

OPIOID RECOVERY & REMEDIATION ADVISORY COUNCIL

STRATEGIC PLAN



SPRING 2025



CONTENTS

Section 1: Executive Summary

Section 2: At-A-Glance Summary

Section 3: NJ Opioid Recovery and Remediation Advisory Council Strategic Plan - Narrative

Section 4: Appendices

NEW JERSEY

OPIOID RECOVERY & REMEDIATION ADVISORY COUNCIL

STRATEGIC PLAN

EXECUTIVE SUMMARY

SPRING 2025



EXECUTIVE SUMMARY

Beginning in 2022, the State of New Jersey and qualifying counties and municipalities (subdivisions) began receiving settlement payments from major nationwide litigation and settlements that involve the opioid industry. The New Jersey Opioid Recovery and Remediation Advisory Council (Advisory Council) was established in 2023 to make recommendations for how the State's share of the opioid settlement funds should be allocated. Since 2023, the Advisory Council has used public input portals, listening sessions, and a roundtable discussion to hear the experiences and perspectives of those most closely affected by the risks of drug use, substance use disorder (including opioid use disorders), and the overdose crisis across New Jersey. This public input was reviewed and integrated by the Advisory Council to make three sets of funding recommendations for investing settlement funds to date (July 2023, February 2024, and October 2024).

The set of funding recommendations made by the Advisory Council included support for the development of a *Strategic Plan* to guide the ongoing allocation of remaining settlement funds. This five-year *New Jersey Opioid Recovery and Remediation Advisory Council Strategic Plan* (*Strategic Plan*) is the result of that work. It presents a data-informed roadmap to guide recommendations for using opioid settlement funds in New Jersey through 2030. The *Strategic Plan* is designed with flexibility in mind so that it can evolve in response to shifting community needs, emerging research, and changes in available funding. This document explains how the plan was developed and lays out the vision, mission, guiding principles, goals, and strategies of the plan. As well, it includes a framework for monitoring and evaluation that outlines key performance indicators to measure ongoing progress.

ADVISORY COUNCIL MEMBERS (JANUARY 2025)

Public Members

Mavis Asiedu-Frimpong

Director, Senator Walter Rand Institute for Public Affairs at Rutgers University – Camden

Bre N. Azañedo

Community Ambassador, CDC's Stop HIV Together Campaign & Programs Manager, BLM Paterson

Robert Detore

Chief Executive Officer, Turning Point, Inc.

Jenna Mellor

Executive Director, New Jersey Harm Reduction Coalition

Solomon Middleton-Williams

Director of Community Engagement, Public Works Alliance

Shirla Simpson

Director, Human Services, Burlington County

Brian Thompson

Housing Coordinator, Camden Coalition

Morgan Thompson

Chief Executive Officer, Prevention Links

Debra Wentz

President and CEO, New Jersey Association of Mental Health and Addiction Agencies

EXECUTIVE SUMMARY

Ex-Officio/Members Representing State Agencies

Sarah Adelman

Commissioner, Department of Human Services and Chairperson of the Advisory Council

Michele Calvo

Director, Opioid Response and Policy, Public Health Services, Department of Health Designee for the Commissioner of Health

Carmen Diaz-Petti

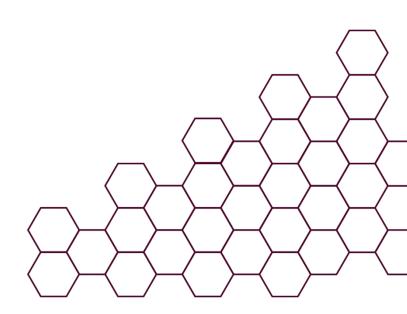
Deputy Commissioner, Department of Children and Families Designee for the Commissioner of Children and Families

Tiffany Wilson

Director, Office of Alternative and Community Responses, Office of the Attorney General, Department of Law and Public Safety Designee for the Attorney General

PLANNING PROCESS

The Advisory Council used a two--phase process to develop the *Strategic Plan* from January 2024 through March 2025. It partnered with the Center for Research and Evaluation on Education and Human Services (CREEHS) at Montclair State University to facilitate the process.



Phase 1

During Phase 1 of the strategic planning process (January 2024 through September 2024), the Advisory Council directed the completion of a *Needs Assessment* to identify the needs, resources, and gaps related to substance use disorder in New Jersey. This assessment included four key components:



Advisory Council engagement to set goals for the Needs Assessment.



Secondary data collection and review of substance use related indicator data, demographic data, as well as an inventory of programs and services for substance use disorder.



Material review of public perceptions, public input, and published documents, including feedback from public listening sessions, public comments, and public roundtables.



Primary data collection of 10 interviews with Advisory Council members; 13 interviews with 16 stakeholders providing substance use-related services; and five focus groups with 41 individuals with lived or living experience and families of youth with substance use disorder.

From these components, a set of consistent *Needs Assessment* findings were synthesized and then used to identify a set of commonly agreed upon overarching goals and strategic objectives.

Phase 2

During Phase 2 of the strategic planning process (September 2024 through March 2025), the Advisory Council interpreted the *Needs Assessment* findings and prioritized strategic objectives to develop the *Strategic Plan*. This phase also consisted of four key components:



Co-interpretation to review and understand the results of the *Needs Assessment*.



Priority setting to rank the strategic objectives and identify a set of strategies.



Specification to draft, review, and revise the components of the *Strategic Plan*, which included the vision, mission, set of guiding principles for using settlement funds, goals, strategic objectives, and strategies.



Strategic Plan finalization to assess members' overall agreement with the *Strategic Plan* components and solicit additional detailed feedback.

OVERVIEW OF CURRENT NEED IN NEW JERSEY

In New Jersey, about 2,800 confirmed overdose deaths were recorded in 2023, representing a 10% decrease from 2021 (New Jersey Overdose Data Dashboard, March 2025). Historical trends in total overdose deaths in New Jersey, however, mask substantial variation by race and ethnicity. Key findings from the Needs Assessment, which references data compiled in March through July 2024, are presented below. These data reflect a snapshot of data available during that time period.^a

- Populations Uniquely Affected by Substance Use Disorder and the Opioid Crisis: Although substance use disorder and the overdose crisis impact individuals across all demographic groups, some populations are disproportionately harmed. As of 2022 data (the most recent year for which demographic data on overdose deaths were available as of the close of the Needs Assessment in September 2024), overdose deaths were on the decline for White residents in New Jersey but were increasing steadily for Black and Hispanic residents. Older adults, youth, incarcerated individuals, individuals with mental health disorders, unhoused individuals, and rural populations are also affected by increasing overdose rates or factors related to accessing treatment services (e.g., Medicaid reimbursement, eligibility restrictions based on co-occurring disorders).
- Successful Strategies to Preserve Life: Housing assistance, naloxone distribution, medications
 for opioid use disorder treatment, Harm Reduction Centers, and whole-family support services
 are evidenced-based and best practice strategies supported by all Needs Assessment
 stakeholder groups for reducing the harmful effects of substance use disorder.
- Persistent Barriers to Service Delivery Across the Continuum of Care: Expanding access to effective services is a salient need in New Jersey, especially for residents who remain underserved or are disproportionately impacted by the opioid crisis. Consistent barriers include: stigma around substance use disorder, harm reduction, and medications for opioid use disorder treatment; suboptimal coordination across agencies and sectors of care; workforce capacity (e.g., staff shortages); and unmet basic needs like housing, transportation, and food. Community-based organizations (e.g., local non-profits, street teams, faith-based organizations) and/or some local businesses (e.g., barber shops, corner stores) may be well-suited to enhance service provision because they are able to gain trust and a nuanced understanding of their communities.
- Accessibility of Treatment: Substance use-related treatment admissions in New Jersey have been declining since 2019 with a significant dip in admissions observed in 2020 (i.e., at the height of the COVID-19 pandemic). Although there was a slight uptick in treatment admissions for all substances from 2020 to 2021, admission rates have not recovered to pre-pandemic levels, especially for opioid admissions, for which there have been the steepest declines.

^a Since the *Needs Assessment* and the strategic planning process were completed, data for 2023 were released in February 2025, revealing declines in New Jersey's overall overdose death rates and among all racial groups for the first time in over a decade. For the most recent data available, please see New Jersey Overdose Data Dashboard.

NEW JERSEY OPIOID RECOVERY AND REMEDIATION ADVISORY COUNCIL STRATEGIC PLAN

The New Jersey Opioid Recovery and Remediation Advisory Council Strategic Plan (Strategic Plan) is designed to guide the Advisory Council's funding recommendations over a five-year period (2025 through 2030). It focuses on the priorities that emerged from the Advisory Council's review and interpretation of the 2024 Needs Assessment findings. While many important needs emerged throughout the process, this Strategic Plan focuses on goals and strategies that Advisory Council members collectively agreed upon.

VISION

Individuals and communities will view substance use disorder as a health condition and those impacted by it will have equitable access to treatment and long-term support services that meet their basic needs, reduce harm, and foster recovery and wellbeing, ultimately **reducing drug-related fatalities.**



MISSION

The Advisory Council will provide data-driven and equity-focused recommendations for the allocation and distribution of opioid settlement funds in New Jersey. The Advisory Council will engage in the following ongoing activities to accomplish this mission.



TRANSPARENCY

The Advisory Council will use a systematic process to recommend how to allocate funds.



FEEDBACK

The Advisory Council will routinely gather, review, make public, and strongly consider input from relevant stakeholder groups with a focus on including individuals and families with lived and living experience.



DATA TRACKING & EVALUATION

The Advisory Council will continuously monitor historical, county-level, and statewide data to identify shifts in trends over time and track the impact of funded initiatives.



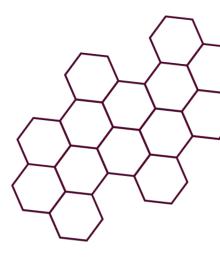
REFINEMENT

The Advisory Council will review and adjust the Strategic Plan in accordance with changes to available funding streams, drug supply, populations disproportionately affected, and available evidence.



COMMUNICATION

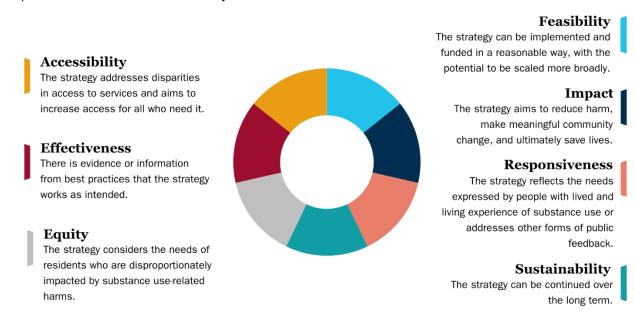
The Advisory Council will routinely share information about its activities and funding opportunities with public stakeholders via their established networks and listservs.



Guiding Principles for Funding Recommendations

The Advisory Council will rely on several criteria when reviewing proposals to make funding recommendations (Figure ES-1). All guidelines should be considered but not all must be satisfied for the recommendation to be prioritized.

Figure ES-1. The Advisory Council uses seven guiding principles to inform their recommendations for using opioid settlement funds in New Jersey



To further aid in the prioritization of funding activities, the Advisory Council will look to the *Statement* on *Funding Recommendations* which outlines the values of the Advisory Council and articulates three types of activities that it will not recommend for funding.

The New Jersey Opioid Recovery and Remediation Advisory Council recognizes the devastating impacts and complex needs presented by the ongoing opioid crisis. In light of these challenges, the Advisory Council is choosing to pursue human-centered, community-driven, and evidence-based frameworks in our funding recommendations for these limited opioid abatement funds. The Advisory Council will continue to prioritize equity and utilize available data to ensure these funds reach communities that are experiencing higher rates of overdose, opioid use, or substance use.

The Advisory Council's primary focus is to support programs and initiatives that directly address the opioid crisis, such as prevention and education, harm reduction and overdose prevention, treatment, recovery services, and services strengthening social determinants of health. The Advisory Council believes that this approach will have the most significant impact in helping individuals and communities affected by the opioid crisis. As such, the Advisory Council will not recommend that funding be used for (i) activities or programs that are not evidence-based or promising practices for opioid abatement; (ii) non-Federal Drug Administration (FDA) authorized medications for the treatment of opioid use disorder or substance use disorder; (iii) purchases of equipment for law enforcement use in search and seizure, suspect apprehension, or evidence gathering, or items that run counter to the evidence-driven and individual-first approach that we have embraced.

Goals, Strategic Objectives, Strategies, and Progress Measures

The goals, strategic objectives, and strategies of the *Strategic Plan* are outlined below, providing a broad roadmap to guide the development of specific funding recommendations and future investments (Figure ES-2). Investing in activities across all strategic objectives, and doing so in integrated ways, is likely to make more progress in achieving the vision of the *Strategic Plan* than focusing on one strategic objective alone. Moreover, the concept of funding community-based organizations is woven into several strategies as these organizations are uniquely positioned to reach those populations and geographic areas that are underserved and/or disproportionately impacted by SUD and the overdose crisis.

Monitoring and Evaluation

The three-component monitoring and evaluation framework is presented to inform the assessment of the scope and reach of the investments made using opioid settlement funds as well as to track progress on a set of statewide indicators linked to the goals of the *Strategic Plan*. The framework capitalizes on existing State infrastructure and balances research design rigor in ways that require modest investment in evaluation and maximizes funding to direct services (Figure ES-2). The actual evaluation design will reflect the specific programs funded as well as other relevant context (e.g., resources available). Due to the challenges with establishing causal relationships, this design assesses associated changes and broader outcomes to which investment activities may contribute.

- 1. Grantee-specific outputs (i.e., units of services delivered): This component of the framework is designed to measure the units of services delivered that are aligned with each goal of the Strategic Plan. Together, these outputs and related details provide a picture of the services delivered as a direct result of the settlement funds invested. They inform questions about how funding allocation is increasing access to evidence-based and best practice services for residents who remain underserved or are disproportionately impacted by SUD and the overdose crisis.
- 2. Program-specific activities: Using information from grantee agencies and/or organizations, this component is designed to examine barriers and facilitators to implementing programs and document outcomes that are directly related to those programs. This component informs questions about whether and how programs and services are meeting the needs of residents experiencing substance use disorder-related harm and how effectively programs can overcome salient obstacles to service delivery.
- 3. State-level indicators: A set of 10 state-level indicators that can be tracked over time are presented to provide a broad picture of trends related to substance use in New Jersey. This component informs questions about how disparities in outcomes shift, identifying priority populations or geographic areas, and shaping future funding recommendations.

Next Steps

This *Strategic Plan* serves as a roadmap for investing New Jersey opioid settlement funds through 2030. The goals, strategic objectives, strategies, and other components are responsive to the findings of the *Needs Assessment* and public input, aligned with evidence-based and best practice information, and designed to save lives and improve the health and wellbeing of individuals and families affected by substance use disorder and the overdose crisis. The following activities aim to maintain the plan's effectiveness, responsiveness, and adaptability over time.

- Review the Strategic Plan annually by monitoring progress toward the goals and strategic objectives. This review may also include identifying areas for improvement and ensuring that resources are being allocated efficiently and effectively. The plan may be adapted based on the latest evidence, public input, available resources, and context.
- Make funding decisions that apply the Guiding Principles for Funding Recommendations and invest across all the goals, strategic objectives, and strategies in this Strategic Plan. Invest in activities that continue for multiple years (e.g., three years or more). As well, maintain mechanisms for tracking the distribution of settlement funds, particularly in underserved populations, and this includes using findings from monitoring and evaluations to make future funding decisions. Collaborate with stakeholders outside of the Advisory Council to encourage implementation of strategies.
- Engage the public and stakeholders, including service providers, community organizations, and individuals with lived or living experience with substance use disorder, on at least an annual basis throughout the lifespan of this *Strategic Plan*.

The New Jersey Opioid Recovery and Remediation Advisory Council Strategic Plan is a tool for the Advisory Council to use in making decisions about how to use funds from the opioid settlement over the next five years and beyond. It is shaped by the expertise and lived experiences of the Advisory Council, New Jersey stakeholders working in the substance use-related field, and individuals directly impacted by substance use disorder. It is rooted in the vision that substance use disorder is a health condition and that fatalities may be reduced when equitable access to treatment and long-term support services meet people's basic needs, reduce harm, and foster health and wellbeing. Over the coming years, the Advisory Council will continue in its mission to provide data-driven and equity-focused recommendations for the allocation and distribution of opioid settlement funds in New Jersey related to housing, harm reduction, treatment, and coordinated wraparound services for substance use disorder.

Figure ES-2. The Strategic Plan focuses on investing in 12 strategies across housing, harm reduction, treatment, and coordinated wraparound service goals and includes a set of indicators to measure progress

GOAL	STRATEGY	OUTPUT MEASURE	STATE-LEVEL INDICATOR
Safe, Stable, and Supportive Housing Increase the availability and accessibility of housing for individuals and families affected by substance use disorder (e.g., Housing First approaches)	Expand Housing First initiatives Expand affordable, supportive, and transitional and permanent housing models	 # of people placed in housing % of people placed in housing who access harm reduction, recovery, and wraparound support services # of housing units and vouchers made available 	Drug-related hospital visits (all drugs) Homelessness among those accessing treatment
Harm Reduction Services Increase access to harm reduction services for people who use substances	1. Distribute Harm Reduction supplies through community-based organizations 2. Integrate Harm Reduction services into health care settings 3. Train emergency services in harm reduction	 # of Harm Reduction supplies distributed, by type and location # of health care organizations using protocols for Harm Reduction services delivery and referral # of staff trained, by location 	MOUD prescriptions Naloxone distribution in communities Naloxone incidents
Treatment Services Increase access to treatment services for people who use substances	1. Conduct a treatment gap analysis 2. Expand evidence-based/best practice treatment services (medication for opioid use disorder (MOUD) and trauma- informed care) 3. Train facility staff in evidence-based/best practice treatment approaches	List of areas without accessibility to MOUD and/or Medicaid-accepting or state-funded treatment facilities # of facilities that offer MOUD, by county # of treatment facility staff trained, by location	New hepatitis C infections Overdose deaths Recovery support service participation
Coordinated Wraparound Services Improve the coordination of wraparound supports (e.g., transportation, legal services) provided to individuals and families affected by substance use	Enhance or expand transportation options Develop guidelines for discharge planning Expand peer specialist (PS) capacity to provide case management services Expand family support groups and treatment programs	 # of transports provided # of treatment facilities applying guidelines for connection to resources # of individuals with discharge plan # of PSs trained in case management # of new/expanded family support groups, by location 	Substance use disorder among people experiencing homelessness Treatment admissions

Note: The monitoring and evaluation framework prioritizes the use of routinely collected grantee-specific output measures and publicly available state-level indicators. Additional outputs and indicators may be included (e.g., percent of individuals accessing harm reduction services who are experiencing homelessness, new injection-related HIV infections) as additional data are identified and made available. The monitoring and evaluation plan is intended to assess associated changes and broader outcomes to which investment activities may contribute and is not designed to estimate causal relationship.

NEW JERSEY

OPIOID RECOVERY & REMEDIATION ADVISORY COUNCIL

STRATEGIC PLAN

AT-A-GLANCE

SPRING 2025

AT-A-GLANCE

The New Jersey Opioid Recovery and Remediation Advisory Council Strategic Plan (Strategic Plan) is designed to guide the New Jersey Opioid Recovery and Remediation Advisory Council's (Advisory Council) funding recommendations over a five-year period (2025 through 2030). It focuses on the priorities that emerged from the Advisory Council's review and interpretation of the 2024 Needs Assessment findings. While many important needs emerged, this Strategic Plan focuses on strategies that Advisory Council members collectively agreed upon. It reflects careful consideration and deliberation among Advisory Council members, with a commitment to centering the lived and living experiences of individuals and families affected by substance use disorder in New Jersey.

This *Strategic Plan* is a dynamic, living document. It requires regular review of its progress and alignment with the latest evidence, public input, available resources, and context to maintain its effectiveness and responsiveness to New Jersey and the communities affected by substance use disorder.

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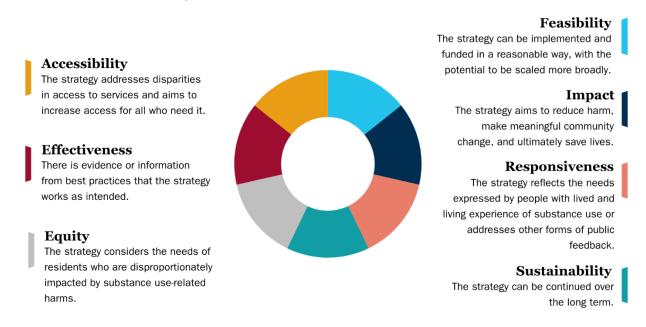
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Figure 1. The Advisory Council uses seven guiding principles to inform their recommendations for using opioid settlement funds in New Jersey



Goals, Strategic Objectives, Strategies, and Progress Measures

The goals, strategic objectives, and strategies of the *Strategic Plan* are outlined below, providing a broad roadmap to guide the development of specific funding recommendations and future investments (Figure 2). Investing in activities across all strategic objectives, and doing so in integrated ways, is likely to make more progress in achieving the vision of the *Strategic Plan* than focusing on one strategic objective alone. Moreover, the concept of funding community-based organizations is woven into many strategies as these organizations are uniquely positioned to reach those populations and geographic areas that are underserved and/or disproportionately impacted by substance use disorder.

The three-component monitoring and evaluation framework informs the assessment of the scope and reach of the investments made using opioid settlement funds and tracks progress on a set of statewide indicators linked to the goals of the *Strategic Plan*. The framework capitalizes on existing State infrastructure and balances research design rigor in ways that require modest investment in evaluation to maximize funding to direct services (Figure 2). It will focus on measuring **grantee-specific outputs** (i.e., units of services delivered), **program-specific activities**, and **state-level indicators** to address a series of suggested questions to inform the Advisory Council's ongoing efforts.

Figure 2. The Strategic Plan focuses on investing in 12 strategies across housing, harm reduction, treatment, and coordinated wraparound service goals and includes a set of indicators to measure progress

GOAL	STRATEGY	OUTPUT MEASURE	STATE-LEVEL INDICATOR
Safe, Stable, and Supportive Housing Increase the availability and accessibility of housing for individuals and families affected by substance use disorder (e.g., Housing First approaches)	Expand Housing First initiatives Expand affordable, supportive, and transitional and permanent housing models	 # of people placed in housing % of people placed in housing who access harm reduction, recovery, and wraparound support services # of housing units and vouchers made available 	Drug-related hospital visits (all drugs) Homelessness among those accessing treatment
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Note: The monitoring and evaluation framework prioritizes the use of routinely collected grantee-specific output measures and publicly available state-level indicators. Additional outputs and indicators may be included (e.g., percent of individuals accessing harm reduction services who are experiencing homelessness, new injection-related HIV infections) as additional data are identified and made available. The monitoring and evaluation plan is intended to assess associated changes and broader outcomes to which investment activities may contribute and is not designed to estimate causal relationships.

NEW JERSEY

OPIOID RECOVERY & REMEDIATION ADVISORY COUNCIL

STRATEGIC PLAN

NARRATIVE

SPRING 2025

DEDICATION

The New Jersey Opioid Recovery and Remediation Advisory Council dedicates this *Strategic Plan* to the communities, families, and individuals affected by the opioid crisis in New Jersey and beyond. We are committed to amplifying the voices and experiences of those most impacted, whose strength and resilience guide and inspire our work. The Advisory Council is honored to be a part of this work, which is rooted in compassion for and memory of the lives affected and lost in this crisis. We thank all who have contributed to this *Strategic Plan* as we strive for the healing and recovery of our families and communities.





RESOURCE DIRECTORY

If you or someone you know needs support related to substance use in New Jersey, the following resources may be helpful for you.

Substance Use

Addiction Services Treatment Directory

https://njsams.rutgers.edu/TreatmentDirectory/ Directory of Medication-Assisted Treatment, inpatient and outpatient services, and resources for withdrawal management

Harm Reduction Centers

https://www.nj.gov/health/hivstdtb/hrc/ List of authorized Harm Reduction Centers in New Jersey

NJ Children's System of Care - Perform Care

https://www.performcarenj.org/

1-877-625-7624

A single point of access to behavioral health, intellectual and developmental disability services, as well as substance use treatment for youth and families

NJ Connect 4 Recovery Helpline

https://www.njconnectforrecovery.org/855-652-3737

Resources for families and friends of those who use substances; provides emotional support, education, family and peer guidance, and referrals to treatment options

Reach NJ Addiction Helpline

https://www.reachnj.gov

1-844-REACHNJ or 1-844-732-2465

Central call-line for residents looking for help with substance use disorder; provides trained addiction counselors, referrals to treatment, and support services

Recovery Centers

https://nj.gov/humanservices/reachnj/help/cent ers/

Directory of Community Peer Recovery, Family Support, and Harm Reduction Centers in New Jersey

Mental Health and Suicide Prevention

2NDFLOOR Youth Mental Health

Helplinehttps://www.2ndfloor.org/ 1-888-222-2228

A confidential and anonymous helpline for New Jersey's youth and young adults with a message board and mental health counselors available

24/7 365 days a year

988 Suicide and Crisis Lifeline https://www.988lifeline.org/chat 988

Helpline that connects people via call, text, or chat to crisis counselors; provides emotional support and crisis counseling

Directory of Mental Health Services

https://www.nj.gov/humanservices/dmhas/home/hotlines/MH_Dir_COMPLETE.pdf

List of State contracted mental health providers

NJ Children's System of Care - Perform Care

https://www.performcarenj.org/

1-877-625-7624

A single point of access to behavioral health, intellectual and developmental disability services, as well as substance use treatment for youth and families

NJ Self-Help Group Clearinghouse

https://www.njgroups.org/

1-800-367-6274

Resources for starting or participating in a selfhelp group related to a range of conditions or across a range of physical and mental conditions, situations

NJMentalHealthCares Helpline

https://www.njmentalhealthcares.org/

1-866-202-HELP

Behavioral health information and referral service to help individuals and families get the services needed



RESOURCE DIRECTORY

Basic Needs

ACCESS American Sign Language and Videophone Helpline

973-870-0677

Helpline for emotional support tailored to deaf and hard of hearing individuals

Garden State Community Outreach

https://gardenstateoutreach.us/

A program finder that connects New Jersey residents to eligible, cost-saving, and life-changing programs

NJ 2-1-1

https://nj211.org/

211

Resource for connecting individuals to community services such as housing, food assistance, health care, and disaster support

NJ Helps

https://www.njhelps.gov/

Central point to check eligibility and apply for food assistance (SNAP), cash assistance (WFNJ/TANF or WFNJ/GA), and health insurance (NJ FamilyCare/Medicaid)

NJ Housing Resource Center

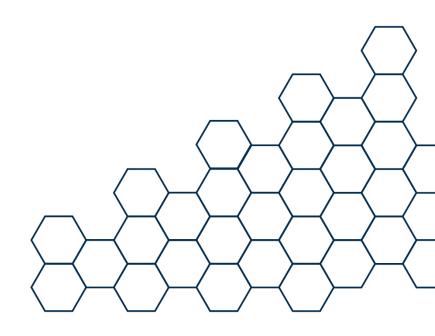
https://www.nj.gov/njhrc/

1-877-428-8844

Central listing to search for and list available affordable and accessible housing units in NJ

TABLE OF CONTENTS

GLOSSARY OF ACRONYMS AND KEY TERMS	i
INTRODUCTION	1
PLANNING PROCESS	4
OVERVIEW OF CURRENT NEED IN NEW JERSEY	7
STRATEGIC PLAN	12
Vision	12
Mission	13
Guiding Principles for Funding Recommendations	14
Goals, Strategic Objectives, Strategies, and Progress Measures	15
Monitoring and Evaluation Plan	28
NEXT STEPS	33
REFERENCES	36





GLOSSARY OF ACRONYMS AND KEY TERMS

Acronym	Definition
СВО	Community-based organizations
CREEHS	Center for Research and Evaluation on Education and Human Services
EMS	Emergency medical services
GIS	Geographical information system
HR	Harm reduction
HRC	Harm Reduction Center
LE	Law enforcement
MOUD	Medication for opioid use disorder
OUD	Opioid use disorder
PEH	People experiencing homelessness
PS	Peer specialists
SU	Substance use
SUD	Substance use disorder
SWOT	Strengths, weaknesses, opportunities, and threats
U.S.	United States

Key Terms	Definition
Community-based organization	A type of organization, typically non-profit, that works at the local level to meet community needs. May be social service agencies, nonprofit organizations, collaborative coalitions, educational programs, faith-based organizations, grassroot movements, health centers, recovery centers, and others.
Continuum of care	An integrated system of care that guides and tracks a person over time through a comprehensive array of health services appropriate to the individual's need(s). A continuum of care may include prevention, early intervention, treatment, continuing care, and recovery support.
Evidence-based and best practices	Interventions that are guided by the best research evidence, practice-based expertise, and cultural competence. ²
Harm reduction	An approach to prevent and reduce overdose and risk of infectious disease transmission. Harm reduction practices may include syringe exchange programs, naloxone distribution, drug testing supplies, and overdose education. ¹
Housing First	A homeless assistance approach that prioritizes providing permanent housing without preconditions and barriers to entry. Supportive services are offered to maximize housing stability and improve quality of life. ³
Goals	The general activities that need to be accomplished to achieve the vision of the Strategic Plan.
Guiding principles for funding recommendations	A guide for the Advisory Council to make informed decisions about which activities to recommend for use of the State's share of opioid settlement funds.
Medications for opioid use disorder (MOUD)	Treatment option for opioid use disorder using medications such as methadone, buprenorphine, or naltrexone. MOUD is one form of medications for addiction treatment or medication-assisted treatment (MAT). ⁴
Mission	The role the Advisory Council plays in the Strategic Plan; its purpose and why it exists.
Peer specialist	An individual with lived or living experience of a mental health condition, substance use disorder, or both. They provide support to others experiencing similar challenges. They provide non-clinical, strengths-based support and are "experientially credentialed" by their own journey (adapted from source). ²

People with lived or living experience	Individuals with personal knowledge gained through direct, first-hand involvement. Includes people who currently use or formerly used substances or their family members (adapted from source). ²	
Progress measure	A measure by which progress on the Strategic Plan will be assessed.	
Recovery	A process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. Abstinence is not always the goal and recovery occurs via many pathways. Four major dimensions of recovery include (1) health: overcoming or managing one's disease(s) or symptoms, and making informed, healthy choices that support physical and emotional wellbeing; (2) home: having a stable and safe place to live; (3) purpose: conducting meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society; and (4) community: having relationships and social networks that provide support, friendship, love, and hope. ²	
Stigma	Discrimination against an identifiable group of people, a place, or nation. Stigma about people with substance use disorder mig include inaccurate or unfounded thoughts like they are dangerou incapable of managing treatment, or at fault for their condition Stigma also may include inaccurate or unfounded thoughts abo people who receive certain benefits or utilize certain services.	
Strategic objective	The specific definition of each goal in the Strategic Plan.	
Strategy	A specific approach to be taken to accomplish each goal in the Strategic Plan.	
Substance use disorder	Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home (adapted from source).4	

Trauma-informed models, care, or approaches	Trauma-informed approaches recognize and intentionally respond to the lasting adverse effects of experiencing traumatic events, defined through six key principles: (1) safety: participants and staff feel physically and psychologically safe; (2) peer support: peer support and mutual self-help are vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their lived experience; (3) trustworthiness and transparency: decisions are conducted with the goal of building and maintaining trust; (4) collaboration and mutuality: importance is placed on partnering and leveling power differences; (5) cultural, historical, and gender issues: culture- and gender-responsive services are offered while moving beyond stereotypes/biases; and (6) empowerment, voice, and choice: organizations foster a belief in the primacy of the people who are served to heal and promote recovery from trauma. ²
Vision	The desired future state; what will be different about New Jersey because of Strategic Plan efforts.
Wraparound services	Wraparound services are non-clinical services that facilitate engagement and retention in care as well as wellness and ongoing recovery. This can include services to address client needs related to transportation, employment, childcare, housing, legal and financial problems, among others. ¹



INTRODUCTION

Beginning in 2022, the State of New Jersey and qualifying counties and municipalities (subdivisions) began receiving settlement payments from major nationwide litigation and settlements that involve the opioid industry. These settlements hold opioid manufacturers, distributors, and retailers accountable for their roles in creating and fueling the opioid epidemic and for aggressively marketing prescription opioids while also downplaying their risks to health care providers and the public. As of the time of this publication, New Jersey has entered into settlement agreements with the following companies: opioid manufacturer Johnson & Johnson; the country's three largest pharmaceutical distributors – McKesson, Cardinal Health, and AmerisourceBergen; global pharmaceutical maker Mallinckrodt PLC; pharmacy chains CVS, Walgreens, and Walmart; and drug makers Teva Pharmaceuticals and Allergan.

To date, New Jersey stands to receive more than \$1 billion in settlement funds to be paid in different allotments through 2038. According to an agreement made by the State of New Jersey and its qualifying subdivisions ("the State Subdivision Agreement"), almost all of the funds will be divided evenly—with 50 percent distributed to the State and 50 percent distributed to eligible subdivisions.⁵ The settlement funds will be used to make critical investments in harm reduction (HR) and data-driven strategies and will bolster opioid use disorder (OUD) resources and programs in New Jersey.⁶ These investments will strengthen New Jersey's ability to save lives by preventing overdose deaths and connecting New Jersey families to support and treatment when and where they need it most. This *Strategic Plan* describes the processes and plans related to using the State share of these funds and may be an informational resource for eligible subdivisions.

New Jersey Opioid Recovery and Remediation Advisory Council

On August 31, 2022, Governor Murphy signed Executive Order No. 3057 to create the Opioid Recovery and Remediation Advisory Council (Advisory Council) and, in December 2022, the inaugural 10 public members were appointed. These members reflect New Jersey's diversity, and include individuals with lived experiences, representatives of key stakeholder groups, people of varying academic backgrounds, and engaged community leaders, with many public members bringing an intersection of these backgrounds. In addition, the Attorney General and the Commissioners of the Departments of Children and Families and of Health, or their designees, are included as ex officio members. The Commissioner of the Department of Human Services (Human Services) serves as the Chairperson of the Advisory Council (Appendix A).

Governor Murphy and the State Legislature codified the Advisory Council in March 2023 (P.L. 2023, c. 25) and tasked it with several responsibilities (Figure 1).8,9

Figure 1. Advisory Council roles and responsibilities focus on soliciting feedback, reviewing data, and making recommendations for spending the State share of opioid settlement funds

Providing recommendations to the Governor and Executive Branch departments and agencies with regard to spending from the State share.

Reviewing proposals, data, and analysis and engaging with stakeholders and community members to develop and provide recommendations.

Soliciting feedback from

stakeholders, providers, advocates, those with lived or living experience with substance use, and others regarding services and programs needed.



Evaluating approaches taken by New Jersey and other states in administering proceeds from national opioid litigation resolutions.

Gathering and evaluating data

regarding the availability of, gaps in, and barriers to substance use disorder prevention, treatment, and recovery programs and services to prevent overdose deaths, provide wraparound supports, and expand harm reduction efforts.

Reviewing and evaluating recommendations

submitted by the public via online portals.

A cornerstone of New Jersey's approach to using the settlement funds involves soliciting, integrating, and making meaningful use of public input about the needs and gaps in New Jersey related to substance use (SU) prevention, HR, treatment, and recovery. In 2022, a public email address (OpioidSettlement@dhs.nj.gov) and website (https://www.nj.gov/opioidfunds/) were created to provide opportunities for members of the public and other interested stakeholders to submit materials and input for review by the Advisory Council. Three additional mechanisms have been employed to hear the experiences and perspectives of those most closely affected by the risks of drug use, substance use disorder (SUD) (including OUD), and the overdose crisis. These include online public input portals, listening sessions, and a roundtable discussion. This public input was reviewed and integrated by the Advisory Council to make three sets of funding recommendations for investing \$121,711,800 in settlement funds to date (July 2023, February 2024, and October 2024).

Purpose of this Strategic Plan

The set of funding recommendations so far made by the Advisory Council included support for the development of a strategic plan to guide the ongoing allocation of the remaining State's share of settlement funds (estimated at more than \$478 million through 2038). This five-year *New Jersey Opioid Recovery and Remediation Advisory Council Strategic Plan* (*Strategic Plan*) is the result of that work. It presents a data-informed roadmap to guide recommendations for using opioid settlement funds in New Jersey through 2030. This document:

- explains how the plan was developed;
- lays out the vision, mission, and guiding principles for use of settlement funds in New Jersey;
- describes the goals and strategic objectives; and for each objective, lists strategies for future investment activities, and
- outlines a monitoring and evaluation framework to track key performance indicators.

The *Strategic Plan* is designed with flexibility in mind so that it can evolve in response to shifting community needs, emerging research, and changes in available funding. It is not intended as a one-time effort, but as a dynamic document that balances the immediate need for high-impact investments with a commitment to data-driven planning. It is expected that a new or revised *Strategic Plan* will be developed in 2030.





PLANNING PROCESS

The Advisory Council used a two-phase process to develop the *Strategic Plan* from January 2024 through March 2025. The Advisory Council, through Human Services, partnered with the <u>Center for Research and Evaluation on Education and Human Services</u> (CREEHS) at Montclair State University to facilitate this process (Appendix B).

Phase 1

During Phase 1 of the strategic planning process (January through September 2024), the Advisory Council directed the collection and synthesis of information to conduct a needs assessment. This *Needs Assessment* identified the needs, resources, and gaps that emerged from existing data and materials, stakeholder interviews, and focus groups with individuals with lived or living experience and families impacted by SUD (Figure 2). This assessment included four key components, facilitated by CREEHS.



Advisory Council Engagement: The Advisory Council collectively set goals for the *Needs* Assess*ment*, including what information should be gathered and how those data should be gathered for the assessment (March through May 2024).



Secondary Data Review: Directed by Advisory Council decisions, CREEHS compiled SU-related outcome indicator data, demographic data, and an inventory of existing programs and services for SUD. A selection of these data informed the development of a multi-layered interactive geographical information systems (GIS) map and static GIS story map to explore the geographic distribution of resources, SU-related indicators, and population characteristics (May through August 2024).



Material Review Informed by the Advisory Council, CREEHS compiled and reviewed materials related to the settlement including public input already solicited through public comments (more than 500 submissions from providers, academic experts, individuals in recovery, loved ones, family members or friends of someone with or in recovery from a SUD, and others, including 13 people who disclosed active SU) and public listening sessions (five sessions with a total of 67 individuals submitted testimony), observation of a roundtable discussion with five individuals sharing the perspective of a family member or advocate for families of people with living experience, proposals submitted for Advisory Council funding review, and existing plans and other states' strategic plans related to the opioid settlements (February through July 2024).



Primary Data Collection: The Advisory Council provided feedback on data collection instruments developed and used by CREEHS to collect primary data from stakeholders, including: 10 interviews with Advisory Council members; 13 interviews with 16 stakeholders providing SU-related services (e.g., Harm Reduction Center [HRC] frontline or director-level staff, non-profit service providers); and five focus groups with 41 individuals with lived or living experience and families of youth with SUD (May through September 2024). These focus groups engaged individuals with a range of perspectives (e.g., individuals newly in SUD treatment, pregnant and parenting people, parents of students with SUD, individuals re-entering treatment, peer specialists (PS) who work with people who are not engaged in treatment) and were located at an inpatient treatment center, a center providing outpatient medication for OUD (MOUD), a recovery high school, and a recovery center that provides support for those not engaged or engaged in treatment.

A sixth focus group, located at an HRC, was attempted to engage people with living experience who are not engaged in treatment. Hearing the perspectives of this population was a priority for the Advisory Council (Appendix B). Unfortunately, this focus group was not completed because of scheduling difficulties and the short timeline for data collection. To mitigate this limitation, additional efforts were made to engage HRC frontline staff and PSs working with individuals not engaged in treatment in data collection. This is a limitation to this process and the Advisory Council is committed to identifying opportunities (e.g., focus groups, roundtable discussions) for ongoing engagement with individuals with living experience that interact with HRCs.

Overall, the *Needs* Assessment compiled information from the public comments, listening sessions, and roundtable discussions as well as collected new information through interviews with Advisory Council members and stakeholders providing SUD-related services. It also collected new information through interviews with stakeholders and focus groups with individuals with lived or living experience and families of youth with SUD. Across these sources, a range of perspectives were provided including, but not limited to the following:

- Individuals with lived or living experience
- Individuals new to treatment, returning to treatment, or in a stage of recovery (e.g., those receiving MOUD, those with incarceration history, pregnant and parenting people)
- Family members or friends of individuals with, in recovery from, or lost from a SUD (e.g., parents of youth who have SUD)
- Physical, mental, and behavioral health providers
- HR, treatment, and recovery front line and director-level staff (e.g., HRC staff, PSs)
- Other community service providers (e.g., prevention programming with school-aged populations, local outreach providers, faith-based organizations providing supports)
- Emergency medical services (EMS) personnel
- Statewide program or health informatics administrators
- Academic experts

The Montclair State University Institutional Review Board provided oversight for the protection and ethical treatment of individuals participating in data collection. Participants were explicitly asked not to share information about any personal SU during the interview or focus group to protect confidentiality.

Each data source was analyzed independently to identify themes and then synthesized with other sources. From that, a set of consistent *Needs Assessment* findings were gleaned from the data and used to identify a set of commonly agreed upon overarching goals to inform the *Strategic Plan*. Corresponding strategic objectives and strategies that address key barriers and facilitators of effective service delivery were developed based on the *Needs Assessment* findings.

Phase 2

During Phase 2 of the strategic planning process (September 2024 through March 2025), the Advisory Council interpreted the *Needs Assessment* findings and prioritized goals and strategic objectives. This phase consisted of four key components facilitated by CREEHS and culminated in the development of a final *Strategic Plan*.



Co-Interpretation: The Advisory Council reviewed and co-interpreted the results of the *Needs Assessment* (September 2024) via presentations of the results, discussions about the findings, and individual review.



Priority Setting: The Advisory Council ranked goals and strategic objectives based on scope (i.e., what is in the purview of the Advisory Council) and importance (e.g., what is not already funded and is supported by best practice or evidence). A set of strategies were then identified using a Strengths, Weaknesses, Opportunities, and Threats (SWOT) approach facilitated by CREEHS for each of the prioritized strategic objectives. Advisory Council members unable to attend this in-person discussion provided feedback during virtual "Office Hours" discussions (October 2024).



Specification: Using the prioritized strategic objectives, strategies, and Advisory Council feedback, CREEHS drafted the components of the *Strategic Plan*, which included a vision and mission statement, a set of guiding principles for using settlement funds, goals, strategic objectives, and strategies for the *Strategic Plan*. The Advisory Council reviewed, discussed, and revised these components during a virtual meeting (November 2024).



Strategic Plan Finalization: The revised Strategic Plan components were shared with the Advisory Council for final review during a virtual meeting. An online survey was conducted to assess members' overall agreement with the Strategic Plan components and solicit additional detailed feedback (January 2025). The Advisory Council also discussed the key components of a monitoring and evaluation plan to measure progress of the Strategic Plan over time (January 2025). CREEHS further developed this monitoring and evaluation plan using the feedback and guidance from the Advisory Council.

Advisory Council members reviewed this full *Strategic Plan* and once again provided feedback. This feedback was integrated as appropriate into the current document, reflecting the deliberations, priorities, and consensus of the Advisory Council.



OVERVIEW OF CURRENT NEED IN NEW JERSEY

Results from the 2021-2022 National Survey on Drug Use and Health indicate that 17% of U.S. residents over the age of 11 years have a SUD and 2% have an OUD, for whom the risk of drug overdose is high. In New Jersey, prevalence rates of SUD and OUD are comparable to national averages (16% and 2%, respectively).¹⁰

Overdose deaths in the U.S. are estimated to have declined by 24% from 2023 to 2024 according to provisional overdose death counts published by the National Center for Health Statistics. ¹¹ Despite this decrease, overall counts remain high with 94,490 U.S. overdose deaths provisionally reported between June 2023 and June 2024. In comparison, in 2023, about 2,800 New Jersey residents died of an overdose, representing a 10% decrease from 2021. ¹² Historical trends in total overdose deaths in New Jersey, however, mask substantial variation by race and ethnicity.

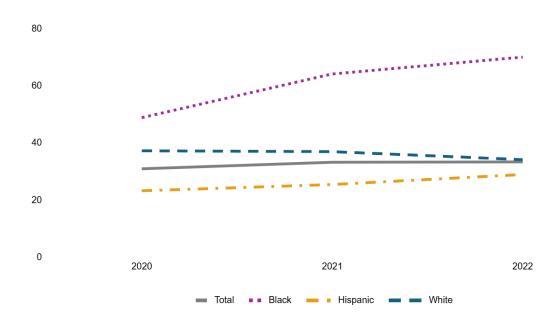
The following sections outline key findings from the *Needs Assessment*, which compiled and collected data in March through July 2024. This reflects a snapshot of available data during that time period. More recent data may now be available from publicly available sources (e.g., <u>NJ Overdose Data Dashboard</u>). See Appendix B and C for more detail on methods and data sources.

Populations Uniquely Affected by SUD and the Opioid Crisis

Although SUD and the opioid crisis impact individuals across demographic groups, some populations are disproportionately impacted, specifically in terms of overdose deaths (Appendix C). As of 2022 data (the most recent year for which demographic data on overdose deaths were available as of the close of the *Needs Assessment* in September 2024), overdose deaths were on the decline for White residents in New Jersey but were increasing steadily for Black and Hispanic residents (Figure 2). ^{12 a} Black residents accounted for the highest rate (age-adjusted per 100,000 residents) of overdose deaths in nearly every county in New Jersey. Put differently, in all but one county (i.e., Middlesex) for which data are available, the rate of overdose deaths among Black residents is higher than that among White and Hispanic residents.

^a Since the *Needs Assessment* and the strategic planning process were completed, data released for 2023 revealed declines in overdose death rates in New Jersey and among all racial groups for the first time in over a decade. For the most recent data available, please see New Jersey Overdose Data Dashboard.

Figure 2. Age-adjusted rates of overdose deaths by race and ethnicity (2020 to 2022) which illustrate the disproportionate burden of overdose deaths among Black residents in New Jersey



Note: Age- and race-adjusted data (number of overdose deaths per 100,000 residents, by racial group) last retrieved from public <u>NJ SUDORS Overdose Mortality Data Explorer</u> in March 2025. Refer to this site for continuously updated counts of overdose deaths.

Moreover, older adults, youth, incarcerated individuals, individuals with mental health disorders, unhoused individuals, and rural populations are also affected by SUD in terms of increasing overdose rates or factors limiting access to treatment services (e.g., Medicaid reimbursement and admission restrictions based on co-occurring disorders) (Appendix C). As of 2022 data (the most recent year for which demographic data on overdose deaths were available as of September 2024), overdose deaths were concentrated in the southern counties of New Jersey, except for Essex County in the northeast (Figure 3).¹²

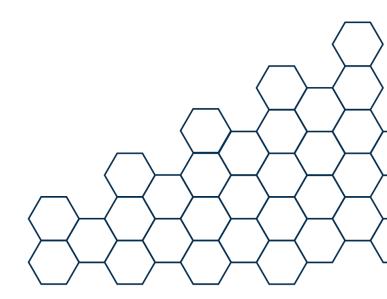
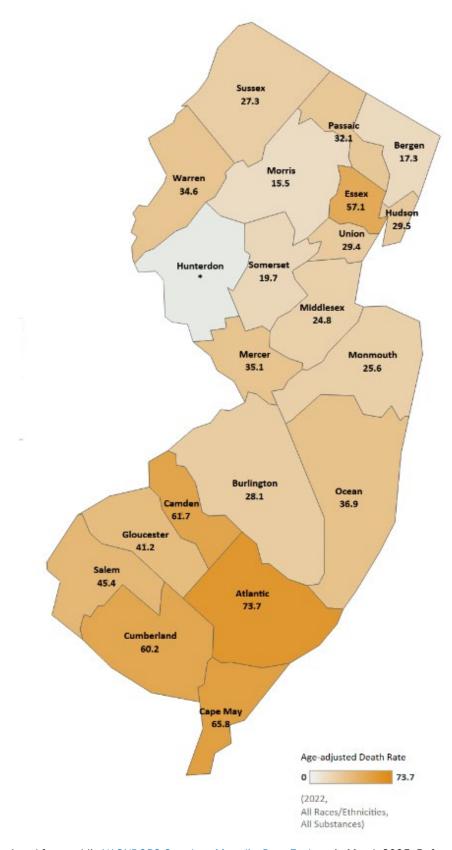


Figure 3. 2022 Age-adjusted overdose death rates by county illustrate regional variation in overdose deaths across New Jersey



Note: Image retrieved from public <u>NJ SUDORS Overdose Mortality Data Explorer</u> in March 2025. Refer to this site for continuously updated counts of overdose deaths.

Successful Strategies to Preserve Life

Needs Assessment findings that informed this Strategic Plan indicate that housing assistance; naloxone administration by law enforcement (LE), EMS, and other providers and residents; MOUD; HRCs and recovery centers; and whole-family support services are evidenced-based and best practice strategies supported by all stakeholder groups for reducing the harmful effects of SUD, including overdose deaths (Appendix C).



"With [intensive outpatient programs] or residential treatment, you're expected to engage at a certain frequency. Whereas with recovery centers and HRCs...the greatest barrier is just being able to walk through the door. You don't get faced with cumbersome assessment and commitments...It really starts with just hospitality and connection and welcome. And I think that's what people are looking for...to be supported rather than taken through this very clinical process."

-Needs Assessment interview respondent



Persistent Barriers to Service Delivery Across the Continuum of Care

Expanding access to effective services is a salient need in New Jersey, especially for residents who remain underserved or are disproportionately impacted by the opioid crisis. Data collected through the *Needs Assessment* indicate that stigma around SUD, HR, and MOUD; suboptimal coordination across agencies and sectors of care; and unmet basic needs like housing, transportation, and food were consistent barriers to effective service delivery. Moreover, across *Needs Assessment* interview, focus group, and public comment respondents, workforce capacity issues and staff shortages are noted as a key barrier to effective service delivery. Limited qualified and appropriate staff in the locations where people with lived or living experience obtain services and a high level of staff turnover create significant barriers to providing consistent, evidence-based and best practice services throughout New Jersey. Parallel to this need is a call among stakeholders to engage community-based organizations (CBOs) and some local businesses to enhance service provision. Findings suggest that CBOs (e.g., neighborhood agencies, local non-profits, street teams, faith-based organizations) and/or some local businesses (e.g., barber shops, corner stores) may be well-suited to garner trust and have a nuanced understanding of the needs, assets, and challenges of their communities (Appendix C).



"You get acquainted with one counselor and all of a sudden they're moving on to someone else, you got to start with another one. Start your whole story all over with someone that doesn't know nothing about you, which you might feel uncomfortable doing, sharing with so many people."

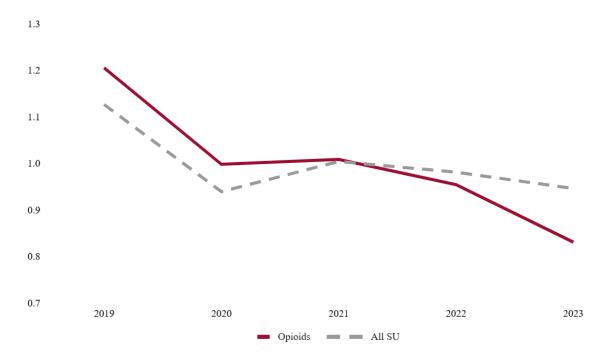
-Needs Assessment focus group respondent



Accessibility of Treatment

SU-related treatment admissions in New Jersey have been declining since 2019 with a significant dip in treatment admissions observed in 2020 (i.e., at the height of the COVID-19 pandemic). Although there was a slight uptick in treatment admissions for all substances from 2020 to 2021, admission rates have not recovered to pre-pandemic levels, especially for opioid admissions, for which there have been the steepest declines (Figure 4). Understanding what factors contribute to the declines in SU-related treatment admissions (e.g., changes in treatment accessibility or availability) is important for understanding how access to treatment can be enhanced.

Figure 4. From 2019 to 2023, normalized counts of treatment admissions for opioid use have declined more steeply than treatment admissions for all substances



Note: Raw count data retrieved from the public NJSAMS website in May 2024 (https://njsams.rutgers.edu/njsams/Reports/SummaryReport/StateSummaryReportMenu.aspx). Refer to this site for routinely updated counts of treatment admissions. Treatment admission counts were normalized by dividing the value for each year by the mean value across years. This figure is not designed to report specific counts, but rather, to display how the counts change over time consistent with other indicators in the Needs Assessment. This approach facilitates the comparison of rates across indicators.

Considering current needs in New Jersey, findings from the *Needs Assessment*, and priorities of the Advisory Council, this *Strategic Plan* is designed to address the overarching need to increase access to evidence-informed and best-practice services by empowering community organizations to reach residents who remain underserved or are disproportionately impacted by SUD, particularly related to opioids. For a more detailed description of the *Needs Assessment* findings, see Appendix C.

STRATEGIC PLAN

The New Jersey Opioid Recovery and Remediation Advisory Council Strategic Plan (Strategic Plan) is designed to guide the Advisory Council's funding recommendations over a five-year period, from 2025 through 2030. It focuses on the priorities that emerged from the Advisory Council's review and interpretation of the 2024 Needs Assessment findings. While many important needs emerged throughout the planning process, this Strategic Plan focuses on goals and strategies that Advisory Council members collectively agreed:

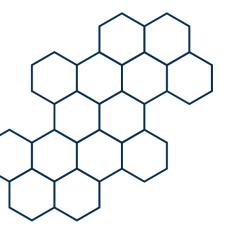
- are achievable by using finite settlement funds,
- do not duplicate existing efforts,
- are responsive to the needs of people with lived or living experience and/or address public feedback,
- reach a critical mass of those in need of services, and
- are supported by evidence and best practices.

Several additional recommendations and strategies identified in the *Needs Assessment* are not specifically addressed in this *Strategic Plan* because they are not achievable by using the finite settlement funds. They remain important and may be considered by other entities to pursue (Appendix D).

The *Strategic Plan* framework includes the vision, mission, guiding principles for funding recommendations, goals, strategic objectives, and strategies. It also includes a monitoring and evaluation framework that outlines how progress on the *Strategic Plan* can be tracked.

VISION

Individuals and communities will view substance use disorder as a health condition and those impacted by it will have equitable access to treatment and long-term support services that meet their basic needs, reduce harm, and foster recovery and wellbeing, ultimately reducing drug-related fatalities.



MISSION

The Advisory Council will provide data-driven and equity-focused recommendations for the allocation and distribution of opioid settlement funds in New Jersey. The Advisory Council will engage in the following ongoing activities to accomplish this mission.



TRANSPARENCY

The Advisory Council will use a systematic process to recommend how to allocate funds.



FEEDBACK

The Advisory Council will routinely gather, review, make public, and strongly consider input from relevant stakeholder groups with a focus on including individuals and families with lived and living experience.



DATA TRACKING & EVALUATION

The Advisory Council will continuously monitor historical, county-level, and statewide data to identify shifts in trends over time and track the impact of funded initiatives.



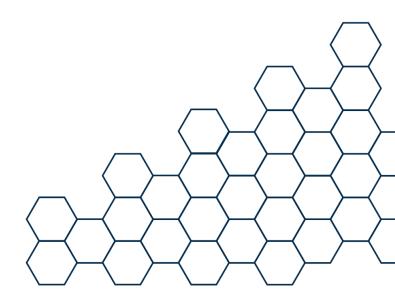
REFINEMENT

The Advisory Council will review and adjust the Strategic Plan in accordance with changes to available funding streams, drug supply, populations disproportionately affected, and available evidence.



COMMUNICATION

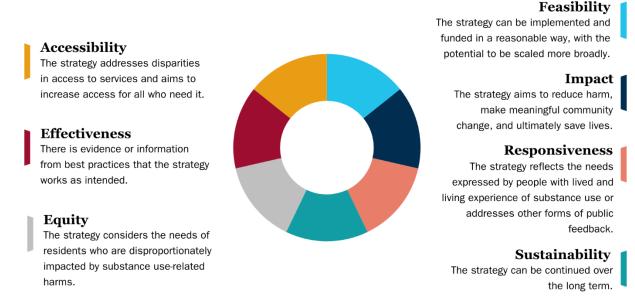
The Advisory Council will routinely share information about its activities and funding opportunities with public stakeholders via their established networks and listservs.



Guiding Principles for Funding Recommendations

The Advisory Council will rely on several criteria when reviewing proposals to make funding recommendations. The Advisory Council will use a set of criteria to identify and rank proposals that align with its mission and community needs (Figure 5). All guidelines should be considered but not all must be satisfied for the recommendation to be prioritized.

Figure 5. The Advisory Council uses seven guiding principles to inform their recommendations for using opioid settlement funds in New Jersey



To further aid in the prioritization of funding activities, the Advisory Council will look to its *Statement* on *Funding Recommendations* which outlines the values of the Advisory Council and articulates three types of activities that it will not recommend for funding.

The New Jersey Opioid Recovery and Remediation Advisory Council recognizes the devastating impacts and complex needs presented by the ongoing opioid crisis. In light of these challenges, the Advisory Council is choosing to pursue human-centered, community-driven, and evidence-based frameworks in our funding recommendations for these limited opioid abatement funds. The Advisory Council will continue to prioritize equity and utilize available data to ensure these funds reach communities that are experiencing higher rates of overdose, opioid use, or substance use.

The Advisory Council's primary focus is to support programs and initiatives that directly address the opioid crisis, such as prevention and education, harm reduction and overdose prevention, treatment, recovery services, and services strengthening social determinants of health. The Advisory Council believes that this approach will have the most significant impact in helping individuals and communities affected by the opioid crisis. As such, the Advisory Council will not recommend that funding be used for (i) activities or programs that are not evidence-based or promising practices for opioid abatement; (ii) non-Federal Drug Administration (FDA) authorized medications for the treatment of opioid use disorder or substance use disorder; (iii) purchases of equipment for law enforcement use in search and seizure, suspect apprehension, or

Four strategic goals identified by the Advisory Council as essential to accomplish the vision of the *Strategic Plan* will guide funding recommendations. The goals focus on increasing access among individuals and families affected by SUD to:



Each goal is defined by a corresponding strategic objective, which outlines the intended change (Figure 6). Each strategic objective is supported by evidence collected through the *Needs Assessment* informing this plan and described in peer-reviewed literature. Further, a list of strategies is presented to illustrate how each of the strategic objectives will be accomplished (see Appendix E for a list of example investment activities for each strategy). Progress measures will be used to track the strategic objectives and have been prioritized based on current availability of data (these are further explained in the Monitoring and Evaluation section).

The strategic objectives with corresponding supporting evidence, strategies, and progress measures are outlined below, providing a broad roadmap to guide the development of specific funding recommendations and future investments. Taken together, the strategic objective-strategy pairs are mutually reinforcing across goals. That is, investing in activities across all strategic objectives and doing so in integrated ways, is likely to make more progress in achieving the vision of the *Strategic Plan* than focusing on one strategic objective alone. Moreover, the concept of funding CBOs is woven into many strategies as they are uniquely positioned to reach those populations and geographic areas that are underserved and/or disproportionately impacted by SUD and the overdose crisis.

Figure 6. The Strategic Plan focuses on investing in 12 strategies across housing, harm reduction, treatment, and coordinated wraparound service goals and includes a set of indicators to measure progress

GOAL	STRATEGY	OUTPUT MEASURE	STATE-LEVEL INDICATOR
Safe, Stable, and Supportive Housing Increase the availability and accessibility of housing for individuals and families affected by substance use disorder (e.g., Housing First approaches)	Expand Housing First initiatives Expand affordable, supportive, and transitional and permanent housing models	 # of people placed in housing % of people placed in housing who access harm reduction, recovery, and wraparound support services # of housing units and vouchers made available 	Drug-related hospital visits (all drugs) Homelessness among those accessing treatment
Harm Reduction Services Increase access to harm reduction services for people who use substances	Distribute Harm Reduction supplies through community-based organizations Integrate Harm Reduction services into health care settings Train emergency services in harm reduction	# of Harm Reduction supplies distributed, by type and location # of health care organizations using protocols for Harm Reduction services delivery and referral # of staff trained, by location	MOUD prescriptions Naloxone distribution in communities Naloxone incidents
Treatment Services Increase access to treatment services for people who use substances	1. Conduct a treatment gap analysis 2. Expand evidence-based/best practice treatment services (medication for opioid use disorder (MOUD) and trauma- informed care) 3. Train facility staff in evidence-based/best practice treatment approaches	List of areas without accessibility to MOUD and/or Medicaid-accepting or state-funded treatment facilities # of facilities that offer MOUD, by county # of treatment facility staff trained, by location	New hepatitis C infections Overdose deaths Recovery support service participation
Coordinated Wraparound Services Improve the coordination of wraparound supports (e.g., transportation, legal services) provided to individuals and families affected by substance use	1. Enhance or expand transportation options 2. Develop guidelines for discharge planning 3. Expand peer specialist (PS) capacity to provide case management services 4. Expand family support groups and treatment programs	# of transports provided # of treatment facilities applying guidelines for connection to resources # of individuals with discharge plan # of PSs trained in case management # of new/expanded family support groups, by location	Substance use disorder among people experiencing homelessness Treatment admissions

Note: The monitoring and evaluation framework prioritizes the use of routinely collected grantee-specific output measures and publicly available state-level indicators. Additional outputs and indicators can be included (e.g., percent of individuals accessing harm reduction services who are experiencing homelessness, new injection-related HIV infections) as additional data are identified and made available. The monitoring and evaluation plan is intended to assess associated changes and broader outcomes to which investment activities may contribute and is not designed to estimate causal relationships.

GOAL: SAFE, STABLE, AND SUPPORTIVE HOUSING



Strategic Objective 1. Increase the availability and accessibility of housing for individuals and families affected by substance use disorder (e.g., Housing First)

Supporting Evidence

People experiencing homelessness (PEH) are cited by all key informants in the *Needs Assessment* as a priority population that is uniquely impacted by the opioid crisis. According to CDC's SUDORS Dashboard: Fatal Drug Overdose Data, overdose deaths for PEH in New Jersey increased from 5% in 2021 to 6% in 2022, an increase of approximately 20%.¹³ National estimates from the U.S. Department of Housing and Urban Development indicate that 17% of PEH in the U.S. had a SUD in 2023¹⁴ and in New Jersey, estimates from the Point-In-Time Count report approximately 19% of PEH had a SUD in 2024.¹⁵ Research suggests that PEH less frequently access lifesaving MOUD treatment options than their housed counterparts.¹⁶

Housing is a key lever essential for stability and long-term recovery and wellbeing. *Needs Assessment* findings and published literature highlight that the Housing First model is a critical and effective method to provide housing for New Jersey residents who use substances. This model does not have eligibility restrictions based on sobriety or treatment engagement. Instead, it adheres to the principle that housing is a basic need that must be met before other goals (e.g., employment, treatment) can be pursued. The Housing First model often offers optional wraparound support services (e.g., counseling, job services, MOUD options) that participants can access to the extent desired. Published results from systematic reviews and randomized controlled trials indicate that the Housing First model is cost-effective¹⁷ and increases participant access to psychiatric counseling and medication treatment for mental health or SUD.¹⁸

Needs Assessment findings also indicate that additional housing interventions are necessary to address unmet needs. Respondents with lived or living experience (i.e., focus group and public input portal respondents) reported that a continuum of housing options, including sober living options, be are beneficial, along with recovery housing that is not conditional on abstinence. These findings highlighted the importance of making a diversity of housing supports available to individuals across the continuum of treatment and recovery.



"I see the successes of what housing can do for somebody that was out on the streets, that was in active addiction, and have completely turned their life around. [They become] community advocates and promote recovery...And a lot of them, the clients say it's all because they had access to stable housing."

-Needs Assessment interview respondent



^b While *Needs* Assessment respondents voiced a need for sober-living arrangements, there is limited evidence about the effectiveness of this housing model for individuals who have lived or living experience with SU. Moreover, the Advisory Council has expressed concerns about the conditional nature of some sober living options available in New Jersey.

Strategies and Existing Funding Recommendations

- Expand Housing First initiatives for individuals and families affected by SUD without mandating abstinence or engagement of any services.
- 2. Expand access to affordable, supportive, and transitional and permanent housing models tailored to individuals across the continuum of recovery (e.g., sober-living, recovery housing, housing assistance programs, supportive housing).

EXISTING FUNDING RECOMMENDATIONS



- Housing Options for Individuals with Substance Use Disorder (February 2024)
- New Jersey Keeping Families Together (KFT) Expansion (February 2024)

Progress Measures

To assess progress on the investments made to advance safe, stable, and supportive housing, the following grantee-specific outputs and relevant state-level indicators may be monitored.



GRANTEE-SPECIFIC OUTPUTS

- Number of people placed in grant-supported housing
- Percent of people placed in housing who access HR, recovery, and wraparound support services
- Number of housing units and vouchers made available for residents living with a SUD





STATE-LEVEL INDICATORS

- Drug-related hospital visits (all drugs)
- MOUD prescriptions
- Overdose deaths
- Rate of homelessness among treatment engaged individuals
- SUD among PEH

GOAL: HARM REDUCTION SERVICES

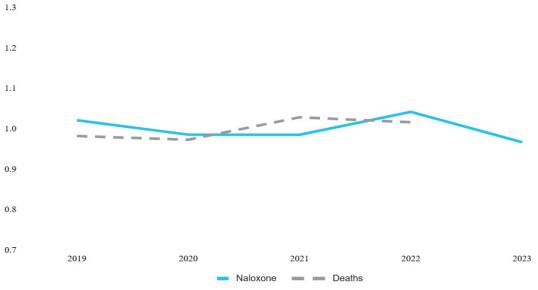


Strategic Objective 2. Increase access to HR services for people who use substances

Supporting Evidence

Findings from the *Needs* Assessment uniformly emphasize that the increased availability of naloxone has been one of New Jersey's most notable successes toward reducing the frequency of overdose deaths. This includes New Jersey's Naloxone 365 initiative that provides naloxone freely and anonymously through participating pharmacies as well as the Naloxone DIRECT program, which offers naloxone to eligible organizations for their distribution and administration. Trend analysis findings in the *Needs* Assessment reveal that small changes in naloxone incidents (i.e., naloxone administration by LE or EMS) correspond with small inverse changes in opioid overdose deaths from 2019 through 2022 (Figure 7). Although observational and limited, these data provide emerging evidence that increases in naloxone administration use may be a key contributing factor to the decline in overdose deaths in New Jersey. Naloxone is highly effective at reversing opioid overdoses and can be administered by civilians with minimal training. 19,20 *Needs* Assessment respondents called for continued investment in naloxone distribution and community-based training to specifically ensure access for populations disproportionately impacted by overdose deaths. These calls were confirmed by geospatial analysis in the *Needs* Assessment, which illustrated that naloxone incident rates are inconsistent across counties with similar overdose death rates.

Figure 7. From 2019 through 2022, small changes in normalized counts of naloxone incidents administered by LE and EMS correspond with small inverse changes in opioid overdose deaths



Note: Raw overdose count data retrieved from NJ SUDORS Overdose Mortality Data Explorer in May 2024 (https://www.nj.gov/health/populationhealth/opioid/sudors.shtml). Raw naloxone administration count data retrieved from New Jersey public Naloxone Data Dashboard (https://www.nj.gov/health/populationhealth/opioid/opioid_naloxone.shtml). Refer to these sites for continuously updated counts of overdose deaths and naloxone administrations. Opioid overdose death and naloxone incidents by LE and EMS were normalized by dividing the value for each year by the mean value across years. This figure is not designed to report specific counts, but rather, to display how the counts change over time consistent with other indicators in the Needs Assessment. This approach facilitates the comparison of rates across indicators. Data displayed in this figure includes only LE and EMS administered naloxone incidents. They are not inclusive of naloxone administrations from other public residents or sites.

In addition to naloxone distribution, HRCs, recovery centers, and grassroots agencies provide a wide range of HR services and supplies including HIV testing, sterile syringes and other safer use equipment, and fentanyl and xylazine test strips. Increasingly, treatment and recovery support agencies in New Jersey, including mobile units, are integrating HR supplies like fentanyl test strips and naloxone kits into their service delivery. According to key informants in the *Needs Assessment*, agencies providing HR services uniquely support individuals affected by SU by creating a welcoming and judgment-free environment where connections to care are made.

Needs Assessment key informants report that many people who could benefit from HR do not access the services due to the stigmatization of HR (i.e., the belief that cessation of all drug use is the only worthy goal, rather than HR which prioritizes health and wellbeing over abstinence). Training health care workers and emergency responders and integrating HR into those settings can help to normalize HR as routine health care for individuals affected by SU.^{21,22,23,24} Moreover, empowering trusted CBOs (i.e., via funds and technical assistance) can help resources reach communities that are disproportionately impacted and/or remain underserved.



"I believe that if we start working on the inside with the people, that we would get better results, because nobody cares [to ask] 'What happened to you?' 'Why are you here?' or anything like that. They just want to ship everybody off to treatment...If somebody feels welcome and treated with respect, then that kind of normalizes things, and then people don't have to be hiding or feeling shameful or guilty."

-Needs Assessment interview respondent



Strategies and Existing Funding Recommendations

- 1. Provide funding to CBOs and/or some local businesses (e.g., non-profits, barbershops, hair salons, faith-based organizations, corner stores) for distribution of HR supplies to populations and geographic areas of need. This may include capacity training or technical assistance to apply for and manage funding awards.
- 2. Integrate HR services into health care settings (e.g., Federally Qualified Health Centers, primary care, EMS). This may include, but is not limited to, integrating peer specialists (PSs) into the health care team.
- 3. **Invest in training and education efforts** for first responders, emergency departments, primary health care providers, and ancillary health care providers about HR services.

Progress Measures

To assess progress on the investments made to advance HR services, the following grantee-specific outputs and state-level indicators may be monitored.



GRANTEE-SPECIFIC OUTPUTS

- Number of HR supplies distributed, by type and location
- Number of health care organizations using protocols for HR service delivery and referral
- Number of emergency response staff trained in the use of HR approaches





STATE-LEVEL INDICATORS

- Naloxone distributed in New Jersey communities
- Naloxone incidents
- New hepatitis C infections
- Overdose deaths

GOAL: TREATMENT SERVICES



Strategic Objective 3. Increase access to treatment services for people who use substances

Supporting Evidence

Low-barrier MOUD treatment is cited among key informants in the *Needs Assessment* as another of the successful strategies New Jersey has implemented in the opioid crisis to preserve human life. *Needs Assessment* key informant and focus group respondents noted that low-barrier MOUD treatment can be easier to access than traditional clinical treatment (both inpatient and outpatient) by allowing virtual assessment and follow-up care, same-day treatment, flexible dosing and timelines, and no insurance requirements or lengthy paperwork. Moreover, it provides an alternative pathway to recovery outside traditional abstinence-only treatment models.

The evidence for MOUD effectiveness at reducing non-prescription opioid use and overdose is well established.^{25,26,27} However, *Needs* Assessment key informants report that there are still regions of New Jersey where access to MOUD treatment is limited, and this is at least partially due to stigma. Therefore, programs need to be strategically expanded to ensure the availability and accessibility of evidence-based and best practice-backed treatment models in every community across New Jersey.

In addition to MOUD treatment, *Needs Assessment* findings highlight that the availability of inpatient SU treatment services (e.g., treatment facilities) is limited for some individuals. Respondents engaged at the county and local levels report significant barriers to accessing available treatment including:

- wait times due to limited availability of beds at treatment facilities,
- requirements to have a valid form of identification,
- restrictions based on age (specifically for older adults and adolescents),
- restrictions based on co-occurring diagnoses or mental health status, and
- restrictions based on the types of substances used.

Findings also reveal that there are limitations to the quality of treatment currently available such as the short duration of treatment (i.e., not long enough for medically recommended OUD or SUD care), limited availability and quality of Medicaid-accepting treatment facilities (e.g., limited number of facilities that accept Medicaid and have availability, limited or no recreational activities available in the facility), and too often poor cultural competence and degrading treatment of patients (both due to and reinforcing of stigma).



"The criteria for getting into [treatment centers] varies from place to place. I had mentioned that I had suicidal ideations, so a lot of people right away just cut me off, said 'No', which makes no sense because the average person that suffers addiction is probably having those thoughts. So, I thought that was odd."

-Needs Assessment focus group respondent



Strategies and Existing Funding Recommendations

- 1. Improve surveillance of treatment gaps and needs, specifically related to MOUD, ages served (e.g., adolescents, older adults), and Medicaid reimbursement.
- 2. Expand the availability and accessibility (including hours of operation, availability of beds, and/or eligibility criteria) of evidence-based or best practice treatment services, including low-threshold MOUD and trauma-informed models of care, for populations and geographic areas in need. This may be based on the findings from surveillance of treatment gaps and needs (Strategy 1 above).
- 3. Invest in training treatment facility staff in best practice or evidence-based treatment approaches, including MOUD, cultural competence, and trauma-informed models of care.

EXISTING FUNDING



- Youth Substance Use Initiative Expansion (October 2024)
- Rapid Referral Platform for Low-Threshold Medication Access for OUD (February 2024)
- Mobile Medication for Addiction Treatment (MAT) Expansion (February 2024)

Progress Measures

To assess progress on the investments made to advance treatment services, the following grantee-specific outputs and state-level indicators may be monitored.



GRANTEE-SPECIFIC OUTPUTS

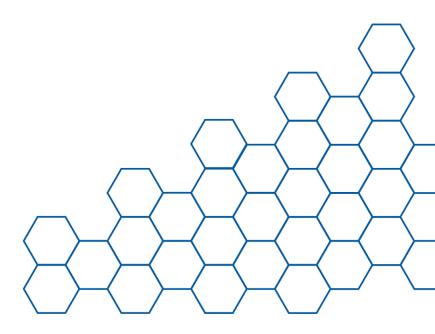
- List of areas without accessibility to MOUD and/or Medicaid-accepting or statefunded treatment facilities (based on assessment of treatment gaps)
- Number of facilities that offer MOUD and corresponding number of MOUD prescriptions by county (compared to areas with identified treatment gaps)
- Number of treatment facility staff trained in evidence-based best practice models of care





STATE-LEVEL INDICATORS

- MOUD prescriptions
- Overdose deaths
- Treatment admissions



GOAL: COORDINATED WRAPAROUND SERVICES



Strategic Objective 4. Improve the coordination of wraparound supports (e.g., transportation, food assistance, legal services) provided to individuals and families affected by substance use

Supporting Evidence

Many individuals and families affected by SU are also facing challenges meeting their basic needs. *Needs Assessment* findings highlight that making connections to support services at key points throughout the continuum of care (e.g., emergency response, HR, treatment, recovery) can strengthen their pathway to wellbeing and recovery.

Despite a desire to better coordinate services, *Needs Assessment* findings suggest that the agencies involved in service delivery across SU-related sectors (e.g., prevention, emergency response, HR, treatment, recovery) are siloed. When coordination across sectors has been successful (e.g., between LE and PSs), stigma^c around SU, addiction, HR, and MOUD is reduced; a continuum of care is established; and stakeholders benefit from the collaborative pursuit of a mutual goal. Respondents highlighted specific examples of cross-sector collaboration such as pairing emergency response coordination with recovery support services (e.g., PSs are deployed alongside first responders on overdose cases), establishing recovery courts in collaboration with Prosecutor's offices, providing recovery consult services with PSs for individuals in treatment, and providing help with discharge planning to individuals while in treatment (e.g., applications for food assistance, re-entry programs, housing, health insurance, legal aid) to facilitate continued progress upon discharge.

Findings also cited substantial needs for evidence-based and best practice wraparound support services related to transportation, activities that help people who use drugs bond with their family members, and peer-driven support in navigating the continuum of care. Reliable transportation increases continuous use of recovery services, 28 whole-family SU counseling improves family functioning and health outcomes, 29,30 and training of PSs prepares them to advocate for others navigating a complex network of resources. 31,32 PSs may be uniquely positioned to compassionately help people with lived or living experience navigate the continuum care in ways that meet individuals where they are and to reach historically underserved populations (e.g., non-Hispanic Black residents, young adults). 33

^c Needs Assessment respondents reported that the most universally problematic form of stigma is associated with the criminalization of addiction and the belief that addiction is a lifestyle choice as opposed to a chronic

with the criminalization of addiction and the belief that addiction is a lifestyle choice as opposed to a chronic disease. A secondary form of stigma is the belief that HR and MOUD are enabling factors that contribute to the rise of SU and the perpetuation of SUD.



"When we get out of [treatment], I don't know, for me, I don't have anybody. And, it's like I'm starting from scratch all over again. I just wish they helped you while you're [in treatment], try to get food stamps. I don't understand why they don't help you get food stamps while you're here... You go to re-entry [after], they should do the reentry while you're here. I don't get it."

-Needs Assessment focus group respondent



Strategies and Existing Funding Recommendations

- 1. Enhance or expand transportation options for individuals who use substances to reach a range of support services (e.g., legal services, food pantries) and access care at HRCs, recovery centers, and treatment providers.
- 2. Develop guidelines and provide support for treatment facilities and HRCs to integrate discharge planning into treatment. This may include partnering with PSs to facilitate the planning process and providing capacity-building support for facilities that do not currently have case management or navigation services. Guidelines should include housing, food assistance, legal services, transportation, job training, child care, and other basic needs.

EXISTING FUNDING RECOMMENDATIONS



- Legal Services for Individuals with SUD (October 2024)
- 3. Expand the capacity of PSs to provide case management services and connect agencies to improve the coordination of services across the continuum of care. This may include training and other efforts designed to bolster the case management workforce.

EXISTING FUNDING RECOMMENDATIONS



- Community Peer Recovery Center Expansion (February 2024)
- 4. Expand and sustain family support groups and whole-family treatment programs (e.g., family bonding activities). This may include funding a backbone agency to provide sub-awards to CBOs.

Progress Measures

To assess progress on the investments made to advance coordinated wraparound services, the following grantee-specific outputs and state-level indicators may be monitored.



GRANTEE-SPECIFIC OUTPUTS

- Number of transports provided to HRCs, treatment, recovery centers, support groups and other SU-related services
- Number of treatment facilities and HRCs following guidelines for connection to resources
- Number of individuals with discharge plan upon treatment exit
- Number of PSs trained in case management
- Number of people attending family support groups





STATE-LEVEL INDICATORS

- Overdose deaths
- Recovery support service participation
- Treatment admissions

MONITORING AND EVALUATION PLAN

The multi-component monitoring and evaluation framework is presented to inform the assessment of the scope and reach of the investments made using opioid settlement funds and to track progress on a set of statewide indicators linked to the goals of the *Strategic Plan*. The framework capitalizes on existing State infrastructure to monitor short-term grantee outputs and long-term state-level indicators in ways that require modest investment in evaluation and maximizes funding to direct services (Figure 8). For example, to the extent possible, state-level indicators rely on publicly available data that are already collected and reported as part of ongoing surveillance and tracking efforts. This design balances rigor, ethics, statewide context, and available resources. Due to the challenges with establishing causal relationships (e.g., resources, ethics), this design assesses associated changes and broader outcomes to which investment activities may contribute.

The monitoring and evaluation framework is broken into three components – grantee-specific outputs, program-specific outcomes, state-level long-term indicators – each with unique goals and suggested research questions, data sources, and analysis plans (Figure 8). Some investment may be necessary to collect and analyze data as well as report findings to inform progress. The actual evaluation design will reflect the specific programs funded as well as other context (e.g., funding, availability of data).

Grantee-Specific Monitoring and Evaluation: Scope and Reach

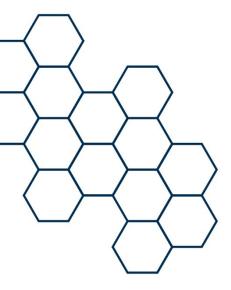
The first component of the framework focuses on **grantee-specific outputs** (i.e., units of services delivered) and processes.

- What: These outputs include those aligned with each goal of the Strategic Plan and typically include the units of service delivered, such as the number of people placed in housing and the number of naloxone kits distributed (i.e., grantee-specific outputs in each goal) (Figure 8). The grantee-specific outputs included in this plan are a starting point. Each output measure will be finalized by grant administrators and may include other information relevant to grant projects. Output data will be collected by grant administrators as part of routine reporting procedures.
- ➤ Why: Together, these outputs and related details provide a picture of the services delivered as a direct result of the settlement funds invested. Monitoring these grantee-specific outputs will inform the grantee-specific evaluation questions (Figure 8). This will allow the Advisory Council to evaluate the Strategic Plan in terms of how funding allocation is increasing access to evidence-based and best practice services, by type of service, for residents who remain underserved or are disproportionately impacted by SUD and the overdose crisis.
- ➤ How: Suggested grantee-specific evaluation questions will be informed by regularly submitted grantee reports (e.g., every six months). These data may include types of service and locations of service delivery. Additional demographic data from the U.S. Census will be used to describe the residents who reside in served areas. Together, these data will be used to calculate the percentage of services (by grantee and overall) that are provided in priority areas.
- Limitations: A limitation of this approach is that it relies on grantee-reported data. Grantee agencies, especially CBOs, are often limited in their capacity to collect, organize, and report data. Therefore, a goal of this monitoring component is to keep data collection simple and only request data that is needed to answer the key evaluation questions. This will ideally reduce the burden of data collection on grantee agencies while simultaneously increasing the quality of the data submitted and the proportion of funds to direct service.

Program-Specific Monitoring and Evaluation: Direct Outcomes

The second component of the framework focuses on the **implementation of specific programs or activities** funded with settlement investments.

- ➤ What: It will gather qualitative information from grantee agencies, beneficiaries, and State grant administrators to examine barriers and facilitators to implementing programs and document outcomes that are directly related to those programs.
- ➤ Why: Examining program-specific mechanisms and outcomes will provide the Advisory Council with greater insight as to how programs and services are meeting the needs of residents experiencing SUD-related harm and how effective programs can overcome salient obstacles to service delivery, especially for priority populations (Figure 8).
- ➤ How: To inform suggested program-specific evaluation questions, interviews and/or focus groups with grantee program directors and State grant administrators, at minimum, will be conducted every two years. Individuals who receive services from the program will be engaged in the evaluation to ensure that their perspectives and voices are heard. Interview/focus group responses will be analyzed for key themes within and across programs that focus on successes, limitations, and outcomes of the initiatives funded with settlement dollars.
- ➤ Limitations: A limitation of this approach is that the data gathered will be based on self-report from grantee program directors, beneficiaries, and State grant administrators. Also, while qualitative data facilitates the identification of grantee- and program-specific processes and outcomes, it has limited use toward determining causal effects. But, as is true with the other monitoring and evaluation components described in this section, estimating the causal effects of funded initiatives is not part of this evaluation plan.



State-Level Monitoring and Evaluation: Trends Over Time

The third component of the framework focuses on **state-level indicators**. It tracks 10 suggested key indicators cited in the *Needs Assessment* or in the published literature as being linked to the goals of the *Strategic Plan* (Figure 8).

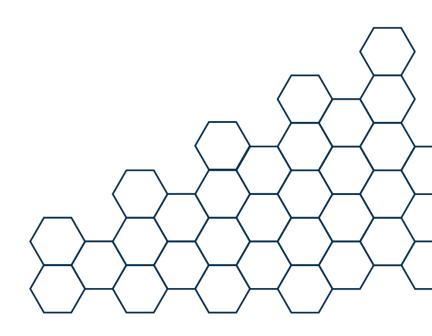
- ➤ What: State-level long-term indicators include drug-related hospital visits, homelessness among those accessing treatment, MOUD prescriptions, naloxone distribution in communities, naloxone incidents, new hepatitis C infections, overdose deaths, recovery support service participation, SUD among PEH, and treatment admissions. Together, these indicators provide a broad picture of trends related to SU in New Jersey (Appendix F).
- Why: Monitoring these indicators over time will inform the suggested statewide evaluation questions, which are designed to help the Advisory Council understand how disparities in indicators shift (Figure 8). This will facilitate the identification of priority populations and shape future funding recommendations.
- ➤ How: To inform the statewide evaluation questions, indicator data will be tracked each year for at least three years (at least three years are needed to examine changes in trends over time). These data will be disaggregated by county, race and ethnicity, age, and other demographic characteristics whenever possible. Additional data may be compiled to compare indicator data to population estimates. At the time of this plan, most of these indicator data are publicly available in New Jersey (e.g., on the New Jersey Overdose Data Dashboard and NJCARES websites). Collaboration and annual data sharing across the Departments of Human Services and Health may be necessary if additional details are needed.
- Limitations: A noteworthy limitation of this component of the evaluation and monitoring framework is that state-level indicators are influenced by multiple factors (e.g., other State initiatives designed to address the opioid crisis or related issues, drug supply, economic trends). Therefore, changes in these indicators cannot be attributed solely to Strategic Plan investments. Previous research indicates that the investments identified above can be expected to contribute to positive changes in state-level indicators, but assessing causality is beyond the scope of this monitoring plan.

Figure 8. The monitoring and evaluation framework is broken into three components – grantee-specific outputs, program-specific outcomes, state-level long-term indicators - each with unique goals and suggested research questions, data sources, and analysis plans

Suggested Evaluation Question	Analysis Method	Update Timing	Data Required	
Grantee-Specific Monitoring and Evaluation				
How many units of service were delivered, by strategic objective and type of service?	Review, compilation, and organization of grantee reports	Regularly (e.g., six months, varies by State agency administering program)	Units of services delivered, by type of service	
In what geographic areas and demographic	Organization of grantee reports by location	Annually	Units of services delivered, by location	
populations were services delivered?	Refer to U.S. Census data for population characteristics		American Community Survey (ACS) population data; U.S. Census block group level	
To what extent were services delivered in previously underserved geographic areas and for populations that are disproportionately	Identification of priority areas Calculation of the percent of	on of the percent of Annually y grantee, overall) that	Units of services delivered, by location	
impacted by the opioid crisis?	services (by grantee, overall) that were provided in priority areas		List of priority areas identified	
	Program-Specific Monitoring	and Evaluation		
To what extent are the services provided meeting the needs of participants, by strategic objective and type of service?	Qualitative analysis of interview data	Every two years	Transcript of interviews/focus groups with program directors, beneficiaries, and State grant administrators	
What are the key barriers to and facilitators of effective implementation of <i>Strategic Plan</i> strategies, by strategic objective and type of service?	Qualitative analysis of interview data	Every two years	Transcript of interviews/focus groups with program directors, beneficiaries, and State grant administrators	
What innovative strategies have worked to engage priority populations in service utilization, including PEH and communities of color?	Qualitative analysis of interview data	Every two years	Transcript of interviews/focus groups with program directors, beneficiaries, and State grant administrators	
To what extent were CBOs a) awarded opioid settlement funds, b) supported in grant	Review of grantee reports		Transcript of interviews /focus groups	
management, and c) satisfied with their grant experience?	Qualitative analysis of interview data	Every two years	with program directors, beneficiaries, and State grant administrators	

Evaluation Question	Analysis Method	Update Timing	Data Required	
State-Level Monitoring and Evaluation				
To what extent are desired changes in indicators observed over time?	Trend analysis	Annually	Indicator data for at least a 3-year period	
To what extent are there differences in rates of change by county, race/ethnicity, and age?	Trend analysis by subgroup	Annually	Indicator data for at least a 3-year period; broken down by county, race/ethnicity, and age	
To what extent are some subgroups disproportionately impacted by SUD?	Comparison of population- adjusted indicator statistics	Annually	Indicator data for the most recent year available; broken down by race/ethnicity and age	
. , , , , , , , , , , , , , , , , , , ,			ACS population data; state and county levels	

Note: Observed changes in indicators cannot be attributed solely to Strategic Plan investments. This design assesses associated changes and broader indicators to which investment activities may contribute.



NEXT STEPS

This Strategic Plan serves as a roadmap for investing New Jersey opioid settlement funds through 2030. The goals, strategic objectives, strategies, and other components are responsive to the findings of the 2024 Needs Assessment and public input, aligned with evidence-based and best practice information, and designed to save lives and improve the health and wellbeing of individuals and families affected by SUD and the overdose crisis. The following key recommendations aim to maintain the plan's effectiveness, responsiveness, and adaptability over time.

Ongoing Review of the Strategic Plan

This *Strategic Plan* is a dynamic, living document that requires regular review to assess its effectiveness and alignment with the evolving needs of New Jersey and the communities affected by SUD. Changes in health care, mental health, and substance use funding and policies may necessitate adjustments. Annual review of the plan will be necessary with a focus on the following elements.

- Monitoring progress toward the goals and strategic objectives outlined in the plan. This may
 include updating state-level indicator data annually, summarizing grantee-specific outputs,
 and reviewing trends over time.
- Identifying areas for improvement and ensuring that resources are being allocated efficiently
 and effectively. This information could be provided in the form of annual financial and progress
 reports using the data collected from grantees.
- Adapting the plan based on the latest evidence, public input, available funding and other resources, and context.

By 2030, a new strategic planning cycle should be completed to update the goals and strategies. This process should begin no later than 2029 and include a review of relevant data, solicitation of public input, assessment of progress made during the five-year implementation of this *Strategic Plan*, and generation of a new plan.

Funding Investment Decisions

The purpose of the *Strategic Plan* is to guide the Advisory Council in making recommendations for investment activities through 2030. When deliberating on investment activities, the following processes should be followed.

• Ensure that investment activities generally fall within the goals, strategic objectives, and strategies in this Strategic Plan. A relationship between the activity and how it will contribute to the strategic objective should be clear. Investment activities also should align with the approved uses of settlement funding.

- Consider the statement on and apply the guiding principles for funding recommendations when recommending activities for investment. While not all principles must be satisfied, they should be considered. Similar to the process used to develop the February 2024 spending recommendations, the Advisory Council may use a process whereby it rates potential investment activities against each of these principles (e.g., on a scale of one to five, with one being "does not address the principle at all" and five being "completely meets the principle"). The sum of Advisory Council member ratings may then be used to help prioritize and select investments.
- Invest in activities across all goals and strategies of the *Strategic Plan*. This *Strategic Plan* includes mutually reinforcing strategies so that investing in activities across all strategic objectives in integrated ways is likely to make more progress in achieving the vision of the *Strategic Plan* than focusing on one strategic objective alone. Consider whether certain investments are necessary to make before others and when existing investments could be expanded upon to integrate strategy implementation.
- Invest in activities that continue for multiple years (e.g., three years or more) to allow time for startup activities and offer longer-term and more stable services in communities.
- Establish and maintain mechanisms for tracking the distribution of settlement funds, particularly in underserved populations. Track investments based on Strategic Plan goals and strategies to encourage alignment with and use of the plan. Integrate progress tracking of grantee-specific outputs, program-specific outcomes, and state-level outcomes to provide a comprehensive picture of Strategic Plan implementation and outcomes. Make future funding decisions informed by findings of monitoring and evaluations.
- Collaborate with stakeholders outside of the Advisory Council to encourage implementation of strategies and activities that are not included in this Strategic Plan (Appendix D).

Public Involvement

Engaging stakeholders—including service providers, CBOs, and individuals affected by SUD—throughout the lifespan of this *Strategic Plan* will ensure the investments remain relevant, responsive, and effective. This collaborative approach can provide valuable input and feedback that informs decision-making and future funding priorities. Feedback from the public should be solicited no less than annually through the public input portal, public listening sessions, roundtable discussions, or similar mechanisms to assess the needs and gaps in New Jersey related to SU prevention, HR, treatment, and recovery.

Conclusion

The New Jersey Opioid Recovery and Remediation Advisory Council Strategic Plan is a tool to guide the Advisory Council in making recommendations about how to use funds from the opioid settlement over the next five years and beyond. It is shaped by the expertise and lived or living experiences of the Advisory Council, New Jersey stakeholders working in SU-related fields, and individuals directly impacted by SUD. It is rooted in the vision that SUD is a health condition and fatalities may be reduced when equitable access to treatment and long-term support services meet people's basic needs, reduce harm, and foster wellbeing and recovery. Over the coming years, the Advisory Council will continue in its mission to provide data-driven and equity-focused recommendations for the allocation and distribution of opioid settlement funds in New Jersey related to housing, HR, treatment, and coordinated wraparound services for SUD.



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NEW JERSEY

OPIOID RECOVERY & REMEDIATION ADVISORY COUNCIL

STRATEGIC PLAN

APPENDICES

SPRING 2025



APPENDICES

Appendix A: Strategic Planning Process and Methods

Appendix B: Needs Assessment Findings (Phase 1)

Appendix C: Overview of Strategies Not Addressed by the Strategic Plan

Appendix D: Example Activities by Strategic Plan Strategy

Appendix E: Summary of State-Level Indicators



APPENDIX A: STRATEGIC PLANNING PROCESS AND METHODS

The two-phase process to facilitate the development of the Strategic Plan was collaborative and iterative.

During Phase 1 (January 2024 through September 2024), the Advisory Council directed the collection and synthesis of information to conduct a *Needs Assessment*. This *Needs Assessment* identified the needs, resources, and gaps identified from existing data and materials, stakeholder interviews, and focus groups with individuals or their families with lived and living experience of substance use (SU).

During Phase 2 (September 2024 through March 2025), the Advisory Council interpreted the *Needs Assessment* findings and refined and prioritized goals and strategic objectives. This phase consisted of co-interpretation, priority setting, and specification, and culminated in the development of the final *Strategic Plan*.

The following sections describe in detail the Phase 1 Needs Assessment process (see Appendix C for the findings) and the Phase 2 co-interpretation and revision process toward this final Strategic Plan.

Phase 1

To generate a comprehensive picture of the current state of the opioid crisis in New Jersey, the Advisory Council first needed to assess the needs, resources, and gaps in New Jersey. With direction from the Advisory Council, the Center for Research and Evaluation on Education and Human Services (CREEHS) at Montclair State University gathered existing data from a variety of sources (e.g., New Jersey Overdose Data Dashboard, U.S. Census Bureau, and state administrative databases) along with primary data via interviews and focus groups with relevant stakeholders. Along the way, CREEHS gathered input from Advisory Council members regarding the data sources to include, the information to gather from stakeholders, and the findings from the *Needs* Assessment to prioritize in decision making. The following sub-sections describe the core Phase 1 activities.

Advisory Council Engagement

CREEHS facilitated discussions for Advisory Council members to collectively set goals about what information should be gathered to inform the *Strategic Plan*, how data should be gathered, and from whom it should be gathered (March, April, and May 2024). This included soliciting feedback on the secondary data indicators to be compiled, the perspectives and voices to be heard through primary data collection, and the gaps to be explored through data analysis. It also included inviting feedback on data collection instruments from, and providing progress updates to, the Advisory Council.

Figures B-1 and B-2 present information gathered from Advisory Council Members during Phase 1 that guided the data collection efforts for the *Needs Assessment*.

Figure B-1. Information Needs for Future Decision-Making – Summary of Advisory Council Feedback

"Fast forward six months from now...you are working through the *Strategic Plan* priorities, what information (e.g., assets, needs, tools) do you want to have on hand?

What questions will you want answers to?"

Information Needs for Future Decision-Making



What information do you want to have?

- Data illustrating the need, demand for services, and availability of services that are in demand, in an at-a-glance format (e.g., dashboard) or mapping tool
- A system for monitoring and evaluating the outcomes of investments, which may include a standardized set of outcomes or a quality framework
- Monitoring and outcome measures used by philanthropic organizations or others
- The processes used, strategies funded, and outcomes of activities supported by other states using settlement funding

What questions will you want answers to?

- Clear definitions of key terms used in planning, decision-making, and monitoring of funded initiatives (e.g., "evidence-based," "best practices")
- Geographic hot spots of needs and gaps in services
- · Special population groups
- How the needs and gaps in services align with the original "buckets" and funded "buckets"
- Details about what and how services are already being delivered (e.g., activities, service delivery, outcomes)
- Information on what is being experienced and what "success" looks like for PWLE and CBOs
- Progress made on and any outcomes available from the first set of funding recommendations

Note: "PWLE" was used to reflect people with lived or living experience.

Figure B-2. Key Informant Interviews and Focus Groups - Summary of Advisory Council Feedback

"What information would you like to be collected via interviews with stakeholders and focus groups with individuals with lived experience? Whose voice is critical to have?"

Key Informant Interviews

Whose voices do we need to hear?

Trusted people in the community:

- Barbershops
- Pharmacies
- · Bodegas selling paraphernalia
- · School personnel or educators
- · Faith-based organizations

Frontline staff/practitioners:

- · EMS and ER staff
- Program administrators in opioid spaces/agencies
- · Staff at harm reduction centers
- Small nonprofits

What information do we want to collect?

- Understanding the perceptions, gaps, and needs of patrons, clients, and community members
- Understanding the gaps, needs, and opportunities of nonprofits and businesses that may be potential OSF grantees
- Specific activities and efforts happening throughout the state
- School-based prevention strategies/programs and referral systems
- How people are accessing information about the Council's activities as well as their perceptions of these activities
- · Variation and gaps across counties and municipalities
- Best practices for sharing information with community members, organizations, and across multiple sectors as well as potential gaps in where and how individuals are informed/engaged

Focus Groups

Whose voices do we need to hear?

Parents, caregivers, or family members:

- · Have loved ones with SUDs
- · Lost children to overdose

Incarcerated people:

- · Began using while incarcerated
- Had SUDs prior to being incarcerated

Homeless individuals with SUDs

Youth voices:

- · With SUDs in recovery
- Not yet in treatment or services

Unengaged people (not in portal or "less connected")

People across the spectrum of service experience:

- At different stages of "recovery"
- Not ready to be engaged
- Engaged in different types of services (e.g., visiting harm reduction centers)
- At some early stage of recovery
- People re-entering treatment
- Special populations (e.g., institutionalized populations)

What information do we want to collect?

- Life experiences and pathways leading to SUDs
- Experiences with resources and services
- Access to wrap-around services, transportation, child care access, and healthy foods
- Perceptions of safe spaces for vulnerable populations
- How people are accessing information about the Council's activities as well as their perceptions of these activities

Secondary Data Collection and Analysis

Secondary, or existing, data sources were identified and recommended by DHS, members of the Advisory Council, and via independent searches conducted by CREEHS. The types of existing data CREEHS collected and analyzed as part of the *Needs Assessment* included the following.

- Indicator data: State and county-level indicator data including but not limited to overdose
 deaths, naloxone incidents, treatment admissions, and childhood outcomes (e.g., substanceaffected newborns, children entering care due to parental SU).
- Demographic data: U.S. Census block group-level data on population characteristics including but not limited to poverty, racial and ethnic composition, and housing cost burden.
- Resource inventory data: Locations of Harm Reduction Centers (HRCs), treatment facilities, naloxone-dispensing pharmacies, homeless shelters, and publicly accessible food pantries, among others.
- Public perceptions: Public comments (more than 500 submissions from providers, academic
 experts, individuals in recovery, loves ones, family members or friends or someone with or in
 recovery from a substance use disorder (SUD), and others, including 13 people who disclosed
 active SU), public listening sessions (five sessions with a total of 67 individuals submitted
 testimony), and observation of a roundtable discussion with five individuals sharing the
 perspective of family members with a loved one who used drugs.
- Published documents: Peer-reviewed literature and other states' settlement funding plans.

Each data source identified was examined and subsequently selected for inclusion based on a set of criteria. Data were included in the Phase I analysis if they met at least one of the following criteria:

- The data centers the voices of those with lived and living experience (e.g., public perception data).
- The data are from verifiable state or federal sources (e.g., U.S. Census).
- The data are available at the county level, if not more granular when possible (i.e., for the geospatial exploration of indicator, demographic, and program inventory data).
- The data are available for at least three consecutive years where the most recent year is 2022 or after (i.e., for historical trend analysis).

Data were reviewed and compiled during the period of February through July 2024. Figure B-3 presents the data used in the Phase 1 analysis and Figure B-4 presents data that were considered but not included in the Phase 1 analysis.

Figure B-3. Secondary Quantitative Data Used in Phase I Map and Analyses^a

Data Source	Variables/Indicators	Years of Data Included	Reason for Inclusion/Prioritization	
Indicator Data				
DOH - Overdose Data Dashboard (by email request)	Overdose deaths (all and opioid-specific, ageadjusted, disaggregated by age group)*	2020-2022		
	Overdose deaths (all and opioid-specific, raceadjusted)	2019-2022	Available at the county level, by race/ethnicity, and for a recent historical period by age	
<u>DOH - Overdose Data Dashboard</u> (from website)	Hospital visits (all and opioid-specific)	2019-2022		
	Naloxone incidents	2019-2023		
	Overdose deaths among persons with a mental health diagnosis	2020-2022	- Available at the state- level for a recent - historical period	
CDC - SUDORS Overdose Death	Overdose deaths among persons who had at least one prior overdose	2020-2022		
<u>Circumstances Data</u> (from website)	Overdose deaths among persons recently released from institutional setting	2020-2022		
	Overdose deaths among persons experiencing homelessness or housing instability	2020-2022		
	Number of drug Overdose deaths among persons currently being treated for pain	2020-2022		
DHS - NJ Substance Abuse Monitoring System (from website)	Treatment admissions (all and opioid-specific)	2019-2023		
DOH - NJ State Health Assessment Data (NJSHAD) (from website)	New Hepatitis B & C infections	2019-2022	Available at the county level and for a recent historical period	
DOH - NJ Prescription Monitoring Program (from website)	Opioid prescriptions	2019-2023		
NJ Office of Drug Monitoring & Analysis Program (by email request)	Drug related arrests*	2019-2023		
DCF (by email request)	Children entering care due to parental SU*	2019-2023	_	
Doi (by email request)	Substance affected newborns*	2019-2023		
NJDHS - NJ Middle School Risk and Protective Survey (by email request)	Youth reporting past year SU (marijuana or alcohol)	2021, 2023	Available at the county level and for recent period	
Population Demographic Data				
	Percent below 185% of poverty	2022	Available at the U.S. Census block group level and for recent period	
	Percent unemployed	2022		
U.S. Census - American Community	Percent without a car	2022		
Survey 2022 5-Year Estimates	Percent housing cost burdened	2022		
(ACS, from website)	Percent of housing units non-seasonally vacant	2022		
	Percent Black	2022		
	Percent Hispanic	2022		
NJ Economic Development Authority (from website)	Food Desert Factor Score (adjusted for 2022 LSA status)	2021		

^a CREEHS accessed these data between March 1, 2024 and July 31, 2024. Please see the original data source website link for indicator definitions, inclusion and exclusion criteria, and limitations.

Data Source	Variables/Indicators	Years of Data Included	Reason for Inclusion/Prioritization
NJ Department of Environmental Protection (from website)	Area designations (minority, poverty, and limited English)	2022	Available at the township level and for recent period
Program/Resource Location Data			
Substance Abuse and Mental Health Services Administration - FindTreatment.gov (from website) Vital Strategies (by email request)	Treatment facilities (comprehensive list)	2024	
NJDHS (by email request)	Naloxone pharmacies	2024	
NJDOH (by email request)	Harm reduction centers	2024	
NJ Department of Community Affairs (by email request)	Homeless shelters	2024	
The Food Bank of NJ (by email request) Community Food Bank of NJ	-		Available at the location level and for
(by email request)			recent period
NORWESCAP Food Bank (from website)	-		
Mercer Street Friends (from website)	Food Pantries*	2024	
Fulfill Food Bank: Monmouth County Food Pantries (from website)	-		
Fulfill Food Bank: Ocean County Food Pantries (from website)	-		
NJDHS (from website)	County boards of social services	2024	

^{*} Non-publicly available data requested by email from data owners.

Figure B-4. Secondary Quantitative Data Examined and Excluded from Phase 1 Analysis

Data Source	Variables/Indicators	Reason for Exclusion	
County-Level Indicator Data			
NJDOH - NJSHAD	Number of new HIV infections	Most recent data available is for 2021	
AG - NJCARES	Naloxone incidents	Most recent data available is for 2021 and not available by race/ethnicity (Overdose Data Dashboard prioritized)	
NJ Office of the Chief State Medical Examiner	Overdose deaths	Counts are suspected deaths (Overdose Data Dashboard prioritized)	
NJ Department of Education (DOE) - Annual Reports: Student Safety Data System	School reported SU incidents	At state level only and historical patterns are erratic (likely due to COVID)	
CDC Naloxone Dispensing Rate Map	Naloxone dispensing rate	At state level only (Overdose Data Dashboard prioritized)	
DOSE Dashboard: Nonfatal Overdose Syndromic Surveillance Data	Overdoses	Suspected overdose rates (Overdose Data Dashboard prioritized)	
National Survey on Drug Use and Health (NSDUH)	Substance use rates	Most recent data available is for 2021	
DOE - NJ Student Health Survey	Substance use rates	Most recent data available is for 2021	
NJ Office of Drug Monitoring &	Recidivism	No baseline data for those who complete diversion	
Analysis	Drug seizures	Data not reported consistently across counties	
NJ DMHAS Licensed Facility List	Treatment facilities (reduced list)	Data from June 2022, with comprehensive details, but a small number of facilities	
NJ Transit (NJGIN Open Data)	Bus and Rail Stops and Routes	Data from 2023, did not include for parsimony	

Select quantitative data were transformed for analysis to enhance interpretability. Specifically:

- Historical data values were normalized to examine changes in indicator counts over time.
 Indicators were normalized by dividing the value for each year by the mean value across years.
 This approach facilitates the comparison of rates across indicators from multiple sources and demographic subgroups. It is not used to present specific rate estimates.
- County-level indicator data are presented so that values represent counts per ten thousand residents (according to ACS 2022 5-year estimates). For indicators with data available by race, the values represent counts per 10,000 residents relative to the size of the race-specific population (e.g., number of overdose deaths among Black residents per ten thousand Black residents).

Secondary data were analyzed qualitatively and quantitatively. Public perception data—which capture a wide range of stakeholder perspectives including those of people with lived and living experience of SUD, engaged community members, and agencies leading SU-related work—were analyzed qualitatively to identify salient themes. Indicator, demographic, and resource data were analyzed quantitatively to examine historical trends and across-county variation.

CREEHS also explored the indicator, demographic, and resource data geospatially using geographical information systems (GIS). Two maps were developed to combine previously separate public data sets in order to catalyze discussion about the distribution, availability, and accessibility of SUD-related services relative to SU-related indicators. They are designed to inform program development and not designed for epidemiological or tracking purposes. A multi-layered interactive GIS map was developed to present the geographic distribution of resources, SU-related indicators, and population

characteristics (sample screenshot in Figure B-5). Additionally, a more static GIS story map was compiled with specific combinations of layers to inform guiding questions (sample screenshot in Figure B-6). These maps include only publicly available data and are accessible to the Advisory Council for ongoing use and updating.

Figure B-5. Interactive GIS map of indicators, population characteristics, and resources

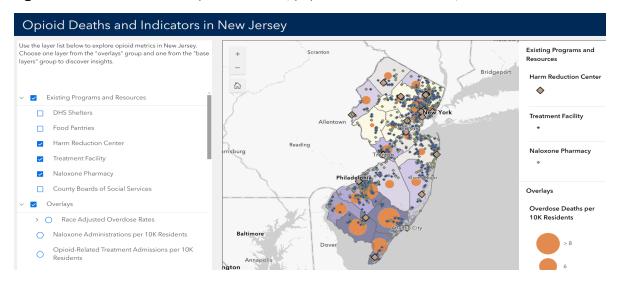
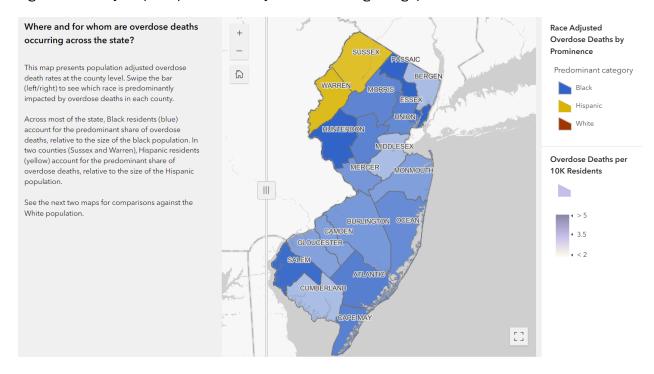


Figure B-6. Story map of specific data layers to address guiding questions



Primary Data Collection and Analysis

A priority for the Phase I data collection and analysis was to gather perspectives from each member of the Advisory Council (including ex officio members), individuals with lived or living experience of SUD, and other key informants. Human Services and the Advisory Council informed a list of perspectives, potential individuals, and agencies to recruit for key informant interviews and focus

groups sites (see Appendix C). This list served as a guide for recruitment, and CREEHS selected a subset of nominees that represented perspectives across regions of the state (i.e., north, central, and south), role on the continuum of care (e.g., prevention, emergency response, harm reduction [HR], treatment, and recovery), and type of organization (e.g., non-profit, HRC, front-line response, recovery support service, community-based, government).

In total, CREEHS invited:

- 14 Advisory Council members, 10 of whom completed an interview
- 28 key informants, 16 of whom (from 13 agencies) completed an interview and include representatives from:
 - o Northern, central, and southern regions of New Jersey
 - All sectors of the continuum of care including prevention, emergency response, HR, treatment, and recovery
 - Multiple agency types including HRC, local non-profit service providers working with school-aged populations, and faith-based organizations
- Eight focus group sites, four of which hosted at least one focus group (five focus groups total) representing the voices of 41 individuals with lived and living experience and families of youth with SUD:
 - Inpatient treatment center (two focus groups with individuals in SUD treatment, including individuals newly engaged in treatment, individuals re-entering treatment, those with an incarceration history, and pregnant and parenting people)
 - Outpatient medication for opioid use disorder (MOUD) center (one focus group with individuals in SUD treatment and those re-entering treatment)
 - Recovery high school (one focus group with parents of students with SUD)
 - Recovery center (one focus group with peer specialists working with individuals with living experience and not engaged in treatment)

A sixth focus group, located at an HRC, was attempted to engage people with living experience who are not engaged in treatment. Hearing the perspectives of this population was a priority for the Advisory Council (Figure B-2). Unfortunately, this focus group was not completed because of scheduling difficulties and the short timeline for data collection. To mitigate this limitation, additional recruitment efforts were made to engage HRC frontline staff and peer specialists working with individuals not engaged in treatment in data collection. This is a limitation to this process and the Advisory Council is committed to identifying future opportunities (e.g., focus groups, roundtable discussions) to engage with individuals with living experience that interact with HRCs.

Interview and focus group questions were reviewed by the Advisory Council. The questions varied by stakeholder group, but all interviews were designed to collect information about a) the strengths and weaknesses of New Jersey's opioid response, b) gaps in the services provided and barriers to accessing available services, and c) strategies for information sharing and accessing hard-to-reach populations. Respondents were specifically asked not to share personal experience with SU, but rather, asked about how to address SU for all people in New Jersey.

Interviews and focus groups lasted approximately 60 to 90 minutes each, were conducted both in person and virtually, were conducted primarily in English (though also offered in Spanish), and audio recorded with participant consent. Focus group participants were offered compensation in the form of generic gift cards for sharing their valuable perspectives as were hosting agencies for supporting focus group recruitment efforts and providing space to conduct the focus groups.

Interview and focus group transcription, coding, and analysis occurred on a rolling basis as interviews and focus groups were conducted. Once an interview or focus group was completed, the audio recording was sent to a third-party transcription service and returned to CREEHS for verification and analysis. Each interview was coded by the CREEHS research team for salient themes and to identify specific recommendations regarding effective strategies, avenues of communication, barriers to access and gaps in services, and existing programs poised for expansion.

The Montclair State University Institutional Review Board provided oversight for the protection and ethical treatment of individuals participating in data collection.

Synthesis of Findings Across Data Sources

Each of the primary and secondary data sources was analyzed independently to identify key themes and then synthesized, first across sources within a category, and then across categories, to identify consistencies across all data sources. For example, public comments were analyzed independently, synthesized across all public perception data, and then key findings from the public perception data were synthesized with the key findings from the secondary indicator data, published documents, and primary data (Figure B-7).

Once all findings were synthesized within and across data categories, a set of consistent themes emerged from the data. These salient themes were used to identify a set of distilled and commonly agreed upon overarching goals to inform the *Strategic Plan*. Corresponding recommendations and example strategies that address key barriers and facilitators of effective service delivery were then developed based on the public perception and primary data analysis.

Figure B-7. Phase I Data Synthesis Workflow

Public Comments	Public Perception				
Listening Sessions	Themes				Strategy #1a
Round Table Discussions	THEITIES			Recommendation #1	Strategy #1b
State Historical Data Findings	Secondary Indicator				Strategy #1c
County Data Findings	Secondary Indicator Themes Published Document	Key Findings	Goals	Recommendation #2	Strategy #2a
Geographic Analysis Findings		Across Data			Strategy #2b
Effectiveness Literature		Sources			Strategy #2c
Other State Plans	Themes				Strategy #3a
Focus Group Themes	Primary Data Themes			Recommendation #3	Strategy #3b
Key Informant Interview Themes					Strategy #3c
OAC Interview Themes					

The resulting *Needs Assessment* was submitted to the Advisory Council for review in September 2024 and further refined toward the development of the final *Strategic Plan* in Phase 2.

Strengths and Limitations

The approach used in Phase I to gather, analyze, and synthesize the data incorporated a wide array of stakeholder perspectives; captured multiple years of indicator data; and used mixed methods to collect, analyze, and synthesize the data. However, any data-informed approach has limitations linked to the availability of data and stakeholders.

One key limitation of the data collected is that there was limited information accessible about the SUD resources that are currently available in New Jersey. Specifically, CREEHS was able to compile a list of treatment facilities by querying federal, administrative, and privately-developed databases (e.g., SAMHSA and Vital Strategies). However, details about funding sources, measures of accessibility (e.g., hours of operation, insurance accepted, entry requirements), and the specific services delivered (e.g., residential, outpatient, MOUD) were incomplete. Existing lists also sometimes contradicted each other. Moreover, comprehensive lists of existing SU prevention and SUD recovery programs in New Jersey (and their locations) are not available. Compiling a full list of all SUD-related resources, organized by program type, and with complete details about program offerings and funding sources will require a coordinated effort across state agencies and counties and ongoing management and upkeep to stay up-to-date.

A second limitation of the current approach is that overdose death rates (and related indicators) were made available only at the state and county level for this analysis. Although examining overdose deaths at the county level reveals important patterns, much within-county variation exists and is obscured by county-level analysis. Moving forward, Human Services and the Advisory Council may continue to explore the possibility of accessing more localized overdose death data to enhance the geographic analysis of resource gaps.

A third limitation is that indicator data is pulled from multiple sources that have different reporting timelines, definitions, scales, and data formats (e.g., raw counts, rates, and population-adjusted rates). To address this issue, counts were normalized so that Advisory Council members could visually examine layered changes in multiple indicators over a common time period (2020 through 2022). This was designed to help describe general trends in SU-related indicators happening simultaneously. It does not present specific estimates of those indicators.

A fourth limitation is that data on naloxone incidents are from emergency response (i.e., law enforcement or emergency medical services) only. With the expansion of free naloxone distribution programs in New Jersey, it is expected that many more naloxone incidents, administered by those other than law enforcement or emergency medical services, are occurring than are being counted. Examination of the relationship between overdose deaths and naloxone incidents would be improved if all (i.e., including community-based) naloxone incidents were reported. One alternative would be to include data on naloxone distribution rates from all participating pharmacies and other organizations (e.g., HR programs).

A fifth limitation of the data collected is that the focus group with people with living experience who are not engaged in treatment (i.e., at the HRC) was not completed. This unfortunate gap limits the inclusion of the unique experiences and perspectives of those who are using substances and not currently engaged in treatment. While 13 individuals who submitted public comments reported that currently use substances and efforts were taken to recruit frontline staff who work with these individuals via HR, future efforts are needed to more directly hear the experiences and perspectives of people who currently use substances without treatment engagement.

Phase 2

Phase 2 of the planning process involved narrowing the *Needs Assessment* (drafted in Phase 1) to focus on the priorities identified by the Advisory Council as being impactful and attainable using opioid settlement funds. Throughout the process, CREEHS facilitated discussions among the Advisory Council members to a) co-interpret findings from the *Needs Assessment*, b) prioritize strategic objectives and strategies for the final *Strategic Plan*, c) further refine and specify the vision, mission, guiding principles, and components of the *Strategic Plan*, and d) finalize the plan and develop a monitoring and evaluation plan. The *Strategic Plan* was continuously revised in response to Advisory Council feedback and multiple iterations of the content were presented. Advisory Council members were invited to provide feedback on every portion of the *Strategic Plan* including the vision, mission, and guiding principles, the goals and strategic objectives, and the monitoring and evaluation plan.

The following subsections describe the ways in which the Advisory Council prioritized the content for and guided the development of the final *Strategic Plan* during Phase 2.

Co-Interpretation

The Advisory Council met virtually to review, discuss, and collectively co-interpret the results of the *Needs Assessment* (September 2024). A formal presentation described the methods used; outlined the key findings from the *Needs Assessment*; and presented a list of potential guiding principles, goals, strategic objectives (initially named as priority areas), and strategies that emerged from the *Needs Assessment* results. Advisory Council members then discussed the findings, clarified details, and worked together to refine the guiding principles. Following the meeting, Advisory Council members received a set of questions to facilitate a more detailed independent review of the *Needs Assessment*.

Priority Setting

A series of activities were conducted to prioritize the goals, strategic objectives, and strategies to be included in the *Strategic Plan* (October 2024).

• In-Person Meeting: The Advisory Council participated in an extended in-person meeting to rank strategic objectives and strategies. Interactive strategies and discussion prompts engaged members in meaningful conversations designed to build consensus about concepts, expectations, and overall goals of the Strategic Plan.

To prioritize strategic objectives, Advisory Council members first defined what was "out of scope" for the *Strategic Plan* and defined what would make a strategic objective or strategy "important" to fund. Using these criteria, members individually identified strategic objectives (or specific strategies) that were deemed "out of scope" and then ranked the strategic objectives based on the agreed upon definition of "importance". At the end of the activity, a set of five strategic objectives emerged as priorities that were in-scope for the *Strategic Plan* and were most frequently ranked as important.

Advisory Council members then participated in a breakout discussion around one of the five prioritized strategic objectives. Members considered what specific strategies could be implemented to address the strategic objective using a Strengths, Weaknesses, Opportunities, and Threats (SWOT) assessment approach. A list of specific strategies related to each prioritized strategic objective resulted from the discussions.

Virtual Office Hours: Not all Advisory Council members were able to attend the extended inperson meeting. To ensure that each member had the opportunity to contribute to the
prioritization process, CREEHS facilitated two office hour sessions in October and scheduled
them on different days and times to accommodate varying schedules. These conversations
focused on reviewing the five prioritized strategic objectives and discussing additional
strategies related to each strategic objective.

Specification

Using the feedback and priorities gathered during the in-person and office hour meetings, components of the *Strategic Plan* – vision, mission, guiding principles for making funding recommendations, goals, strategic objectives, and strategies – were drafted. These components were then shared with the Advisory Council members during a virtual meeting (November 2024). Discussion prompts were used to guide the conversation to solicit feedback about and make changes to the structure, organization, and content of the plan components.

Finalization

The Advisory Council engaged in several additional cycles of review and feedback to finalize the Strategic Plan.

- Virtual Meeting: The revised Strategic Plan components were then presented to the Advisory
 Council for a second feedback cycle during a virtual meeting (January 2025). At this time,
 members also reviewed and provided feedback on the structure and function of a monitoring
 and evaluation plan to track progress on the Strategic Plan.
- Feedback Survey: Following this meeting, CREEHS conducted a survey of Advisory Council members collecting individual feedback on the *Strategic Plan* mission, vision, guiding principles, strategic objectives, and strategies (January 2025). The goal of this survey was to ensure that all members had a way to share their feedback about the *Strategic Plan* in a confidential and unbiased way.
- Individual Review: In February 2025, the full revised draft of the Strategic Plan was presented
 to the Advisory Council members for final review and feedback. Advisory Council members
 were invited to provide written feedback on each section of the Strategic Plan. All feedback
 was considered, and the final draft was completed and submitted to Human Services for final
 review in March 2025.



APPENDIX B: NEEDS ASSESSMENT FINDINGS (PHASE 1)

The following findings are based on the synthesized qualitative and quantitative data analyzed as part of the Phase 1 *Needs Assessment*. These findings reflect key themes that were most salient across data sources, based on the data available during the period of March through September 2024. Additionally, a set of emerging themes are presented at the end of the section to highlight findings that are present and noteworthy but were less consistently or less prominently reflected in the data. These emerging themes may offer meaningful opportunities for exploration and programming.

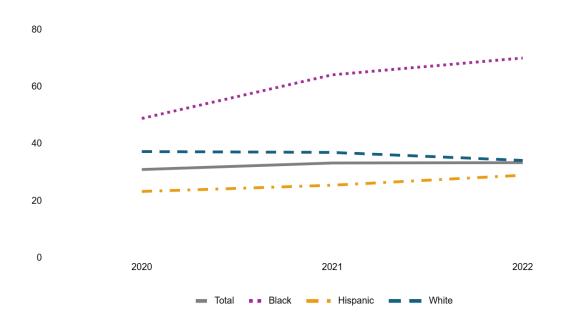
1. POPULATIONS UNIQUELY AFFECTED BY SUD AND THE OVERDOSE CRISIS

SUD (including OUD) and the overdose crisis broadly impact individuals across demographic groups, some populations are disproportionately impacted, specifically in terms of overdose deaths. Understanding who is at greatest risk for overdose death can help guide policy and practice to meet the unique needs of those most affected.

Black and Hispanic Residents

The historical trends in total overdose deaths in New Jersey from 2020 to 2022 mask substantial variation by race and ethnicity. As of 2022 data (the most recent year for which demographic data on overdose deaths were available as of the close of the *Needs Assessment* in September 2024), overdose deaths were on the decline for White residents in New Jersey but were increasing steadily for Black and Hispanic residents (Figure C-1). Moreover, according to the most recent publicly available overdose death data (2022), Black residents account for the highest rate (of age-adjusted per 100,000 residents) of overdose deaths in all but one county (i.e., Middlesex) for which data are available. The total overdose death rate is relatively low in Hudson County with an approximate 0.3 overdose deaths per 100,000 residents. However, the race-adjusted overdose death rates in that county are 0.8 deaths per 100,000 Black residents versus 0.4 deaths per 100,000 White residents and 0.2 deaths per 100,000 Hispanic residents.

Figure C-1. Age-adjusted counts of overdose deaths by race and ethnicity (2020 to 2022) which illustrate the disproportionate burden of overdose deaths among Black residents in New Jersey.



Note: Age- and race-adjusted data (number of overdose deaths per 100,000 residents, by racial group) retrieved from public <u>NJ SUDORS Overdose Mortality Data Explorer</u> in March 2025. Refer to this site for continuously updated counts of overdose deaths.

Despite the clarity and consistency of the quantitative trend data, very few stakeholders discussed perceptions that reflect a thorough understanding of these racial and ethnic disparities. Some leaders noted that the recent overall decline in overdose deaths does not capture the rise in deaths among Black residents. However, despite being prompted, few stakeholders across the primary and public data collected and reviewed detailed a need to tailor services to better reach this disproportionately impacted group.

Additional Special Populations

Historical trends and qualitative data suggest that there are other groups of New Jersey residents that are also disproportionately impacted by SUD.

Older Adults (65 years or older)

Older adults emerged as a special population specifically impacted by SUD-related harms. Historical trends apparent in quantitative data (2020 to 2022) reveal increasing overdose deaths among adults over the age of 65 years. Advisory Council members and other key informants noted the high risk for SUD among older adults due to:

- Physical ailments that require (multiple) prescription medications
- Limited access to SUD treatment due to no Medicare reimbursement
- Rural poverty and the associated necessity to engage in manual labor into old age

Further, published population research reports that, nationally, 8% of Medicare beneficiaries over the age of 65 years have a SUD, 44% of whom had past-year serious psychological distress.^b

Incarcerated Individuals

Incarcerated individuals also appear to be specifically impacted by SUD-related harms. While quantitative data show overdose deaths decreasing among New Jersey residents recently released from incarceration (2020 to 2022), qualitative data collected from multiple sources, including Advisory Council members, other key informant interviewees, and focus group participants, suggest that incarcerated individuals experience unique barriers to accessing treatment and engaging in their own wellness and recovery journey. Additionally, according to the Bureau of Justice Statistics, nationally, 47% of incarcerated people have a SUD°, and population estimates suggest that only 11% receive any kind of SUD treatment.^{d,e}

Individuals with Mental Health Disorders

Individuals with mental health disorders also experience unique challenges accessing SUD-related services due to the scarcity of practitioners equipped to treat the complexity of their co-occurring disorders. According to Jones and McCance-Katz (2019), nationally, approximately 64% of individuals with SUD also have a co-occurring mental health condition. Further, while quantitative trend data (2020 to 2022) reveal decreasing overdose deaths for New Jersey residents with a mental health

^b Parish, W. J., Mark, T. L., Weber, E. M., & Steinberg, D. G. (2022). Substance use disorders among Medicare beneficiaries: prevalence, mental and physical comorbidities, and treatment barriers. American journal of preventive medicine, 63(2), 225-232.

^c U.S. Department of Justice. (2024) Office of Justice Programs. Survey of Prison Inmates Data Analysis Tool (SPI DAT). Accessed on September 9, 2024. Available here.

^d Ohringer, A. R., Ezer, T., & Serota, D. P. (2020). Prison-based harm reduction services are needed to address the dual substance use disorder and infectious disease epidemics in US prisons. EClinicalMedicine, 22.

e Califano Jr, J. A. (2010). Behind bars II: Substance abuse and America's prison population. New York, NY: National Center on Addiction and Substance Abuse at Columbia University.

^f Jones, C. M., & McCance-Katz, E. F. (2019). Co-occurring substance use and mental disorders among adults with opioid use disorder. Drug and alcohol dependence, 197, 78-82.

diagnosis, qualitative data collected from stakeholders with lived experience indicate that individuals often turn to SU to self-treat undiagnosed mental health disorders.

Unhoused Individuals

Unhoused individuals were also identified as a special population uniquely impacted by SUD-related harms. Quantitative trend data (2020 to 2022) reveal increasing overdose deaths for people experiencing homelessness (PEH) in New Jersey. Further, across all stakeholder groups and data sources, individuals experiencing homelessness were identified as a priority population. According to SUDORS Overdose Death Circumstances Data, overdose deaths for PEH in New Jersey increased by 20% from 2021 to 2022.g National estimates from the U.S. Department of Housing and Urban Development indicate that 17% of PEH in the U.S. had a SUD in 2023h and in New Jersey, estimates from the 2024 Point-In-Time Count report approximately 19% of PEH have a SUD. When individuals are focused on securing their most basic needs, like housing, they are not prepared to simultaneously address a SUD. Housing is a key lever because having a safe place to sleep is essential to stability and long-term wellbeing and recovery.

Rural Populations

As reported across stakeholder groups, New Jersey residents living in rural areas frequently experience resource scarcity and challenges associated with reliable transportation. Geospatial exploration of available resources reveals that resources are frequently clustered in high population density areas. This is true for both SU-specific resources (e.g., treatment facilities and HRCs) as well as resources related to social determinants of health (e.g., food pantries and homeless shelters). This pattern of rural resource scarcity is most readily observed in New Jersey's southern counties with the highest overdose death rates (i.e., Atlantic, Cape May, Cumberland, and Salem) (Figure C-2).

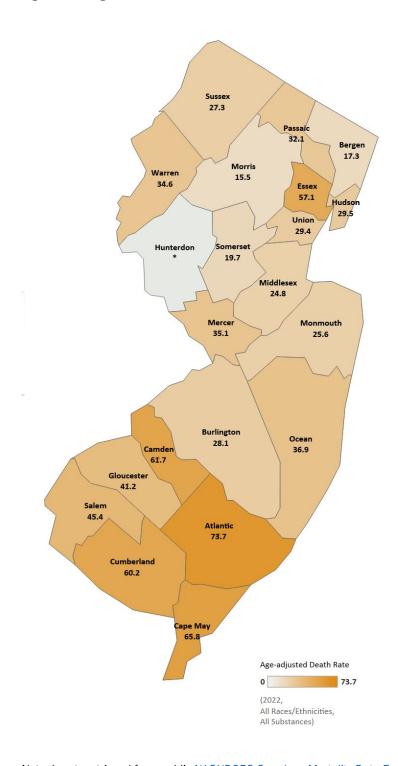
^g Center for Disease Control: Overdose Prevention – SUDORS Dashboard; Fatal Drug Overdose Data. (2025). Accessed March 2025. https://www.cdc.gov/overdose-prevention/data-research/facts-stats/sudors-dashboard-fatal-overdose-

data.html?CDC AAref Val=https://www.cdc.gov/drugoverdose/fatal/dashboard/index.html

^h de Sousa, T., Andrichik, A., Prestera, E., et al. (2023). The 2023 Annual Homelessness Assessment Report to Congress - Part 1: Point-in-Time Estimates of Homelessness. U.S. Department of Housing and Urban Development. Available here.

ⁱ Monarch Housing Associates (2024). NJ Counts: 1.23.2024. New Jersey Housing and Mortgage Finance Agency. Accessed March 2025. https://monarchhousing.org/wp-content/uploads/2024/10/New-Jersey-PIT-Report-2024.pdf

Figure C-2. Age-adjusted overdose death rates by county in 2022



Note: Image retrieved from public <u>NJ SUDORS Overdose Mortality Data Explorer</u> in March 2025. Refer to this site for continuously updated counts of overdose deaths.

2. SUCCESSFUL STRATEGIES TO PRESERVE LIFE

Across the data sources analyzed, and consistent with the published literature, naloxone distribution, MOUD treatment, and the establishment of HRCs are the most agreed upon resources that preserve human life. Each of these services and their wide-reaching benefits are described in the following sections.

Naloxone Distribution

The increased availability of naloxone is cited uniformly by key informants and members of the Advisory Council as one of New Jersey's greatest successes toward reducing the frequency of overdose deaths. Public input via public comments and listening sessions agree in their call for continued investment in naloxone distribution and community-based training. Published research suggests that, with minimal training, civilian bystanders can administer naloxone effectively.^{k,l}

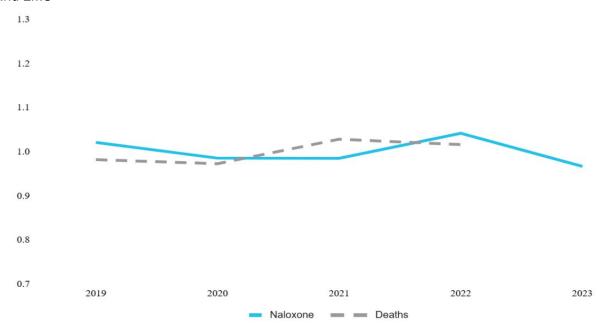
Lending additional support to the importance of naloxone distribution are findings from the quantitative trend analysis that reveal a consistent inverse pattern between naloxone incidents (i.e., naloxone administration by law enforcement [LE] or emergency medical services [EMS]) and opioid-specific overdose deaths (Figure C-3). That is, small changes in naloxone incidents co-occur with small inverse changes in opioid overdose deaths from 2019 to 2022. Although observational and only observed over three consecutive years for administrations by LE and EMS (i.e., not including any naloxone administered by other supporters), it is emerging evidence that increases in naloxone use may be a key contributing factor to the decline in overdose deaths at the state level.

^j Bahji, A., & Bajaj, N. (2018). Opioids on trial: a systematic review of interventions for the treatment and prevention of opioid overdose. Canadian Journal of Addiction, 9(1), 26-33.

^k Eggleston, W., Calleo, V., Kim, M., & Wojcik, S. (2020). Naloxone administration by untrained community members. Pharmacotherapy: The Journal of Human Pharmacology and Drug Therapy, 40(1), 84-88.

^l Miller, N. M., Waterhouse-Bradley, B., Campbell, C., & Shorter, G. W. (2022). How do naloxone-based interventions work to reduce overdose deaths: a realist review. Harm reduction journal, 19(1), 18.

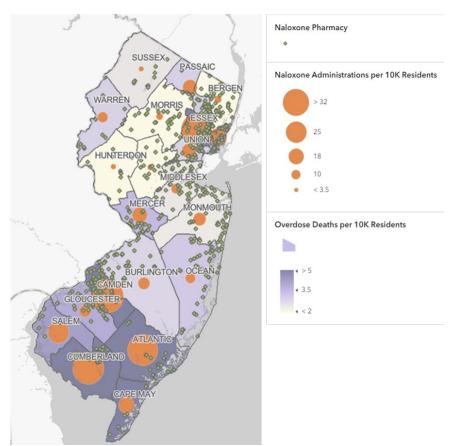
Figure C-3. Change in Normalized Counts of Opioid Overdose Deaths and Naloxone Incidents by LE and EMS



Note: Raw overdose count data retrieved from public NJ Overdose Data Dashboard in May 2024 (https://www.nj.gov/health/populationhealth/opioid/sudors.shtml). Raw naloxone administration count data also retrieved from New Jersey public Naloxone Data Dashboard in May 2024 (https://www.nj.gov/health/populationhealth/opioid/opioid_naloxone.shtml). Refer to these sites for routinely updated counts of overdose deaths and naloxone administrations. Opioid overdose death and naloxone incident counts were normalized by dividing the value for each year by the mean value across years. This figure is not designed to report specific counts, but rather, to display how the counts change over time consistent with other indicators in the Needs Assessment. This approach facilitates the comparison of rates across indicators. Data displayed in this figure includes only LE and EMS administered naloxone incidents. They are not inclusive of naloxone administrations from other public residents or sites.

The findings presented thus far point to fairly widespread buy-in for naloxone distribution. However, exploratory geospatial analysis of indicator data suggests that naloxone incident rates are inconsistent across the state. For example, despite having similar overdose death rates, Cape May and Gloucester counties have relatively low naloxone incident rates (i.e., approximately three incidents per overdose death) compared to Camden and Cumberland (i.e., approximately five incidents per overdose death). These patterns appear to be unrelated to the number of naloxone dispensing pharmacies in each county (i.e., one measure of community-based naloxone distribution, Figure C-4).

Figure C-4. Variation in Naloxone Incidents by LE and EMS in Relation to Overdose Deaths and the Location of Naloxone Pharmacies



Note: Raw overdose count data retrieved from public NJ Overdose Data Dashboard in May 2024 (https://www.nj.gov/health/populationhealth/opioid/sudors.shtml). Raw naloxone administration count data also retrieved from public NJ Naloxone Data Dashboard in May 2024

(https://www.nj.gov/health/populationhealth/opioid/opioid_naloxone.shtml). The locations of naloxone pharmacies were pulled from the New Jersey public Naloxone365 site in May 2024 (https://data.nj.gov/Human-Services/Naloxone365-NJ-Free-Naloxone-at-Pharmacies-Program/nfsa-3664/about_data). Refer to these sites for continuously updated locations of naloxone pharmacies and counts of overdose deaths and naloxone administrations. The purple base layer is population includes values that represent counts per 10,000 residents (according to the U.S. Census 2022 5-year estimates). The dots representing naloxone administrations are also based on counts per 10,000, with larger dots representing higher counts per 10k residents.

Medication for Opioid Use Disorder

MOUD was consistently reported as a life-saving treatment across key informants, the Advisory Council, public comments, listening sessions, and the round-table discussion. In addition to saving lives, stakeholders report that the expansion of MOUD removes barriers to treatment by:

- Creating low threshold treatment options (e.g., allowing virtual assessment and follow-up care, same-day treatment, flexible dosing and timelines, and no insurance requirements or lengthy paperwork); and
- Providing alternative pathways to wellbeing and recovery outside traditional abstinence-only treatment models.

According to key informants and members of the Advisory Council, MOUD programs have been expanded over the past decade by non-profit and private treatment providers and EMS (i.e., delivering first doses of MOUD in the field after reversing an overdose using naloxone). However, according to other key informants, MOUD programs can be expanded further to ensure availability and accessibility in every community across the state.

Harm Reduction Centers

The role and importance of having HRCs and recovery centers in the community was also highlighted in the data collected. In an effort to increase access to the life-saving services provided by HRCs, DOH allocated funding to establish a HRC in every New Jersey county (to be in operation by 2025). In addition to the official HRCs, recovery support centers, grassroots agencies, and mobile units provide HR services and supplies (e.g., HIV testing, syringe exchange, safe use sites, take-home naloxone kits).

Key informants report that agencies providing HR services uniquely support individuals with SUD by:

 Creating a welcoming, culturally competent, and judgment-free environment for people with SUD to connect to care and gain access to wraparound support services like food assistance:

"With [intensive outpatient programs] or residential treatment, you're expected to engage at a certain frequency. You have to meet requirements in terms of acuity and diagnosis. Whereas with recovery centers and HRCs, you just walk in and the greatest barrier is just being able to walk through the door. You don't get faced with all this cumbersome assessment and commitments and having to sign a million pieces of paper. It really starts with just hospitality and connection and welcome. And I think that's what people are looking for in that moment is just to be welcomed and to be supported rather than taken through this very clinical process."

"I believe that if we start working on the inside with the people, that we would get better results, because nobody cares [to ask] 'What happened to you?' 'Why you here?' or anything like that. They just want to ship everybody off to treatment...If somebody feels welcome and treated with respect, then that kind of normalizes things, and then people don't have to be hiding or feeling shameful or guilty."

 Stakeholder interview respondents

Reducing the transmission of SUD-related communicable diseases like Hepatitis and HIV;

- Making communities safer and reducing the frequency of SU in public spaces (i.e., in parks and on the street); and
- Connecting individuals with SUD to treatment, if and when they are ready.

Despite the evidence supporting the effectiveness of HR services^m, data suggest some communities are reluctant to support the establishment of HRCs in their area due to stigma. The limited public buyin to HR strategies to prevent deaths and create connections to care across agencies is a barrier to successful establishment of and access to these services.

3. PERSISTENT BARRIERS TO SERVICE DELIVERY ACROSS THE CONTINUUM OF CARE

Several barriers to effective service delivery were identified across data sources and stakeholder perspectives. A subset of these barriers was reported consistently across all stakeholder groups. These agreed upon barriers are described below in descending order of stakeholder reported importance. Additional barriers noted across data sources (albeit less consistently) are described in the Emerging Themes section.

Stigma

Stigma around SUD, addiction, HR, and MOUD is the barrier most agreed is preventing successful service delivery. According to the data collected, all stakeholder groups are affected by stigma including those with SUD and their families, the public, medical professionals, first responders, and other stakeholders providing direct services (e.g., treatment providers and counselors).

The problem of stigma is multi-pronged with some forms of stigma impacting multiple stakeholder groups uniformly and other forms having a narrower influence on a specific subset of stakeholders. Stakeholders reported that the most universally problematic form of stigma is associated with the criminalization of addiction and the belief that addiction is a lifestyle choice as opposed to a chronic disease. A secondary form of stigma is the belief that HR and MOUD are enabling factors that contribute to the rise of SU and the perpetuation of SUD. Both forms of stigma influence decisions and behaviors across the stakeholder spectrum in multiple ways.

According to the data collected:

 People with SUD and their families are reluctant to address SU-related issues and access available resources due to shame and fear of social and/or legal repercussions.

^m Wilson, D. P., Donald, B., Shattock, A. J., Wilson, D., & Fraser-Hurt, N. (2015). The cost-effectiveness of harm reduction. *International Journal of Drug Policy*, 26, S5-S11.

- The public is resistant to establishing visible resource hubs for people with SUD, especially when HR and MOUD resources are included, due to fear that visible resources will bring problems of addiction into their communities and encourage SU.
- First responders (e.g., LE, EMS, and emergency departments) frequently treat SUD as an acute crisis (sometimes criminal) with limited training and attention to evidence-based follow-up care.
- Many parallel agencies (e.g., courts, faith-based organizations, and homeless shelters) reinforce stigma around HR and MOUD by promoting abstinence-only models of diversion, treatment, and recovery.
- Medical professionals (e.g., primary care and mental health physicians) frequently view SUD as a condition that resides outside of the realm of general and mental health, and do not attempt to treat it.
- Direct service providers (e.g., treatment providers and counselors) frequently treat patients with limited cultural competence and compassion and pay insufficient attention to follow-up and recovery care.

These stigma-related findings are uniquely illuminated by findings from the focus groups conducted with individuals in SUD treatment (both traditional abstinence-based treatment and MOUD). Although these stakeholders did not identify stigma as a barrier to accessing services (as did other stakeholder groups), stigma was reflected in their discussions. Participants disagreed with one another about the benefits of HR and MOUD. Some participants voiced perspectives in support of HR and MOUD (i.e., that these approaches save lives) while others voiced commonly held perspectives that reflect stigma (i.e., that HR and MOUD are encouraging and enabling people to use substances). These discussions focused on naloxone availability in schools, safeuse sites, and the long-term use of MOUD.

The limited buy-in to HR and MOUD approaches is a barrier to successful establishment of and access to these services.

"We have helped both the community and law enforcement recognize that [collaboration] is a benefit to them...And we actually end up with more robust programs for less money done more efficiently and done in partnership."

"Unless you're going to say to an ED, 'We want you to do this work and here's how we're going to support these people that are going to help you do this work'...unless there is a way to incentivize people to do the right thing, a lot of times, especially if it's going to come at a cost, they aren't going to do it."

"In cities and areas where services are readily available, the population is more informed about those services. But in other cities and towns where they're not as welcoming to harm reduction practices, the services and the information is harder to come by."

 Stakeholder interview respondents

Cross-Sector Coordination of Care

Despite a desire to better coordinate care, data collected suggests that the agencies involved in service delivery across SU-related sectors (e.g., prevention, emergency response, HR, treatment, recovery) are siloed. When coordination across sectors has been successful (e.g., between LE and peer specialists [PSs]), stigma is reduced, a continuum of care is established, and stakeholders benefit from the collaborative pursuit of a mutual goal.

Example forms of inter-sector collaboration that stakeholders believe will improve service delivery include:

- Pairing emergency response coordination with recovery support services (e.g., PSs are deployed alongside first responders on overdose cases),
- Establishing recovery courts in collaboration with the Prosecutor's office,
- Providing recovery consult services with PSs for individuals in treatment, and
- Administering MOUD in the emergency department with referrals to HRCs and treatment facilities.

In addition to stigma, a key barrier to inter-agency coordination is the cost of collaboration due to demands on workforce capacity and limited resources. For example, meaningful partnering and relationship building takes time and effort in addition to the regular responsibilities of individuals working in treatment facilities, health departments, health care and hospital settings, and others. Without financial support, technical assistance, and clear direction from policy and leaders, many agencies may be reluctant to engage in meaningful partnership.

Workforce Capacity

Across stakeholder groups and public perception data, staff shortages are noted as a key barrier to effective service delivery. Workforce capacity investments are needed to improve operations at every level including:

- State, county, and local health departments to enhance collaboration across agencies and provide oversight and support to local initiatives,
- Treatment facilities to expand services to serve more people and extend hours of operation,
- PSs to expand services and create connections to care across the continuum, and
- Street teams and mobile units to connect with hard-toreach populations.

"You get acquainted with one counselor and all of a sudden they're moving on to someone else, you got to start with another one. Start your whole story all over with someone that doesn't know nothing about you, which you might feel uncomfortable doing, sharing with so many people."

- Focus group respondent

Many stakeholders also noted that there are significant barriers—in addition to limited funds—that make it challenging to hire and retain staff including:

- The work is demanding and undesirable because it often involves engaging in traumatic events (e.g., overdose deaths, injury, family loss and separation).
- The work is unstable with limited job security, benefits, and career advancement due to short funding timelines.
- The work requires a high level of compassion and case management skill without adequate training offerings.

These barriers result in a high level of turnover among staff, especially among those who work most closely with individuals with SUD. For individuals with SUD, this lack of consistency also poses a significant barrier to care.

"When we get out of [treatment], I don't know, for me, I don't have anybody. And it's like I'm starting from scratch all over again. I just wish they helped you while you're [in treatment], try to get food stamps. I don't understand why they don't help you get food stamps while you're here...You go to re-entry [after], they should do the re-entry while you're here, I don't get it."

- Focus group respondent

Provision of Basic Needs

Many individuals and families affected by SU-related harms are also facing challenges meeting their basic needs, and when focused on securing food, housing, and transportation, they are often unable to simultaneously address a SUD. Making connections to social support services at key points throughout the entirety of the continuum of care (e.g., emergency response, at HRCs, during treatment, during recovery) can reduce these additional stressors and facilitate the successful life-long management of a SUD.

Housing is an unmet need that was noted persistently across stakeholder groups. Stable housing is essential to long-term wellbeing and recovery, and individuals with SUD have unique housing needs. The housing needs reported by key informants and individuals with lived experience include sober living arrangements, halfway houses, and long-term housing vouchers.

Finally, there are few family support services that provide activities that help people who use drugs bond with their family members and overcome the generational effects of SU-related harms. This gap-noted by stakeholders in the public comments, listening sessions, round table discussion, and focus groups-is important because children of individuals with SUD are uniquely impacted.

"The lack of support, the food insecurities, the lack of housing and having to live in hotels. That's what we're seeing. 'I can't even afford to put clothes on these kids.' So, I can't even begin to worry about if they're using or their mental health or housing."

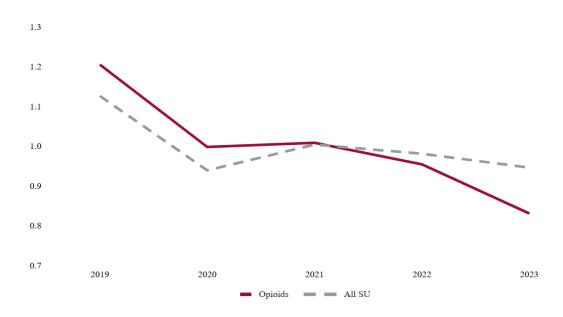
"I see the successes of what housing can do for somebody that was out on the streets, that was in active addiction, and have completely turned their life around. [They become] community advocates and promote recovery...And a lot of them, the clients say it's all because they had access to stable housing."

 Stakeholder interview respondents

4. ACCESSIBILITY OF TREATMENT

SU-related treatment admissions are on the decline from 2019 with a significant dip in treatment admissions observed in 2020 (i.e., at the height of the COVID-19 pandemic). Although there was a slight uptick in treatment admissions for all substances from 2020 to 2021, treatment admission rates have not recovered to pre-pandemic levels, and this is specifically true for opioid admissions, for which there have been the steepest declines (Figure C-5). Understanding what factors contribute to the declines in SU-related treatment admissions is important for understanding how access to treatment can be enhanced.

Figure C-5. Change in Normalized Counts of Treatment Admission Rates for All Substances and Opioids, 2019 through 2023



Note: Raw count data retrieved from the public NJSAMS website in May 2024 (https://njsams.rutgers.edu/njsams/Reports/SummaryReport/StateSummaryReportMenu.aspx). Refer to this site for routinely updated counts of treatment admissions. Treatment admission counts were normalized by dividing the value for each year by the mean value across years. This figure is not designed to report specific counts, but rather, to display how the counts change over time consistent with other indicators in the Needs Assessment. This approach facilitates the comparison of rates across indicators.

Geospatial exploration of the locations of treatment facilities and reports from some state-level stakeholders suggest that the availability of treatment facilities is not a significant barrier to accessing treatment because there are a substantial number of treatment facilities across the state. However, stakeholders engaged at the county and local levels report significant barriers to accessing available treatment which include:

- Wait times due to limited availability of beds at treatment facilities
- Requirements to have a valid form of identification
- Restrictions based on age (specifically for older adults and adolescents)
- Restrictions based on mental health status and co-occurring diagnoses
- Restrictions based on the types of substances used

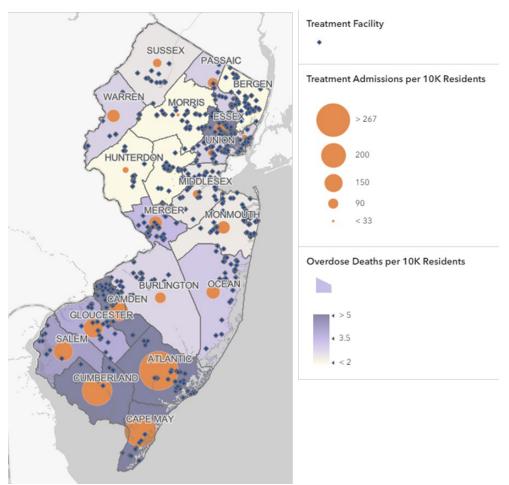
The restrictions based on mental health status and types of substances used are uniquely problematic because, as noted above, population research suggests that, nationally, up to 64% of individuals with SUD have a co-occurring mental health condition and up to 73% have a co-occurring SUD (i.e., polysubstance use).

Geospatial exploration of across-county variation in indicators suggest that there is variation in the rate of treatment admissions in counties with the highest overdose death rates, which appears unrelated to the availability of treatment centers (Figure C-6). For example, the ratio of treatment admissions to overdose deaths is higher in Atlantic County (i.e., 37 treatment admissions for every overdose death) than in Camden County (i.e., 22 treatment admissions for every overdose death) even though there are fewer treatment facilities in Atlantic County than Camden County (i.e., 56 versus 82, respectively).

"The criteria for getting into [treatment centers] varies from place to place. I had mentioned that I had suicidal ideations, so a lot of people right away just cut me off, said no, which makes no sense because the average person that suffers addiction is probably having those thoughts. So, I thought that was odd."

- Focus group respondent

Figure C-6. Variation in Treatment Admissions in Relation to Overdose Deaths and the Location of Treatment Facilities



Note: Raw overdose count data retrieved from public NJ Overdose Data Dashboard in May 2024 (https://www.nj.gov/health/populationhealth/opioid/sudors.shtml). Raw treatment admission count data retrieved from public NJSAMS site in May 2024

(https://njsams.rutgers.edu/njsams/Reports/SummaryReport/StateSummaryReportMenu.aspx . Refer to these sites for routinely updated counts of overdose deaths and treatment admissions. The purple base layer is calculated so that values represent counts per 10,000 residents (according to the U.S. Census 2022 5-year estimates). The dots representing treatment admissions are also based on counts per 10,000, with larger dots representing higher counts per 10k residents. The locations of treatment facilities were compiled using the SAMSHA FindTreatment.gov site and Vital Strategies lists provided by Human Services.

Understanding what gives rise to variation in treatment admission rates across counties is essential to identifying key resource gaps. However, many questions remain and need to be answered in order to identify the root cause of declining treatment admission rates.

Key unanswered questions include:

- What proportion of New Jersey's existing operational treatment facilities accept Medicaid?
- How are the treatment facilities that accept Medicaid geographically distributed across the state?
- What percent of Medicaid-accepting treatment facilities offer MOUD programs? How are these facilities geographically distributed across the state?
- What is the capacity of each treatment facility and how does capacity correspond with need at the community level?
- To what extent do Medicaid-accepting treatment facilities have admission restrictions based on identification requirements, age, mental health status, and type of substances used?

An additional consideration when working to identify the root cause of the decline in treatment admissions is the extent to which individuals with SUD are confident in the quality of the treatment they will receive. Findings from the public comments, listening sessions, key informant interviews, and focus groups reveal perceptions that there are limitations to the treatment currently available including:

- The short duration of treatment (i.e., not long enough for medically recommended opioid use disorder care);
- The poor quality of Medicaid-accepting treatment facilities (e.g., limited activities, availability, services); and
- Limited cultural competence and degrading treatment of patients (i.e., both due to and reinforcing of stigma).

"I get so frustrated because we work so hard. Sometimes it takes us literally five to six hours to place one individual. That's ridiculous...I sent someone into detox on Thursday. Sunday they were sitting outside with no transportation, had no place to go [because] the wait list for treatment was two weeks."

 Stakeholder interview respondent

5. EMERGING THEMES

In addition to the findings reported most consistently and outlined above, several themes emerged from the data as noteworthy but were neither consistent across all data sources nor as prominent. These themes, however, point to meaningful opportunities to improve service delivery, education, and communication efforts around SUD.

- Best practices are not consistently implemented across the state with the most effective strategies (e.g., collaboration across agencies and easy access to MOUD) occurring only in some municipalities and counties. This finding emerged consistently across key informant interviews but is in conflict with findings from the Advisory Council interviews. Many Advisory Council respondents cited resource availability and the consistent implementation of evidence-based strategies as a New Jersey strength.
- Prevention in schools (e.g., middle and high schools) is needed to ensure that youth
 understand the risks of fentanyl and other synthetic opioids, understand the signs of SUD, and
 know where to go for help, if needed. This perception is particularly signaled among the
 stakeholders who are closest to the work (e.g., in the key informant interviews, focus groups,
 and round-table discussion), including those with lived experience.
- The public is not aware of Advisory Council activities, despite concerted efforts by Human Services and the Advisory Council to share information via the website and multiple public feedback sessions and events. Key informants reported being involved in local and county-level committees and coalitions, but unaware of statewide Advisory Council activities. More specifically, key informants from CBOs held misconceptions of the Advisory Council (e.g., that it was composed of government representatives only and no one with lived experience) and reported not knowing how to pursue opioid settlement funding opportunities.



APPENDIX C: OVERVIEW OF STRATEGIES NOT ADDRESSED BY THE STRATEGIC PLAN

The Advisory Council's *Statement on Funding Recommendations* (*Figure D-1*) outlines the values of the Advisory Council and identifies three types of activities that it will not recommend for funding. Excluding these types of activities, *Needs Assessment* findings suggested several potential strategies to be used to address SUD in New Jersey. Many of these were outlined in the *Needs Assessment*, and the Advisory Council engaged in an iterative process to prioritize and refine a set of strategic objectives and strategies that were within the scope of the settlement funds, not already underway, or of critical importance to fund with the finite resources available (see Appendix B for additional details). The strategic objectives and strategies that were not prioritized for the *Strategic Plan* remain specific needs among New Jersey residents. They address various needs within the State's response to SUD, including prevention, HR, and recovery support services and serve as a valuable reference for other agencies and stakeholders looking to implement strategies that address documented needs in New Jersey.

Figure D-1. Advisory Council statement on funding recommendations

The New Jersey Opioid Recovery and Remediation Advisory Council recognizes the devastating impacts and complex needs presented by the ongoing opioid crisis. In light of these challenges, the Advisory Council is choosing to pursue human-centered, community-driven, and evidence-based frameworks in our funding recommendations for these limited opioid abatement funds. The Advisory Council will continue to prioritize equity and utilize available data to ensure these funds reach communities that are experiencing higher rates of overdose, opioid use, or substance use.

The Advisory Council's primary focus is to support programs and initiatives that directly address the opioid crisis, such as prevention and education, harm reduction and overdose prevention, treatment, recovery services, and services strengthening social determinants of health. The Advisory Council believes that this approach will have the most significant impact in helping individuals and communities affected by the opioid crisis. As such, the Advisory Council will not recommend that funding be used for (i) activities or programs that are not evidence-based or promising practices for opioid abatement; (ii) non-Federal Drug Administration (FDA) authorized medications for the treatment of opioid use disorder or substance use disorder; (iii) purchases of equipment for law enforcement use in search and seizure, suspect apprehension, or evidence gathering, or items that run counter to the evidence-driven and individual-first approach that we have embraced.

STRATEGIC OBJECTIVES AND STRATEGIES NOT ADDRESSED BY THE STRATEGIC PLAN

The Advisory Council, during the prioritization phase, worked collaboratively to narrow down a list of potential strategies identified in the *Needs Assessment*, focusing on high-impact priority areas. During this process, some strategies were categorized as either "currently underway" if they were similar to or duplicative of existing initiatives or "out-of-scope". Strategies were deemed "out-of-scope" if they were already funded by other sources; required state, county, or local infrastructure or legislative changes that were not likely within the timeframe of this plan; demanded significant oversight or lacked infrastructure for sustainability; were not supported by evidence-based or best practices; or, not within the allowable uses under the terms of the settlement. Figure D-2 provides a list of these strategies by potential strategic objective, along with the reasons they were identified as out-of-scope.

Figure D-2. Strategies currently underway or considered outside of the scope of the Strategic Plan

Strategy	Reason for Decision
Housing	
Provide long-term housing vouchers for individuals in recovery who need sober-living housing support.	Currently underway
Expand the capacity of homeless shelters and halfway houses for recovery-appropriate shelter.	Currently underway
Identify locations for and establish new vacancies for sober living, which may include using vacant buildings in communities.	Out-of-Scope: Requires significant and continued investment
HR Services	
Establish new service agreements or HR services, particularly in the areas where the populations most impacted by overdose live or spend time.	Currently underway
Invest in the enhancement of existing HRCs and programs to expand HR programs and services, particularly in the areas where the populations most impacted by overdose live or spend time.	Currently underway
Support the establishment of new mobile units to dispense MOUD and provide HR services, particularly in the areas where populations most impacted by overdose live or spend time.	Currently underway
Monitor and assess the relationship between the provision of HR services and the rate of overdose deaths.	Currently underway

Strategy	Reason for Decision
Treatment Services	
Hire additional staff to provide extended hours of operation (i.e., evenings and weekends).	Out-of-Scope: Requires significant and continued investment
Provide age-specific residential and outpatient treatment options for adolescents and older adults.	Out-of-Scope: Requires significant and continued investment
Provide funding pathways (alternative to Medicare) for older adults entering treatment.	Out-of-Scope: Requires significant legislative changes
Coordinated Wraparound Services	
Develop or leverage existing resource listings relevant to social determinants of health (e.g., food pantries, job training programs, childcare supports, housing assistance programs) and connect them with HR, treatment, and other continuum of care service locations.	Out-of-Scope: Requires significant infrastructure changes
Connect statewide assistance programs with continuum of care service locations to provide information, outreach, and education. This may include SNAP application assistance, WorkFirst NJ guidance, and others.	Out-of-Scope: Requires significant infrastructure changes

Additionally, some strategies were considered within the scope of the *Strategic Plan* but were not prioritized. The Advisory Council emphasized the importance of keeping this list as a reference point for future efforts and funding opportunities. These strategies included:

- Expand successful models of coordination across prevention, law enforcement, emergency departments, HR centers, treatment facilities, recovery supports, and health departments.
- Provide prevention education and information to New Jersey residents about SU, the dangers
 of fentanyl, and the benefits of HR and MOUD to increase awareness and reduce stigma about
 SUD and related services.
- Provide tailored education, information, and ongoing technical support to community service providers about SUD, HR approaches, and available resources to increase capacity and reduce stigma.
- Revise treatment admission restrictions to reduce barriers to access.
- Support existing coalitions and committees in expanding their networks and maintaining an inventory of available SUD prevention, HR, treatment, and recovery services along the continuum of care.



APPENDIX D: EXAMPLE ACTIVITIES BY STRATEGIC PLAN STRATEGY

Figure E-1 outlines the goals, strategic objectives, and strategies included in this Strategic Plan. It also provides example activities that could be invested in to achieve the strategy and make progress toward the strategic objective. These activities are based on the data collected in the Needs Assessment. They are included to provide examples of specific programs or efforts that may fall within the strategy and offer concrete ideas about what is meant by each strategy.

Figure E-1. Example investment activities by goal, strategic objective, and strategy

Goal <i>Strategic Objective</i> (How to Reach the Goal)	Strategy (Plans to Achieve the Objective)	Example Activities/Investments (Steps to Take to Achieve the Strategy)
Safe, Stable, and Supportive Housing Increase the availability and	1. Expand Housing First initiatives for individuals and families affected by SUD without mandating abstinence or engagement in any services.	1.1. Fund Housing First or similar evidence-based and best practice and models for individuals who need housing support without mandating engagement in any services.
accessibility of housing for individuals and families affected by substance use disorder (e.g., Housing First)	2. Expand access to affordable, supportive, and transitional housing models tailored to individuals across the continuum of recovery (e.g., soberliving, recovery housing, housing assistance programs, supportive housing).	2.1. Provide housing assistance for individuals in recovery who need housing support.

Goal <i>Strategic Objective</i> (How to Reach the Goal)	Strategy (Plans to Achieve the Objective)	Example Activities/Investments (Steps to Take to Achieve the Strategy)
Harm Reduction Services Increase access to HR services for people who use substances	1. Provide funding to CBOs (e.g., local non-profits, street teams, faith-based organizations) and/or some local businesses (e.g., barber shops, corner stores) for distribution of HR supplies to	1.1. Fund technical assistance and training initiatives to CBOs and/or some local businesses for applying for and managing government and other grant awards to address SUD.
	populations and geographic areas of need. This may include capacity training or technical assistance to apply for and manage funding awards.	1.2. Invest in training and outreach efforts for public health organizations, schools, CBOs, and others that may distribute HR supplies about HR services (e.g., naloxone, syringe services).
	2. Integrate HR services into health care settings (e.g., Federally Qualified Health Centers, primary care, Emergency Medical Services). This may include, but is not limited to, integrating peer	2.1. Fund evidence-based or best practices that integrate HR with existing health care services for populations and geographic areas in needs. This may include efforts to incentivize distributing MOUD to patients and integrating peer specialists into the health care team.
	specialists into the health care team.	2.2. Invest in technical assistance efforts to support the implementation of HR integration in health care services.
	3. Invest in training and education efforts for first responders, emergency departments, primary health care providers, and ancillary health care providers about HR services.	3.1. Fund technical assistance and outreach efforts for primary health care providers about the benefits of naloxone, syringe services, and similar HR services as well as how to connect patients with these services.

Goal <i>Strategic Objective</i> (How to Reach the Goal)	Strategy (Plans to Achieve the Objective)	Example Activities/Investments (Steps to Take to Achieve the Strategy)	
Treatment Services Increase access to treatment services for people who use substances	1. Improve surveillance of treatment gaps and needs, specifically related to MOUD, ages served (e.g., adolescents, older adults), and Medicaid reimbursement.	1.1. Fund research to identify treatment and resource gaps in New Jersey, specifically related MOUD practices, ages served, funding pathways, integration with HR and wraparound supports, and other factors.	
	2. Expand the availability and accessibility (including hours of operation, availability of beds, and/or eligibility criteria) of best practice or	2.1. Fund initiatives that expand low-threshold MOUD options (e.g., funding HRC to provide MOUD), especially in those locations where individuals who use substances already seek services.	
	evidence-based treatment services, including low- threshold MOUD and trauma-informed models of care, for populations and geographic areas in need.	2.2. Invest in mobile provision of treatment, HR, and recovery services, especially where transportation is less available. This may include integrating PSs into the mobile team.	
	3. Invest in training treatment facility staff in best	3.1. Fund initiatives that expand treatment options based on the treatment and resource gaps identified.	
	practice or evidence-based treatment approaches, including MOUD, cultural competence, and trauma-informed models of care.	3.2. Fund initiatives that expand treatment options for populations and in geographic areas in need. This may include youth and older adults.	

Goal <i>Strategic Objective</i> (How to Reach the Goal)	Strategy (Plans to Achieve the Objective)	Example Activities/Investments (Steps to Take to Achieve the Strategy)
Coordinated Wraparound Services Improve the coordination of wraparound supports (e.g., transportation, food assistance, legal services) provided to individuals and families affected by substance use	1. Enhance or expand transportation options for individuals who use substances to reach support services and access care at HRCs, recovery centers, and treatment providers.	1.1. Fund programs to provide transportation to treatment, recovery, or support services for individuals who use substances, particularly for youth, those individuals who are high-risk, or serving high-need areas.
	2. Develop guidelines and provide support for treatment facilities and HRCs to integrate discharge planning into treatment. This may include partnering with PSs to facilitate the planning process and providing capacity-building support for facilities that do not currently have case management or navigation services. Guidelines should include housing, food assistance, legal services, transportation, job training, child care, and other basic needs.	2.1. Invest in training and education efforts for SUD treatment providers, HR service providers, CBOs, and others about available resources and recovery planning guidelines for wrap-around supports.
	3. Expand the capacity of PSs to provide case management services and connect agencies to improve the coordination of services across the continuum of care. This may include training and other efforts designed to bolster the case management workforce.	3.1. Provide funding for PSs or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an overdose.
	4. Expand and sustain family support groups and whole family treatment programs (e.g., family bonding activities). This may include funding a backbone agency to provide sub-awards to CBOs.	4.1. Provide education and training for families by families (e.g., PSs) related to SUD and resources.



APPENDIX E: STATE-LEVEL INDICATORS AND BASELINE DATA

A set of 10 indicators cited in the *Needs Assessment* or in the published literature as being linked to the goals of the *Strategic Plan* are suggested for state-level monitoring and evaluation of the *Strategic Plan*. Together, these indicators provide a broad picture of trends related to SU in New Jersey. Monitoring them over time will inform statewide evaluation questions and ultimately help the Advisory Council understand how disparities shift. Figure F-1 outlines suggested measures, baseline values, and data sources for each of the 10 indicators. Where possible, data are broken down by race and ethnicity and by age (although not included here, the *Strategic Plan* includes break downs by county where possible as well). Final indicators and baseline values may be adjusted.

Figure F-1. Outline of suggested state-level indicators, baseline values, and data sources

State-Level Indicator	Specific Measure	Baseline Value (2022)	Data Source
Overdose Deaths	Confirmed overdose deaths per 10k residents*: Total	3.3	
	Confirmed overdose deaths per 10k residents*: non- Hispanic White	2.8	_
	Confirmed overdose deaths per 10k residents*: non- Hispanic Black	7.3	NI Overdere Data Dealth cond
	Confirmed overdose deaths per 10k residents*: Hispanic	2.9	 NJ Overdose Data Dashboard NJ SUDORS Overdose Mortality Data Explorer Opioid Overdose Deaths/Fatal Overdoses https://www.nj.gov/health/populationhea https://www.nj.gov/health/populationhea https://www.nj.gov/health/populationhea https://www.nj.gov/health/populationhea https://www.nj.gov/health/populationhea
	Confirmed overdose deaths per 10k residents*: Youth (under 25)	0.7	
	Confirmed overdose deaths per 10k residents*: Adult (25-44)	5.5	
	Confirmed overdose deaths per 10k residents*: Adult (45-64)	5.9	
	Confirmed overdose deaths per 10k residents*: Senior (65+)	1.4	

State-Level Indicator	Specific Measure	Baseline Value (2022)	Data Source
Homelessness Among those Accessing Treatment	Percent of individuals experiencing homelessness when entering treatment	10.6%	NJ DMHAS Substance Abuse Treatment Provider Performance Report https://www.nj.gov/humanservices/dmha s/publications/performance/PR Provider dir 20230816.pdf
	Percent of individuals experiencing homelessness when exiting treatment	5.6%	
SUD among PEH	Percent of individuals experiencing homelessness who report a substance use disorder (categorized as substance abuse disorder)	19.4% (Baseline value from 2024)	New Jersey Housing & Mortgage Finance Agency and Monarch Housing Associates Point in Time Count https://monarchhousing.org/nj-counts/
Drug-Related Hospital Visits (all drugs)	Opioid related hospital visits per 10k residents*: Total	9.5	NJ Overdose Data Dashboard Drug-Related Hospital Visits https://www.nj.gov/health/populationhea lth/opioid/opioid_hospital.shtml
	Opioid related hospital visits per 10k residents*: non- Hispanic White	6.7	
	Opioid related hospital visits per 10k residents*: non- Hispanic Black	25.6	
	Opioid related hospital visits per 10k residents*: Hispanic	6.4	
MOUD Prescriptions	New MOUD prescriptions	Not publicly available	Proprietary State-owned administrative data
New Hepatitis C Infections	New Hepatitis C infections per 10k residents* (Disaggregation by race, ethnicity, and age are not currently publicly available but might be possible to calculate using proprietary State-owned data)	5.1	NJSHAD https://www-doh.state.nj.us/doh- shad/query/result/commdis/CommDis/Count.html
Naloxone Incidents	Naloxone administrations per 10k residents*: Total	14.0	Overdose Data Dashboard Naloxone Incidents https://www.nj.gov/health/populationhea

State-Level Indicator	Specific Measure	Baseline Value (2022)	Data Source
Naloxone distribution in communities	Naloxone distributed by Human Services through Naloxone Direct and Naloxone 365 Programs to pharmacies and eligible agencies, including emergency personnel, HRCs, treatment facilities, and others (May be disaggregated by naloxone dispending pharmacies and HRCs)	149,644 kits ⁿ (Baseline value from August 2023)	New Jersey Department of Human Services Substance Abuse Prevention and Treatment and Community mental Health Services Block Grant https://www.nj.gov/humanservices/dmhas/publications/federal/FY%202024-2025%20Combined%20MHBG%20and%20SUPTRSBG%20Plan%20App.pdf
Treatment Admissions	Drug-related treatment admissions per 10k residents* (Disaggregation by race, ethnicity, and age are not currently publicly available but might be possible to calculate using proprietary State-owned data)	85.4	NJSAMS Substance Use Treatment Admissions https://njsams.rutgers.edu/njsams/Reports/SummaryReports/StateSummaryReportmenu.aspx
Recovery support service participation	Individuals receiving recovery support services at State- funded Regional Recovery Centers or Community Peer Recovery Centers	10,620°	New Jersey Department of Human Services Substance Abuse Prevention and Treatment and Community mental Health Services Block Grant https://www.nj.gov/humanservices/dmha s/publications/federal/FY%202024- 2025%20Combined%20MHBG%20and% 20SUPTRSBG%20Plan%20App.pdf

Note: Counts per 10k residents are calculated by dividing the raw counts for each indicator by the total population count according to the U.S. Census Bureau data and multiplying the resulting value by 10,000. It is important to use the population count relative to each demographic subgroup (i.e., divide the number of white overdose deaths by the number of white residents). Data from many of these publicly available sources are routinely updated. The data used to calculate the baseline measures in this table reflect counts reported as of May 2024.

ⁿ Baseline estimates are based data extracted from the Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant Assessment and Plan and limited to Naloxone Direct and Naloxone 365 programs for which the same time period of data was presented. Baseline data may be adjusted if counts from other naloxone distribution programs (e.g., Opioid Overdose Prevention Network) are made available.

^o Baseline estimates are based data extracted from the Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant Assessment and Plan and limited to Regional Recovery Centers and Community Peer Recovery Centers for which the same time period of data were presented. Baseline data may be adjusted if counts from other recovery support programs (e.g., Opioid Overdose Recovery Program, Support Teams for Addiction Recovery, Maternal Wraparound Program, Family Support Centers) are made available.

