State of New Hampshire
Department of Health and Human Services

NEW HAMPSHIRE RECOVERY EVALUATION REPORT:

EVALUATION OF PEER RECOVERY SUPPORT SERVICES FUNDED BY THE STATE OF NEW HAMPSHIRE

SFY2021

DATA AND ANALYSIS BY

afmc℠
Healthy **People.** Healthy **Businesses.**
Healthy **Communities.**

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NEW HAMPSHIRE TREATMENT EVALUATION: EVALUATION OF SUBSTANCE USE DISORDER TREATMENT SERVICES FUNDED BY THE STATE OF NEW HAMPSHIRE

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GLOSSARY OF ACRONYMS

AFMC	Arkansas Foundation for Medical Care
BARC-10	Brief Assessment of Recovery Capital
BDAS	Bureau of Drug & Alcohol Services
BPQ	Bureau of Program Quality
CDC	Centers for Disease Control and Prevention
COVID-19	Coronavirus disease
DHHS	Department of Health & Human Services
DCYF	Division for Children, Youth & Families
ED	Emergency department(s)
EMS	Emergency medical services
FO	Facilitating organization
GED	General education development
LGBTQ+	Lesbian, gay, bisexual, transgender and queer with a "+" to recognize the limitless sexual orientations and gender identities
NHHPP	New Hampshire Health Protection Program
NIAAA	National Institute on Alcoholism and Alcohol Abuse
NSDUH	National Survey on Drug Use and Health
OD2A	Overdose Data to Action
PRSS	Peer recovery support services
RCOs	Recovery community organizations
SABG	Substance Abuse Block Grant
SAMHSA	Substance Abuse and Mental Health Services Administration
SFY	State fiscal year
SHADAC	State Health Access Data Assistance Center
SOR	State Opioid Response
SUD	Substance use disorder
TA	Technical assistance
TRS	Telephone recovery services

TERMS

Brief check-in	Sessions that are used to record Telephone Recovery Support services; approximately 15 minutes long and serve as wellness check-ins or continuous recovery monitoring
Completed goals	Recovery plan goals that participants have achieved
Completed referrals	Recovery referrals that have been fulfilled
Follow-up engagement sessions	A session in which a recovery coach assists participants in the maintenance and ongoing development of a recovery plan to reduce barriers and facilitate access to resources through system navigation; approximately 60 minutes long
Qualitative data	Data that is non-numerical in nature; also known as categorical data
Quantitative data	Data that can be counted or measured in numerical values
Total meetings	Number of meetings across all engagements

EXECUTIVE SUMMARY

According to the United States Department of Health and Human Services Office of the Surgeon General, "alcohol and drug misuse and related disorders are major public health challenges that are taking an enormous toll on our society" (2022). Although New Hampshire continues to rank as one of the healthiest and safest places to live and raise a family, similar to other areas of the country, substance misuse in general and opioid misuse in particular, have had a devastating impact on individuals, families and communities across New Hampshire (Pulkkinen, 2021).

According to a report published by the State Health Access Data Assistance Center (SHADAC), Centers for Disease Control and Prevention (CDC) data shows that the 2019 rate of alcohol related deaths in New Hampshire was 12.2 deaths per 100,000 people (n=203) (State Health Access Data Center [SHADAC], 2021). Data from the CDC shows that from 2016 to 2019, the rate of synthetic opioid overdoses increased exponentially in New Hampshire, peaking in 2018 with the third highest rate of 31.3 deaths per 100,000 persons (n=386) (Centers for Disease Control and Prevention [CDC], 2021).

The opioid epidemic in New Hampshire has placed a tremendous strain on local institutions. The number of emergency medical services (EMS) naloxone administrations nearly tripled between 2013 (n=1,039) and 2017 (n=2,774), and from 2018-2019, there were over 5,000 opioid related hospital emergency department (ED)visits per year (NH Information & Analysis Center, 2022). An average of 473 children were born drug exposed annually from 2015–2019, meaning that infants were exposed to the misuse of illicit substances while in utero, which results in withdrawal symptoms at birth (NH Department of Health & Human Services [DHHS] Division for Children, Youth & Families [DCYF], 2021). Furthermore, over 500 children in New Hampshire suffered from confirmed substance related abuse and/or neglect annually from 2017–2019 (NH Department of Health and Human Services, 2021). In total, the economic impact of substance misuse in New Hampshire costs $2.36 billion annually (Polecon Research, 2017).

New Hampshire has responded to this crisis by bringing unprecedented resources and services to the state, including an array of prevention, early intervention, crisis intervention, treatment and recovery support services. In addition to new resources, initiatives have included efforts to develop new service capacity and to better coordinate services across health and social service systems.

The New Hampshire model for peer recovery support services (PRSS) serves New Hampshire citizens over the age of 17 who are seeking to gain, maintain or enhance their recovery from substance misuse. PRSS help people become engaged and stay connected with the recovery process and are designed and delivered by peers who are in recovery themselves and who are trained to help others to be successful in their recovery. Harbor Care, the state contracted facilitating organization (FO), subcontracts with 14 recovery community organizations (RCOs) throughout the state providing oversight and support of all state funded peer support services administered by the RCOs.

The contract with DHHS required an evaluation of outcomes. The goals of this evaluation are:

1. Determine and demonstrate the value of PRSS.

2. Identify which PRSS services and activities provided by the RCOs have the most statistically significant impact on positive recovery outcomes.

3. Use the information gleaned from these analyses to help guide ongoing program development and quality improvement of PRSS.

Data for this evaluation was collected during SFY2021 from RecoveryLink™ and virtual site visits conducted by AFMC. All quantitative data was collected from RecoveryLink™, which is a platform specifically designed to collect data for PRSS.

After obtaining the quantitative data from RecoveryLink™, AFMC conducted a variety of statistical analyses, including a paired samples t-test, logistic regression and linear regression. For purposes of these analyses, all significance is reported at a level of 95%, meaning that the probability of the results occurring by chance is 5% (0.05) or less. All results shown in this report are statistically significant.

AFMC staff conducted virtual site visits with key staff members from each of the BDAS-funded RCOs to collect qualitative data that could not otherwise be gleaned from the RecoveryLink™ data. The primary goal of the site visits was to provide a venue for the RCOs to discuss any successes, barriers and positive impacts that they have encountered as a result of the BDAS funding during SFY2021, specifically. Qualitative data from the site visits was summarized and a thematic analysis was conducted, which involves examining the data to identify themes and patterns in the data.

- During SFY2021, a total of 2,926 participants received PRSS.
- Of the 2,926 participants, most (88.4%, n=2,587) identified as white.
- Over half of the participants identified as male (54.3%, n=1,589).
- Over half of the participants had at least a high school diploma or GED (52.0%, n=1,522).
- 63.0% (n=1,843) of participants were aged 25-44.

There was a significant difference between Brief Assessment of Recovery Capital (BARC-10) scores at intake and most recently reported BARC-10 scores. The average increase in scores was 2.4 points. Therefore, analyses indicated that PRSS were effective, as shown by increased recovery capital. Recovery capital is conceptually linked to protective factors and wellness, which can be divided into internal and external resources. These categories encompass many factors, such as physical health, basic needs, social relationships, attitudes, policies and other resources (White & Cloud, 2008). Recovery capital is measured using the BARC-10. The BARC-10 is a validated strengths-based measure that can be used to assess levels of an individual's personal and social resources that are used to initiate and sustain recovery. The BARC-10 can be completed at any of the following engagement sessions: brief check-ins, follow-up engagements, full intake sessions, care coordination sessions and initial recovery plan sessions.

Analyses showed that the most common PRSS associated with increased recovery capital include:

- Attending a higher number of total meetings
- Attending a higher number of prosocial activities
- Attending a higher number of advocacy activities
- Completing recovery plan goals

Regression analyses were conducted to identify predictors of higher BARC-10 scores and overall engagement using a variety of dependent or outcome variables. Some of the independent variables included in the analyses are services not directly provided by the RCOs. However, services provided by the RCOs can even have a positive influence on these factors. Analyses showed that the most common contributing factors associated with increased recovery capital include:

- Having a higher quality-of-life
- Being stably housed
- Being employed full-time
- Having an income
- Having access to or owning transportation
- Currently being on probation or parole
- Increased average recovery plan progress
- Having a higher level of engagement with friends
- Having a higher level of engagement with family
- Having a higher level of engagement with community
- Having a higher level of physical health
- Having a higher level of mental health
- Having a higher level of self-satisfaction

Analyses showed that the following demographics were key predictors of recovery capital and overall engagement:

- Identifying as heterosexual
- Identifying as bisexual
- Being 45–64 years of age

Improving the completion rate of BARC-10 assessments and encouraging participants to complete a BARC-10 at every engagement is recommended to increase the sample size for future evaluations.

Based on the results of the analyses, it is recommended that the RCOs implement or emphasize the following:

1. Improving data quality and availability and/or evaluation design and methodology
2. Improving the operational effectiveness of RCOs
3. Placing greater focus on engaging participants in activities associated with increasing recovery capital, thus improving outcomes
4. Increasing community-based services

BACKGROUND

In 2022, the United States Department of Health and Human Services Office of the Surgeon General reported:

> Alcohol and drug misuse and related disorders are major public health challenges that are taking an enormous toll on our society. Recently, more than 27 million people in the United States reported that they are using illicit drugs or misusing prescription drugs, and nearly a quarter of adults and adolescents reported binge drinking in the past month. The annual economic impact of substance misuse is estimated to be $249 billion for alcohol misuse and $193 billion for illicit drug use (para. 1).

Although New Hampshire continues to rank as one of the healthiest and safest places to live and raise a family, like other areas of the country, substance misuse specifically the misuse of opioids have had a devastating impact on individuals, families and communities across New Hampshire (Pulkkinen, 2021). According to the 2019 National Survey on Drug Use and Health (NSDUH), New Hampshire nationally ranks in the top 15 for the use of cocaine, binge drinking (five or more alcohol drinks for males or four or more alcoholic drinks for females on the same occasion), use of marijuana and illicit drug use (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020) (**Figure 1**).

FIGURE 1. PREVALENCE OF SUBSTANCE USE IN NEW HAMPSHIRE AND THE UNITED STATES

Type of Substance Use	Percentage of NH Population	Percentage of U.S. Population	NH National Ranking
Cocaine	2.6%	2.0%	7th
Binge Drinking	27.9%	24.4%	8th
Marijuana	21.4%	16.7%	11th
Illicit Drug Use	15.7%	12.3%	12th
Heroin	0.3%	0.3%	26th
Illicit Use of Prescription Pain Medication	0.3%	0.4%	42nd
Methamphetamine	0.4%	0.7%	43rd

Source: NSDUH, 2019

CONSEQUENCES OF SUBSTANCE MISUSE

CONSEQUENCES OF ALCOHOL USE

The National Institute on Alcoholism and Alcohol Abuse (NIAAA) reported that "an estimated 95,000 people (approximately 68,000 men and 27,000 women) die from alcohol-related causes annually, making alcohol the third-leading preventable cause of death in the United States" (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2022).

According to a report published by the SHADAC, CDC data shows that the 2019 rate of alcohol related deaths in New Hampshire was 12.2 deaths per 100,000 people (n=203), which is statistically significantly higher than the national alcohol death rate (10.4 deaths per 100,000 people) (SHADAC, 2021).

CONSEQUENCES OF DRUG USE

The impact of opioid misuse has been far reaching in New Hampshire. For instance, the number of children removed from parental care during the opioid epidemic by the Division of Children, Youth and Families (DCYF) increased by 42.4% from 2016 (n=958) to 2018 (n=1,405). DCYF also reports that the number of child protection family services cases that had founded substance abuse allegations increased by 63.1% from 2015 (n=157) to 2017 (n=256) (NH DHHS DCYF, 2021). An average of 473 children were born drug exposed annually from 2015-2019, meaning that infants were exposed to the misuse of illicit substances while in utero, which results in withdrawal symptoms at birth (NH DHHS DCYF, 2021). Furthermore, over 500 children in New Hampshire suffered from confirmed substance related abuse and/or neglect annually from 2017-2019 (NH DHHS, 2021). Data from the CDC shows that from 2016 to 2019, the rate of synthetic opioid overdoses increased exponentially in New Hampshire, peaking in 2018 with the third highest rate of 31.3 deaths per 100,000 persons (n=386) in the United States. The increase in synthetic opioid overdoses is being driven by fentanyl and fentanyl-analogs, such as carfentanil, which are 50 to 10,000 times more potent than morphine (CDC, 2021). New Hampshire remained in the top ten highest drug overdose rates from 2016 to 2019, despite the rate decreasing slightly each year (**Figure 2**).

FIGURE 2. NEW HAMPSHIRE OVERDOSE DEATHS, 2016–2019

		All Drug Overdoses	Synthetic Opioid Overdoses	Prescription Opioid Overdoses	Heroin Overdoses
2016	Deaths	481	34	89	34
	Rate per 100,000	39.0	2.8	6.5	208
	National Ranking	**3rd**	**29th**	**18th**	**26th**
2017	Deaths	467	28	62	28
	Rate per 100,000	37.0	2.8	4.8	2.4
	National Ranking	**5th**	**27th**	**23rd**	**27th**
2018	Deaths	452	386	43	N/A
	Rate per 100,000	35.8	31.3	3.1	N/A
	National Ranking	**6th**	**3rd**	**39th**	**N/A**
2019	Deaths	407	343	45	N/A
	Rate per 100,000	32.0	27.6	3.3	N/A
	National Ranking	**9th**	**6th**	**36th**	**N/A**

Source: CDC, 2021

The opioid epidemic in New Hampshire has also placed a tremendous strain on local institutions, including emergency medical services (EMS), hospital ED and an array of other local health care and social service providers. The number of EMS naloxone administrations nearly tripled between 2013 (n=1,039) and 2017 (n=2,774), with the number of cases dropping to 1,635 in 2021 (NH Information & Analysis Center, 2022). From 2018-2019, there were over 5,000 opioid related hospital ED visits each year. Additionally, there were 1,655 and 1,792 stimulant related ED visits in 2018 and 2019, respectively (NH Information & Analysis Center, 2022). Data shows that frequent hospital and ED visits are associated with nonfatal and fatal overdoses (Krawczyk, et al., 2020). Emergency responders, hospital ED staff and providers have all expressed concerns about the undue stress and fatigue that the opioid epidemic, on top of the COVID-19 pandemic, has placed on New Hampshire's health and social service systems in a fragile state (Metcalf, et al., 2022).

According to a report prepared by Polecon Research, most recently available data shows that the economic impact of substance misuse in New Hampshire costs $2.36 billion annually, which is equal to $1,780 for every person residing in the state (Polecon Research, 2017). These costs are associated with:

- Increases in substance use related health care costs
- Criminal justice costs
- Lost productivity
- Lost state and local revenue

DIRECT EFFORTS TO ADDRESS THE MISUSE OF ALCOHOL AND DRUGS IN NEW HAMPSHIRE

The level of impact outlined above requires a comprehensive approach that addresses underlying conditions that place individuals at heightened risk for misusing alcohol and drugs and that includes a continuum of prevention, early intervention, crisis intervention, treatment and recovery support services.

New Hampshire has leveraged unprecedented federal and state resources over the past five years bringing critically needed services across the state. This has included introducing the New Hampshire Health Protection Program (NHHPP) in 2014, which evolved into the Granite Advantage Healthcare Program in 2019. This program includes an array of substance use disorder benefits and provides health insurance coverage at little or no cost for qualifying individuals (Covering New Hampshire, 2021). Federal resources include funding from the Overdose Data to Action (OD2A) grants from the CDC and State Opioid Response (SOR) Grants from the Substance Abuse and Mental Health Services Administration (SAMHSA).

Since 2016, New Hampshire has used funding from the Substance Abuse Block Grant (SABG) and Governor's Commission on Alcohol & Other Drugs, in addition to other funding sources, to develop PRSS. PRSS are a system of social support designed and delivered by individuals who have experienced substance use disorder (SUD) and recovery. This peer-based model helps individuals engage in the recovery process and embodies a message of hope for the recovering community (SAMHSA, 2009). These services support individuals making progress in the four dimensions of recovery. PRSS are relatively inexpensive and play an essential role in the continuum of services, assisting individuals initiating and maintaining their recovery.

EVALUATION PURPOSE

The New Hampshire model for PRSS serves New Hampshire citizens over the age of 17 who are seeking to gain, maintain or enhance their recovery from substance misuse. Services are also included to promote involvement and to support participants' families and caregivers throughout the recovery process. PRSS help people become engaged and stay connected with the recovery process and are designed and delivered by peers who are in recovery themselves and who are trained to help others to be successful in their recovery.

Harbor Care, the state contracted FO, subcontracts with 14 RCOs throughout the state, providing oversight and support of all state funded peer support services administered by all the RCOs (**Figure 3**).

FIGURE 3. LOCATIONS OF RCOS IN NEW HAMPSHIRE

RCO	Number of recovery centers	Location(s)
White Horse Recovery	2	Center Ossipee, North Conway
Safe Harbor Recovery Center	1	Portsmouth
SOS Recovery Community Organization	3	Dover, Hampton, Rochester
Keene Serenity Center	1	Keene
TLC Recovery Programs	1	Claremont
Addiction Recovery Coalition of New Hampshire	1	Milford
Revive Recovery Center	2	Derry, Nashua
Archways*	3	Concord, Franklin, Tilton
Navigating Recovery of the Lakes Region	1	Laconia
Mount Washington Valley Supports Recovery	1	Center Conway
HOPE for NH Recovery	1	Manchester
Reality Check	1	Jaffrey
The Shed at Serenity Center**	1	Littleton
Plymouth Area Recovery Connections	1	Plymouth

**Formerly known as Greater Tilton Area Family Resource Center*

***Formerly known as North Country Serenity Center and is now operating under White Horse Recovery Center*

The FO has developed data collection processes for participant-level data for all RCOs they contract with through the RecoveryLink™ database platform. The FO provides ongoing technical assistance (TA) to the RCOs to ensure the integrity of the data collection process. The contract with DHHS required an evaluation of outcomes. The goals of this evaluation are:

1. Determine and demonstrate the value of PRSS.
2. Identify which services and activities provided by PRSS have the most statistically significant impact on positive recovery outcomes.
3. Use the information gleaned from these analyses to help guide ongoing program development and quality improvement of PRSS.

To determine the effectiveness of PRSS, analyses were conducted to determine if recovery capital increased as a result of receiving PRSS from the RCOs. Recovery capital is conceptually linked to protective factors and wellness, which can be divided into internal and external resources. These categories encompass many factors such as physical health, basic needs, social relationships, attitudes, policies and other resources (White & Cloud, 2008). Recovery capital is measured using the BARC-10. The BARC-10 is a validated strengths-based measure that can be used to assess levels of an individual's personal and social resources that are used to initiate and sustain recovery. The BARC-10 can be completed at any of the following engagement sessions: brief check-ins, follow-up engagements, full intake sessions, care coordination sessions and initial recovery plan sessions.

A comprehensive evaluation report was produced for DHHS and the facilitating organization and RCO program directors and managers. This more concise version of this evaluation report has been produced for senior management at DHHS, policy makers and the general public.

DATA SOURCES AND METHODOLOGY

Data for this evaluation were collected during SFY2021 from RecoveryLink™ and virtual RCO site visits conducted by AFMC.

RECOVERYLINK™

All quantitative data was collected from RecoveryLink™, which is a platform specifically designed to collect data for PRSS. Data entry is conducted by RCO staff members, and TA for RecoveryLink™ is provided by Harbor Care. RecoveryLink™ data is collected for every participant who received recovery coaching or TRS services at any of the BDAS-funded RCOs. At the end of the evaluation period, Harbor Care sent AFMC RecoveryLink™ data for the entire evaluation period. The quantitative data collected in RecoveryLink™ includes, but is not limited to:

- Participant demographics
- Participants' current service type
- History of substance use and mental illness
- Participants' current recovery pathway
- Type and number of PRSS received
- BARC-10 assessment score(s)
- Length of engagement in PRSS

VIRTUAL SITE VISITS

AFMC staff conducted virtual site visits with key staff members from each of the BDAS-funded RCOs to collect qualitative data that could not otherwise be gleaned from the RecoveryLink™ data. The primary goal of the site visits was to provide an outlet for the RCOs to discuss any successes, barriers and positive impacts that they have encountered as a result of the BDAS funding during SFY2021, specifically.

After obtaining the quantitative data from RecoveryLink™, AFMC conducted a variety of statistical analyses, including a paired sample t-test, logistic regression and linear regression. The goals of these analyses were:

- Determine the effectiveness of PRSS
- Identify which peer recovery support services were possible predictors of BARC-10 scores
- Identify predictors of BARC-10 scores using a variety of dependent or outcome variables
- Identify possible demographic predictors of recovery capital and overall engagement

For purposes of these analyses, all significance is reported at a level of 95%, meaning that the probability of the results occurring by chance is 5% (0.05) or less. Significance is denoted by the letter p. Therefore, if $p \leq 0.05$, results are statistically significant. All results shown in this report are statistically significant.

Qualitative data from the site visits was summarized and a thematic analysis was conducted, which involves examining the data to identify themes and patterns in the data.

Some barriers were encountered during the analyses. For instance, there were inconsistencies in how the data was entered into RecoveryLink™ by the RCOs. Therefore, standardization of the data entry process is recommended in the future. Additionally, there was a small sample size of the participant population that had completed multiple BARC-10 assessments. Since more than one BARC-10 score is required to evaluate the effectiveness of PRSS, these analyses could only be conducted on a portion (18.4%) of participants. With the completion of only one BARC-10 assessment, analyses are unable to determine the effects of PRSS on one's recovery capital. Having a larger sample size would provide a more accurate and complete representation of the data.

KEY FINDINGS AND CONCLUSIONS

- During SFY2021, a total of 2,926 participants received PRSS (**Figure 4**).
- Of the 2,926 participants, most (88.4%, n=2,587) identified as white.
- Over half of the participants identified as male (54.3%, n=1,589).
- Over half of the participants had at least a high school diploma or GED (52.0%, n=1,522).
- 63.0% (n=1,843) of participants were aged 25-44.
- At the time of the evaluation, 35.9% (n=1,050) of participants reported that they had attended SUD treatment in the past, and over half of the participants (50.6%, n=1,481) reported that they were currently in recovery.

FIGURE 4. NUMBER OF PARTICIPANTS SERVED AT EACH RCO

RCO	Number of participants
Addiction Recovery Coalition of New Hampshire	5
Archways*	278
HOPE for NH Recovery	389
Keene Serenity Center	70
MWV Supports Recovery	58
Navigating Recovery of the Lakes Region	491
Plymouth Area Recovery Connection	32
Reality Check	28
Revive Recovery Resource Center	426
Safe Harbor Recovery Center	103
The Shed at Serenity Center**	133
SOS Recovery	657
TLC Recovery Programs	146
White Horse Recovery Center	110

**Formerly known as Greater Tilton Area Family Resource Center*

***Formerly known as North Country Serenity Center and is now operating under White Horse Recovery Center*

BARC-10 ANALYSIS

To determine the effectiveness of PRSS, analyses were conducted to determine if recovery capital increased as a result of receiving PRSS. Recovery capital is conceptually linked to protective factors and wellness, and it can be divided into internal and external resources. These resources encompass many factors, such as physical health, basic needs, social relationships, attitudes, policies and other resources (White & Cloud, 2008). Recovery capital is measured using the BARC-10. The BARC-10 is a validated strengths-based measure that can be used to assess levels of an individual's personal and social resources that are used to initiate and sustain recovery (**Appendix 1**). The BARC-10 can be completed at any of the following engagement sessions: brief check-ins, follow-up engagements, full intake sessions, care coordination sessions and initial recovery plan sessions. Brief check-ins are telephone recovery support (TRS) services, which consists of weekly calls, lasting approximately 15 minutes that serve as wellness check-ins, which also provide an opportunity to monitor recovery progress. During brief check-ins, participants can request referrals for other services, including assistance with daily living skills, housing, and mental or physical health services. Support services also include

job seeking skills, assistance with managing personal finances, educational opportunities, safety, legal aid, improving interpersonal relationships, and spiritual resources. Follow-up engagement sessions typically last one hour and are used to record recovery coaching sessions, in which the recovery coach assists participants in the maintenance and ongoing development of a recovery plan.

Of the 27,455 engagements in which a BARC-10 could have been completed, a BARC-10 was completed at 5,060 of those engagements, which results in a completion rate of approximately 18.4%. Additionally, only 1,322 of the 2,926 participants completed a BARC-10 assessment and only 802 participants completed two or more assessments. Therefore, analyses evaluating the effectiveness of PRSS was conducted on approximately 27.4% of total participants served.

Analyses show that there was a statistically significant difference between BARC-10 scores at intake and the most recently reported BARC-10 scores ($p<0.0001$). The average increase in scores was 2.4 points. This means that as a result of PRSS, BARC-10 scores increased by an average of 4% (2.4 points). Most importantly, this analysis indicates that PRSS are effective at increasing recovery capital.

PEER RECOVERY SUPPORT SERVICES

Regression analyses were conducted to identify which PRSS were most effective at increasing recovery capital. Analyses showed that the most common PRSS associated with increased recovery capital include:

- Attending a higher number of total meetings
- Attending a higher number of prosocial activities
- Attending a higher number of advocacy activities
- Completing recovery plan goals

Participation in PRSS seems to be the most important factor associated with increasing recovery capital. Increased attendance in a variety of meetings and activities is shown to increase recovery capital. Additionally, participants who completed recovery plan goals are associated with having increased recovery capital.

CONTRIBUTING FACTORS

Regression analyses were conducted to identify predictors of BARC-10 scores and overall engagement using a variety of dependent or outcome variables. Some of the independent variables included in the analyses are services not directly provided by the RCOs. However, services provided by the RCOs, such as assisting participants in accessing housing and improving employment skills, could influence these factors, and RCOs should consider these contributing factors when designing and implementing various activities and services. Analyses showed that the most common contributing factors associated with increased recovery capital include:

- Having a higher quality-of-life
- Being stably housed
- Being employed full-time
- Having an income
- Having access to or owning transportation
- Currently being on probation or parole
- Increased average recovery plan progress
- Having a higher level of engagement with friends
- Having a higher level of engagement with family
- Having a higher level of engagement with community
- Having a higher level of physical health
- Having a higher level of mental health
- Having a higher level of self-satisfaction

Based on the results of the analyses, increased physical health, overall quality-of-life, mental health and self-satisfaction are important factors associated with increasing recovery capital. At the time of the evaluation, four (30.8%) of the RCOs offered physical fitness recovery services, such as yoga and CrossFit. In addition to increasing physical fitness, it is also important for participants to having their physical health needs met as well.

Currently being on probation or parole was another common predictor associated with recovery capital. Conditions of probation or parole often include attending or being engaged in a recovery program. It is encouraging that individuals who are on probation or parole are associated with increased active and completed goals, attending follow-up sessions and meetings, completing a higher number of BARC-10 assessments and having a high number of completed referrals.

Having stable housing is also a common predictor of recovery capital. It was mentioned by several RCOs that housing is a substantial barrier that participants face. Not only are there not enough rental properties available, but there is also a very limited amount of transitional housing in New Hampshire. This presents a problem to individuals who are re-entering the community resulting in them continuing to be unstably housed, which is a known risk factor associated with active substance use.

Being employed full-time, and thus having regular income, is associated with an increase in recovery capital and overall engagement in PRSS. During the site visits, several RCOs mentioned that there is a significant stigma associated with hiring individuals in the recovery community, making it more difficult for individuals in recovery to find employment.

Finally, having consistent access to transportation is another common predictor of recovery capital and overall engagement. However, it was explained by several RCOs that transportation is a barrier for many participants, especially in rural areas of the state that lack public transportation.

DEMOGRAPHICS

Key demographic predictors of recovery capital and overall engagement:

- Identifying as heterosexual
- Identifying as bisexual
- Being 45–64 years of age

Of the demographic variables, identifying as heterosexual was the most common predictor of overall recovery capital and overall engagement. Individuals identifying as heterosexual are associated with having higher BARC-10 scores at intake and present time, having higher average BARC-10 scores, having an increase in successful follow-up engagements and brief check-ins, attending more meetings, and having more active and completed referrals. Individuals who identify as bisexual are also associated with having many positive outcomes, such as having higher current BARC-10 scores, having an increase in successful follow-up engagements, completing more goals, attending more meetings, and having more active and completed referrals. Individuals aged 45–64 are associated with many positive outcomes, including higher current BARC-10 scores, higher average BARC-10 scores, a longer length of time in SUD recovery and an increase in the number of successful follow-up engagements and brief check-ins. Additionally, being single or in a domestic partnership are both associated with higher levels of recovery capital and increases in overall engagement.

RECOMMENDATIONS

Objectives for the recommendations outlined in this section are focused on four key areas:

1. Improving data quality and availability and/or evaluation design and methodology
2. Improving the operational effectiveness of RCOs
3. Placing greater focus on engaging participants in activities associated with increasing recovery capital, thus improving outcomes
4. Increasing community-based services

IMPROVING DATA QUALITY AND AVAILABILITY, AND/OR EVALUATION DESIGN AND METHODOLOGY

- The FO should assist RCOs in developing and implementing strategies to increase the number of participants completing initial and subsequent BARC-10 assessments
- Consider conducting an evaluation of the RCOs
- Consider conducting an evaluation of the FO

INCREASING THE OPERATIONAL EFFECTIVENESS OF RCOS

- The FO should assist RCOs in developing and implementing strategies to recruit, train and retain peer recovery support staff
- The FO should assist RCOs in utilizing effective techniques:
  - To engage and retain participants
  - To assist participants in:
    - Developing effective job seeking skills
    - Managing personal finances
    - Accessing transportation
    - Finding stable housing/recovery housing
    - Accessing health insurance
    - Accessing medical, mental health and social services
- The FO should work with RCOs to develop additional programming and support services for:
  - LGBTQ+ participants
  - Participants under the age of 45
- The FO should provide additional training and TA to the RCOs in the following areas:
  - Entering data into RecoveryLink™
  - Assisting the RCOs in submitting their billing and working to better manage cash flow issues and/or work with BDAS to stabilize reimbursement practices
- The RCOs should provide additional training for peer recovery support staff to encourage participants to engage in:
  - Additional meetings
  - Additional prosocial activities (i.e., physical fitness activities, mindfulness, etc.)
  - Additional advocacy activities
  - Developing and completing recovery plan goals

FY2021 data shows that the RCOs are currently providing many of the activities recommended above.

However, the results from this evaluation suggest that all of the RCOs should focus on improving their capacity to effectively provide all of these services where applicable. It should be noted that there are systemic barriers (i.e., a statewide lack of mental health care services and a lack of affordable housing) that prevent the implementation of many of the previously mentioned activities and services. Therefore, the RCOs should only implement these suggestions within their capacity to do so.

PLACING GREATER FOCUS ON ENGAGING PARTICIPANTS IN ACTIVITIES ASSOCIATED WITH INCREASING RECOVERY CAPITAL

- Greater participation in PRSS, including:
  - Meetings
  - Prosocial activities (i.e., physical fitness activities, mindfulness, etc.)
  - Advocacy activities
  - Training to improve:
    - Job seeking skills
    - Ability to access stable housing/recovery housing
    - Interpersonal skills (to improve relationships with family, friends and community members)
- Assisting participants in accessing:
  - Physical fitness activities
  - Employment opportunities
  - Health insurance
  - Medical, mental health and social services as needed
  - Educational/vocational trainings
- Greater participation in developing recovery plans and completing recovery goals

INCREASING COMMUNITY-BASED SERVICES

- Increasing community-based services including:
  - Consistent and timely funding for PRSS
  - Increasing peer recovery support workforce
  - Increasing capacity of community resources that address healthcare, behavioral health, stable housing and transportation.

As previously indicated, the RCOs are already engaging participants in many of these activities, in addition to other activities and services. However, this evaluation suggests that a greater focus should be placed on these specific types of activities.

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APPENDIX

APPENDIX 1. BRIEF ASSESSMENT OF RECOVERY CAPITAL

Please mark the degree to which you agree or disagree with the following statements about your recovery.

Statement	Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
There are more important things to me in life than using substances.	1	2	3	4	5	6
In general, I am happy with my life.	1	2	3	4	5	6
I have enough energy to complete the tasks I set myself.	1	2	3	4	5	6
I am proud of the community I live in and feel part of it.	1	2	3	4	5	6
I get lots of support from friends.	1	2	3	4	5	6
I regard my life as challenging and fulfilling without the need for using drugs or alcohol.	1	2	3	4	5	6
My living space has helped to drive my recovery journey.	1	2	3	4	5	6
I take full responsibility for my actions.	1	2	3	4	5	6
I am happy dealing with a range of professional people.	1	2	3	4	5	6
I am making good progress on my recovery journey.	1	2	3	4	5	6

DATA AND ANALYSIS BY

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