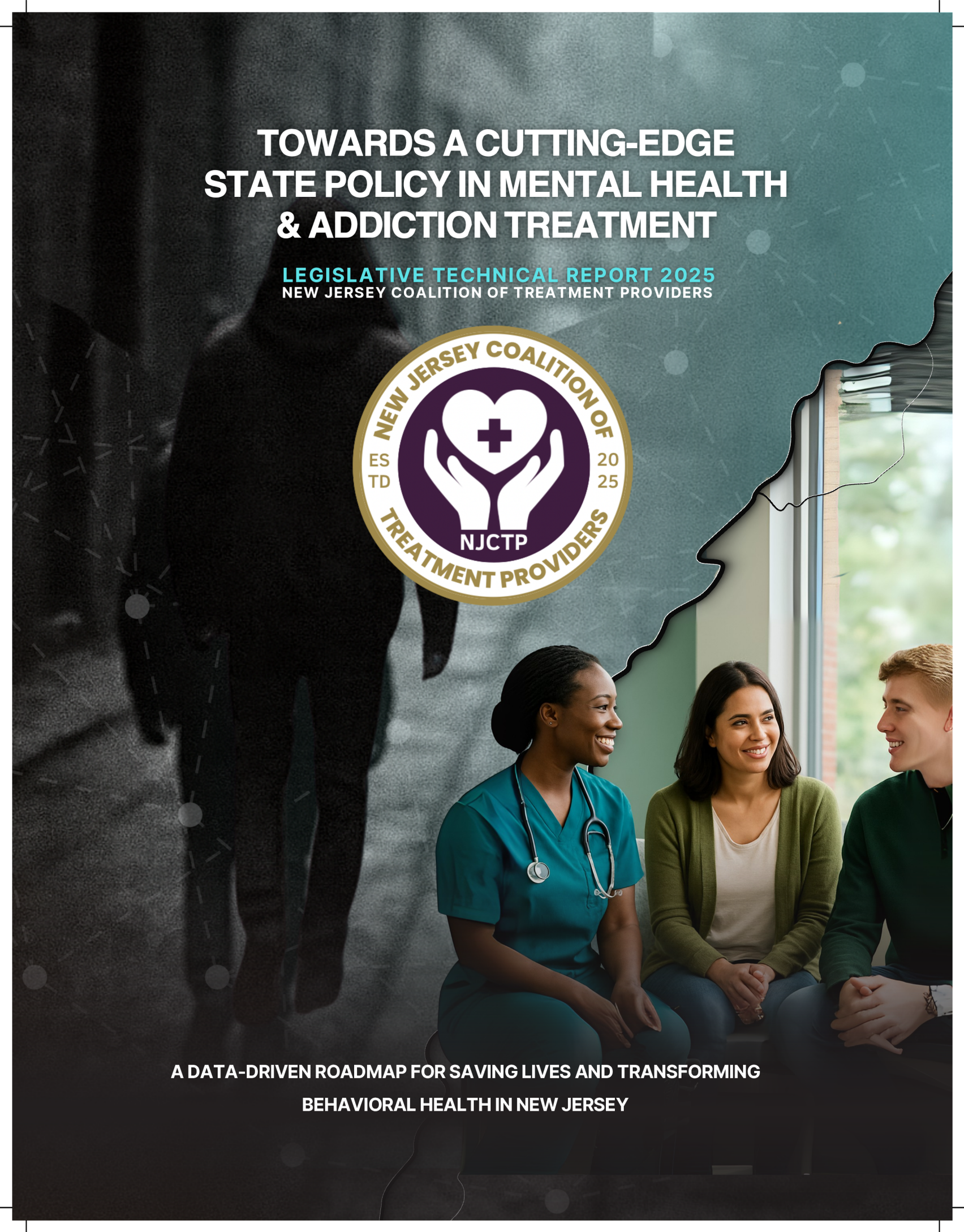
TOWARDS A CUTTING-EDGE STATE POLICY IN MENTAL HEALTH & ADDICTION TREATMENT

LEGISLATIVE TECHNICAL REPORT 2025

NEW JERSEY COALITION OF TREATMENT PROVIDERS



A DATA-DRIVEN ROADMAP FOR SAVING LIVES AND TRANSFORMING BEHAVIORAL HEALTH IN NEW JERSEY

NEW JERSEY COALITION OF TREATMENT PROVIDERS

LEGISLATIVE TECHNICAL REPORT 2025

Towards a Cutting-Edge State Policy in Mental Health and Addiction Treatment

Comprehensive proposal to elevate New Jersey to the highest national standards in behavioral health policies

August 2025

NJCTP Research and Legislative Strategy Team

Contact: www.njctp.org | contact@njctp.org

August 2025

The Honorable Philip D. Murphy, Governor of the State of New Jersey
Members of the New Jersey Senate and General Assembly

Dear Governor Murphy, Esteemed Senators, and Honorable Members of the General Assembly,

On behalf of the New Jersey Coalition of Treatment Providers (NJCTP), it is my privilege to present to you the enclosed Legislative Technical Report 2025: Towards a Cutting Edge State Policy in Mental Health and Addiction Treatment.

This report is the product of rigorous research, comparative legal analysis, and strategic consultation. It aspires to place New Jersey at the forefront of national innovation in behavioral health policy. By studying successful legislative models from other states, reviewing federal guidelines, and analyzing current data within our own borders, the NJCTP has developed a comprehensive roadmap to address the pressing challenges of mental health and addiction that affect millions of our residents.

At this historical juncture, the State of New Jersey has both the obligation and the opportunity to enact reforms that ensure equitable access, clinical excellence, financial sustainability, and system wide accountability. This report offers recommendations that are not aspirational alone, but feasible, evidence based, and ethically grounded.

The urgency is clear: rising rates of mental illness and substance use disorders, combined with gaps in parity enforcement, insufficient stabilization services, and deceptive marketing practices in the treatment sector, demand a legislative response that is bold, transparent, and uncompromising in its protection of public health.

We respectfully submit this report as both an academic resource and a practical legislative tool. Its pages provide statistical evidence, comparative case studies, and specific policy proposals ranging from parity enforcement and telepsychiatry expansion, to sustainable funding models and the regulation of emerging therapies. Each recommendation is grounded in a commitment to the dignity of every individual and the public trust vested in your leadership.

It is our sincere hope that this report will not only inform debate, but also inspire legislative action that secures for New Jersey a place among the national leaders in mental health and addiction treatment reform.

With profound respect for your service to the people of this State, I remain,

Faithfully submitted,

Daniel Regan

President

New Jersey Coalition of Treatment Providers (NJCTP)

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1. **EXECUTIVE SUMMARY**

On the threshold of the third quarter of the 21st century, New Jersey is at a critical crossroads in terms of mental health and addiction treatment. Despite important legislative advances in recent years, the State has not yet implemented structural mechanisms that have been successfully applied in other states, such as comprehensive crisis care models, parity legislation with effective compliance, innovative funding systems, and support for emerging therapies. This report compares national practices, identifies persistent barriers in New Jersey, and presents a set of feasible legislative proposals, evaluated under criteria of impact, cost-benefit, and population equity. It is accompanied by updated statistics and a technical analysis prepared by researchers and legislative strategists of the New Jersey Coalition of Treatment Providers.

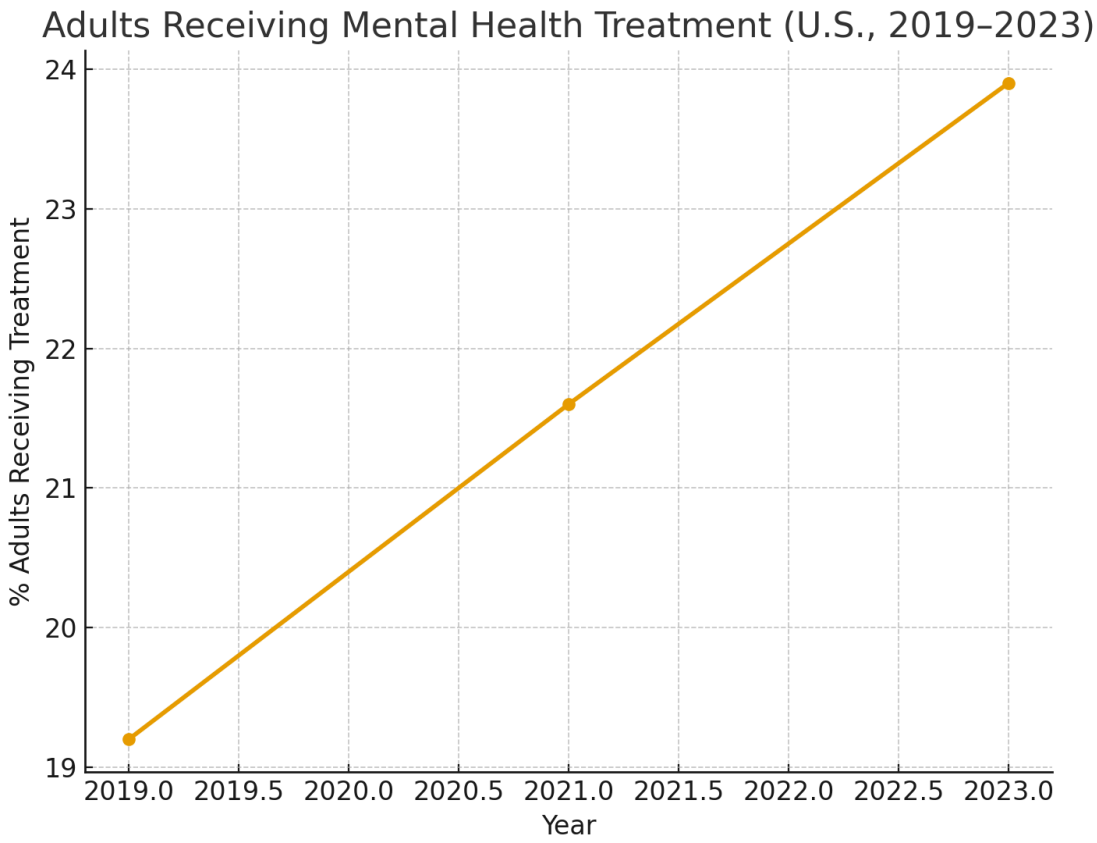
2. **INTRODUCTION**

We at the New Jersey Coalition of Treatment Providers have created a legislative report detailing our findings and our strategic recommendations on how public policy can better support residents.

Mental health is no longer a peripheral matter. In 2025, according to the National Center for Health Statistics, 1 in 3 American adults reports significant symptoms of anxiety or depression. The problematic use of substances, exacerbated by the pandemic and its social consequences, has increased the rates of overdoses, hospitalizations, and the need for multidisciplinary interventions. The State of New Jersey, with more than 9 million inhabitants, faces a high demand for services without the legal, technological, and community infrastructure fully consolidated to respond efficiently. In response to this gap, we present this report as a roadmap for our legislators to adopt proven models, aligned with the guidelines of SAMHSA, NAMI, and the National Academy of Sciences Engineering and Medicine.

The rising need for services has brought many new service providers to the State of New Jersey. This increase in behavioral health providers creates competition in the space which brings benefits of innovation but also can bring kickback schemes and deceptive marketing tactics. In 2024, New Jersey's State Commission of Investigation (SCI) documented widespread fraud, deceptive marketing, brokering schemes, and weak oversight across the recovery/treatment continuum, prompting a 2025 legislative push targeting predatory practices. Any NJ reforms should directly answer the SCI findings with defined offenses, uniform standards, transparent data, and cross-agency enforcement. NJ.govNJ.govNew Jersey MonitorNJ Spotlight NewsNew Jersey Legislature

Nationwide, there is increasing momentum around innovative addiction and mental health support services. New Jersey has an opportunity to develop more effective community care systems — reducing emergency room strain, improving long-term treatment outcomes, and expanding treatment access for vulnerable populations in an ethical and responsible way.



1. Adults Receiving Any Mental Health Treatment:In 2019, 19.2% of U.S. adults received some form of mental health treatment in the past year. This increased to 21.6% by 2021, marking a modest upward trend. By 2023, the figure had climbed further to 23.9%. Summary: Adult mental health service uptake in the U.S. rose steadily from 19.2% in 2019 to 23.9% in 2023.

This Report Includes:

- Current Context in New Jersey
- Comparative Analysis of Successful Legislation
- National Models and Their Results
- Statistics and Projections
- Strategic Legislative Recommendations
- A formal Petition
- Methadone Policy Recommendation
- Mental Health, Suicide, and Substance Use Disorder Service Recommendation
- Provider Accountability reform

Our Key Recommendations Include:

- Enforcing insurance parity through independent audits
- Establishing permanent funding through a progressive tax model
- Expanding mobile crisis teams and stabilization centers
- Scaling telepsychiatry across emergency departments
- Supporting safe, evidence-based research on emerging therapies
- Expand body brokering and deceptive marketing tactics

3. **CURRENT CONTEXT IN NEW JERSEY**

3.1 Key statistics (2022–2024)

- New Jersey has an unmet mental health care provider need of 27.8% (Bureau of Health Workforce)

- 27.7% of adults in New Jersey report symptoms of Anxiety and/or depressive disorder (KFF, 2023)

- New Jersey received an "F" (54/100) rating in compliance with insurance parity (Mental Health Parity Report Card, 2024)

-x New Jersey had 2816 recorded unintentional overdose deaths in 2023 (NJDOH)

- Only 25% of New Jersey outpatient facilities were accepting patients in 2022 (Mental Health Association NJ)

3.2 Current Legislation

Although progress has been made, such as: - The Seabrooks-Washington Community Crisis Act - S1500 legislation (without prior authorization for severe mental health conditions) - Partial deployment of line 988 Structural challenges persist: the lack of stabilization centers, poor supervision of insurers, lack of permanent funding for community services and almost zero state investment in research into innovative therapies.

-Bill 3978 Establishes “SUD and Addiction Treatment Best Practice Task Force”

-Bill A3959/S2555 Seeks to fill a large gap of care in NJ by recognizing Mental Health Primary Residential Care.

- Bill A3979 Requires certain providers to disclose conflicts of interest before receiving state funds, licensure or certification

-S91 Establishes new guidelines for the definitions of involuntary commitment which includes thresholds for Substance Use Disorder

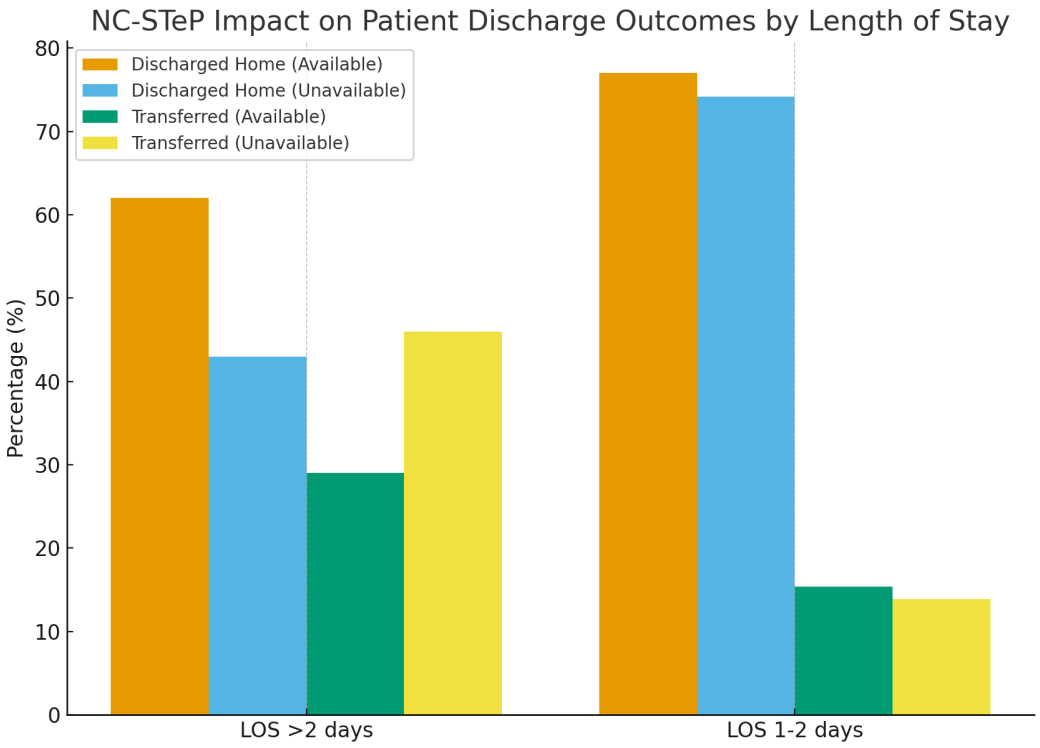
-Bill 3974 Prohibits use of deceptive marketing tactics by substance disorder treatment providers

4. **COMPARATIVE ANALYSIS OF SUCCESSFUL STATE LEGISLATION**

This section examines specific examples of state legislation that have had a positive and measurable impact on the treatment of mental health and addictions. The comparison is based on criteria of implementation, sustainability and replicability, also considering the demographic and fiscal characteristics of each state.

4.1 North Carolina: Telepsychiatry in emergency rooms

The NC-STeP (North Carolina Statewide Telepsychiatry Program) has shown exceptional results in reducing waiting times and hospital costs. Since its implementation, it has avoided prolonged hospitalizations and has saved more than $59 million to the state health system. Its replicability in New Jersey would be highly beneficial, especially in saturated rural and urban hospitals.

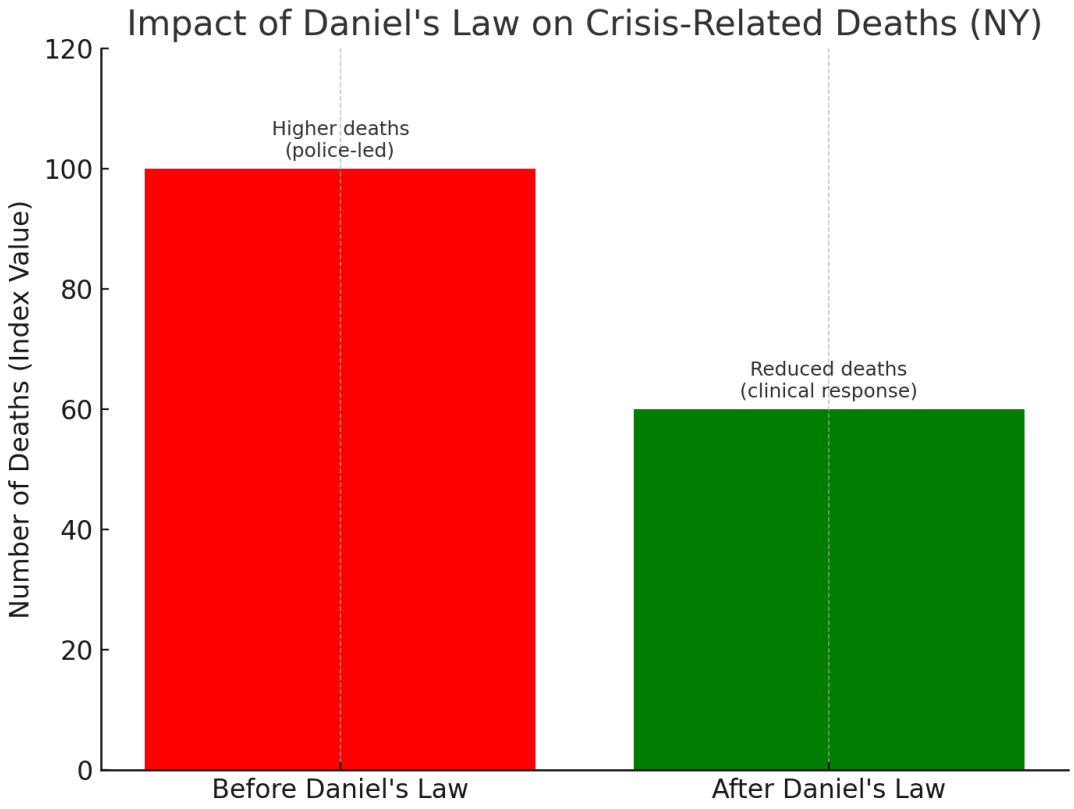


4.2 California: Sustainable financing through progressive taxes

The Mental Health Services Act (MHSA) implemented in California imposes a 1% tax on personal income greater than $1 million, generating exclusive resources for community mental health programs. This law has made it possible to stabilize long-term financing, finance preventive, early intervention projects, and reduce dependence on federal funds.

4.3 New York: Legislation for non-coercive intervention

Daniel's Law, proposed in New York State, prioritizes that emergency calls related to mental health crises are answered by clinical teams rather than police forces. This approach has reduced unnecessary deaths and has favored the humanization of the care system. New Jersey does not yet have a clear legal mandate of this nature.



4.4 Texas and Indiana: Research on Emerging Therapies

Both states have legislated to allow and fund scientific research with substances such as psilocybin and ibogaine, for therapeutic purposes in controlled contexts. This advance has been

applauded by academic institutions and opens the door to new alternatives for the treatment of resistant addictions.

4.5 Florida, California and North Carolina: Anti-Depervative Marketing and Anti-kickback Laws

Florida ban offering/soliciting anything of value for referrals; set felony penalties and enhanced fines for volume; expressly cover "split-fee" arrangements and lead-generators. Florida SenateFindlawDLA Piper

North Carolina SAFE Act (2023), defines recovery residence, treatment facility/provider; and prohibits kickbacks and misleading marketing. It requires knowing violations for criminal liability. North Carolina General Assembly+1North Carolina General Assembly+1Legislative Reporting Service

California SB 1228/SB 349 line has barred deceptive ads and requires maintaining referral logs to and from recovery residences (audit trail). LegiScannelsonhardiman.com

5. **NATIONAL MODELS AND THEIR RESULTS**

The adoption of comprehensive care models has generated significant impacts in states that have followed the guidelines of SAMHSA, the National Association of State Governments and the National Council of Behavioral Welfare. These models are built on three fundamental pillars: accessibility, community integration and economic sustainability.

5.1 SAMHSA National Guidelines 2025

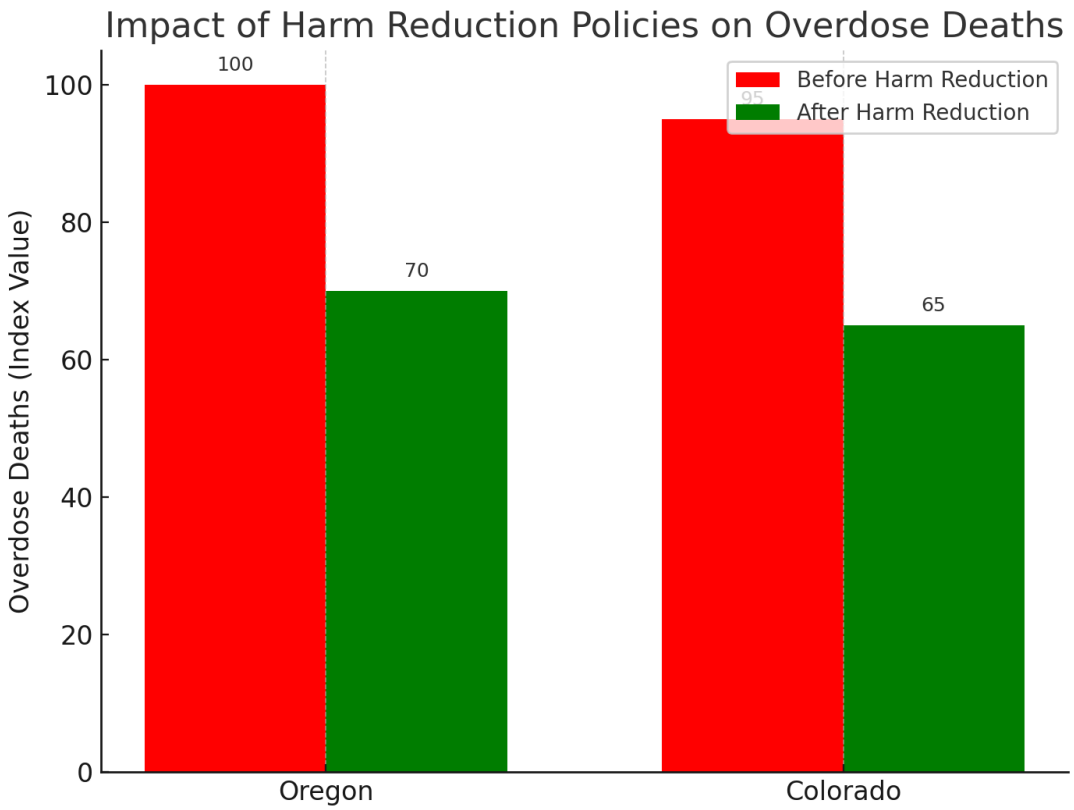
SAMHSA's '2025 National Guidelines for Behavioral Health Crisis Care' establish a tripartite structure for effective response to mental health crises: (1) 24/7 hotlines (such as line 988), (2) mobile community intervention equipment, and (3) stabilization centers with immediate admission without requiring hospitalization. These components have significantly reduced the use of hospitals and the criminalization of the crisis.

5.2 Models of comprehensive treatment with assisted medication (MAT)

Programs that combine approved medication (buprenorphine, methadone, naltrexone) with psychosocial counseling and support have shown higher rates of treatment retention, reduced relapses, and lower criminal recidivism. The limitation of access to these treatments in New Jersey represents a critical gap.

5.3 Harm reduction as a public policy

States such as Oregon and Colorado have passed laws that integrate harm reduction services: supervised consumption centers, naloxone distribution and fentanyl tests. These strategies have contributed to a decrease in overdose deaths.



5.4 Anti-brokering enforcement

After Florida's 2017 reforms (marketing rules and patient-brokering crackdowns) and the Palm Beach County Sober Homes Task Force, tip-line intel led to arrests and prosecutions of "bad actors," including kickback and money-laundering cases tied to treatment and sober homes. Federal and state partners reported dozens of fraud prosecutions in South Florida during this period. This shows enforceability and measurable activity (arrests/charges), though it's not a clean causal readout on patient outcomes. 15th Circuit State Attorney's OfficeDepartment of JusticeOffice of Inspector General

California's brokering ban (SB 1228); Since 2019, the state health department (DHCS) has clear authority to investigate and sanction facilities for referral remuneration (including license suspension and per-violation penalties). That gives regulators concrete leverage; public notices document the sanction powers and implementation. Outcome studies are limited, but the enforcement framework exists and is being used.

5.4 National Accreditation of Recovery Residences Policy Adoption

Recovery-housing certification (Florida): Florida's statute set up third-party certification and inspection (FARR/FCB). Legislative analyses describe active certification, re-certification, and disciplinary processes; the state's opioid abatement council now recommends FARR certification statewide and, effective Jan 1, 2025, certified homes may not deny housing solely for MAT use, a quality/protections upgrade with clear compliance hooks. Rigorous statewide outcome data (e.g., safety or relapse rates) are still thin, but operational oversight has tightened. The Florida

5.5 System-wide quality models

Strongest "results" evidence comes from the Certified Community Behavioral Health Clinic model. Independent evaluations and national impact reports show expanded access and reductions in BH emergency-department use and some hospitalizations in demonstration states i.e., measurable quality/utilization gains when states adopt CCBHC standards and funding.

5.6 Parity/utilization-review transparency

States that ramped up parity enforcement (reporting on prior auths/denials, NQTL reviews, public scorecards) have created documented compliance pressure on plans; recent briefs compile state actions and federal audit findings. These show process improvements (data collection, corrective orders), but again, patient-level outcomes are not consistently published.

6. **STATISTICS AND PROJECTIONS**

- Medications for opioid use disorder reduce the risk of overdose deaths and behaviors that increase the risk of infectious disease, including HIV and hepatitis C virus. However, fewer than 1 in 5 people with opioid use disorder are treated with these medications. (NIH)

- Among people aged 18 or older with past-year SMI who did not receive mental health treatment in the previous year, 8.0 percent sought treatment and were not able to receive it, 41.7 percent thought they should get treatment did not seek it (NIH)

– Based on demand for behavioral healthcare in 2022, an estimated 25.2% of Americans (84 million people) will require behavioral health services (Trilliant Health)

- The incorporation of an EmPATH unit (aligns with and incorporates the SAMHSA crisis model) resulted in a 60% increase in a 30-day follow-up care established at the time of discharge (NIH)

-48.5 million Americans aged 12 and up had a substance use disorder (SUD) in 2023. Only 4.5% of this group received treatment for their condition. (bhbusiness)

7. STRATEGIC LEGISLATIVE RECOMMENDATIONS

New Jersey must take bold legislative action to close critical gaps in behavioral health access, quality, and accountability. Establish mandatory compliance mechanisms for mental health and substance use disorder insurance parity, including independent annual audits of all carriers, with penalties for non-compliance and public transparency in findings. Finance stabilization units and mobile crisis care centers under the SAMHSA National Guidelines for Crisis Care model, fully integrating the 988 Suicide & Crisis Lifeline with local emergency response and community-based services to create a seamless crisis continuum. Adapt the North Carolina Statewide Telepsychiatry Program (NC-STeP) model for New Jersey hospitals to expand 24/7 telepsychiatric assessment, reducing ED boarding times and unnecessary hospitalizations.

Legislate a permanent State Mental Health Fund supported by a progressive tax model inspired by California's Mental Health Services Act, dedicated exclusively to expanding and sustaining behavioral health programs. Advance legislation to allow responsible, regulated research into emerging therapies such as psilocybin and ibogaine for treatment-resistant mental health and addiction disorders, with safeguards aligned to FDA and DEA research protocols. Adopt non-coercive crisis intervention protocols inspired by New York's Daniel's Law, prioritizing trained mental health professionals over law enforcement as first responders in behavioral health emergencies. Mandate the publication of annual behavioral health system performance reports, including key outcome indicators—disaggregated by demographic, racial, and geographic data—to guide equity-driven policy reforms.

8. **FORMAL PETITION TO THE STATE OF NEW JERSEY: ADOPTING THE HEALTH HOME MODEL FOR SUBSTANCE USE DISORDERS (SUD)**

A Data-Driven Proposal to Transform the State's Mental Health and Addiction Treatment System

New Jersey Coalition of Treatment Providers (NJCTP)

August 2025

8.1 Introduction

National evidence is unequivocal: states that adopt comprehensive, person-centered, and coordinated care models for substance use disorders achieve lower hospitalization rates, increased treatment adherence, greater equity, and improved health outcomes. Michigan is a proven, replicable, and well documented example.

The New Jersey Coalition of Treatment Providers (NJCTP) formally issues this technical, institutional, and ethical call for the State of New Jersey to adopt this transformative model.

8.2 The Model: Lessons from Michigan

Since 2018, Michigan has implemented a Medicaid-based Health Home system for individuals with opioid use disorder (OUD). In 2024, this model was expanded with approval from the Centers for Medicare & Medicaid Services (CMS) to include alcohol and stimulant use disorders (AUD and StUD). The results speak for themselves:

7-day follow-up after SUD-related emergency visit: 67.9% (vs. 27.6% under traditional care)

Access to approved pharmacotherapy: 96.5% (vs. 62.4%)

Sustainable payment structure: $364.48 per enrollee/month (90% covered by CMS in first two years)

The model includes a minimum interdisciplinary staffing standard of nurses, behavioral health specialists, peer recovery coaches, medical consultants, and psychiatrists and is structured around regional governance entities (Lead Entities), ensuring localized coordination and accountability.

8.3 Proposal for New Jersey

We respectfully call upon the State of New Jersey to:

A. Legislate the establishment of specialized Health Homes for SUD, expanding coverage beyond opioids to include alcohol, methamphetamines, and other substances.
B. Establish regional Lead Entities to manage networks of health providers, including community-based organizations, rural clinics, hospitals, federally qualified health centers (FQHCs), tribal centers, and licensed addiction treatment providers.
C. Leverage the federal CMS funding structure, which covers 90% of the program cost for the first two years—minimizing fiscal impact on the state budget.
D. Pilot the program in three high-need counties, based on overdose rates, structural inequity, and service gaps: Essex, Camden, and Atlantic.
E. Implement data-based quality metrics, including post-discharge follow-up, treatment retention, reduction in emergency department visits, and overall patient well being.

8.4 Strategic Argument

New Jersey has the infrastructure, provider network, and leadership capacity to act decisively. What is missing is a clear, coordinated, and forward-thinking public policy.

Adopting the SUD Health Home model is a realistic and fiscally sound solution that would:

Improve care access for vulnerable populations

Raise clinical standards statewide

Reduce the burden on emergency departments and hospitals

Break cycles of relapse, marginalization, and criminalization

Position New Jersey as a national leader in behavioral health policy

8.5 Conclusion: A Call for Political Will

The time to act is now. The data is clear. The model works. Lives are at stake.

On behalf of thousands of behavioral health professionals, nonprofit leaders, families, and survivors, we respectfully call upon state leaders to legislate, fund, and implement the SUD Health Home model across New Jersey.

This is an urgent, viable, and deeply human solution.

9. **TOWARD A MODERN STATE POLICY FOR METHADONE TREATMENT IN NEW JERSEY**

Removing Regulatory and Financial Barriers to Save Lives

Based on the analysis by The Pew Charitable Trusts, published in Governing (March 2025)

9.1 Introduction: An Effective Medicine Trapped in an Ineffective System

Methadone has long been recognized as one of the most effective treatments for opioid use disorder. Yet in New Jersey, as in many other states, access to this life-saving medication remains limited due to outdated state regulations, systemic stigma, and flawed financial incentives. These structural barriers prevent individuals from starting and staying in treatment, despite the scale of the crisis.

With more than 100,000 overdose deaths annually nationwide since 2021, New Jersey must undertake a thorough reform of its methadone access and treatment model.

9.2 Current Barriers to Methadone Access in New Jersey

Daily in-person requirements: Many clinics require patients to attend daily for dosing, even for those who are clinically stable. This excludes individuals working multiple jobs, caring for children, or relying on limited public transportation.

Mandatory counseling requirements: Access to methadone is often conditioned on participation in counseling, regardless of patient preference or clinical necessity.

Misaligned financial incentives: Clinics are frequently reimbursed based on visit frequency, discouraging take-home doses and encouraging rigid, one-size-fits-all all care.

Lack of alignment with federal regulations: Despite SAMHSA's 2024 reforms eliminating mandatory counseling for methadone access, New Jersey has not yet updated its state rules accordingly.

9.3 Lessons from Other States: Evidence-Based Modernization

States such as Colorado, California, Minnesota, Ohio, and Washington have taken steps to align with federal guidance and scientific evidence:

Permit multi-day take-home dosing for stable patients

Require clinics to establish Patient Advisory Boards

Ensure payment parity between in-person and take-home services

Track demographic disparities in access and publish disaggregated data

Research on pandemic-era emergency regulations showed that relaxing restrictions did not increase harm, but instead improved retention, reduced dropouts, and enhanced patient dignity.

9.4 NJCTP Recommendations for New Jersey: A Comprehensive Reform Package

To modernize methadone treatment access and improve outcomes, NJCTP proposes a five-pillar policy reform:

A. Eliminate mandatory counseling as a condition for medication
    a. Counseling should be clinically indicated and voluntary, not bureaucratically imposed.
B. Allow take-home dosing for stable patients
    a. With appropriate clinical supervision, this practice reduces stigma, supports employment, and improves adherence.
C. Align financial incentives
    a. Clinics should receive the same reimbursement for take-home doses as for in-person visits, following Colorado's model.
D. Engage patients in governance
    a. All treatment programs should establish Patient Advisory Boards to reduce stigma, inform clinic practices, and ensure patient-centered care.
E. Track and publish equity metrics
    a. The state should require demographic reporting on methadone access, disaggregated by age, race, gender, and region, to guide equity-focused reforms.
F. Conclusion:
    a. Methadone Saves Lives but Only If People Can Access It

As The Pew Charitable Trusts stated:

“The work ahead is not easy, but we know more than ever how to make addiction treatment more accessible. Methadone saves lives, but only if patients can get it.”

New Jersey must act with moral urgency, fiscal responsibility, and policy leadership. Every day that outdated rules remain in place is a day in which lives are lost and opportunities for healing are missed.

Technical Source: Frances McGaffey, Better Policies to Fight Opioid Addiction, The Pew Charitable Trusts, published in Governing, March 26, 2025.

Adapted and expanded for legislative and clinical policy relevance by the New Jersey Coalition of Treatment Providers (NJCTP).

10. **MENTAL HEALTH, SUICIDE, AND SUBSTANCE USE DISORDERS: AN URGENT CALL FOR SERVICE INTEGRATION IN NEW JERSEY**

Adapted from Pew Charitable Trusts, February 2025

10.1 Overview: The Link Between Addiction and Suicide

Over 200,000 annual deaths in the United States are attributed to the combined causes of suicide, overdose, and alcohol-related illnesses. Individuals with substance use disorders (SUDs) are at significantly higher risk of suicidal ideation and attempts compared to the general population.

Recent studies indicate:

Individuals with opioid use disorder (OUD) are 1.86 times more likely to experience serious suicidal thoughts.

Those with alcohol use disorder (AUD): 1.81 times more likely.

In the case of sedatives/tranquilizers, the risk of attempted suicide rises to 2.3 times.

In New Jersey, where the mental health crisis overlaps with high rates of addiction, this reality demands immediate legislative and clinical action.

10.2 Key Data and Disparities in New Jersey

From 2015 to 2019, suicidal ideation increased by 42.2% among adults with AUD and among those who used cannabis, tobacco, or alcohol.

Suicide attempts increased by 48% among Black adults and by 82% among multiracial adults, while they decreased by 33% among White adults.

Only 36% of Black adults reporting suicidal ideation accessed mental health care, compared to 53.1% of White adults.

These data reveal deep structural inequities requiring differentiated, culturally competent, and legislatively supported responses.

10.3 Critical Barriers Identified

- Dual Stigma
    - The combined stigma surrounding mental illness and substance use discourages people from seeking help.
- Lack of Universal Screening in Hospitals and Clinics
    - Many patients are not systematically assessed for suicide risk.
- Inadequate Financial Incentives
    - Payment structures fail to promote integrated, preventive care.
- Insufficient Provider Training
    - Many clinicians are not equipped to simultaneously address suicide risk and SUD.
- Unequal Access to Care Among Racial and Ethnic Minorities.

10.4 Strategic Recommendations for the State of New Jersey

Implement Universal Suicide and SUD Risk Screening

Mandate all accredited hospitals and outpatient clinics to conduct standardized screening for suicidal ideation and substance use, regardless of the reason for the visit.

Use evidence-based protocols endorsed by The Joint Commission and Pew Charitable Trusts (2023).

10.5 Expand Access to Mental Health Services for People with SUD

Fund cognitive-behavioral therapy, co-occurring disorder programs, and community counseling services.

Prioritize high-risk populations based on clinical, demographic, and geographic factors.

Ensure access to FDA-approved medication (methadone, buprenorphine, naltrexone) without unnecessary regulatory barriers.

10.6 Establish Culturally Competent Programs

Train providers in culturally sensitive care, focusing on Black, Latino, Asian American, and Native American populations.

Support community-based initiatives with localized leadership and linguistically adapted services.

10.7 Equalize Reimbursement for In-Person and Telehealth Services

Make permanent Medicaid coverage for mental health and SUD services delivered via telehealth, reimbursed at the same rate as in-person visits.

Promote the use of telehealth for collaborative safety planning for individuals at risk.

10.8 Enact Emergency Legislation on Suicide and SUD Prevention

Introduce a Comprehensive Suicide and Substance Use Disorder Prevention Act, including:

- Mandatory screening
- Integrated treatment
- Individualized safety plans
- Racial equity monitoring
- Creation of a State Mental Health and Suicide Observatory

11. PROVIDER ACCOUNTABILITY AND STATE OVERSIGHT PROCEDURES

11.1 Outlaw Patient Brokering & Deceptive Marketing

What to adopt:

- All‑payor anti‑kickback for SUD mirroring EKRA (18 U.S.C. §220): make it a felony to pay/receive remuneration for referrals to treatment, labs, or recovery homes; include aiding/abetting, attempt, and conspiracy. Clarify it applies to any payor (public or private).
- Ban offering/soliciting anything of value for referrals; set felony penalties and enhanced fines for volume; expressly cover "split‑fee" arrangements and lead‑generator
- Define recovery residence, treatment facility/provider; prohibit kickbacks and misleading marketing; require knowing violations for criminal liability.
- Bar deceptive ads; require maintaining referral logs to and from recovery residences (audit trail).

NJ implementation options:

1. New Title (e.g., "NJ Behavioral Health Integrity Act") with:

    a. Criminal offense: patient brokering (2nd/3rd‑degree felony tiers by dollar counts or patient volume).

b. Civil enforcement: AG and consumer-affairs authority for injunctions, restitution, treble damages, disgorgement.

c. Private right of action for patients and compliant providers harmed by unfair competition.

d. Mandatory referral-log retention (5 years) and whistleblower protections.

e. Digital marketing rules: clear branding; ban misrepresentation of services/licensure; prohibit provider-operated directories that divert or spoof competitor names (track NAATP Code of Ethics).

11.2 Quality Assurance via Accreditation & Clinical Standards

What to adopt:

- Require BH facilities receiving state funds or network participation to maintain accreditation (Joint Commission/CARF) within a phase-in window; allow DOH to recognize equivalent state standards.

- Codify use of ASAM Criteria (latest edition) for SUD level-of-care determinations, continued stay, and discharge planning; many states already require this through Medicaid policy and §1115 waivers.

- Align with SAMHSA CCBHC criteria for access, crisis capacity, care coordination, data and outcomes reporting; permit NJ to designate "CCBHC-aligned" providers with payment incentives.

NJ implementation options:

- Licensure condition: accreditation within 18–24 months; ASAM-consistent medical-necessity policies; annual quality plan; critical-incident reporting; staff background checks.

- Public quality dashboard: post-survey findings, sentinel events (de-identified), utilization, readmissions, MAT access rates.

11.3 Recovery-Housing: Protect Residents, Professionalize Operations

What to adopt :

- Voluntary certification statute (Florida §397.487 model): approve a credentialing entity; define certification requirements, inspections, code of ethics, disqualifying offenses, and administrator credentialing; tie certain referral/marketing privileges or public contracts to certified homes.

- Fair-housing compliance: codify that municipalities must treat certified recovery residences as residential uses and provide reasonable accommodations, reflecting HUD/DOJ joint statements and City of Edmonds v. Oxford House.

NJ implementation options:

- Preempt local spacing/density caps aimed at sober homes; allow neutral life-safety codes equally applied.

- Create state registry of certified homes; require treatment programs to disclose any ownership/financial ties to housing (an SCI recommendation).

11.4 Transparency, Data, and Enforcement Infrastructure

Central tactics:

- Disclosure regime: public-facing ownership charts; related-party transactions; marketing vendors; call-center/lead-gen arrangements; referral logs (with privacy protections).

- AG/DOH joint unit: specialized BH Integrity Unit for brokering, deceptive marketing, and parity review; cross-deputize investigators; fund with penalty revenues.

- Whistleblower channel integrated with SCI findings; require posters and website notifications in plain language.

11.5 Drafting Notes & Model Clauses

1. Definitions (borrow from NC SAFE + federal usage): *recovery residence; treatment provider; treatment facility; remuneration; deceptive marketing; lead generator; directory operator*. Legislative Reporting Service

2. Prohibited Acts: remuneration for referrals; misbranding (false/misleading claims about services, licensure, network status, location); unbranded ads; web "spoofing" of competitor names; undisclosed paid placements. (Mirror NAATP ethics provisions.) naatp.org+1naatp.org+1

3. Safe Harbors: evidence-based patient navigation paid at fair market value without referral-contingent compensation; bona fide employment; grants without volume/value correlation; outcomes-based arrangements vetted by DOH.

4. Penalties: criminal (tiered by amounts/patients), civil per-violation fines, restitution, license action, payer sanctions for parity/NQTL violations.

5. Records & Reporting: 5-year retention for ads, referral logs, utilization reviews; annual public reports.

12. **EXECUTIVE CONCLUSION**

New Jersey is in a historic position to transform its mental health and addiction treatment system into a national model of excellence. National evidence demonstrates that states investing in community-based care models, structured and sustainable financing, early intervention, and progressive legislation consistently achieve better health, economic, and social outcomes.

By adopting the recommendations in this report, New Jersey can lead the nation in behavioral health innovation and equity. This includes establishing mandatory insurance parity compliance mechanisms with independent annual audits, financing SAMHSA-compliant stabilization and mobile crisis care centers fully integrated with 988 and local community services, and adapting

the NC-STeP telepsychiatry model to expand rapid access to psychiatric care in hospitals statewide. It also calls for legislating a permanent State Mental Health Fund supported by a progressive tax model inspired by California's MHSA, advancing regulated research into emerging therapies such as psilocybin and ibogaine, and enacting Daniel's Law; style non-coercive intervention protocols that place trained mental health professionals at the forefront of crisis response.

To ensure transparency, accountability, and equity, New Jersey must also publish annual behavioral health performance reports with demographic, racial, and geographic disaggregation of key indicators which will empower policymakers, providers, and communities to track progress and close disparities.

This is not a distant vision, this is an urgent roadmap. With decisive action, New Jersey can safeguard lives, strengthen communities, and set a new national benchmark for ethical, effective, and equitable behavioral health care.

ABOUT THIS REPORT

This Legislative Technical Report from the New Jersey Coalition of Treatment Providers presents a data driven roadmap to transform the State's mental health and addiction treatment systems. Drawing on national best practices, cutting edge research, and proven models from across the country, this report outlines actionable policy recommendations to improve access, equity, and outcomes for all residents of New Jersey.

With an urgent call to adopt innovative funding models, expand crisis intervention capacity, and integrate mental health with addiction care, this report serves as both a legislative guide and a vision for a healthier, more equitable New Jersey.


Independent insurance parity audits


Expansion of mobile crisis teams and stabilization centers

Telepsychiatry integration in emergency departments


Modernized methadone treatment policies


Support for emerging therapy research

About Us:

The New Jersey Coalition of Treatment Providers (NJCTP) is a statewide alliance of more than 290 behavioral health professionals, accredited providers, and advocates committed to advancing ethical, inclusive, and evidence-based policies. Grounded in a steadfast commitment to participant centered care, NJCTP addresses systemic challenges, combats corruption and fraud, and promotes reforms that strengthen mental health and addiction recovery services. Serving as a bridge between frontline providers and policymakers, the Coalition ensures that both lived experience and professional expertise shape a more equitable, responsive, and sustainable behavioral health system for all New Jersey residents.

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