOMES: FY2025

Access: 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 on off hours.

FY2025: Essex: Screening: 0 referral; STCF: 48 referrals; LTC: 14 referrals; Morris: Screening: 0 referral; STCF: 13 referrals; LTC: 9 referrals; Sussex: Screening: 2 referral; STCF: 13 referrals; LTC: 1 referral

Monthly: Essex: 1 Screening Referrals; 7 STCF Referrals; 3 LTC Referrals
Morris: 1 Screening Referrals; 7 STCF Referral; 3 LTC Referrals
Sussex: 1 Screening Referrals; 7 STCF Referrals; 3 LTC Referrals
Essex: Screening: 0 referral; STCF: 96 referrals; LTC: 0 referrals
Morris: Screening: 0 referral; STCF: 23 referrals; LTC: 9 referrals
Sussex: Screening: 2 referral; STCF: 13 referrals; LTC: 1 referral

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

FY2025: Essex: 84% of the charts were compliant
Morris: 100% of charts were compliant
Sussex: 100% of charts were compliant

Quarterly: ≥80% chart compliance
Essex: 92% of the charts were compliant
Morris: 80% of charts were compliant
Sussex: 83% of charts were compliant

Effectiveness: AOT measures the recidivism rates to ensure quality of services and outcomes via court ordered treatment on a monthly basis; these statistics are then calculated yearly. Recidivism is defined as any instance of hospitalization visits including ER (screening) visits, psychiatric admissions including involuntary, voluntary, long term care, and arrests, incarceration, and homelessness.

FY2025: Essex: 21 clients enrolled went to a local ER for screening, 2 clients enrolled were admitted to Long Term Care, 2 client enrolled was arrested, 2 clients enrolled was incarcerated, 10 clients enrolled were voluntarily hospitalized, 2 clients enrolled were homeless
Morris: 11 clients enrolled went to a local ER for screening, 2 clients enrolled were admitted to Long Term Care, 1 client enrolled was arrested, 1 client enrolled was incarcerated, 9 clients enrolled were voluntarily hospitalized, 3 clients enrolled were homeless
Sussex: 14 clients enrolled went to a local ER for screening, 0 client enrolled were admitted to Long Term Care, 3 clients enrolled was arrested, 2 clients enrolled was incarcerated, 6 clients enrolled were voluntarily hospitalized., 7 clients enrolled was homeless

Monthly: Essex: < 6 ER Admissions; < 3 Voluntary Admissions; < 2 Involuntary Admissions; < 3 LTC Admissions; < 3 Arrested; < 3 Incarcerated; < 3 Homeless
Morris: ≤ 4 ER Admissions;
≤ 2 Voluntary Admissions; ≤ 2 Involuntary Admissions; ≤ 2 LTC Admissions;
≤ 2 Arrested; ≤ 2 Incarcerated; ≤ 2 Homeless
Sussex: ≤ 3 ER Admissions;
≤ 1Voluntary Admissions; ≤ 1Involuntary Admissions; ≤ 2 LTC Admissions;
≤ 1 Arrested; ≤ 1 Incarcerated; ≤ 1 Homeless
Essex: 10 clients enrolled went to a local ER for screening, 2 clients enrolled were admitted to Long Term Care, 6 clients enrolled was arrested, 2 clients enrolled was incarcerated, 10 clients enrolled were voluntarily hospitalized, 0 clients enrolled were homeless
Morris: 21 clients enrolled went to a local ER for screening, 5 clients enrolled were admitted to Long Term Care, 6 clients enrolled was arrested, 0 clients enrolled was incarcerated, 14 clients enrolled were voluntarily hospitalized, 5 clients enrolled were homeless
Sussex: 15 clients enrolled went to a local ER for screening, 2 clients enrolled were admitted to Long Term Care, 2 clients enrolled was arrested, 1 client enrolled was incarcerated, 3 clients enrolled were voluntarily hospitalized., 6 clients enrolled was homeless

Satisfaction: AOT implements an annual satisfaction survey of AOT consumers. Consumer responses are then recorded and analyzed for trends.

FY2025: Essex: 100% satisfactory rate; Morris: 100% satisfactory rate; Sussex: 100% satisfactory rate

Measured: Annually
≥85%
Essex: 100% satisfactory rate; Morris: 100% satisfactory rate; Sussex: 100% satisfactory rate

MENTAL HEALTH ASSOCIATION

PERFORMANCE INDICATORS: FY 2026

PLAN FOR OUTCOME MEASURES
July 1, 2025 – June 30, 2026

PROGRAMS AND INDICATORS:

CENTER FOR BEHAVIORAL HEALTH	OUTCOMES: FY2025
<u>Access:</u> Wait for service and wait for assignment are indicators of standards of professionalism and operations. Thresholds of performance are ≤5 business days between initial call and intake and between intake and assignment to service. <i>FY2025: 3.6 days wait for intake; 0 day wait for assignment</i>	<u>Annually:</u> ≤5 business days <i>3.6 days wait for intake; 0 day waits for assignment</i>
<u>Effectiveness:</u> CBH uses the DASS-21 Depression, Anxiety and Stress Scale designed to measure emotional status of depression, anxiety and stress. <i>FY2025: 85% of clients showed an average of 20% decrease in overall symptoms 6 months into treatment</i>	<u>Annually:</u> 80% of clients will show an average of 20% decrease in overall symptoms 6 months into treatment. The overall symptom score is a combined number of the individual depression, anxiety, and stress scores from the DASS-21 screening tool. <i>90% of clients showed an average of 20% decrease in overall symptoms 6 months into treatment</i>
<u>Client Satisfaction:</u> Annually, CBH conducts a survey of clients' satisfaction with responsiveness, services rendered, privacy, accessibility, perceived effectiveness of services. <i>FY2025: 95% satisfaction rate</i>	<u>Annually:</u> 80% satisfaction <i>95% satisfaction rate</i>
<u>Efficiency:</u> CBH utilizes a cancellation policy for all clients. After two missed appointments without providing 24-hour notice, the case is closed. CBH monitors productivity rate for clinicians and Medical Director. <i>FY2025: 90% productivity</i>	<u>Annually:</u> 90% Productivity <i>90% productivity reported</i>

MENTAL HEALTH ASSOCIATION

PERFORMANCE INDICATORS: FY 2026

PLAN FOR OUTCOME MEASURES
July 1, 2025 – June 30, 2026

PROGRAMS AND INDICATORS:

COLLABORATIVE JUSTICE SERVICES (CJS)	OUTCOMES: FY2025
<u>Effectiveness:</u> Community linkages. Clients' community reintegration can be measured by the number of linkages to local mental health programs and social organizations. <i>FY2025: Essex: 164 consumers were successfully linked to community services as outlined in their Individualized Service Plan.</i> <i>Morris: 106 linkages to mental health and social organizations.</i>	<u>Monthly:</u> 75 clients linked to community providers <i>Essex: 217 consumers were successfully linked to community services as outlined in their Individualized Service Plan</i> <i>Morris: 83 linkages to mental health and social organizations.</i>
<u>Effectiveness:</u> Recidivism to jail within 30 days. Successful linkages to community providers, in addition to successful integration to community living and needed social supports will result in lower rates of recidivism with incarceration within 30 days. <i>FY2025: Essex: 14 consumers returned to jail within 30 days throughout the fiscal year.</i> <i>Morris: 0 consumer returned to jail within 30 days throughout the fiscal year.</i>	<u>Monthly:</u> Less than 25 clients <i>Essex: 10 consumers returned to jail within 30 days throughout the fiscal year.</i> <i>Morris: 0 consumers returned to jail within 30 days throughout the fiscal year.</i>
<u>Effectiveness:</u> Recidivism to jail within 60 days. Successful linkages to community providers, in addition to successful integration to community living and needed social supports will result in lower rates of recidivism with incarceration within 60 days. <i>FY2025: Essex: 3 consumers returned to jail within 60 days throughout the fiscal year</i> <i>Morris: 0 consumers returned to jail within 60 days throughout the fiscal year</i>	<u>Monthly:</u> Less than 50 clients <i>Essex: 1 consumers returned to jail within 60 days for throughout the fiscal year.</i> <i>Morris: 0 consumers returned to jail within 60 days throughout the fiscal year</i>
<u>Efficiency:</u> CJS will decrease consumers' incarceration days by working with the consumer and the courts to develop an aftercare plan. <i>FY2025: Essex: Consumers decreased incarceration days by 22,293</i> <i>Morris: Consumers decreased incarceration days by 1,642</i>	Decrease incarceration days by 1000: <i>Essex: Consumers decreased incarceration days by 4,006</i> <i>Morris: Consumers decreased incarceration days by 364</i>
<u>Client Satisfaction:</u> Clients completed a survey that rates satisfaction with staff responsiveness, availability and linkages. This survey also measures the efforts made with different providers. <i>FY2025: Essex: 100% Satisfaction rate</i> <i>Morris: 100% Satisfaction rate</i>	<u>Annually:</u> 80% satisfaction <i>Essex: 100% Satisfaction rate</i> <i>Morris: 100% Satisfaction rate</i>
<u>Access:</u> Wait for Service: The target wait for intake and/or admission to the program is within 5 days. <i>FY2025: Essex: The average wait for service for intake and/or admission was 3 business days.</i> <i>Morris: The average wait for service for intake and/or admission was 3 business days.</i>	<u>Monthly:</u> Less than 5 days: monthly <i>Essex: The average wait for service for intake and/or admission was 3 business days.</i> <i>Morris: The average wait for service for intake and/or admission was 3 business days.</i>

MENTAL HEALTH ASSOCIATION
PERFORMANCE INDICATORS: FY 2026

PLAN FOR OUTCOME MEASURES
 July 1, 2025 – June 30, 2026

PROGRAMS AND INDICATORS:

COMMUNITY ADVOCACY PROGRAM/SOCIAL CLUB	OUTCOMES: FY2025
<u>Accessibility:</u> Community Advocacy Program /Social club ensure easy access of programs for all participants by having numerous groups available for participants. These groups include topics such as exercise group, community rides and all about you. The number of groups held annually in both programs provide indication of the accessibility for the community to attend these groups. FY2025: There were 2280 groups held.	<u>Annually:</u> 566 groups are expected There were 2487 groups held
<u>Efficiency:</u> Community Advocacy Program/Social Club ensures that all services are provided in highly efficient manner by tracking how quickly consumers obtain services. Wait for Service is a state and agency-generated indicator, which is based on high standards of professional practice. The first indicator measures the time elapsed from when a referral is received to first contact with consumer. FY2025: 1 day wait for service	<u>Quarterly:</u> ≤ 1 business days 1 day wait for service
<u>Effectiveness:</u> There are numerous types of groups offered by both Social Club and Community Advocacy Program. Feedback is provided for these programs utilizing several questions throughout the Consumer Satisfaction Survey distributed annually. Overall satisfaction of outcomes is based on responses to questions discussing if groups have introduced consumer to new low cost activities and new friends, improved self-image and increased independence in the community. FY2025: 100% satisfaction rate; 80% satisfaction rate with Social Club members	<u>Annually:</u> 90% consumer satisfaction rate with groups 100% satisfaction rate with Community Advocacy Program 100% satisfaction rate with Social Club members
<u>Satisfaction:</u> The MHAEM Quality Assurance Coordinator directly receives and analyzes response-data from annual consumer satisfaction questionnaires. FY2025: 94% satisfaction rate	<u>Annually:</u> 90% satisfaction among respondents 100% satisfaction rate

MENTAL HEALTH ASSOCIATION

PERFORMANCE INDICATORS: FY 2026

PLAN FOR OUTCOME MEASURES
July 1, 2025 – June 30, 2026

PROGRAMS AND INDICATORS:

COMMUNITY EDUCATION PROGRAM	OUTCOMES: FY2025
<u>Accessibility:</u> Community Education Program ensure easy access of programs for all participants by having numerous groups available for participants. These programs include Mental Health First Aid which provide indication of the accessibility for the community to attend these trainings. <i>FY2025: There were 17 trainings held.</i>	<u>Annually:</u> 4 groups are expected <i>There were 18 trainings held</i>
<u>Efficiency:</u> Community Education Program ensures that all services are provided in highly efficient manner by tracking how quickly community members obtain services. Wait for Service is a state and agency-generated indicator, which is based on high standards of professional practice. The indicator measures the time elapsed from when a referral is received to first contact with consumer. <i>FY2025: 1 day wait for service</i>	<u>Quarterly:</u> ≤ 2 business days <i>1 day wait for service</i>
<u>Effectiveness:</u> When the 8-hour Community Education Program course is completed, the participants are certified in Mental Health First Aid. The certification must be renewed every three years. The goal of the program is to be able to certify all participants in Mental Health First Aid as well as to help community members recognize signs of a mental health crisis and how to intervene. <i>FY2025: 100% of Participants received their certification</i>	<u>Annually:</u> 90% Completion Rate <i>100% of participants received their certification</i>
<u>Satisfaction:</u> The MHAEM Quality Assurance Coordinator directly receives and analyzes response-data from annual consumer satisfaction questionnaires. <i>FY2025: 99% satisfaction among respondents</i>	<u>Annually:</u> 90% satisfaction among respondents <i>99% satisfaction among respondents</i>

MENTAL HEALTH ASSOCIATION

PERFORMANCE INDICATORS: FY 2026

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July 1, 2025 – June 30, 2026

PROGRAMS AND INDICATORS: COMMUNITY SUPPORT SERVICES (CSS)	OUTCOMES: FY2025
<u>Effectiveness:</u> Employment: CSS measures employment rates as an indicator of community integration for consumers receiving services. Employment includes full and part-time competitive work, volunteer positions and educational programs. The availability of affordable housing and supportive services maximize these employment opportunities. This rate is statistically related to increases in resources and greater self-determination. FY2025: 10.5% employment rate	Quarterly: ≥10% employment 13% employment rate
<u>Effectiveness:</u> Recidivism: CSS monitors recidivism rates to ensure quality of services and outcomes on a monthly basis; these statistics are then compounded annually. Recidivism is defined as any instance of hospitalization for psychiatric purposes to a state/county hospital or short-term care facility. This rate is linked to quality of care. FY2025: 0.6% recidivism rate to County/State hospitals, 3% recidivism to Short Term Care Facilities	Monthly: ≤ 20% recidivism rate to psychiatric hospitals 0% recidivism rate to County/State hospitals 2.5% recidivism rate to Short Term Care Facilities
<u>Effectiveness:</u> Residential Stability: The main goal of a supportive housing program is to stabilize the residential circumstances of a vulnerable population. Effective services provided and appropriate housing opportunities correlate with tenant retention rates. FY2025: 99% of individuals remained in housing for 12 months	Monthly: ≥80% of tenants will maintain their housing for 12 months monitored through movement statistics 98.5% of individuals remained in housing for 12 months
<u>Efficiency:</u> Clinical Data: The use of the AWARDS program clinical database for CSS documentation allows for efficient and orderly clinical records. Also, through multiple report modules, supervisory staff is better able to track staff interventions and potential crises. AWARDS are utilized by the State of NJ for collection of HMIS data. FY2025: 90% of charts were complaint	Monthly: ≥80% chart compliance 90% of charts were compliant
<u>Access:</u> CSS is available 24 hours a day, including holidays and weekends, with the use of on-call support. In order to meet the unique needs of the individuals served, staff work a flexible schedule including hours on Saturday and Sunday. FY2025: 90% consumer satisfaction	Annually: ≥80% client satisfaction: monitored yearly 94% consumer satisfaction

MENTAL HEALTH ASSOCIATION

PERFORMANCE INDICATORS: FY 2026

PLAN FOR OUTCOME MEASURES
July 1, 2025 – June 30, 2026

PROGRAMS AND INDICATORS:

Community Wellness Centers (CWC)	OUTCOMES: FY2025
<u>Access:</u> The CWCs ensures easy access to the centers by meetings contract standards for operational days and hours in each center. The CWCs are open 5 days a week; including two late nights and one weekend day to promote relationships and convenience for the members. Operational days and hours are monitored to ensure access and convenience of services and outcomes on a monthly basis; these statistics are then compounded annually. <i>FY2025: Morris 874 hours/190; Sussex 844 hours/186</i>	<u>Annually:</u> 1152 hours/152 Days of operation <i>Morris: 1826 hours/300 days</i> <i>Sussex: 1777/301 days</i>
<u>Efficiency:</u> CWCs ensure that all services are provided in a highly efficient manner by how quickly community members obtain services. The indicator measures the time elapsed from when a referral is received to first contact. The Wellness Centers are a same day, walk in service that has no walk time for services and are open on later nights and weekends. <i>FY2025: Centers are opened after typical business hours on Mondays, Wednesday and Saturdays to meet the needs of member.</i>	<u>Annually:</u> 2 Weekday Evenings, 1 Weekend Day <i>Morris and Sussex: 149 weekdays, evenings and weekends</i>
<u>Effectiveness:</u> CWCs track effectiveness of the centers, staff and groups provided by tracking group attendance, which is encouraged but not mandated. Members who attend the center are welcome to any group or activity planned for the day of attendance or are able to participate in alternate activities, socializing with peers, or are given opportunities to lead activities of their own. Satisfied members of the Community Wellness Centers are members that attend frequently and are active participants in the center and all they have to offer. The Community Wellness Centers track the frequency of member's attendance through a duplicated count of visits to the center. In the CWC's first year in operation the centers were open only a portion of the year. <i>FY2025: Morris: 1883; Sussex: 2234</i>	<u>Annually:</u> Morris: 19,000; Sussex: 15,200 <i>Morris: 4783; Sussex: 6759</i>
<u>Satisfaction:</u> CWC teams analyze feedback given in weekly community empowerment meetings and on an ongoing basis with its Realtime surveys available to members and the community via the Wellness Centers and agency website. Staff are also available to assist members providing their feedback when they need that support. <i>FY2025: Morris: 100%; Sussex: 100%</i>	<u>Annually:</u> 90% Satisfaction Rate <i>Morris: 100%; Sussex: 100%</i>

MENTAL HEALTH ASSOCIATION

PERFORMANCE INDICATORS: FY 2026

PLAN FOR OUTCOME MEASURES
July 1, 2025 – June 30, 2026

PROGRAMS AND INDICATORS:

CRIMINAL JUSTICE REFORM (CJR) & MORRIS MENTAL HEALTH DIVERSION (MMHD)	OUTCOMES: FY2025
<u>Effectiveness:</u> Community linkages. Clients' community reintegration can be measured by the number of linkages to local mental health programs and social organizations. FY2025: CJR: 171 consumers were successfully linked to community services as outlined in their Individualized Service Plan MMHD: 289 linkages to mental health and social organizations	<u>Monthly:</u> 75 clients linked to community providers CJR: 69 consumers were successfully linked to community services as outlined in their Individualized Service Plan MMHD: 174 linkages to mental health and social organizations
<u>Effectiveness:</u> Recidivism to jail within 30 days. Successful linkages to community providers, in addition to successful integration to community living and needed social supports will result in lower rates of recidivism with incarceration within 30 days. FY2025: CJR: 0 consumers returned to jail within 30 days throughout the fiscal year MMHD: 0 consumer returned to jail within 30 days throughout the fiscal year	<u>Monthly:</u> Less than 25 clients CJR: 0 consumers returned to jail within 30 days throughout the fiscal year MMHD: 0 consumer returned to jail within 30 days throughout the fiscal year
<u>Effectiveness:</u> Recidivism to jail within 60 days. Successful linkages to community providers, in addition to successful integration to community living and needed social supports will result in lower rates of recidivism with incarceration within 60 days. FY2025: CJR: 2 consumer returned to jail within 60 days throughout the fiscal year MMHD: 0 consumer returned to jail within 60 days throughout the fiscal year	<u>Monthly:</u> Less than 25 clients CJR: 0 consumers returned to jail within 60 days throughout the fiscal year MMHD: 0 consumer returned to jail within 30 days throughout the fiscal year
<u>Efficiency:</u> MMHD will decrease consumers' incarceration days by working with the consumers and the courts to develop an aftercare plan/CJR will facilitate case dismissals FY2025: MMHD: Consumers decreased incarceration days by 10,950 CJR: 15 total case dismissals	MMHD Decrease incarceration days by 1000: MMHD: Consumers decreased incarceration days by 10,45,615 CJR will facilitate case 10 case dismissals: CJR: 55 total case dismissals
<u>Client Satisfaction:</u> Clients completed a survey that rates satisfaction with staff responsiveness, availability and linkages. This survey also measures the efforts made with different providers FY2024: CJR: 100% satisfaction rate MMHD: 100% satisfaction rate	80% satisfaction rate: annual CJR: 100% satisfaction rate MMHD: 100% satisfaction rate
<u>Access:</u> Wait for Services. The target wait for intake and/or admission to the programs within 5 days FY2024: CJR: the average wait for service for intake and/or admission was 0 days MMHD: the average wait for services for intake and/or admission was 3 days	<u>Monthly:</u> Less than 5 days wait for intake and/or admission CJR: the average wait for service for intake and/or admission was 0 days MMHD: the average wait for services for intake and/or admission was 3 days

MENTAL HEALTH ASSOCIATION
PERFORMANCE INDICATORS: FY 2026

PLAN FOR OUTCOME MEASURES
July 1, 2025 – June 30, 2026

PROGRAMS AND INDICATORS:

CULTURAL COMPETENCY	OUTCOMES: FY2025
<u>Consumer Satisfaction:</u> MHA ensures that services are provided in a culturally competent manner to all consumers and family members, including those with limited English proficiency. MHA's Quality Assurance Coordinator directly receives, documents and response to all grievances. Quality Assurance Coordinator also ensures satisfaction surveys are distributed, reviewed and analyzed annually <i>FY2025: 0 cultural competency grievances reported; 91% satisfaction rate</i>	Annually: MHA will receive less than 2 cultural competence grievances <i>0 cultural competence grievances reported</i> Annually: 95% satisfaction rate on consumer and family survey <i>91% satisfaction rate</i>
<u>Effectiveness:</u> MHA staff provide services to all consumers and family members regardless of their ages, cultures, race, ethnicity, or religion. To support this, MHA Quality Assurance Director reviews the demographic profile of service areas to ensure MHA reflects the communities it serves. Cultural Competency, Diversity and Inclusion Committee Chair reviews and updates the staff language bank quarterly <i>FY2025: 100% of demographics profiles of the service area reviewed; language lists were reviewed, updated and distributed quarterly</i>	<u>Annually:</u> 100% of demographic profiles of the service areas will be reviewed <i>100% reviewed</i> <u>Quarterly:</u> Staff language list will be reviewed, updated and distributed <i>Language list were reviewed, updated and distributed quarterly</i>
<u>Efficiency:</u> MHA ensures that staff are educated in cultural competency to better serve consumers and family members. MHA conducts cultural competency trainings through a web-based system during initial orientation and annually thereafter. Through these trainings and annual cultural competence events, staff become more culturally sensitive and competent when providing services to consumers and family members <i>FY2025: 100% of staff received Cultural Diversity training; 100% of staff received educational information via email from Cultural Competence Committee quarterly.</i>	<u>Annually:</u> 100% of staff will receive Cultural Diversity training <i>100% of staff received Cultural Diversity training</i> <u>Quarterly:</u> Cultural Competency, Diversity and Inclusion Committee will distribute educational information to 100% of staff <i>100% of staff received educational information via email from the Cultural Competency, Diversity and Inclusion Committee quarterly</i> <u>Annually:</u> MHA will hold a Cultural Competence event to educate staff about different cultures <i>MHA held its 18th Annual Multicultural Potluck</i>
<u>Access:</u> MHA recognizes the importance of communicating with consumers and family members in their preferred language. MHA provides agency literature, promotional brochures and agency forms that are culturally relevant and available in various languages <i>FY2025: 100% of agency literature, brochures and forms were reviewed and were found relevant</i>	<u>Annually:</u> 100% of agency literature, brochures and forms will be reviewed for cultural relevance <i>100% of agency literature, brochures and forms were reviewed and were found relevant</i>

MENTAL HEALTH ASSOCIATION

PERFORMANCE INDICATORS: FY 2026

PLAN FOR OUTCOME MEASURES
July 1, 2025 – June 30, 2026

PROGRAMS AND INDICATORS:

HEALTH HOME (CARE COORDINATION)	OUTCOMES: FY2025
<u>Effectiveness:</u> Health: Research has shown that individuals diagnosed with a mental illness have a shortened life span due to untreated preventable diseases. Through care coordination, a holistic approach will be utilized to ensure that appropriate services are identified and appointments are scheduled and maintained. Through regular medical checkups, individuals' physical health will improve as evidence by BMI, vitamin D, glucose and blood pressure levels being within normal range. <i>FY2025: BMI- average of 35% within normal range; vitamin D- average of 58% within normal range; glucose level-average of 66% within normal range; blood pressure-avg. of 61% within normal range</i>	<u>Annually:</u> An increase of 20% of individuals will be within normal range in the areas of BMI, Vitamin D, Glucose level and blood pressure <i>BMI- average of 38% within normal range; vitamin D- average of 49% within normal range; glucose level-average of 63% within normal range; blood pressure-avg. of 63% within normal range</i>
<u>Efficiency:</u> Service Utilization: Care Coordination promotes the integration of behavioral and physical health services through the use of MHA's on-site medical services and/or external services. Care Coordination will enhance the likelihood of individuals' utilizing medical attention. <i>FY2025: 206 visits were made to MHA's Prospect Primary Care on-site. 94% of consumers throughout the agency have identified a medical provider</i>	<u>Annually:</u> Care Coordination will increase physician visits by 20% <i>198 visits were made to MHA's Prospect Primary Care on-site. 96% of consumers throughout the agency have identified a medical provider</i>
<u>Access:</u> Wait for service is a measure of efficiency and indicates standards of professionalism and operations. Access to MHA programs are monitored by the time taken to set a first or subsequent appointment once referral is made. <i>FY2025: 0 business days</i>	<u>Monthly:</u> ≤5 business days: <i>0 business days</i>
<u>Client Satisfaction:</u> Annually, MHA programs conduct a survey of clients' satisfaction with responsiveness, services rendered, privacy, accessibility, perceived effectiveness of services. <i>FY2025: 99% satisfaction rate</i>	<u>Annually:</u> 80% overall satisfaction rate: <i>94% satisfaction rate</i>

MENTAL HEALTH ASSOCIATION

PERFORMANCE INDICATORS: FY 2026

PLAN FOR OUTCOME MEASURES
July 1, 2025 – June 30, 2026

PROGRAMS AND INDICATORS:

INTEGRATED CASE MANAGEMENT SERVICES (ICMS)	OUTCOMES: FY2025
<u>Access:</u> Clients discharged from county and state psychiatric hospitals are seen within 72 hours of discharge. FY2025: Essex/Morris: 100% of consumers were seen within 72 hours of discharge Passaic: 100% of consumers were seen within 72 hours of discharge	<u>Annually:</u> 80% compliance: monthly monitoring Essex: 100% of consumers were seen within 72 hours of discharge Morris: 100% of consumers were seen within 72 hours of discharge Passaic: 100% of consumers were seen within 72 hours of discharge
<u>Effectiveness:</u> Recidivism rates among ICMS clients are tracked and monitored as a benchmark of effective reduction in re-hospitalization rates at county and state psychiatric hospitals. Tracked monthly and aggregated annually, rates of recidivism are expected to occur for less than 20% of the active caseload, per year. FY2025: Essex/Morris: 5% recidivism to all hospitals; 1% to state and county hospital; 4% to community hospitals; 2% to short term care facilities Passaic: 0% recidivism to all hospitals; 1% to state and county hospital; 1% to community hospitals; 0% to short term care facilities	<u>Annually:</u> ≤20% monthly monitoring, annual aggregate Essex: 4% recidivism to all hospitals; 1% to State and county hospital; 1% to community hospitals; 2% to short term care facilities. Morris: 2% recidivism to all hospitals; 0% to state and county hospital; 1% to community hospitals; 1% to short term care facilities. Passaic: 4% recidivism to all hospitals; 1% to state and county hospital; 1% to community hospitals; 2% to short term care facilities
<u>Effectiveness:</u> In reviewing employment rates, nationally and within New Jersey among PACT and ICMS clients, this program seeks to target 62 of its clients toward employment, including volunteer work, supported employment, part-time and full-time. FY2025: Essex: 16% consumers from the active caseload were employed; Morris: 7% consumers from the active caseload were employed; Passaic: 19% consumers from the active caseload were employed	<u>Annually:</u> 15% of case load employed: yearly Essex: 16% of consumers from the active caseload were employed Morris: 7% of consumers from the active caseload were employed Passaic: 19% of consumers from the active caseload were employed
<u>Client Satisfaction:</u> Clients are surveyed for satisfaction with staff responsiveness and availability, treatment participation and progress, and collaborative efforts. FY2025 :Essex/Morris/Passaic: overall satisfaction was 95%	<u>Annually:</u> 80% satisfaction Essex/Morris/Passaic: overall satisfaction was 99%
<u>Efficiency:</u> Continued stay rates among ICMS clients are tracked and monitored as a benchmark of efficiency, reduction in clients remaining on the active caseload. Rates are based on six- and eighteen-months' length of stay. This process saves time, money and gives clients a chance to be more independent. This is tracked monthly and aggregated annually, rates of continued stay are expected to occur less than 10% of the active caseload, per year. FY2025: Essex/Morris: 100% required continued stay; 100% Justified continued stay. Passaic: 100% required continued stay; 100% Justified continued stay	<u>Quarterly:</u> 10% of caseload will require continued stay Essex/Morris: 100% required continued stay; 100% Justified continued stay Passaic: 100% required continued stay; 100% Justified continued stay

MENTAL HEALTH ASSOCIATION
PERFORMANCE INDICATORS: FY 2026

PLAN FOR OUTCOME MEASURES
July 1, 2025 – June 30, 2026

PROGRAMS AND INDICATORS:

INTENSIVE FAMILY SUPPORT SERVICES (IFSS)	OUTCOMES: FY2025
<u>Accessibility:</u> IFSS ensures easy access of services for all family members by having professional staff on-call 24 hours a day, every day of the year, including holidays. Families can request services through phone calls or through the NAMI-IFSS or MHAEM website. The ease of a family's accessibility to IFSS services will be measured by their specific response to question #5 on the IFSS questionnaire which asked if families were seen quickly enough when requesting services, and question #1 which asked if it was easy to find out about this program. <i>FY2025: Essex: 100% felt IFSS services were accessible</i> <i>Sussex: 100% felt IFSS services were accessible</i>	<u>Annually:</u> ≥ 90% felt IFSS services were accessible <i>Essex: 100% felt IFSS services were accessible</i> <i>Sussex: 100% felt IFSS services were accessible</i>
<u>Efficiency:</u> IFSS ensures that all services are provided in a highly efficient manner by tracking how quickly families obtain services. Wait for Service is a state and agency-generated indicator, which is based on high standards of professional practice. The first indicator measures the time elapsed from when a referral is received to first clinical contact with client. The second indicator measures the time elapsed from the first initial contact to a scheduled intake date. This ensures that all program services are provided in a highly efficient manner to meet the emergent needs of all program clients. <i>FY2025: Essex: <2 wait for service; <5 days wait for intake;</i> <i>Sussex: <0-day wait for service; <1 days wait for intake</i>	<u>Quarterly:</u> ≤ 5 business days <i>Essex: <1 days wait for service;</i> <i><2 days wait for intake</i> <i>Sussex: <0 day wait for service;</i> <i><1 days wait for intake</i>
<u>Effectiveness:</u> The Family Concerns Scale (formerly the Family Burden Scale) measures effectiveness and impact of services on family stress. This indicator is NJDMHAS mandated; a 24 item standardized burden questionnaire is administered upon admission, at six months, and then annually, to all IFSS families. Expected outcome of successful service is a general reduction of family stress (burden) as reported by family-respondents. <i>FY2025: Essex:13% reduction in levels of stress/burden reported by families;</i> <i>Sussex: 7% reduction in levels of stress/burden reported by families.</i>	<u>Semi-Annually:</u> semi-annually through pre and post-tests; ≥10% reduction in stress/burden <i>Essex: IFSS families reported 28% reduction in levels of stress/burden.</i> <i>Sussex: IFSS families reported 13% reduction in levels of stress/burden</i>
<u>Satisfaction:</u> An independent Family Advisory Committee records and analyzes response-data from annual family satisfaction questionnaires. The 10 item survey is standardized and mandated by NJDMHAS for IFSS programs. <i>FY2025: Essex: 100% overall satisfaction</i> <i>Sussex: 100% overall satisfaction</i>	<u>Annually:</u> threshold of achieving 90% satisfaction among respondents <i>Essex: 100% overall satisfaction</i> <i>Sussex: 100% overall satisfaction</i>

MENTAL HEALTH ASSOCIATION
PERFORMANCE INDICATORS: FY 2026

PLAN FOR OUTCOME MEASURES
 July 1, 2025 – June 30, 2026

PROGRAMS AND INDICATORS:

MOBILE CRISIS OUTREACH RESPONSE TEAMS (MCORT)	OUTCOMES: FY2026
<u>Access:</u> MCORT provides 24/7 access to crisis response services to ensure individuals can receive support at any time, day or night. The team maintains continuous on-call and dispatch coverage, with staff available to respond to calls for service around the clock, including nights, weekends, and holidays. Access and coverage schedules are reviewed regularly to identify and address any gaps in availability. We can measure our success and effectiveness at MCORT by tracking the percentage of hours per month that 24/7/365 crisis response coverage was successfully maintained. <i>FY2025: Baseline</i>	<u>Annually:</u> 100% access to 24/7 crisis response services <i>100% of the time MCORT maintained 24/7/365 coverage</i>
<u>Efficiency:</u> Sum of minutes from dispatch to on-scene arrival is monitored. MCORT is committed to minimizing response time and ensuring timely arrival to calls for service through appropriate staffing levels, efficient dispatch procedures, route planning, and use of available technology. Average response time is tracked monthly to identify and address any trends or delays that may impact service delivery. <i>FY2025: Baseline</i>	<u>Annually:</u> Less than an average of 60 mins from dispatch to on-scene arrival <i>43 mins average from dispatch to on-scene arrival</i>
<u>Effectiveness:</u> MCORT utilizes crisis intervention and stabilization strategies to divert individuals from unnecessary emergency services. The team assesses each individual's level of risk and connects them to the least restrictive, most appropriate level of care, including community-based supports, outpatient services, and crisis stabilization resources. We can measure our success and effectiveness at MCORT by the number of dispatches requiring emergency services involvement during the measurement period. <i>FY2025: Baseline</i>	<u>Monthly:</u> 90% of dispatches by MCORT handled without law enforcement or EMS involvement <i>100% of MCORT dispatches were handled without law enforcement or EMS involvement</i>
<u>Client Satisfaction:</u> MCORT conducts a survey of clients' satisfaction with responsiveness, services rendered, perceived effectiveness of services <i>FY2025: Baseline</i>	<u>Annually:</u> 80% overall satisfaction rate <i>95% overall satisfaction rate</i>

MENTAL HEALTH ASSOCIATION
PERFORMANCE INDICATORS: FY 2026

PLAN FOR OUTCOME MEASURES
July 1, 2025 – June 30, 2026

PROGRAMS AND INDICATORS:

NEW JERSEY STATE WIDE STUDENT SUPPORT SERVICES (NJ4S)	OUTCOMES: FY2025
<u>Accessibility:</u> NJ4S ensures easy access of programs for all participants by offering numerous services. These services focus on community education, prevention programming in schools or brief counseling. Using multimedia platforms, the community is made aware of the programs and presentations offered. Services are tailored to the needs of the organization or school hosting the service, including topic, location and the delivery method. For example, through Zoom, and YouTube. The number of groups held annually provides indication of the community's accessibility to these presentations. FY2025: Tier 1 presentation: 373; Tier 2 presentation: 118; Total: 691 presentations	<u>Annually:</u> 200 presentations Tier 1 presentation: 463 Tier 2 presentation: 57 Total: 520 presentations
<u>Efficiency:</u> The NJ4S program ensures that services are delivered efficiently by measuring how quickly community members obtain them. The indicator tracks the time elapsed from when an application is received to first contact. Requests for information are made via email or through the Department of Children and Families online portal. FY2025: < 1 business day	<u>Quarterly:</u> 90% of requests for information will be returned in 2 business days < 1 business day
<u>Effectiveness:</u> After each presentation, questionnaires and one-to-one discussions are utilized to collect feedback on the learning experience. This approach measures the knowledge and skills gained by participants as a result of the training. FY2025: 88% gained knowledge	<u>Quarterly:</u> 85% of participants will gain knowledge of the topic 91% gained knowledge
<u>Satisfaction:</u> The NJ4S Data Analysis team directly receives and analyzes response data from surveys collected after each presentation. FY 2025: 91% satisfaction among 2821 survey respondents	<u>Semi-Annually:</u> 85% overall satisfaction among respondents 87% satisfaction were satisfied with the presentation

MENTAL HEALTH ASSOCIATION
PERFORMANCE INDICATORS: FY 2026

PLAN FOR OUTCOME MEASURES
July 1, 2025 – June 30, 2026

PROGRAMS AND INDICATORS:

PROJECTS FOR ASSISTANCE IN TRANSITION FROM HOMELESSNESS (PATH)	OUTCOMES: FY2025
<u>Access:</u> PATH conducts regular outreach in the community to ensure homeless individuals and those at-risk of homelessness have access to PATH services. Whether at a local drop-in center, soup kitchen or under a bridge; PATH provides services throughout Essex and Morris counties. <i>FY2025: Essex: PATH outreached 503 homeless or at imminent risk of homelessness consumers.</i> <i>Morris: PATH outreached 168 homeless or at imminent risk of homelessness consumers</i>	<u>Annually:</u> Essex: 500 Outreaches <i>Essex: 5439 consumers were outreached</i> <i>Morris: PATH outreached 198 homeless or at imminent risk of homelessness consumers</i>
<u>Efficiency:</u> To be considered eligible for PATH services, consumer must be diagnosed with severe and persistent mental illness and/or co-occurring substance use disorders and be homeless or at imminent risk of homelessness. Of all consumers outreached by PATH staff, eligible consumers should be enrolled in PATH services and provided with linkages to temporary and permanent housing, mental health, substance use and medical/dental treatment, financial services, as well as, habilitation/employment assistance. <i>FY2025: Essex: 237 homeless consumers were enrolled in the PATH Program and were provided linkages to needed resources</i> <i>Morris: 114 homeless consumers were enrolled in the PATH Program and were provide linkages to needed resources</i>	<u>Annually:</u> Essex: 200 Individuals to be served <i>Essex: 131 consumers were served</i> <i>Morris: 96 homeless consumers were enrolled in the PATH Program and were provided linkages to needed resources</i>
<u>Effectiveness:</u> PATH monitors successful linkages of consumers in the community. It is the goal of the PATH Program to provide services to consumers who might otherwise not engage in mainstream services. Getting consumers off the streets and into temporarily shelters allows them to focus on their mental and physical health needs and effectively paves the way toward ending their homelessness. <i>FY2025: Essex: 40 Consumers were successfully linked to Temporary Housing (shelter).</i> <i>Morris: 46 Consumers were successfully linked to Temporary Housing (Shelter)</i>	<u>Annually:</u> Essex: 35 Consumers linked to Temporary Housing <i>Essex: 33 consumers linked</i> <i>Morris: 39 Consumers were successfully linked to Temporary Housing (Shelter)</i>
<u>Effectiveness:</u> Ending a consumer's homelessness and setting them up for future success is crucial when working with the homeless population. <i>FY2025: Essex: 50 Consumers successfully linked to safe, affordable, permanent housing</i> <i>Morris: 33 Consumers were successfully linked to safe, affordable permanent housing</i>	<u>Annually:</u> Essex: 40 Consumers linked to Permanent Housing <i>Essex: 53 consumers linked</i> <i>Morris: 36 Consumers were successfully linked to safe, affordable permanent housing</i>
<u>Satisfaction:</u> PATH enrollees are surveyed annually regarding their satisfaction with being treated with dignity and respect, staff prioritizing treatment participation and ending homelessness, and meeting self-identified basic needs. <i>FY2025: Essex: overall consumer satisfaction was 100%</i> <i>Morris: overall consumer satisfaction was 100%</i>	<u>Annually:</u> Essex: 80% Satisfaction Rate <i>Essex: overall consumer satisfaction was 100%</i> <i>Morris: overall consumer satisfaction was 91%</i>

MENTAL HEALTH ASSOCIATION

PERFORMANCE INDICATORS: FY 2026

PLAN FOR OUTCOME MEASURES
July 1, 2025 – June 30, 2026

PROGRAMS AND INDICATORS:

PROSPECT HOUSE (PH)	OUTCOMES: FY2025
<u>Effectiveness:</u> In an effort to decrease psychiatric crises, PH aims to have medical staff on-site 5 days per week <i>FY2025: Medical staff on-site 5 days per week</i>	<u>Annually:</u> Medical staff on-site: 5 days per week: annual <i>Medical staff on-site 5 days per week</i>
<u>Effectiveness:</u> Employment: Through partial care pre-vocational skills training, members will obtain the skills needed to gain employment through volunteer work, part-time or full-time employment <i>FY2025: 15% of members gained employment</i>	<u>Quarterly:</u> ≥15% <i>15% of members gained employment</i>
<u>Efficiency:</u> Clinical Data: The use of the AWARDS clinical database for PH documentation allows for efficient and orderly clinical records. Also, through multiple report modules, supervisory staff is better able to track staff interventions and potential crises. <i>FY2025: 90% of charts were in compliance</i>	<u>Monthly:</u> ≥80% chart compliance: monitored monthly <i>90% of charts were in compliance</i>
<u>Access:</u> To ensure a successful transition into the community, members will participate in a Comprehensive Intake Assessment within 14 days of acceptance into the program. <i>FY2025: 93% of members participated in a Comprehensive Intake Assessment within 14 days of acceptance into the program</i>	<u>Annually:</u> Initial psychiatric evaluations completed with 14 days: 90% <i>93% of members participated in a Comprehensive Intake Assessment within one month of acceptance into the program</i>
<u>Client Satisfaction:</u> Clients complete a survey that rates satisfaction with program and staff, perceived empowerment to manage illness, self-assessed improvement in activities of daily living. <i>FY2025: 96% of consumers were satisfied with Prospect House services</i>	<u>Annually:</u> 80% satisfaction <i>96% of consumers were satisfied with Prospect House services</i>

MENTAL HEALTH ASSOCIATION
PERFORMANCE INDICATORS: FY 2026

PLAN FOR OUTCOME MEASURES
July 1, 2025 – June 30, 2026

PROGRAMS AND INDICATORS:

RISKIN CHILDREN’S CENTER (RCC)	OUTCOMES: FY2025
<u>Access:</u> Wait for service and wait for assignment are measures of efficiency, required by NJDMHAS. They are indicators of standards of professionalism and operations. Thresholds of performance are <5 business days between the initial call and the intake appointment and <5 days between the intake and assignment to services. <i>FY2025: 3.5 days wait for service, 0 days wait for assignment</i>	<u>Annually:</u> <5 business days between the initial call and the intake appointment and <5 days between the intake and assignment to services. <i>4.8 day wait for service, 0 day wait for assignment</i>
<u>Effectiveness:</u> Age-appropriate screening tools are distributed to all youth at intake. For youth under 12, the Mood and Feeling Questionnaire – short version is given to the youth while the Mood and Feeling Questionnaire – Parent-Report on Child is given to the youth. Kutcher scales includes ones specific for depression, social anxiety, ADHD, and PTSD. The screening tool that was given at intake is given again to the youth and parent (if given in the beginning) to be able to compare scores. <i>FY2025: 85% of all participants showed decreases in aggressive behavior, anxiety, depression, attention problems, delinquent behavior, social problems, somatic complaints and thought problems 6 months into treatment</i>	<u>Annually:</u> 80% of youth will show an average of 20% decrease in overall symptoms 6 months into treatment. 80% of parents will indicate an average of 20% decrease in symptoms of their youth’s functioning. <i>90% of all participants showed decreases in aggressive behavior, anxiety, depression, attention problems, delinquent behavior, social problems, somatic complaints and thought problems 6 months into treatment</i>
<u>Client Satisfaction:</u> RCC conducts a survey of satisfaction annually with the youth who are receiving services and their parents/guardians. This survey measures overall satisfaction with the therapist, services, and the child and adolescent psychiatrist. It also measures whether they felt they were treated with respect, whether the child made progress and whether the therapist included the parent in treatment and whether the child felt listened to by their therapist. <i>FY2025: 100% satisfaction rate</i>	<u>Annually:</u> 80% satisfaction rate <i>100% satisfaction rate</i>
<u>Efficiency:</u> The use of Foothold technology, the agency’s electronic clinical database, for RCC documentation allows for efficient clinical record keeping. Also, through multiple report modules, the Program Director and Medical Director are better able to track staff interventions and potential crises. Using an electronic clinical record also allows for multi-disciplinary coordination of treatment between Medical Director and clinical staff. AWARDS is utilized by the State of NJ for collection of HMIS data. <i>FY2025: 92% of consumer records are compliant with agency standards</i>	<u>Monthly:</u> ≥80% chart compliance <i>95% of consumer electronic clinical records are compliant with agency standard.</i>

MENTAL HEALTH ASSOCIATION
PERFORMANCE INDICATORS: FY 2026

PLAN FOR OUTCOME MEASURES
 July 1, 2025 – June 30, 2026

PROGRAMS AND INDICATORS:

SUBSTANCE USE RECOVERY AND EMPOWERMENT	OUTCOMES: FY2025
<u>Access:</u> Waiting time for an assignment is an indicators of professionalism and operational standards. The performance thresholds is less than 3 business days between the initial prescreening and assignment <i>FY2025: 1 days wait for intake from the time of referral</i>	<u>Monthly:</u> Wait for assignment is less than 3 days <i>1 days wait for intake from the time of referral</i>
<u>Effectiveness:</u> SURE utilizes a service plan with measurable objectives related to substance use and/or co-occurring conditions to help consumers achieve their goals through therapy. To graduate from treatment, the consumer must meet treatment goals. <i>FY2025: 98% of clients achieved service plans goals and objectives on a quarterly basis</i>	<u>Quarterly:</u> Measurable goals achieved <i>93% of clients achieved service plans goals and objectives on a quarterly basis</i>
<u>Client Satisfaction:</u> Annually, SURE conducts a survey to assess consumer satisfaction regarding responsiveness, services rendered, privacy, accessibility, and perceived effectiveness of services <i>FY2025: 89% satisfaction rate</i>	<u>Annually:</u> 80% satisfaction rate <i>93% satisfaction rate</i>
<u>Efficiency:</u> To ensure consumers are being served, the agency measures staff service engagement on a weekly basis <i>FY2025: 67% client engagement</i>	Weekly: 50% client engagement <i>65% client engagement</i>

MENTAL HEALTH ASSOCIATION

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July 1, 2025 – June 30, 2026

PROGRAMS AND INDICATORS: SUICIDE PREVENTION SERVICES	OUTCOMES: FY2025
<u>Accessibility:</u> Suicide Prevention Education ensures easy access of programs for all participants by having numerous presentations available to the community. Using multimedia platforms, the public is made aware of what programs and presentations are offered. Presentations are tailored to the needs of the organization that is hosting the training. This includes not only the topic being discussed, but also the location and the delivery of the training. For instance, through Zoom, Facebook and YouTube. The number of groups held annually provide indication of the accessibility for the community to attend these presentations. FY2025: 123 presentations, workshops, groups and tabling events	<u>Annually:</u> 24 presentations 105 presentations, workshops, groups and tabling events
<u>Efficiency:</u> Suicide Prevention Services ensures that all services are provided in a highly efficient manner by how quickly community members obtain services. The indicator measures the time elapsed from when a referral is received to first contact. Request for information is made through the suicide prevention website. FY2025: 1 business day	<u>Quarterly:</u> 90% of request for information will be returned in 2 business days 1 business day
<u>Effectiveness:</u> When the presentation is complete, questionnaires and one-to-one discussions are utilized to collect feedback on the learning experience. This approach measures the knowledge and skills gained by learners as a result of the training. FY2025: 98% gained knowledge of the topic	<u>Quarterly:</u> 85% of participants will gain knowledge of the topic 95% of participants gained knowledge on the topic
<u>Satisfaction:</u> The MHA Quality Assurance Coordinator directly receives and analyzes response-data from surveys collected from each presentation. FY2025: 98% satisfaction among respondents	<u>Semi-Annually:</u> 85% overall satisfaction among respondents 93% satisfaction among respondents

MENTAL HEALTH ASSOCIATION

PERFORMANCE INDICATORS: FY 2026

PLAN FOR OUTCOME MEASURES
July 1, 2025 – June 30, 2026

PROGRAMS AND INDICATORS:

SUPPORTED EMPLOYMENT SERVICES (SES)	OUTCOMES: FY2025
<u>Efficiency:</u> Expected timeframe of job placement is 50% of clients within four (4) months of entry into the program. <i>FY2025: 23% of consumers were placed into employment within the targeted period</i>	<u>Quarterly:</u> 50% in 4 months <i>38% of consumers were placed into employment within the targeted period of time</i>
<u>Efficiency:</u> 4718 units of service are expected; staff productivity will continue to be monitored. <i>FY2025: 70% of units of service were achieved</i>	<u>Quarterly:</u> 4718 units of service are expected; 100% quarterly: <i>100% units of service were achieved</i>
<u>Effectiveness:</u> An outcome of successful placement and job support is measured by retained employment of three (3) months or more. <i>FY2025: 42% of consumers placed retained employment for 3 months or more</i>	<u>Quarterly:</u> 60% retention <i>43% of consumers placed successfully retained employment</i>
<u>Effectiveness:</u> Client-oriented programs strive to place individuals in occupations of their choice. <i>FY2025: 100% of consumers placed were placed in occupations of their choice</i>	<u>Quarterly:</u> 80% placed in chosen jobs <i>100% of consumers were placed in jobs of their preference</i>
<u>Client Satisfaction:</u> Annually, satisfaction with services, responsiveness of staff, and preparation for employment are surveyed. <i>FY2025: 96% of consumers were satisfied services, responsiveness of staff and preparation for employment</i>	<u>Annually:</u> 80% satisfaction <i>96% of consumers were satisfied services, responsiveness of staff and preparation for employment</i>
<u>Employer Satisfaction:</u> Annually, employers where clients are placed are surveyed for satisfaction on the collaboration with SES staff. <i>FY2025: 100% satisfaction rate</i>	<u>Annually:</u> 80% satisfaction <i>100% satisfaction rate</i>
<u>Access:</u> Wait for Service: referrals are received from the Division of Vocational Rehabilitation Services. The target wait for intake is 10 days; and admission to the program is within 2 days. <i>FY2025: 52 new consumers were registered and referred. The average time for intake was 0 business days and enrollment into SE was 3 business day</i>	<u>Quarterly:</u> 10 days for intake, 2 days for admission <i>54 new consumers were registered and referred. The average time for intake was 3 business days and enrollment into SES was 1 business day.</i>

MENTAL HEALTH ASSOCIATION
PERFORMANCE INDICATORS: FY 2026

PLAN FOR OUTCOME MEASURES
July 1, 2025 – June 30, 2026

PROGRAMS AND INDICATORS:

VETERAN AND FAMILY SUPPORT	OUTCOMES: FY2025
<u>Effectiveness:</u> Mental Health Counseling: These services are designed to engage, support and integrate veterans into the community setting of their choice, and facilitate their use of needed resources and available supports to maximize their integration back into civilian life. FY2025: 315.75 hours of mental health counseling were provided	<u>Annually:</u> 400 hours of Mental Health Counseling 119.75 hours of mental health counseling were provided
<u>Effectiveness:</u> Education Groups: These groups are designed to help families understand the first signs of mental illness and to help them develop concrete strategies for intervention. FY2025: 11 education groups were facilitated	<u>Annually:</u> 12 Education Groups 13 education groups were facilitated
<u>Effectiveness:</u> Support Groups: Individuals who consistently attend support group benefit in the following area: knowing that you're not alone in your struggles, learning how to talk about your feelings and experiences with others, discovering new ways to handle day-to-day challenges, meeting friends or mentors that can have a positive impact on your life, and hearing new perspectives to develop positive coping skills. FY2025: 37 support groups were facilitated	<u>Annually:</u> 35 Support Groups 31 support groups were facilitated
<u>Efficiency:</u> Case Management: helps individuals successfully transition back to civilian life. FY2025: 82 units of case management were provided	<u>Annually:</u> 72 Units of Case Management 70 units of case management were provided
<u>Client Satisfaction:</u> Clients completed a survey that rates satisfaction with staff responsiveness, availability and linkages. This survey also measures the efforts made with different providers. FY2025: 100% satisfaction rate	<u>Annually:</u> 80% Satisfaction 100% satisfaction rate
<u>Access:</u> Wait for Service: The target wait for intake and/or admission to the program is within 5 days. FY2025: The average wait for service for intake and/or admission was 3 business days	<u>Annually:</u> Average wait for service for intake and/or admission: less than 5 days: monthly The average wait for service for intake and/or admission was 3 business days

MENTAL HEALTH ASSOCIATION

PERFORMANCE INDICATORS: FY 2026

PLAN FOR OUTCOME MEASURES
July 1, 2025 – June 30, 2026

PROGRAMS AND INDICATORS:

WELLNESS HUB	OUTCOMES: FY2025
<u>Access:</u> Wait for service is a measure of efficiency and indicates stands of professionalism and operations. Access to MHA's programs are monitored by the time taken to see a first or subsequent appointment once referral is mad. The Wellness HUB is designed and staffed to see consumers with exacerbated symptoms of mental illness immediately to avoid the need to be seen in the Emergency Room or inpatient care <i>FY2025: 100% of consumers were able to access a mental health professional at time of walk in to the Wellness HUB</i> <i>99% of consumers were offered access to a psychiatric provider within 24 hours of walking in for treatment</i>	<u>Annually:</u> 100% access to mental health professional within 24 hours: annually 90% access to a psychiatric prescriber within 24 hours <i>100% of consumers were able to access a mental health professional at time of walk in to the Wellness HUB</i> <i>99% of consumers were offered access to a psychiatric provider within 24 hours of walking in for treatment</i>
<u>Efficiency:</u> The Wellness HUB is a mental health urgent care designed to see consumers who are struggling with exacerbated symptoms of mental illness. The Wellness HUB seeks to assist 1100 consumers yearly with access to assessment, crisis counseling, group programming, psychiatric evaluation and medication monitoring. The main goal of the Wellness HUB is to provide immediate access to care in the least restrictive setting <i>FY2025: 1% of consumers seen were sent for psychiatric screening for a higher level of care</i>	<u>Annually:</u> Less than 5% of caseload referred for psychiatric screening <i>1% of consumers seen were sent for psychiatric screening for a higher level of care</i>
<u>Effectiveness:</u> The Wellness HUB utilizes treatment plans to meet the Targeted Case Management and Outpatient treatment standards. They are developed at intake, updated and reviewed within the first 30 days of treatment and again every 90 days. Treatment/Service plans are developed collaboratively with our consumers and the treatment team to address the consumer's identified goals and strengths. We can measure our success and effectiveness at the Wellness HUB by the completion of individual goals. <i>FY2025: 98% of Wellness HUB consumer's goals were achieved at discharge.</i>	<u>Monthly:</u> 90% of goal attainment at discharge <i>100% of Wellness HUB consumer's goals were achieved at discharge.</i>
<u>Client Satisfaction:</u> Wellness HUB conducts a survey of clients' satisfaction with responsiveness, services rendered, privacy, accessibility, perceived effectiveness of services <i>FY2054: 100% satisfaction rate</i>	<u>Annually:</u> 80% overall satisfaction rate <i>100% satisfaction rate</i>

Incident Analysis

Description

Given the volume of individuals served, Mental Health Association (MHA) recognizes that incidents will occur from time to time, and each one is examined with an eye toward identifying opportunities for improvement. The Chief Operating Officer and the Director of Quality Assurance are responsible for overseeing incident recording, submitting required incidents to the New Jersey Division of Mental Health and Addiction Services (DMHAS), and conducting special case reviews that yield recommendations and surface emerging patterns. Critical incidents are examined by the Chief Executive Officer, Chief Operating Officer, and Director of Quality Assurance before being brought to the Quality Assurance Committee (QAC) at its monthly meetings; QAC is charged with an annual analysis of incident causes, trends, and corrective actions. The Health and Safety Committee, meeting six times a year, separately monitors incidents specific to health and safety. Following any significant incident, staff are encouraged to take part in debriefings with their treatment team and are referred to the agency's Employee Assistance Program for further support, as needed.

Incident Specifics and Analysis

In the course of delivering these vital services, MHA recorded 78 incidents agency-wide during FY2026, up 7% from the 73 incidents reported the previous year. Of these, 19 were classified as critical incidents, those meeting DMHAS reporting requirements, a category that includes persons-served deaths, suicide attempts, overdoses, serious injuries, alleged sexual or physical abuse, and operational incidents. This marks a 44% decrease from last year. As a share of total incidents, critical incidents fell to 24% in FY2026, a 51% decrease from FY25. It bears noting that MHA served more than 20,000 individuals this year and continued to grow its programming, staffing, and population served, factors that can naturally contribute to a rise in overall incident volume.

Fiscal year 2026 saw no known completed suicides across the agency. Four suicide attempts occurred off-premises, unchanged from the prior year, and were reported by two Morris County programs: Integrated Case Management Services (ICMS) and Assisted Outpatient Treatment (AOT).

Ten client deaths were reported, all occurring off-premises, a significant 66% decrease from the 29 deaths reported in fiscal year 2025. These were reported across the following programs: Integrated Case Management Services in Essex, Passaic, and Morris; Prospect House; Community Support Services in Essex and Morris; and Assisted Outpatient Treatment in Morris.

One of MHA's core strengths is its proactive, integrated approach to health and wellness, extending beyond behavioral health to address the full range of needs of the individuals it serves. The agency encourages every person served to build a physical health goal into their treatment plan and to maintain a medical doctor on file. This commitment is reinforced by Prospect House Primary Care, a full-service medical facility on-site at Prospect House that provides yearly physicals to all individuals served regardless of ability to pay or insurance status, meaningfully expanding access to essential medical care. In fiscal year 2026, MHA reported 1 psychiatric and 13 medical ambulance or police response incidents, a 75% overall increase over last year. These

incidents were reported across Prospect House, Substance Use Recovery and Empowerment, Community Support Services in Essex, Community Wellness Centers in Morris and Sussex, and Assisted Outpatient Treatment in Morris.

The Quality Assurance Committee conducts rigorous reviews of all incidents and after-action plans. This process includes record reviews and staff interviews to meticulously track key data points such as last contact presentation, risk of hospitalization ratings, and Columbia Suicide Severity Rating Scale scores. Across this review, all incidents were found to be in compliance with agency policies and practices, as well as DMHAS standards, regulations, and related statutes, with programs consistently operating within their scope of services. This detailed analysis also drives continuous refinement of practice: in response to recent reviews, MHA added overdose risk education to all client orientations, clinicians were able to attend a Stanley-Brown Safety Planning Intervention training, and agency forms were updated, including the incident report, to capture data more concisely and accurately. This ongoing cycle of review and refinement demonstrates MHA's unwavering commitment to maintaining a high standard of care and continuously strengthening its protocols to safeguard the safety and well-being of the individuals it serves.

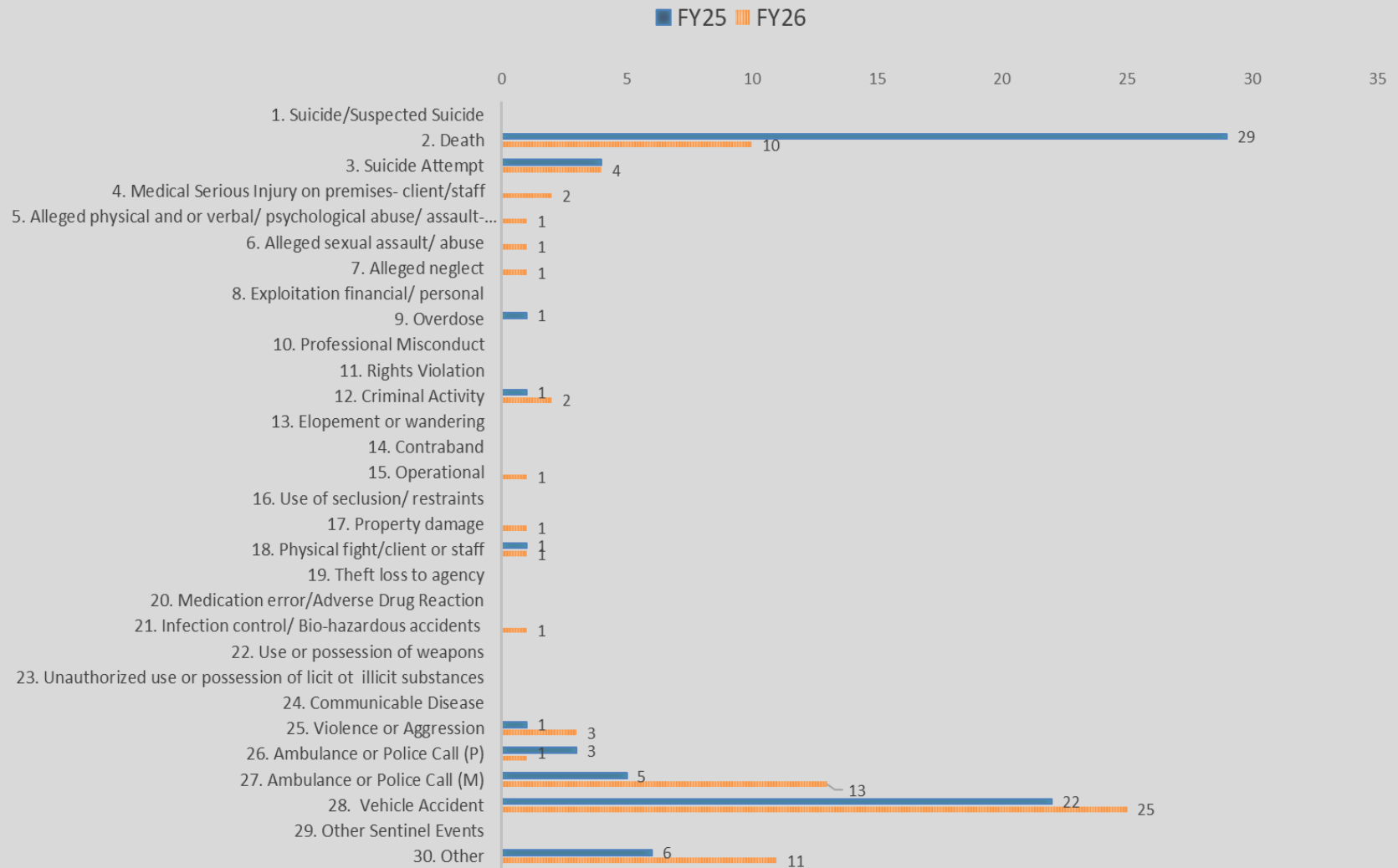
The FY26 Incident Report Comparison Graph below highlights two especially notable shifts between the two years. Most prominent is the decline in client deaths, which fell from 29 in FY25 to 10 in FY26, a 66% reduction and the single largest movement on the chart. The second notable shift moved in the opposite direction: ambulance or police response incidents rose from 8 in FY25 (3 psychiatric, 5 medical) to 14 in FY26 (1 psychiatric, 13 medical), a 75% increase driven almost entirely by medical responses.

Both shifts are significant enough to warrant close attention going forward. MHA will continue to monitor these trends closely in the year ahead, working to identify the underlying factors driving each change and to determine whether they reflect emerging patterns worth a more targeted response. MHA's ability to analyze this sensitive data swiftly and transparently, and to commit to ongoing monitoring, reflects a proactive, responsible leadership approach dedicated to the safety and well-being of its clients.

FY 2027 Goals

The Quality Assurance Committee remains focused on building a culture of safety, learning, and continuous improvement. Incident analysis will continue to guide the identification of patterns and root causes, enabling targeted interventions where needed. QAC will also continue promoting transparent communication and shared learning from incidents among staff, with the goal of preventing recurrence and strengthening consumer safety agency-wide.

MHA INCIDENT REPORTING COMPARISON FY25-FY26



Mental Health Association

FY 26 Incident Reporting

Type of Incident	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	Jun.	Total
1. Suicide/Suspected Suicide	0	0	0	0	0	0	0	0	0	0	0	0	0
2. Death	0	1	1	2	0	1	2	0	0	1	1	1	10
3. Suicide Attempt	0	0	0	0	0	0	0	0	2	1	1	0	4
4. Medical Serious Injury on premises- client/staff	0	0	0	0	0	0	0	0	2	0	0	0	2
5. Alleged physical and or verbal/ psychological abuse/ assault- client/staff	0	0	0	0	0	0	0	0	0	0	0	1	1
6. Alleged sexual assault/ abuse	0	0	0	0	0	0	0	0	0	1	0	0	1
7. Alleged neglect	0	0	0	0	0	0	0	0	1	0	0	0	1
8. Exploitation financial/ personal	0	0	0	0	0	0	0	0	0	0	0	0	0
9. Overdose	0	0	0	0	0	0	0	0	0	0	0	0	0
10. Professional Misconduct	0	0	0	0	0	0	0	0	0	0	0	0	0
11. Rights Violation	0	0	0	0	0	0	0	0	0	0	0	0	0
12. Criminal Activity	0	0	0	1	0	0	0	0	1	0	0	0	2
13. Elopement or wandering	0	0	0	0	0	0	0	0	0	0	0	0	0
14. Contraband	0	0	0	0	0	0	0	0	0	0	0	0	0
15. Operational	0	0	0	0	0	0	0	0	0	0	0	1	1
16. Use of seclusion/ restraints	0	0	0	0	0	0	0	0	0	0	0	0	0
17. Property damage	1	0	0	0	0	0	0	0	0	0	0	0	1
18. Physical fight/client or staff	0	0	0	0	0	1	0	0	0	0	0	0	1
19. Theft loss to agency	0	0	0	0	0	0	0	0	0	0	0	0	0
20. Medication error/Adverse Drug Reaction	0	0	0	0	0	0	0	0	0	0	0	0	0
21. Infection control/ Bio-hazardous accidents	0	0	0	1	0	0	0	0	0	0	0	0	1
22. Use or possession of weapons	0	0	0	0	0	0	0	0	0	0	0	0	0
23. Unauthorized use or possession of licit or illicit substances	0	0	0	0	0	0	0	0	0	0	0	0	0
24. Communicable Disease	0	0	0	0	0	0	0	0	0	0	0	0	0
25. Violence or Aggression	0	1	0	0	0	0	0	1	0	1	0	0	3
26. Ambulance or Police Call (P)	0	0	0	0	0	0	0	0	1	0	0	0	1
27. Ambulance or Police Call (M)	1	0	1	0	0	2	1	1	0	1	3	3	13
28. Vehicle Accident	4	3	0	8	1	1	2	0	1	2	1	2	25
29. Other Sentinel Events	0	0	0	0	0	0	0	0	0	0	0	0	0
30. Other	1	0	0	2	0	1	0	0	3	0	3	1	11
Total	7	5	2	9	1	6	5	2	11	7	9	9	78

Health and Safety

The Risk Management/Safety Committee at the Mental Health Association (MHA) is comprised of designated Safety Officers from each program/location site and a Committee Chair. Safety Officers include both administrative and outreach staff, ensuring broad representation across the organization. The Committee meets six times per year to review ongoing health and safety matters, including compliance with the Health and Safety Grid, adherence to agency policies and procedures, staff training needs, driver safety reports, and incidents related to infection control, communicable diseases, and vehicle accidents. The Committee also addresses broader health and safety concerns affecting the agency.

Healthy & Safe Work Environment

In addition to committee meetings, each program/location holds quarterly Health and Safety meetings to discuss agency needs, review emergency procedures, and confirm the location and maintenance of emergency equipment, including exits, first aid kits, biohazard containers, fire suppression systems, and AED devices. Each program/location conducts evacuation drills on a monthly, quarterly, or annual basis, as applicable, to simulate real-life emergencies. Drills are documented in detail, including post-drill analysis, and are complemented by quarterly safety surveys completed during each shift to identify and address maintenance or safety concerns. Urgent issues are escalated to the Program/Location Director for prompt resolution.

Comprehensive health and safety inspections are conducted annually by external agencies, including local fire departments and security alarm companies, with identified concerns addressed promptly. All sites maintain written emergency procedures for fires, bomb threats, natural disasters, utility failures, medical emergencies, and violent or threatening situations. AED devices are located at each site and are equipped for adult use, with annual servicing conducted by the leasing agency, including battery and software updates.

Incident reporting is an essential component of MHA's safety practices. Reportable incidents include, but are not limited to, suicides or suspected suicides, serious injuries to staff or clients, allegations of abuse or neglect, significant property damage or theft, vehicle accidents, communicable disease outbreaks, violent or aggressive behavior, and incidents that attract media attention or involve criminal charges. All incidents are documented promptly and reviewed monthly by the Quality Assurance Committee, with an annual analysis conducted to identify causes, trends, and improvement opportunities. When appropriate, staff are referred to the Employee Assistance Program for support following critical incidents.

Vehicle Safety

As of FY2026, MHA operates 113 insured vehicles. During the fiscal year, 25 vehicle incidents were reported, compared with 22 in FY2025. Despite the increase in reported incidents, auto claim costs decreased significantly, from \$157,755 in FY2025 to \$22,059 in FY2026, a reduction of \$135,696, or 86%. These results demonstrate a significant reduction in the financial impact of vehicle-related incidents and reflect continued progress in fleet risk management. MHA attributes this progress, in part, to the continued implementation of the Mindful Driving Program, regular safety communications, driver training, and employee recognition incentives designed to reinforce safe driving practices and accountability.

MHA utilizes several measures to promote safe vehicle operations. Each agency vehicle undergoes a monthly inspection conducted by program/location staff to verify that it is in proper working order, necessary repairs are identified and addressed promptly, and required safety equipment—including first aid kits, fire extinguishers, reflective warning triangles, and other emergency supplies—is properly stocked and secured. Monthly inspection records are documented and monitored as part of the agency’s overall Health and Safety program. Newly purchased vehicles are equipped with safety technologies such as lane-assist systems, backup cameras, and collision-avoidance features. MHA also utilizes GPS and telematics systems to monitor driver behavior, provide feedback, and receive maintenance alerts. Forward-facing cameras are installed in select vehicles to enhance safety and accountability, and all vehicles display “Safety First – How’s My Driving?” decals to encourage public feedback. Staff are required to complete annual defensive driving training through Relias.

The Transportation Safety Manual is reviewed annually and updated as needed to reflect changes in laws, best practices, and agency policies. A copy is maintained in every agency vehicle as a quick-reference resource. The manual provides step-by-step accident reporting procedures; guidance for vehicle breakdowns, flat tires, and mechanical failures; contact information for towing, roadside assistance, and approved auto body repair vendors; and requirements for safely transporting consumers, operating vehicle safety features, completing pre- and post-trip inspections, and complying with agency driving policies.

Building on the safety education provided in FY2026, the Health and Safety Committee uses the monthly safety newsletter to reinforce formal training, address trends identified through vehicle accidents and Safety-First reports, and provide timely guidance related to seasonal and emerging risks. FY2026 topics included defensive driving, hazard awareness, accident prevention, distracted driving, mobile device restrictions, speed compliance, pedestrian awareness, school zone safety, and winter driving. This ongoing communication provides an opportunity to reinforce expectations throughout the year and connect training to real-world conditions experienced by MHA staff.

FY 2027 Goals

In FY2027, MHA will continue its focus on vehicle safety and accident prevention while placing increased emphasis on emergency preparedness and response across all programs and locations. The Health and Safety Committee will continue monitoring vehicle incident trends, reinforcing defensive driving practices, and using targeted safety communications and training to address emerging risks.

MHA has also expanded its emergency drills to move beyond basic evacuation exercises and incorporate real-life scenarios, expected staff responses, outcomes, and lessons learned. In FY2027, the Committee will build on this approach by continuing to develop more realistic, scenario-based drills that strengthen staff readiness, clarify roles and responsibilities, identify gaps in emergency procedures, and translate lessons learned into meaningful improvements. This enhanced focus on preparedness, combined with MHA’s continued commitment to vehicle safety, will support a proactive culture of safety and better prepare staff to respond effectively to emergencies while protecting the well-being of staff, clients, and the community.

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 that they have access to comprehensive outpatient services. Through 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

AOT Essex is currently staffed by one full-time Licensed Program Director, three full-time Master's Level Case Managers, and two part-time Psychiatrists. In addition, one full-time Licensed Program Director oversees both AOT Sussex and Morris: AOT Sussex is currently staffed by one full-time Bachelor's Level Case Manager, one full-time Master's Level Case Manager and one part-time Psychiatrist.; AOT Morris is currently staffed by two full-time Master's Level Case Managers, and one part-time Psychiatrist.

Caseload

Essex: As of June 30, 2026, there were 40 active cases. During FY 2026, 71 referrals were enrolled into the AOT program; 75% of the referrals were made through Short Term Care Facilities (STCF) and/or private hospitals via conversion or amended hearings; 8% of the referrals were made from county hospitals; and 17% were made through conversion hearings or amended hearings from state hospitals.

Sussex: As of June 30, 2026, there were 9 active cases. During FY 2026, the program served 34 unduplicated individuals; 76.19% of the referrals were made through Short Term Care Facilities (STCF) and/or private hospitals via conversion or amended hearings; 19.04% were made through conversion hearings at long-term care facilities, such as state hospitals; and 4.76% of referrals were enrolled through the designated screening centers.

Morris: As of June 30, 2026, there were 31 active cases. During FY 2026, the program served 64 unduplicated individuals; 44.18% of the referrals were made through Short Term Care Facilities (STCF) and/or private hospitals via conversion or amended hearings; and 55.81% 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 or older, are 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 29% female, 70% male, and 1% undisclosed; AOT Sussex, 44.4% were male, 44.4% were female and 11.1% that did not identify as male or female; and in AOT Morris, 38.7% were female, 58.0% were male and 3.2% were transgender female.

Ethnicity: During Fiscal Year 2026, AOT Essex provided services to individuals who self-reported the following races and ethnicities: 57% Black or African American, 17% Hispanic/Latino, 14% White, 8% unknown or declined to disclose, 2% of individuals who identified as multiracial, 1% Asian or Asian American, and 1% Indigenous or Alaska Native. AOT Sussex provided services to individuals who self-reported the following races and ethnicities: 74.2% Non-Hispanic/Non-Latino, 16.1% Hispanic/Latino, 6.5% declined to specify, and 3.2% with no data collected. The racial breakdown was: Asian 3.2%, Black or African American 9.7%, Multiracial 3.2%, Other 6.4%, Other Multiracial 6.4%, Unknown 3.2%, White 64.5%, and no data collected for 3.2%. AOT Morris provided services to individuals who self-reported the following races and ethnicities: 76.7% Non-Hispanic/ Non-Latino, 15% Hispanic/ Latino, 1.7% Declined to Specify, 6.7% with no data collected. The racial breakdown was: White 61.7%, Asian 8.3%, Asian and White 1.7%, Black or African American 15%, Decline to specify 3.4%, Native American or other Pacific 1.7%, Other 1.7%, and no data collected 6.37%.

Age: AOT Essex provided services to 41% of individuals between the ages of 18-29, 30% between the ages of 30-39, 13% between the ages of 40-49, 9% between the ages of 50-59, and 7% aged 60 or above. AOT Sussex provided services to 27.27% of individuals between the ages of 18-29, 30.30% between the ages of 30-39, 21.21% between the ages of 40-49, 18.18% between the ages of 50-59, and 3.03% aged 60 or above. AOT Morris provided services to 17.18% of individuals between the ages of 18-29, 28.14% between the ages of 30-39, 14.06% between the ages of 40-49, 12.5% between the ages of 50-59, and 28.12% aged 60 or above.

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 the past fiscal year, AOT 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 referrals via screening, Short Term Care Facilities (STCF) and/or Long-Term Care (LTC) facilities in order to assess consumers for appropriateness for AOT services. AOT staff is available 24 hours a day, 7 days a week, via an on-call system if a referral needs to be seen outside regular hours. This year, AOT collectively received 1 referral from local screening centers, 137 STCF referrals, and 42 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 feedback 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 40 surveys were delivered to consumers in Essex, Morris, and Sussex counties. Of the consumers who responded, there was a 100% satisfaction rate with AOT services across all counties.

Program Highlights

Program Success: The Assisted Outpatient Treatment programs continue to demonstrate a meaningful impact, with a total of 50 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 providing 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: AOT was able to assist several consumers in obtaining daily household items, toiletries, clothing, phones, and county, state, or driver's identification to promote dignity, respect, empowerment, and autonomy.

Advocacy Activities

AOT staff work closely with consumers to assist them in developing self-advocacy skills for sustainable community success, as well as engaging in systems collaborations to further advocacy efforts at the state and county levels. 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 within IOC programs.

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

Acute Care/System Review Committee are monthly meetings. 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 committees provide education and advocacy to the community, mental health providers, consumers of mental health services and their families, and advocacy on the needs of the mental health system in the counties of operation.

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.

FY 2027 Goals

The Assisted Outpatient Treatment 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 to increase the overall number of meaningful contacts with consumers, their families, and associated service providers. This enhanced communication aims to strengthen staff and consumer rapport, build upon existing community relationships, improve coordination and continuity of care, and foster a more consistent and responsive support system for enhanced success beyond AOT.
- 2. Strengthen Collaboration with the Public Defender's Office:** AOT will continue to work closely with the Public Defender's Office to ensure that legal and clinical coordination 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 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. Increase Referrals to Program** AOT will continue to strengthen and maintain collaborative relationships with key referral sources, including Short Term Care Facilities (STCFs), state and county psychiatric hospitals, and local designated screening centers, to support

sustained growth in admissions and overall caseloads. Through ongoing outreach, regular communication, and participation in community and provider networking opportunities, AOT will ensure these partners remain informed about the referral process and the program's benefits to consumers once they are in the community. These efforts will enhance our visibility within the behavioral health continuum of care, improve census stability, and support our goal of serving a greater number of individuals in need of community-based mental health services.

5. **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.
6. **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.

Center for Behavioral Health

Description

Founded in 1957, the Center for Behavioral Health (CBH) continues to provide quality outpatient mental health treatment including assessments, psychotherapy, psychiatric evaluations and medication management services. CBH works toward its the mission of providing high-quality behavioral health services to low-income clients, many of whom are enrolled in Medicaid or have limited financial means to pay for services. Beyond direct clinical services, CBH actively strengthens local networks by providing specialized training and behavioral health outreach to our many valued community partners.

Personnel

The program operates under the direction of a full-time Program Director, a part-time Psychiatrist, a part-time Advanced Nurse Practitioner (APN), one full-time LCSW therapist and seven part-time licensed therapists. Throughout the year, CBH also works with graduate social work and counseling interns who provide clinical services under the supervision of the Director and other staff. This fiscal year, the program served as an educational site for twelve interns in the fields of social work, art therapy, and clinical mental health counseling.

Caseload

CBH provided services to 176 individuals during FY26 with a total of 9,732 contacts. This included providing services to 41 new clients.

Demographics

As of 7/1/26, the CBH census was 131 with an average monthly census of 139. Clients range in age from 18 to 90. Clients identified their gender as the follows: 64% female, 33% male, and 3% transgender. The self-reported ethnicities of the consumers enrolled with CBH were as follows: 19% Hispanic/Latino and 81% non-Hispanic/Latino. More specifically, the self-reported races of clients enrolled with CBH were as follows: 50% White/Caucasian, 35% African American, 8% Asian, 6% identifying as multiracial, and 1% identifying as other. CBH consumers are insured through Medicaid (55%), Medicare (28%), uninsured and enrolled in NJMHAPP (16%), and other (1%).

Performance Outcomes

The Center for Behavioral Health remained committed to delivering high-quality, accessible, and integrated services, achieving strong clinical outcomes across the program.

Low Hospitalization Rate: Maintained an average monthly psychiatric hospitalization rate of 1% of the active caseload, reflecting effective outpatient treatment and symptom management.

Successful Treatment Outcomes: Of all client discharges, 53% were positive discharges, indicating that clients met their treatment goals or no longer required services. The remaining discharges included 25% lost to contact, 12% referred to a higher level of care, and 10% due to relocation.

Clinical Improvement: 90% of clients demonstrated a reduction in symptoms within six months of treatment and 90% made measurable progress toward their individualized treatment goals.

Accessible Care: CBH continued to provide clients with flexible access to services through both in-person and telehealth modalities, allowing individuals to receive care based on their needs, preferences, and circumstances.

Integrated Behavioral Health: 66% of clients received medication management from the program's psychiatrist or advanced practice nurse (APN), supporting a collaborative, team-based approach to care.

Timely Access to Services: When accepting new clients, CBH maintained an average wait time of 3.6 days from referral to intake. When the program reached capacity, staff ensured individuals received appropriate referrals and linkage to community resources.

Serving a Diverse Population: CBH provided services to 40% of clients under age 40 and 10% age 70 or older, reflecting the program's ability to meet the behavioral health needs of diverse age groups.

Consumer Satisfaction Surveys

In order to measure satisfaction with services, consumer satisfaction surveys were distributed via email, text, and in person to all active clients. Overall, clients who receive services at CBH continue to report a high level of satisfaction, with 95% of surveyed clients agreeing or strongly agreeing that they are satisfied with services. In addition, 100% of respondents felt included in the treatment planning process, 95% stated that they have made progress in dealing with the problems that brought them to treatment and 95% would recommend the program to others.

Program Highlights

The Center for Behavioral Health continued to strengthen community partnerships and expand access to behavioral health services through outreach, education, and supportive programming.

- Aging Well Program Pilot: In partnership with the Township of Montclair, the Center for Behavioral Health launched the Aging Well program to increase access to behavioral health services for older adults, a population that has historically been hesitant to seek services.
- Community Education and Support: The Center for Behavioral Health continued to provide free community-based groups and workshops that offered emotional support, psychoeducation, and practical coping strategies to promote mental wellness, build resilience, and strengthen community connections.
- In April 2026, staff and interns facilitated the Cultivating Resilience workshop, which was attended by 16 community members.
- The Comfort Zone, a drop-in support group for anyone with a mood disorder, meets twice weekly and averages five participants per session.
- The Center for Behavioral Health offers periodic art therapy groups, providing participants with creative therapeutic opportunities to support emotional well-being while introducing an alternative modality for self-expression and healing.
- Workforce Development: Through its robust internship program, the Center for Behavioral Health remained committed to training the next generation of behavioral health professionals. Recognized as a premier field placement for MA and MSW students, the program provides high-quality clinical education and hands-on experience while strengthening the future behavioral health workforce.

Advocacy Activities

The Center for Behavioral Health actively drives community engagement by partnering with local municipalities, including Bloomfield, Montclair, West Orange, and Newark as well as organizations across Essex County to increase awareness of its vital services. CBH staff participate in tabling events and community resource fairs, serve as panelists, and maintain an up-to-date, comprehensive directory of local mental health resources. Furthermore, staff members contribute to community public health task forces, helping to integrate mental health considerations into broader public health planning and ensuring local behavioral health needs remain a priority.

FY 2027 Goals

CBH will continue to expand its community presence by strengthening its established relationships throughout Essex County. As a trusted community partner, CBH is regularly invited to participate in local events, serve on expert panels, and provide educational presentations. Two community presentations are already scheduled for early fall, with additional outreach opportunities expected throughout the year.

Among its core priorities is the expansion of the Aging Well program, which launched in early 2026. CBH aims to scale this initiative to meet the growing demand for dedicated older adult behavioral health services as referral volume continues to rise. Additionally, building on strong participant feedback from the Cultivating Resilience workshop, CBH will maintain its focus on evidence-based group programming. By offering these workshops on a more regular basis, the center will provide community members with ongoing opportunities to build practical coping skills, foster peer connections, and engage in long-term mental wellness.

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, Middlesex County in the City of Perth Amboy and in Morris County in the Township of Mount Olive.

The ARRIVE (Alternative Responses to Reduce Instances of Violence & Escalation) Together program is a partnership between the Mental Health Association and police departments throughout Morris County to improve responses to behavioral health crises. Originally introduced by the New Jersey State Police, the program uses a Close in Time/Follow-up response model in which a Crisis Intervention Team (CIT)-trained law enforcement officer (when available) and a mental health specialist respond to behavioral health-related emergency calls or conduct follow-up visits, 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, helping individuals access treatment while reducing the likelihood of unnecessary hospitalization or involvement with the criminal justice system

Personnel

MHA has 12 clinical co-responders across Essex, Morris, and Middlesex counties who are stationed inside 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/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 individual received the appropriate level of care in order to promote treatment and recovery and prevent involvement in the criminal justice system. During FY2026, MHA co-responded to 1553 incidents in 39 municipalities. From July 1, 2025 to June 30, 2026, Co-Response Programs served a total of 4,209 individuals.

Performance Outcomes

During FY2026, across 39 municipalities, MHA co-responded to 1553 incidents and received 2996 referrals for follow up. In addition, the following outcomes were measured:

- For Co-Response Program, 422 of 987 Co-Responses/Follow Ups required transport to the hospital.
 - 73 involuntary hospital transports
 - 349 voluntary hospital transports
 - 542 Co-Responses were resolved at the scene
- For ARRIVE, 1,284 of 2,685 Co-Responses/Follow Ups required transport to the hospital.
 - 212 involuntary hospital transports
 - 1,072 voluntary hospital transports
 - 1,401 Co-Responses were resolved without incident
- A total of 1,219 linkages (i.e., mental health services, substance services, community resources) were made in the community as a result.

As evidenced by these outcomes, Co-Response Programs have 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 partnered with police departments to support the important process of utilizing community resources in an effort to promote options of prevention, intervention, treatment, and overall wellness and recovery.

Program Highlights

- During the fiscal year, MHA was able to provide over 57 trainings to police departments and dispatchers.
- In August 2025, Co-Response Programs participated in events in several municipalities for their annual National Night Out.
- ARRIVE staff participated in Bottle Hill Day with Madison Police Department in October 2025.
- During FY26, staff provided multiple trainings on de-escalation to multiple police departments.
- During FY26, staff participated in multiple Coffee with a Cop events throughout Morris County.
- During FY2026, the ARRIVE Program Director and the Morris County Prosecutor's Office provided 160 hours of Crisis Intervention Team (CIT) training to approximately 105 law enforcement officers and 36 mental health professionals.
- The Morris County CIT Program was awarded the 2026 Program of the Year at the 11th Annual CIT-NJ Conference and Awards

- In August 2025, the ARRIVE Program Director attended the CIT International Conference held in Anaheim, California. The purpose of the conference was to bring together law enforcement, mental health professionals, advocates and public safety leaders.
- In April 2026, Co-Response attended the West Orange Police Department's Senior Citizen Police Academy.
- In April 2026, Perth Amboy Co-Response attended Perth Amboy's Annual Community Resource Night.
- In May 2026, South Orange Co-Response attended a South Orange Police Department vs Seton Hall Alumni basketball game to raise awareness for Autism.
- In April 2026, Program Directors for ARRIVE and Mt. Olive Co-Response presented on Bridging Crisis Response: Social Workers & Police Co-Response in New Jersey at the 70th Annual NJ NASW Conference in Atlantic City.
- During FY26, clinicians responded to six critical incidents. The Critical Incident model ensures that a mental health professional is available 24 hours a day, 7 days a week, 365 days a year to assist with incidents involving barricaded individuals who appear to require medical or behavioral 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 a meeting with Unitarian Universalist Faith Action NJ to assist in advocating for more comprehensive data collection for co-response programs in NJ.

FY 2027 Goals

Looking ahead, the future goals of the co-response programs 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.

Collaborative Justice Services (CJS)

Description

Collaborative Justice Services (CJS) offers a jail re-entry program for adults diagnosed with a mental illness released from Essex and Morris County Correctional Facilities. Upon referral from police, court, jail, and social agencies, CJS begins services immediately, starting intake and discharge planning on day one by using a consumer-centered, wellness-based approach. CJS assesses consumers' strengths and needs to develop personalized plans that aim to reduce or eliminate additional jail time by promoting therapeutic outcomes. The goals are to decrease arrests and incarceration, reduce repeated offenses, and improve access to mental health and social services post-release. CJS also provides mental health training for law enforcement officers to enhance awareness and best practices regionally.

Personnel

Collaborative Justice Services continues to benefit from high staff retention, fostering continuity and trust in operations. At the Essex campus, the team includes three Forensic Case Managers (FCMs) and a Program Director, all of whom operate both within the jail and in the broader community. At the Morris campus, the staff comprises one Program Director and one Forensic Case Manager, who similarly serve clients within the Morris County Correctional Facility and follow them in the community as needed.

Caseload

As of June 30, 2026, Collaborative Justice Services Essex is managing 43 active cases, illustrating engagement with the community and county systems. Referrals originate from a wide range of sources: the Mental Health and Medical Departments at Essex County Correctional Facility (ECCF), the Essex County Office of the Public Defender, Essex County Probation, and the Essex County Prosecutor's Office. Additional referrals come through the ECCF Social Services Department, Justice-Involved Services programs, state prisons, as well as self-referrals, family members, and internal CJS staff networks, reflecting a well-integrated consortium of justice, legal, and community stakeholders. At the same time, CJS Morris had 15 active cases on the same date. Referrals to this campus are made by the Morris County Prosecutor's Office, Morris County Correctional Facility, Morris County Public Defender's Office, Community Connections, community organizations, and Morris County Probation Services, underscoring similarly broad collaboration in that jurisdiction. This referral breadth across both campuses highlights CJS's strong interagency relationships and its capacity to engage individuals at multiple entry points within the justice system, whether entering through court systems, corrections, or community-based relationships. It also reflects CJS's active role in identifying and supporting individuals at risk of incarceration via direct, self, and family-initiated referrals. By mid-2026, both campuses were steadily serving clients across the entire referral spectrum, from legal entities to families, supporting reentry through tailored service planning, linkage, and discharge support.

Demographics

MHA's CJS program provides services to residents of Essex and Morris counties who are 18 years of age and older, are diagnosed with a mental illness and have a history with the justice involved system.

Gender: At the end of the fiscal year, self-reported gender for individuals served in CJS Morris was 80% male, 7% female, with the remaining 13% declining to specify. CJS Essex was 81% male and 19% female. **Ethnicity:** During FY 2026, CJS Morris provided services to individuals who self-reported the following races and ethnicities: 33% Caucasian, 40% African American, 7% American Indian/Alaska Native/Indigenous, 7% Asian, and 13% Unknown. CJS Essex provided services to individuals who self-reported the following races and ethnicities: 2% American Indian or Alaskan Native, 0% Asian, 63% Black or African-American, 2% Multiracial, 2% Hispanic, 14% White, and 17% Not Reported. **Age:** CJS Morris provided services to 7% between the ages of 20-29, 33% between the ages of 30-39, 47% between the ages of 40-49, and 13% between the ages of 50-59. CJS Essex provided services to 20% of individuals were ages of 18 to 24, 37% are between 25 and 34 years old, and another 16% fall within the 35 to 44 age range. Those aged 45 to 54 make up 23%, while the 55 to 64 group represents 2%. Lastly, 2% of the population is between 65 years old or older.

Performance Outcomes

Performance outcomes for Collaborative Justice Services were systematically measured and monitored through the Mental Health Association (MHA), Quality Assurance (QA) Committee. During Fiscal Year 2026, Essex CJS tracked consumer recidivism to the Essex County Correctional Facility at key intervals, specifically within 30, 60, 90, and 120 days post-release. According to the QA threshold, fewer than 50 consumers were expected to return to jail within each of the 30/90-day and 60/120-day timeframes. Of the consumers monitored, 12 were re-incarcerated within either 30 or 90 days of their release, while only 5 were re-incarcerated within either 60 or 120 days, demonstrating relatively strong outcomes against the program's target benchmarks.

At the Morris campus, consumer recidivism was also monitored monthly for return to jail within 30, 60, 90, and 120 days following release. The QA threshold in Morris aimed to have fewer than five consumers re-incarcerated within 30 and 90 days, and fewer than ten within 60 and 120 days. During FY2026, no consumers returned to jail within any of the measured intervals at 30, 60, 90, and 120 days. These results underscore the effectiveness of discharge planning and community linkage strategies at the Morris location and reflect a highly successful year in terms of recidivism prevention.

During FY2026, CJS Essex successfully reduced consumers' county sentence by a total of 4,006 days. CJS continues to monitor the cost-effectiveness of its impact on county costs. In FY2026, the program saved approximately \$813,218.00 in county costs. (Please note the approximate cost to house a county inmate daily is \$203.00). Based on the data gathered, CJS will continue to monitor time saved for consumers both for county and state time.

During FY 2026, CJS Morris made significant strides in collaborative efforts with the Morris County Correctional Facility, the Morris County Prosecutor's Office, and the Morris County Public Defender's Office. Through these partnerships, staff successfully diverted individuals from potential incarceration, preventing approximately 364 county jail days. These efforts translated into substantial fiscal impact: the program delivered estimated savings of \$73,892.00 in county-level incarceration costs. This outcome reflects both the effectiveness of the diversion work and the value of close cross-agency coordination in achieving cost-avoidance and safer community outcomes.

Consumer Satisfaction Surveys

Essex

Collaborative Justice Services in Essex County distributed satisfaction surveys to consumers, hand-delivered, mailed, or left at their residences, with assurances that responses would remain confidential. Ultimately, 100% reported being overall satisfied with CJS services. These surveys align with best practice standards for preserving confidentiality and promoting high-quality, trustworthy data collection. Transparency about data use, secure collection methods, and assurance of anonymity all help build respondent trust and boost survey participation and honesty. In addition, best practices recommend monitoring and auditing survey processes to prevent data breaches and to maintain integrity—measures especially important when serving vulnerable populations. By assuring confidentiality and protecting identities, CJS not only met a notable satisfaction benchmark but also upheld ethical standards essential to serving justice-involved individuals with mental illness.

Gender

Of the consumers who responded to the survey, 50% were male and 50% were female.

Ethnicity

Of the consumers who responded to the survey, 50% identified as Hispanic and the other 50% identified as White.

Age

Of the consumers who responded to the survey, 50% were in the age range of 25-34 and the other 50% were in the range of 35-44.

Morris

In Morris County, surveys were distributed to consumers—either hand-delivered, mailed, or personally left at residences—all accompanied by sealed envelopes to reinforce anonymity. Recipients were informed that their responses would remain completely confidential, and they were offered multiple secure return options to ensure privacy. Recent survey results show a remarkable 100% satisfaction rate on key measures, including overall satisfaction, dignity and respect and staff availability. Furthermore, the program encourages self-direction and personal choice, with 100% of individuals reporting they are encouraged to make their own decisions and actively participate in their treatment goals.

Gender

Of the consumers who responded to the survey, 100% were male and 0% were female.

Ethnicity

Of the consumers who responded, 33.33% of the consumer identified as Caucasian, 33.33% identified as Hispanic/Latino, and 33.33% preferred not to answer.

Age

Of the consumers, 66.67% identified as being 25-34 years old, and 33.33% as 55-65 years old.

Program Highlights

- During Fiscal Year 2026, the CJS Essex program continued to strengthen its impact through comprehensive case management, strategic community partnerships, and collaborative advocacy efforts aimed at improving outcomes for justice-involved individuals living with behavioral health needs.
- During Fiscal Year 2026, CJS Essex staff successfully facilitated 217 community linkages, connecting participants to essential supports that addressed both immediate and long-

term needs. These referrals included access to mental health treatment, substance use services, stable housing, financial assistance, healthcare, transportation, and other community-based resources.

- During Fiscal Year 2026, to further strengthen cross-system collaboration, the CJS Essex Program Director conducted numerous in-service educational presentations throughout the fiscal year. These trainings increased awareness of behavioral health issues, highlighted the role of Collaborative Justice Services, and reinforced the value of treatment-focused interventions for justice-involved populations. Presentations were delivered to key criminal justice stakeholders, including the Essex County Prosecutor's Office, the Office of the Public Defender, Essex County Municipal Court, and the Essex County Correctional Facility. These outreach efforts enhanced interdisciplinary partnerships, expanded understanding of diversion opportunities, and reinforced a shared commitment to improving outcomes for individuals with behavioral health needs involved in the justice system.
- During Fiscal Year 2026, the CJS Essex Program Director, in partnership with the Essex County Prosecutor's Office, delivered 40 hours of Crisis Intervention Team (CIT) training to approximately 55 law enforcement officers.
- CJS Essex also remained actively engaged in agency-wide initiatives that promoted recovery, wellness, and community inclusion. Program representatives participated in the agency's Annual Consumer Achievement Awards, recognizing individuals for their treatment progress, recovery milestones, and personal accomplishments. Staff also supported the Annual Consumer Picnic, fostering social connectedness, health promotion, and meaningful engagement among consumers, families, and community partners.
- During Fiscal Year 2026, CJS Morris staff facilitated 83 community linkages, helping clients access a range of essential services, including behavioral health care, housing assistance, substance use treatment, employment resources, and other supports critical to successful community reintegration.
- In collaboration with the Morris County Prosecutor's Office, the Program Director led a total of 160 hours of Crisis Intervention Team (CIT) training, reaching approximately 104 law enforcement officers and 36 mental health professionals throughout the year.
- In August 2025, Program Director attended the CIT International Conference held in Anaheim, California. The purpose of the conference is to bring together law enforcement, mental health professionals, advocates and public safety leaders.
- Morris County CIT Program was awarded the 2026 Program of the Year at the 11th Annual CIT-NJ Conference and Awards.
- Throughout the year, CJS Morris consumers engaged in several community-building and social wellness events in partnership with other Mental Health Association of Essex and Morris (MHAEM) adult programs. These included a summer picnic at Hedden Park, a fall festival hosted at the Morris campus, and a holiday celebration organized by Holiday Express at the Ukrainian American Cultural Center of New Jersey. These gatherings play a meaningful role in promoting recovery, fostering social connection, and reducing isolation among participants.
- CJS also took part in the Annual Consumer Achievement Awards ceremony held at the Morris campus, recognizing the resilience, accomplishments, and personal progress of clients involved in the program. Celebrating these milestones helps to reinforce hope, highlight recovery journeys, and affirm the impact of supportive services.

Advocacy Activities

CJS actively participates in several key systems-level meetings across both counties, including the System Review Committee (SRC), Professional Advisory Committee (PACADA), the Mental Health Initiative, the Essex County Task Force, the Essex County Prosecutor's Mental Health Diversion Program, Review Team for the Morris County Prosecutor's Office Mental Health Diversion Program, the Morris County Crisis Intervention Team (CIT) Steering Committee, and the New Jersey State CIT Committee. These collaboratives provide an essential platform for interagency communication, service coordination, and strategic planning. In addition, CJS engages in regular case review meetings with the Essex County Correctional Facility, and partners closely with CFG (Correctional Focus Guidance) and the facility's Mental Health Team to support integrated care planning and transition support for incarcerated individuals.

Both Morris and Essex County CJS programs participate in the Statewide CJS Directors' Meetings convened by the New Jersey Division of Mental Health and Addiction Services (DMHAS). These meetings serve as a critical venue for exchanging insights with peer programs from other counties, addressing challenges in service delivery, identifying best practices, and staying informed on policy changes, protocol updates, and new initiatives impacting CJS statewide.

CJS staff across both counties also work directly with consumers to build self-advocacy skills, promoting active participation in their recovery and encouraging involvement in peer-led organizations and advocacy groups such as self-help centers and NAMI-NJ. Through open dialogue and individualized support, clients are empowered to take a more active role in shaping their own treatment and in representing the needs of the justice-involved mental health community.

FY 2027 Goals

CJS staff will focus on increasing the total number of contacts with consumers, their families, and service providers. They will continue to work closely with the Public Defender's Office to enhance collaboration and support for consumer success. Additionally, CJS will persist in collecting data and closely monitoring all performance indicators to ensure ongoing improvement. The team will also continue to work with consumers to empower them to achieve their goals. To enhance their effectiveness, CJS staff will attend relevant trainings to expand their knowledge of best practice measures. They will also conduct trainings and presentations as needed to educate others about the role of CJS, including local law enforcement. Furthermore, CJS will maintain collaboration efforts with the Essex and Morris County Correctional Facilities to increase referrals and will continue working with the County Prosecutor's Office to provide CIT training to local law enforcement.

Morris Mental Health Diversion (MMHD) (Morris) Criminal Justice Reform (CJR) (Essex)

Description

The Morris Mental Health Diversion (MMHD) Program, part of the CJS team, promotes recovery by engaging individuals, assessing their readiness for change, and connecting them to mental health, housing, and other supportive services. The program partners with local law enforcement and courts to divert eligible individuals from the criminal justice system at an early stage, with the goal of reducing recidivism and supporting long-term wellness and recovery.

The Essex Criminal Justice Reform (CJR) Program is a consumer-centered outpatient behavioral health initiative that diverts justice-involved individuals with mental health needs from deeper involvement in the criminal justice system by connecting them to treatment and community-based supports. Through strong partnerships with the Administrative Office of the Courts, Essex County Superior and Municipal Courts, Essex County Correctional Facility, Pre-Trial Services, Probation, Central Judicial Processing Court, and the Public Defender's Office, eligible individuals are identified early using a Social Determinants of Health (SDOH) screening tool and referred for a comprehensive clinical assessment while at Essex County Correctional Facility. The program provides a full continuum of care, including individual counseling, psychiatric services, peer support, and advocacy. By supporting diversion efforts in both Superior and Municipal Courts, CJR aims to reduce recidivism, promote recovery, facilitate charge downgrades or dismissals when appropriate, and improve long-term stability and successful community reintegration

Personnel

At MMHD, there is one Program Director, one Forensic Case Manager (FCM), and one Licensed Forensic Clinician. Staff work within the jail and in the community, completing intakes and developing treatment plans for consumers who are eligible for the Morris and Sussex County Prosecutors' Mental Health Diversion Program.

CJR is staffed by a multidisciplinary team consisting of one Program Director, one Peer Support Specialist, and two licensed clinicians (LCSW/LPC). Team members operate both within Essex County Correctional Facility and in the community, conducting screenings and intake assessments and providing treatment to eligible individuals approved for pre-trial release.

Caseload

As of June 30, 2026, MMHD had 28 active cases. During FY 2026, referrals for MMHD were made through the Morris County Prosecutor's Office, the Morris County Public Defender's Office, the Sussex County Prosecutor's Office, and the Morris County Sheriff's Department (Community Connections).

As of June 30, 2026, CJR had 32 active cases and served a total of 67 consumers during the year. During FY 2026, referrals for CJR were made through Essex County Correctional Facility, Essex Municipal Courts, and Probation.

Demographics

MMHD accepts individuals who are 18 years of age or older and are mental health consumers who are not yet incarcerated but are at risk for incarceration due to criminal involvement, as well as criminally charged adult residents of Morris County who have a mental illness or co-occurring mental illness and substance use disorder and who are either: Pending discharge from or incarcerated in the Morris County Correctional Facility (MCCF); or Released, or charged on a summons, and facing indictable charges.

CJR accepts individuals who are 18 years of age or older, have a positive mental health screening, and are criminally charged adult residents of Essex County who are on pre-trial release and have third- or fourth-degree charges.

Performance Outcomes

Performance outcomes were measured and monitored through MHA's Quality Assurance (QA) Committee. MMHD consumer recidivism to jail within 30, 60, 90, and 120 days was monitored monthly. The threshold indicates that fewer than five consumers would return within 30 and 90 days, and fewer than ten consumers would return to jail within 60 and 120 days. During FY 2025, 0 consumers returned to jail within 30 days, 0 consumers returned within 60 days, 0 consumers returned within 90 days, and 0 consumers returned within 120 days.

During FY 2026, MMHD successfully collaborated with the Morris and Sussex County Prosecutors' Offices to admit 22 clients into the Prosecutors' Mental Health Diversion Program. As a result, staff successfully diverted consumers from a criminal sentence, avoiding approximately 45,615 prison days. For FY 2026, the program saved approximately \$9,259,845 in state costs as the approximate daily cost to house an inmate is \$203.

CJR's performance outcomes were measured and monitored through MHA's Quality Assurance (QA) Committee. One key metric tracked monthly was consumer recidivism to Essex County Correctional Facility within 30, 60, 90, and 120 days post-release. During FY 2026, 0 consumers returned to jail within 30 days, 2 returned within 60 days, and 2 returned within 90 and 120 days. Furthermore, beyond the initial 120-day follow-up period, four individuals were re-incarcerated, resulting in a 6% recidivism rate (4 of the 67 consumers served during the fiscal year). This reflects a 94% success rate in preventing re-incarceration among program participants.

CJR also collaborated effectively with Essex County Superior Court, Municipal Courts, and the Essex County Public Defender's Office to facilitate the dismissal of 15 cases. During FY 2026, Municipal Court Mental Health Diversion Programs were established in Newark, East Orange, and Irvington. By the end of the fiscal year, 15 consumers were actively participating in diversion, with 5 successfully graduating from the program.

Consumer Satisfaction Surveys

In Morris and Essex Counties, surveys were distributed and tallied to measure consumer satisfaction. All consumers were informed that their responses would remain confidential. They were provided with a sealed envelope to protect anonymity and informed of several methods for returning the surveys.

MMHD

Surveys were distributed to consumers resulting in a 63% response rate for the program. A core strength of the MMHD program is its exceptional client satisfaction and commitment to creating a respectful and empowering environment. Recent survey results show a remarkable 100% satisfaction rate on key measures, including overall satisfaction, dignity and respect, and staff availability. Furthermore, the program encourages self-direction and personal choice, with 100% of individuals reporting that they are encouraged to make their own decisions and actively participate in their treatment goals. The data also underscores the program's effectiveness in its primary mission, as 100% of clients reported receiving resources and support to avoid incarceration, demonstrating the program's real-world impact. **Gender:** Of the consumers who responded to the survey, 70% were female and 30% were male. **Ethnicity:** Of the consumers, 30% identified as Hispanic and 70% identified as Caucasian. **Age:** The exact ages of the consumers were collected. Of the consumers, 20% identified as being between 25–34 years old, 40% were between 35–44 years old, and 40% were between 45–54 years old.

Essex CJR

In Essex County, surveys were distributed and tallied to measure consumer satisfaction. All consumers were informed that their responses would remain confidential. Consumers were provided with a sealed envelope to protect their anonymity and informed of several methods for returning the surveys, resulting in a 33% response rate. 100% of respondents strongly agreed that they were satisfied overall with CJR services.

The 2026 Criminal Justice Reform (CJR) Satisfaction Survey shows overwhelmingly positive feedback from participants, with 100% strongly agreeing that staff assisted them in achieving their goals. All respondents also reported active participation in treatment planning, feeling culturally understood, and being willing to recommend the program. Open-ended responses highlighted improvements in mental health, independence, access to employment and education, and overall life satisfaction. **Gender:** Of the consumers who responded to the survey, 100% were male. **Ethnicity:** Of the consumers, 40% identified as African American and 60% identified as Hispanic. **Age:** Of the consumers, 20% was between 18–24 years old, 20% were between 25–34 years old, one 20% was between 45–55 years old, and 20% was between 56–64 years old.

Program Highlights

- MMHD staff successfully connected clients to 174 community resources and linkages.
- The Morris Program Director and the Morris County Prosecutor's Office provided 160 hours of Crisis Intervention Team (CIT) training to approximately 104 law enforcement officers and 46 mental health professionals.
- A Morris County Mental Health Diversion graduate participated in four CIT trainings to educate law enforcement officers on effective communication strategies for interacting with individuals experiencing a mental health crisis. By sharing their lived experience, the graduate helped enhance officers' understanding of de-escalation techniques and foster more compassionate and effective responses to individuals in crisis.
- The Morris County CIT Program was awarded the 2026 Program of the Year at the 11th Annual CIT-NJ Conference and Awards.
- 4 consumers successfully graduated from the Morris County Prosecutor's Mental Health Diversion Program, resulting in the full dismissal of their criminal charges.

- There were 12 new admissions into the Morris County Prosecutor's Mental Health Diversion Program and 10 new admissions into the Sussex County Prosecutor's Mental Health Diversion Program.
- In August 2025, the Program Director attended the CIT International Conference in Anaheim, California. The purpose of the conference was to bring together law enforcement, mental health professionals, advocates, and public safety leaders.
- MMHD consumers, in collaboration with other MHAEM adult programs, attended a picnic at Hedden Park, a fall festival at the Morris Campus, and a holiday party hosted by Holiday Express at the Ukrainian American Cultural Center of New Jersey.
- MMHD participated in the Annual Consumer Achievement Awards ceremony, held at the Morris Campus, recognizing the success and progress of program clients.
- CJR staff pre-screened 386 individuals using the Social Determinants of Health tool at Essex County Correctional Facility and completed 56 clinical assessments.
- CJR staff successfully connected consumers to 69 community resources and linkages.
- CJR, in partnership with Essex Municipal Courts, established Mental Health Diversion Courts in Newark, East Orange, and Irvington, meeting one Friday per month.
- CJR presented on Criminal Justice Reform at the American Counseling Association annual conference, and the program was highlighted in the association's monthly newsletter.
- CJR partnered with the Orange Police Department to conduct community engagement events in September 2025.
- CJR participated in a Mental Health Awareness event with CareWell Health.
- The CJR Program Director continues to offer Mental Health First Aid and Motivational Interviewing training to the community and within MHA.
- CJR participated in the Annual Achievement Awards, held at The Elks Lodge in West Orange, celebrating the mental health achievements of consumers.
- CJR participated in the annual boat trip, Halloween party, Thanksgiving party, holiday party, and annual picnic during the fiscal year. These events highlight MHA's commitment to fostering community.

Advocacy Activities

The MMHD Program Director participates as a member of the Review Team for the Morris County Prosecutor's Office Mental Health Diversion Program, the Morris CIT Steering Committee, and the NJ State CIT Committee.

The CJR Program Director and CJR clinicians actively participate in monthly review meetings for the Newark, Irvington, and East Orange Mental Health Diversion Courts. In addition, they continue to advocate for consumers involved in other municipal courts, Superior Courts, and civil cases by collaborating closely with community partners to ensure comprehensive support and representation.

Morris and Essex County staff work closely with consumers to assist them in developing self-advocacy skills by maintaining an open dialogue about various ways they can become involved in different levels of advocacy (i.e., self-help centers and NAMI-NJ).

FY 2027 Goals

MMHD staff will focus on increasing the total number of contacts with consumers, their families, and service providers. They will continue to work closely with the Public Defender's Office to

enhance collaboration and support consumer success. Additionally, MMHD will continue collecting data and closely monitoring all performance indicators to ensure ongoing improvement. The team will also continue working with consumers to empower them to achieve their goals. To enhance their effectiveness, MMHD staff will attend relevant trainings to expand their knowledge of best practices. They will also conduct trainings and presentations as needed to educate others about the role of MMHD, including local law enforcement. Furthermore, MMHD will maintain collaborative efforts with the Morris County Correctional Facility to increase referrals and will continue working with the Morris County Prosecutor's Office to provide CIT training to local law enforcement.

C

JR staff will focus on increasing the total number of consumers served and expanding the number of contacts with consumers, their families, and service providers. They will continue to work closely with Essex County program partners, including the Administrative Office of the Courts, Superior Court, Municipal Courts, Central Judicial Processing Court, Pre-Trial Services, the Public Defender's Office, and Probation, to enhance collaboration and support consumer success. Additionally, CJR will continue collecting data and closely monitoring all performance indicators to ensure ongoing improvement. The team will continue working with consumers to empower them to reach their goals and will attend relevant trainings to enhance their knowledge of best practices. CJR will also conduct presentations as needed to educate others about the program and will maintain collaborative efforts with Essex County Correctional Facility to increase referrals.

Community Support Services (CSS)

Description

The mission of Community Support Services (CSS) is to increase accessibility to quality, affordable housing in Essex and Morris counties for adults (18+) diagnosed with a serious and persistent mental illness, and to provide comprehensive, high-quality mental health services. The goal of CSS is to assist individuals who are currently hospitalized, homeless, or living in substandard housing in gaining access to adequate, affordable housing. Since its inception in 2006, CSS has been able to identify and develop housing opportunities, such as two residences in Bloomfield, one in Nutley, and one in Montclair, along with creating relationships with landlords in the community to secure lease-based housing for our consumers. CSS also offers flexible support services that are based on wellness and recovery principles.

CSS works collaboratively to build on each individual's capacities, resiliencies, and talents to develop an individualized, strengths-based rehabilitation plan. This plan promotes successful reintegration into the community while supporting individuals in resuming or engaging in new life roles (e.g., tenant, partner, caregiver, friend, student, and employee). It is the belief of the program that, with support and access to a safe, affordable living environment, individuals in recovery will be able to live in the community and achieve a higher quality of life.

Personnel

The CSS quality services are provided by 1 Director, 2 Recovery Coordinators, 4 Clinical Coordinators, 7 Senior Recovery Counselors, 14.5 Recovery Counselors, 2 Housing Specialists, and 2 Full-Time Nurses. CSS has 1 staff fluent in Creole, 2 fluent in French, and 2 fluent in Spanish.

CSS provides flexible services tailored to each individual's needs. The program has consistently gone above and beyond typical supportive housing services and has demonstrated creativity in its services and referrals. CSS staff are available for support and crisis intervention 24 hours a day, 365 days a year. A system has been developed to ensure prompt access to the appropriate on-call personnel, identifying a responsible party as the chief point of contact for on-call coverage. Our ability to respond to individuals around the clock has prevented numerous psychiatric hospitalizations and emergency room visits.

Caseload

Community Support Services has successfully placed over 331 individuals diagnosed with a serious and persistent mental illness from a wide variety of referral sources, such as Greystone Park Psychiatric Hospital, Essex County Hospital Center, community-based providers, higher level of care/service organizations, self-referrals and shelters due to homelessness. Additionally, CSS provided supportive services to 71 individuals who have their own residence but needed additional care to ensure their stability in the community.

Demographics

As of June 30, 2026, the active caseload for Community Support Services was 300. On this date, there were 53.5% male, 45% female, and 1.5% transgender. The self-reported ethnicities of the consumers enrolled with CSS are as follows: 9% Hispanic/Latino; 89% non-Hispanic/Latino, and 2% individuals who did not want to disclose. The self-reported races of the consumers enrolled with CSS are as follows: 2% Asian; 1% Black or African-American & White; 45% Black or African-American, 1% multi-racial; 1% Native Hawaiian or Other Pacific Islander; 3% Other; 45% White; 2% who did not want to disclose.

CSS works with consumers throughout Essex and Morris counties. Remaining cognizant of the importance of wellness and recovery, CSS consumers primarily live-in residences that are convenient to mass transportation, employment opportunities, social service organizations, and natural community supports.

Performance Outcomes

Community Support Services (CSS) participates in the agency-wide Quality Assurance Committee (QAC) which conducts monthly meetings and collects data on utilization of services, quality assessment, quantitative monitoring, incident review and risk management, satisfaction surveys, and measured outcomes of performance.

CSS performance indicators measure the rate of recidivism to the County/State hospitals and recidivism rate to the Short-Term Care Facilities on a monthly basis. During this fiscal year, the overall recidivism rate to the County/State hospitals was 0% and the recidivism rate for Short-Term Care Facilities was 3%. Both of these rates of recidivism are below the threshold of twenty percent (20%) for a population who, traditionally, relies heavily on acute care services.

CSS performance indicators also measure the linkage to employment which includes full-time work, part-time work, volunteer work, and educational programs. This performance indicator is monitored quarterly. During this past fiscal year, CSS was able to assist 13% of our consumers to secure and/or maintain involvement with employment, vocational programs or schools.

Health and Wellness continues to be one of the primary areas of focus within the CSS program. 100% of individuals participating in CSS were educated on “Summer Heat and Sun Risks for Antipsychotic Medication Users.” The CSS staff provide ongoing medication education and support. This includes identification and management of side-effects.

Consumer Satisfaction Surveys

MHA is continuously refining services based on consumer input, which is received through various methods, including the annual Consumer Satisfaction Survey. This year, one hundred ten (110) individuals served completed the surveys. The overall satisfaction rate was 94%, with 94% of respondents feeling they can freely voice their issues or concerns. Additionally, 96% indicated that they felt they were treated with dignity and respect, that staff encourage individuals to make their own decisions, that they actively participate in their rehabilitation plan, and that staff are respectful of their cultural backgrounds.

Program Highlights

This year, MHA participated in a research study with NYU on Overdose Prevention in Permanent Supportive Housing. Both Housing Specialists from the CSS program participated and were able to share knowledge and tools with the rest of the program. In addition, a consumer from the agency-owned Drill apartments participated in the study and reported feeling proud to be part of something that could potentially save lives.

As a result of this successful study, MHA was invited to participate in the Permanent Supportive Housing Overdose Prevention+ (POP+) Project. This project is a collaboration with the Committee of Supportive Housing (CSH), the National Harm Reduction Coalition, Rutgers University, and NYU Grossman School of Medicine to inform best practices in supportive housing settings that will help providers reduce the risk of overdose and death related to opioid use, and to improve overall health outcomes for supportive

housing residents. We are very excited to build off the success of our first POP Study and to continue to impact and support the field.

This year, CSS staff participated in Narcan Training conducted by Prevention is Key and are all certified to administer Narcan in the event of a potential overdose. Additionally, all staff received training in Motivational Interviewing to enhance service engagement and provide staff with the case management skills necessary to deliver high quality services to the individuals served.

CSS Morris is in its third year as a Housing Authority managing the Safe Haven Permanent Supportive Housing project. This program provides rental subsidies to 12 consumers and offers case management services as well. Seven of the twelve consumers are enrolled in the CSS program and are happy to have their Housing Authority managed by MHA as well. During the past year, the Safe Haven program underwent a Site Monitoring audit which resulted in an overall score of 93%, as well as a perfect score for Program Evaluation and Data Quality. During the past year, the Safe Haven program successfully “graduated” one of its consumers, who completed Nursing school, secured full time employment and is able to maintain her apartment without the use of a rental subsidy. The project is at full capacity with 2 recent admissions, both of whom had a history of chronic homelessness and now have a place to call home.

CSS continues to own and operate two single-family homes in Bloomfield, a 6-unit apartment building in Nutley, and two 6-unit buildings in Montclair. These properties provide permanent supportive housing to a total of 25 individuals diagnosed with severe and persistent mental illness. CSS ensured that the buildings’ exterior and interior met or exceeded the quality of the housing in the neighborhood. CSS retains professional landscaping services and contractors who specialize in construction, heating, air conditioning, electric, plumbing, and snow plowing. During this year’s CARF review, the Drill apartments in Montclair were visited by the CARF reviewer who noted the exceptional condition and upkeep of the property. Several consumers were interviewed by CARF who reported that it was evident that the residents were provided wrap-around services specific to their needs which allowed them to feel supported and well cared for in a place that felt like home.

The CSS program held several group sessions at the properties throughout the year on topics such as Roommate Relationships, Stress Management, and Maintaining Healthy Coping Skills. The feedback from the consumers was very positive, with requests for more groups in the future.

CSS continued to develop strong relationships with landlords and other service providers throughout Essex and Morris counties in order to better meet the needs of the individuals served. CSS has a Housing Specialist in each county to build on landlord networking and establish supportive positive relationships with them to keep consumers housed and prevent eviction. As a result, 7 homeless individuals and 2 CEPP individuals leaving State Hospitals were housed in the past year. Several other consumers were able to prevent eviction due to the advocacy and strong relationships with landlords who trust that the CSS program will go above and beyond to support their consumers and get them the help they need to remain stable in their apartments.

CSS participates in the Annual Consumer Achievement Awards. This year’s award recipient in Morris was a young woman who one year prior, was on the verge of eviction, unstable and living in an unkempt apartment, refusing to engage with staff. Due to the tenacity and persistence of the CSS Recovery counselors, the consumer finally agreed to reconnect with mental health treatment, allowed her case manager to assist in cleaning her apartment, and was able to advocate to the landlord to withdraw the

eviction application. The Essex County award recipient was an individual who over the course of the year, was able to obtain his driver's license, find part-time employment, and was able to graduate from his Methadone maintenance program, all while dealing with the death of both his brother and mother.

CSS goes above and beyond when assisting consumers with special requests that, while out of the ordinary, represent important milestones in their recovery. For example, a husband and wife, both CSS consumers, were able to maintain regular visitation while the wife experienced a broken hip and spent several weeks in the hospital and rehab facility. CSS staff outreached the husband twice a day to ensure he was taking his medication, maintaining his apartment, and was able to keep in contact with his wife.

At MHA's Kingsland Avenue property in Nutley, two neighboring consumers developed a close friendship that became a meaningful source of companionship for both of them. When one individual had to relocate to a nursing home due to increasing medical needs, MHA remained committed to supporting their bond by arranging regular visits for the other consumer. These visits continued until the individual's passing, allowing the friends to spend precious time together in his final days. By making these visits possible, MHA helped provide comfort, connection, and a sense of closure during a difficult time.

Advocacy Activities

CSS staff work closely with each individual to develop self-advocacy skills and to encourage involvement in both program-level and systems-level advocacy. These skills are used to procure on-going and necessary services and supports. Staff provided education on direct skills and linked individuals to trainings and activities related to the consumer movement (Self-Help Centers, Consumer Advocacy Partnership). Individuals were also encouraged to participate in self-help groups, NAMI-NJ, and other MHANJ advocacy initiatives.

In addition, CSS staff continued to participate in the following Committees and Meetings:

- Comprehensive Emergency Assistance System (CEAS)
- Community Assistance Services (CAS)
- Essex and Morris County Residential Meeting (which is a sub-committee to the System Review Committee (SRC))
- Community Assessment Team (CAT)
- Landlord Support Program (LSP)
- Morris County Data Quality Committee
- Supportive Housing Association (SHA)
- Morris County Provider Resource Committee (MCPRC)
- CSS Monthly Meeting by DMHAS

FY 2027 Goals

CSS aims to achieve a 100% lease-up rate for all tenants residing in MHA owned properties and to fill all vacant beds promptly in both Essex and Morris counties. The program also seeks to maintain weekly Medicaid billing in preparation for the anticipated transition to a fee-for-service model. CSS continues to proactively prepare for evolving federal regulations affecting Permanent Supportive Housing while remaining steadfast in its commitment to ensuring that no consumer returns to homelessness. Through strategic planning and a person-centered approach, CSS is dedicated to maintaining stable housing and providing the support individuals need to thrive despite a changing regulatory landscape.

Community Wellness Centers- The Gathering Place

Description

MHA's Community Wellness Centers are peer-driven, community-based resources that provide a safe and welcoming space where individuals can engage in a variety of therapeutic and recreational activities aimed at promoting mental, emotional, and physical well-being. Services are designed to empower individuals, foster independence, and promote self-efficacy in an environment that encourages social connection and personal growth. Through workshops, group activities, and social events, the Centers encourage self-expression and skill-building while supporting individuals in achieving their wellness goals. Program elements include peer support/self-help activities, socialization, training and education, wellness and recovery activities, community outreach, and advocacy. Through these elements, the Centers aim to maximize members' independence, increase their quality of life, and cultivate a community of recovery that supports the development of healthy social support systems.

Personnel

Each location has a Program Director who provides oversight, support, and supervision to the programs as needed. The Community Wellness Centers are staffed by a full-time Wellness Manager at each site who supervises the part-time Support Specialists, bilingual Support Specialists, and Community Resource Navigators. All staff members are professionals with lived experience and personal experience with mental health and/or substance use recovery.

Caseload

In their second year of operation, the Morris and Sussex Wellness Centers engaged 387 new individuals with lived experience of mental health and/or substance use challenges. Members of The Gathering Place in Morris and Sussex Counties visited the Centers an impressive 11,542 times throughout the year. Each Center serves a unique population within its respective community and structures its schedule to meet the needs and interests of its members.

Members of the Centers are adults 18 years of age or older. They have a history of mental health or substance use diagnoses and are at various stages of recovery. Each member of the Wellness Centers has a unique story. It is our belief that members can use their experiences to help guide their peers in their own recovery journeys. Some members are new to the mental health system but have lived with symptoms for most of their lives, while others are experiencing symptoms for the first time.

Performance Outcomes

The Community Wellness Centers participate in the agency-wide Quality Assurance (QA) program, which conducts monthly meetings and collects data on the utilization, quality, and effectiveness of services and treatment provided by each Mental Health Association program.

The Community Wellness Centers' performance indicators measure overall consumer satisfaction, accessibility (whether the Centers are open during times convenient for members), effectiveness (the number of visits made to the Centers), and efficiency (the ease of accessing the Centers). During this fiscal year, 100% of members surveyed reported that they were satisfied with the Community Wellness Centers. Our Centers are available after typical business hours on Mondays, Wednesdays, and Saturdays to meet the needs of members. In FY 2026, the Morris Center recorded 4,783 member visits, while the Sussex Center recorded 6,759 member visits, for a total of 11,542 visits.

Consumer Satisfaction Surveys

Wellness Managers at the Centers focus on engaging new members and ensuring that the Centers remain safe and welcoming environments. We continue to hold weekly community meetings called **Community Empowerment Meetings**. During these member-run meetings, all attendees are able to voice concerns in real time. Members participate in the planning process for new groups, trips, and activities, as well as efforts to engage new members and identify ways to improve the Centers overall.

In Fiscal Year 2026, 100% of survey respondents reported that they were satisfied with the CWC. Additionally, 91% felt that the peer providers were welcoming, friendly, and professional, and 87% of consumers who attend the Community Wellness Centers reported that they attend more than once a week. In addition, 100% of members surveyed reported that they had been introduced to new friends while attending the Centers.

Program Highlights

This fiscal year, The Gathering Place served as a vital sanctuary for adults navigating mental health and substance use challenges in Morris and Sussex Counties. By fostering healing, connection, and personal growth through peer-led groups, supportive services, and meaningful socialization, the Centers stand as a beacon against loneliness and isolation. They provide a respectful, stigma-free space where individuals feel accepted, empowered, and supported on their journeys toward recovery and whole-health wellness. Regular visits from partners, including Nourish, CHOICES, County College of Morris, Sussex County partners, Hope One, Navigating Hope, JBWS, Family Promise, and other treatment and program providers, have been instrumental in connecting members to critical resources, education, and care. These collaborations strengthen the Centers' ability to offer comprehensive, person-centered support that extends beyond the walls of the program. In addition, members were offered the opportunity to participate in vital trainings, including Narcan administration and CPR and First Aid certification.

The Community Wellness Centers offer a rich array of groups and activities designed to support mental, emotional, and social well-being. Therapeutic and recovery-focused offerings include art therapy; depression and anxiety support groups; All Recovery meetings; mindfulness and meditation sessions; coping skills and stress management groups; and peer-led discussions on self-esteem and healthy relationships.

Wellness and life-skills programming features wellness and nutrition workshops, document assistance, creative writing circles, and book club. Movement and mind-body practices include yoga and gentle movement classes. Social connection is nurtured through game nights, music jams, and walking clubs that foster inclusive networks where participants feel welcome, valued, and connected.

In addition, both Centers participated in a Rutgers University project to pilot an innovative intervention, **Positively Happier**. The program integrated positive psychology with psychiatric rehabilitation techniques and consisted of a structured framework of 15 modules designed to enhance participants' skills related to happiness. Key elements included harnessing individual strengths, fostering grit, enriching social connections, and building resilience.

Community meals at the Centers are about far more than food; they provide nourishment for both body and spirit. Sharing a meal creates a natural space for conversation, connection, and belonging. For many participants, these gatherings are a rare opportunity to sit at a table surrounded by friendly faces, to be welcomed without judgment, and to feel seen and valued. The simple act of eating together helps break

down barriers, reduce isolation, and foster a sense of dignity. Through meal preparation and gardening, participants do more than cook; they connect, share stories, and build a shared sense of pride and belonging. This year, we took an additional step toward shifting from staff-run meals to meals that are planned, scheduled, prepared, and served by members, with love.

In FY 2026, both Centers participated in a nutrition-focused group called **Food & Mood**, where members learned how specific foods can support good health, stabilize mood, and boost energy while also having the opportunity to taste and experience these foods firsthand.

This year, both Centers were awarded a Wellness Grant through the NJ Peer Connection Whole Health Learning Collaborative, a statewide initiative funded by the New Jersey Division of Mental Health and Addiction Services to advance whole-health approaches in wellness centers. Grant funds support community outings and enhanced wellness programming, including sporting events, movie nights, bowling, and visits to zoos or museums to promote social connection and community engagement. Funds also support the hiring of external health and fitness professionals to lead yoga, pet therapy, and similar activities, expanding the quality and variety of health-focused offerings.

Members have already enjoyed special events such as movies, pet therapy sessions, and a trip to the zoo, as well as a community picnic filled with good food, laughter, and fellowship. These experiences give participants an opportunity to step away from daily challenges, connect with peers, and enjoy the simple pleasures of friendship and shared traditions.

Advocacy Activities

Core advocacy activities include advocacy groups, community education on mental health and substance use disorders, challenging myths and stereotypes, and creating open conversations that normalize seeking help. The Centers engage members in peer-led leadership training so individuals can become advocates for themselves and others, speaking at public forums, legislative hearings, and community meetings. Staff work with local and state partners to support policies that improve access to affordable treatment, housing, employment, and wraparound recovery services.

Each month, members at The Gathering Place take an active role in advocacy through a dedicated group that empowers them to understand and address issues impacting their lives. During these sessions, participants learn about current developments and proposed changes that may affect their income, benefits, housing, and access to services. The group also serves as a vital forum where members can bring forward personal concerns or community challenges, discuss them openly, and work together to identify possible solutions.

FY 2027 Goals

In Fiscal Year 2027, The Gathering Place will place a strong focus on increasing community awareness and expanding participation in its programs. The goal is to ensure that more residents, especially those affected by mental health challenges, substance use recovery, and related life stressors, know about the Centers' services, feel welcomed, and feel encouraged to participate.

To achieve this, The Gathering Place will strengthen its outreach through presentations at community events, partnerships with local organizations, and regular visits from trusted partners. Promotional materials and success stories will be shared through the Centers' newsletters, social media campaigns, and direct engagement with community groups, faith organizations, and service providers.

The Centers will also explore creative ways to connect with potential participants, from hosting in-house events and wellness workshops to inviting the public to attend social activities such as community meals, art therapy sessions, and seasonal events. By combining personal outreach with broader publicity efforts, The Gathering Place aims to increase awareness, build trust, and welcome more individuals into a supportive environment where they can heal, learn, and grow.

In addition, the Centers aim to recruit at least five community members into an active advocacy network. These members will become vital voices for change, helping to increase awareness and drive community action. To support this goal, The Gathering Place will participate in community events, sharing accessible and empowering information about the Centers. Monthly calendars will also feature discussion groups dedicated to mental health and substance use recovery, creating opportunities for education, open dialogue, and community engagement.

Partnerships will continue to be a cornerstone of the Centers' advocacy work. These collaborations will enable improved wraparound supports that address the full spectrum of needs for individuals in recovery, from housing and employment to healthcare and social connection.

Family Resource Center (FRC)

Description

The FRC includes the following programs and services:

Intensive Family Support Services (IFSS) in Essex and Sussex County:

Intensive Family Support Services (IFSS) are designed to provide support, education, advocacy, and respite to family members coping with the mental illness of a loved one. Over the past year, IFSS services were delivered in a hybrid format, offering families the option to attend in person or receive services through virtual platforms. Through individual supportive counseling sessions, psychoeducational workshops, family support groups, respite services, and telephone consultations, families learn skills to help them manage the stress associated with caring for a loved one with mental illness.

Family Respite Services “Thursdays” Consumer Drop-In Center:

For over 20 years, IFSS Essex has facilitated “Thursdays,” a consumer drop-in center that meets every Thursday for 2.25 hours, from 6:30 PM to 8:45 PM. Through this service, families are provided with 2.25 hours of out-of-home respite and relief from caring for their loved ones with mental illness. IFSS families have been comforted by the knowledge that their loved ones can get out of the house and make positive social connections with peers, which are both critical to wellness and recovery.

Project F.ER.S.T. – Family Emergency Room Support Team:

Acute Care Family Support (ACFSP), also known as “Project F.ER.S.T.,” is the NJDMHAS contracted service component that provides in-person support, education, and advocacy to families while their loved ones are in local acute care hospital emergency rooms, accompanying them through the psychiatric screening process. As one of the few community-based acute care family support programs in the state, Project F.ER.S.T. faces unique challenges in receiving referrals from all of the Essex County acute care hospitals, which include three psychiatric screening centers. The success of Project F.ER.S.T. depends on its ability to maintain relationships with screeners and hospital staff, as these relationships generate the majority of its referrals. Consequently, Essex County families benefit from emotional support and education regarding hospital procedures and commitment laws while their loved ones are experiencing a mental health crisis.

Information and Referral Services:

The information and referral (I&R) service component continues to serve as a major gateway for individuals in the general public seeking mental health services or information. This component involves responding to phone requests received at the Montclair, Parsippany, and Newton offices. It also includes responding to requests for mental health services from individuals who walk in off the street, communicate via e-mail, or make inquiries through the agency’s website. These requests for information and referrals are handled by staff, graduate students, and volunteers from the different programs at each agency location.

Personnel

IFSS Essex – One Coordinator/Family Support Specialist, one part-time Family Support Specialist, one full-time Family Support Counselor, and several graduate interns and community volunteers.

IFSS Sussex - One Coordinator/Family Support Specialist and one part-time Family Support Counselor.

“Thursdays” respite group is led by one full-time Family Support Counselor and MHA interns.

Project F.ER.S.T.: One full-time Acute Family Support Counselor

Performance Outcomes

IFSS Essex: The IFSS Essex program produced 2799 units of service, representing 110% of its overall targeted program commitment for the 2026 fiscal year. Multiple Family Support Groups (134%) significantly exceeded contracted thresholds. Psychoeducational sessions, conducted both in-person and through virtual platforms, also exceeded expectations (134%). Some IFSS families returned to in-person consultations, with many opting to continue virtual telehealth support. Combined, these efforts exceeded targeted goals at 116%. The “Thursdays” drop-in social group for consumers, along with other respite activities, contributed to out-of-home respite services exceeding projections for the year (136%). Collateral contacts also surpassed their target goal this year (258%). Overall, IFSS Essex served 195 families during this fiscal year.

IFSS Sussex: IFSS Sussex produced 1829 units of service, reaching 106% of its overall targeted program commitment for FY2026. The program exceeded its commitments in several areas, including: total families served (148%), off-site visits (112%), multi-family support groups (102%), psychoeducational sessions (141%), and supportive phone calls (151%). IFSS Sussex served 111 families during this fiscal year.

Project F.ER.S.T.: During fiscal year 2026, the Acute Family Support Counselor served 117 families, either through referrals received by hospital emergency departments or through other emergency-based resources such as Co-Response or Mobile Crisis Outreach Response Teams. Additionally, 150 face-to-face offsite follow-up contacts were provided, totaling 347 units of service.

Consumer Satisfaction Surveys

IFSS: Satisfaction with the Essex and Sussex IFSS programs was measured through consumer surveys. The Essex survey had a 28% response rate, with respondents consisting of 82% parents, 17% siblings, 7% spouses/partners or significant others, and 7% children or grandchildren. Overall, Essex families reported a 100% satisfaction rate. The Sussex survey had a 21% response rate, with respondents consisting of 89% parents, 5% children or grandchildren, and 5% siblings. Overall, Sussex families also reported a 100% satisfaction rate.

Project F.ER.S.T.: To ensure the highest quality of services for families, a questionnaire is provided annually to families who received services. According to the responses: 100% of respondents agreed or strongly agreed that they would recommend Project F.ER.S.T. and that they were satisfied with the services they received. Additionally, 100% agreed that they were treated with respect by the Project F.ER.S.T. counselor; 100% reported they coped more effectively with their loved ones’ hospitalizations as a result of receiving Project F.ER.S.T. services; and 100% felt supported and listened to by the counselor.

Program Highlights

IFSS Essex: During FY2026, IFSS facilitated 335 family support group sessions. In addition, 121 psychoeducational workshops and 408 respite sessions were conducted to counteract stress related to their loved ones’ illnesses. IFSS Essex offered four distinct opportunities for families to engage in professionally facilitated support groups during the past fiscal year. Psychoeducational series focused on educating family members about available resources for their loved ones, including local resources such as NAMI chapters, education on Mental Health First Aid and Suicide Prevention Services. This year, IFSS Essex hosted multiple family respite groups and opportunities including Wellness Wednesdays which

resulted in a group collage mosaic, expressing both challenges and resilience experienced by parents, siblings and partners, displayed at the 8th Annual Tea Party for Family Members.

IFSS Sussex: During FY2026, IFSS Sussex facilitated 298 family support group sessions and 130 psychoeducational program sessions. These programs aimed to teach families about how to handle a crisis, diagnoses, available services and coping skills for caring for loved ones. IFSS Sussex offered respite groups during each quarter of FY26, providing 31 respite events this year. During these gatherings, families had time to focus on themselves, rather than caregiver for their loved one. At Greystone Park Psychiatric Hospital, IFSS Sussex continued to advocate at the monthly Concerned Families Group meetings to assist Sussex County families in advocating for their loved ones hospitalized at Greystone.

“Thursdays” Respite: “Thursdays” has seen an increase in participation, with at least 20 individuals attending each week. Throughout the year, “Thursdays” has offered invaluable activities that incorporate the whole person, such as karaoke, an ice cream social, and attendance at “First Thursday” at the Montclair Art Museum, which is a free community event.

Project F.E.R.S.T.: Due to the decrease in family presence at the local emergency departments, Project F.E.R.S.T. staff have found creative ways to connect families to this crucial service. Staff attended psychiatric screening team meetings at local hospitals, connected with Co-Response Social Workers at police departments, and collaborated with Mobile Crisis Outreach Response Teams. Over FY2026, Project F.E.R.S.T. served 117 families and provided 150 follow-up contacts. Throughout the year, the program maintained a presence at the monthly Essex County Systems Review Committee meetings, providing opportunities to collaborate with community providers and promote program services.

Information and Referral Services: The continued use of electronic health records allowed multiple MHA sites (Montclair, Parsippany, Newton) to collect and analyze data more efficiently. During FY2026, a total of 1150 I&R requests were documented across the agency.

Advocacy Activities

IFSS Essex: Staff hosted an appreciation lunch for the NAMI Essex/Passaic chapter this year. During this lunch, staff, interns and volunteers from both groups got together to break bread, acknowledge past projects, and share ideas for future partnerships. Additionally, Mental Health Association of New Jersey hosted a family forum for IFSS Essex families. This forum, held at the Montclair Public Library, asked families for their feedback on the mental health system and ways they felt the system could be improved.

IFSS Sussex: In Fall 2025, Annette Hoffman participated in the panel discussion *Hearing Someone into Existence: A Cross-Curricular Conversation Inspired by Harvey* at Sussex County Community College. Following a theater department performance of a scene from *Harvey*, Annette and Psychology Professor Richard Linden explored the stigma surrounding mental illness, ways to support individuals experiencing mental health challenges, available community resources, and coping strategies for navigating today's social and political climate. The discussion emphasized that, with self-care and appropriate treatment, people living with mental health conditions can lead meaningful and fulfilling lives.

FY 2027 Goals

IFSS Essex & Sussex: IFSS Essex & Sussex will strengthen their ongoing commitment to empowering families to overcome challenges, reach their personal goals, and enhance their overall well-being. This goal will be achieved through fostering effective communication within families and providing them with

the necessary resources and support to navigate complex situations. By equipping families with the tools, knowledge, and connections they need, the programs aim to create lasting positive impacts that promote resilience and stability. Both programs are dedicated to serving a specific number of families in their respective counties, with a goal of reaching 170 families in Essex and 75 families in Sussex each year. Through ongoing outreach, education, and resource provision, IFSS Essex & Sussex strive to build stronger, healthier families and communities, fostering a supportive environment where families can thrive despite life's challenges.

“Thursdays” Respite: The "Thursdays" respite program aims to deepen and expand its role within the community by fostering stronger connections and partnerships that will bring in additional resources, services, and engaging activities for program members. By collaborating with local organizations, community groups, and service providers, the program seeks to create a vibrant and supportive environment that offers diverse social and recreational opportunities tailored to the needs and interests of participating families. In addition to enhancing the variety of activities, the program will continue to actively encourage families to participate regularly, emphasizing the importance of self-care and providing a much-needed break for caregivers. This respite not only benefits parents and guardians by offering them time to rest, recharge, or attend to personal matters but also provides loved ones with a safe, engaging, and supportive setting. Ultimately, the "Thursdays" respite program strives to strengthen community ties, improve the quality of life for families, and promote a sense of belonging and support for all participants.

Project F.ER.S.T.: Project F.ER.S.T. will strengthen and expand its efforts to deliver critical services within emergency room settings during psychiatric crises involving family members' loved ones. Recognizing the urgent need for immediate intervention, the program will provide rapid support to families facing these challenging situations, ensuring they receive the care and guidance necessary to manage acute mental health emergencies. In addition to offering immediate emotional and practical assistance, Project F.ER.S.T. will continue to serve as a vital resource for helping families navigate the often complex and overwhelming mental health system, connecting them with appropriate services and ongoing support. The program remains committed to its goal of assisting a total of 144 families a year, ensuring that more individuals and their loved ones receive the timely help they need during their most critical moments.

Information and Referral: As the agency continues to expand its services across Northern New Jersey, the reach of our information and referral system will also grow accordingly. Individuals seeking support will now receive assistance not only in Essex, Morris and Sussex counties but also in Hudson County. This expansion aims to provide more comprehensive and accessible guidance, ensuring that families and community members across these regions can connect with the resources and services they need to address their challenges effectively.

Health Home (Care Coordination)

Description

The goal of the Home Health services is to enhance individuals' overall well-being by integrating physical and behavioral health care. All services are individualized to meet the needs of each person served and are designed to facilitate a seamless continuum of care. Care coordination embodies a recovery-focus model of care that respects and promotes independence and responsibility.

Personnel

The Health Home program consists of 1 Program Director, and 2 Registered Nurses (RN). The Program Director oversees daily operations of the program to ensure quality service delivery and regulatory compliance, and to supervise nursing staff. The RNs provide health assessment and monitoring, education, and rehabilitative support to consumers while coordinating physical and behavioral health services. The RNs also assist in coordinating and facilitating health education groups and community health events.

Caseload

Health Home services are accessible to all MHA consumers and are adaptable to consumer preferences and needs, allowing individuals to access care at a time, place, and manner that best suits their needs. Consumers are referred to health home services through internal referrals from other MHA programs. Health Home had 152 individuals enrolled and actively receiving services as of the end of FY2026.

Demographics

The program delivered comprehensive care across the adult lifespan, supporting consumers ranging from 22 to 82 years of age. Of the individuals served, 55.9% identify as male, 41.4% as female, 1.3% as transgender, and 3.3% chose not to disclose. The self-reported races of the consumers enrolled within the Health Home program are as follows: 53.9% Black or African-American; 28.9% White; 7.2% Other; 2.0% Asian; and 7.9% who did not wish to disclose or specify.

Performance Outcomes

All programs continue to conduct Comprehensive Intake Assessments which determine the coordination of services needed. Staff gather information such as past medical and behavioral health history, family health history, and past hospitalizations. They also collect data on current medication use, medication profile and treatment, current or past substance use, and any current health concerns or needs. Suicide Risk Assessments are completed with each individual to promote prompt identification of life-threatening concerns and the need for appropriate intervention. Identification of chronic disease status is also completed, including, but not limited to the presence of asthma, cardiovascular disease, pulmonary disease, diabetes, hypertension, and obesity.

Individuals across the agency programs collaborate with MHA staff to create a person-centered plan that addresses areas of need in both physical and behavioral health. This plan is developed by the individual, and all staff members involved in the individual's care have access to this plan to promote continuity of care. Staff assist individuals in identifying appropriate services and scheduling appointments based on their needs.

Prospect Primary Healthcare monitors Body Mass Index (BMI), vitamin D levels, glucose levels, and blood pressure readings for the individuals who participate in this program as they are considered high risk. As of the end of FY2026, Prospect Primary reported a BMI average of 38% within normal range, vitamin D average of 49% within normal range, glucose level average of 63% within normal range, and blood pressure average of 63% within normal range.

Program Highlights

MHA is dedicated to improving our consumers' overall health by ensuring they receive individualized care tailored to their health needs. MHA staff continues to support each consumer in selecting physical and behavioral health service providers and assist in coordinating these services appropriately. Each individual is given the option of receiving behavioral health services through MHA programs and medical services through MHA's Prospect Primary Healthcare, located in the same building as MHA's day treatment program Prospect House. If an individual chooses to utilize a healthcare provider outside of MHA, staff remains committed to assisting in coordinating services and identifying their strengths and needs. For those without a primary care provider, individuals served by our agency are offered a yearly physical at Prospect Primary Healthcare regardless of insurance coverage or income. MHA staff continue to model and teach skills to help individuals advocate their needs to their health care providers. All individuals have access to Medical Provider Communication forms, which can be filled out with the assistance of MHA staff prior to medical appointments to help promote continuity and quality of care. MHA also provides other basic clearance forms, including a Medical Clearance Form that can be filled out by their healthcare provider to allow consumers to utilize on site gym facilities at Prospect House.

MHA staff continue to support individuals in managing their health concerns by providing resources, education, and linkage to health services. Skills-based groups are conducted by MHA staff in several programs, covering topics such as coping skills and stress management. Along with skills-based groups, health education groups are run regularly by a Registered Nurse and all individuals MHA serves are welcome to join. During these groups, individuals learn about health promotion and chronic disease management and prevention practices. During the FY2026, 414 consumers attended MHA's health education groups. Health education and counseling provided by MHA nursing staff are available to all consumers on an individualized basis.

MHA staff recognize the importance of consistent staff education to better serve the individuals in our programs and community. All staff are provided with written educational materials and are offered guidance on how to use this information to assist individuals with their health needs. Each program site maintains a binder labeled "Health Home" which contains written educational documents on the most prevalent disease processes and the most commonly used medications within the population served. These documents are also available digitally on a shared network for staff to access for themselves or for consumer education. Additionally, all MHA staff are provided with annual psychopharmacology and summer heat and sun risk training to ensure they are knowledgeable on current psychotropic medications being prescribed and to assist staff in providing important education about these medications to consumers. Agency staff were also provided with the option to attend a training on navigating the health care system, including an overview of health insurance types and coverage options, to better support and assist the population we serve. MHA staff can also contact nursing staff from the Health Home program to provide individualized health education depending on staff or department needs.

MHA staff, throughout all programs, continue to be flexible in order to meet the needs of the individuals served. This includes ensuring that appointments are scheduled at a place and time that is convenient and

comfortable for the individual. In the event of a planned or unplanned absence of staff, another team member assumes responsibility for duties and continues services without interruption. All on-call needs are met either by phone or in-vivo, and are available 24 hours a day, 7 days a week, including holidays and weekends. This service is available for support and crisis intervention, including onsite and offsite supports via telephone, face-to-face contact and collateral contacts with caregivers and other service providers.

Advocacy Activities

One of the ways MHA staff continue to support individuals in managing their health concerns and conditions is by providing access to mobile health events at MHA sites. MHA nursing staff provide on-site blood pressure monitoring and education to consumers during the annual Consumer Picnic events, and quarterly throughout MHA's sites. Health Home staff also collaborate with community providers to bring important medical screening and treatment events to MHA consumers to improve access to care. MHA partners with Zufall Community Healthcare to provide health screenings and services to MHA's sites, including blood pressure clinics, seasonal vaccination clinics, and mobile dental clinics. MHA also works with EDGE NJ to bring mobile rapid HIV testing and PrEP counseling to our sites. During this fiscal year, MHA established a collaboration with Newark Beth Israel Hospital to provide monthly sexual health education and resource events at MHA's Prospect House mental health day program. These health events are accessible to all consumers throughout the agency as well as for staff to utilize. By the end of the FY2026, 209 consumers and staff were served at our mobile health events.

During this fiscal year, Health Home continued to strengthen relationships with local health care partners to remain informed about emerging programs, services, and resources available to support the population we serve. This included participating in a networking event hosted by Nirvana Health Care focused on collaboration among community partners to reduce barriers to health care. Health Home also connected with Care Well Hospital's behavioral health center, which provides an additional treatment option for individuals experiencing medication-resistant psychiatric symptoms.

FY 2027 Goals

The Health Home program aims to expand service capacity and enhance agency-wide delivery efficacy. For FY2027, goals include increasing both the frequency and clinical variety of mobile health events. Furthermore, the program aims to actively establish new partnerships and strengthen existing partnerships with new and existing community healthcare providers to broaden consumer access to essential medical services. Lastly, the Health Home program aims to provide pain management training to 100% of agency staff through training during onboarding for new hires and annual training sessions for existing staff.

Integrated Case Management Service Essex, Morris and Passaic

Description

Integrated Case Management is an 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 in its respective county. Program staffing includes two Program Directors, three Program Coordinators, 6 Senior Case Managers, and 21 Case Managers. ICMS staff include bilingual Case Managers fluent in Spanish and Kru, with half of 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 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 for six months to 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, 2026, the ICMS caseload totaled 912 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 212 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 355 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 contacts, amounted to 90,112 units, representing approximately 22,528 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, Newark has the largest number of residents served with 112, closely followed by East Orange with 93 and Irvington with 31. In Passaic County, Paterson is the most populous municipality with 77 residents, while Morristown is the most populous municipality in Morris County with 30 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 various 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 79, with an average age of 44. Gender identity is reported as 47% female, 50% male, and 3% non-binary/gender diverse. Self-reported race of enrolled consumers are as follows: White/Caucasian (32%), Black or African-American (39%), Asian (1%), American Indian or Alaska Native (1%), Hispanic (25%) other (1%), multiracial (1%), 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 (80%), Spanish (18%), 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 rate of 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 2% in Essex, 0% in Morris and 1% in 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) in Essex County to increase employment rates and opportunities for individuals with severe mental illness. In fiscal year 2026, Passaic ICMS identified an average of 15% of the active caseload as employed, Essex ICMS identified 13%, 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 100% 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 99% of clients reported overall satisfaction, with a similar 98% feeling that they are treated with dignity and respect. Furthermore, the program is highly effective at fostering client empowerment, as 95% 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 96% 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 consumers through several meaningful initiatives throughout the year. Over 150 winter coats, along with hats and gloves as needed, were purchased and distributed to consumers and their families. This annual effort recognizes that some individuals may lack the means or ability to obtain essential items to navigate New Jersey's harsh winter months.

In addition to winter gear, food donations were received and distributed to both consumers and families. Consumers 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 provided blankets, sheets and other hygiene products to clients throughout the year.

In June 2026, 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 provide 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 for consumers transitioning or aging out of services provided by the 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 the mental health 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 of discussing 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, the 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 it receives, reviews factors, trends, gaps, and barriers that cause or play a role in fatal overdoses. From there the committee identifies any and all gaps or barriers to services, promotes and engages in cross-sector coordination and collaboration, engage in thorough discussions, and develops and provides recommendations and implementations for changes that will support the Team’s ultimate goal in reducing fatal overdoses in Passaic County and saving lives. The ICMS Director participates in Resource Subcommittee.

FY 2027 Goals

- ICMS will continue to strengthen the quality of clinical documentation through ongoing internal chart audits, focused quality improvement initiatives, and participation in relevant in-service trainings to support successful audits.
- ICMS staff will increase meaningful engagement with consumers by enhancing the frequency of contacts with consumers, their families, and community service providers to support recovery-oriented care and improve coordination of services.
- ICMS Directors will strengthen community partnerships and collaborations with local courts, law enforcement agencies, hospitals, and other community stakeholders to increase referrals and improve access to case management services for eligible individuals.
- ICMS staff and leadership will participate in ongoing professional development by attending relevant trainings, including Rutgers Foundations trainings and other evidence-based educational opportunities, to enhance clinical knowledge and promote best-practice standards in behavioral health case management.

Mobile Crisis Outreach Response Teams (MCORT)

Description

MHA plays a critical role in 988 services through its Mobile Crisis Outreach Response Teams (MCORT), providing immediate support to non-life-threatening mental health, substance-related, or suicidal crises in Essex and Hudson Counties when deployed by the 988 Crisis Lifeline call centers. When possible, MCORT will be dispatched without law enforcement, ensuring a calm and supportive response when it's deemed safe. This partnership is vital in providing timely and effective support to those in need. The core goal is to de-escalate the immediate crisis, assess safety and need, and connect the person to the least restrictive, most appropriate level of care, diverting from unnecessary law enforcement involvement, ED visits, or psychiatric hospitalization whenever clinically safe to do so.

Personnel

The program operates under the direction of the full-time Program Director, 5 full-time clinical supervisors, and 11 teams made up of full-time, part-time and per diem bachelor level Crisis Outreach Responders and Certified Peer Support Specialists.

Caseload

During FY 26, MCORT completed dispatches with 196 individuals with a total of 762 contacts.

Demographics

Individuals range in age from 18 to 94. Individuals identify as the following for gender: 59% female, 40% male, and 1% transgender. The self-reported ethnicities of the individuals are as follows: 14% Hispanic/Latino and 86% non-Hispanic/Latino. More specifically, the self-reported races of individuals are as follows: 27% White/Caucasian, 52% African-American, 5% Asian, 15% identifying as multi-racial, and 1% identifying as other. Individuals are insured through Medicaid (46%), Medicare (3%), uninsured (24%), private insurance (22%) and other (5%)

Performance Outcomes

During this baseline year, MCORT saw steady growth in activity, with dispatches received rising from 48 in Q1 to 86 in Q4, and unduplicated consumers served growing similarly from 34 to 75. MCORT exceeded all established performance benchmarks during the reporting period, demonstrating strong outcomes in crisis stabilization and community-based care. The program achieved a 100% completion rate for follow-up calls within 72 hours, surpassing the 90% target, and 97% of individuals were successfully connected with community-based services at case closure, exceeding the 75% benchmark. Additionally, 92% of individuals avoided a higher level of care within 72 hours, outperforming the 80% target, while 100% of dispatches were managed without law enforcement or EMS involvement, exceeding the 90% goal and reflecting the program's effectiveness in providing safe, person-centered crisis intervention in the community.

Consumer Satisfaction Surveys

In order to measure satisfaction with services, consumers satisfaction surveys were distributed via email, text, and in person to all individuals open. Overall, individuals who receive services at

MCORT continue to report a high level of satisfaction with 94% of all surveyed agreeing or strongly agreeing they are satisfied with services

Program Highlights

Some highlights and activity from this year includes:

In August 2025, MCORT participated in Jersey City's annual National Night Out and their annual Overdose Awareness Resource Fair.

In FY 26, MCORT participated in a total of eight Crisis Intervention Team (CIT) trainings for Essex and Hudson counties to provide information on 988 Suicide and Crisis Lifeline and MCORT services.

MCORT Program Director presented on MCORT to the Essex County Mental Health Advisory Board.

MCORT set up tabling events to educate the community about 988 Suicide and Crisis Lifeline and MCORT services at North Bergen Public Library, Hoboken Public Library, Jersey City Public Library, and Prevention Links.

MCORT completed presentations to provide information on 988 Suicide and Crisis Lifeline and MCORT services to local community providers such as EDGENJ, Parent Agency, PerformCare, Jersey City Medical Center, Hudson Speaks,

In May 2025, MCORT participate in Montclair's Reach Out Montclair Collaborative Health Fair;
In June 2025, MCORT participated in the 43rd Annual Montclair Run with the Montclair YMCA;
In April 2025, MCORT participated in the New Jersey Reentry Corporation will host its Annual Reentry Conference.

Advocacy Activities

MCORT Program Director was interviewed by Seton Hall's Men's Basketball Commentator for a conversation about mental health, community outreach, and ending stigma surrounding mental illness including education and awareness of 988 Suicide and Crisis Lifeline and MCORT services.

FY 2027 Goals

In FY27, MCORT will continue expanding community awareness of the 988 Suicide & Crisis Lifeline and mobile crisis response services through outreach presentations, community events, and educational trainings for partner organizations. The program will strengthen collaboration with hospitals, behavioral health providers, social service agencies, first responders, and other community stakeholders to enhance coordination of care and ensure individuals experiencing a behavioral health crisis have timely access to appropriate supports. MCORT will also utilize performance data and quality improvement initiatives to evaluate outcomes, identify opportunities for enhancement, and improve service delivery. Ongoing investment in staff training and professional development will ensure the team remains equipped to implement evidence-based and recovery-oriented practices. Collectively, these efforts will support a responsive, community-based crisis system that promotes recovery, reduces unnecessary emergency department utilization and hospitalizations, and connects individuals to the ongoing services needed to achieve long-term stability and wellness.

NJ Statewide Student Support Services (NJ4S)

Description

The New Jersey Statewide Student Support Services (NJ4S) program provides mental health and prevention services to students and families across the state. It offers support through school-based hubs, delivering universal education, small group programs, and individual counseling to promote well-being, resilience, and academic success. The Mental Health Association covers Morris and Sussex counties.

Personnel

NJ4S staff consists of 1 Program Director, 1 Assistant Director, 2 Supervising Prevention Consultants, 1 Marketing Specialist, 1 Data Analysis Specialist, 4 Licensed Clinicians, 12 Prevention Consultants, and 2 Scheduling Coordinators.

Caseload

NJ4S services are structured across three tiers to meet varying levels of need. *Tier 1* includes universal prevention information and resources that are available to all students, families, and schools, regardless of their participation in the NJ4S program. During the last fiscal year, 10,287 individuals attended Tier 1 programs. *Tier 2* consists of evidence-based prevention programs delivered in small groups, focusing on topics such as substance use, sexual health, and bullying prevention. The program served 1,350 unduplicated students through these targeted programs. *Tier 3* provides brief clinical interventions, including assessments and short-term counseling, with referrals to community providers for ongoing support. Last year, 178 students received Tier 3 brief counseling services.

Demographics

The student population included close to 400 students in each high school grade, with slightly fewer students in 7th grade, followed by 6th and then 8th grade. Most students identified as white (63%), followed by a significant number identifying as Hispanic (20%). The gender breakdown included male (39%) and female (59%) students, with a smaller number identifying as transgender or nonbinary.

Performance Outcomes

Over the past year, NJ4S delivered a total of 463 Tier 1 programs, providing universal prevention education and resources to students, families, and school communities. Additionally, 57 Tier 2 evidence-based program applications were implemented, targeting specific areas such as substance use, sexual health, and bullying prevention. For Tier 3 services, 194 students were referred for counseling services and 178 students received them. Tier 3 services offer brief clinical interventions and connected students to appropriate ongoing support when needed. The five students who did not receive services were already participating in counseling programs that the school was unaware of at the time of the referral.

Program Highlights

During FY26, NJ4S continued to strengthen its regional prevention infrastructure, expand evidence-based programming, and deepen partnerships with schools and community organizations across Morris and Sussex counties. Key accomplishments included:

Expanded School Engagement and Access to Services

NJ4S Morris/Sussex achieved strong regional engagement, with 92% of the 87 eligible schools signing up to access NJ4S services. This level of participation reflects continued relationship-building with school communities and increased awareness of NJ4S as a resource for prevention, mental health promotion, and student support.

Development of a Tier 2 Evidence-Based Program Catalogue

The team developed a comprehensive Tier 2 catalogue of evidence-based programs to support schools in identifying programming that aligns with their students' needs. The catalogue provides school personnel with clear information about available curricula, target populations, program structure, and intended outcomes. It has become an instrumental component of the initial consultation process, allowing NJ4S staff and school partners to make more informed and intentional program selections based on identified school and student needs.

LGBTQ+ Staff Training and Capacity Building

NJ4S partnered with a consultant to support the leadership team in developing an LGBTQ+ Training Plan for staff. The resulting professional development opportunities strengthened staff knowledge and capacity to provide culturally responsive, affirming, and supportive services to LGBTQ+ students and their families.

Preparation for Expanded Eating Disorder Prevention and Support

In anticipation of New Jersey Assembly Bill A4984 and the potential expansion of eating disorder awareness and prevention within the scope of NJ4S services, two licensed NJ4S clinicians enrolled in and completed Rutgers University's Eating Disorders Clinical Certificate Program. This proactive investment in staff expertise positions the program to respond effectively to emerging statewide priorities and provide informed support related to eating disorder prevention and early identification.

Expansion of Evidence-Based Prevention Programming

As part of an ongoing staff prevention training initiative, the prevention team was trained in the Teen Connections Project (TCP) during Summer 2025. TCP offers a condensed, 12-week adaptation of the yearlong Teen Outreach Program (TOP), increasing the team's ability to provide positive youth development and prevention programming within schools that may not have the capacity to commit to a full-year intervention.

Yearlong Teen Outreach Program (TOP) Implementation

NJ4S successfully implemented Teen Outreach Program (TOP) groups in two schools throughout the entire academic year. The yearlong format provided students with consistent opportunities to develop social-emotional skills, strengthen relationships, engage with their communities, and build protective factors through evidence-based positive youth development programming.

Positive Safe Dates Outcomes

The Safe Dates teen dating violence prevention program was successfully implemented at Kittatinny Regional High School and Sparta High School. Across participating classes, outcome data demonstrated a reduction in risk related to teen dating violence, highlighting the impact of comprehensive, evidence-based prevention education focused on healthy relationships, communication, and violence prevention.

Mental Health Training for Youth-Serving Professionals

NJ4S expanded its community prevention efforts by providing mental health education and training to adults who regularly interact with youth. Mental health training was provided to Girl Scouts of Northern New Jersey camp staff, while Youth Mental Health First Aid was delivered to Vernon PAL camp and before/after-care staff. These efforts strengthened the capacity of community partners to recognize signs of mental health and substance use challenges, respond appropriately, and connect youth with additional support when needed.

Advocacy Activities

NJ4S clinicians continuously engaged in advocacy efforts on behalf of their clients, focusing on academic needs and fair disciplinary practices (504 plans, IEP plans, and discussions with school counselors, school administration, and teachers). The clinicians also advocated for mental health and medical services for students, working with their parent/guardians when clinically or medically indicated.

FY 2027 Goals

- **Expand Tier 2 Programming:** Continue to expand the breadth and reach of Tier 2 prevention programming available to schools, with an emphasis on identifying evidence-based and evidence-informed programs that address emerging and commonly identified student needs. This will provide schools with a broader range of targeted prevention options and strengthen NJ4S's ability to match programming to identified needs.
- **Strengthen Community Provider Partnerships:** Build upon existing partnerships with community-based providers, including the DAWN Center for Independent Living, TAARA, and other organizations with specialized expertise. These partnerships will help enhance programming, increase access to specialized resources and training, and strengthen NJ4S's ability to respond to the diverse needs of students, families, and school communities.
- **Leverage Strong School Partnerships to Expand Engagement:** Continue strengthening relationships with schools that have demonstrated high levels of engagement with NJ4S services. Utilize these established partnerships, successful outcomes, and school experiences as a springboard for outreach to schools that have had limited or no prior engagement with NJ4S, including opportunities for existing school partners to serve as program champions and share their experiences with other districts.
- **Increase Overall School Engagement and Program Reach:** Use a more targeted outreach and consultation approach to increase awareness and utilization of NJ4S services among less-engaged schools. By combining stronger prevention-planning tools, established community partnerships, and the experiences of highly engaged schools, NJ4S will work toward increasing equitable access to prevention programming throughout Morris and Sussex counties.

Projects for Assistance in Transition from Homelessness (PATH)

Description

The PATH program includes the following programs and services: outreach, intensive case management, and housing support to adults 18 years of age and older who are homeless or at risk of homelessness, and who are diagnosed with a mental illness or 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 works with those who lack access to traditional services and have minimal community support, meeting them wherever they are, on the streets, at 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, 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 while providing companionship and constant inspiration. Edna's Haven uses 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.

Personnel

Essex PATH services are provided by one Director, one Master's Level Coordinator, one Co-Occurring Counselor, three Outreach Case Managers, and one Peer Outreach Case Manager. 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, and one part-time Outreach Case Worker. Edna's Haven services are provided by one part-time Certified Peer Recovery Specialist and volunteers.

Caseload

During fiscal year 2026, PATH conducted outreach with 628 homeless individuals and those at imminent risk of homelessness throughout Essex and Morris counties. 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, and 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, Carewell Health Medical Center, University Hospital, Saint Michael's Medical Center, Morristown Medical Center, Saint Clare's Hospital, Summit Oaks, Bergen Regional, and 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.

Edna's Haven operates using a drop-in center model and has provided various resources, linkages, and services to 261 individuals.

Demographics

As of June 30, 2026, Essex and Morris PATH provided services to a total of 227 individuals. Among them, 131 were male (60%), 93 female (40%), and 3 identified as transgender (0.5%). The self-reported ethnicities were 35 Hispanic/Latino (15.5%) and 192 non-Hispanic/Latino (84.5%).

The following reflects the municipalities in Essex and Morris Counties where consumers reported sleeping the night before being outreached by PATH: Belleville, Morristown (21), Bloomfield (4), Mine Hill (2), Boonton (4), Newark (58), Budd Lake (5), Nutley (1), Dover (12), Orange (6), East Orange (21), Parsippany (26), Ledgewood (4), Rockaway (3), Livingston (1), Irvington (9), West Orange (2), Montclair (23), Whippany (13), Morris Plains (15), and South Orange (1).

Consumers who were outreached by the PATH Program reported sleeping in the following locations the night before engagement: 200 in the street or in a place not meant for human habitation (33%), 194 in an emergency shelter, including motels paid with emergency assistance (31%), 111 were couch surfing (18%), 7 were incarcerated (1%), 26 were in a Substance Use Disorder Treatment Facility, Detox Center, or halfway house (4%), 7 were in an inpatient hospital (1%), and 55 were in housing pending eviction (9%). Others serviced did not wish to provide this information.

Performance Outcomes

PATH participates in the agency-wide Quality Assurance Committee, which holds monthly meetings to collect and analyze data on the utilization and quality of services provided by each MHA program. In fiscal year 2026, PATH successfully linked individuals to the following services: Community Mental Health, substance abuse treatment, financial benefits, temporary housing, permanent housing, medical/dental, and rehabilitation/habilitation services.

Consumer Satisfaction Surveys

Approximately 58 satisfaction surveys were completed by consumers enrolled in the PATH Program. The feedback from these surveys indicated a high level of satisfaction, with 95% 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 eighty-nine 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 101 attendees and comprised over 33 local agencies. The event included HIV testing for 33 individuals, glucose and cholesterol checks for 27, and 4 flu vaccinations. Over 100 hygiene bags and 75 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.

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

PATH Essex Director organized monthly events with the Division of Family Assistance and Benefits (DFAB) who provided individuals with NJ SNAP (formerly Food Stamps) and Work First NJ (Cash Assistance). This fiscal year, new services were added to include: Medicaid applications for those in need of health insurance, Coordinated Entry, Senior Services and assistance for those who need to apply for Emergency Assistance.

PATH Essex Director continued the collaboration with the Newark YMCA to obtain three emergency housing rooms to be utilized by PATH consumers as an alternative to shelter placement.

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 Director continued to strengthen relations with the Department of Consumer Affairs, Morris County Housing Authority, local shelters and Morris County CoC to reduce the need for the unsheltered population and to house individuals in the PATH Program.

PATH Morris Director established regular participation in the CoC Morris County Permanent Supportive Housing Case Conferencing, with a goal to obtain permanent housing vouchers for PATH Consumers.

PATH Morris continued to implement the Homeless Outreach Case Management and Step off the Street outreach positions funded by the Morris County Human Services Department. Through these positions, PATH Morris was able to conduct outreach with an additional 319 people and provide over 3,191 additional units of service during the fiscal year.

PATH Morris participated in the Hanover Housing Sprint Initiative with the NJ Department of Consumer Affairs which assisted in obtaining 14 housing vouchers and housing opportunities for 14 PATH consumers.

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 attended 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, Laundry Wednesdays, along with hosting a Boutique Clothing Giveaway event to foster engagement and connection among attendees.

Advocacy Activities

PATH Essex and Morris Directors are voting members of their respective counties Continuum of Care (CoC) and sit on various subcommittees with the goal of advocating for and achieving better housing outcomes for homeless individuals.

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

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

PATH Essex and Morris Directors both attend DMHAS PATH Coordinator's Meetings.

PATH Essex Director participates in a quarterly meeting with Social Workers assigned to Libraries across New Jersey to discuss how to better assist homeless individuals who seek support at their local libraries.

PATH Morris Director has established a working relationship with the NJ Coalition to End Homelessness and participates in quarterly outreach meetings focused on advocacy.

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.

Prospect House (PH)

Description

Established in 1956, Prospect House is the Mental Health Association's adult day partial care program serving individuals aged 18 and older with severe and persistent mental illness. PH provides person-centered services focused on psychiatric stabilization, recovery, and community reintegration. Members are empowered to pursue their life goals through group therapy, wellness activities, vocational support, and medical care. The program operates Monday through Friday from 8:30 a.m. to 5:00 p.m. and is committed to destigmatizing mental illness while fostering an environment that supports recovery and resilience.

Personnel

Prospect House is staffed by a dedicated, multidisciplinary team committed to providing comprehensive support to its members. The team includes one Program Director, one part-time Psychiatrist, one full-time and one part-time Advanced Practice Nurse (APN), one Registered Nurse (RN), two Program Coordinators, one Intake Coordinator, and ten Case Managers.

Caseload

Prospect House served a total of 210 members, including 66 new admissions. The average daily attendance was 98 members. The primary service areas include Newark, East Orange, Irvington, and other municipalities within Essex County.

Demographics

The age range of members served at Prospect House spans from 19 to 82 years. In terms of race and ethnicity, 75% identify as African American, 20% as White, 4.5% as Mixed Race, and 0.5% as Asian. Regarding gender identity, 40.2% of members identify as male, 58.8% as female, 0.5% as transgender, and 0.5% preferred not to disclose their gender.

Performance Outcomes

Prospect House provided a total of 1409 medication monitoring appointments, along with 67 initial psychiatric evaluations and 216 updated psychiatric evaluations. Additionally, 491 injectable medication appointments were completed. All members received summer safety and medication education. Psychiatric services were fully accessible to members five days per week.

Consumer Satisfaction Surveys

A survey conducted with participants revealed an overall satisfaction rate of 95%. The relationship with case managers received a high approval rating of 95%, and 98% of members reported satisfaction with their relationship with their case manager. Members praised the program's supportive environment and individualized services.

Program Highlights

Prospect House continued to offer a comprehensive array of services designed to enhance individual skills, promote overall health and well-being, and foster stronger connections within the community. These services were tailored to support personal development, facilitate access to healthcare resources, and

encourage active participation in community life, ultimately empowering individuals to lead more independent and fulfilling lives. During the FY2026, additional highlighted services and activities included:

On-site mobile outreach programs, provided at no out-of-pocket cost to all members, such as:

- The New Jersey Motor Vehicle Commission's (NJMVC) Mobile Unit, which offered services to obtain driver's licenses and non-driver state identification.
- Zufall, a community-based medical mobile outreach program that provided dental, medical, and women's health care. These services included community health screenings that establish linkages to primary care, blood pressure monitoring, glucose readings, and flu and COVID-19 vaccines. The program also assisted individuals with enrollment in medical insurance coverage. Additionally, Zufall operated a dental van offering comprehensive dental services such as cleanings, fillings, and denture fittings, as well as referrals for more extensive dental work.
- EDGE NJ, an LGBTQ+ social service organization that provided mobile rapid HIV testing and Hepatitis C screening, along with education, counseling, and referral services.
- Onsite Prospect Primary Care Services, which continued to provide primary healthcare to members throughout the fiscal year, supported by a navigator who assisted with appointment scheduling and referrals to specialists. The program also maintained an ongoing collaboration with LabCorp to provide offsite bloodwork.
- A full calendar of social activities designed to foster connection, build community, and promote a sense of belonging among members. Highlights included MHA's annual boat trip aboard the Spirit Cruise in Hudson, where members enjoyed views of the Statue of Liberty while dining across three decks, and the annual MHA Picnic at Eagle Rock Reservation, a favorite opportunity for outdoor relaxation and social interaction. Members also took part in community outings to local shops and a wellness walk through a park in East Orange, NJ. The program hosted its first Annual Wellness Day, welcoming community members and hospital staff to tour the facility with members serving as tour guides, as well as its first Breast Cancer Awareness event. A series of seasonal and cultural observances, including National Wear Red Day, Black History Month, Halloween, Thanksgiving, and December holiday celebrations, rounded out a year of meaningful community engagement.
- MHA held its Annual Member Awards, recognizing two members for their perseverance, leadership, and recovery.
- Prospect House groups continued to offer various activities such as art therapy, physical exercise, support groups, and vocational groups. In direct response to member feedback, the program introduced a new late-afternoon group held from 3:00 to 4:00 p.m., created for members who work earlier in the day and wish to attend program later, as well as for those interested in learning meal-preparation and other independent living skills after regular program hours.
- Members continued to cultivate the on-site vegetable garden, selecting and planting a variety of edible plants and dedicating time throughout the year to preparing the soil, choosing seeds, and tending the garden to support healthy growth. The garden has flourished into a sustainable source of fresh vegetables and a valued educational experience in agriculture and teamwork. In preparation for a successful CARF accreditation survey this year, members also replanted indoor greenery across all units. They welcomed new betta fish and goldfish to the program's common spaces.
- The transitional employment program continued to play a vital role in supporting members' development of essential work-readiness skills and facilitating successful job placements.

Advocacy Activities

Prospect House continues to prioritize stigma reduction through ongoing family and community education initiatives. Weekly member-led community meetings provide a platform for open dialogue and active engagement. The program fosters strong partnerships with local organizations and managed care plans to enhance services and support. Additionally, member voices are actively empowered and included in program development and decision-making processes through the program's Member Board, which will continue to guide new initiatives that strengthen services and advance the program's mission into the current fiscal year and beyond.

FY2027 Goals

Prospect House's goals will continue to be centered on providing accessible, effective, and personalized support to individuals who require partial care. These goals include continuing to expand access, enhancing the quality and responsiveness of services, and fostering collaboration among community providers to deliver comprehensive care. By developing individualized treatment plans, Prospect House aims to promote recovery, independence, and overall well-being. Additionally, increasing member engagement and education, along with continuously monitoring outcomes, will ensure ongoing improvement and positive results. Key initiatives for the coming year include implementing a new sensory room and dedicated sensory unit to expand therapeutic offerings, opening a new café within the program space, adding outdoor seating for members to enjoy, and launching a bicycle initiative to promote physical health and wellness. Ultimately, Prospect House's goal is to continue providing a supportive environment that empowers individuals to achieve stability and thrive within their communities.

Riskin Children's Center (RCC)

Description

The Riskin Children's Center (RCC) is a comprehensive outpatient mental health service for youth ages 6 to 18. RCC provides individual therapy, family therapy, psychiatric evaluations, medication management, and group therapy. At RCC, the mission is to provide high quality mental health services to children, adolescents, and their families, many of whom are insured by Medicaid or have limited financial means to pay for private practice care.

Personnel

RCC operates under the direction of the full-time Program Director, a part-time Medical Director/Psychiatrist, and two therapists. Throughout the year, RCC works with graduate social work and counseling interns who provide clinical services to youth, all under the supervision of the Director and other staff.

Caseload

RCC provided services to 41 individuals during FY26 with a total of 885 sessions held. This includes providing services to 17 new clients.

Demographics

As of 7/1/26, the census of RCC was 26. Clients range in age from 6 to 18. Clients identify as the following for gender: 60% female, 32% male, and 8% transgender. The self-reported ethnicities of the consumers enrolled with CBH are as follows: 52% Hispanic/Latino and 48% non-Hispanic/Latino. More specifically, the self-reported races of clients enrolled with CBH are as follows: 64% White/Caucasian, 12% African-American, 20% identifying as biracial (African-American/White), and 4% identifying as other. RCC consumers are insured through Medicaid (92%) and self-pay (8%).

Performance Outcomes

- Increased Service Capacity: RCC expanded service delivery by 7% in FY26 compared to the previous fiscal year.
- Demonstrated Clinical Progress: 90% of clients surveyed experienced a measurable reduction in symptoms six months into treatment, while 67% of client discharges were successful completions in which treatment goals were met.
- Minimizing Crisis Interventions: Psychiatric hospitalization rates remained remarkably low at an average of 2% per month.
- Collaborative Psychiatric Care: 72% clients received medication management through RCC's Program Psychiatrist, ensuring close coordination between clinical therapists and medical care.

Consumer Satisfaction Surveys

In our ongoing commitment to quality care, RCC distributed consumer satisfaction surveys to clients and families via email, text, and in-person. We achieved a 50% response rate among youth and a 36% response rate among parents and guardians.

Overall satisfaction remains exceptionally high: 100% of respondents reported being satisfied or strongly satisfied with their care. Additionally, 100% of youth reported feeling heard by their therapist, and 100% of parents stated they would recommend RCC to others (along with 90% of youth).

Program Highlights

- **Targeted Therapeutic Groups:** RCC facilitated two specialized youth groups, Art Therapy and Social Skills, designed to provide short-term, targeted support. These sessions gave participants a safe space to build coping skills, enhance social interactions, and foster emotional well-being.
- **Family Engagement:** To strengthen relationships between youth and their families, RCC therapists delivered 163% more family counseling sessions this year.
- **Board-Certified Psychiatric Services:** RCC provides dedicated, onsite psychiatric care through a board-certified youth psychiatrist, offering everything from comprehensive consultations and medication monitoring to specialized educational recommendations. Direct access to psychiatric expertise ensures our youth receive timely early intervention, collaborative support, and integrated care.
- **Workforce Development:** RCC continues to host dedicated MSW and MA interns, providing hands-on training and mentorship to the next generation of youth mental health clinicians.

Advocacy Activities

Throughout the year, RCC staff participated in tabling and community outreach events across both Morris and Essex Counties to provide mental health resources and raise awareness of the department and its offerings. RCC staff also maintain a resource guide of referral and linkage services for youth in our service area.

For Mental Health Awareness Month in May, RCC participated in multiple onsite mental health fairs at local public schools. Across three resource fairs, the team distributed critical mental health resources, screenings, and education to more than 1,000 youth.

FY 2027 Goals

RCC continues to deliver high-quality mental health care to local youth. Amid a significant shortage of regional providers accepting NJ FamilyCare/Medicaid, RCC serves as a vital safety net for families. To further address community needs, RCC is expanding its group therapy programming. Group settings offer unique therapeutic value for children and teens, fostering mutual support, constructive feedback, and a safe space to practice and generalize key social skills into everyday life. Moving forward, RCC aims to scale up capacity to offer regularly facilitated social skills groups.

Recognizing the growing demand for family-centered care, RCC continues to expand its family therapy sessions. In FY2027, RCC will implement targeted measurement frameworks to systematically evaluate the clinical efficacy of these interventions. These findings will determine the feasibility and structure for offering standalone family therapy services in the future. As we look ahead, RCC remains committed to building upon our 15-year legacy of delivering accessible, high-quality mental health care to youth across Essex County and neighboring areas.

School Based Counseling Services

Description

East Orange School-Based Counseling: For more than 30 years, MHA has applied for and received a Community Development Block Grant (CDBG) from the City of East Orange to deliver supportive mental health counseling services to high school and middle school students across various East Orange schools.

Montclair Child Development Center Mental Health Counseling: MHA offers clinical mental health consultation services to the Montclair Child Development Center (MCDC) across its four locations, Montclair, Glen Ridge, Orange, and Belleville, for their Head Start and Early Head Start programs. This fee-for-service agreement has enabled MHA to provide MCDC with a licensed counselor who conducts classroom observations, assessments, and offers in-class supportive interventions. Additionally, services and support are available to staff and parents, including psychoeducational presentations that introduce positive behavioral support strategies for both groups.

NJ Performing Arts Center / MHA Collaboration: Supported by a grant from the Healthcare Foundation, NJ Performing Arts Center (NJPAC) and MHA formed a collaborative partnership. This alliance allows MHA to offer mental health resources to NJPAC students, parents, and teaching artists as NJPAC carries out its creative programming. In-class support is provided to students when addressing sensitive topics, and ongoing parent support groups are co-led by MHA clinicians.

Personnel

East Orange School-Based Counseling: This program utilizes the services of one part-time Licensed Clinical Social Worker, who works with one or two graduate social work or counseling interns.

Montclair Child Development Center Mental Health Counseling: One part-time Mental Health Clinician, working 20 hours per week, provides evaluations, assessments, and counseling to MCDC preschool students and their families.

NJ Performing Arts Center / MHA Collaboration: One part-time Licensed Clinical Social Worker.

Program Highlights

East Orange School-Based Counseling: During FY2026, MHA provided mental health counseling services to students in the following East Orange schools: Cicely Tyson and STEM Middle and High Schools. The Licensed Clinical Social Worker, along with a graduate-level social work intern, served 39 middle and high school students. Below are some examples of how students utilized their time with MHA mental health clinicians:

- Coping with symptoms of depression and anxiety
- Processing health concerns and new diagnoses
- Learning skills on how to navigate relationship issues
- Emotional regulation
- Addressing issues surrounding school refusal

Montclair Child Development Center Mental Health Counseling: In FY2026, the counselor dedicated 771.25 hours to providing classroom support to children and teachers, as well as parent support at each location. Resources such as PerformCare and Big Brothers/Big Sisters were provided to children and their families to help bridge service gaps. Children received individual sessions incorporating techniques such

as mindfulness, play therapy, emotional regulation, and self-expression to help them better understand and manage their behaviors. The MHA counselor also conducted outreach and educational series for parents and families, including informational sessions on substance use and suicide prevention, successfully engaging them in the services offered at MCDC. Additionally, the counselor provided training and guidance to teachers on how to effectively support the children in the program.

NJ Performing Arts Center / MHA Collaboration: In FY2026, the MHA Licensed Clinical Social Worker provided a total of 283 hours of professional and personal development sessions, support groups, and direct services. The professional and personal development sessions covered topics such as classroom management techniques for addressing behavioral challenges and strategies for engaging students in activities. Support groups offered NJPAC parents a supportive space to connect and discuss issues affecting their children, including managing stress and anxiety, supporting their children in making friends, and coping with bullying. Direct services included individual youth sessions focused on concerns such as family issues, anxiety, bullying, emotional regulation, inattentiveness, and impulse control. Additionally, the Licensed Clinical Social Worker provided support to students during the Dodge Poetry Program, which celebrates poetry as a catalyst for social change, and Ritual4Return which helps formerly incarcerated citizens process trauma, share their stories, and mark their transition back into the community.

FY 2027 Goals

East Orange School-Based Counseling: MHA will maintain its commitment to delivering supportive mental health counseling services to a minimum of 50 students across STEM and Cicely Tyson Middle and High Schools in East Orange. Through personalized counseling, students will receive emotional support, behavioral interventions, and strategies to enhance their well-being and academic success. For students requiring additional or specialized services beyond what MHA can provide, appropriate referrals will be made to community partners and external mental health resources to ensure comprehensive support. This ongoing effort aims to foster a nurturing environment where students can thrive academically, socially, and emotionally.

Montclair Child Development Center Mental Health Counseling: MHA is dedicated to offering ongoing mental health consultation to the MCDC community. This comprehensive support includes guidance on effective classroom management techniques to promote a positive learning environment, psychoeducational sessions to increase awareness and understanding of mental health topics, and assistance in connecting families and staff with relevant resources and external support services. Additionally, MHA facilitates support groups designed to foster peer connection, provide emotional support, and promote resilience among students, staff, and families. Through these efforts, MHA aims to create a supportive and empowering community that prioritizes mental health and well-being for all members of MCDC.

NJ Performing Arts Center/MHA Collaboration: MHA is committed to sustaining and strengthening its partnership with NJPAC, recognizing the partnership as a vital resource that has significantly benefited students, teaching artists, and parents alike. MHA will continue to provide a licensed clinician who will offer individualized and group counseling services tailored to meet the diverse needs of the NJPAC community. In addition to direct counseling, the clinician will provide ongoing consultation to staff and teaching artists to support the integration of mental health best practices within programming. MHA will also assist in connecting families and participants with relevant resources and community services to ensure comprehensive support. This continued collaboration aims to foster a nurturing environment that promotes emotional well-being, resilience, and personal growth for all involved in NJPAC's creative and educational initiatives.

Self Help Advocacy and Education

Description

Self Help, Advocacy and Education includes the following programs and services:

Community Education - Mental Health First Aid (MHFA) is a nationally recognized, evidence-based program that trains individuals to recognize mental health signs and respond compassionately. Through an 8-hour certification course by the National Council for Mental Wellbeing, participants learn to identify early warning signs, approach those in need, and connect them to professional resources. The Mental Health Association (MHA) has staff certified in both Adult and Youth MHFA, enabling us to offer this training to churches, schools, companies, and community groups. In addition, MHA's community education efforts challenge stereotypes, promote understanding, and work to reduce mental health stigma, emphasizing its importance to overall well-being.

Hope One is a mobile outreach unit that travels across Morris County, providing direct access to mental health, addiction, and recovery services. A partnership between the Morris County Sheriff's Office, CARES, the Department of Human Services, and MHA, Hope One connects community members to treatment and recovery programs, bypassing long waits and barriers. It also offers free Narcan training and distributes Narcan and harm reduction kits to families, friends, and supporters of those with opioid addiction, empowering them to save lives.

Social Club offers a welcoming, judgment-free space for individuals experiencing homelessness, at risk of hospitalization, or with a history of hospitalizations, serving Dover, Morristown, Boonton, and nearby areas. Held three days a week (Tuesdays, Thursdays, Saturdays), it provides free or low-cost activities to help participants socialize, make friends, and enjoy community. Activities include game nights, socials, outings, cultural events, and wellness activities, all fostering belonging, confidence, and mental wellbeing. Transportation options, with central pick-up points, ensure members can regularly participate and connect.

Community Companion Program offers one-on-one companionship and daily living support for people with mental illness. Volunteers visit clients for at least two hours a week, engaging in mutually agreed activities to promote socialization and wellness. Pairings last three months, after which volunteers can choose to extend or be paired with someone else.

Mental Health Resource Network partners houses of worship with MHA to provide material, emotional, and spiritual support. Congregations donate items like food, clothing, toiletries, and household goods, and they host donation drives and collections. These partnerships ensure consumers receive practical resources and feel valued in the community.

Mental Health Faith Liaison Program trains faith leaders to address mental health needs. MHA offers clergy clinical support, referral guidance, and education through presentations, MHFA training, and discussion groups, strengthening faith communities' ability to respond compassionately.

Self-Help Programs offer socialization, wellness, and mobility support for mental health consumers discharged from hospitals or currently living in the community. Groups include pet therapy, exercise, advocacy, art therapy, and professional-led presentations, helping participants develop independence and enjoy healthy lives.

Elizabeth T. Dorl Educational Assistance Fund provides eligible consumers up to \$1,000 for educational certificates. Because mental illness often emerges in young adulthood, often interrupting education or career paths, the fund helps individuals resume their pursuits after these challenges.

Peer Support to Greystone brings individuals with lived mental health experience into the hospital to share recovery stories with current patients. These visits inspire hope, build confidence, and create a bridge from inpatient care to community life.

Personnel

Community Education - Mental Health First Aid has 13 instructors certified in Adult, Youth, Senior, Teen First Responder, and/or Veterans Curriculum.

Hope One has one full time mental health professional.

Community Companion has four volunteers.

A Program Director and a Program Coordinator supervise the following services alongside the staff listed below:

Social Club, which employs five part-time drivers

Mental Health Resource Network

Mental Health Faith Liaison Program

Self-Help Programs, including part-time drivers

Elizabeth T. Dorl Educational Assistance Fund

Peer Support to Greystone, facilitated by volunteers

Performance Outcomes

Community Education – Mental Health First Aid: In FY 2026, MHA exceeded its goals by delivering 18 trainings and certifying 229 community members, achieving 450% of the target trainings and 460% of the participant goal—highlighting increased demand and capacity.

Hope One: This year, Hope One made 1,904 stops, reaching over 7,700 community members. Eleven individuals entered rehab or recovery services, while several thousand accessed mental health care, family support, information, and/or other services. In addition, 1,525 received Narcan training. The program also distributed essential supplies and partnered with PAARI to support law enforcement efforts, creating gateways to hope and healthier communities.

Social Club: The Social Club hosted 137 sessions for 2,141 consumers, offering low-cost activities like trivia, socials, outings, and events. Every participant (100%) reported satisfaction, emphasizing its role as a welcoming space for connection and belonging.

Community Companion: Four consumers remained paired with volunteers. In addition, volunteers have taken part in consumer events, resulting in over 300 hours of companionship. Regular face-to-face visits and calls foster trust, reduce isolation, and promote emotional well-being.

Mental Health Resource Network: Contributions from houses of worship, community members, and local businesses provided essential items—furniture, clothing, electronics, and emergency supplies—supporting daily needs and emergencies. Partner organizations also hosted dinners and drives, donating over \$30,000 and over 1,392 holiday gifts, spreading joy and dignity. The Network has also added five houses of worship to be a part of the Resource Network.

Mental Health Faith Liaison Program: The team partnered with 21 houses of worship, providing education and support to faith leaders as well as members. This led to 48 referrals, strengthening community ties and access to support.

Self-Help Programs: The CAP Self-Help & Wellness program delivered 23,530 service units (111% of target), with 100% of participants reporting improved health and well-being—demonstrating its impact on recovery and resilience.

Elizabeth T. Dorl Educational Assistance Fund: In FY 2026, the fund supported five individuals pursuing certifications, GED prep, trade training, driver's education, school supplies/equipment, and college, helping them achieve independence and personal growth.

Peer Support to Greystone: Peer specialists supported 186 patients preparing for discharge, facilitating smoother transitions from inpatient care to community living and supporting ongoing recovery.

Consumer Satisfaction Surveys

Community Education – Mental Health First Aid: Satisfaction surveys for MHFA are administered by certified instructors at the end of training, either in the classroom or via an online portal provided by the National Council for Mental Wellbeing. The surveys gather quantitative satisfaction ratings, qualitative feedback on strengths and weaknesses, and information on skill application, knowledge, attitudes, and confidence related to mental health first aid. This year, MHFA received a 99% satisfaction rate from 229 participants.

Social Club: To ensure quality, members complete an annual feedback survey. In the most recent year, 11 surveys were returned, providing insights into the program's impact. Eighty-two percent of respondents reported that the Club introduced them to new, low-cost community activities, and 100% strongly agreed it helped them build new friendships. 100% of members would recommend the Social Club, reflecting its welcoming environment and meaningful impact. Overall satisfaction was rated at 100%, highlighting its role in fostering connection, reducing isolation, and improving quality of life.

Self-Help Programs: Members complete an annual 24-question survey. In the most recent year, 10 responses provided valuable feedback: 100% felt better about their self-image, 100% reported increased comfort in group settings, and 100% expressed overall satisfaction. These results underscore the programs' effectiveness in building confidence, fostering social connections, and enhancing well-being.

Advocacy Activities

Advocacy is the thread that connects each of the Mental Health Association's education, outreach, and support programs. It ensures that the voices, needs, and rights of individuals living with mental illness are heard, respected, and acted upon — both on an individual level and within the broader community.

Community Education – Mental Health First Aid (MHFA): Advocacy in MHFA begins with the belief that greater understanding reduces stigma and fosters stronger support networks. By training community members to recognize and respond to signs of mental distress, MHA is advocating for early intervention, mental health literacy, and equal recognition of mental health needs alongside physical health. Staff-certified trainers extend this message to churches, companies, and community groups, encouraging a culture of compassion and informed action. In FY2026, 8894 individuals participated in community educational trainings.

Hope One Mobile Outreach: Hope One embodies advocacy through action — bringing resources directly into communities where they are most needed. MHA's role in this partnership ensures that individuals impacted by addiction and mental health challenges access services and are treated with dignity and urgency. By distributing Narcan, harm-reduction kits, mental health resources, and information, Hope One advocates for saving lives, meeting people where they are, and promoting recovery.

Social Club: The Social Club advocates for the fundamental right to social connection and inclusion. By creating safe, supportive, and affordable opportunities for engagement, the program challenges the isolation often experienced by people facing homelessness, hospitalizations, or severe mental illness. Facilitating wellness activities and community participation is a direct stand against the stigma that limits integration. In FY 2026, 137 Social Club sessions were held.

Community Companion Program: This program advocates for the importance of human relationships in mental health recovery. Through volunteer companionship, it promotes dignity, shared experiences, and social belonging. Companions help individuals rediscover community connections, reinforcing that mental illness should never exclude someone from meaningful relationships.

Mental Health Resource Network & Faith Liaison Program: These initiatives advocate for the faith community to be actively engaged in mental health support. By equipping clergy and congregations with training, referrals, and resources, MHA ensures that spiritual leaders are better prepared to guide and support members in crisis — bridging the gap between faith and mental health services.

Self Help Programs: By creating spaces where mental health consumers lead and participate in groups, MHA promotes self-advocacy, empowerment, and peer leadership. Programs like pet therapy, art therapy, and advocacy groups help individuals reclaim agency over their lives, skills, and community participation. This fiscal year, 53 MHA clients participated in Mental Health Boards and other community advocacy groups. In addition, 77 staff training/support hours were provided to these clients.

Elizabeth T. Dorl Educational Assistance Fund: At its core, this fund advocates for equity in education and career opportunities for individuals whose mental illness interrupted their goals. By providing financial assistance, MHA ensures that mental health challenges do not permanently bar someone from pursuing their aspirations.

Peer Support to Greystone: Peer support advocacy derives from lived experience — peers tell their own recovery stories to inspire hope and to demonstrate that transitioning back to community life is possible. These interactions challenge stereotypes and promote a recovery-oriented mental health system. Advocacy within these programs means more than speaking on behalf of individuals; it's about creating systems, opportunities, and mindsets that remove barriers, reduce stigma, and champion recovery and wellness. MHA's work ensures that individuals are not defined by their diagnoses but supported as whole, capable members of their communities.

FY 2026 Highlights

- The Social Club and Self-Help programs connected MHA clients with a range of events and special activities. More than 150 clients entered the holiday season with the help of Holiday Express, a community program that brings *live, interactive musical celebrations*, led by volunteers, *a warm meal*, festive holiday activities, *gift bags* filled with practical items like blankets, toiletries, hats, scarves, and gloves and fun gifts too. During celebrations, attendees shopped at a pop-up boutique sponsored by Pinebrook Jewish Center filled with wonderful items at no cost.
- The MHA ladies celebrated Galentine's Day in February. This was a beautiful bonding moment where they were pampered with skin and nail care, enjoyed a great meal, treats, and played fun games. They also wrote love letters to themselves; several of which were shared with the group. The initiative provided support and hope to each other.
- Throughout the year, clients were able to take part in several cultural programs, live music concerts, stage plays, comedy revues, and exhibits at the Roxbury Arts Alliance.
- Clients were introduced to pet and equine therapy and experienced firsthand the comfort, connection, and joy these special interactions can bring. Spending time with the animals helped promote relaxation, build trust, and encourage emotional well-being, while also creating meaningful moments of healing and hope.
- MHA clients took part in a special raffle supporting clients who are making meaningful progress in their recovery. The winner received a Lenovo laptop and HP printer—valuable tools that can help empower their recovery journey, support daily living, and move them closer to their personal and professional goals.

FY 2027 Goals

Community Education – Mental Health First Aid (MHFA): MHFA will work to expand training opportunities across churches, businesses, schools, and community organizations, empowering more residents to recognize and respond effectively to mental health crises. Outreach will focus on workplaces, school staff, and faith leaders, while the program strives to maintain a 99% satisfaction rate among participants.

Hope One Mobile Outreach: The initiative aims to connect at least 300 individuals to immediate mental health, addiction, and recovery services. It will distribute more than 500 Narcan kits, train 400 community members in overdose response, and strengthen partnerships with health and social service agencies to provide additional resources at outreach stops.

Social Club: The club will continue fostering social connection and wellness by increasing membership and adding at least two new wellness activities and one cultural or community outing each quarter.

Community Companion Program: The program will expand its volunteer base to create more active matches, provide specialized training in mental health awareness and communication, aim for at least

60% of matches to last beyond three months, and host quarterly social events to strengthen relationships and reduce isolation.

Mental Health Resource Network: MHA will grow its faith-based partnerships from 61 houses of worship, coordinate at least three drives for essential goods, and train over 100 faith-based volunteers in mental health literacy.

Mental Health Faith Liaison Program: The program will enhance clergy support by hosting four educational presentations for faith leaders, training clergy, staff, and members in MHFA, and producing a Faith & Mental Health Resource Guide to help congregations support members in crisis.

Self-Help Programs: The program will add at least one new peer-led wellness group, maintain a minimum 80% participation rate, integrate practical skill-building sessions such as budgeting and meal planning, and host four community integration events throughout the year.

Elizabeth T. Dorl Educational Assistance Fund: The fund will award at least six grants to eligible individuals and track recipients' educational and vocational progress at three, six, and twelve months.

Peer Support to Greystone: The program will conduct six visits to meet with at least 80 inpatients, sharing hope and recovery stories through lived experience, and will establish post-discharge follow-up contact with at least 25% of those individuals to support their transition back to the community. In addition, the program will work with Greystone to increase participation in community activities.

Senior In Home Therapy Program (SIT)

Description

The Senior In-Home Therapy Program (SIT), offered by the Mental Health Association in Morris County, provides high-quality, person-centered therapy services to adults, age 60 and older, who are unable to leave their homes due to physical, emotional, or environmental barriers. Designed to help seniors regain emotional wellness and improve their overall quality of life, the program offers individualized psychotherapy that promotes day-to-day functioning, reduces mental health symptoms, and fosters the development of healthy coping strategies. In addition to therapeutic support, seniors are assisted in connecting with vital community resources, empowering them to re-engage as active individuals, family members, and community participants. This program is available to older adults residing in Morris County with identified mental health needs and is supported in part by the Morris County Commissioners.

Personnel

Senior In-Home Therapy is staffed by a dedicated team consisting of one Program Director and one therapist (LCSW). Together, the team provides compassionate, in-home mental health services tailored to meet the unique needs of each senior served.

Caseload

As of June 30, 2026, Senior In-Home Therapy had an active caseload of 16 consumers. Over the course of the fiscal year, a total of 22 seniors were enrolled in the program. Referrals were received through various sources, including community partners, the Morris County Division of Aging, and other MHA programs such as The Gathering Place and Co-Response, reflecting strong collaboration and outreach within the local support network.

Demographics

Senior In-Home Therapy serves individuals aged 60 and older who reside in Morris County and face challenges accessing traditional outpatient mental health services due to physical, emotional, or situational barriers. The individuals we serve reflect the diverse experiences of aging within Morris County, with approximately 90% identifying as White and the remaining 10% representing other racial and ethnic backgrounds. Our clients range across the older adult lifespan, with 31% between the ages of 60 and 64, 19% between 65 and 69, 31% between 70 and 79, and 19% aged 80 and older. Consumers live throughout Morris County, from Lincoln Park and Towaco to Dover, Parsippany, Hackettstown, Butler, and beyond. This wide geographic distribution highlights both the accessibility challenges faced by older adults in suburban and semi-rural communities and the importance of our ability to meet them where they are.

Performance Outcomes

During Fiscal Year 2026, the Senior In-Home Therapy (SIT) Program provided person-centered mental health services to 22 older adults in Morris County, including two new enrollments, through consistent weekly psychotherapy, follow-up care, and monthly medication education. Program outcomes demonstrated strong effectiveness, with 100% of consumers who completed the Mental Health Quality of Life (MHQOL) assessment showing improvement after six months of treatment. On average, MHQOL scores increased by 3 points, reflecting meaningful gains in emotional well-being, daily functioning, and overall quality of life. The program also achieved 96% treatment goal attainment, highlighting the success

of individualized treatment planning and collaborative therapeutic engagement. These outcomes demonstrate the SIT Program's ability to provide accessible, high-quality mental health care that produces measurable improvements for older adults facing barriers to traditional outpatient services.

Consumer Satisfaction Surveys

Senior In-Home Therapy conducted its annual satisfaction survey to assess consumer satisfaction with services. Surveys were distributed to 16 consumers via email, hand delivery, mail, or placement at their residences. Three surveys were returned, resulting in a 19% response rate.

For Fiscal Year 2026, the Satisfaction Survey demonstrated exceptionally high consumer satisfaction, with all three respondents reporting overall satisfaction with services and improvements in their quality of life. Consumers unanimously strongly agreed that staff treated them with dignity and respect, encouraged them to make their own decisions, provided adequate time during visits, responded to their needs, and created a safe, culturally respectful therapeutic environment. Open-ended comments further highlighted the strength of the therapeutic relationships, with consumers describing their therapist as respectful, supportive, and instrumental in their personal growth.

Gender: Two (2) of the consumers identified as female and one (1) consumer identified as male.

Ethnicity: Two (2) of the consumers identified as White/Caucasian and one (1) consumer preferred not to answer.

Age: Of the three (3) consumers, one (1) was in the age range of 55 to 64 (33%), and two (2) were in the age range of 65+ (67%).

Program Highlights

During FY2026, Senior In-Home Therapy provided a total of 1,256 hours of counseling services to the consumers served. Additionally, staff participated in the Annual Consumer Achievement Awards ceremony at the Morris campus, celebrating the accomplishments of program participants. The Program Director also completed Mental Health First Aid Instructor Training for Older Adults, enhancing the program's capacity to support mental health awareness and intervention.

Advocacy Activities

Throughout the year, Senior In-Home Therapy actively engaged in advocacy to ensure consumers received the resources and support necessary to enhance their quality of life. During individual sessions, staff consistently connected participants to programs funded by the Morris County Division of Aging, as well as a wide range of community-based services. The program's advocacy efforts focused on increasing wellness, reducing symptoms, promoting socialization, and supporting independence for as long as possible. When appropriate, family members and psychiatrists were incorporated into the treatment process, fostering a coordinated approach to care. This personalized advocacy empowered consumers to access essential resources and make meaningful progress toward their personal goals.

FY 2027 Goals

The Senior In-Home Therapy Program remains committed to exceeding its goals by providing more than 820 counseling hours annually, administering the MHQOL survey for each consumer, and maintaining individualized treatment plans. The program will continue to strengthen partnerships with community agencies and MHA programs while collecting and monitoring performance data to ensure accountability.

and improved outcomes. Staff will also engage in ongoing professional training and deliver presentations as needed to stay current with best practices, all while empowering consumers to achieve their personal goals, enhance their quality of life, and stay connected to their communities.

SUPPORTED EMPLOYMENT SERVICES (SES)

Description

Supported Employment Services (SES), established by MHA, is dedicated to empowering individuals with mental illness to achieve their goals related to employment, independence, wellness, and recovery. We offer personalized support through group sessions and one-on-one job development, helping participants identify strengths, develop skills, and improve their chances of finding and maintaining meaningful work.

Our person-centered approach involves coordinating with other service providers to create tailored support plans that meet each individual's unique needs and aspirations. Once participants secure employment, our Employment Specialists provide ongoing coaching, both on-site and off-site, and continuously monitor progress to promote long-term success and stability in the workplace.

Personnel

Supported Employment Services (SES) is composed of a team of four staff, including two full-time and one part-time Employment Specialists, along with a Licensed Program Director. The SES team brings a range of backgrounds and experiences, which supports the delivery of services and helps build strong, meaningful connections with consumers.

Caseload

Between July 1, 2025, and June 30, 2026, Supported Employment Services (SES) served a total of 154 clients, of which 54 were new enrollees.

Referrals came from a wide range of sources, including self-referrals, word of mouth, and various partner programs and organizations. These included internal program referrals, Northwest Essex Community Healthcare, Ancora Psychiatric Hospital, Greystone Psychiatric Hospital, Inspira Inpatient Behavioral Health, Newark Beth Israel Hospital, Care Plus Behavioral Health Paramus, Greater Essex Counseling Services, Caldwell Mental Health, Millennium Wellness, and Summit Oaks Hospital. This referral network highlights the collaborative and community-integrated approach of SES in supporting individuals with serious and persistent mental illness on their path to employment and recovery.

Demographics

The majority of clients served by Supported Employment Services identify as African American (67%), followed by Caucasian (21%), Hispanic (11%), and Asian (1%). While SES serves individuals across all of Essex County, the highest concentration of consumers resides in the East Orange and Newark areas. Additional consumer representation comes from various other municipalities within the county, including Belleville, Bloomfield, Cedar Grove, Fairfield, Glen Ridge, Irvington, Orange, Maplewood, Montclair, Nutley, West Orange, South Orange, and Livingston. This broad geographic distribution underscores the program's broad reach and accessibility within the region.

Performance Outcomes

The target number of clients to be served was 130, but SES exceeded this goal by serving 154 clients. Additional key outcomes include 86 individuals placed into full-time employment and 86 individuals placed into part-time employment. At the close of the fiscal year, SES maintained an active caseload of 116 consumers. SES placed 38% of clients into employment within 120 days of program entry. Notably, 100% of those placed were employed in occupations of their choice. By the end of the year, 43% of clients retained employment for three months or longer.

Employment Specialists worked diligently to support clients, providing consistent motivation and conducting multiple follow-ups to ensure a smooth transition into the workforce by assisting with onboarding activities, training and advocacy as needed. Staff actively engaged clients in Job Readiness activities focused on key areas such as technology use, interviewing skills, work ethics, problem-solving, and positive communication. The target wait time for intake was three business days and admission was completed within one day. Individual Service Plans were developed collaboratively with consumers and reviewed on a monthly and quarterly basis, with additional reviews conducted as needed to support consumer progress and goal attainment.

Consumer Satisfaction Surveys

MHA continuously refines its services based on consumer input, ensuring that every individual has the opportunity to share feedback and have their voice heard. Feedback is collected through various methods, including the annual Consumer Satisfaction Survey. The survey was made available via SurveyMonkey, distributed through email, and offered in-person to maximize accessibility. Results indicated a 96% overall satisfaction with SES services.

Program Highlights

Employment Placements: SES consumers work successfully in a wide range of competitive jobs, including *Accountant, Activities Assistant, Case Manager, Cashier, Clinical Data Science Lead, Data Annotator, Dishwasher, Dietary Aide, Doc Runner, School Lunch Aide, Clinical Lab Assistant, Custodian, Customer Service Representative, Certified Nurse Aide, Direct Support Professional, Food Service Worker, Front Desk Receptionist, Front End Associate, Food Handler, Groundskeeper, Home Health Aide, Housekeeper, Inventory Specialist, Package Handler, Teacher Assistant, Office Assistant, Office Manager, Patient Care Technician, Pet Food Vendor, Receiving Clerk, Receiving Support Specialist, Retail Sales Associate, Security Guard, Server, Stock Associate, Substitute Teacher, Support Worker, Team Member, Tutor, Unit Clerk, Vocal Music Teacher, Warehouse Worker, and Zoo Guest Experience Keeper.*

Transitional Employment Program: SES continued oversight of the in-house Transitional Employment Program, providing paid training and ongoing support to seven consumers employed as Receptionists and Cleaning Technicians within MHA offices to strengthen their work experience and build their résumés.

Warm Line Support: Employment Specialists provided ongoing support to Peer Support Specialist on the Peer-to-Peer Warm Line, reinforcing the value of lived experience in service delivery.

Dress for Success Partnership: SES maintained its partnership with Dress for Success Northern NJ by referring and assisting three women in receiving professional attire for job interviews and the workplace. The clothing included dress suits, pantsuits, dresses, blouses, slacks, shoes, and more. In addition to this partnership, SES also utilized the PATH Program Clothing Pantry as a resource for professional attire.

Support (Technology, Certifications, Other): SES provided direct assistance to consumers by helping a consumer apply for driver's lessons through the Mental Health Resource Network in order to obtain their driver's license, paying for drug screen testing for employment onboarding processes, paying for background checks, paying for a Mobile Dental Clinic fee for a consumer whose insurance was interrupted and needed care, purchasing a coat for a consumer in need, purchasing work uniforms and gloves for consumers who were starting new jobs, purchasing 5 bus cards, and paying for high school diploma information and certification of education for a consumer who was born outside the United States.

Referrals and Supportive Services: SES referred consumers to key community resources including local food pantries, the Community Health Law Project, Bridgeway Support Services for Supported Education, Dress for Success, Commission for the Blind, as well as to internal MHA programs.

Health Insurance Support: MHA staff included Certified Application Counselors who assisted uninsured individuals in applying for health coverage.

Academic Partnerships: SES served as an internship site for Fairleigh Dickinson University College of Pharmacy & Health Sciences and Rutgers University School of Social Work, supporting student training in real-world mental health service environments

Employment Partnerships: Ongoing collaboration with Gourmet Dining Services, a provider to Seton Hall University, has resulted in the employment of several consumers. SES also continued its partnership with Care Well Health's Human Resource Department to explore and pursue job openings within their hospital network.

Advocacy Activities

Monthly Outreach Community Meetings are regularly attended to strengthen collaboration with community partners and stakeholders, with the goal of increasing referrals and ensuring that community needs are effectively addressed. Professional Advisory Committee (PAC) meetings are also regularly attended to stay informed about industry best practices, emerging trends, and community priorities. This ongoing engagement helps ensure that program strategies remain aligned with current standards and effectively meet the evolving needs of the population served.

FY 2027 Goals

SES will continue its collaborative efforts with community providers to secure additional employment opportunities by leveraging internal resources within partner organizations and agencies. By strengthening these relationships, SES aims to expand the network of available job opportunities and facilitate more effective placement for consumers. Additionally, the program will focus on improving employment outcomes by actively reducing service gaps, enhancing linkages between different service providers, and ensuring smooth transitions between various stages of support for consumers. This approach is designed to create a seamless experience and better support sustained employment. Furthermore, SES will continue to prioritize in-person engagement with consumers throughout FY2027 whenever appropriate and feasible, recognizing the value of face-to-face interactions in building trust, providing personalized support, and addressing individual needs more effectively.

Suicide Prevention Services (SPS)

Description

Suicide Prevention raises awareness about suicide prevention by offering educational presentations and time-limited trainings to enhance the community's understanding of mental illness, treatment options, and coping skills. These presentations are designed for schools (e.g., faculty, support staff, administrators, and students), communities (e.g., parents, family members, congregants, and college students), and specialized groups (e.g., law enforcement, first responders, faith leaders, and college professionals). Topics include, but are not limited to, an overview of mental health and mental illness, suicide prevention, how to talk about suicide, stress management, communication, wellness and self-care, mindfulness, grief and loss, and more. Workshops and groups are delivered to help individuals, from elementary school students to older adults, increase self-awareness, build coping skills, and express themselves through brief mindfulness and art-based activities. Additional services include implementing Mental Health Players and supervising two non-crisis warmlines.

Mental Health Players

Mental Health Players educate audiences through interactive role-plays that address important issues such as employment challenges, staff conflicts, aging, drug and alcohol use, parent/child conflicts, and mental illness. Role-playing is an effective way to engage audiences and encourage interaction, especially when traditional lecture-style methods may leave audiences disengaged or unresponsive. Performances last approximately 45 minutes, consist of two role-plays, and can be scheduled during the day or evening.

Peer-to-Peer Support Line

The Peer-to-Peer Support Line has been serving the community since 2005. This warmline is staffed by individuals with lived experience of mental illness and/or substance use disorders who provide support and guidance to others facing similar challenges. The goal of this service is to offer a safe space for non-crisis peer support via telephone, promoting resilience and wellness through shared understanding and empathy for individuals living with mental illness and/or substance use disorders. All Peer-to-Peer Support Line staff complete an individualized training program before working on the Line. The Line operates seven days a week, 365 days a year, from 5 p.m. to 10 p.m., and on five weekdays from 11 a.m. to 2 p.m.

Teen Connect Support Line

The Teen Connect Support Line has been serving the community since 2022. This warmline is staffed by young people, for young people. The intended population is youth ages 13–24. Teen Connect staff provide coverage on two lines (one call and one text) Monday through Friday, from 5 p.m. to 10 p.m.

Personnel

A Program Director supervises the following services alongside the staff listed below:

Suicide Prevention Services: 1 Community Educator

Mental Health Players: 40 Volunteers

Peer-to-Peer Support Line: 19 Peer Line Staff

Teen Connect Support Line: 10 Teen Line Staff

East Orange YMCA Grant: 1 Clinician

Consumer Satisfaction Surveys

Suicide Prevention Training Survey Outcomes

According to feedback from FY 2026 surveys, 86% of participants agreed that they feel more confident in recognizing the signs that someone may be experiencing a mental health issue or expressing suicidal thoughts. Additionally, 88% indicated that they are more likely to intervene when they encounter someone experiencing a mental health crisis. Furthermore, 95% reported being more aware of the resources available to assist someone in crisis. These results demonstrate increased awareness and preparedness among participants to support individuals facing mental health challenges.

Peer-to-Peer Support Line Survey Outcomes

96% of callers reported that the Peer-to-Peer Support Line was very helpful in providing emotional support, and 100% of callers stated that the line met their needs. Additionally, 100% of Peer Line workers expressed satisfaction with their experience working on the Peer-to-Peer Support Line. These results highlight the positive impact of the service on both callers and Peer Line staff.

Program Highlights

The Suicide Prevention team facilitated 105 presentations, workshops, groups, and tabling event activities to 2,682 individuals ranging from elementary age students to older adults. Below is a detailed overview of these services.

Gizmo's Pawesome Guide to Mental Health was delivered to more than 20 students at Cleveland Elementary School in Newark. Gizmo's Pawesome Guide to Mental Health adopts an upstream approach to supporting the mental health and wellness of 3rd and 4th graders. The guide aims to introduce concepts of mental health and wellness, as well as ways to care for one's mental health. It highlights the characteristics of trusted adults, encourages students to identify trusted adults in their lives, and provides opportunities to practice conversations with them, promoting proactive communication. The program also provides youth with the opportunity to create a personal mental health plan, an action plan they can use daily and during times of need to help prevent crises.

The Signs of Suicide (SOS) Program was delivered to over 40 students at Barringer High School in Newark, NJ. It is an evidence-based youth suicide prevention program for middle and high school students. SOS teaches students how to identify signs of depression and suicide in themselves and their peers, while training school professionals, parents, and community members to recognize at-risk students and take appropriate action. The curriculum includes facilitation guidance with prompts for classroom discussion, age-appropriate videos featuring real stories and modeled scenarios, and a brief depression screen that encourages students to reflect on how they are feeling.

Mental health presentations, workshops, groups, and tabling events were delivered to various audiences, including adults in treatment for substance use, youth, older adults, faith-based communities, parents, teachers, support staff, community members, and public servants. These events took place within the following communities: the Hope Institute, our Community Wellness Centers (CWC), the Livingston Old Guard, Montclair NAACP, Skanska USA Building Inc., Garden State Federal Credit Union, Montclair Child Development Center (MCDC), Briarcliff Middle School, Lacordaire Academy, YouthBuild, NJ 211, Church of the New Covenant, The Love of Jesus Family Church, The Presbyterian Church of Chatham Township, our Intensive Family Support Services (IFSS) in Essex, Shiv's Third Eye Foundation, The YANA Foundation (You Are Not Alone), and Darren Clark Jr. Memorial Foundation.

The Suicide Prevention team continued to implement an interactive, strength-based approach that included mindfulness and art-based activities to support the community through mental health presentations, workshops, and group topics. The team is trained in embodied modalities (e.g., trauma-informed yoga, mindfulness, and art therapy), which are effective for connecting with individuals of all ages, especially youth. These modalities can also serve as protective factors for mental health by: (1) helping individuals process, understand, and communicate complex thoughts and emotions; (2) providing constructive outlets for challenging feelings; (3) encouraging self-expression and emotional regulation; (4) engaging the senses, feelings, and physical action; (5) fostering an understanding of different perspectives; and (6) nurturing confidence and a sense of identity. The image below is a drawing created by an older adult to visually process what they would like to release (e.g., anger and pain) and what they would like to retain (e.g., love, growth, and peace) for overall well-being.



In partnership with the Mayors Wellness Campaign grant for the Township of West Orange and the Healthcare Foundation of the Oranges grant for the East Orange YMCA, the Suicide Prevention team expanded its services to provide mental health programming to these communities. More than 70 older adults in West Orange were able to share their experiences, learn from one another, and develop coping skills through support groups, book discussion groups, creative expression groups, and other wellness activities. Additionally, more than 20 youth between the ages of 5 and 13 received support in developing skills related to emotional regulation, communication, social interaction, and self-esteem through individual supportive counseling sessions at the East Orange YMCA.

SPS continues to spread awareness through two youth suicide prevention webpages. These webpages received a total of 5,031 pageviews during this fiscal year.

- **StopTeenSuicide.mhainspire.org** provides information on warning signs and practical ways to communicate with a young person experiencing suicidal thoughts. Additionally, it features testimonials from young people who have attempted suicide and from family members and friends affected by the loss of someone to suicide. This landing page received 645 pageviews.
- **YouAreNotAlone.mhainspire.org** offers guidance, comfort, and hope to young people struggling with suicidal ideation, along with coping strategies and important resources to access during a crisis. This landing page received 4,386 pageviews.

Mental Health Players

A Mental Health Players performance was delivered to over 20 older adults in West Orange. Through this interactive performance, older adults gained more knowledge about the distinction between grief and mental illness in widowhood, as well as the advantages and disadvantages of retirement.

Peer-to-Peer Support Line

The Peer-to-Peer Support Line provided hope, encouragement, and resources to 272 people during a total of 6,168 hours of calls. Although most calls originated from New Jersey, additional calls came from out of state.

Teen Connect Support Line

The Teen Connect Line provided hope, encouragement, and resources to 83 young people during a total of 2,610 hours of calls and texts. This consisted of 77 calls and 80 text conversations. Although most calls and texts originated from New Jersey, some came from out of state.

FY 2027 Goals

The Suicide Prevention team will continue to facilitate presentations, workshops, groups, and brief wellness activities during tabling events for various ages and populations within the community. The team will also (1) facilitate evidence-based suicide prevention programming, (2) implement 2-4 Mental Health Players performances, (3) increase the number of people served on the Peer-to-Peer Support Line and Teen Connect Support Line, and (4) provide ongoing training to improve the service quality of the warmlines.

Substance Use Recovery and Empowerment (SURE)

Description

The Substance Use Recovery and Empowerment (SURE) program's goal is to assist individuals diagnosed with a substance use disorder or co-occurring disorder in achieving long term recovery while living fulfilling and productive lives. SURE provides ASAM 2.1: Intensive Outpatient (IOP) and ASAM 1.0: Outpatient levels of care to individuals 18 years of age and older. The SURE program offers support and assistance in developing a recovery management plan that addresses substance use, process addictions, and co-occurring disorder concerns. SURE provides individual and group counseling, psychiatric evaluations, and medication monitoring to support individuals with substance use and co-occurring disorders throughout their recovery. The duration of treatment is determined based on clinical indication and medical necessity. The estimated length of treatment for ASAM 2.1 Level of care is approximately 14 to 16 weeks, while the estimated length of treatment for ASAM Level 1.0 is approximately 8 to 12 weeks.

Personnel

The SURE Program is staffed by one Licensed Program Director, one Licensed Co-Occurring Counselor, and one to two graduate level interns.

Caseload

During FY2026, the SURE Program admitted 98 individuals. Of these 98 consumers, 44 were admitted to the ASAM 2.1: Intensive Outpatient Program level of care, and 54 were admitted into ASAM 1.0: Outpatient Program level of care.

SURE consumers are insured primarily through Medicaid (72%), and Medicare (5%). The program also has grant funding through Morris County that covers individuals who are uninsured, with the goal of increasing access to treatment.

Demographics

The SURE Program provides services to individuals residing in Morris, Sussex, Essex, Warren, Union, and Hudson Counties.

The program served consumers ranging in age from 19 to 78 years old. Of those served, 70% were male, and 30% were female. Regarding ethnicity, 53% identified as White or Caucasian, 13% Hispanic or Latino, 30% Black or African American, and 4% preferred not to say.

Performance Outcomes

In FY2026, the SURE Program delivered 1,738 units of service for ASAM Level 2.1, which exceeded the program's targeted benchmark. In addition, the program delivered 1,060 units of service for ASAM Level 1.0: again, exceeding the overall targeted program commitment.

Consumer Satisfaction Surveys

In May 2026, SURE consumers were given the opportunity to participate in a Consumer Satisfaction Survey. The confidential survey included a total of fourteen questions formatted using a five-point Likert scale, demographic collection, and optional comment section. The survey was prepared in both English

and Spanish and offered in both paper format and a web-based web-based link (SurveyMonkey). There was a 94% response rate with an overall satisfaction score of 93.1%.

Program Highlights

In FY2026, the SURE Program expanded access to medication-assisted treatment (MAT), with the program psychiatrist now prescribing Naltrexone, Vivitrol, and Suboxone to support individuals in their recovery from opioid and alcohol use disorders.

Additionally, the SURE Program expanded its community involvement throughout FY2026 by increasing outreach and engagement opportunities focused on Narcan education and training, relapse prevention, long-term sobriety, and recovery support. These efforts have strengthened the program's connection with community partners while increasing awareness of overdose prevention and recovery resources. The program also emphasized helping individuals build a stronger support network that promotes sustained recovery, improved health and wellness, and greater stability within the community.

Advocacy Activities

In FY2026, the SURE Program Director presented at the Morris County Overdose Fatality Review Team end-of-fiscal-year meeting, increasing awareness of evidence-based co-occurring treatment services, strengthening community partnerships, and expanding opportunities for collaboration and referrals.

The SURE Program also participates in monthly meetings with the Morris County Overdose Fatality Review Committee and its subcommittees to inform system-level improvements and align program practices with identified community needs. Through this involvement, the SURE Program engaged with Assemblywoman Aura Dunn to increase awareness of program services. This outreach resulted in the program being featured in a widely distributed newsletter, reaching approximately 76,000 individuals and further supporting community awareness and potential referrals.

In addition, the SURE program strengthened and expanded relationships with Recovery Court, Probation, Morris County Aftercare to increase referral pathways and ensure clients are connected to appropriate levels of substance use and co-occurring treatment.

FY 2027 Goals

For FY2027, the SURE Program will focus on expanding access to integrated substance use and mental health treatment while strengthening client engagement, retention, and recovery outcomes. The program will work to increase the census and service utilization through enhanced community outreach, referral development, and partnerships with hospitals, Recovery Court, probation/parole, DCP&P, healthcare providers, detoxification and residential programs, and other community organizations.

The SURE Program will continue to strengthen ASAM Level 2.1 IOP and Level 1.0 outpatient services while exploring opportunities to expand programming including evening IOP services, to improve accessibility. The program will also focus on improving coordination with psychiatric and medical providers, increasing access to medication-supported recovery, and addressing barriers related to housing, transportation, healthcare, employment that may impact treatment participation and recovery.

Overall, the SURE Program will continue to prioritize high-quality, recovery-oriented services that promote sustained recovery, improved mental health and substance use outcomes, increased community stability, and successful long-term independence for individuals with co-occurring disorders.

Veteran and Family Support

Description

It is well documented that, compared to their non-disabled peers, veterans with a disability have a higher incidence of mental health issues including depression, Post Traumatic Stress Disorder (PTSD), isolation, and social withdrawal, and are less likely to participate in treatment in the community. In addition, most veterans struggle with family reunification and community integration post-military life. Providing support to the family's infrastructure yields positive outcomes for both the veteran and their family.

Personnel

One (1) Full-Time licensed Clinician

Caseload

As of June 30, 2026, Veteran and Family Support had a caseload of 30 cases. During FY2026, referrals for Veteran and Family Support were made through self-referral, the Morris County Prosecutors Office, and the Morris County website.

Demographics

The program accepts veterans and their family members who are 18 years of age or older regardless of their discharge status.

Performance Outcomes

Performance outcomes were measured and monitored through MHAEM's Quality Assurance Committee. During FY2026, 119.75 of mental health counseling were provided, 70 units of case management provided, 13 education groups were facilitated, and 31 support groups were also facilitated.

Consumer Satisfaction Surveys

Within the program, surveys distributed and tallied to measure satisfaction. All consumers were informed that answers would remain confidential. Consumers were provided with a sealed envelope to protect anonymity and informed of several ways on how to return the surveys:

Approximately 11 surveys were delivered to consumers (hand delivered, mailed and/or left at their residence). Out of the 11 surveys delivered, 11 individuals responded, resulting in 100% percent response rate.

Results

Our commitment to client-centered care is a core strength, reflected in our recent satisfaction survey. One hundred percent of client reported being satisfied overall and felt they were treated with dignity and respect. Furthermore, consumers reported feeling understood by staff, being able to freely voice concerns, and being actively involved in their service plans, confirming our success in creating a respectful and empowering environment.

Program Highlights

Veteran and Family Support provides a range of services aimed at addressing the unique needs of veterans and their families. During this year, some highlighted services and activities included:

- In November 2025, staff hosted the 4th annual Coffee with a Veteran event at the Morris Campus.
- In January 2026, the Veteran and Family Support Program was honored during the Seton Hall Men's Basketball game against Xavier University. Prior to tipoff, veterans participating in the program were recognized at half court and presented with the official game ball as part of the pregame ceremony. During halftime, the Program Director participated in an on-court interview, highlighting the mission, impact, and services of the Veteran and Family Support Program to those in attendance.
- In May 2026, the program offered its 2nd annual Equine Therapy Session to group participants in collaboration with Sisu Psychotherapy and Wellness.
- The program met with a representative from the New Jersey Department of Veterans Affairs, along with Morris County leadership to having meaningful conversations centered on advocacy and collaboration for veterans.
- Veteran and Family Support staff provided multiple trainings in FY26 on veteran services throughout Morris County.
- The Program Director provided education regarding veteran services during the Crisis Intervention Team training to approximately 104 law enforcement officers and 36 mental health professionals.

Advocacy Activities

Veteran and Family Support staff work closely with consumers to assist them in developing self-advocacy skills by keeping an open dialogue on various ways they can become involved in different levels of advocacy (i.e., self-help centers, NAMI-NJ).

FY 2027 Goals

Veteran and Family Support staff are committed to increasing the total number of contacts with consumers, their families, and service providers to ensure comprehensive outreach and support. Staff will continue to collect and analyze data meticulously, closely monitoring all performance indicators to evaluate program effectiveness and identify areas for improvement. They will persist in working with veterans and their families to empower them to achieve their personal goals, fostering independence and self-advocacy.

To enhance their skills and remain current with best practices, staff members will attend relevant training sessions and professional development opportunities. Additionally, they will continue to conduct trainings and presentations as needed, sharing information about the program's role and services with community partners, stakeholders, and other interested parties to promote awareness, collaboration, and access to available resources.

Early Intervention Support Service- The Wellness HUB

Description

It is the mission of the Wellness HUB, an Early Intervention Support Services (EISS) Program, to provide the highest quality of mental health services to any adult age 18 or older who resides, works, or attends school or prefers to participate in treatment in Sussex County and is experiencing exacerbated symptoms of mental illness. The Wellness HUB is designed as a “living room” to provide the most comfort to the visitors, their friends and family when in a crisis. Consumers can walk in during any of the extended office hours, including normal off hours for traditional outpatient clinics. The Wellness Hub functions as a mental health urgent care clinic that offers immediate access to crisis intervention services without having to rely on hospital emergency departments. The Wellness HUB provides immediate access to outreach, assessment, medication monitoring, therapy, and support with few barriers to participating in our treatment.

The main goal of the Wellness HUB is to provide immediate support to avoid the need for psychiatric hospitalization. Our mental health urgent care is designed to provide immediate and wrap-around support to those reporting exacerbated mental health symptoms. We understand that “crisis” can look and feel different for everyone and we work to design an individualized treatment plan for each person who walks in our doors.

Wellness HUB Services include crisis prevention and counseling, psychiatric assessment and medication management, short-term therapy, family/couples counseling, substance use counseling, linkage and referral to community resources, peer support, and transportation. The philosophy of our mental health urgent care is to immediately provide support and treatment to those who are in need; regardless of their ability to pay, access to transportation and any other barriers in their way. We offer a comfortable, calm, and inviting environment to help people on their way to recovery.

Personnel

The Wellness HUB operates with a team of clinical and case management staff under the direction of a Program Director and Program Coordinator. The clinical team includes a part-time Psychiatrist, part-time Advanced Practice Nurses (APN), and licensed therapists. The Case Management team includes Case Managers, BA-level Substance Use Specialists, and Peer Support Specialists with lived mental health and substance use experience. The teams work closely together to ensure that all of our consumers’ needs are met. There is also an administrative assistant providing support to the “living room” and interns at different levels of education.

Caseload

Of the 825 walk-ins served at the Wellness HUB in FY2026, 560 consumers were provided emergency Psychiatric Evaluation, Medication Management, Crisis Counseling, and Case Management for a period of thirty days or more. Consumers who walk in for care and are not opened, for a variety of reasons, are assisted with walk-in case management, crisis care and immediate linkage to an appropriate community program. We found in this fiscal year, that some walk-ins were only looking for immediate support to curb their crisis and were not in need of the full spectrum of services provided at the HUB.

The Wellness HUB is located in Newton, NJ, in the county of Sussex. Most parts of Sussex County, New Jersey are considered rural. To that end, the consumers in Sussex County are dealing with a number of barriers to receiving treatment. This includes a vast lack of resources, lack of employment opportunities, and housing resources, as well as no access to transportation services. Regarding treatment, the County of Sussex has one hospital with limited outpatient mental health, Acute Partial/Intensive Outpatient, and one community partial care provider. Waitlists for outpatient treatment for those covered by Medicaid can be as long as a 90-day wait. The Wellness HUB is able to assist those awaiting their needed treatment and bridge the gap of care.

Demographics

Of the 825 walk-ins at the Wellness HUB, 85% identified as White/Caucasian, 6% as Black/African American, 1% as Asian, and 8% as other. Ethnicity breakdown included 85% non-Hispanic and 15% Hispanic/Latino(a)(x), and of those identifying as Hispanic, 6 consumers seen were non-English speakers, who were treated at the Wellness HUB with help from the Language Line. The Wellness HUB consumers identify as 44% Male, 52% Female, and 4% Gender Non-Conforming or transgender.

Of those served in FY2026, 30% were under the age of 30 and 17% were over the age of 60. The outliers include 24 consumers 18 and 19 years old and 7 consumers were 80 years old or older. Our youngest consumer was 18 years old, and our oldest was 89 years old.

The Wellness HUB is a grant funded program that is contracted to treat all consumers regardless of their ability to pay. We have found in the past year a significant number of consumers that have no insurance coverage, who are not eligible for Medicaid due to income limits but who also report an inability to pay for their own insurance coverage. This makes it difficult for the consumers to engage in treatment post-Wellness HUB treatment.

Of the 825 walk-ins at the Wellness HUB, 89% resided in Sussex County. The other 11% resided in surrounding Morris County, Warren County, Other NJ Counties, and out of state in Pennsylvania and New York. The Wellness HUB turns no consumers away from the HUB regardless of their insurance coverage, ability to pay, immigration status, or county/state of residency.

Performance Outcomes

The Wellness HUB participates in the agency-wide Quality Assurance (QA) program which conducts monthly meetings and collects data on the utilization, quality, and effectiveness of services and treatment provided by each MHA program.

Wellness HUB's performance indicators measure overall consumer satisfaction, access to immediate care, and quality of care. During this fiscal year, 100% of consumers surveyed were satisfied with their treatment at the Wellness HUB. 98% of walk-ins were offered an appointment with a psychiatric provider within 24 hours of walking in for treatment. There is no wait for care at the Wellness HUB, with an average wait time of zero days. We work to assist our consumers in engaging in immediate counseling and medication evaluation to avoid the need for psychiatric screening at the hospital for a higher level of care or need for inpatient psychiatric care.

Consumer Satisfaction Surveys

MHAEM is continuously refining services based on consumer input. This is received through various methods, including the annual Consumer Satisfaction Survey. Thirty-four (34) Wellness HUB consumers were surveyed during our survey period.

Of the consumers surveyed, 100% of consumers selected Strongly Agree or Agree that they were satisfied with services at the HUB. 100% of consumers felt initial services were received in a timely manner. 100% of consumers felt HUB staff were respectful of their cultural background. 100% of consumers felt appointments were scheduled for convenient times and days. 83% of consumers felt their case manager was available to assist them with needed linkages and referrals, 90% of consumers felt the treatment team worked collaboratively to provide the best treatment. 92% of consumers felt they have made progress in dealing with their identified problems. 95% of consumers would recommend this service to another. Those surveyed responded to two open-ended questions as follows: (1) How has the Wellness HUB improved your life? and (2) Additional comments.

- The Wellness HUB has been wonderful source of resources for me to manage my life and this stage of things. I am very appreciative for the HUB.
- Excellent therapist. Easy to talk to.
- Gave me all the resources to improve my mental health.
- Gave me a free outlet as a poor person.
- Calm approach. They have listened to my input.
- It has helped me overcome trauma, manage depression and to bring my family out of homelessness
- Treatment has helped me recognize what is going on both physically and mentally.
- It has helped me navigate life through a more relaxed and positive way
- All the staff was excellent to work with. Elisa was great at her job but she was also very caring and committed to my wellbeing. Helping with both short- and long-term care.
- Very friendly, caring staff.
- Everyone is wonderful. The most help I've had in years. I'll be sad when my stupid insurance runs out. So, thanks to everyone who has helped me. 10 Star Review!!
- Jodie has been wonderful helping me each step of the way.

Program Highlights

The Wellness HUB's biggest achievement in FY2026 is being able to support 825 consumers with acute mental health and substance use needs with immediate support. To this end, the Wellness HUB was recognized by our funder, the Division of Mental Health and Addiction Services, as one of the top-performing Early Intervention Support Services (EISS) in the state. With respect to our contract expectations, we are one of the only EISS programs providing treatment as soon as consumers walk through our doors, 100% of the time, with access to a mental health professional and prescriber within 24 hours of making contact with the Wellness HUB.

The Wellness HUB Director was a participant in the county of Sussex's first Crisis Intervention Training (CIT) in five years. Through the CIT training, more than 30 police officers were able to be educated on the programs available in Sussex County, and techniques for addressing, in real time, individuals struggling with mental health and substance use challenges.

Wellness HUB staff participated in health fairs at Project Self-Sufficiency, Sussex County Community College, and local schools. We participated in Overdose Awareness Night and the CFPC Annual Recovery “Changing the face of Addiction” Walk, showing support of local agencies and our consumers in sustained recovery, as well as, attending Sussex Vo-Tech’s Game of Life to provide mental health resourcing to a group of graduating students.

Advocacy Activities

Advocacy at the Wellness HUB means that the HUB is not just providing treatment and support to those in need but being a vocal and steady member of the Sussex County community. The Wellness HUB Director is the chair of the PAC/PACADA meetings, a monthly meeting where mental health and substance use providers come together to ensure we are providing quality care. The Director also serves on the Sussex County Overdose Fatality Review Committee, in an effort to reduce stigma and lower the number of Sussex residents lost to an accidental overdose.

FY 2027 Goals

With four years of service under our belt, we would like to expand our scope in the next fiscal year. When we first opened our doors in August 2022, we never expected to see as many consumers in Sussex County consistently year after year. Within this fiscal year, the Wellness HUB will expand its outreach to the Sussex community. The Wellness HUB will place a strong focus on increasing community awareness and expanding outreach to the residents of Sussex County. The goal is to ensure that more residents, especially those affected by mental health challenges, substance use recovery, and related life stressors know about the HUB’s services, feel welcomed, and feel encouraged to take part. This goal will not only address getting those into mental health services but also reduce mental health and substance use stigma in our communities.

In addition, FY2027, will bring an expansion of Wellness HUB services to include the addition of Saturday 9:00 am to 5:00 pm walk-in hours including an additional part-time therapist and APN. This addition is scheduled to start in July 2026.

MENTAL HEALTH ASSOCIATION

Program Contact Information

Arrive Together

1160 Parsippany Blvd.
Parsippany, NJ 07054
973-334-3496
Townships: All of Morris County
Co-Response: Mount Olive

Assisted Outpatient Treatment (AOT)

AOT Essex Campus
80 Main Street, Suite 500
West Orange, NJ 07052
973-842-4141

AOT Morris Campus
1160 Parsippany Blvd.
Parsippany, NJ 07054
973-334-3496

AOT Sussex Campus
83 Spring Street, Suite 302B
Newton, NJ 07860
973-579-4399

Center for Behavioral Health

33 South Fullerton Avenue
Montclair, NJ 07042
973-509-9777

Collaborative Justice Services (CJS)

CJS Essex Campus
80 Main Street, Suite 500
West Orange, NJ 07052
973-676-9111

CJS Morris Campus
60 Washington Street, Suite 301
Morristown, NJ 07960
973-334-3496

Community Support Services (CSS)

CSS Essex Campus
80 Main Street, Suite 370
West Orange, NJ 07052
973-509-3777

CSS Morris Campus
1160 Parsippany Blvd.
Parsippany, NJ 07054
973-334-3496

Community Wellness Center (CWC)

CWC Morris
90 East Halsey Road, Suite 385
Parsippany, NJ 07054
973-334-3496

CWC Sussex
65 Spring Street
Newton, NJ 07860
862-946-6544

Co-Response

80 Main Street
West Orange, NJ 07052
973-509-9777
Townships: West Orange, South Orange, Perth Amboy

Criminal Justice Reform (CJR)

80 Main Street, Suite 500
West Orange, NJ 07052
973-676-9111

Integrated Case Management Services (ICMS)

ICMS Essex Campus
80 Main Street, Suite 500
West Orange, NJ 07052
973-676-9111

ICMS Morris Campus
1160 Parsippany Blvd.
Parsippany, NJ 07054
973-334-3496

ICMS Passaic Campus
1373 Broad Street, Suite 312
Clifton, NJ 07013
973-470-3142

Intensive Family Support Services (IFSS)

IFSS Essex Campus
33 South Fullerton Avenue
Montclair, NJ 07042
973-509-9777

IFSS Sussex Campus
83 Spring Street, Suite 302B
Newton, NJ 07860
973-579-4399

MENTAL HEALTH ASSOCIATION

Program Contact Information

988 Mobile Crisis Outreach Response Teams (MCORT)

MCORT Essex Campus

80 Main Street, Suite 280
West Orange, NJ 07052
Call or Text 988

MCORT Hudson Campus

110A Meadowlands Parkway, Suite 203
Secaucus, NJ 07094
Call or Text 988

Self-Help, Advocacy and Education

1160 Parsippany Blvd.
Parsippany, NJ 07054
973-334-3496

Senior In Home Therapy

1160 Parsippany Blvd.
Parsippany, NJ 07054
973-334-3496

New Jersey Statewide Student Support Services (NJ4S)

1160 Parsippany Blvd., Suite 103
Parsippany, NJ 07054
973-334-4052

Substance Use Recovery and Empowerment (SURE)

1160 Parsippany Blvd.
Parsippany, NJ 07054
973-334-3496

Projects for Assistance in Transition from Homelessness (PATH)

PATH Essex Campus

80 Main Street, Suite 150
West Orange, NJ 07052
973-842-4127

PATH Morris Campus

1160 Parsippany Blvd.
Parsippany, NJ 07054
973-334-3496

Suicide Prevention Services (SPS)

1160 Parsippany Blvd.
Parsippany, NJ 07054
973-334-3496

Supported Employment Services (SES)

80 Main Street, Suite 500
West Orange, NJ 07052
973-395-1000

Prospect House (PH)

424 Main Street
East Orange, NJ 07018
973-674-8067

Veteran and Family Support Services (VFS)

60 Washington Street, Suite 301
Morristown, NJ 07960
973-334-3496

Prospect Primary Healthcare

424 Main Street
East Orange, NJ 07018
973-414-6988

Wellness Hub/Early Intervention Support Services (EISS)

83 Spring Street, Suite 303
Newton, NJ 07860
973-840-1850

Riskin Children's Center (RCC)

33 South Fullerton Avenue
Montclair, NJ 07042
973-509-9777