pennsylvania
DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS

RECOVERY NEEDS IN PENNSYLVANIA

Pennsylvania Department of Drug and Alcohol Programs
Survey developed by the Pennsylvania Advisory Council on Drug and Alcohol Abuse

SEPTEMBER 2020

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Executive Summary

The Pennsylvania Advisory Council on Drug and Alcohol Abuse, the advisory council to the Pennsylvania Department of Drug and Alcohol Programs (DDAP), developed a survey in early 2019 to assess the unmet needs of the recovery community in Pennsylvania. The 12-question survey, available in both English and Spanish, focused on supports that were utilized as well as recovery needs identified by people in recovery. The survey was distributed both online and through paper copies through relevant listservs and contacts. The results in this report are based on responses from the 1,052 respondents who qualified to complete the survey. Quantitative analysis of recovery supports utilized and recovery needs were evaluated by length of recovery; qualitative results through open-ended responses were also captured. In general, recovery supports utilized, as well as recovery needs identified, varied by respondents' length of time in recovery, reflecting shifting priorities during one's journey. Understanding the gaps within recovery support services – as well as how these needs differ over time, geographically, or between special populations – is critical for making progress on Pennsylvania's goal to empower sustained recovery.

Survey Objectives and Methods

The Pennsylvania Advisory Council on Drug and Alcohol Abuse, the advisory council to the Pennsylvania Department of Drug and Alcohol Programs (DDAP), conducted a survey in early 2019 in order to assess the needs of the recovery community in Pennsylvania. The 12-question survey, available in both English and Spanish, focused on recovery supports that were utilized as well as recovery needs identified by people in recovery.

The survey was distributed both online (via SurveyMonkey) and through paper copies through relevant listservs and contacts, including all Single County Authorities (SCAs), DDAP, the Pennsylvania Recovery Organization Alliance (PRO-A), the RASE Project, and Council members. In addition to email distribution, the survey was posted on PRO-A's website and social media for PRO-A, the RASE project, and Council members. The survey was open for six weeks and closed on April 1, 2019.

Results

There were 1,489 respondents who submitted the survey, with 1,052 respondents answering *yes* to both *being told or concerned about use* and *considering themselves in recovery*. The results in this report are based on responses from the 1,052 respondents who qualified to complete the survey. Quantitative analysis of recovery supports utilized and recovery needs were evaluated by length of recovery.

Quantitative Results

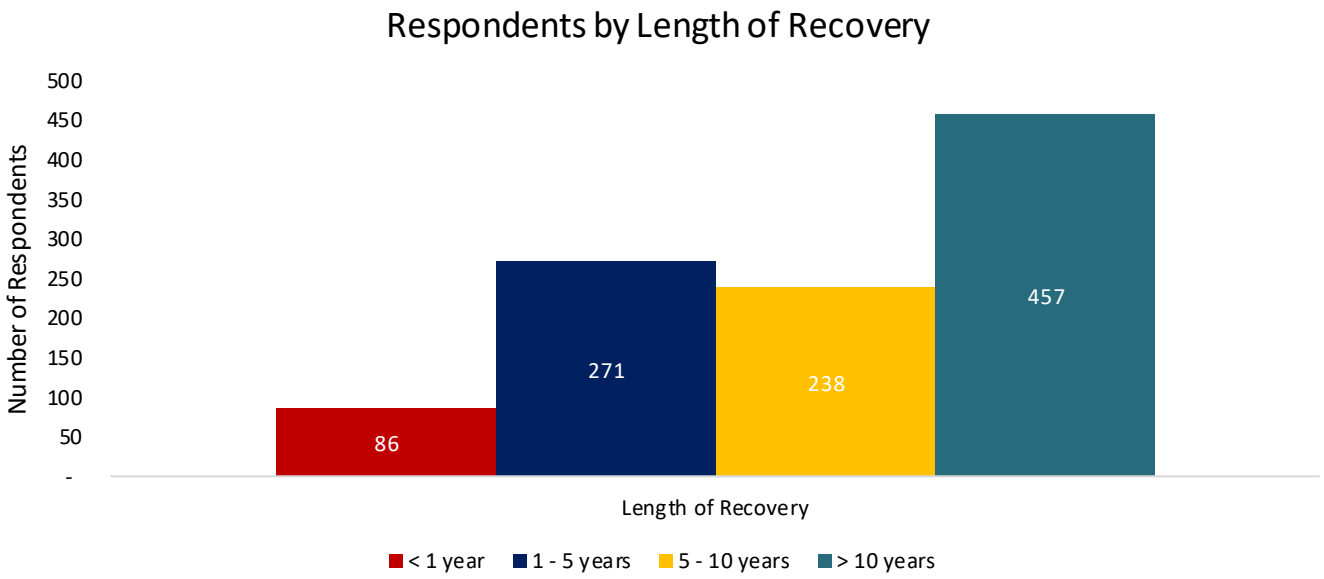
1. Demographics of Participants

Of the 1,052 respondents, 58% identified as female, 42% identified as male, and 0.9% identified as non-binary/third gender/prefer to self-describe/prefer not to say. Respondents 55-64 years old accounted for 25% of responses, followed by those 35-44 years old (22%), those 45-54 years old (21%), and those 25-34 years old (19%). Those 65 years and older and those younger than 25 years old accounted for 10% and 2% of responses, respectively.

Out of Pennsylvania's 67 counties, 62 counties were represented in the survey, with 10% of responses from Allegheny, 8% from Cumberland, and 5% from both Dauphin and Philadelphia. A table with number of responses by county can be found in the Appendix.

Length of recovery ranged from less than one year to more than ten years and were grouped into four categories. Respondents in recovery for more than ten years accounted for 43% of the sample, followed by those in recovery for one to five years (26%). People in recovery for five to ten years accounted for 23% and those in recovery for less than one year made up 8%. Figure 1.1 shows the number of respondents by length of recovery.

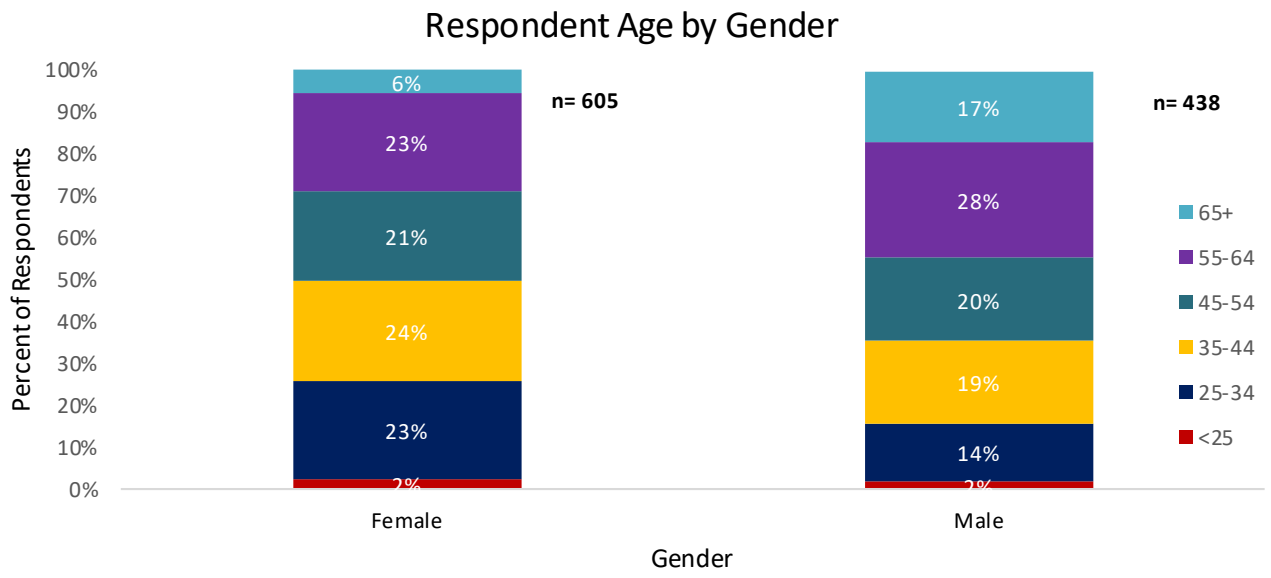
Figure 1.1 Respondents by Length of Recovery



In terms of educational levels, 26% of respondents had some college, while 25% had a college degree. People with post graduate degrees accounted for 24% of responses and 17% had a high school diploma.

Figure 1.2 shows respondent age by gender. Of male respondents, 28% were in the 55-64 age range, followed by 20% in the 45-54 age range. Of female respondents, 24% were in the 35-44 age range, followed by 23% in both the 55-64 and 25-34 age range. For both genders, 2% of respondents were under the age of 25. Those 65 and older made up 17% of male respondents but only 6% of female respondents.

Figure 1.2 Respondent Age by Gender



Length of recovery by gender is shown in Figure 1.3. For both genders, those that indicate more than ten years in recovery make up the largest group of respondents, followed by those with one to five years in recovery, then those with five to ten years in recovery. Those with more than ten years in recovery account for 40% of female respondents and 49% of male respondents, while those with less than one year in recovery account for 9% of female respondents and 7% of male respondents.

Figure 1.3 Length of Recovery by Gender

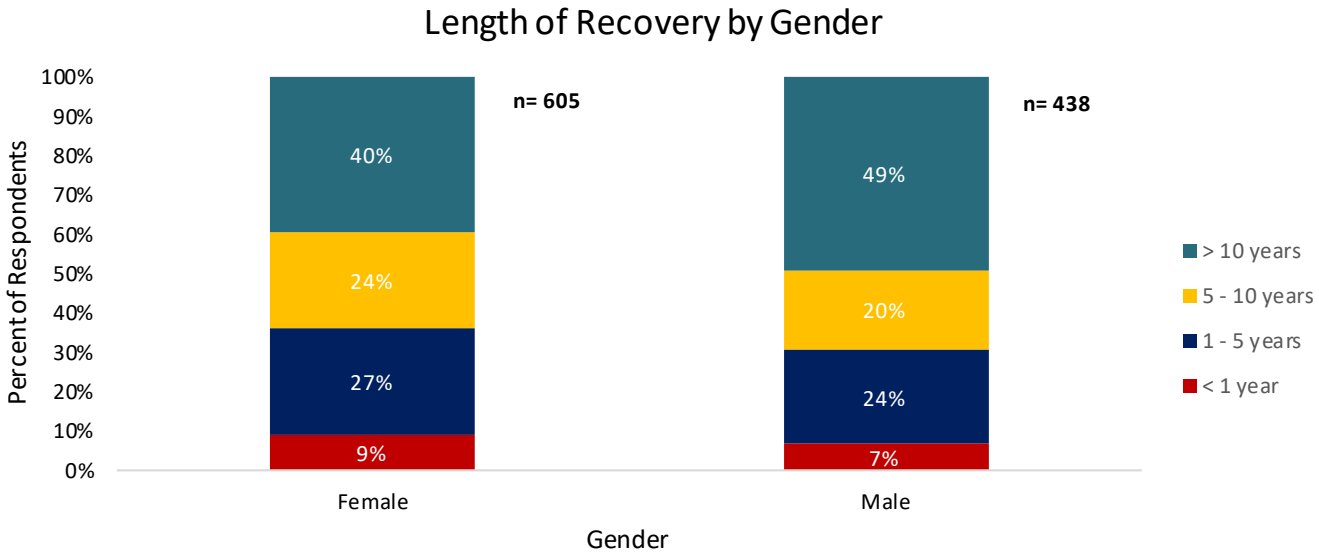
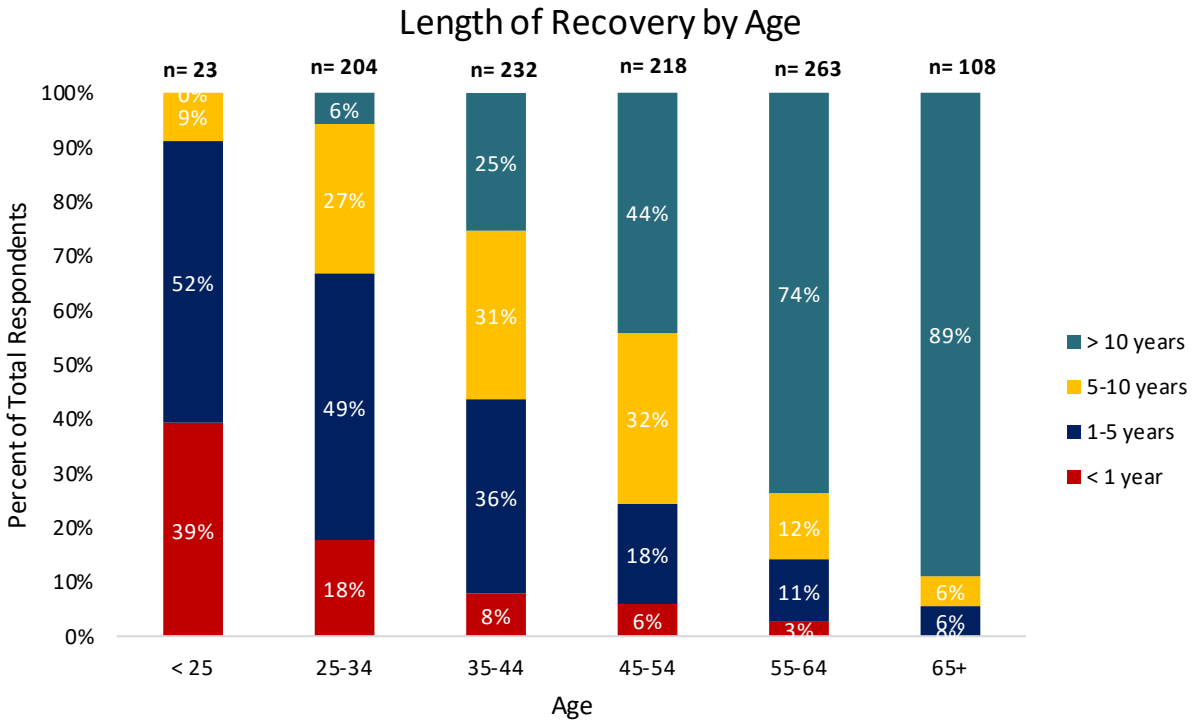


Figure 1.4 depicts length of recovery by age. As seen below, age correlates with years in recovery, with the percentage of people in recovery for longer increasing as age increases. For respondents 44 years of

age and younger, the most frequent length of recovery is one to five years. Comparatively, the most frequent length of recovery for respondents 45 years of age and older is more than ten years.

Figure 1.4 Length of Recovery by Age

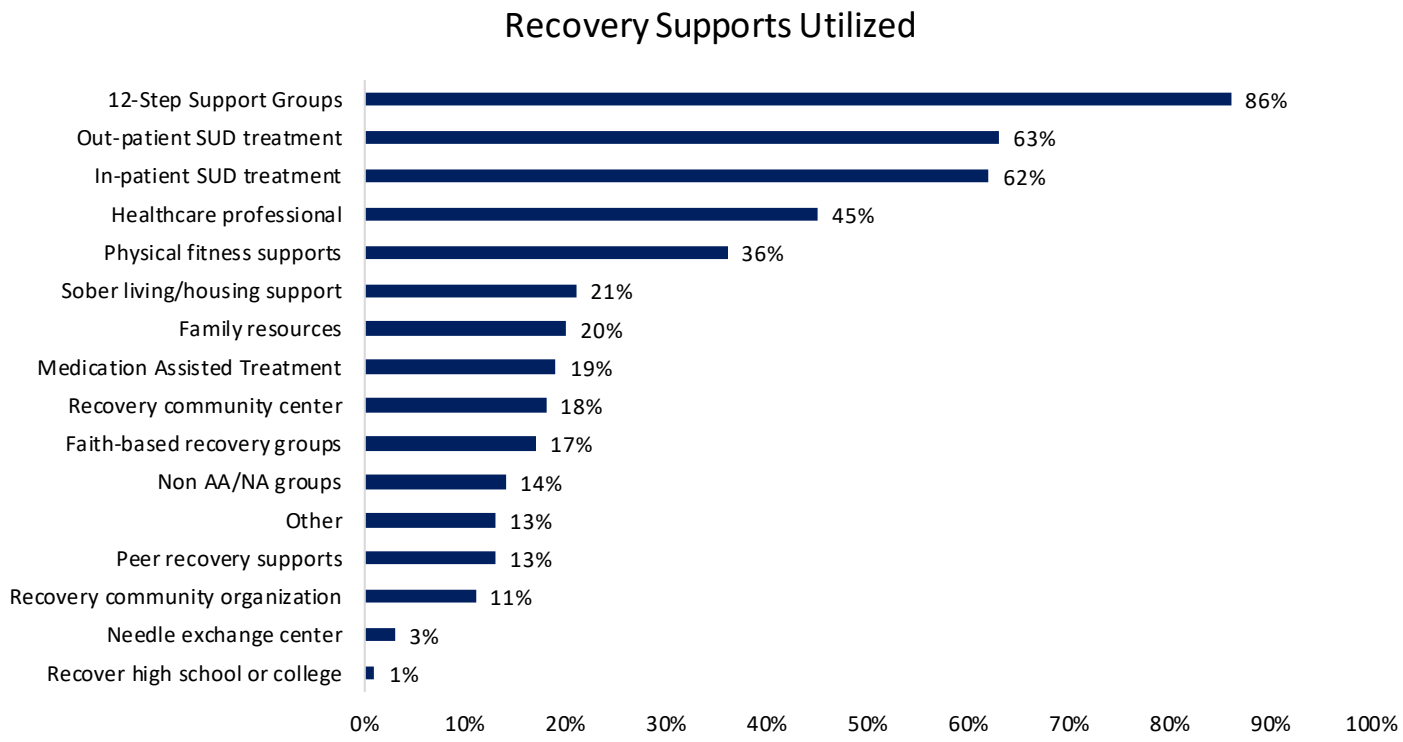


2. Recovery Supports and Needs

In the survey, participants were asked to select from a variety of recovery supports that they had used to begin, and/or are currently using to support, their own recovery.

Figure 2.1 indicates the breakdown from all respondents. The vast majority, 86%, indicated twelve-step support groups were utilized during their recovery. Outpatient and inpatient substance use disorder (SUD) treatment programs were utilized by 63% and 62% of respondents, respectively. Few respondents indicated the use of recovery high schools or college programs, or needle exchange centers.

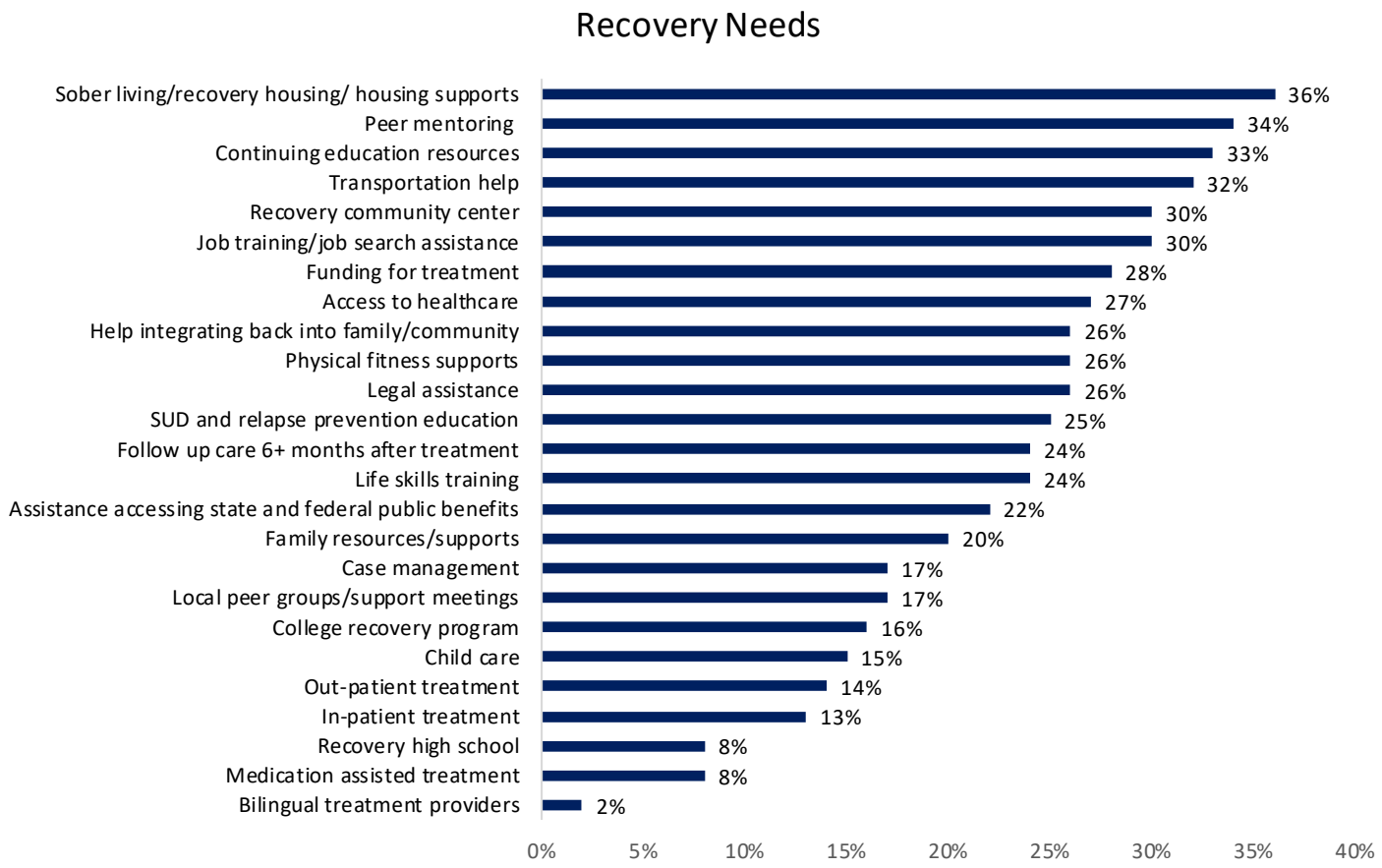
Figure 2.1: Recovery Supports Utilized



Participants were also asked to select from a variety of supports that would have been helpful in their treatment or recovery but were not available.

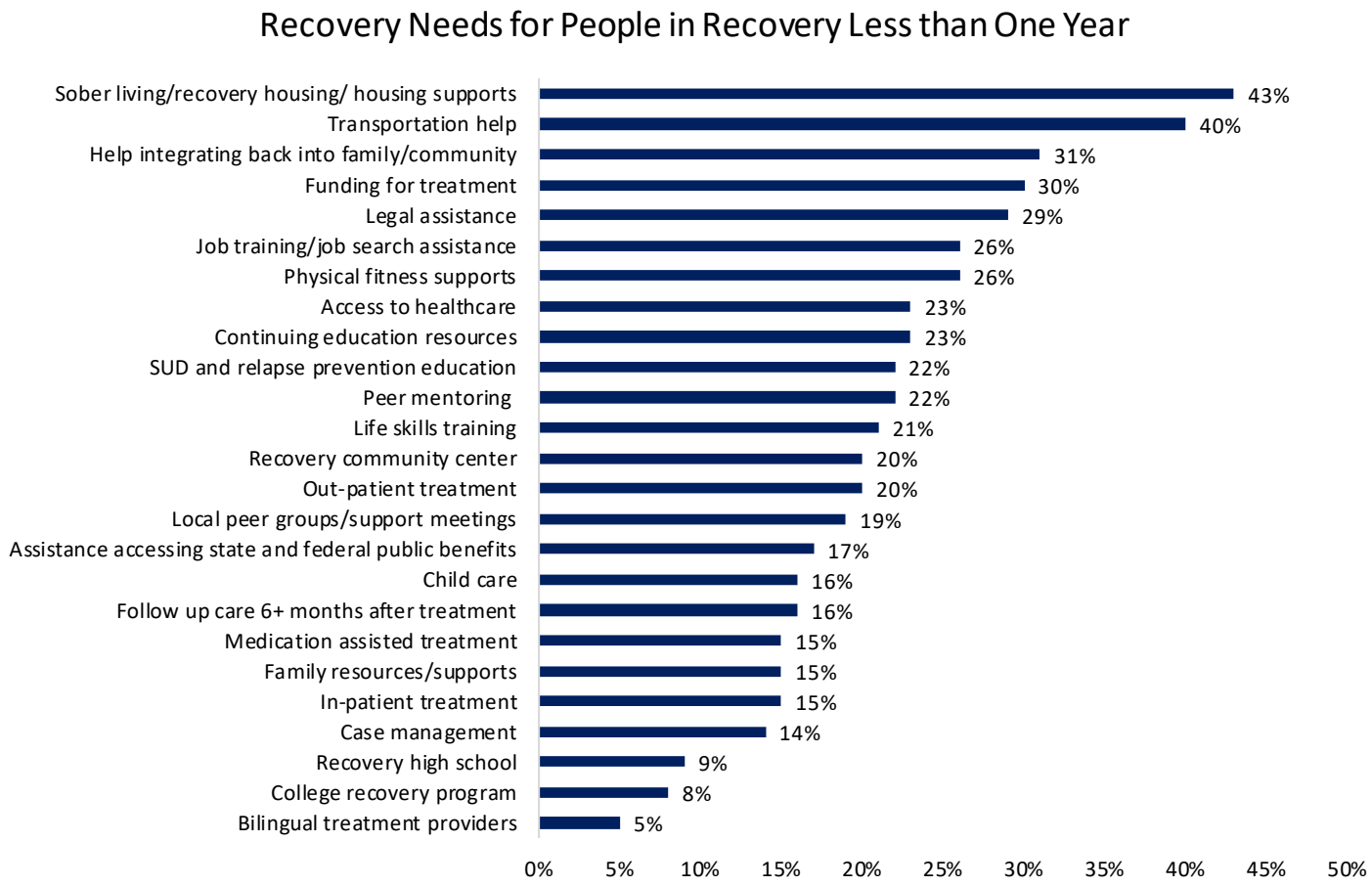
Figure 2.2 shows the recovery needs identified by the survey respondents. The top needs include sober living/recovery housing/housing supports (36%), peer mentoring (34%), continuing education resources (33%), transportation help (32%), recovery community centers (30%), job training and job search assistance (30%), and housing support (30%). Although 15% of respondents indicated childcare as a need, 22% of women indicated it as a need compared to 6% of men.

Figure 2.2 Recovery Needs



The breakdown of recovery needs for people in recovery for less than one year is seen in Figure 2.3, with housing and transportation as the top recovery needs for respondents followed by help integrating back into family/community, funding for treatment, and legal assistance. The housing variable reflected combines two housing variables from the survey in order to compare with the corresponding recovery supports housing variable as well as to adequately reflect the need for housing.

Figure 2.3: Recovery Needs for People in Recovery for Less than One Year



The breakdown of recovery needs for respondents in recovery for 1-5 years is below, with 40% of respondents indicating a need for housing supports and 38% indicating a need for peer mentoring.

Figure 2.4 Recovery Needs for People in Recovery for One to Five Years

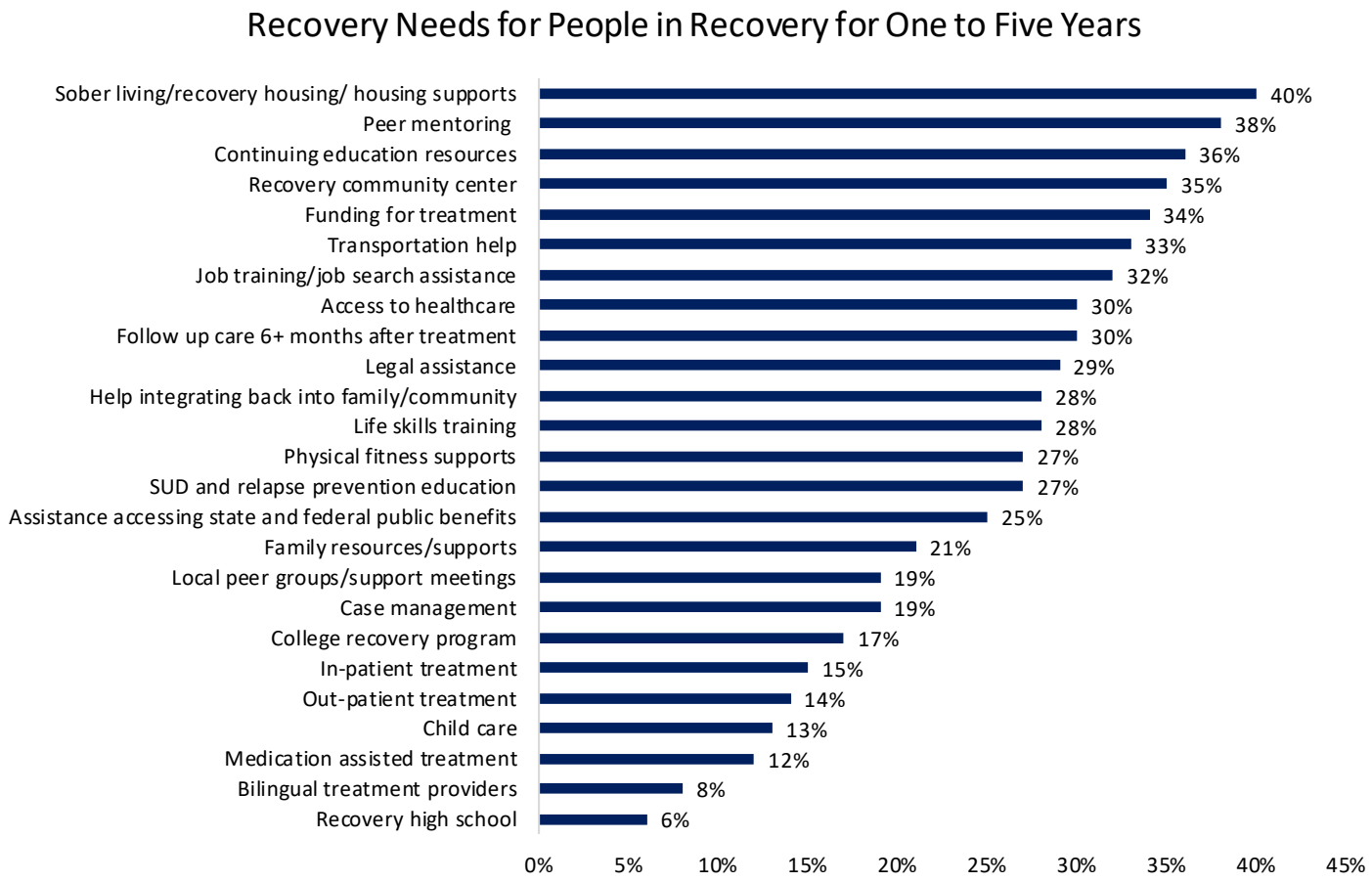
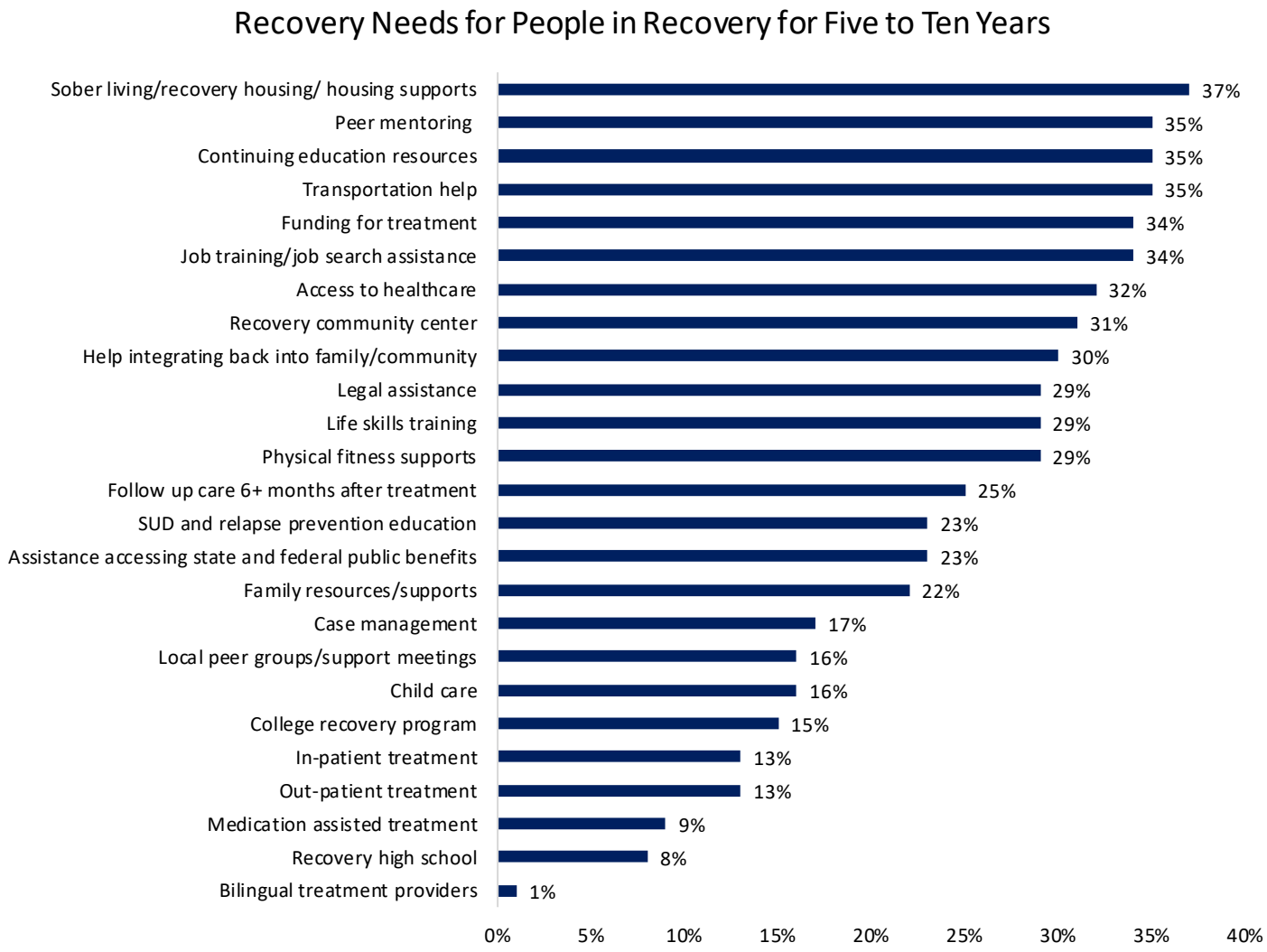


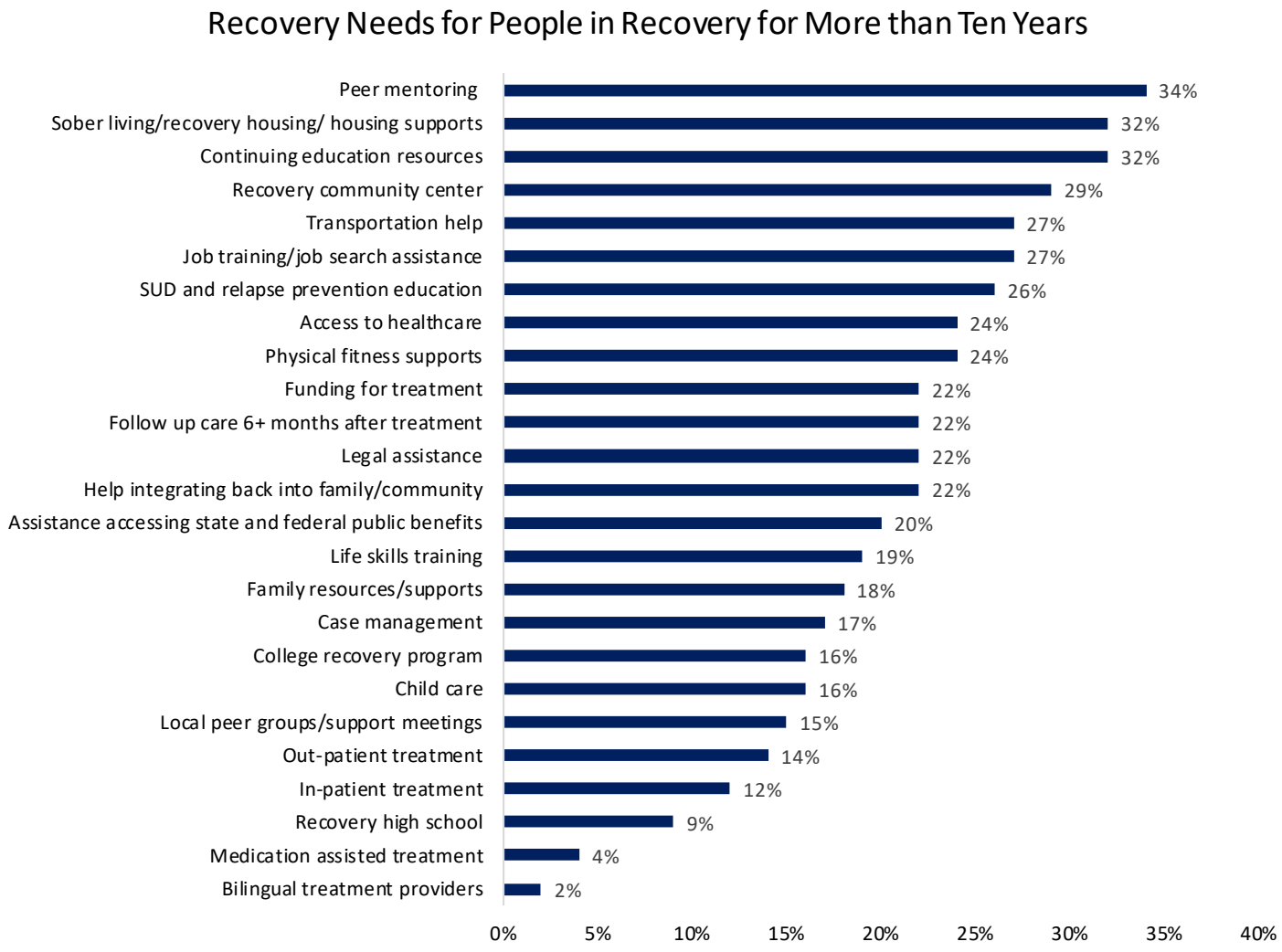
Figure 2.5 shows the breakdown of recovery needs for people who have been in recovery for five to ten years. The top need indicated was housing supports, with 37% of respondents.

Figure 2.5 Recovery Needs for People in Recovery Five to Ten Years



Responses from people in recovery for more than ten years are shown in Figure 2.6. Peer mentoring tops the list with 34% of respondents, followed by housing supports and continuing education resources.

Figure 2.6 Recovery Needs for people in Recovery for More than Ten Years



3. Comparison of Recovery Supports and Needs by Length of Recovery

Supports utilized and supports needed may differ by a variety of factors, including age, time in recovery, or education level. The following results compare variables related to "recovery supports" with their corresponding "recovery need" variable by length of recovery. Note that not all variables in the recovery supports section had a comparable variable in the recovery needs section, and therefore not all variables presented in the above section are compared in this section.

Figure 3.1 Support Groups by Length of Recovery

During recovery, support groups provide integral support to many, as seen in Figure 3.1. For people in recovery for more than ten years, 91% participated or continue to participate in some type of twelve-step support group. Although that percentage declines as time in recovery decreases, 71% of those less than one year into recovery have participated in support groups, with 19% identifying it as an unmet need.

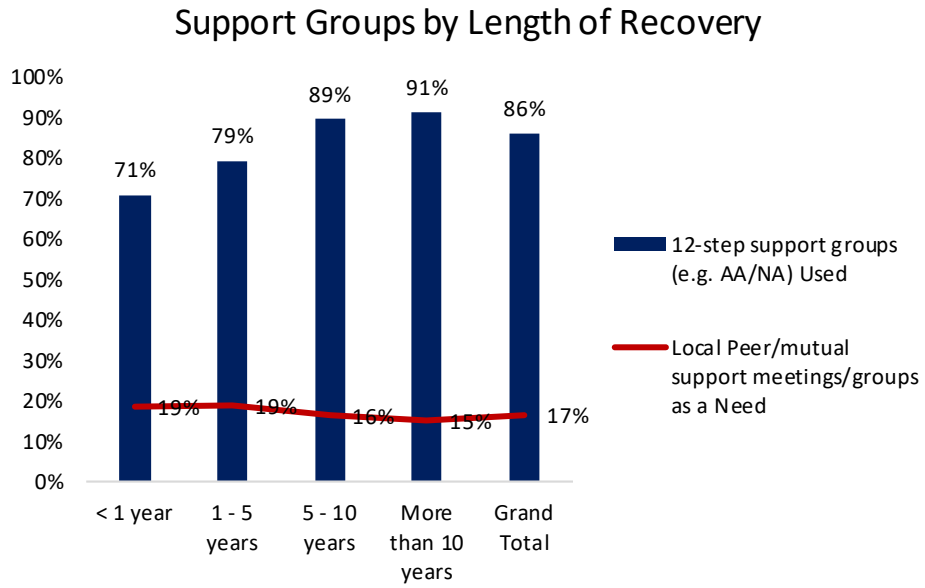
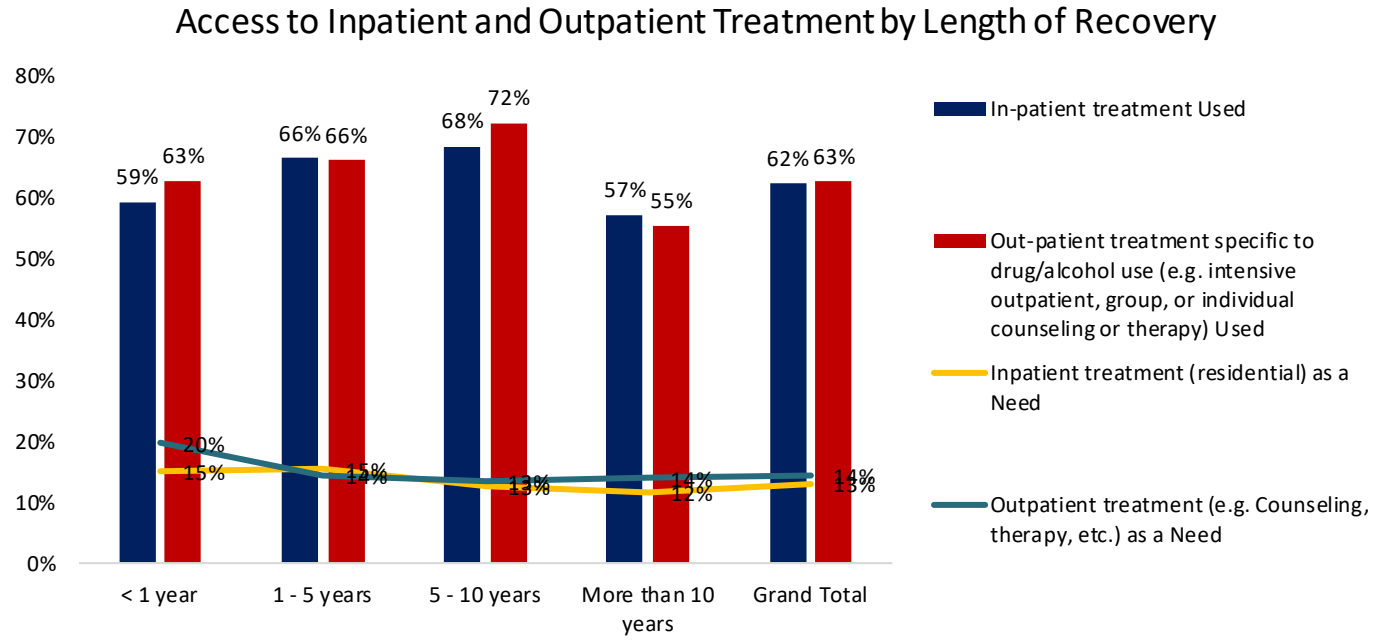


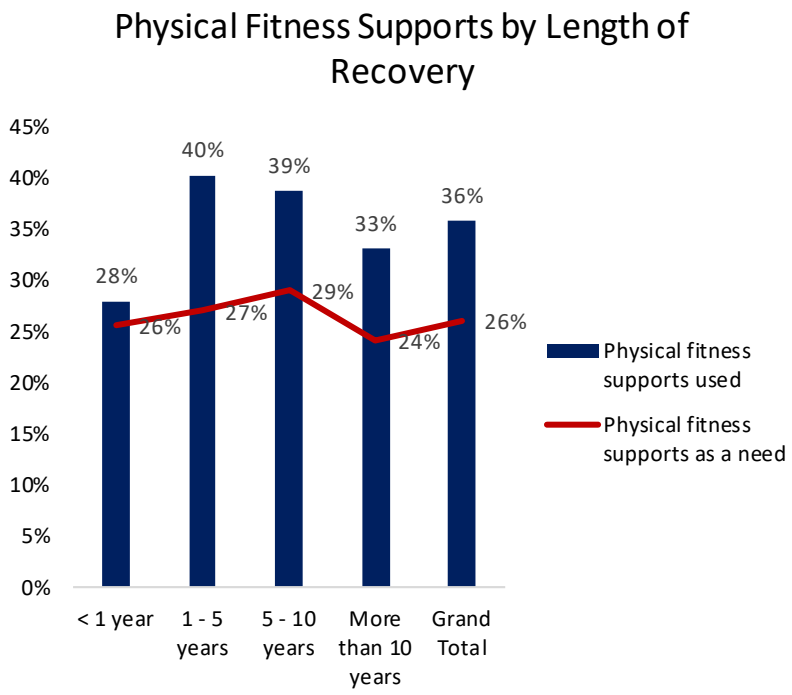
Figure 3.2 Access to Inpatient and Outpatient Treatment by Length of Recovery



Inpatient and Outpatient treatment were utilized by most respondents. Figure 3.2 shows the utilization of these services versus the unmet need. Overall, 62% utilized inpatient treatment and 63% utilized outpatient treatment, with the unmet need being 13% and 14% respectively. It is important to note that these responses do not indicate length of treatment, so although many have utilized, it is unknown how long treatment engagement was.

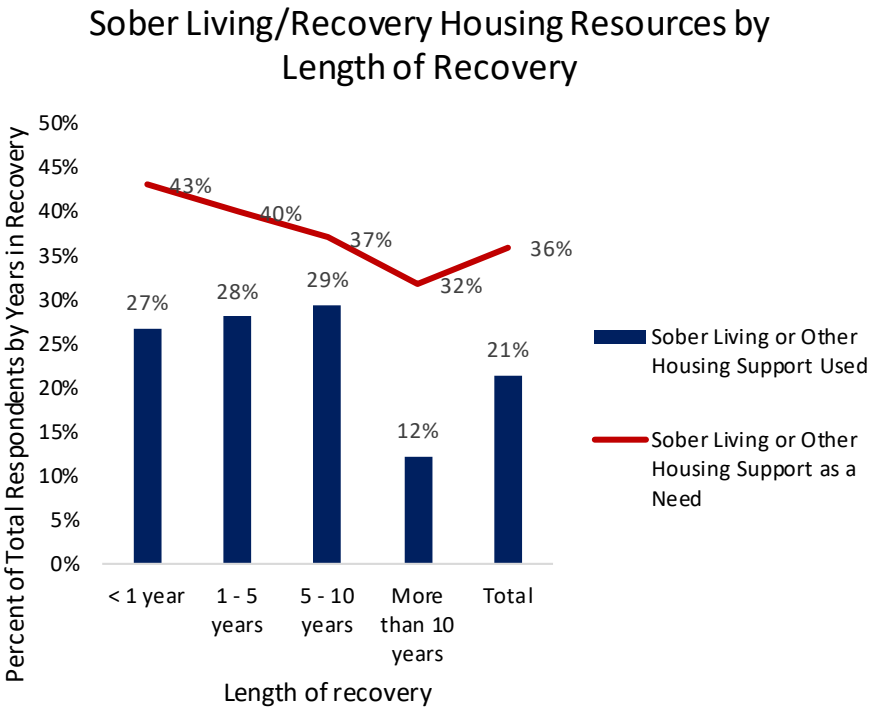
Figure 3.3 Physical Fitness Supports by Length of Recovery

Physical fitness supports are both utilized resources as well as a need, as seen in Figure 3.3. People in recovery for one to five years and five to ten years both have the greatest utilization of physical fitness supports and have an unmet need for physical fitness supports.



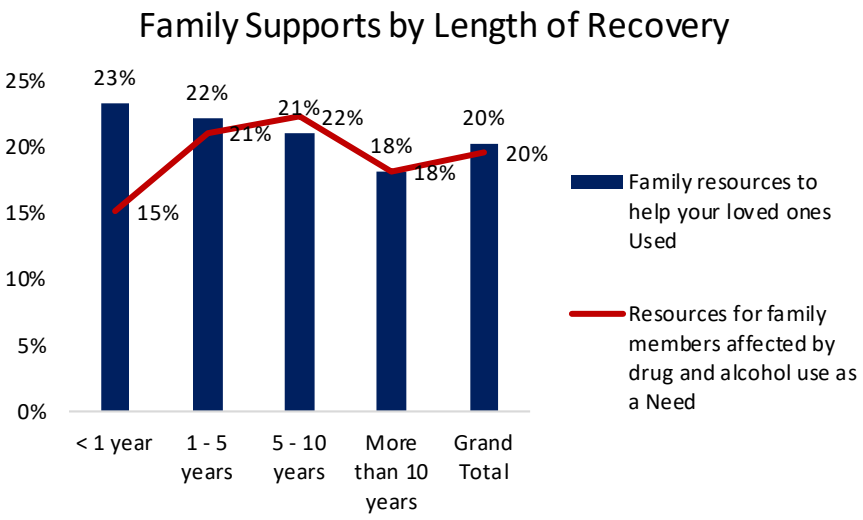
Housing is a crucial component to the recovery process. There remains a multitude of barriers to obtaining safe, secure, and affordable housing that will provide a conducive environment for individuals to focus on recovery. Figure 3.4 highlights how important that need is, with 21% of respondents overall indicating utilizing housing supports, while 36% of respondents overall indicating that housing was an unmet need for them.

Figure 3.4 Sober Living/Recovery Housing Resources by Length of Recovery



For those in recovery for less than one year, 43% indicated an unmet need for housing supports. The gap between those both utilizing and needing housing supports is greatest for those in recovery for less than one year and those in recovery for more than ten years.

Figure 3.5 Family Supports by Length of Recovery



A family-centered approach to recovery is beneficial to both the individual in recovery and the family. In Figure 3.5, family supports by length of recovery is shown. The utilization of family supports is consistent across groups based on length of recovery. Unmet need, overall, is equal at 20%, with those in recovery less than one year indicating the lowest need (15%).

Figure 3.6 Medication Assisted Treatment by Length of Recovery

Medication assisted treatment (MAT) has expanded and new options have become available over the last 20 years. This is reflected in the relatively higher utilization rate for those more recently in recovery (Figure 3.6). According to Figure 3.6, the cohort that has been in recovery for less than one year utilized MAT significantly more than those in recovery more than ten years (41% versus 8%); this group also indicated the greatest unmet need (15%). It is important to note, however, that the survey did not ask respondents to indicate the substances for which they sought treatment, so in some cases, MAT may not be applicable.

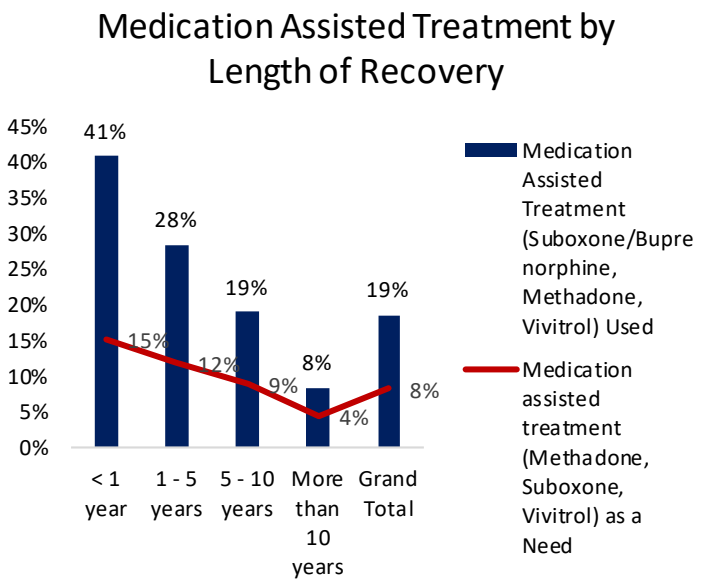


Figure 3.7 Recovery Community Center by Length of Recovery

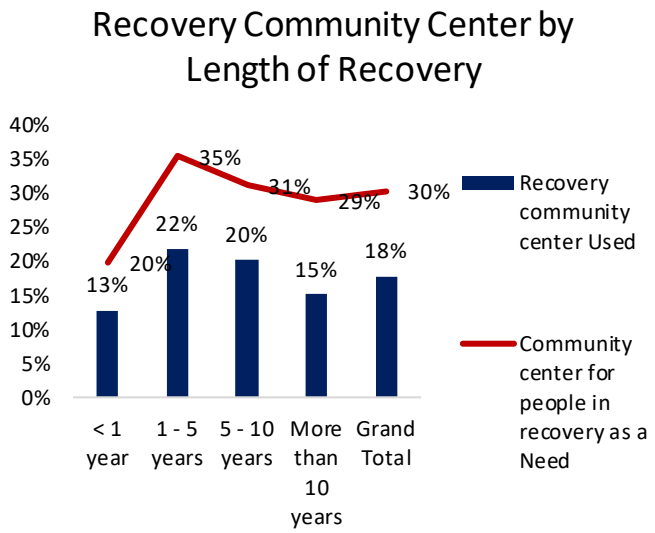
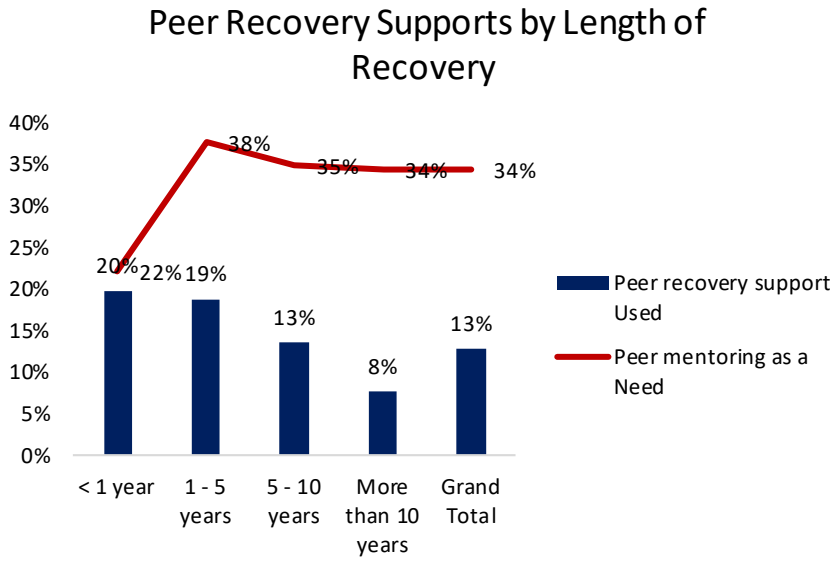


Figure 3.7 depicts the utilization versus unmet need of recovery community centers by length of recovery. Recovery community centers were identified as one of the top unmet needs for the recovery community, with 30% of respondents indicating them as a need. Specifically, people in recovery for one to five years had the highest unmet need in this area, but also utilized recovery community centers more compared to the other groups.

Figure 3.8 Peer Recovery Supports by Length of Recovery



Peer mentoring/recovery supports was the most frequently identified recovery need after housing supports in the survey, as depicted in Figure 3.8. Overall, 34% of people indicated an unmet need for peer support/mentors, with an unmet need of 38% for people with one to five years of recovery. Aside from people with less than one year of recovery, the gap between utilization and unmet need is great, ranging from 19% to 26%.

Qualitative Results

The survey also solicited written feedback on resources that would have been helpful but were not available as well as any unmet needs in the community relative to treatment and recovery. The qualitative responses reinforce the needs identified in the quantitative part of the survey, as well as provide additional insights into unmet needs of specific populations.

Below is a word cloud compiling the top 76 most frequently mentioned words/phrases in the open-ended responses. Responses highlighted the importance of housing, transportation, recovery community centers and activities, variety and accessibility of support groups, peer support/CRS services, education around substance use disorder to combat stigma, access to mental healthcare, quality treatment options, funding for treatment, and a multitude of other factors.

1. Helpful for Treatment

Access remains a need regarding multiple aspects of treatment. Access to quality mental healthcare was one of the unmet needs specified in the qualitative responses. Respondents identifying this need indicated the importance of treating co-occurring disorders; a lack of mental health education and support; lack of quality mental health professionals, including therapists and psychiatrists, leading to long waiting lists, with one respondent saying they were on an eight month waiting list; a desire for more one on one counseling; and a need for affordable and quality care.

> ***"Please do not forget that substance use is a mental health challenge. Let's not separate services that should be and are helpful when supported together."***

> ***"I think it is too difficult to get a psychiatrist and therapist once released from inpatient treatment. I was also lucky that I had a PCP willing to continue my medications until I found one/had one assigned, I heard many stories while I was in inpatient where this was a reason they were back in inpatient treatment."***

Responses indicated the need for improved access to treatment as well as more treatment options, specifically detoxification, inpatient, and rehab centers, mentioning that many are full and have wait lists. In addition, longer inpatient treatment was identified as a treatment need. Funding for appropriate care, mental health treatment, comprehensive treatment, affordable insurance, and inpatient and outpatient treatment was also identified as a need through the responses.

"Having insurance that covers a longer stay then 30 days. I wasn't given enough time in rehab to learn how to stay sober when under stress. I had a dual diagnosis and wanted to stay longer but couldn't. There needs to be more training in how to stay sober when dealing with life issues."

Respondents identified the need for more accessible MAT. Some respondents indicated a need for more doctors and addiction psychiatrists while others specified non-agonist MAT. Some responses were concerned with oversight and monitoring of physicians prescribing MAT, and others stated opposition to MAT.

"Immediate access to MAT after my first failed rehab attempt would have saved me about 10 years of destruction."

Specific to discharge, respondents identified a lack of comprehensive aftercare plans and follow-up care needed post treatment in order to support recovery. Trauma informed care and addressing adverse childhood experiences (ACEs) as well as the need for warm hand-offs were also identified as treatment needs.

"We need more services to support people coming out of inpatient treatment. This would allow for better treatment plans that address living problems that create barriers to recovery."

"Trauma informed integrated approaches. No one took into account why I was using, they just slapped an AA bandaide on me and sent me on my way. Trauma is the underpinning of the majority of abuse and it must be treated in conjunction with recovery"

2. Helpful for Recovery

Unmet recovery needs included housing, recovery community centers and sober activities, transportation, variety and availability of group meetings, education around substance use and recovery to reduce stigma, peer support/CRS services, childcare services, job assistance and career training services, family supports, alternatives to criminal justice involvement, legal aid, financial education, continuing education, and physical fitness.

> ***"I want to stress the importance of leaving rehab with no money, my parents choosing not to support me in any form, no transportation, very little clothing, and wanting to live in a recovery house with no money for security deposit and rent."***

Safe, adequate, and affordable housing was often mentioned. Housing refers to responses pertaining to recovery housing, sober housing, transitional housing, halfway housing, and housing supports for individual housing. Within this need, many responses referred to needing oversight of recovery housing, including regulations and requirements in order to ensure "real, not fraudulent", and "reputable" housing. There were specific needs mentioned for housing that accepts people on MAT, for men, for women, for people with children, and for people with co-occurring disorders.

> ***"I have been an addict for 20 years, in and out of rehab, clean for 10 years, then relapse. This time I believe I can do this, with the help of suboxone and continued outpatient. I wanted to go to a half-way house, then ¾ house, but there are none that will take me if I'm on suboxone. I had to move back home with my parents, I would benefit so much more living in an environment with my peers that I could talk to freely, that understand addiction…"***

Another trend was the need for places for people in recovery to socialize, as well as low cost activities, such as a recovery community center. Social supports and activities, as mentioned in responses, include sports, wellness and recreation centers, recovery-based events, clubhouses, book clubs, places to drink coffee, and activities for families and children. The importance of having activities and spaces that do not involve drinking or bars was frequently mentioned.

"Aside from meetings and making healthy relationships at those meetings, there really is nothing for people in recovery to do or go around here. We need a facility for people whom are in recovery can go for company outside of a meeting. Re introduce that recovery is fun and you can live life without substance of any kind with the right people surrounding you."

"All communities need to be recovery oriented. We have to improve this. There is this expectation that because folks 'get better' in treatment the same is to be carried through in their individual communities. Communities that are saturated with easy access to alcohol and drugs and people in recovery are expected to thrive. Communities with bars and liquor stores on every corner, alcohol being sold beside chocolate milk and not one place for people in recovery to work on socialization and reintegration except for that hour spent in a church basement being anonymous. We need to do better. Change people places and things rolls so easily off the tongue. Putting it into practice is a different ballgame, especially when everything around stays the same and our system won't let us back in to become contributing members of the community and society as a whole."

Transportation access and funding was a top unmet need. People need transportation to meetings and for treatment, and access or funding is inadequate in some areas; specifically, rural or suburban areas where methadone clinics or group meetings are a significant distance from a person.

"I feel like the main need is transportation. I am a recovery specialist and one of the main reasons people don't show up or keep appointments is because of lack of transportation."

"In my job alone, I could use about 500 more 10 trip UNDERFUNDED bus passes for my clients to get to work in their first 2 weeks of work till they get their first pay check and passes for others to attend IOP and medical appointments."

There was an emphasis on the need for more variety of, and accessibility to, support groups and meetings, whether they be faith-based, non-secular, AA/NA, or other twelve-step. Within the need for support groups, support meetings for people on MAT was specifically mentioned. In addition, there were responses indicating the need for more promotion of AA/NA and more availability, while there were also responses on overutilization of AA/NA and needing additional options. More faith-based/spiritual support was also brought up frequently. Groups for families and parents were another specific population with an unmet need for group meetings. Other categories of support meetings mentioned include non-secular, SMART recovery, groups for refugees, groups for non-English speakers, groups for women only and men only, groups for LGBTQ+, culturally specific groups, groups for overdose

survivors, mom groups, groups for members of law enforcement, Gamblers Anonymous, Adult Children of Alcoholics and dysfunctional families, and Co-dependents Anonymous.

> ***"I felt the AA education/philosophy and attendance at meetings for six solid years was my fundamental transition to sober living. It allowed and supported me in increasing my self-esteem to complete a doctorate in psychology in my forties..."***

> **"I would love for there to be more access to SMART recovery and other non-spiritual groups."**

Another theme in the qualitative responses was stigma – specifically, stigma as a barrier to reaching out for treatment or as a barrier to community support and understanding. The need for education and awareness around drug and alcohol recovery as well as prevention activities was clear from these responses. In particular, education for family members to improve their understanding of substance use in order to aid in the treatment and recovery process was a top trend. The need for prevention education in middle and high school was mentioned frequently. Responses highlighted addressing stigma through education, reinforcing the disease concept, and emphasizing compassion. In terms of targeting groups that need specific education relative to their role in treatment in recovery were probation and parole officers as well as others in the legal system; community members; and doctors and pharmacists. Suggestions included implementing a statewide messaging campaign to address stigma, as well as educating the public surrounding ACEs and trauma.

> ***"Community education so the public can better understand addiction."***

Having access to a peer with lived experience can be a crucial support in the recovery process, and responses indicated a need for more CRS availability in their area. Responses relating to the need for CRS services included needing more peer support in rural areas, having CRSs work with police and first responders, having CRS services in jails for recovery and wraparound services, allowing CRSs to transport, and providing training funds to people who want to become CRSs. Other types of peer support, such as Certified Family Recovery Specialists (CFRS), were mentioned as well.

> ***"All of the resources I've utilized were found outside of the county in which I resided. If these resources were made available in rural, recovery lacking communities, the death toll would decrease dramatically. I became a CRS and accepted a position with...where recovery resources are desperately scarce. So many would benefit from these resources being available there."***

> ***"We have very little access to CRS's and CPS in the area. This would have made a huge impact on my recovery. My family knew nothing about addiction and how to continue life with me so it would have helped them as well."***

Job assistance programs and career training was also identified in the responses. Comments relating to jobs included a need for return to work programs, support for people with suspended professional licenses that allow MAT, the need for stipends while building skills, the idea of a having a career and not just a job, and programs for formerly incarcerated individuals. Affordable childcare, including structured

after school programs, day cares, and care at treatment programs was also mentioned. The need for family supports, including for grandparents raising grandchildren and for addressing co-dependency arose in order to rebuild relationships and facilitate an understanding of SUD and recovery. The importance of offering physical fitness resources and tools, such as recovery centers with fitness training; gyms; mind/body/spirit tools and resources; yoga and meditation; boxing, Reiki; massages; and Orange Theory, were mentioned.

> ***"I'm going on 5 years clean and my biggest success was finding a career not just a job and the training and everything started in rehab."***

Other recovery supports needed included, alternatives to criminal justice system involvement, legal aid, support for continuing education, financial education and management, and church/spiritual advisors.

3. Harm Reduction

Harm reduction was mentioned in the open-ended responses. Responses relating to harm reduction mentioned safe injection sites, needle exchanges, naloxone, and fentanyl test strips. Responses also touched on needing education surrounding harm reduction, more accessible medication drop off locations/times, and the Good Samaritan Law.

> ***"What we do not have is Harm Reduction, I would like to see more effort to reduce the harm with people in active addiction while at the same time trying to engage them into treatment and recovery."***

4. Treatment and Recovery Needs by Specific Population

The following populations and concerns were specifically mentioned in the open-ended responses, however, because the mention of these subsets was low, the comments may refer to only one or two responses. Even so, it is important to highlight responses that apply to specific populations that may not be apparent when looking at what is helpful for recovery.

Incarcerated and Formerly Incarcerated Individuals

Substance use sometimes involves justice system involvement and resources helpful for recovery specifically for incarcerated and formerly incarcerated individuals were highlighted. Comments regarding resources helpful for recovery included re-entry support such as jobs, housing, transportation, and social support following release from a facility. Stigma and policies surrounding employment of formerly incarcerated individuals was a concern, specifically regarding background checks. Other concerns for incarcerated individuals were the availability of treatment and MAT while incarcerated and after release. For individuals leaving jail or prison, suggestions included receiving education on where to find help and support once released, ensuring people have a Pennsylvania ID upon release in order to obtain services and find employment sooner, and clarification over how residence is defined in order to receive SCA funding for services.

Women

Comments regarding what would be helpful for women in recovery indicated the need for recovery houses; specifically, housing that allows children as well. Other needs included housing for women on MAT, homeless women, and people who have been convicted of a felony. Additional needs specific to

women included more group support for women; more help for single mothers; post-partum depression classes and support; trauma informed resources; more treatment for women with small children so that women do not need to surrender their children, including halfway houses; and more female sponsors. Other needs included resources for women needing help with self-esteem, financial aid, and childcare.

LGBTQ+ Community

Needs specific to the LGBTQ+ community were mentioned. Needs included treatment and recovery services targeted specific to the LGBTQ+ community, sober housing, 12-step meetings, and programs for transgender individuals.

Non-English Speakers/English as a Second Language

The need for multi-lingual programs and meetings was acknowledged. Specifically, for the Latinx community, there is a need to increase the number of Spanish-speaking counselors, recovery houses for Spanish speakers, detoxification services, and mental health services.

Black/African-American Community

While SAMHSA includes "culture" as one of its 10 guiding principles of recovery, responses indicated a general lack of diversity and acknowledgement of culture for all communities. Peer support is helpful in the recovery process, but another response indicated that there are few CRSs that reflect diversity, leading to lack of shared experiences and difficulty relating. Another response indicated the need for more facilities in predominantly African-American neighborhoods.

> ***"Diversity, there are very few African Americans during peer support on a local and state level in Pennsylvania. For instance in my county, there are NO (not one) African American CRS available."***

Adolescents

Needs specific to adolescents included more adolescent treatment facilities, services for at-risk teens and adolescents, and activity centers. One concern detailed lack of transportation for young friends who do not have parental support to get to outpatient treatment, support group meetings, or work. Adolescents typically rely on guardian support for daily life, making this an additional challenge for adolescents who need SUD services. Suggestions for social supports included more sober activities for teenagers on weekends so that adolescents "can have a fun lively night out while feeling safe and confident."

> ***"My young friends who do not have the support of their parents have no way to get to outpatient treatment or 12-step meetings, and only rely on members of 12-step programs. This makes it very difficult to regularly attend therapy and meetings and to find work."***

Seniors

Like adolescents, older adults have specific needs. Responses indicated a need for expanded treatment options under Medicare, particularly for outpatient, as well as for medication coverage. There was a suggestion to hold recovery meetings in senior centers for easier access as well as for support from peers of similar age. Housing for older women was also mentioned.

Limitations

There are limitations to note when viewing the results of the survey. First, although there was a Spanish survey option circulated, there was only one usable Spanish survey submitted, indicating a limitation in distribution and capturing diverse populations. In addition, additional demographic information such as race, ethnicity, and sexual orientation were not captured, limiting the understanding of the population captured and if needs differ. Third, the survey did not capture primary substance of choice, which could provide additional insights on support services needed. For example, the need for greater MAT accessibility would not be applicable for those who indicate a stimulant as their primary substance of choice versus those indicating opioids or alcohol. Finally, when interpreting responses, there is a limitation regarding the perspective of the survey-taker, as questions could be interpreted as both supports needed at the beginning of the recovery journey or supports needed in their current stage of recovery. As evidenced by the survey results, individuals have different needs depending on where they are on their recovery journey. Similarly, supports indicated as "utilized" could range from being used in the past to being used currently.

Discussion and DDAP's Work in the Recovery Space

Recovery needs for people in recovery for less than one year are different than for those in recovery for more than ten years for a multitude of reasons, which is why recovery supports and needs were analyzed by length of recovery. The quantitative questions asked 1. *What resources have you used to begin and/or support your recovery* and 2. *Indicate any/all resources that would have been helpful to your treatment/recovery but were not made available to you.* Due to the phrasing of the questions, answers from respondents earlier in their recovery are more likely to indicate current supports and needs and reflect the current recovery landscape, while answers from respondents in recovery for longer represent supports and needs across their time in recovery, not necessarily their current supports or needs. This is important to note for a few reasons. First, the recovery space may have changed; for example, something was not easily accessible ten years ago may now be accessible. Secondly, respondents' current supports or needs versus their supports or needs during a different time in their recovery cannot be distinguished. An example of where both may be true when looking at the trend is the use of MAT by years in recovery. The trend shows that MAT is utilized most by people in recovery for less than one year and decreases the longer someone has been in recovery. This trend could reflect the increased accessibility to MAT that people more recent to recovery have experienced compared to people who began their recovery journey years ago. It could also reflect that people who have been in recovery for many years may no longer have as great a need for MAT as those beginning their recovery.

As outlined in DDAP's State Plan for 2019-2022, DDAP is committed to reducing stigma, intensifying primary prevention, strengthening treatment systems, and empowering sustained recovery, all of which were touched upon in some way in the survey. The Substance Abuse and Mental Health Services Administration (SAMHSA) outlines recovery support into four major dimensions: health, home, purpose, and community[1]. All four of these dimensions were represented in the survey questions and responses.

[1] SAMHSA. "Recovery and Recovery Support." *SAMHSA*, www.samhsa.gov/find-help/recovery.

Recovery Supports Utilized

When looking at overall recovery supports utilized, a majority of people use or used twelve-step support groups. Although a majority currently or previously participated in twelve-step support groups, the qualitative comments highlight areas for improvement. Comments named specific types of groups such as faith based, twelve-step, non-faith based, groups specific for people on MAT, for women, and others, indicating a need for a variety of accessible groups so that people can find a group that best fits their needs. It was also noted that transportation is a barrier to attending support meetings. Access, availability, and variety are imperative to ensuring people can participate in support groups that will aid them in their recovery journey.

According to the survey, outpatient and inpatient treatment were used by a majority of the respondents, and to a similar degree. There is a greater need for outpatient treatment for respondents in recovery for less than one year compared to those in recovery for longer as well as compared to inpatient treatment. This may be due to the differing treatment needs for each group depending on where they are in their recovery. Even with high utilization indicated, there are still gaps and barriers to accessing treatment as well as utilizing quality treatment to its full potential. Open-ended responses indicate that there need to be longer treatment stays covered by insurance, access to quality mental healthcare, and treatment of co-occurring disorders. Long waitlists for treatment and mental health services are also a barrier.

Although MAT was indicated as a recovery support utilized overall for 19% of respondents, 41% of those in recovery for less than one year and 28% of those in recovery for one to five years indicated use of MAT. Comparatively, only 8% of those in recovery for more than ten years indicated the use of MAT. The difference between utilization between categories may indicate a change in accessibility and attitudes surrounding MAT. In addition, MAT is not available for every substance so may not have been applicable for all respondents. Qualitative responses referencing MAT indicated a need for more doctors and addiction psychiatrists, a need for increased accessibility, as well as the need for oversight and monitoring.

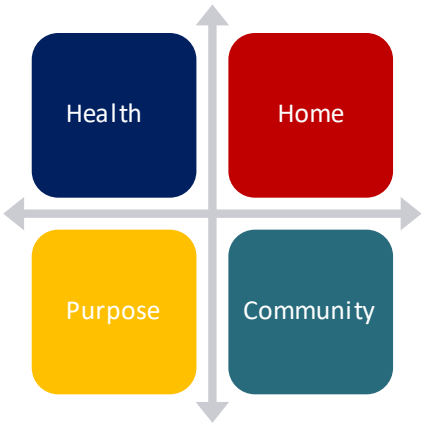
Recovery Needs

Below are the top five recovery needs based on years in recovery. There is overlap with many of the top needs regardless of years in recovery. Housing is consistently at the top of the list for all categories, with special attention to safe housing. Peer mentoring is a top need for people who have been in recovery for a year or more. Use of peer mentoring for people in recovery for less than a year is about equal to the need, whereas the need increases to 38% for those in recovery for one to five years. Comments indicated that there needs to be more availability, more diversity, and more accessibility in rural areas. A potential reason the need is lower could be due to receiving adequate supports in current treatment programs or being focused on other aspects of early recovery. This indication of differing priorities could also explain why legal assistance and integrating back to family/community are top needs for those in recovery for less than one year but not for other categories. In addition, transportation is a higher need for those in recovery for less than one year, although it is still a top need for people in recovery for five or more years. Similarly, continuing education is a top need for people in recovery for one year or more but not for those in recovery for less than one year, perhaps due to shifting priorities during recovery. Keeping in mind the limitations and that it is unknown whether people in recovery are indicating if these are current needs or supports that would've been helpful earlier in recovery, job training is a need for

people in recovery for five years or more. Funding is a top need for people in recovery for ten years or less. Recovery community centers are a need for people in recovery one to five years and ten or more years, which aligns with SAMSHA's recovery support dimension of the importance of community. Respondents mentioned the importance of spaces and activities that people in recovery can participate in that do not revolve around bars and drinking, as well as being family-friendly and low-cost.

<1 Year in Recovery	1-5 Years in Recovery	5-10 Years in Recovery	>10 Years in Recovery
1. Housing	1. Housing	1. Housing	1. Peer mentoring
2. Transportation	2. Peer mentoring	2. Peer mentoring	2. Housing
3. Integrating back to family/community	3. Continuing education supports	3. Continuing education supports	3. Continuing education supports
4. Funding	4. Recovery community center	4. Transportation	4. Recovery community center
5. Legal assistance	5. Funding	5. Funding	5. Transportation
		5. Job training/assistance	5. Job training/assistance

Qualitative responses reinforce the quantitative results, add additional context, and include other important aspects to support recovery. Additional aspects that are helpful for recovery but are not highlighted in the top five quantitative results above include education around SUD and recovery to reduce stigma, childcare services, family supports, financial education, alternatives to criminal justice system involvement, and physical fitness. Responses also included aspects helpful for treatment such as access to quality mental health care, access to more quality treatment options, access to MAT, longer inpatient and outpatient treatment, centralized resources for accessing treatment and support services, case management, trauma informed care approaches, and warm hand-offs.



Initiatives to Empower Sustained Recovery

DDAP is committed to empowering sustained recovery and has focused initiatives in this space. Below is some of the work DDAP has dedicated to empowering sustained recovery broken down by SAMHSA's four dimensions of recovery supports.

Health

DDAP recognizes the importance of MAT in treatment and recovery and supports the adoption and expansion of MAT to ensure access in multiple ways. In the fall of 2019, Department of Health (DOH) and DDAP convened eight regional MAT Summits in order to increase awareness and understanding of MAT options as well as increase the number of providers using the waiver to prescribe buprenorphine in an office-based

setting. DDAP has a crucial partnership with the Department of Corrections that facilitates progress in this space for justice involved individuals. Through the partnership, funding has been used to expand Vivitrol at all twenty-five state correctional institutions, launch a Sublocade pilot, hire an addiction specialist to expand agonist treatment, provide CRS services to State Intermediate Programs in two counties, provide naloxone for reentrants, as well as plans to hire MAT social workers to improve continuity of care for reentrants. With funding provided from DDAP, The Pennsylvania Commission on Crime and Delinquency (PCCD) has also made strides in the expansion of MAT including implementing county jail based Vivitrol programs in 16 counties and implementing county jail-based MAT programs that include Cognitive Behavioral Therapy (CBT). The Department of Human Services (DHS) has been a partner in implementing the Rural Access to MAT Program (RAMP), which trains primary care providers on MAT prescribing in order to increase access in rural areas. Importantly, in DDAP's 2020-2025 Case Management and Clinical Services Manual, SCAs must ensure availability of MAT medications at all levels of care within their counties. They must assist with payment, ensure sufficient provider capacity to treat individuals who use MAT, and ensure coordination of care when the prescriber and the treatment provider are not the same.

Understanding the importance of transportation, DDAP requires applicants of funding through Grant Initiative Funding Announcements (GIFA) or Funding Initiative Announcements (FIA) to include a description of how transportation will be addressed in the proposed project (with the exception of GIFA 19.03 Opioid Prevention in Higher Education). These funding announcements have addressed specific supports relating to recovery such as pregnancy support services, community recovery support services, employment support services, and family and recovery support services.

In order to provide a single resource for people to get the help and resources they need, DDAP created the Get Help Now Hotline in November 2016 where people receive warm-line connections not only to treatment, but also to a cadre of social and recovery supports in their areas.

DDAP has convened an Adolescent Workgroup with the goal of improving capacity to effectively serve adolescents with SUD. The workgroup is focusing on improving adolescent access to SUD treatment and services, improving quality of adolescent SUD treatment and services, and improving access to adolescent recovery support services. DDAP has reconvened the Women and their Children Health (WATCH) workgroup focusing on gender-responsive treatment for women with substance use disorders.

Home

Housing is a top recovery need regardless of how long someone has been in recovery. Repeatedly, the need for safe housing, potentially by regulations and oversight, was mentioned in the qualitative section. To address the concern of safe and adequate housing, The General Assembly passed Act 59 of 2017 to grant regulatory authority to DDAP to license recovery houses receiving referrals or funding from public sources. These regulations aim to create standards to ensure safe and quality housing to people in recovery. Furthermore, State Opioid Response Grant (SOR) funding was awarded to DHS to focus on housing support services assistance. DHS focused on counties with high overdoes rates, funding projects that served 17 counties. Over 2,000 individuals received a variety of housing supports including case management, rental assistance, housing education, employment services and

transportation. DDAP plans to continue housing related supports through partnerships with Single County Authorities.

Purpose

DDAP's partnership with the Department of Labor and Industry (L&I) has created opportunities to focus on the workforce and employers. L&I has four grantees being funded through the National Health Emergency Dislocated Worker Demonstration Grants focused on addressing the opioid crisis by integrating treatment and employment services, expanding related medical and treatment services, and educating and engaging employers. To continue this work after the grant period, DDAP facilitated a connection between L&I and Penn State's Project ECHO (Extension for Community Healthcare Outcomes). Project ECHO creates knowledge sharing networks through a virtual learning community led by experts to mentor community providers. The partnership between L&I and Project ECHO led to the ECHO series Supporting Employers, Supporting Employees in Recovery, which aims to empower employers to encourage the success of their employees in recovery. This is set to launch in September 2020 and will be the first ECHO to address the employer community.

Through a GIFA focused on employment support services for individuals with opioid use disorder (OUD) (GIFA 20-01), DDAP distributed over $2 million to 13 organizations. Organizations are using this funding for a variety of activities, including supporting individuals in recovery looking for employment, as well as educating employers intending to hire more individuals in recovery.

Community

DDAP has issued multiple GIFAs that address recovery support services, highlighting the importance of supporting work that will strengthen recovery supports. GIFA 19-02, Community Recovery Support Services, distributed $2.1 million in funding to five organizations proposing innovative projects to improve community support services. GIFA 20-02, Family and Recovery Support Services, distributed over $3.3 million to 12 organizations supporting pioneering work in family recovery supports.

DDAP's Substance Use Peer Recovery Support Services (SUPRSS) taskforce is working to standardize CRS services statewide by providing recommendations and guidelines. The scope of work of the taskforce includes defining peer recovery support services and how they relate to the continuum of care, defining the role and function of recovery support services within the service system, and establishing and monitoring recovery support service development.

In order to address stigma, DDAP has partnered with Penn State University, the Public Goods Project, and Shatterproof on a year-long, state-wide stigma reduction campaign to be launched in September of 2020.

"One thing I have learned is to keep an open mind, and realize that not everyone has the same definition of recovery, or what it takes to get there. Yes, multiple resources are essential, but a non-judgmental, open mind, and a caring attitude toward those who need the help are the truly essential tools."

Appendix

Appendix Attachment 1: Recovery Needs Survey

Recovery Needs Survey

1. What is your age?
2. What county do you live in?
3. With what gender do you most identify?
4. What is your highest level of education? (options w/b grade school, high school, college, post-graduate studies)
5. Have you ever been told or been concerned that your use of alcohol or other substances was problematic? (Yes or No)
   If 'yes', please continue the survey below.
6. Have you ever participated in treatment specifically related to the use of drugs and or/alcohol? (Yes or No)
7. Do you consider yourself to be 'in recovery' from drug, alcohol or other substance use? (Yes or No)
   If 'yes' pleased proceed with the survey.
8. How long have you been 'in recovery'?
   Less than one year
   1-5 years
   5-10 years
   >10 years
9. What resources have you used to begin and/or support your recovery?
   - Health care professional (e.g. doctor, nurse practitioner, etc.)
   - 12-step support groups (e.g. AA/NA)
   - In-patient treatment
   - Out-patient treatment specific to drug/alcohol use (e.g. intensive outpatient, group, or individual counseling or therapy)
   - Smart Recovery, Refuge Recovery, Life Ring, Women for Sobriety, etc. (non-AA/NA groups)
   - Medication Assisted Treatment Suboxone/buprenorphine), Methadone, Vivitrol
   - Faith-based recovery groups (Celebrate Recovery) & supports
   - Recovery community center (They offer sober activities, peer support meetings and other resources, a sober place to hang out, etc.)
   - Recovery Care Organization
   - Peer recovery support via certified recovery specialist or recovery coach
   - Family resources to help your loved ones (e.g. therapy, support groups, etc.)
   - Sober living or other housing support
   - Recovery high school or recovery college
   - Physical fitness (yoga, gym, etc.)
   - Needle exchange center
   - Other
10. Please indicate any/all resources that would have been helpful to your treatment/recovery, but were not made available to you) (Check all that apply)
    - Housing support
    - General education about substance use as well as how to prevent relapse and develop healthy stress management & coping skills

- Legal assistance
- Better access to health care
- Child care
- Assistance with accessing state and federal public benefits (e.g. Medicaid)
- Help with transportation (getting to appointments, therapy, etc.)
- Treatment providers who speak Spanish or other non-English language
- Sober living/recovery housing
- Help integrating back into your family and/or community
- Life skills training (cooking, maintaining a bank account, etc.)
- Medication assisted treatment (methadone, suboxone, Vivitrol)
- Job training and job search assistance
- Help continuing your education
- Continued follow up care after treatment for at least 6 months?
- Funding for treatment
- Peer mentoring (having someone who has dealt with similar problems and overcome them like a certified recovery specialist or recovery coach to help you over time)
- Inpatient treatment (residential)
- Outpatient treatment (e.g. Counseling, therapy, etc.)
- Inpatient/residential treatment
- Local Peer/mutual support meetings/groups
- Medication assisted treatment like methadone, Suboxone/buprenorphine, Vivitrol
- Community center for people in recovery (activities, meetings, safe place to hang out, etc.)
- Resources for family members affected by drug and alcohol use (e.g. therapy, support groups, education, etc.)
- Recovery high school
- College Recovery program
- Physical fitness center or gym access (yoga, exercise, etc.)

11. Please list any other resources, not listed above, that you think would have been or would be helpful to you in your recovery. (open ended answer)
12. Please list any needs that are not being met in your community relative to treatment and recovery. (open ended answer)

Appendix Table 1: Response by County

County	Number of Respondents
Adams	5
Allegheny	109
Armstrong	10
Beaver	13
Bedford	2
Berks	43
Blair	4
Bradford	6
Bucks	43
Butler	30
Cambria	11
Carbon	8
Centre	9
Chester	27
Clarion	3
Clearfield	2
Columbia	3
Crawford	13
Cumberland	81
Dauphin	51
Delaware	23
Erie	26
Fayette	6
Franklin	21
Fulton	2
Greene	3
Huntington	1
Indiana	6
Jefferson	2
Juniata	1
Lackawanna	27
Lancaster	40
Lawrence	12
Lebanon	5
Lehigh	23
Luzerne	22
Lycoming	17
McKean	1
Mercer	11
Mifflin	2
Monroe	7

Montgomery	43
Montour	3
Northampton	20
Northumberland	6
Perry	1
Philadelphia	55
Pike	2
Potter	2
Schuylkill	20
Snyder	2
Somerset	5
Susquehanna	4
Tioga	14
Union	2
Venango	6
Warren	1
Washington	40
Wayne	4
Westmoreland	33
Wyoming	8
York	43