NEW JERSEY

OPIOID RECOVERY & REMEDIATION ADVISORY COUNCIL

STRATEGIC PLAN

APPENDICES

SPRING 2025

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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.

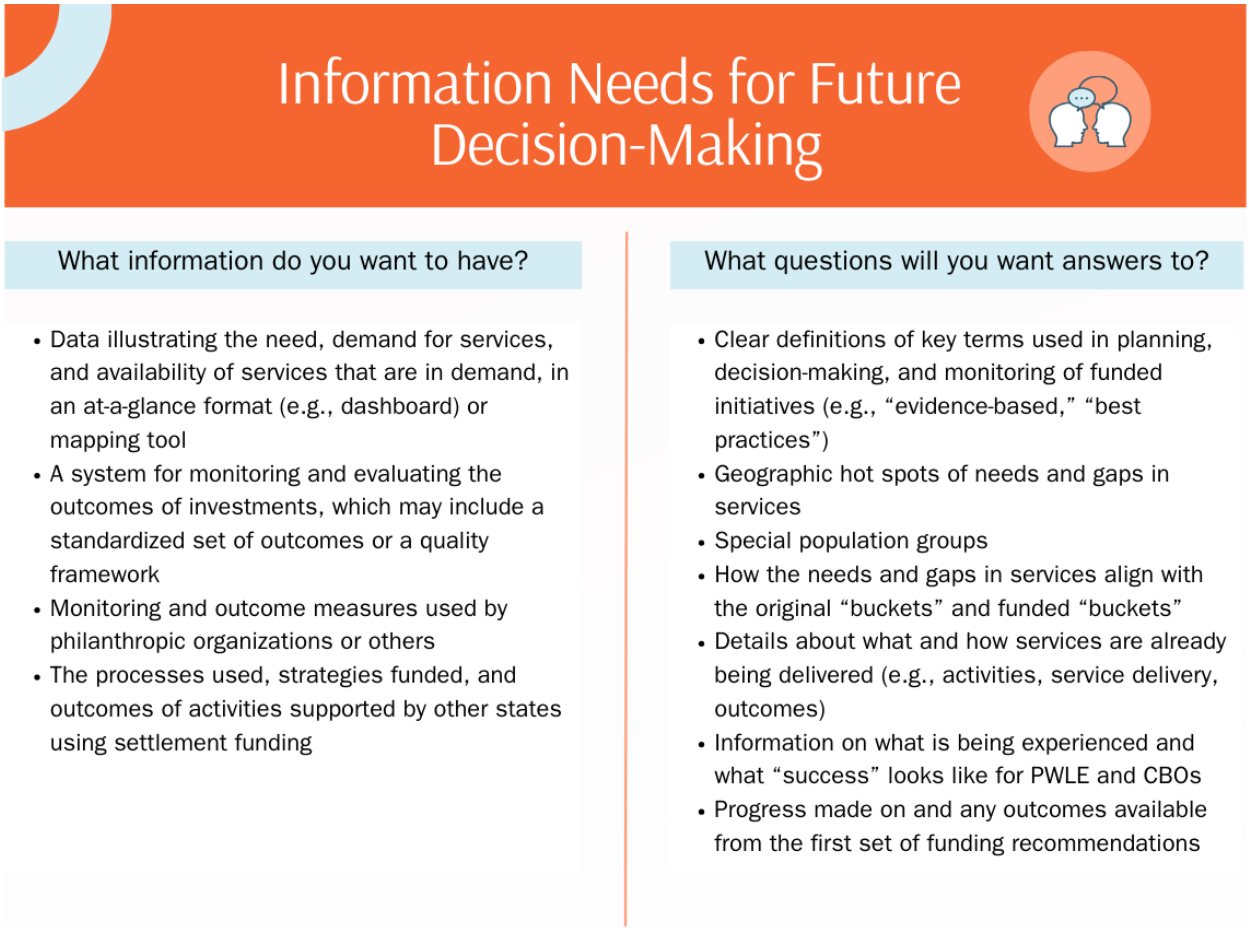
Advisory Council Engagement

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?"



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., substance-affected 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, age-adjusted, disaggregated by age group)*	2020-2022	Available at the county level, by race/ethnicity, and for a recent historical period by age
DOH - Overdose Data Dashboard (from website)	Overdose deaths (all and opioid-specific, race-adjusted)	2019-2022	
	Hospital visits (all and opioid-specific)	2019-2022	
	Naloxone incidents	2019-2023	
CDC - SUDORS Overdose Death Circumstances Data (from website)	Overdose deaths among persons with a mental health diagnosis	2020-2022	Available at the state-level for a recent historical period
	Overdose deaths among persons who had at least one prior overdose	2020-2022	
	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	Available at the county level and for a recent historical period
DOH - NJ State Health Assessment Data (NJSHAD) (from website)	New Hepatitis B & C infections	2019-2022	
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	
	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			
U.S. Census - American Community Survey 2022 5-Year Estimates (ACS, from website)	Percent below 185% of poverty	2022	Available at the U.S. Census block group level and for recent period
	Percent unemployed	2022	
	Percent without a car	2022	
	Percent housing cost burdened	2022	
	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)	Treatment facilities (comprehensive list)	2024	Available at the location level and for recent period
Vital Strategies (by email request)			
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)	Food Pantries*	2024	
Community Food Bank of NJ (by email request)			
NORWESCAP Food Bank (from website)			
Mercer Street Friends (from website)			
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 & Analysis	Recidivism	No baseline data for those who complete diversion
	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

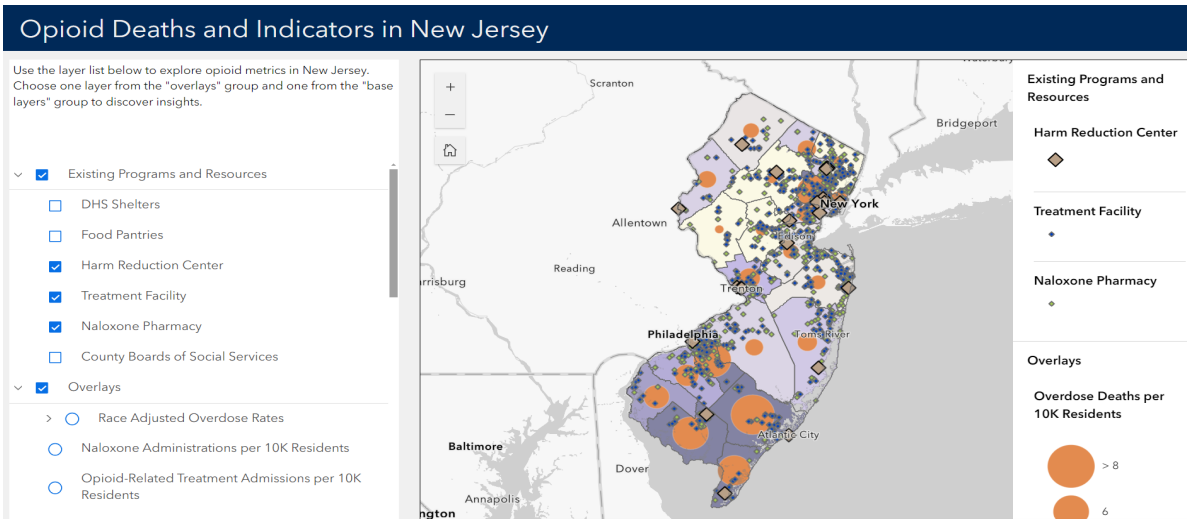
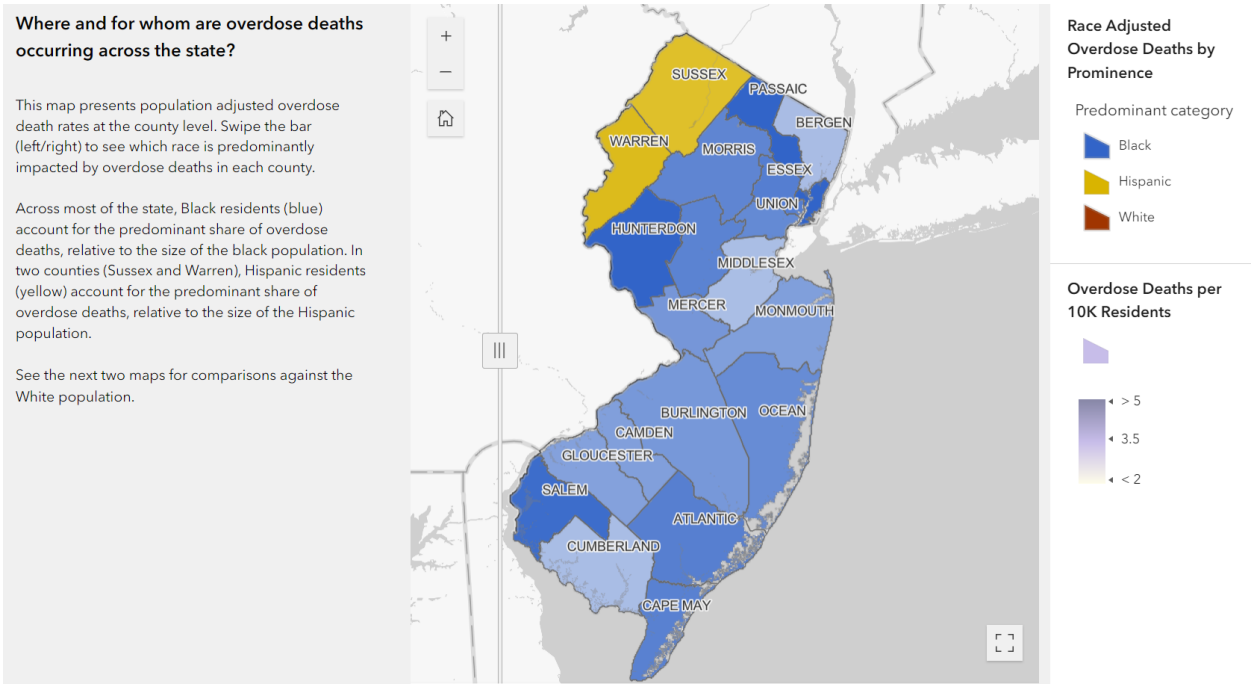


Figure B-6. Story map of specific data layers to address guiding questions



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:
    - 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.

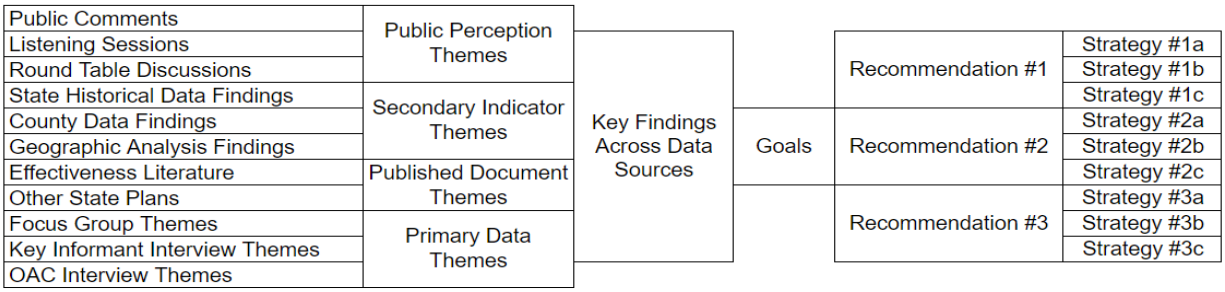
The Montclair State University Institutional Review Board provided oversight for the protection and ethical treatment of individuals participating in data collection.

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



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 in-person 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.

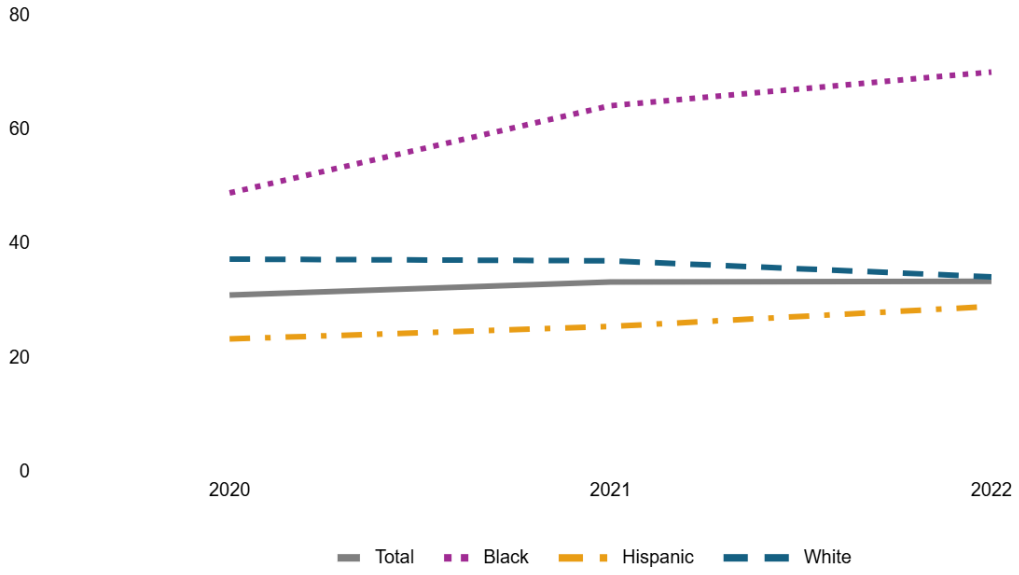
1. POPULATIONS UNIQUELY AFFECTED BY SUD AND THE OVERDOSE CRISIS

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 NJ SUDORS Overdose Mortality Data Explorer 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[c], 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.[f] 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 2023[h] and in New Jersey, estimates from the 2024 Point-In-Time Count report approximately 19% of PEH have a SUD.[i] 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

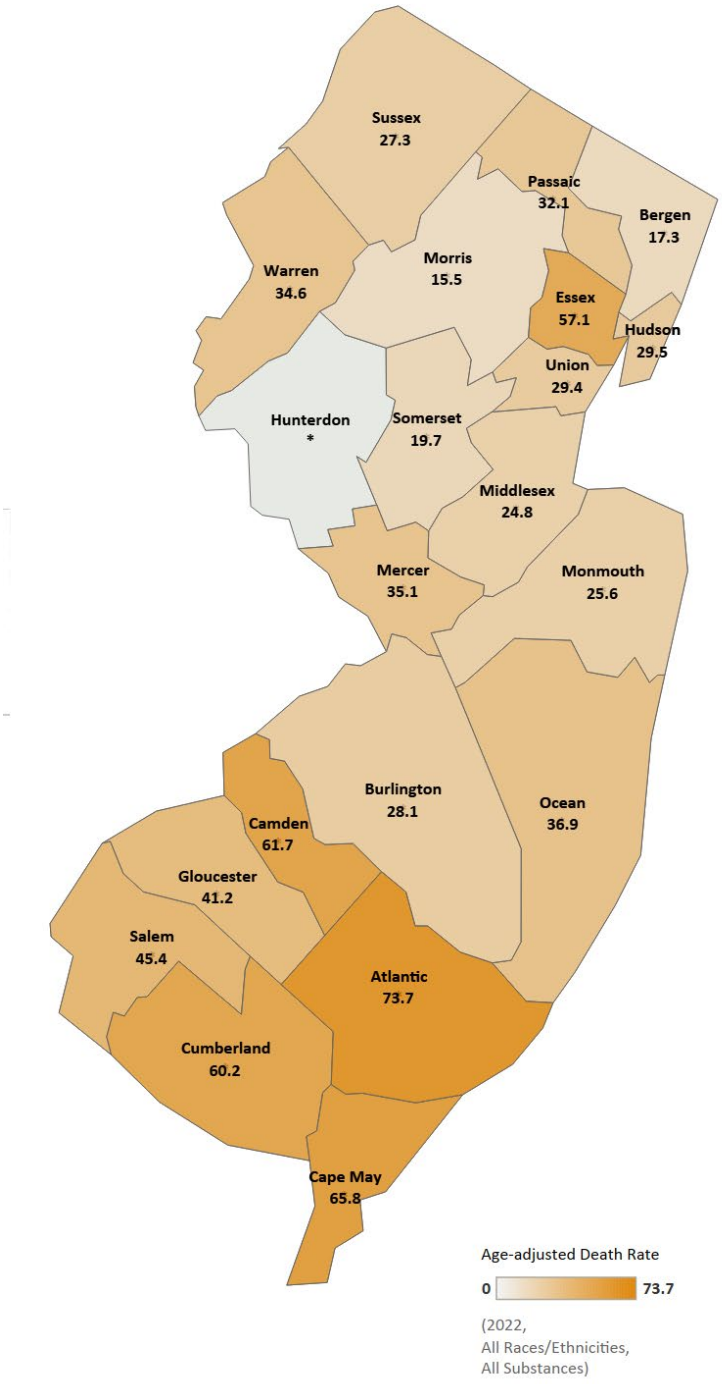
As reported across stakeholder groups, New Jersey residents living in rural areas frequently experience resource scarcity and challenges associated with reliable transportation. Geospatial exploration of available resources reveals that resources are frequently clustered in high population density areas. 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 NJ SUDORS Overdose Mortality Data Explorer 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.[j] Each of these services and their wide-reaching benefits are described in the following sections.

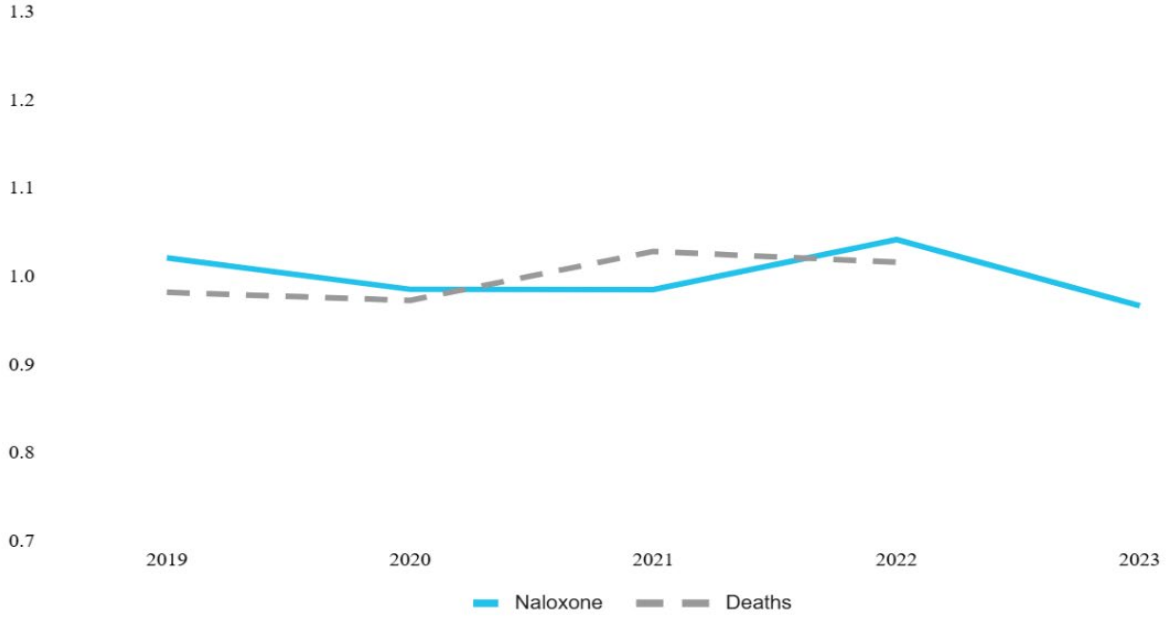
Naloxone Distribution

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.

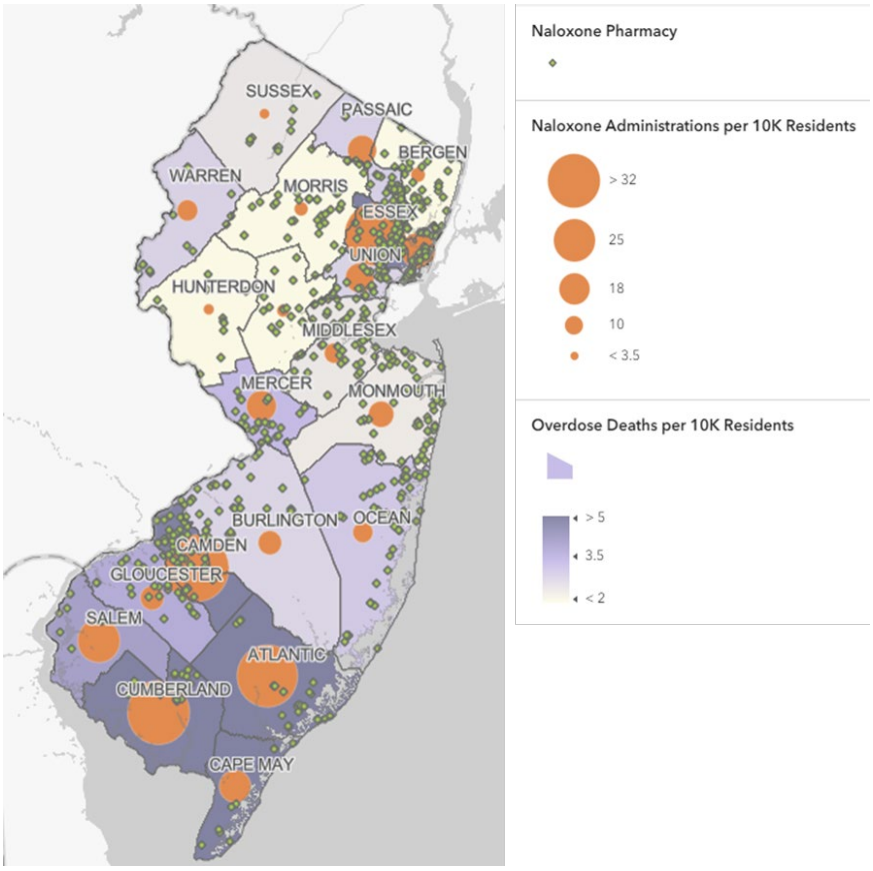
Figure C-3. Change in Normalized Counts of Opioid Overdose Deaths and Naloxone Incidents by LE and EMS



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.

"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

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;
- 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 buy-in 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, safe-use 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-to-reach 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."

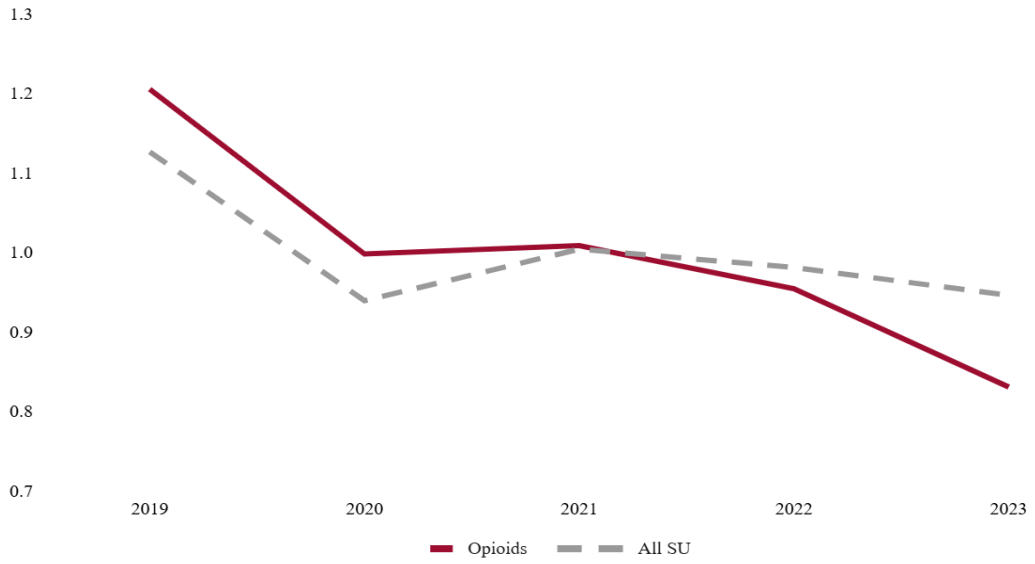
"I see the successes of what housing can do for somebody that was out on the streets, that was in active addiction, and have completely turned their life around. [They become] community advocates and promote recovery…And a lot of them, the clients say it's all because they had access to stable housing."

– 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

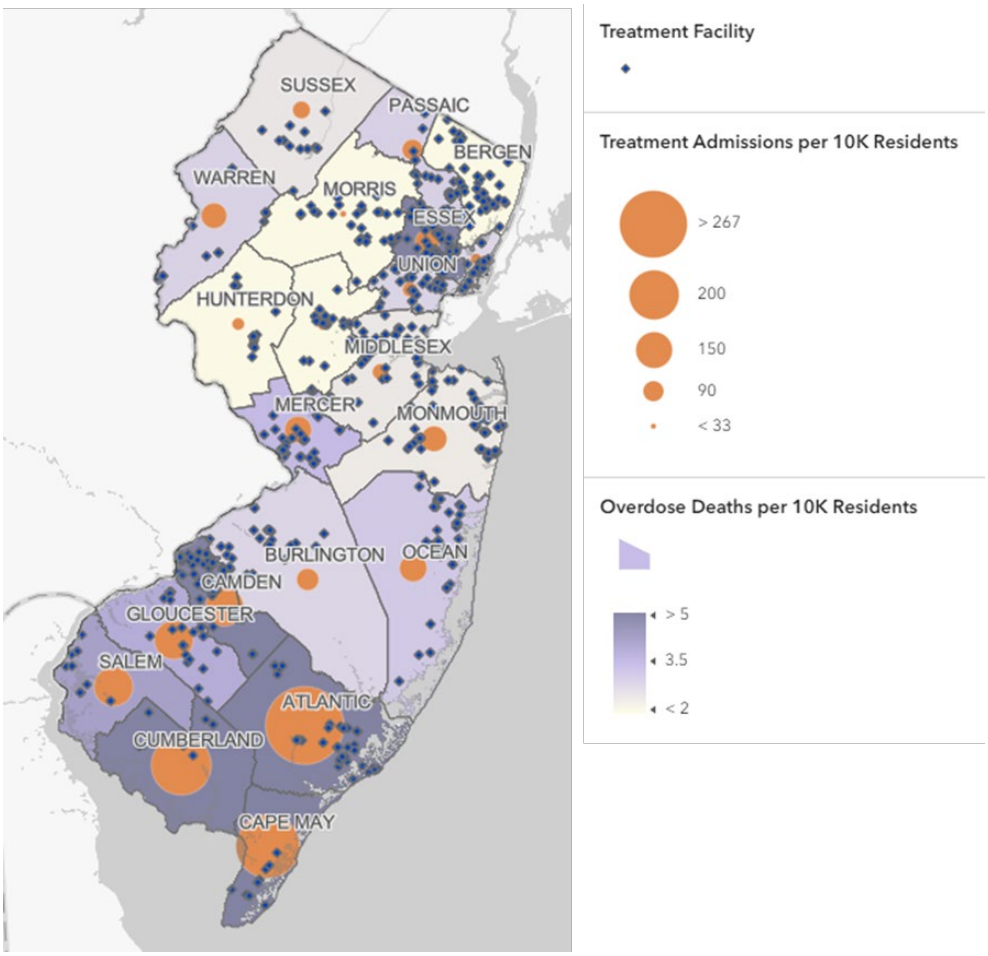
The restrictions based on mental health status and types of substances used are uniquely problematic because, as noted above, population research suggests that, nationally, up to 64% of individuals with SUD have a co-occurring mental health condition and up to 73% have a co-occurring SUD (i.e., polysubstance 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 *Strategic Objective* (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 accessibility of housing for individuals and families affected by substance use disorder (e.g., Housing First)*	**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.
	2. Expand access to affordable, supportive, and transitional housing models tailored to individuals across the continuum of recovery (e.g., sober-living, recovery housing, housing assistance programs, supportive housing).	**2.1.** Provide housing assistance for individuals in recovery who need housing support.

Goal *Strategic Objective* (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 populations and geographic areas of need. This may include capacity training or technical assistance to apply for and manage funding awards.	**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. **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 specialists into the health care team.	**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. **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 *Strategic Objective* (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 evidence-based treatment services, including low-threshold MOUD and trauma-informed models of care, for populations and geographic areas in need.	**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. **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 practice or evidence-based treatment approaches, including MOUD, cultural competence, and trauma-informed models of care.	**3.1.** Fund initiatives that expand treatment options based on the treatment and resource gaps identified. **3.2.** Fund initiatives that expand treatment options for populations and in geographic areas in need. This may include youth and older adults.

Goal *Strategic Objective* (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	NJ Overdose Data Dashboard NJ SUDORS Overdose Mortality Data Explorer Opioid Overdose Deaths/Fatal Overdoses https://www.nj.gov/health/populationhealth/opioid/sudors.shtml
	Confirmed overdose deaths per 10k residents*: non-Hispanic White	2.8	
	Confirmed overdose deaths per 10k residents*: non-Hispanic Black	7.3	
	Confirmed overdose deaths per 10k residents*: Hispanic	2.9	
	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/dmhas/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/populationhealth/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/populationhealth/opioid/opioid_naloxone.shtml
	Naloxone administrations per 10k residents*: non-Hispanic White	8.9	
	Naloxone administrations per 10k residents*: non-Hispanic Black	38.0	
	Naloxone administrations per 10k residents*: Hispanic	9.3	

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/SummaryReport/StateSummaryReportMenu.aspx
Recovery support service participation	Individuals receiving recovery support services at State-funded Regional Recovery Centers or Community Peer Recovery Centers	10,620[o]	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

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.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