



BRIEF

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# Peer Support at Reentry

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## *Evidence and Lessons from Camden County*

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This brief describes a promising peer support program run by the Camden County, New Jersey correctional facility, for people with substance use disorders. Between October 2022 and September 2024, the Camden County Peer Support Reentry Program (PSRP), delivered in partnership with the Center for Family Services (CFS), a regional human services provider, supported individuals with substance use disorders during the critical transition from the Camden County Correctional Facility (CCCF) to the community. The program combined access to medications for opioid use disorder (MOUD) with intensive peer-led engagement grounded in shared lived experience. Peer support teams, each pairing a Certified Peer Recovery Specialist with a justice-impacted peer, began working with participants during incarceration and continued providing structured support after release. A mixed-methods evaluation conducted by the Camden Coalition assessed program implementation, engagement, and post-release outcomes. The findings from this program evaluation are promising: significant reductions in reincarceration among participants despite persistent health vulnerabilities immediately after release and system-level opportunities to strengthen treatment continuity and stabilization pathways.

# Background & program overview

This program was launched and evaluated during a uniquely challenging moment shaped by ongoing fentanyl-driven overdose risk and the post-COVID-19 recovery period in which healthcare systems and substance use treatment programs were rebuilding capacity for on-site treatment. Camden County and the broader New Jersey region provided a dense network of treatment providers. However, that landscape was marked by fluctuating availability of inpatient and outpatient services, housing scarcity, and local criminal justice practices that both supported and sometimes impeded individuals’ reentry trajectories, such as inconsistent release timing.

Operating between October 2022 and September 2024, PSRP was designed to support individuals navigating this environment by integrating MOUD access with peer-led, relationship-centered support beginning inside the jail.<sup>1</sup> Individuals with substance

use disorders were referred to the program through several channels such as the jail’s MOUD navigator team, social workers and staff, and the in-house contracted substance use provider, as well as inmate kiosk requests, classification assessments, and the courts. Individuals were given the opportunity to opt in to the program and participation was not required. Once enrolled, peers collaborated closely with the jail’s Reentry Unit, social workers, and the facility’s medical and MOUD provider to develop individualized Reentry Transition Plans (RTP) addressing participants’ immediate needs such as housing, government documents, and treatment continuity. After release, peers maintained frequent contact, offering emotional support, problem-solving, transportation coordination, and warm handoffs to community-based treatment and recovery programs to help participants stabilize during what is known to be the highest-risk period following incarceration.

**Figure 1. Peer Support Reentry Program (PSRP) phases across the reentry timeline.**

The figure illustrates the core phases of the Peer Support Reentry Program (PSRP) from pre-release through sustained, post-release engagement. Peer support began during incarceration, intensified around the day of release and the first 30 days post-release—when risks of disengagement, overdose, and reincarceration are highest—and transitioned to lower-frequency monitoring and handoffs as participants stabilized. Activities shown reflect the intended structure of the program and the sequencing of peer engagement across the reentry period.

| <b>Pre-Release</b><br>Up to release day   | <b>Release Day</b><br>Day of release from CCCF   | <b>Early Release</b><br>First 30 days post-release   | <b>Sustained</b><br>6 months or longer   |
|---|--|--|--|
| <ul style="list-style-type: none"> <li>✓ In-jail meetings</li> <li>✓ Reentry Transition Plan (RTP) finalized or updated</li> <li>✓ Treatment appointments confirmed</li> <li>✓ Logistics coordinated</li> </ul> | <ul style="list-style-type: none"> <li>✓ Meet at gate if possible</li> <li>✓ Early stabilization</li> <li>✓ Transport to care</li> </ul> | <ul style="list-style-type: none"> <li>✓ High-frequently peer contact</li> <li>✓ Weekly RTP updates</li> <li>✓ Crisis navigation and problem-solving</li> <li>✓ Verify treatment attendance</li> </ul> | <ul style="list-style-type: none"> <li>✓ Monthly RTP updates</li> <li>✓ Progress monitoring and support</li> <li>✓ Planned handoffs</li> <li>✓ Case closure</li> </ul> |

<sup>1</sup> This program was available to any individuals with any substance use disorder. This means that not all participants received MOUD as some did not have opioid use disorder (OUD), as well as a small portion of program participants who had a documented OUD but did not receive MOUD during the program period.

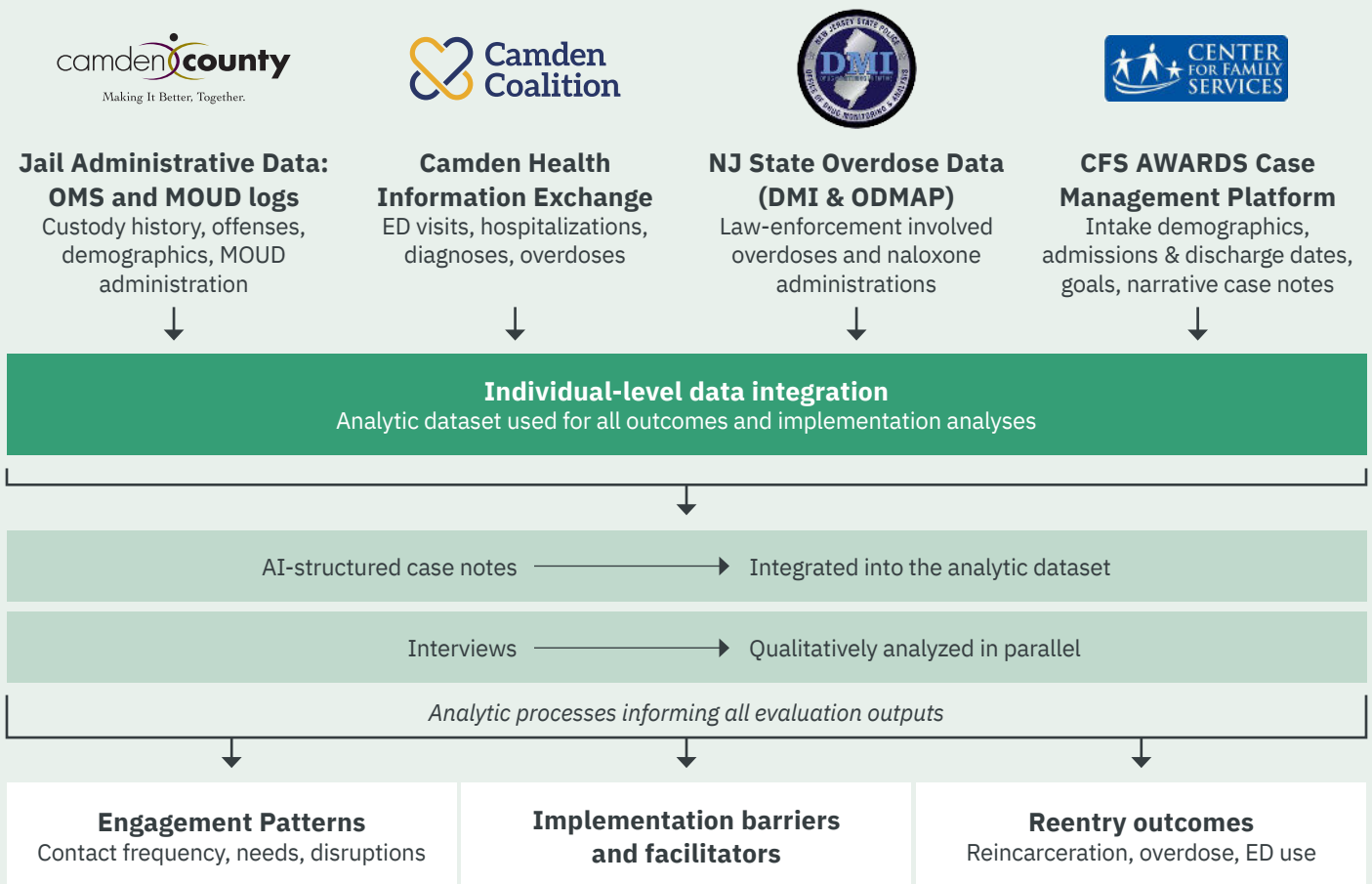
# Evaluation approach

The Camden Coalition conducted a mixed-methods evaluation of the PSRP integrating qualitative, quantitative, and AI-assisted data sources. Interviews with participants, peer specialists, correctional officers, and supervisors examined the experience of reentry and barriers to engagement. Over 14,000 case notes written by peers and managers were analyzed using a HIPAA-compliant large language model platform, using AI to transform unstructured text into structured information

on contact patterns, needs, and engagement. Administrative data from the jail, Camden Coalition’s Health Information Exchange (HIE), and statewide overdose surveillance systems were linked to track outcomes 24 months pre-release and up to 12 months post-release. Interrupted time series (ITS) models tested changes in recidivism, overdose, and emergency department (ED) use.

**Figure 2. Integrated data sources and analytic approach for the PSRP evaluation.**

Administrative, clinical, and programmatic data were linked at the individual level across incarceration and post-release periods. Narrative case notes were transformed into structured measures using AI-assisted methods, and in-depth interviews were qualitatively coded to examine implementation processes and experiences. Integrated analyses examined engagement patterns, reentry outcomes (reincarceration, overdose, and emergency department use), and system-level barriers and facilitators shaping program delivery and outcomes.



# Characteristics of the jail population and PSRP participants

Between October 2022 and September 2024 (the Program Period), 9,715 individuals were booked into the Camden County Correctional Facility. The population was predominantly male (81%), largely in early to mid-adulthood (62% ages 18–39), and racially diverse, with 53% identifying as Black (non-Hispanic), 26% as White (non-Hispanic), and 20% as Hispanic. Most had at least a high school education (81%), yet fewer than one-third (28%) were employed at booking. The 382 program participants did not differ dramatically from the overall jail population, though some demographic variations were evident. PSRP participants were slightly older on average (40 vs. 37 years), had a higher share of women (24% vs. 19%), and differed in racial composition, with more identifying as White (non-Hispanic) (38% vs. 26%) and fewer as Black (non-Hispanic) (45% vs. 53%), reflecting the higher proportion of White individuals in the jail with documented opioid use disorder.<sup>2</sup> Participants also had lower employment rates at booking (12% vs. 28%), suggesting greater socioeconomic marginalization.

Prior criminal justice involvement reflected elevated complexity among program participants. In the two years prior to their first booking between October 2022 and September 2024, participants experienced far more frequent incarcerations than the overall jail population (mean 2.1 vs. 0.4). During this period, participants' bookings commonly involved drug offenses (59%), property offenses (59%), and public order offenses (54%), with slightly over one-half (53%) booked for a violent offense.<sup>3</sup> The accumulation of multiple incarcerations across these offense types indicates persistent and multifaceted justice-system contact among program participants.

Participants' medical histories similarly pointed to heightened need. Nearly nine in ten (86%) had at least one ED visit in the two years prior to the program period, compared with two-thirds (67%) of the broader jail population. ED users in the program also had substantially higher visit volumes (mean 8.9 vs. 5.7), with 21% having had more than 10 visits prior to the program versus 7% of the overall population. Prior inpatient utilization followed the same trend, with program participants nearly twice as likely to have been hospitalized (36% vs. 20%).

Documented behavioral health conditions and substance use disorders were especially elevated among program participants.<sup>2</sup> Rates of schizophrenia spectrum disorders (30% vs. 16%), bipolar disorder (33% vs. 18%), stimulant use disorder (23% vs. 9%), sedative/anxiolytic use disorder (32% vs. 10%), and other psychoactive substance use disorders (41% vs. 18%) were much higher among program participants than in the overall jail population. Additionally, 79% of participants had a documented opioid use disorder (vs. 34%), and for nearly half, a cocaine use disorder was evident in their medical records (49% vs. 16%). These conditions coincided with a sharply higher prevalence of non-fatal overdose in the pre-period (23% vs. 7%), reinforcing the program's reach into individuals facing high medical, behavioral health, and overdose risk.

2 Documented conditions refer only to diagnoses that appeared in either jail medical records or the Camden Coalition Health Information Exchange. This documentation is inconsistent and therefore likely undercounts true prevalence.

3 Percentages exceed 100% because participants may have been booked for more than one offense category during the two-year period. Values represent the share of participants with at least one booking that included the specified offense type.

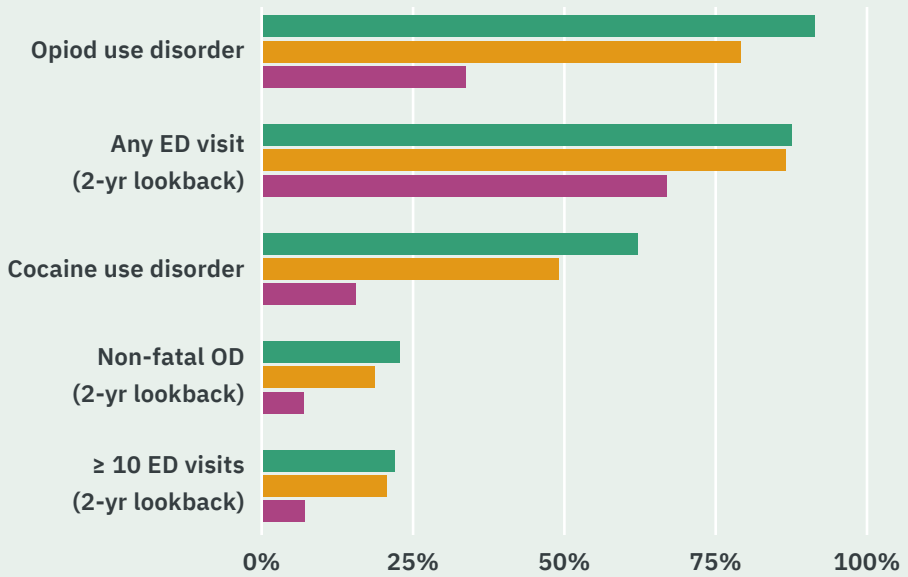
**Figure 3. Outcome-relevant complexity indicators among PSRP participants compared with the overall jail population.**

PSRP participants—and especially those receiving MOUD—had substantially higher prior incarceration, ED use, overdose history, and substance use disorder prevalence, indicating the program served individuals with elevated clinical and justice-system complexity.

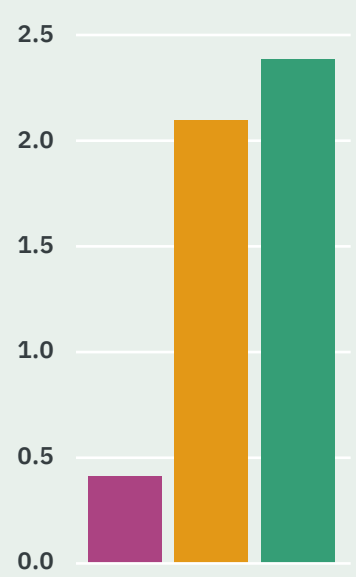
**PSRP Participants Exhibit Higher Clinical and Justice-System Complexity**

■ PSRP + MOUD ■ PSRP ■ Jail population

**Percent with key outcome-relevant indicators**



**Mean prior incarcerations (2-year lookback)**



# Medication for Opioid Use Disorder (MOUD) in the jail

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Camden County has invested significantly in expanding access to treatment for individuals with opioid use disorder (OUD) and other substance use conditions during incarceration and reentry. Beginning with the Co-Occurring Reentry Program (CORP) in 2016 and later through the Comprehensive Opioid Abuse Program (COAP) and the Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP), the county built a progressively stronger clinical and peer-led infrastructure for delivering MOUD, improving continuity of care, and reducing overdose risk. In 2018, the Camden County Department of Corrections received its first Medication Assisted Treatment (MAT) grant from the New Jersey Department of Corrections, with the most recent award issued in October 2025 by the New Jersey Department of Health and Human Services. These grants support continued access to treatment during incarceration and expand availability of MOUD for individuals not previously receiving medication. The PSRP represents the most recent stage of this evolution, integrating clinical MOUD services with intensive, peer-driven engagement to support recovery and stability both inside the jail and after release.

*These grants support continued access to treatment during incarceration and expand availability of MOUD for individuals not previously receiving medication.*

## MOUD in the two years prior to the program period

A small share of individuals booked into the jail during the program period had any history of receiving MOUD while incarcerated in the two years prior (4.3%). Among program participants, however, prior MOUD exposure in the jail was far more common (28%), reflecting both higher underlying OUD prevalence and greater historical contact with treatment systems. Compared to the general jail population, participants also accumulated more time on MOUD during incarceration in the pre-period (mean of 25 days vs. 3 days). Suboxone was the MOUD most predominantly administered during previous incarcerations (78%), with smaller proportions receiving methadone, Sublocade, or Vivitrol. These patterns indicate that individuals who ultimately enrolled in PSRP were more likely than others in the jail to have received MOUD in the facility prior to their program-period incarceration, though at varying levels of intensity.

## MOUD during program-period incarcerations

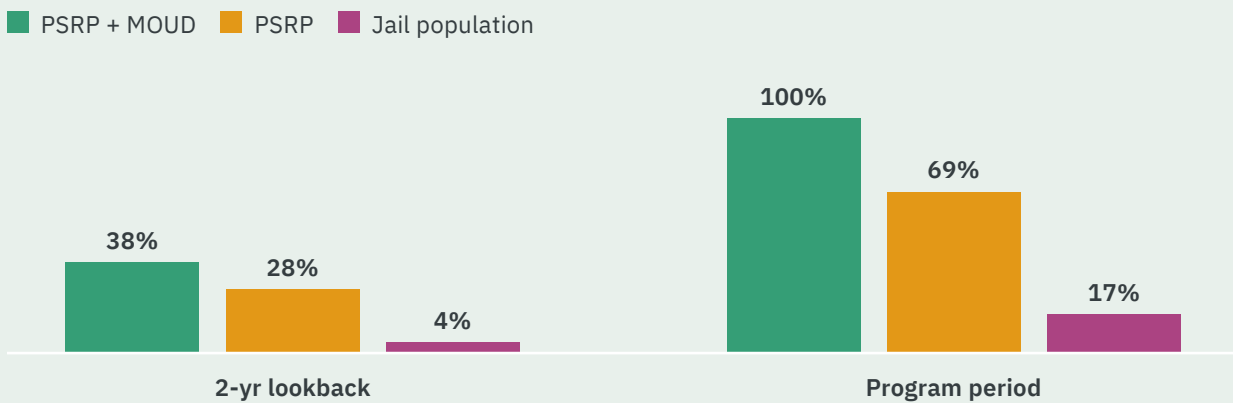
During the program period, MOUD receipt rose sharply compared to the two years before, with 17% of all individuals booked receiving MOUD by the end of the program period in 2024. Among PSRP participants, 69% received MOUD, most commonly Suboxone. For participants who received MOUD, two-thirds (66%) of their incarcerations during the program period involved treatment, and they accumulated a mean of 193 MOUD treatment days (median 140 treatment days), reflecting consistent engagement with clinical services while in custody.

**Figure 4. MOUD exposure before and during the program period among the jail population and PSRP participants.**

The figure compares MOUD exposure across the overall jail population, PSRP participants, and PSRP participants receiving MOUD. Panel A shows the percentage of individuals with any MOUD exposure in the two years prior to incarceration and during the program period. Panel B shows mean days on MOUD during the same periods, illustrating both increased treatment coverage and substantially greater treatment intensity among PSRP participants during the program period.

**MOUD exposure increased during the program period**

*Percent with any MOUD exposure in CCCF*



*Mean MOUD days during incarceration*

○ 2-year lookback    △ Program period



# Qualitative insights into program implementation and participant experience

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Interviews with participants, peers, supervisors, and correctional staff highlighted the relational strengths of the PSRP, the constraints of delivering services in a correctional setting, and the factors shaping engagement before, during, and after release. A total of twenty-three interviews were conducted.

## Cross-cutting themes

Trust was central to the PSRP model. Participants described peers as the first people they felt comfortable confiding in after incarceration, and staff viewed these relationships as key to continued engagement. Interviewees also pointed to ongoing gaps between participant needs and system capacity—especially around housing, eligibility rules, and interagency coordination. Despite these constraints, peers and staff demonstrated notable adaptability, adjusting to unpredictable schedules, shifting needs, and institutional limitations.

## Experiences across the reentry timeline

Inside the jail, participants learned about the program through peers, kiosk referrals, or outreach, often seeking identification, housing support, or assistance with other basic needs. Peer-participant planning was valued but frequently disrupted by lockdowns, staffing shortages, or access barriers. Release was described as highly unpredictable, with sudden or late-night discharges undermining “meet at the gate” coordination despite workarounds to flag participants. After release, engagement often declined, especially among individuals without stable housing or phone access, though those who remained connected reported strong emotional and practical support from peers.

“Initially, when I was to be released from the county, someone from reentry, the plan was for them to pick me up at the gate, and I was supposed to be taken to a motel...I was released at the county jail at like one o'clock in the morning and when I got outside it was nobody there...I got released in January. So I was out there freezing and no money, no transportation...They were supposed to have some bus tickets for me...I know that the plan was, and that was the initial situation, how it was supposed to go down. I don't know what deterred it or what derailed it, but somewhere in there, there was a cross in communication or advocacy, and it didn't happen.”

– Participant

## Operational and system-level factors

Program implementation was shaped by limited workspace, tight budgets, and administrative rigidity, which constrained flexibility and slowed responsiveness. Cultural differences between correctional and community-based agencies also posed early challenges. Over the program period, collaboration strengthened, improving communication and coordination. Peers were widely viewed as the program's core asset, and interviewees emphasized the need for continued training, supervision, and wellness supports to sustain this workforce.

## How system barriers shaped reentry engagement

Barriers affecting peer engagement and service continuity occurred at multiple points across the reentry timeline.

### Inside the jail

- ▶ Limited access to participants due to lockdowns, staffing constraints, and clearance delays
- ▶ Inconsistent availability of private or appropriate meeting space

### At the point of release

- ▶ Unpredictable release timing that disrupted “meet at the gate” plans
- ▶ Transportation and notification gaps that limited immediate stabilization

### After release

- ▶ Loss of contact due to phone instability and housing insecurity
- ▶ Difficulty sustaining engagement during periods of acute competing demands

Together, these barriers constrained the timing, consistency, and intensity of peer engagement, even when planning and outreach were proactive.

“ *The amount of time that you’re able to spend with somebody inside the facility to help foster that relationship and grow that connection definitely has an impact, I think on whether or not they’re more likely to continue seeing you and working with you when you get released.*”

– Leader

## Case notes analysis: Engagement patterns, barriers, and participant needs

Analysis of more than 14,000 case notes, written by peers and managers, and structured using HIPAA-compliant large language model technology provided a real-time view of program delivery that closely mirrored the themes raised in interviews. Engagement levels varied widely across participants: while the median participant had about 26 documented contacts, a smaller group accounted for very high volumes of interaction, and others had only sporadic contact with peers. This uneven pattern reflected the same dynamics highlighted in interviews: participant readiness, unstable living situations, and institutional constraints that shaped the depth and consistency of engagement.

Case notes also confirmed the operational barriers described by peers and program leadership. Sixty percent of program participants encountered at least one in-jail access barrier, and many experienced repeated disruptions due to lockdowns, staffing shortages, unavailable meeting rooms, and clearance delays. These frequent interruptions limited pre-release planning and echoed interview accounts of how jail operations constrained even the most proactive peer efforts.

Finally, the notes documented a wide range of participant needs and the program’s varying ability to address them. Emotional support, guidance, and problem-solving were commonly provided, with these needs often running deeper for participants with sustained engagement with peers. System-dependent needs such as housing, employment readiness, and recovery housing were far harder to resolve, while tasks like transportation or obtaining clothing were met more consistently. This pattern aligns with interview findings: peers were highly effective in providing relational and practical support but frequently constrained by external system limitations.

The case note content reinforces the qualitative themes: PSRP’s strengths laid in trust-building, problem-solving, and emotional support, but outcomes were heavily shaped by system-level barriers that affected access, engagement, and the feasibility of meeting participants’ most pressing needs.

## Interrupted time series results: Immediate and longer-term changes after release

Interrupted time series (ITS) analysis showed that program participants experienced meaningful short-term improvements after release, particularly in reduced reincarceration.<sup>4</sup> Among PSRP participants admitted while incarcerated and subsequently released—with sufficient pre- and post-release observation time—reincarceration declined significantly immediately after release at both 6 and 12 months. At 12 months, this initial reduction was followed by continued month-to-month declines.

As is common during the transition from custody to community, short-term increases in overdose and ED use were observed following release. ED use, however, demonstrated evidence of stabilization over time, with significant downward trends observed at 12 months. In contrast, overdose rates did not show a clear decline during the follow-up period.

Among program participants who received MOUD, these patterns were broadly similar. Upon release, individuals on MOUD were given a 14 day bridge prescription to ensure treatment continuity ahead of their first appointment in the community. Like the overall PSRP cohort, these participants experienced an immediate reduction in reincarceration followed by continued month-to-month decline, with a somewhat steeper post-release slope. They also experienced early post-release increase in overdose and ED use—reflecting the acute vulnerability described by peers in interviews. ED use declined steadily over time, while overdose patterns did not show a clear downward trend. These findings are consistent with the subgroup’s substantially higher prevalence of opioid, cocaine, and sedative/hypnotic use disorders, indicating that individuals at highest clinical risk were especially vulnerable immediately after release and responsive to the combined support of MOUD and peer engagement.

4 ITS analyses were restricted to participants admitted to the program while incarcerated and meeting predefined eligibility criteria, including sufficient follow-up time ( $\geq 180$  days), exclusion of individuals still incarcerated at study end, and those pending state prison transfer. For individuals with multiple admissions, the release from the first incarceration during which the individual enrolled in the program was prioritized as the index event. For program participants who received MOUD, the release from the first incarceration coinciding with program admission and MOUD receipt was prioritized as the index event. As a result, ITS analytic samples were smaller than total program enrollment counts but were demographically and clinically comparable to the broader participant cohort. Findings reflect within-person changes over time and should be interpreted as observational associations rather than causal effects.

## Why we used interrupted time series

### Why this approach?

Evaluating outcomes after jail release presents challenges that make traditional comparison designs difficult. We used interrupted time series (ITS) analysis to address these challenges while preserving analytic rigor. ITS is a rigorous observational approach that compares each individual to themselves over time, rather than relying on an external comparison group. By tracking outcomes across multiple months before and after release, this method accounts for individuals’ pre-existing trends, distinguishes immediate post-release changes from longer-term trajectories, and provides more stable estimates than simple pre/post comparisons. Our analyses used segmented regression ITS models with individual-level outcome trajectories before and after release.

- ▶ **Participants serve as their own controls:** ITS compares outcomes before and after release within the same individuals, accounting for their pre-existing risk and utilization patterns.
- ▶ **Comparable control groups were not available:** Non-participants differed substantially from PSRP participants, and matching approaches produced unstable estimates and reduced analytic samples.
- ▶ **ITS distinguishes immediate changes from longer-term trends:** The approach separates sudden post-release shifts from gradual changes over time.

**What ITS can—and cannot—tell us:** ITS provides strong observational evidence of program-associated change but does not fully eliminate all sources of bias or establish causal effects.

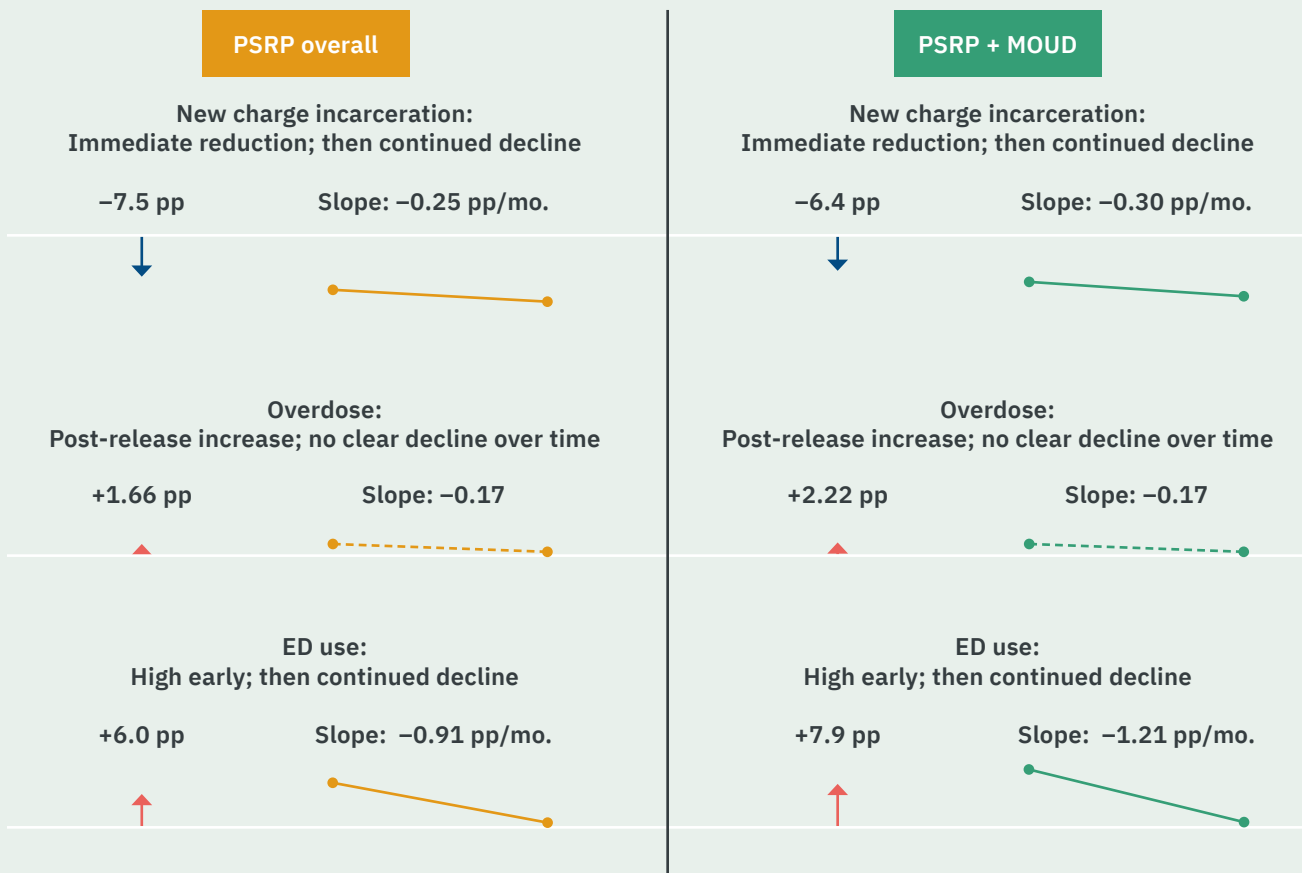
### Figure 5. Twelve-month post-release outcome trajectories among PSRP participants.

The figure summarizes ITS results for monthly incarceration for new charges, overdose, and ED use during the 12 months following jail release among PSRP participants overall (n = 189) and those who received MOUD (n = 130). Arrows indicate immediate level changes at release, while lines represent post-release trends estimated using segmented regression models that distinguish sudden changes from gradual month-to-month trends. Solid lines denote statistically significant slope changes; ED models use HC3 robust standard errors.

Incarceration declined immediately at release and continued to decrease over the 12-month follow-up. ED use increased immediately post-release but then demonstrated a significant downward trend. In contrast, overdose rates rose immediately after release, with limited evidence of sustained decline over 12 months.

Six-month analyses (n = 265 overall; n = 182 MOUD) showed similar directional patterns, though post-release ED declines were not statistically significant at six months. Participants eligible for 12-month follow-up were demographically and clinically comparable to the broader six-month cohort at baseline, suggesting that observed differences reflect extended follow-up rather than meaningful differences in participant characteristics.

Results reflect within-person changes over time and should be interpreted as observational associations rather than causal effects.



## Fatal overdoses after release: Timing, transitions, and system gaps

### What we examined

We examined fatal overdoses among PSRP participants (n=7) and individuals who received MOUD during incarceration but did not participate in the peer program (n=15). Analyses combined administrative data with qualitative review of peer case notes for PSRP participants. MOUD receipt was measured during incarceration; community-based MOUD treatment data were not available.

### Key patterns observed

- ▶ **Mortality risk clustered after release, with distinct timing across groups:** Among PSRP participants, deaths were concentrated in the immediate post-release period (57% within 30 days; median 29 days). Among non-program MOUD recipients, risk was lower immediately but remained elevated over a longer window, with most deaths occurring three to six months after release (median 136 days). Because we lack community MOUD data, these findings indicate potential vulnerability at the transition point, not verified treatment discontinuation.

- ▶ **Peer support addressed barriers but could not fully mitigate structural risk:** Case notes documented intensive discharge planning, outreach, and service coordination prior to death. However, housing instability, communication breakdowns, transportation barriers, competing legal obligations, and voluntary disengagement constrained the ability to sustain engagement during the highest-risk post-release period.

### How to interpret these findings

Fatal overdoses occurred despite active peer engagement and reflect a period of extreme vulnerability during the transition from incarceration to community care. The observed proximity between release from jail-based MOUD and death highlights the importance of reliable treatment transitions and continuity at reentry, rather than indicating program failure or confirming post-release treatment discontinuation.

“ She (Peer) was very, very persistent. I wouldn't answer the phone sometimes... but she was always there. Like to talk, to call. She was always calling, making sure I was focused. Making sure I didn't need much or anything that she could help with. And you know, once I voiced a couple of things to her, she definitely tried to help me, you know, like I said, get like a new living situation and all. Yeah, she was very helpful, very helpful.”

– Participant

# Discussion and conclusions

The evaluation indicates that PSRP effectively engaged individuals with the highest levels of medical, behavioral health, and justice-system complexity, contributing to measurable reductions in reincarceration following release. While the immediate post-release period remained clinically vulnerable, marked by short-term increases in overdose and emergency department use, ED utilization showed evidence of stabilization over time, suggesting gradual re-engagement with community-based care. However, the stability of these gains was often limited by system-level challenges—operational disruptions inside the jail, unpredictable release processes, and uneven access to community-based supports—rather than by shortcomings in peer engagement or participant readiness. These findings underscore the need for targeted improvements across the reentry continuum and point to several concrete opportunities for strengthening system coordination and treatment continuity.

Importantly, the evaluation also demonstrates that the program’s outcomes are consistent with the benefits of integrating clinical treatment and peer support. Participants receiving MOUD alongside peer engagement showed patterns similar to the overall cohort, with somewhat steeper post-release declines in reincarceration and emergency department use. This reinforces the value of integrated, evidence-based approaches that combine medication, relational support, and coordinated supervision during the high-risk transition from custody to community. Strengthening the structural conditions around PSRP—more predictable release processes, consistent MOUD delivery, and institutionalized coordination across correctional, clinical, and community partners—would enhance the program’s ability to stabilize participants and reduce preventable harm. With these system-level improvements in place, the county can better align its public-health and public-safety goals, ensuring that recovery is supported not only by individual effort but by a reliable and equitable reentry infrastructure.

## Recommendations for Strengthening reentry systems

Evaluation findings point to several actionable opportunities to strengthen public safety, treatment continuity, and system coordination.

- ▶ **Ensure true continuity of care across custody and community:** Reentry systems should prioritize uninterrupted access to MOUD and clearly defined accountability for treatment transitions at the point of release.
- ▶ **Standardize and monitor equitable access to MOUD and reentry supports:** Consistent medication delivery for individuals with opioid use disorder should be treated as a baseline expectation, with routine monitoring to identify and address disparities in access.
- ▶ **Treat operational coordination as core infrastructure:** Predictable release planning, reliable in-jail program access, and timely communication across correctional, clinical, and community partners require formal processes rather than ad hoc workarounds.

# Next steps for Camden County

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Building on the evaluation findings, Camden County is advancing several structural initiatives designed to strengthen continuity of care during the transition from custody to community. A central development is the opening of the Reentry Release Center (RRC) on March 5, 2026, which will fundamentally reshape how individuals exit the Camden County Correctional Facility.

The RRC is intended to address several system-level barriers identified in this evaluation—including unpredictable release processes, fragmented service linkage, and gaps in immediate post-release stabilization. Staffed by the Camden County Reentry Unit, the Center will provide a structured transition point where individuals can connect to treatment, peer support, and essential resources at the moment of release. The RRC will also remain accessible to individuals previously released from the jail who continue to need reentry services.

By creating a dedicated reentry environment, Camden County aims to support timely engagement in substance use and mental health treatment, strengthen continuity of prescribed medications, and reduce the destabilization that often contributes to hospitalization, recidivism, and preventable harm.

## Target population

Most individuals released from the Camden County Correctional Facility will transition through the RRC during its operating hours, replacing the current practice of releasing individuals from the booking area. Individuals released when the RRC is closed will continue to be released through the existing process. Current operating hours are 8:30 AM to 4:30 PM, and the County intends to expand evening hours to 7:00 or 8:00 PM once the RRC is fully operational and staffing and workflow are stabilized. The County's goal is to minimize the number of releases occurring outside RRC hours.

## Core services

- ▶ Immediate “soft landing” space for individuals without stable discharge plans
- ▶ Access to food, clothing, showers, and basic stabilization supports
- ▶ On-site assistance from the Reentry Team and community partners to address healthcare, insurance, identification, housing, employment, and other needs
- ▶ Continuity of prescribed medications, substance use treatment, and mental health care
- ▶ Connection to peer mentoring and pro-social engagement opportunities
- ▶ Referrals to community-based treatment and services
- ▶ Support for family reunification where appropriate

In parallel, the Camden County Department of Corrections will continue the Peer Reentry Support Program through a COSSUP grant awarded in 2024. The County is partnering with Maryville Integrated Care to support the next phase of implementation, further strengthening alignment between clinical services and peer-led engagement.

## About the Camden Coalition

The Camden Coalition works to improve care for people with complex health and social needs in Camden, NJ, and across the country. The organization implements person-centered programs and pilots new models that address chronic illness and social barriers to health and well-being. Supported by a robust data infrastructure, cross-sector convening, and shared learning, its community-based programs improve outcomes for some of society's most vulnerable individuals.

The Camden Coalition's National Center for Complex Health and Social Needs (National Center) connects complex care practitioners with each other and with data, tools, and other resources.



**The National Center**  
for Complex Health & Social Needs  
*An initiative of the Camden Coalition*

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