NEW JERSEY

OPIOID RECOVERY & REMEDIATION ADVISORY COUNCIL

STRATEGIC PLAN

SPRING 2025

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DEDICATION

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

RESOURCE DIRECTORY

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

Substance Use

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

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

NJ Children's System of Care - Perform Care
https://www.performcarenj.org/
1-877-625-7624
A single point of access to behavioral health, intellectual and developmental disability services, as well as substance use treatment for youth and families

NJ Connect 4 Recovery Helpline
https://www.njconnectforrecovery.org/
855-652-3737
Resources for families and friends of those who use substances; provides emotional support, education, family and peer guidance, and referrals to treatment options

Reach NJ Addiction Helpline
https://www.reachnj.gov
1-844-REACHNJ or 1-844-732-2465
Central call-line for residents looking for help with substance use disorder; provides trained addiction counselors, referrals to treatment, and support services

Recovery Centers
https://nj.gov/humanservices/reachnj/help/centers/
Directory of Community Peer Recovery, Family Support, and Harm Reduction Centers in New Jersey

Mental Health and Suicide Prevention

2NDFLOOR Youth Mental Health
Helplinehttps://www.2ndfloor.org/
1-888-222-2228
A confidential and anonymous helpline for New Jersey's youth and young adults with a message board and mental health counselors available 24/7 365 days a year

988 Suicide and Crisis Lifeline
https://www.988lifeline.org/chat
988
Helpline that connects people via call, text, or chat to crisis counselors; provides emotional support and crisis counseling

Directory of Mental Health Services
https://www.nj.gov/humanservices/dmhas/home/hotlines/MH_Dir_COMPLETE.pdf
List of State contracted mental health providers

NJ Children's System of Care - Perform Care
https://www.performcarenj.org/
1-877-625-7624
A single point of access to behavioral health, intellectual and developmental disability services, as well as substance use treatment for youth and families

NJ Self-Help Group Clearinghouse
https://www.njgroups.org/
1-800-367-6274
Resources for starting or participating in a self-help group related to a range of conditions or across a range of physical and mental conditions, situations

NJMentalHealthCares Helpline
https://www.njmentalhealthcares.org/
1-866-202-HELP
Behavioral health information and referral service to help individuals and families get the services needed

RESOURCE DIRECTORY

Basic Needs

ACCESS American Sign Language and Videophone Helpline

973-870-0677

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

Garden State Community Outreach

https://gardenstateoutreach.us/

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

NJ 2-1-1

https://nj211.org/

211

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

NJ Helps

https://www.njhelps.gov/

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

NJ Housing Resource Center

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

1-877-428-8844

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

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GLOSSARY OF ACRONYMS AND KEY TERMS

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

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

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

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

INTRODUCTION

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

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

New Jersey Opioid Recovery and Remediation Advisory Council

On August 31, 2022, Governor Murphy signed Executive Order No. 305[7] to create the Opioid Recovery and Remediation Advisory Council (Advisory Council) and, in December 2022, the inaugural 10 public members were appointed. These members reflect New Jersey's diversity, and include individuals with lived experiences, representatives of key stakeholder groups, people of varying academic backgrounds, and engaged community leaders, with many public members bringing an intersection of these backgrounds. In addition, the Attorney General and the Commissioners of the Departments of Children and Families and of Health, or their designees, are included as ex officio members. The Commissioner of the Department of Human Services (Human Services) serves as the Chairperson of the Advisory Council (Appendix A).

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

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

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

Purpose of this Strategic Plan

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

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

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

PLANNING PROCESS

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

Phase 1

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

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

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

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

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

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

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

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

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

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

Phase 2

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

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

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

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

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

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

OVERVIEW OF CURRENT NEED IN NEW JERSEY

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

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

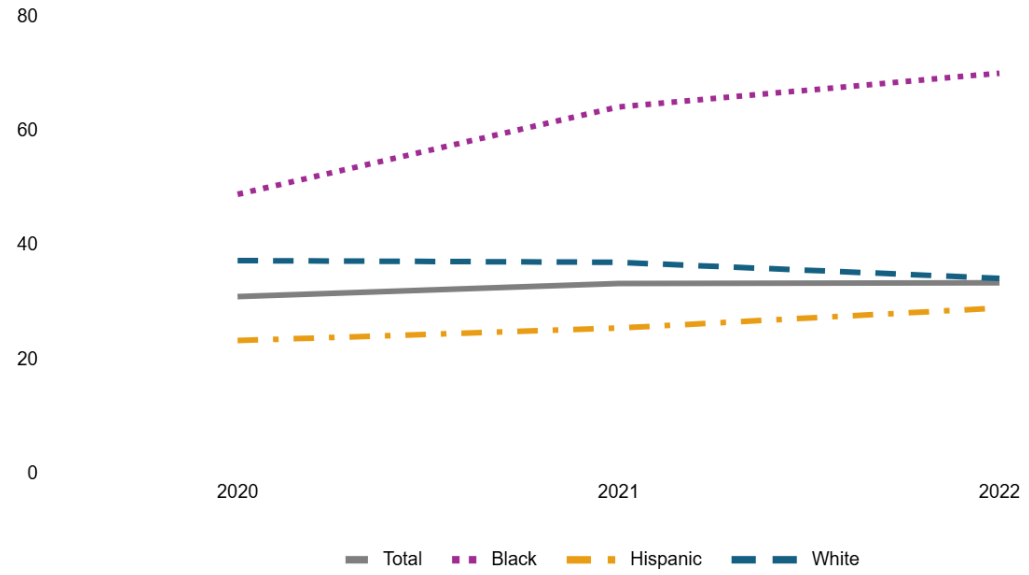
The following sections outline key findings from the *Needs Assessment*, which compiled and collected data in March through July 2024. This reflects a snapshot of available data during that time period. More recent data may now be available from publicly available sources (e.g., NJ Overdose Data Dashboard).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

Populations Uniquely Affected by SUD and the Opioid Crisis

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

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

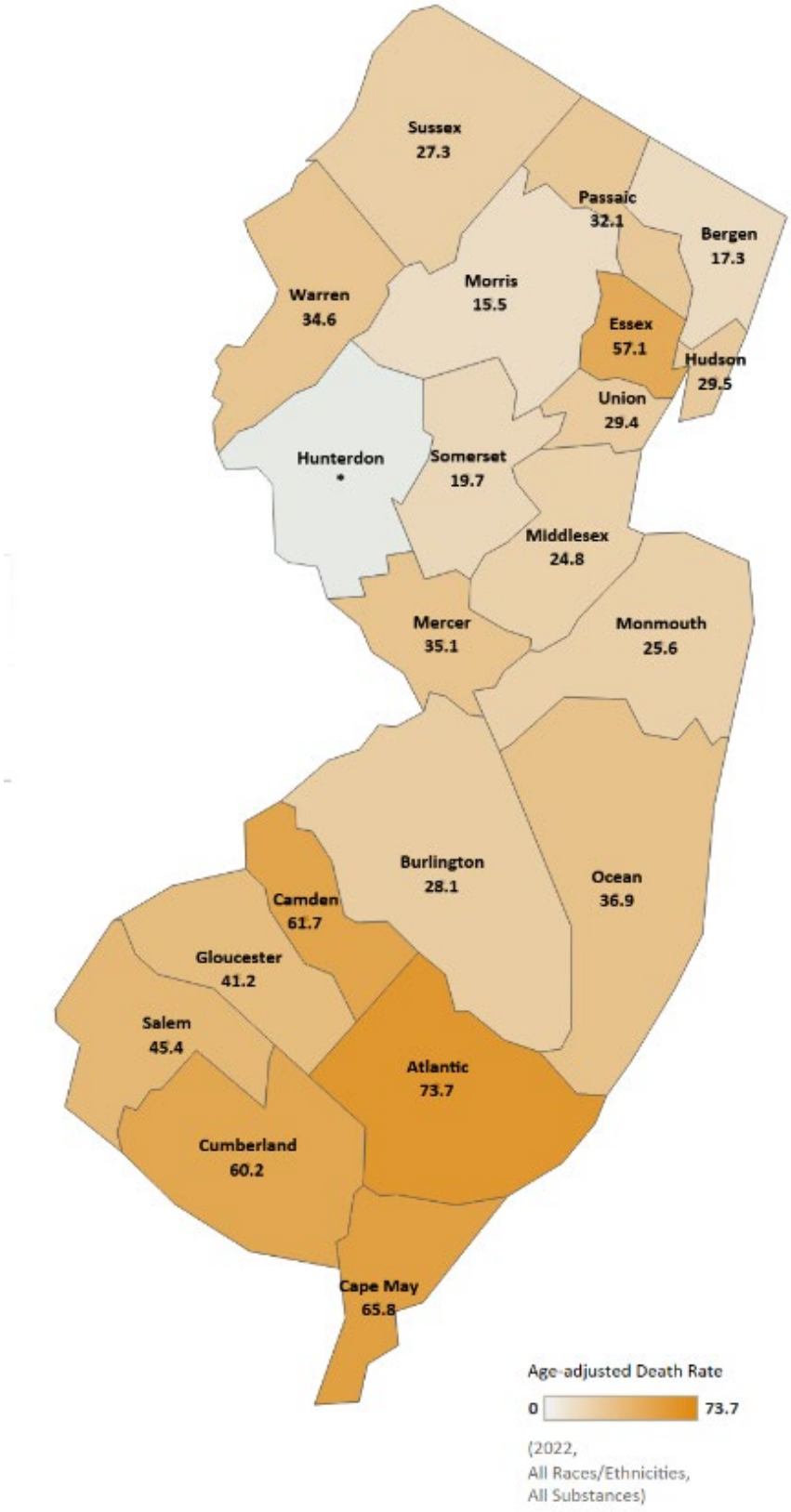
Figure 2. Age-adjusted rates of overdose deaths by race and ethnicity (2020 to 2022) which illustrate the disproportionate burden of overdose deaths among Black residents in New Jersey



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

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

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



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

Successful Strategies to Preserve Life

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

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

Persistent Barriers to Service Delivery Across the Continuum of Care

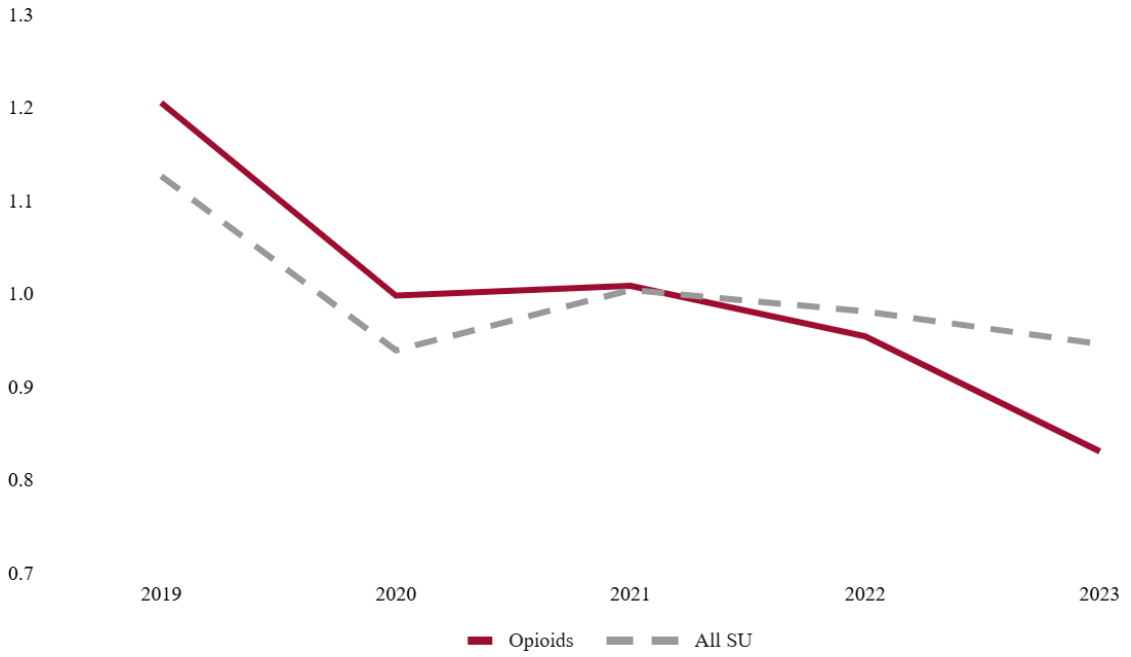
Expanding access to effective services is a salient need in New Jersey, especially for residents who remain underserved or are disproportionately impacted by the opioid crisis. Data collected through the *Needs Assessment* indicate that stigma around SUD, HR, and MOUD; suboptimal coordination across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

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

Accessibility of Treatment

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

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



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

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

STRATEGIC PLAN

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

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

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

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

VISION

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

MISSION

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

TRANSPARENCY

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

FEEDBACK

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

DATA TRACKING & EVALUATION

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

REFINEMENT

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

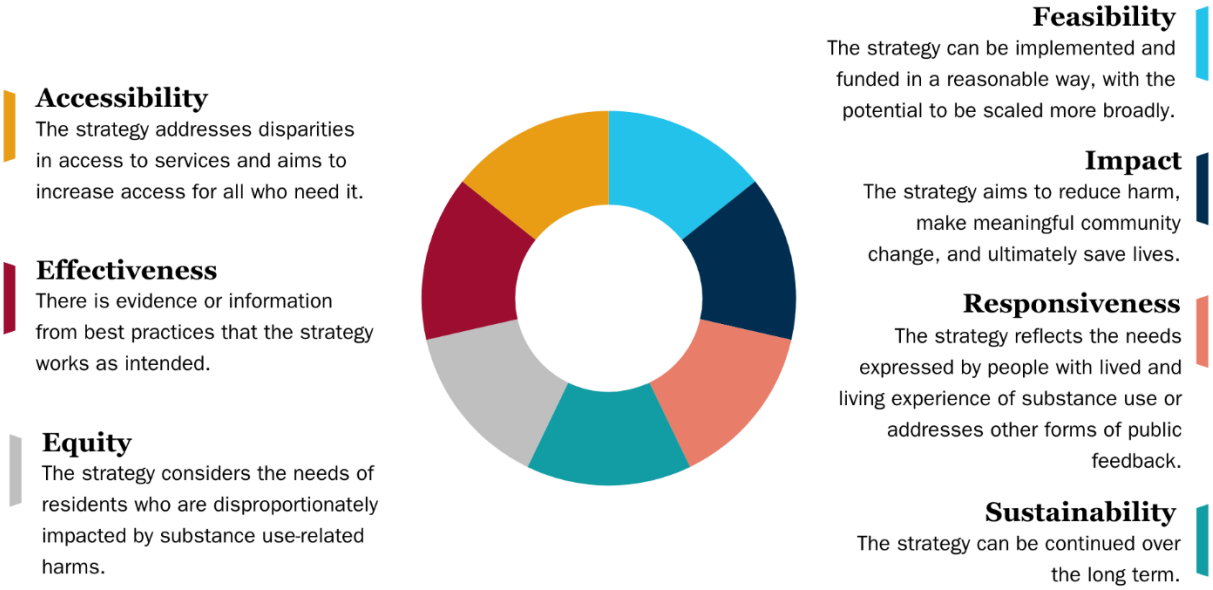
COMMUNICATION

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

Guiding Principles for Funding Recommendations

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

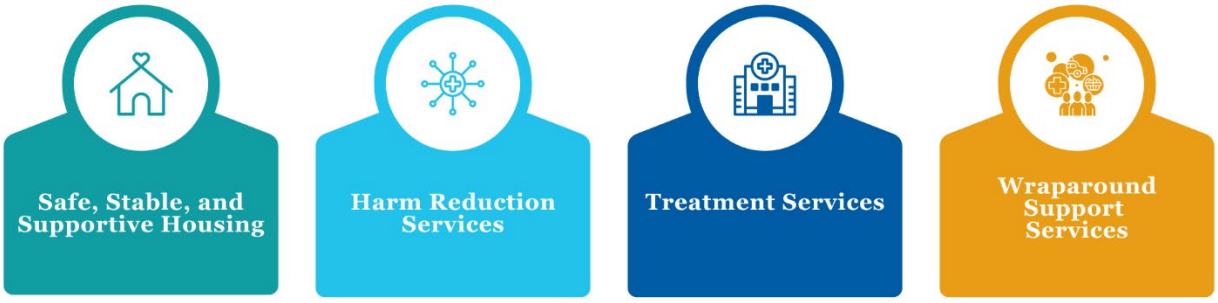
Figure 5. The Advisory Council uses seven guiding principles to inform their recommendations for using opioid settlement funds in New Jersey



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

> *The New Jersey Opioid Recovery and Remediation Advisory Council recognizes the devastating impacts and complex needs presented by the ongoing opioid crisis. In light of these challenges, the Advisory Council is choosing to pursue human-centered, community-driven, and evidence-based frameworks in our funding recommendations for these limited opioid abatement funds. The Advisory Council will continue to prioritize equity and utilize available data to ensure these funds reach communities that are experiencing higher rates of overdose, opioid use, or substance use.*
>
> *The Advisory Council's primary focus is to support programs and initiatives that directly address the opioid crisis, such as prevention and education, harm reduction and overdose prevention, treatment, recovery services, and services strengthening social determinants of health. The Advisory Council believes that this approach will have the most significant impact in helping individuals and communities affected by the opioid crisis. As such, the Advisory Council will not recommend that funding be used for (i) activities or programs that are not evidence-based or promising practices for opioid abatement; (ii) non-Federal Drug Administration (FDA) authorized medications for the treatment of opioid use disorder or substance use disorder; (iii) purchases of equipment for law enforcement use in search and seizure, suspect apprehension, or evidence gathering, or items that run counter to the evidence-driven and individual-first approach that we have embraced.*

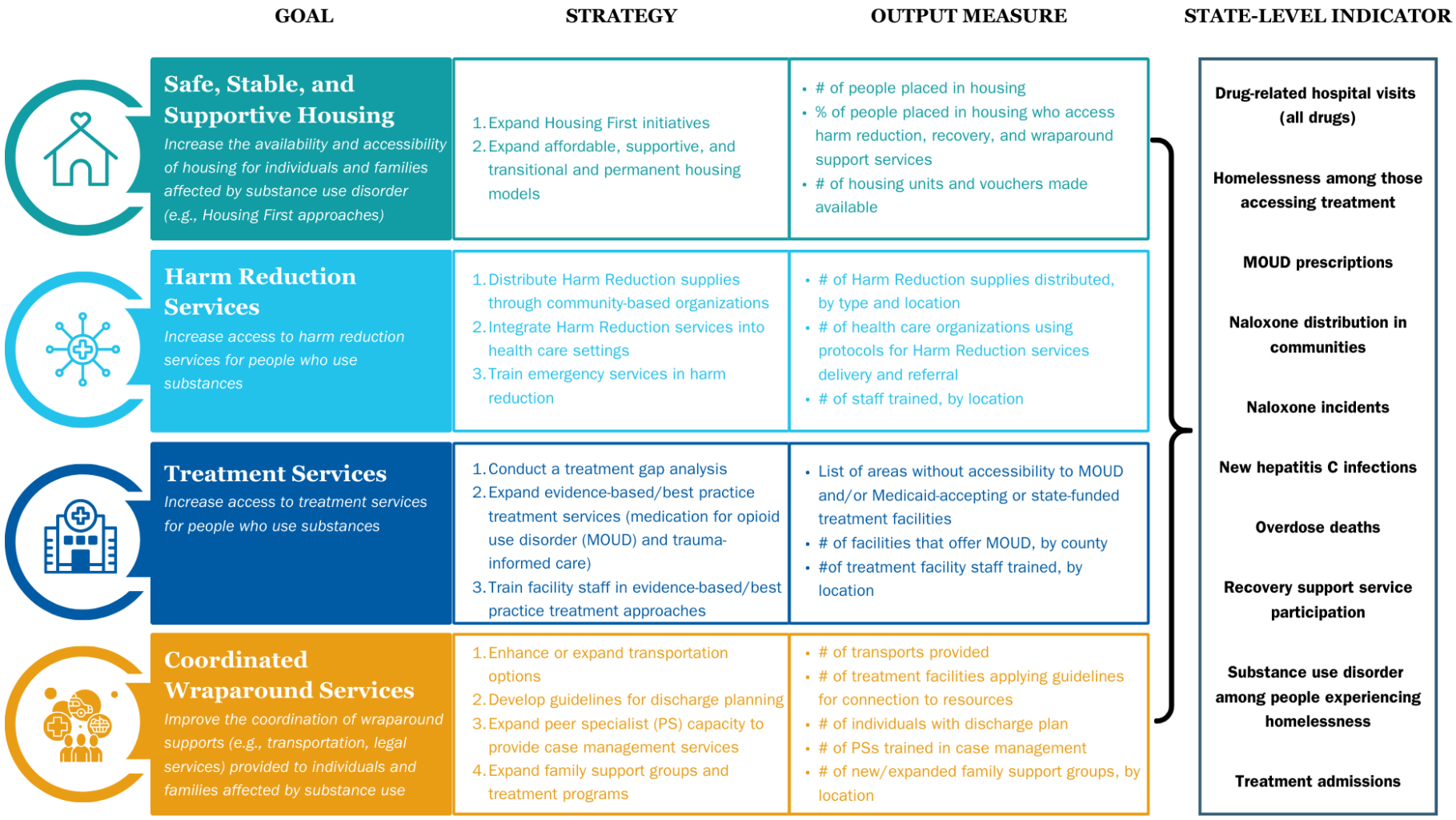
Four strategic goals identified by the Advisory Council as essential to accomplish the vision of the *Strategic Plan* will guide funding recommendations. The goals focus on increasing access among individuals and families affected by SUD to:



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

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

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



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

GOAL: SAFE, STABLE, AND SUPPORTIVE HOUSING

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

Supporting Evidence

People experiencing homelessness (PEH) are cited by all key informants in the *Needs Assessment* as a priority population that is uniquely impacted by the opioid crisis. According to CDC's SUDORS Dashboard: Fatal Drug Overdose Data, overdose deaths for PEH in New Jersey increased from 5% in 2021 to 6% in 2022, an increase of approximately 20%.[13] National estimates from the U.S. Department of Housing and Urban Development indicate that 17% of PEH in the U.S. had a SUD in 2023[14] and in New Jersey, estimates from the Point-In-Time Count report approximately 19% of PEH had a SUD in 2024.[15] Research suggests that PEH less frequently access lifesaving MOUD treatment options than their housed counterparts.[16]

Housing is a key lever essential for stability and long-term recovery and wellbeing. *Needs Assessment* findings and published literature highlight that the Housing First model is a critical and effective method to provide housing for New Jersey residents who use substances. This model does not have eligibility restrictions based on sobriety or treatment engagement. Instead, it adheres to the principle that housing is a basic need that must be met before other goals (e.g., employment, treatment) can be pursued. The Housing First model often offers optional wraparound support services (e.g., counseling, job services, MOUD options) that participants can access to the extent desired. Published results from systematic reviews and randomized controlled trials indicate that the Housing First model is cost-effective[17] and increases participant access to psychiatric counseling and medication treatment for mental health or SUD.[18]

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

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

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

Strategies and Existing Funding Recommendations

1. **Expand Housing First initiatives** for individuals and families affected by SUD without mandating abstinence or engagement of any services.

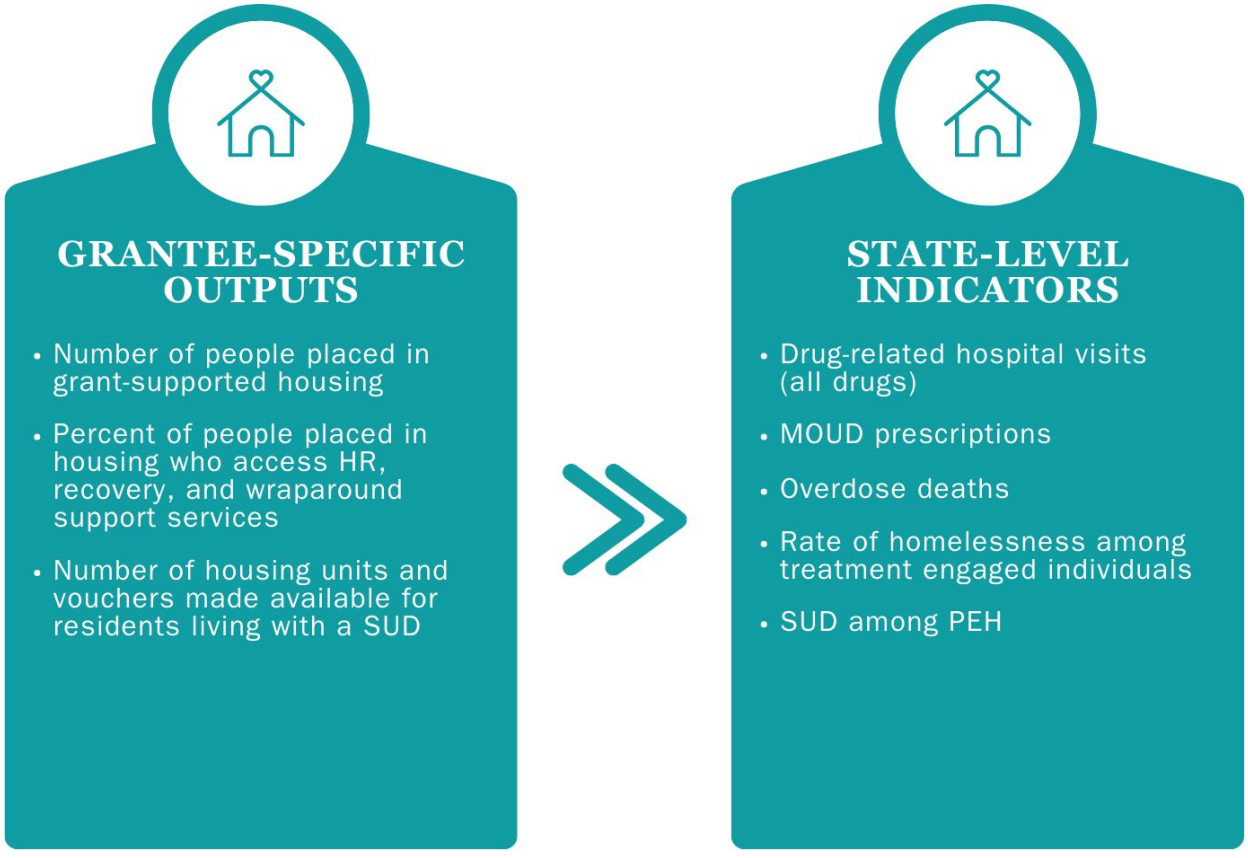
2. **Expand access to affordable, supportive, and transitional and permanent housing models** tailored to individuals across the continuum of recovery (e.g., sober-living, recovery housing, housing assistance programs, supportive housing).

EXISTING FUNDING RECOMMENDATIONS

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

Progress Measures

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



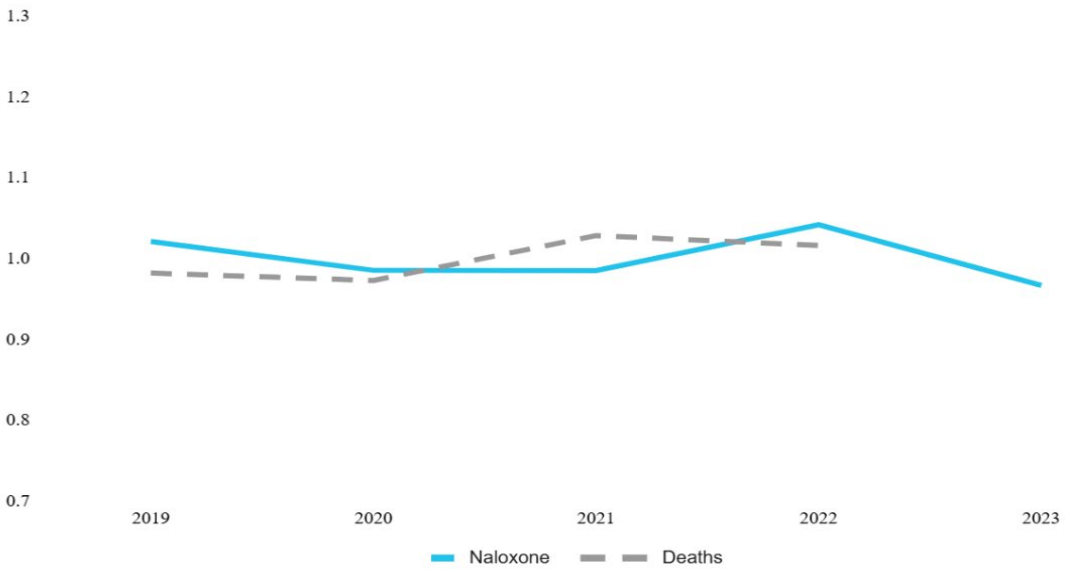
GOAL: HARM REDUCTION SERVICES

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

Supporting Evidence

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

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



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

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

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

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

Strategies and Existing Funding Recommendations

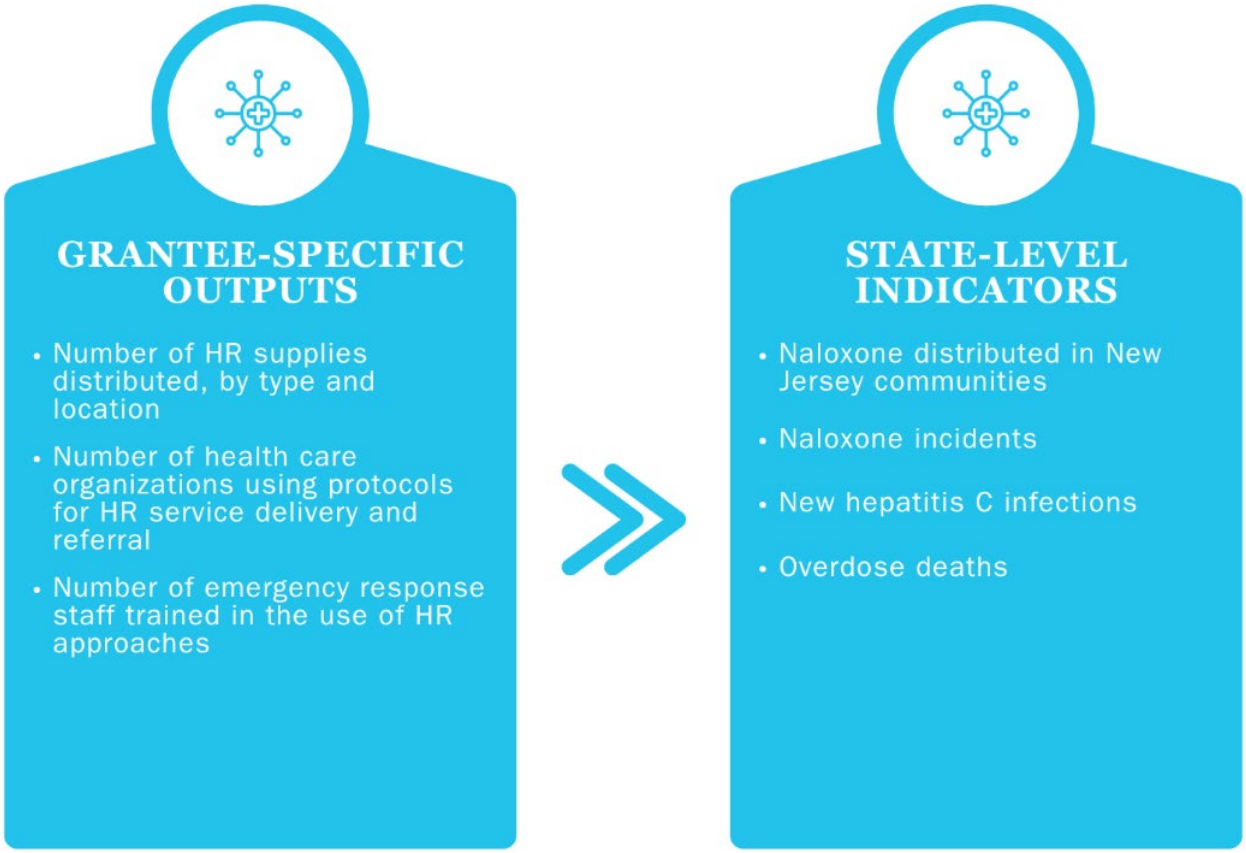
1. **Provide funding to CBOs and/or some local businesses** (e.g., non-profits, barbershops, hair salons, faith-based organizations, corner stores) for **distribution of HR supplies** to populations and geographic areas of need. This may include capacity training or technical assistance to apply for and manage funding awards.

2. **Integrate HR services into health care settings** (e.g., Federally Qualified Health Centers, primary care, EMS). This may include, but is not limited to, integrating peer specialists (PSs) into the health care team.

3. **Invest in training and education efforts** for first responders, emergency departments, primary health care providers, and ancillary health care providers about HR services.

Progress Measures

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



GOAL: TREATMENT SERVICES

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

Supporting Evidence

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

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

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

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

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

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

Strategies and Existing Funding Recommendations

1. **Improve surveillance of treatment gaps and needs**, specifically related to MOUD, ages served (e.g., adolescents, older adults), and Medicaid reimbursement.

2. **Expand the availability and accessibility (including hours of operation, availability of beds, and/or eligibility criteria) of evidence-based or best practice treatment services**, including low-threshold MOUD and trauma-informed models of care, for populations and geographic areas in need. This may be based on the findings from surveillance of treatment gaps and needs (Strategy 1 above).

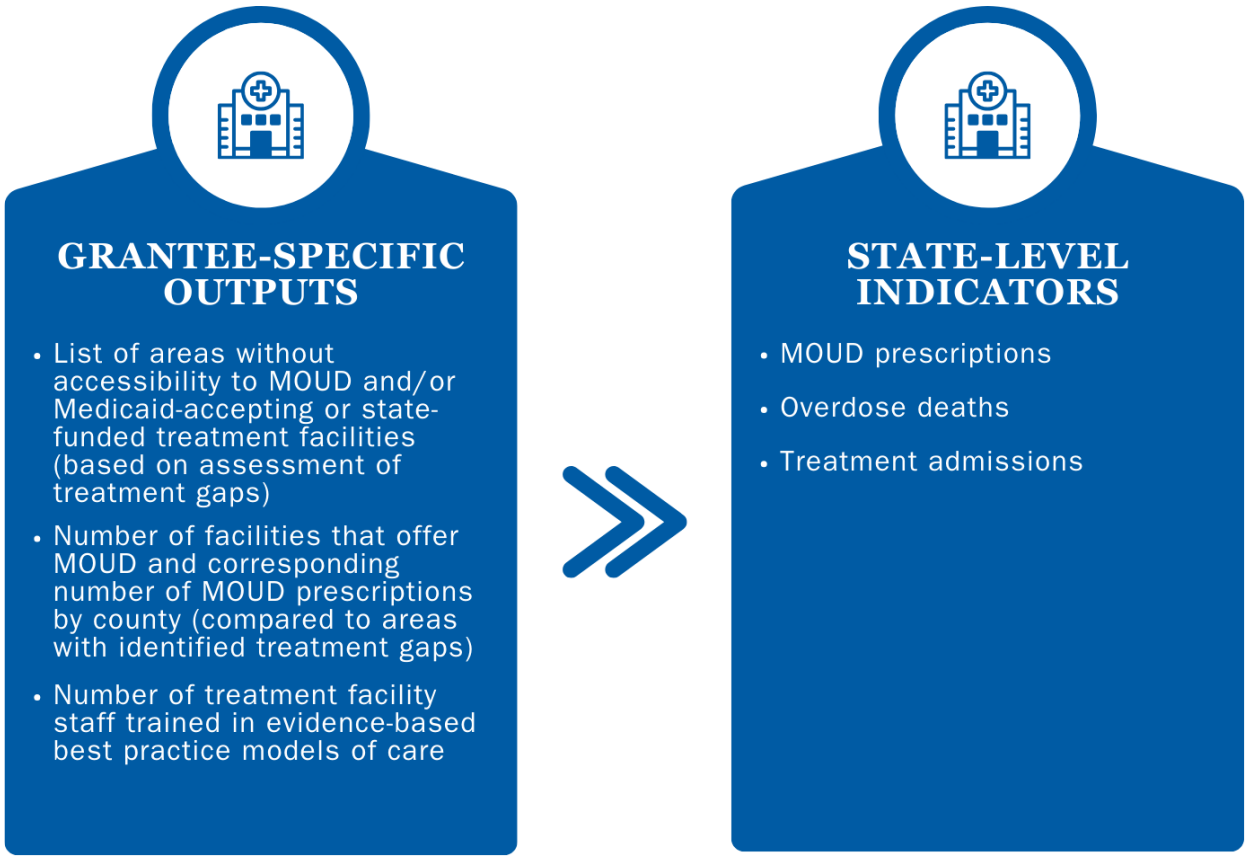
3. **Invest in training treatment facility staff** in best practice or evidence-based treatment approaches, including MOUD, cultural competence, and trauma-informed models of care.

EXISTING FUNDING RECOMMENDATIONS

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

Progress Measures

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



GOAL: COORDINATED WRAPAROUND SERVICES

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

Supporting Evidence

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

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

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

[c] *Needs Assessment* respondents reported that the most universally problematic form of stigma is associated with the criminalization of addiction and the belief that addiction is a lifestyle choice as opposed to a chronic disease. A secondary form of stigma is the belief that HR and MOUD are enabling factors that contribute to the rise of SU and the perpetuation of SUD.

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

Strategies and Existing Funding Recommendations

1. **Enhance or expand transportation options** for individuals who use substances to reach a range of support services (e.g., legal services, food pantries) and access care at HRCs, recovery centers, and treatment providers.

2. **Develop guidelines and provide support for treatment facilities and HRCs to integrate discharge planning into treatment.** This may include partnering with PSs to facilitate the planning process and providing capacity-building support for facilities that do not currently have case management or navigation services. Guidelines should include housing, food assistance, legal services, transportation, job training, child care, and other basic needs.

EXISTING FUNDING RECOMMENDATIONS ⟫

- Legal Services for Individuals with SUD (October 2024)

3. **Expand the capacity of PSs to provide case management services and connect agencies** to improve the coordination of services across the continuum of care. This may include training and other efforts designed to bolster the case management workforce.

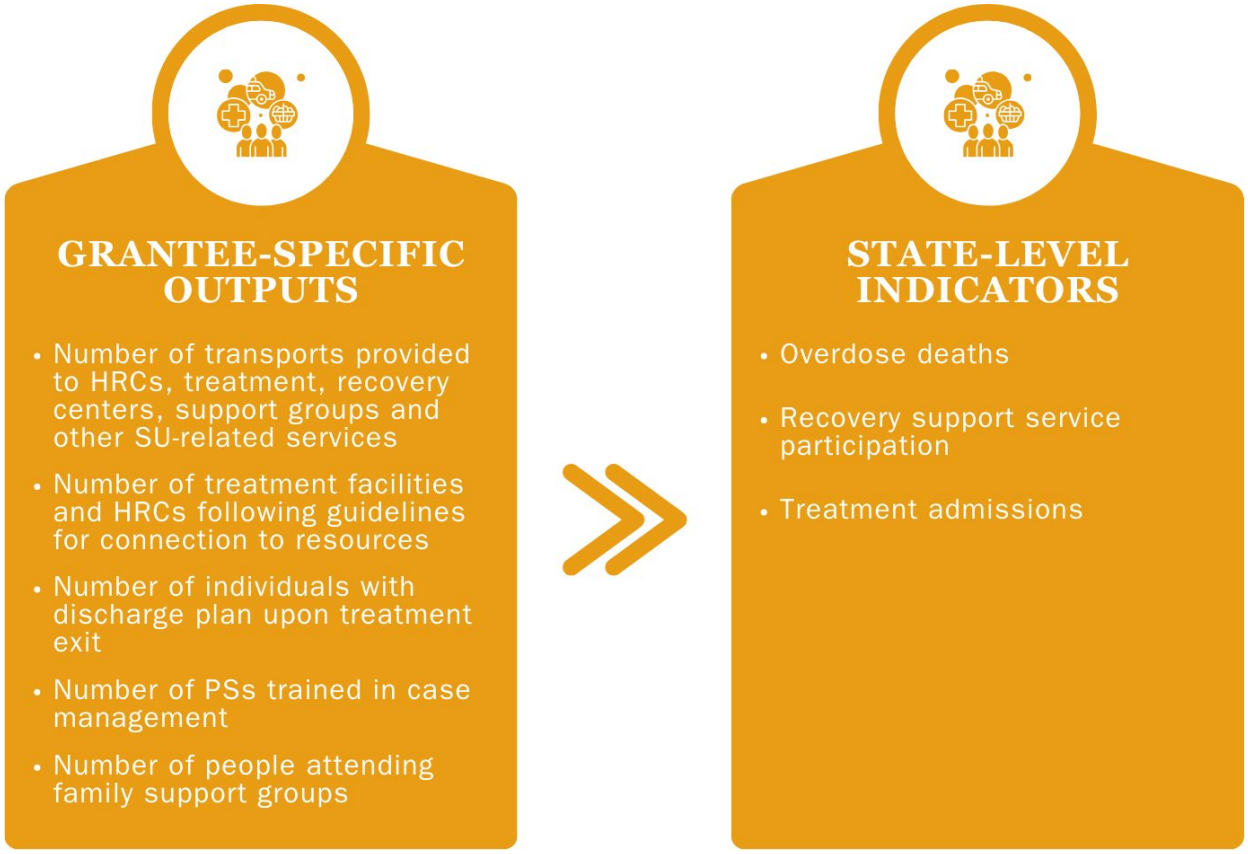
EXISTING FUNDING RECOMMENDATIONS ⟫

- Community Peer Recovery Center Expansion (February 2024)

4. **Expand and sustain family support groups and whole-family treatment programs** (e.g., family bonding activities). This may include funding a backbone agency to provide sub-awards to CBOs.

Progress Measures

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



MONITORING AND EVALUATION PLAN

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

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

Grantee-Specific Monitoring and Evaluation: Scope and Reach

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

- **What:** These outputs include those aligned with each goal of the *Strategic Plan* and typically include the units of service delivered, such as the number of people placed in housing and the number of naloxone kits distributed (i.e., grantee-specific outputs in each goal) (Figure 8). The grantee-specific outputs included in this plan are a starting point. Each output measure will be finalized by grant administrators and may include other information relevant to grant projects. Output data will be collected by grant administrators as part of routine reporting procedures.

- **Why:** Together, these outputs and related details provide a picture of the services delivered as a direct result of the settlement funds invested. Monitoring these grantee-specific outputs will inform the grantee-specific evaluation questions (Figure 8). This will allow the Advisory Council to evaluate the *Strategic Plan* in terms of how funding allocation is increasing access to evidence-based and best practice services, by type of service, for residents who remain underserved or are disproportionately impacted by SUD and the overdose crisis.

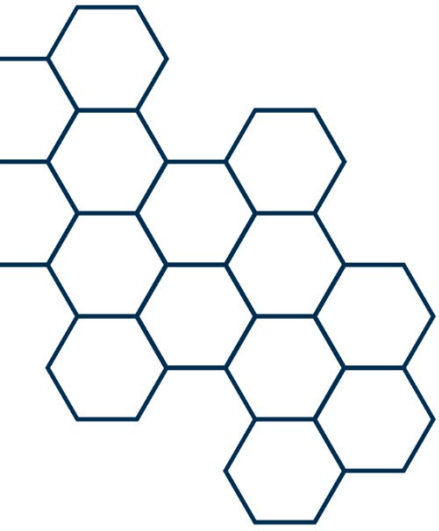
- **How:** Suggested grantee-specific evaluation questions will be informed by regularly submitted grantee reports (e.g., every six months). These data may include types of service and locations of service delivery. Additional demographic data from the U.S. Census will be used to describe the residents who reside in served areas. Together, these data will be used to calculate the percentage of services (by grantee and overall) that are provided in priority areas.

- **Limitations:** A limitation of this approach is that it relies on grantee-reported data. Grantee agencies, especially CBOs, are often limited in their capacity to collect, organize, and report data. Therefore, a goal of this monitoring component is to keep data collection simple and only request data that is needed to answer the key evaluation questions. This will ideally reduce the burden of data collection on grantee agencies while simultaneously increasing the quality of the data submitted and the proportion of funds to direct service.

Program-Specific Monitoring and Evaluation: Direct Outcomes

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

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



State-Level Monitoring and Evaluation: Trends Over Time

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

- **What:** State-level long-term indicators include drug-related hospital visits, homelessness among those accessing treatment, MOUD prescriptions, naloxone distribution in communities, naloxone incidents, new hepatitis C infections, overdose deaths, recovery support service participation, SUD among PEH, and treatment admissions. Together, these indicators provide a broad picture of trends related to SU in New Jersey (Appendix F).

- **Why:** Monitoring these indicators over time will inform the suggested statewide evaluation questions, which are designed to help the Advisory Council understand how disparities in indicators shift (Figure 8). This will facilitate the identification of priority populations and shape future funding recommendations.

- **How:** To inform the statewide evaluation questions, indicator data will be tracked each year for at least three years (at least three years are needed to examine changes in trends over time). These data will be disaggregated by county, race and ethnicity, age, and other demographic characteristics whenever possible. Additional data may be compiled to compare indicator data to population estimates. At the time of this plan, most of these indicator data are publicly available in New Jersey (e.g., on the New Jersey Overdose Data Dashboard and NJCARES websites). Collaboration and annual data sharing across the Departments of Human Services and Health may be necessary if additional details are needed.

- **Limitations:** A noteworthy limitation of this component of the evaluation and monitoring framework is that state-level indicators are influenced by multiple factors (e.g., other State initiatives designed to address the opioid crisis or related issues, drug supply, economic trends). Therefore, changes in these indicators cannot be attributed solely to *Strategic Plan* investments. Previous research indicates that the investments identified above can be expected to contribute to positive changes in state-level indicators, but assessing causality is beyond the scope of this monitoring plan.

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

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

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

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

NEXT STEPS

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

Ongoing Review of the Strategic Plan

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

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

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

Funding Investment Decisions

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

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

- Consider the statement on and apply the guiding principles for funding recommendations when recommending activities for investment. While not all principles must be satisfied, they should be considered. Similar to the process used to develop the February 2024 spending recommendations, the Advisory Council may use a process whereby it rates potential investment activities against each of these principles (e.g., on a scale of one to five, with one being "does not address the principle at all" and five being "completely meets the principle"). The sum of Advisory Council member ratings may then be used to help prioritize and select investments.

- Invest in activities across all goals and strategies of the *Strategic Plan*. This *Strategic Plan* includes mutually reinforcing strategies so that investing in activities across all strategic objectives in integrated ways is likely to make more progress in achieving the vision of the *Strategic Plan* than focusing on one strategic objective alone. Consider whether certain investments are necessary to make before others and when existing investments could be expanded upon to integrate strategy implementation.

- Invest in activities that continue for multiple years (e.g., three years or more) to allow time for startup activities and offer longer-term and more stable services in communities.

- Establish and maintain mechanisms for tracking the distribution of settlement funds, particularly in underserved populations. Track investments based on *Strategic Plan* goals and strategies to encourage alignment with and use of the plan. Integrate progress tracking of grantee-specific outputs, program-specific outcomes, and state-level outcomes to provide a comprehensive picture of *Strategic Plan* implementation and outcomes. Make future funding decisions informed by findings of monitoring and evaluations.

- Collaborate with stakeholders outside of the Advisory Council to encourage implementation of strategies and activities that are not included in this *Strategic Plan* (Appendix D).

Public Involvement

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

Conclusion

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

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