BARC-10 Pilot Report

Implementation with Peers in Virginia

Virginia Department of Behavioral Health & Developmental Services

OMNI

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Submitted to:

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Introduction

As part of the Virginia State Opioid Response (SOR) grant, the Virginia Department of Behavioral Health and Developmental Services (DBHDS) is committed to supporting innovative and impactful recovery services for individuals experiencing substance use disorders, such as peer recovery support. Peer supporters, also referred to as peers or Peer Recovery Specialists (PRS), provide recovery support based on their own lived experience of substance use disorder and recovery.[1] Peers are a rapidly growing workforce in substance use recovery in the U.S.[2] and bring unique value in their ability to work across settings, supporting a wide range of individuals.

As part of this effort to support innovative and impactful recovery services, the SOR team launched a pilot program to capture data related to the unique support that PRS provide the people they work with in their recovery from substance use.

This pilot program had four overarching goals:

1. Inform peer service delivery by providing real time feedback for peer supporters to use in their work with individuals.
2. Support comprehensive reporting to government agencies, funders, and stakeholders by collecting information in a systematic way.
3. Prepare and plan for future expansion of measurement efforts by testing the best ways to administer a quantitative measure (the BARC-10) as part of peer support services.
4. Build a dataset of peer support outcomes by generating a pool of quantitative data from individuals receiving peer support.

The BARC-10

For this pilot program, DBHDS in collaboration with OMNI Institute, who manages evaluation of SOR grant activities for DBHDS, selected the Brief Assessment of Recovery Capital (BARC-10), a quantitative measure that captures ten domains of Recovery Capital to administer via PRS at pilot sites. This measure is intended to capture aspects of change in early recovery from substance use disorder that would be impacted directly and indirectly through work with PRS.

The BARC-10 was developed as a short form of the Assessment of Recovery Capital (ARC), a 50-item measure with ten subscales, each of which is devoted to one internal or external resource that supports recovery from substance use.[3] The BARC-10 is a short form of this scale that uses one question to capture each of those subscales. Respondents rate each question on a scale from 1 to 6, with 1 being “strongly disagree" and 6 being “strongly agree, “such that higher scores on the BARC-10 indicate higher levels of Recovery Capital.

[1] Myrick, K., & del Vecchio, P. (2016). Peer support services in the behavioral healthcare workforce: State of the field. *Psychiatric Rehabilitation Journal*, 39(3), 197.
[2] Bassuk, E. L., Hanson, J., Greene, R. N., Richard, M., & Laudet, A. (2016). Peer-delivered recovery support services for addictions in the United States: A systematic review. *Journal of Substance Abuse Treatment*, 63, 1-9.
[3] Vilsaint, C. L., Kelly, J. F., Bergman, B. G., Groshkova, T., Best, D., & White, W. (2017). Development and validation of a Brief Assessment of Recovery Capital (BARC-10) for alcohol and drug use disorder. *Drug and Alcohol Dependence*, 177, 71-7

BARC-10 Domains and Associated Question

Deprioritizing Substances
There are more important things to me in life than using substances.

Life Satisfaction
In general, I am happy with my life.

Energy Level
I have enough energy to complete the tasks I set for myself.

Community Belonging
I am proud of the community I live in and feel a part of it.

Life Functioning
I am happy dealing with a range of professional people.

Fulfilling Activities
I regard my life as challenging and fulfilling without the need for using drugs or alcohol.

Supportive Housing
My living space has helped to drive my recovery journey.

Personal Responsibility
I take full responsibility for my actions.

Recovery Progress
I am making good progress on my recovery journey.

Social Support
I get lots of support from friends.

The BARC-10 was tested and validated using an initial sample of people in treatment for substance use (n=450) which allowed the researchers to narrow down the possible items to include in the measure. The reduced version of the scale was then tested in an independent sample (n=123). The 10-item measure was found to have high internal consistency (α=.90) and concurrent validity with the original measure (r_{pb} =.90).

Pilot Implementation

At the beginning of the pilot process development, OMNI and DBHDS consulted with potential pilot sites, including the peers who would be directly involved and their supervisors and/or program managers to gather feedback which was used to finalize the pilot process. After pilot sites were confirmed, OMNI provided hands-on support, including initial training and ongoing technical assistance for BARC-10 implementation. OMNI also provided tangible resources to support data utilization, such as a BARC-10 information sheet that included an overview of the BARC-10, how the scores could be interpreted, and most importantly, ways that the information could be useful to the peer supporter in their work with an individual.

The pilot study included two primary data sources: the BARC-10 survey and qualitative interviews with participating PRS.

BARC-10 Survey Administration

For this pilot study, PRS administered the BARC-10 survey to the individuals that they supported through an online platform. In addition to the ten BARC-10 items, the survey included demographic questions including the age, race, ethnicity, and gender of the participants.

The survey was implemented across two pilot sites that employ PRS as part of their harm reduction or treatment services: Bradley Free Clinic, located in Roanoke, Virginia and Wise Harm Reduction located in Wise County, Virginia. Both of these sites receive funding for their PRS services from DBHDS through the SOR grant. BARC-10 surveys were completed by the individual on their own or completed with the peer supporter based on which method worked best for each program. Immediately after completing the survey, the PRS received an email summary of the individual's responses to support treatment planning and reviewing changes in scores over time at the individual level.

Analysis of survey responses was completed by OMNI and are reported cumulatively in this report. Each participating site also received an aggregate summary report of the BARC-10 data collected by their PRS.

Qualitative Interviews with Peers

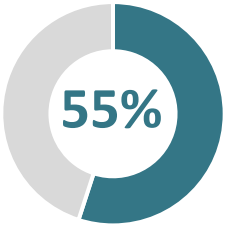
In the spring and early summer of 2022, OMNI conducted a total of 3 interviews with the PRS who had been administering the BARC-10 at the two pilot agencies. These interviews were semi-structured, using an interview guide developed by OMNI. They were designed to gather feedback from the PRS about their experience implanting the BARC-10 as well as their perceptions of the pilot implementation process. Interviews were conducted over Zoom and lasted between 30-60 minutes. Notes from the interviews were then reviewed and coded for themes.

Results

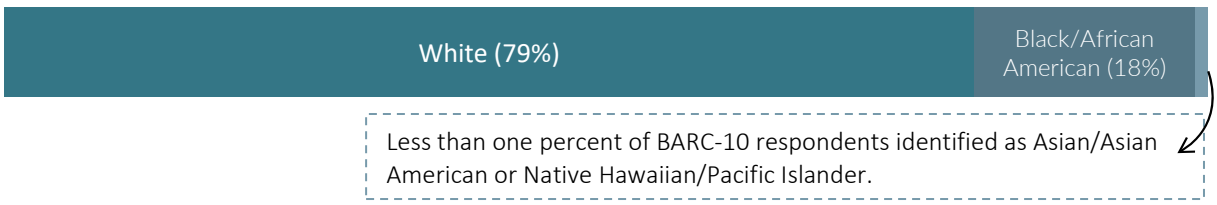
BARC-10 Survey Results

Survey Participants

A total of 323 participants took the BARC-10 at least once. Most survey participants identified as men (55%), followed by participants who identified as women (45%). A category for other gender identities was also presented in the survey but there were not any respondents who selected that option.



The majority of survey participants identified as Non-Hispanic/Latinx (98%) and White (79%), with 18% of participants identifying as Black/African American.

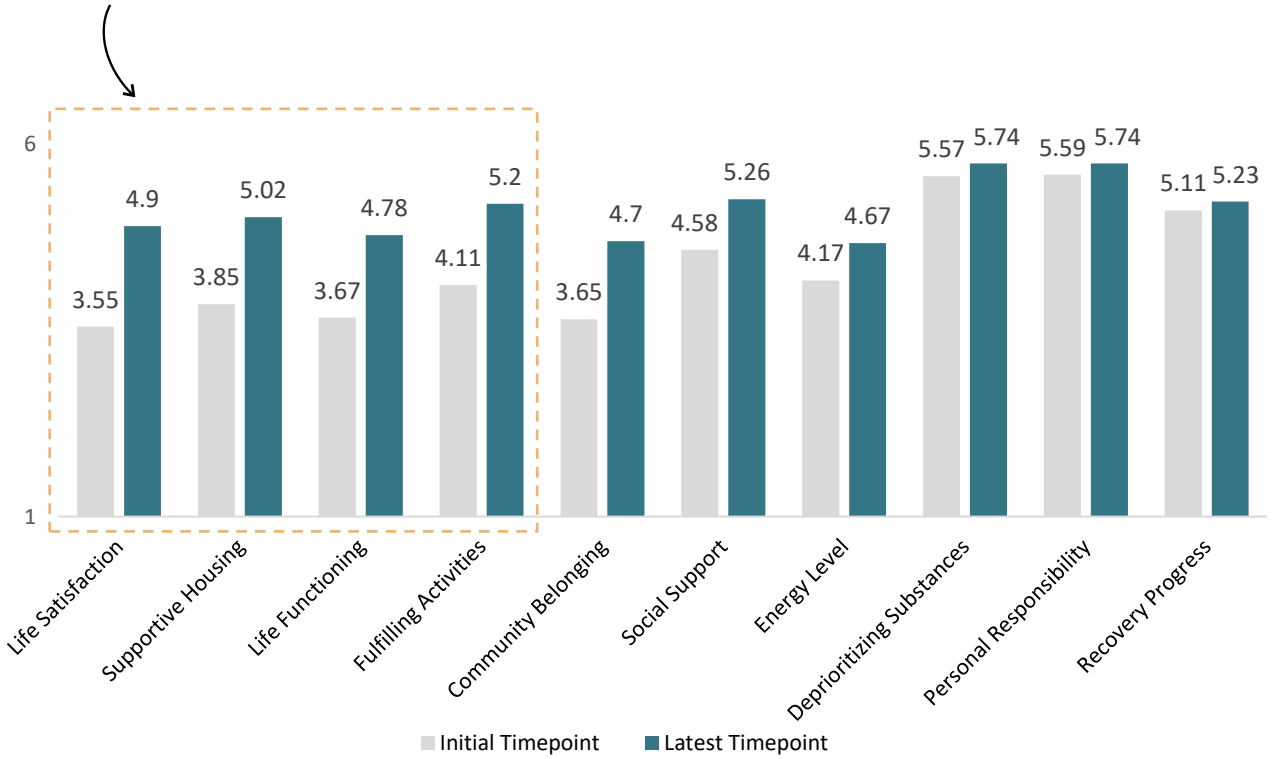


BARC-10 Scores

A total of 322 people took the BARC-10 at least once and the **mean BARC-10 score for all participants at the first or only administration of the scale was 43.84** (possible scores range between 6-60). A total of 90 participants took the BARC-10 at least twice. Those participants' **total BARC-10 scores averaged 46.86** the first time they completed the BARC-10, slightly higher than the initial average score of the entire group.

Participants who completed the BARC-10 two or more times showed a **statistically significant increase of 4.38 points between the initial time they took the BARC-10 and the latest time they took the BARC-10.**

Additionally, average participant scores increased significantly from the initial timepoint to the latest timepoint across all of the individual items. This indicates that, on average, there was an increase in availability of internal or external resources in each of the areas captured by these ten questions. **The largest increases were seen in life satisfaction, supportive housing, life functioning, and fulfilling activities.**



PRS Perspectives

During qualitative interviews with PRS, some important themes emerged when discussing the BARC-10. First and foremost, PRS reported that they found the quantitative measure of growth to be **a useful and inspiring way to capture the changes that the people they work with were experiencing.**

> Being able to watch a numerical thing increase gives a different sort of perspective on success. Because in recovery, a lot of times I get really frustrated when I see a treatment Center say we have a 75% success rate well, what does that really mean and what do you consider success? To watch someone's quality of life in their recovery increased by that numerical number, I think, is great, especially since it is being reported by the individual themselves.

Additionally, peers reported that when participants were able to take the measure a second time and saw an increase in their score between the two timepoints, **the person often felt proud of their growth**.

> The benefit I've seen… as a peer is seeing their numbers increase… the longer that they stay clean. Seeing their work in their recovery and how their lives are changing.

Other peers found that **answering the BARC-10 questions provided an opportunity for individuals to reflect on their own growth in their recovery**. PRS noted that this individualized reflection was more beneficial than focusing on a specific score, since an initially low score could be discouraging for people who are early in recovery and having a difficult time. The structure of the pilot allowed each site and peer to focus their discussion the way that worked best for them and for the individuals that they work with.

> I feel like… the score can be discouraging. So, we don't even give them the score at the end, we just ask a series of BARC-10 questions. We frame it as we're going to ask you these questions periodically throughout the time, we're working with you and it's going to help you get a good idea of how you're making progress. We let their contemplation of how they answer the question be their way of judging their own progress without the label of being an addict or tagging them with a number, since that sometimes can't feel very great. We let their own self-reflection be their tracker of progress, instead of labeling them with a grade.

Peers reported that they **sometimes had participants express confusion** when they were read or presented with some of the questions on the BARC-10 measure. One question that all peers interviewed mentioned as confusing was "I regard my life as challenging and fulfilling without the need for using drugs and alcohol" which is the item that captures the fulfilling activities domain of recovery capital.

> I think that the BARC-10 has worked well, the only thing that a lot of participants struggle with is the challenging and fulfilling question. They don't understand that question and when I first started using it, I didn't understand it either. I keep telling them that it's like are you reaching your goals without needing to use drugs and alcohol. A lot of them don't understand that question and you must go into detail about exactly what that means.

Additionally, PRS indicated that some of the questions were similar to things that they had asked in other parts of their assessment process, which could be frustrating or painful for participants if they felt like they had not been listened to or if they had to rehash a painful experience a second time.

Conclusions & Recommendations

Overall, the pilot was successful in making progress toward initial goals to inform peer service delivery, support comprehensive reporting of peer support services, prepare and plan for future expansion of measurement efforts, and build a dataset of peer support outcomes. This pilot period has also identified recommendations that will continue to inform the peer recovery support field.

Recommendation: Continue to utilize the BARC-10 as an outcomes-focused measure of peer recovery support while also considering other potential areas of measurement.

In this pilot, the BARC-10 reflected the growth of individuals receiving peer support services while also setting the foundation for a consistent dataset of peer support outcomes. This has allowed initial steps toward building a dataset to measure the impact of PRS services over time and continue to build evidence to support these important recovery services. Additionally, the implementation of the BARC-10 and conversations with the PRS who have been using it regularly have begun to illuminate new areas of PRS work that would be beneficial to capture in a quantifiable way. While the BARC-10 provides a wonderful opportunity to measure external and internal resources that support recovery, it is not designed to capture the internal emotional, psychological, and spiritual growth that people who are in recovery experience. Therefore, continuing to capture BARC-10 data while having an ongoing relationship with PRS who use it in their work provides a unique and valuable opportunity to identify additional domains that could include the internal processes that support individuals in their recovery journey.

Recommendation: Continue to share BARC-10 information back with PRS.

All PRS noted that they felt encouraged when they were able to see their growth reflected in BARC-10 scores of the people they worked with. Particularly in early recovery, when support and encouragement are so vital, it is crucial to incorporate sharing BARC-10 survey information back with PRS in future efforts to capture the impact of PRS work for people using recovery support services in Virginia.

Recommendation: Provide additional resources to support PRS in collecting consistent responses to the BARC-10 survey.

While the overall feedback from PRS about the use of the BARC-10 with participants was positive, they also reported a few challenges. PRS mentioned that some participants felt that the BARC-10 asked questions that were similar to other topics discussed in earlier assessments. Therefore, we recommend providing some language for PRS to use at the beginning of the BARC-10 survey that acknowledges that the survey may contain topics that they have already discussed and provides brief rationale for asking these specific questions, including sharing the potential benefits to the individual (e.g., ability to monitor shift in scores over time).

Additionally, PRS reported that they often received questions about the fulfilling activities item and felt the need to explain or rephrase the question so that the participant was able to respond. When each individual PRS provides their own interpretation of the question or explanation of the content, it could impact the validity and reliability of the measure with our sample. To remedy this concern, additional optional language should be built into the BARC-10 survey instrument to help PRS provide consistent guidance so that we can ensure that the measure is being used consistently among PRS around the commonwealth. Providing explicit phrasing to explain each of the items within the survey tool would allow PRS to use that rather than coming up with their own explanation or rephrasing of the item.

These recommendations summarize the successes of the pilot study, while also highlighting opportunities for improvement as use of the BARC-10 grows to other organizations throughout the commonwealth. OMNI and DBHDS will collaborate to consider and incorporate these recommendations as appropriate while expanding on BARC-10 data collection and measuring outcomes related to peer recovery support.