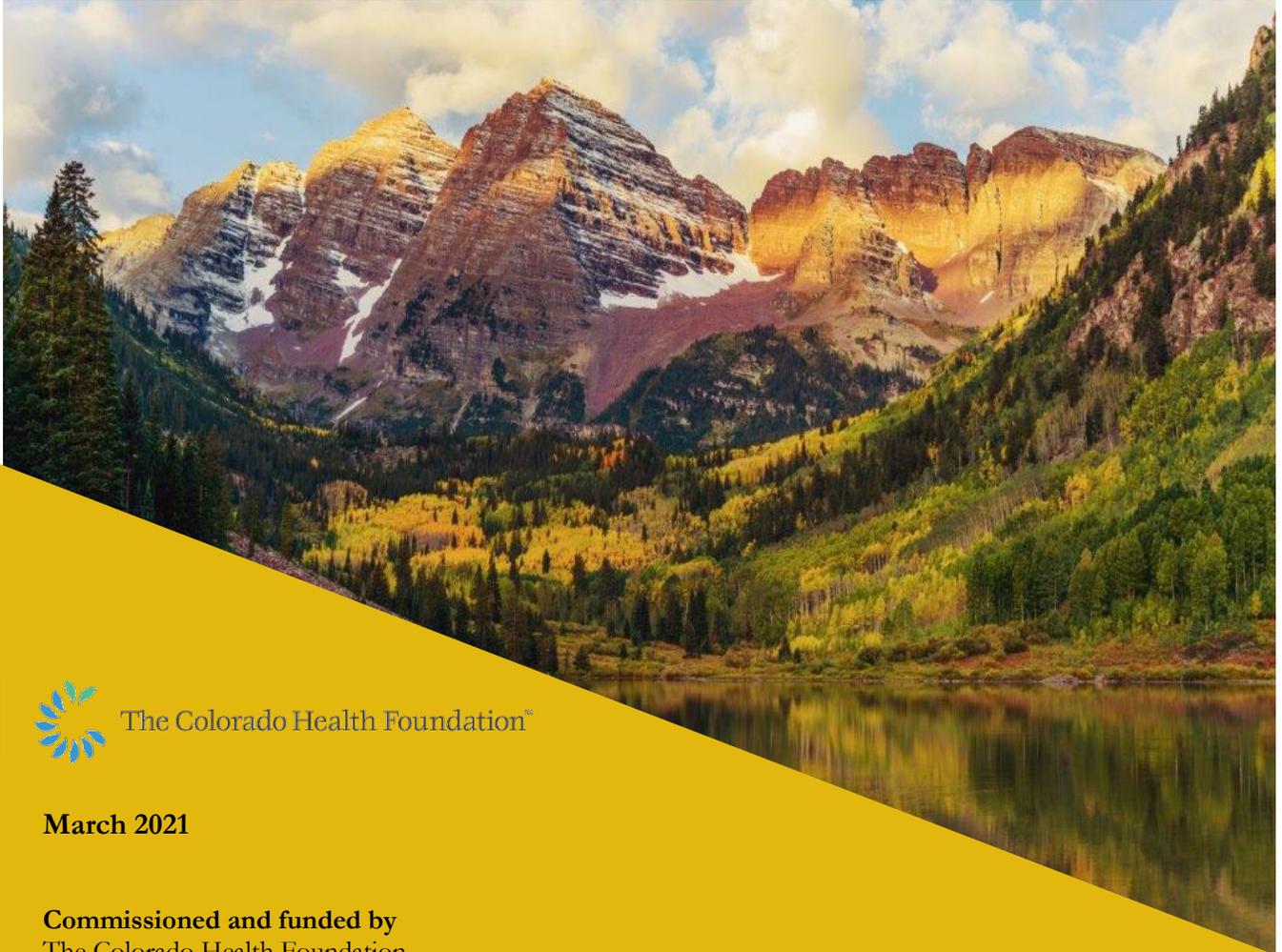


Perspectives on Adult Recovery in Rural and Frontier Colorado: A Look at Lived Experiences, Practices, and Systems



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Table of Contents

<u>Chapter</u>		<u>Page</u>
	In Gratitude.....	iiv
I.	Executive Summary.....	1
II.	Why and How Did We Do This Study?.....	3
	Process for Collecting Information About Recovery Experiences.....	4
III.	What Is the Experience of Adults in Recovery?	6
	Early Experiences Can Set the Stage for Substance Use and/or Mental Health Conditions	6
	There Is No Single Path to Beginning the Recovery Journey	8
	Recovery Journeys Often Include Bumps in the Road	9
	Self-Awareness Comes While Traveling the Path of Recovery	11
	Recovery Challenges Are Common.....	12
	What Can Help the Recovery Process.....	15
IV.	How Do People Experience Recovery Differently?	20
	Influence of Home, Health, Purpose, and Community.....	22
	Structural Inequities, Biases, Socioeconomic and Political Drivers.....	27
	Community-Driven Recovery Solutions (Formal and Informal Services and Supports).....	31
V.	How Effectively Do Systems of Recovery Supports Work Within Communities?	34
	Opportunities for Systems Change in Behavioral Health Recovery.....	35
VI.	Considerations About Systems of Behavioral Health Recovery for Individuals Living on Low Incomes in Rural and Frontier Communities	40
	References	R-1

Appendices

A	Data Collection Protocols.....	A-1
B	Screener for Inclusion for Adults in Recovery Study	B-1
C	How Did We Engage in Equitable Evaluation?.....	C-1
D	Key Definitions of Terms Used in This Report.....	D-1

Tables

II-1.	Oral histories and interviews	5
V-1.	Availability of system services and supports	34
V-2.	Factors/conditions within the system that inhibit or support different dimensions of recovery.....	37
VI-1.	Observations and key questions.....	41

Figure

V-1.	Six conditions of systems change.....	36
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Exhibit

IV-1.	Behavioral health equity and recovery model.....	20
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In Gratitude

All of us involved in creating this report wish to express our thanks to the many Coloradans with lived recovery experience and service providers who openly shared their stories and insights with us in connection with the Adult Recovery study. It was our privilege to be witnesses to your resilience and dedication.

I. Executive Summary

Adults with behavioral health conditions, both mental health and/or substance use, face many challenges on their recovery journeys. The Colorado Health Foundation seeks to “ensure adults have access to local mental health and substance use resources that support their recovery journey, so they have support close to home that will make recovery possible.” Ensuring that resources support recovery in rural and frontier areas is of particular importance. To that end, Westat worked with The Colorado Health Foundation to better understand how individuals living on low incomes in rural and frontier areas of Colorado experienced their recovery journeys, and to explore the relationship of those experiences to both available resources and opportunities for systems change.

Two overarching research questions guided our efforts:

- What is the experience of adults living on low incomes who are in recovery in Colorado?
- How effectively do existing systems of recovery supports work within communities?

In this study, Westat incorporated considerations about equity into every component of the study including the evaluation frame, evaluation process, and what the evaluation team brings to the work. To assess how communities approach recovery, a systems lens was applied to the study design. The Colorado Health Foundation selected eight counties (Alamosa, Gunnison, Larimer, Logan, Montezuma, Prowers, Routt, and Summit) to be the geographical focus for the study. Through oral histories from people with lived experience of mental health and/or substance use conditions and in-depth interviews with providers of mental health and substance use services, we were able to obtain information about the perception of Coloradans living on low incomes who are in recovery and how they are experiencing the recovery process. Additionally, we gained a better understanding of the system of recovery services and supports (informal and formal) that adults living on low incomes access in rural and frontier area in Colorado.

Study participants shared a perception of recovery as an ongoing process, one that requires continuing support. Although the details of recovery journeys varied, several general patterns emerged:

- **Early experiences can set the stage for substance use and/or mental health conditions.** Differences associated with age, gender, race and culture, and financial supports were reflected in the background stories of individuals with lived recovery experience. However, similarities included being raised in homes where substance use and/or mental health conditions were factors in their early life, belief in a mental health component underlying their alcohol and/or drug use, and trauma as a factor in the recovery journey, both before and after the journey began.
- **Varied times and precipitating events for seeking recovery.** Individuals with lived experience began their recovery journeys at different points in their lives and had been engaged in recovery for varying lengths of time. In addition, most individuals we interviewed could identify specific events that led to them seeking help in their

recovery (e.g., intervention by family or friends, incident resulting in involvement in the criminal justice system). However, some people sought treatment without any specific form of external intervention.

- **Recovery and bumps in the road.** Recovery experiences are unique to the individual, but two patterns were evident in the interviews with people with lived experience: (1) experiences of substance use and/or mental health issues (sometimes for years) followed by an intervention accompanied by ongoing treatment and/or supports resulting in a prolonged period of recovery, and (2) intermittent experiences of recovery and relapse in which relapse was often associated with or followed by some type of loss and struggles finding the “right” treatment.
- **Self-awareness while traveling the path of recovery.** Several of those interviewed were very self-aware of situations or events that could threaten their recovery, such as dealing with unaddressed trauma, or controlling their exposure to risky situations and people.
- **Recovery challenges.** Reported challenges varied, but an overarching theme was not getting the type of support needed when it was needed. Challenges included family members who are in denial or unsupportive, community cultures promoting substance use, and difficulty finding the right provider or therapist.
- **Facilitators of recovery.** Although there was a broad set of factors that individuals felt facilitated their recovery, a few experiences were consistently identified across both providers and those in recovery as making a significant difference in their recovery journeys. Facilitators included participating in peer support; support of significant others (e.g., friends, family, teachers, clergy); medication (as appropriate); opportunities to “give back”; and physical activity and healthy living.

This report shines a light on Coloradans’ recovery experiences in rural and frontier areas, looks at them through systems lens, and lifts up questions and opportunities to guide future systems change.

A note on language: People who experience behavioral health conditions use a variety of terminologies to describe themselves. In this report, we use the terms “recovering individuals” or “recovering adults,” and occasionally “consumers.” We also use the terms “Person/Individual with lived experience” to refer to people with experience with either a mental health condition (designated as MH), a substance use condition (SU), or co-occurring mental health and substance use conditions. We use the term “Provider with lived experience” for those providers who shared during our interviews that they live with a behavioral health condition. (See also Appendix D for other key definitions.) Additionally, and to the extent possible, quotes use the language that was shared in the interview or oral history.

II. Why and How Did We Do This Study?

This study sought to understand how individuals living on low incomes in rural and frontier areas of Colorado experienced their recovery journeys. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (SAMHSA, 2012). The prevailing mindset around recovery in most of the current literature, as well as through the voices of people seeking recovery and those who support them, reflects this concept of recovery as a process – not a finite destination to be reached once and for all – and a unique experience for every individual.

Concepts of recovery and the factors that influence recovery vary based on individual experience and culture (SAMHSA, 2020). Those in the field have come to regard recovery’s ultimate goal as improving wellness and enabling people to lead good lives of their choosing, as contrasted with only symptom reduction (Powell, 2009). Moreover, recovery plans and services are deemed most successful when they are grounded in personal goals and honor individual decision-making (Powell, 2009). Definitions of recovery and recovery-focused treatment interventions continue to be impacted by increased recognition of the role of trauma in the development of behavioral health conditions (SAMHSA, 2014) and the frequent co-occurrence of substance use and mental health conditions.

A persistent pitfall in evaluating recovery support systems is confining the scope of work to clinical treatment practices and services. Yet we know, and research increasingly demonstrates, that recovery does not simply happen within the confines of the traditional treatment space – and sometimes happens entirely outside that realm (Slade & Longden, 2015; White, 2010). Recovery is impacted both positively and negatively by the conditions in which people are born, grow, live, work and age that shape health. It is defined by many more factors than an improvement in symptoms or moving beyond crisis mode. Addressing social determinants of health is an essential part of improving health and reducing longstanding disparities in health and health care (Artiga & Hinton, 2019).

Improving the experience and outcomes of Coloradans in recovery necessitates taking a systems change view and factoring in conditions that typically play significant roles in holding a social or environmental problem in place. These conditions exist with varying degrees of visibility to players in the system, largely due to how explicit or tangible they are made to most people. While these conditions can be independently defined, measured, and targeted for change, they are also intertwined and interact with each other. Without stakeholders recognizing the conditions undergirding systems and committing to changing them, substantive and lasting change cannot occur.

Although much is known about adult recovery in Colorado, greater understanding is needed about the experiences of recovery among individuals living on low incomes in rural and frontier areas of the state. Recognizing the importance of supporting adult recovery related to behavioral health issues – both mental health and substance use – The Colorado Health Foundation partnered with Westat to conduct a study with the goal of better understanding the

experiences of Coloradans in recovery, with a particular commitment to considering equity and systems change. Two overarching research questions guided our efforts:

- What is the experience of adults who are in recovery and living on low incomes in Colorado?
- How effectively do existing systems of recovery supports work within communities?

We explored the recovery experiences of Coloradans in rural and frontier areas using three lenses: 1) what themes emerged from the experiences of people in recovery and those who support them, 2) how those experiences relate to foundational components of recovery, and 3) how these interrelate with a model of systems change. Employing differing lenses allowed us to examine the data from various vantage points and gain important insights from each unique lens.

Process for Collecting Information About Recovery Experiences

From the formation of the research team to the process of data analysis, we intentionally embedded principles of equity into the approaches we employed to answer the research questions. We hired consultants with lived experience to help formulate our approach and created opportunities to hear directly from those working in the field and bring them into our sense-making process. The following sections describes our approach to data collection and analysis.

Stakeholder Engagement. To help guide the study approach, Westat collaborated with The Colorado Health Foundation to establish a Community Advisory Board (CAB). The CAB comprised a diverse group of 11 stakeholders including consumer-run services and organizations, local behavioral health coalitions, providers of recovery services, law enforcement, work entry centers, advocates, and others. The CAB engaged in discussions around the behavioral health needs of Coloradans, what stakeholders hoped this study would accomplish, plan activities for the study, and discuss findings and implications. In addition, we sought to ensure that power was shared with community members and so engaged in a participatory analysis and sense making session. During this session, representatives from five of the eight counties (both people with lived experience and providers) helped to interpret findings as related to rural and frontier context.

Oral histories and in-depth interviews were chosen as data collection methods to permit flexible exploration of topics and provide insights into participants' responses that would be unattainable with structured quantitative research. As shown in Table II-1, the research design included 60-minute interviews and 45-minute oral histories. Westat worked with organizations identified as providing services for substance use and mental health, to recruit adults over the age of 18 who were interested in participating in oral histories. Interviews were also conducted with service providers who provide behavioral health services and supports including clinical directors, recovery coaches, certified addiction specialists, case managers, and peer support specialists. Screening Instruments can be found in Appendix B.

Table II-1. Oral histories and interviews

Activity	Number of activities per county	Number of counties	Total number of participants
In-Depth Interviews with Providers	4	8	32
Oral Histories with Adults in Recovery	1-9	8	38
		Total	70

Data Collection and Analysis. Using Foundation-approved protocols (see Appendix A), trained interviewers conducted both oral histories and interviews, exploring the following topics of inquiry:

- Experiences with behavioral health conditions;
- Views, perspectives, and experiences with recovery; and
- Availability and experience with services and supports.

All oral histories and interviews were recorded and transcribed. A team of data analysts pre-coded responses based on predetermined areas of interest (e.g., different aspects of the recovery journey, the role of health, home, community, and purpose, etc.) as described in the interview questions. A thematic analysis was used to identify themes and patterns that emerged in these responses. Additionally, information from the community-based participatory analysis meeting and the third CAB meeting were incorporated into the analysis process to help understand contextual factors.

Limitations. As with all studies, this data collection process is not without limitations. First, findings are not necessarily generalizable to larger group(s) due to small sample sizes and the use of purposeful sampling methods. Additionally, because all data collection was conducted virtually, only individuals with access to technology (e.g., internet, computer, or cell phone) were eligible to participate.

III. What Is the Experience of Adults in Recovery?

Recovery has different meanings for those interviewed. Nevertheless, they share a perception of recovery as an ongoing process, one that requires ongoing support. The information gathered on individual recovery journeys can help identify steps that can be taken to improve experiences for others.

Early Experiences Can Set the Stage for Substance Use and/or Mental Health Conditions

Background stories of those having lived experience with substance use and/or mental health conditions (including providers) varied, reflecting different ages, gender, race and culture, and financial supports of those interviewed. Nevertheless, several patterns emerged within and across the groups – people with lived experience who provided oral histories, and providers with and without lived experience who were interviewed.

Many individuals who shared details of their recovery journey were raised in homes where **substance use and/or mental health were factors in their early lives**. For example, a provider with lived experience of depression disclosed that her father was bipolar and explained how he had become addicted to opioids. In another interview, a person with lived experience described how her father’s abusive rhetoric undermined her religious faith, making her recovery even more challenging:

My father was an alcoholic and when my parents got divorced, he married his mistress... He quit drinking but became a religious fanatic in Catholicism. And so, he used that God to judge my brothers and I - very damning and very judgmental... My brother was going to hell because he was gay. I was going to hell because I moved in with my now husband before we got married. And so for the longest time, it was hard for me to have relationship with a higher power because that was the God that I pictured. [Person with lived experience, co-occurring conditions]

Another person with lived experience recounted how his early childhood exposure to illegal substances paved the way for his subsequent heroin addiction:

And it started off as a young kid. When I first got even introduced that type of environment, I was still in diapers. I was a young baby and my entire family used. So I seen it at a very young age. I didn't really realize that it was wrong until I matured more in life and understood the difference. So it's just become a lifelong habit, almost that just seeing it and then got to where I was doing it. [Person with lived experience, SU]



Most interviewees with lived substance use experience also expressed their belief in a mental health component underlying their alcohol and/or drug use. In discussing relapse, these individuals often referred to **unaddressed mental health issues**, though most primarily self-identified as living with a substance use condition. As an illustration, one person with lived experience emphasized the importance of addressing co-occurring mental health and substance use conditions during recovery:

Recovery and mental health usually go together. I feel like because of everything I went through and the state of my mental health, that's what kind of brought me to even trying drugs and addiction to begin with. I used it to escape from the thoughts and feelings and stuff that I was experiencing because of my past and because of my relationships with that man that I was with who was really abusive and traumatic. I was using drugs with him. Everything that I was once against, I think it's because mentally, I wasn't okay. I think mental health and addiction are kind of one in the same. Usually, if somebody is an addict, mental health is not far behind. [Person with lived experience, SU]

Trauma was often cited as a factor in the recovery journey, both before and after the recovery journey began. This was echoed by persons with lived experience and providers alike. Examples of traumatic events reported included physical and mental abuse; sexual abuse; automobile accident; and the death of someone close (e.g., parent, sibling, teacher). One person with lived experience recovering from alcohol and drug addictions asserted, “*Childhood trauma and pain is a connection that every single addict has.*” Another person with lived experience shared some details of her traumatic childhood, the memories of which continue to challenge her recovery efforts:

I was raised into an alcoholic family with my mom, minus my father. He was not anywhere around. And from the age of birth until seven, I struggled a lot with my mom with... there was several types of abuse - sexual abuse, physical abuse, mental abuse. She was an alcoholic so she didn't pay attention to me very well and I drank. I was also a baby who was... she drank with me while in the womb. So, after the sexual abuse at age seven... when I turned eight I... took my dog and ran away and came back later that night and the police were there and they took me out of her custody. Through that, I was through 32 different placements. [Person with lived experience, co-occurring conditions]

One provider described trauma as pervasive and highlighted its association with substance use conditions:

I mean there's a lot of anxiety, depression, trauma associated with substance abuse the majority of the time... A lot of grief and loss is associated with a lot of my clients at this point... Trauma is so highly correlated with addiction [Provider]

There Is No Single Path to Beginning the Recovery Journey

Individuals' recognition of the need to take steps toward recovery happened in different ways and on varied timelines. People with lived experience shared a variety of experiences and precipitating events related to the beginning of their recovery journeys and the decision to act.

The time since the start of interview respondents' recovery journeys ranged from 2 months to 37 years as of the date of their interview. Most began experiencing substance use or mental health issues between **late adolescence and young adulthood**, though a few had such experiences earlier.

When one person with lived experience began drinking during adolescence, she did not view her heavy drinking as problematic:

Well, both my parents were alcoholics and I started drinking at age 16... I began seriously drinking at age 16 with my boyfriend and thought it was a whole bunch of fun. Continued through college, got married, drank and smoked through three pregnancies, didn't think anything was wrong with that, nobody ever said no, don't do that. I was fortunate that my three children are okay.

[Person with lived experience, SU]

Another person with lived experience had avoided using drugs during adolescence and associates the start of her substance use with a relationship she had in her early 20s:

My mom was a heroin addict and alcoholic, and it affected me as a child because we got taken away and I was bounced around from foster home to foster home. I always told myself that I would never do drugs when I got older and somehow, I got with this guy when I was in my twenties. About 22 is the first time that I started experimenting with hardcore drugs, like cocaine and stuff like that.

[Person with lived experience, SU]

Most individuals we interviewed could identify a **precipitating event that led to them seeking help** in their recovery. These events were varied. Most were influenced by people or events external to the individual, such as family or friends, or in events originating from the corrections system. For one person with lived experience, that precipitating event was a driving under the influence (DUI) incident:

I got a DUI and previously had straight As, really thought highly of myself, and it was kind of a reality check that I wasn't as perfect as I had expected myself to be. That was a good wake-up call I think for me because that span of a year or so when I was suffering, self-induced partially and from all the situations around me, I think that was good. [Person with lived experience, SU]

Another person with lived experience acknowledged that it was the threat of not being able to be with family members that prompted her to seek help:

My brother has two babies and in January he said to me... "If you don't get sober you can't be around your nieces," and I was like, "Well, f#!@ you. Who are you to judge?" And I'm like, well, really, because my brother doesn't do drugs. He drinks a little bit when he wants but he does not do drugs. So, I said, "Fine, then I'll get sober." So, January 27th I dropped to my knees in my bathroom... I got on my knees, I prayed for God just only to remove the desire... to stop, just the desire if that's it, if that's all I need to... and he did. I woke up the next morning, went to an AA meeting, I was really sick so I went to the hospital... but... I got sober January 27th. [Person with lived experience, co-occurring conditions]

Some of those we interviewed concluded on their own that they needed to act to get help and sought treatment without any form of external intervention. "Desperation" was the impetus for one person seeking treatment:

Desperation. I knew that I couldn't do this on my own and I couldn't... I tried so many times and doing the same thing over and over again expecting different results is the definition of insanity. And you feel like you're going insane after a while. And I had realized that that insanity was internal and I had to get some outside help, some intervention from a third party that was more objective than I was, and they were able to look at my situation from an outsider's perspective and say, "Hey, these are the services you need, and this is where we can send you." [Person with lived experience, co-occurring conditions]

Another person we interviewed reflected on the first time they recognized they needed and sought treatment:

And when I graduated college and I was scrolling through social media, I was seeing that all my friends were getting sober or had been sober for a long time or were getting jobs and wives and houses and careers and I was still stuck in a state of arrested development. And so I realized that I needed some serious help, and I ended up going to my computer after I had stole some change off my roommate's floor and went and bought a bottle of alcohol and set it in front of my computer. And I just broke down in front of that computer and I knew that I was going to drink that bottle and I didn't want to. And that scared me. That's the moment I knew that I had lost control. So I ended up drinking that bottle, but before I did, I got on to Google and Googled some rehab facilities and ended up in a rehab center within very short period of time. I think 24 hours, they had me on a plane headed out to Florida. So that was my first step into recovery. [Person with lived experience, co-occurring conditions]

Recovery Journeys Often Include Bumps in the Road

Recovery experiences are unique to the individual, but two patterns were evident in the interviews with people with lived experience. The first pattern we identified involved experiences of substance use and/or mental health issues (sometimes for years) followed by an intervention accompanied by ongoing treatment and/or supports resulting in a prolonged

period of recovery. For example, one person with lived experience described events that prompted his enrollment in a treatment program, which marked the beginning of his subsequent long-term sobriety:

I was doing crystal meth and I was drinking, not sleeping, not eating. And I had an intervention with people, and my brother became a huge part of that, down the road... I joined AA, I went to a treatment program within about 3 hours' notice, picked up the telephone that was attached to the wall at that time, and kept calling places and telling them how desperate I was. That led me, 3 hours later, to be on a plane... And I started a journey in treatment. I've been sober 33 years... It's surreal. It seems like yesterday, yet when I think back, it's been a lot of work. [Person with lived experience, SU]

The second recovery experience pattern we identified involved more intermittent experiences of recovery and relapse. Relapse was often associated with or followed by some type of loss and struggles finding the “right” treatment. One person with lived experience recalled the difficult times during his relapse after 2 years of sobriety:

I relapsed. And during the relapse, it was probably the hardest. My wife left me... My parents were dealing with [another family member's illness] at the time so they didn't really have time to be able to dedicate or devote towards helping me out... And it took about 5 years of this relapse for me to actually get back into a rehab. [Person with lived experience, SU]

I'm going to say most people have went into a residential treatment program. Inpatient residential, a few times. It's just this forward, back, forward, back, forward, back, forward, back motion. Until an individual has kicked the physical and mental addiction, began to deal with the emotional and mental health issues that led to the addiction in the first place, then built a new support group, have new friends, repaired relationships with themselves and others, they're not going to be able to get out of that addiction. [Provider with lived experience, SU]

Another person with lived experience reported numerous attempts to find her way onto the path of recovery. She sought treatment from multiple facilities across the state before finally getting treatment from an out-of-state program that was equipped to address her co-occurring conditions:

Well, I've made a lot of first steps and not made it quite further than that for about the last, gosh, 20 years or so. So, my first step I take in terms of recovery, I have been to a therapist. I went to eating disorder treatment in [another Colorado location] because there is zero eating disorder support here... I went to [agency name, in another Colorado location] twice when I was in my 20s. I went to [agency name, in another Colorado location]. I've been to [agency name, in another Colorado location]. I just wasn't in a place where I was desperate enough to do the work that it required to get into recovery. I wanted to get into recovery, but I was not willing or desperate enough to do all of the change and hard work that was required to do so. My last bout where I actually

started doing the work and got into recovery for both my eating disorder and alcoholism. I went to [a facility in another state], which has a dual diagnosis expertise. [Person with lived experience, co-occurring disorders]

A third person with lived experience recounted the death of a valued mentor, followed by the diagnosis of severe mental illness, and her quest for finding the most appropriate tools to aid in her recovery:

I was diagnosed with depression and anxiety in high school after I lost my [mentor] very suddenly... And they thought that I was just depressed.... But it became clear when I went to college after my senior high school and it became clear that there were more issues at play. And I was diagnosed with bipolar at that point. And a lot of things started to make sense, a lot of past issues and episodes of hypomania and episodes of mania and a lot of depressive episodes. And I kind of finally had an answer for what all that was. Then from there I spent 6 years trying to find the right treatment, lots of different medications. I tried electroconvulsive therapy, a lot of different talk therapies. I was hospitalized many times. [Person with lived experience, MH]

Self-Awareness Comes While Traveling the Path of Recovery

Several of those we interviewed were **very self-aware of situations or events that threaten recovery**, such as dealing with unaddressed trauma, or controlling access to risky situations and people. One person with lived experience talked about the role his family played in addressing trauma as part of his recovery:

Both my parents and both my sisters have been doing family therapy with us. So once a week, we do family therapy to work through some of the traumatic issues that we went through as children... The second most impactful has been really getting to the root of my trauma issues and being able to address those when I don't ever think I really addressed them before. [Person with lived experience, co-occurring conditions]

A response from another person with lived experience suggests he is acutely aware of the risk for potential for relapse, despite his 33 years of sobriety:

I need to remember that I'm an addict and a drug addict. What does wellness or recovery look like to me? I live it every day. I have to. There's not a day that goes by that I'm not calling somebody in one of my 12-step programs. And I can't take for granted that I haven't had a drink, I haven't had a drug, that I haven't thought of suicide. [Person with lived experience, SU]

Similarly, a person with lived experience recovering from co-occurring conditions acknowledges the risk of maintaining unhealthy relationships:

But my using friends don't really understand why I have to make the disconnection and the dissociation with them. It's not that I don't love you or that I don't like you as a person. It's just that I have to have my own best

interest at heart, and if I'm around someone that's an active addiction, it's really hard for me to stay clean. They view that as selfishness and it's not selfish, it's just self-preservation. [Person with lived experience, co-occurring conditions]

Recovery Challenges Are Common

Individuals we interviewed identified several challenges they have experienced at some point during their recovery and in some cases, are still experiencing. Although challenges varied among individuals, a common theme among individuals with lived experience was not getting the type of support needed at the time that it was needed.

Family in denial or unsupportive

One challenge impacting some recovery journeys was family denial of a problem. A related challenge involved family members who were unsupportive of the intent to seek treatment for substance use and/or mental health conditions. One woman was taken aback by her parents' resistance to her seeking help:

Yeah, they really struggled. They were very against... they didn't want me seeking therapy and it was confusing to me, too, because my dad is a doctor, and my mom is a nurse. So I kind of thought they would understand. I thought they would have the perspective of medical professionals, but it was hard, I think, when it was their own kid, to see it that way. So they really struggled to understand for a long time. [Person with lived experience, MH]

Another person with lived experience recognized in retrospect that moving to be close to her father did not provide the supportive environment she was seeking in her recovery:

I mean, it was hard because my biological father was actually on meth and heroin when I moved out there and my only support was my grandma, which was probably the biggest enabler to him, because she was allowing him to live in the basement and she was taking care of my three younger brothers and she still does. He's sober now and stuff, but it was just all bad. When I moved... I started on Xanax and pills and then after that it went to meth... I came to my biological father where I thought that I was going to be loved and I was going to have this other life or something... I don't know what I was thinking. [Person with lived experience, co-occurring conditions]

Community culture of substance use

Local community culture and traditions of accepted behaviors can be a powerful influence on a community member's recovery journey. Some people we interviewed described the social network of their **small rural communities as revolving around substance use**. One respondent seemed to embrace this challenge and expressed almost a sense of accomplishment that he has been able to maintain sobriety despite living in a community culture in conflict with his recovery goals:

I moved down here when I was 2 years old. This is [an area] where there are very high rates of addiction, especially to opioids, and alcohol is the main stage. Tons of DUI cases every year and lots of alcoholism in [this area]. And so making friends here is very difficult because everybody meets at the bar to get together and drink, and that's how they have their social interactions. And so the [area] that I'm in is pretty difficult for recovery if I'm being honest. And that's why I think it's important that I'm here because if I can stay sober here in [this area], I can stay sober anywhere. [Person with lived experience, co-occurring conditions]

In another rural community, alcohol use/abuse seems to be deeply embedded into the culture of the community:

But [Name] County is also "never-never land," the amount is less now, because of COVID, but the amount of festivals, parties like any excuse there is to drink around here. We call it "never-never land" because no one ever grows up there, people are in their 60s and 70s and still going to happy hour every night. There is a large, large, large alcohol problem in this county, but I also don't know how many people are interested in getting help for it. [Person with lived experience, co-occurring conditions]

Difficulty finding the right provider

Several people we interviewed reported challenges in finding a good local provider with whom they felt a connection. This seems to be particularly challenging for those with mental health and co-occurring conditions.

After being told she needed more than general counseling, one person with lived experience sought additional treatment; however, she expressed frustration with healthcare providers she encountered who did not seem to understand her mental health condition:

I first started seeing like a general counselor... my parents brought me to some Christian counseling center, and she very quickly was like, this is above my pay grade. You should see a psychologist... I started seeing someone who had a little bit more experience and I also started seeing a psychiatrist pretty quickly too. Had a terrible experience with my first psychiatrist... She didn't understand... If things were moving forward in my life or good things were happening, why I was depressed?... And I've gotten that response kind of a lot from medical professionals. They always say like, you have these things going for you, you have this, this and this. Why do you feel bad? And I'm like, well, that's why I'm here. [Person with lived experience, MH]

Another person with lived experience expressed disappointment that he still has not been able to connect with a therapist that suits his needs and accepts his insurance:

I went... and got placed with a therapist there. I've done this two times... and both times I had a very negative experience... the therapists there weren't in a recovery themselves, they weren't addicts themselves. And so they didn't really understand what I was going through... So I had to leave... [the area] to find

services that were beneficial and helpful for me. Even the therapist that I have now, I meet with her via Zoom. And she's not from... [the area]. So being able to find a quality therapist here is somewhat difficult, especially when it comes to insurance. Behavioral Health accepts most insurances, so that's why most people go there. But when you try to find a better therapist, maybe a private therapist, they often don't take that insurance. [Person with lived experience, co-occurring conditions]

Stigma toward people with lived experience

Another barrier to recovery identified by both people with lived experience and providers is **stigma toward people living with behavioral health conditions**. Stigma sets a person living with one or both of these conditions apart from others and labels them in negative ways (Government of Western Australia, 2009). When this happens, they are no longer seen as individuals but as part of a stereotyped group. Negative attitudes and beliefs about this group create prejudice, which leads to negative actions and discrimination, represented both in interpersonal interactions and in decision-making that does not take into account the presence and impact of behavioral health conditions in local communities.

And through my lens, just my anecdotal data and experiences there's a huge classism when it comes to justice-involved populations. I mean, there's a stigma inside of addiction which is... I mean, I hear it all the time in treatment especially DUI, but at least I only do alcohol. And you're like.....I don't shoot drugs. I'm not one of them. Even inside of all of that there are select like groups classism that goes on in there that I think, gosh, if you're a substance using minority person who's using illicit drugs intravenously not wanting to be down that train. [Provider]

Stigma is present among the people affected by behavioral health conditions and their families, community members, and business and other leaders in key decision-making roles and impacts recovery from behavioral conditions in multiple ways. Stigma represents a significant major barrier to individuals' recovery, impacting if/when they receive care, how they receive it, what types of services and supports are available to them, and how they can build healthy lives after recovery. The involvement and voices of individuals in recovery in speaking out to the public is key to breaking down stigma and increasing visibility of both community problems and solutions.

Well, I think anything we can do to reduce the stigma, so that people can actually feel like they can talk about their addiction, that they can access resources without that stigma. And I think what we see at least from the people that come to our program is just saying, we're here when you're ready, whatever that ready looks like and having the community take that approach as well, because it is a difficult frustrating process. [Provider]

What Can Help the Recovery Process

Both people in recovery and providers shared a variety of factors that they felt facilitated their recovery, and there were a few experiences that were consistently identified across both groups as making a significant difference in their recovery journeys.

Peer support

Positive connections with others were cited by many as critical to their recovery. Most often, this included connections with persons with similar feelings and experiences, in both group and individual settings. These connections were most often mentioned in the context of the effectiveness of support groups such as AA and other 12-step programs. For example, one person with lived experience stated:

As for what activities and organizations and connections helped me, for sure I would say AA, the 12 steps was probably the best assistance for me. I went to AA every day for my first year in recovery, every single day. And the people I met there were loving and supportive and I felt I had found my tribe of people. And I would say that probably was super helpful. [Person with lived experience, co-occurring conditions]

Although initially skeptical of its benefits, one woman recognizes AA as an essential element in her recovery journey:

I can say a sentence to my friends in recovery, and they just get it. They just know, we are all different stories, but we all have so many similarities. So, I would say those connections I've made with sober women have been life-changing, keep me on the right track, called me on my [b.s.] and are always there to be my cheerleader...AA is amazing because it works and it's amazing people. I used to think, "Oh, AA, all these people that are lame and they're all like 80 and chain-smoke and are so boring and all they do is... [complain] about stuff." And it's just totally the opposite. It's the brightest, most sensitive, hilarious, honest people I've ever met. And that's what kept me coming back. The amazing support" [Person with lived experience, co-occurring conditions]

One person with lived experience emphasized the importance of connecting with others on parallel recovery journeys:

I think that the opposite of addiction is connection. And so connecting and getting out and being with people that are sharing your same struggles, or at least understand what you're going through and being able to talk about those things has been the most impactful thing in my recovery journey. [Person with lived experience, SU]

Another person with lived experience described how she incorporated a variety of support groups in her recovery efforts that meet her unique needs, although the pandemic has made these connections a bit more difficult:

Definitely support groups. I've gone to a lot through NAMI. I've gone to a couple through DBSA... And then also ACA, which is Adult Children of Alcoholics in Dysfunctional Families. That one's also been very helpful when I don't have access to the other two. It's hard right now because everything's virtual and the support groups are kind of weird virtual, and I miss the in-person element, but I made some good friends through those and some good connections and they were very helpful. [Person with lived experience, MH]

In addition to the connections offered by mutual support groups, the value of individually delivered peer support services was recognized:

You can go to the [agency name] for weekly counseling, or you can go to private counseling... And in the middle there somewhere is the peer support specialists who come in, and support what you've got going on there, and we approach it from a lived experience that's not institutional, and sometimes it's pretty personal, because of the nature of how you know each other. [Provider, Peer Specialist]

Supportive significant others

Although significant figures in their lives were not always supportive at first, multiple people we interviewed pointed to the important role supportive friends, family, teachers, clergy, and others played in their wellness journeys. For example, a supportive older sibling was instrumental in one man's recovery journey:

So my biggest support system during that time was my oldest sister. And she was very supportive of me and tried to help me get into certain rehab places. [Person with lived experience, SU]

One woman expressed her appreciation of the support provided by one of her high school teachers and the eventual support of friends and family:

I had a teacher in high school who knew about my situation, and when I was having a hard time in school I could go to his classroom and I could do work there. And if I just needed to... If I was having a panic attack, I had somewhere to go. I had a safe space in school. So, that was really helpful. And of course my friends, it was hard for them too, to understand at first. And sometimes I had a hard time communicating with them about it, but they've grown to be very supportive as well. And my siblings, too, have gotten a lot better about it as well. They're very supportive, of course, now. [Person with lived experience, MH]

Another woman described how a member of her church's leadership went above and beyond to help her and her husband when they relapsed:

I had a really good support system within these last, let's see, 8 years. My church, my elder has been really supportive, helped me along the way. I don't know where I would be without him. He would make sure I made all my appointments. He actually went and got me and my husband from... [another

state] where we were just doing really bad, got on drugs, and he drove all the way to [another state] and picked us up, brought us back and paid for our hotel every day until we... He really helped us. As long as we wanted... Had a plan to want recovery. We were taking the steps. He was there to support us and be there for us. [Person with lived experience, SU]

Medication

Several people with lived experience mentioned the positive influence of medication as part of their recovery efforts. For some, this took the form of medication assisted treatment (MAT) for opioid addiction. For others, medications were instrumental in reducing or eliminating debilitating symptoms of a mental health condition. For example, one person with lived experience with co-occurring substance use and mental health conditions emphasized the importance of medication in treating her severe mental illness: *“My medication is basically the most what’s been helpful. As long as I’m taking my meds, my [medication name] and my [medication name], I’m okay.”*

Another person with lived experience struggled at first with taking prescribed medications when his recovery goal was to be substance free. However, he eventually concluded that these medications were a necessary tool in his recovery journey:

Actually, meds have helped too... I got on an anti-anxiety pill and a sleeping pill, which obviously helps me rest, which the next day I’m not as irritable. And I think that had a big factor on it because I’ve tested it. I’ve told myself, Oh, I’m going to be a hundred percent clean. I don’t want to be on any substances of any kind. I don’t care whether the doctor prescribed or off the streets it’s still using to me. And when I got a hundred percent clean, I started to realize the difference in my behavior as far as how I respond to others and how quickly I get agitated and also my depression. So meds had a big factor in the way that I think.” [Person with lived experience, co-occurring conditions]

Opportunities to “Give Back”

A significant number of individuals interviewed expressed an interest in “giving back,” with some voicing this as important support for their own recovery. For example, one person with lived experience with co-occurring conditions summarized, *“I think the purpose of being a better person, helping others in the community, doing that as well. That also helps keep me on the straight and narrow, not wanting to let down others now.”*

Others identified specific roles they played in others’ recovery journeys with some reporting active involvement as AA counselors or volunteers on a regular basis. For example, one person with lived experience acknowledged the importance of this role during his first span of sobriety before relapse:

So during that first 2 years of sobriety that I had, I was very, very deeply involved in Alcoholics Anonymous. I had sponsored other guys and taken them through the steps. I had started several meetings myself. [Person with lived experience, co-occurring conditions]

In addition, several respondents expressed satisfaction in their ability to use their lived experience for direct services to others beyond the peer group setting. For example, one person talked about career goals to provide clinical services others in the future:

Yeah, now I work for an addictions clinic and I'm going to school to be a mental health counselor because I think a lot of substance use and abuse is partially from the traumas we've experienced as children, or even just one click trauma, like you see your friend OD or something like that and then you don't realize how much that is to bear and carry. [Person with lived experience, SU]

Another respondent described their transition from person with lived experience to provider with lived experience:

"I've kind of switched the role and I am now a counselor myself. In a few months I'll have my CAC II, which is an addictions counseling license. So that's helped me too, helping people has really helped me stay in recovery and seeing where I could be at, especially working at the detox. You really get to see the beginning of people's journey there and it reminds me of why I want to stay in recovery and don't ever want to be back at that place." [Person with lived experience, SU]

A third person with lived experience reported his contribution in a slightly different way through creating a new treatment program:

I wanted to dedicate my life to helping the addict who still suffers. If I was helped by other addicts that were able to recover, I want to be able to pass that on. So I'm working with them to get this inpatient drug and alcohol rehab opened here. And we're in the beginning stages, but I'm very optimistic and very excited about that happening. [Person with lived experience, co-occurring conditions]

Physical activity and overall health

A number of individuals noted the importance of physical activity in their recovery. This ranged from vigorous outdoor activities such as hiking and backpack camping to indoor exercise programs such as yoga. One woman we interviewed described the role of yoga and outdoor activities played in facilitating her recovery journey.

I also joined a yoga teacher training program, which was really healthy for me because we learned about anything from diet to grounding techniques to meditation and yoga and things like that. So, that is what really set me on the path. It was interesting because I had to pay for it and it wasn't necessarily meant to be, get sober type of event, but that's what it ended up being for me... I also led a nature therapy program... so I did a lot of trail maintenance types of jobs, but it was good because I camped a lot. So, there was no opportunity to take part in any bad for my health activities unless I wanted to bring it and carry it in, which was more weight. [Person with lived experience, SU]

Another respondent spoke of the value of incorporating yoga and eating healthy into his recovery efforts:

Well, this is kind of maybe general mental health stuff, but if I can get myself outside in the fresh air that helps, if I can get myself to exercise that helps, yoga helps in a different way than just exercise. It seems to, I don't know, maybe it's because it's such a gentle and thoughtful movement. It's not just aerobics or whatever, that kind of thing. It's much more body awareness focus somehow seems to work differently for me. Eating healthy. [Person with lived experience, MH]

Nevertheless, one person we interviewed cautioned against putting too much emphasis on any one solution – such as physical activity – as this is only one tool to facilitate recovery. For individuals with mental health conditions, one single type of support is unlikely to be enough:

Yeah. Yeah. So I would like people to know that there's rarely ever a simple answer to getting over any kind of mental illness, including depression, anxiety. I see people sometimes posting on the internet or whatever, running is my antidepressants, or something that. And yeah, running, it's good, it's healthy. And it can help, but it's not typically enough for somebody who's mentally ill. [Person with lived experience, MH]

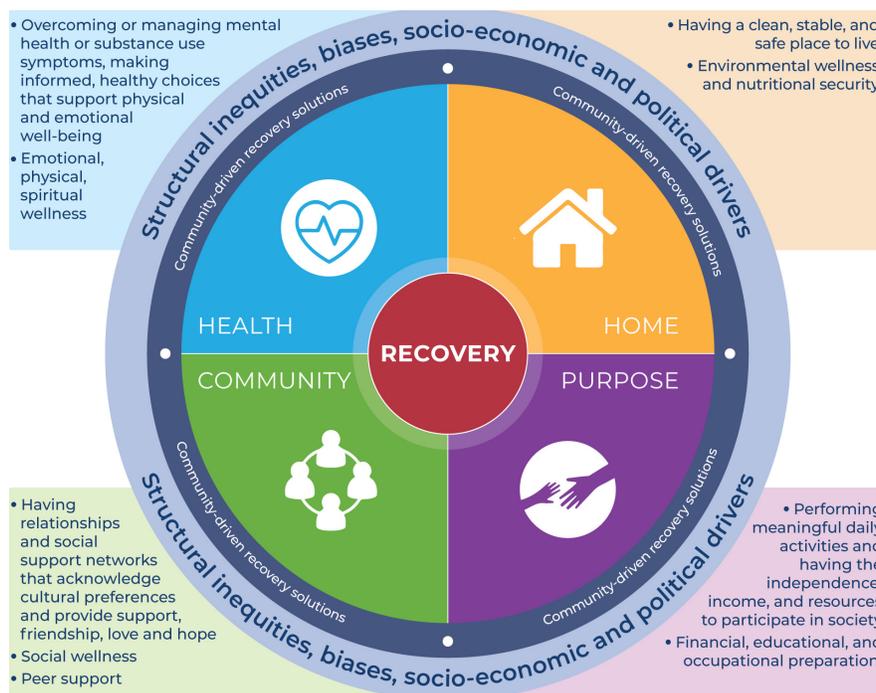
IV. How Do People Experience Recovery Differently?

Through this study we sought to learn if the elements of SAMHSA’s definition of recovery – “A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” – rings true for both people with lived experience and providers of behavioral health services. We listened to members of these groups to understand their experiences of recovery, factors that help and hinder recovery, how recovery is supported in the Colorado counties targeted in this study, what works well, and what needs improvement.

Our behavioral health equity and recovery model (Exhibit IV-1) demonstrates the overlapping relationship between individual experiences of recovery and systems. At the center of this model, are SAMHSA’s dimensions of recovery (SAMHSA, 2020). These four dimensions classify/describe the areas needed to ensure that people with behavioral health conditions are able to progress effectively on their journeys of recovery. SAMHSA’s four major dimensions that support recovery include:

- **Home**—Having a stable and safe place to live.
- **Health**—Overcoming or managing one’s disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being.
- **Purpose**—Conducting meaningful daily activities and having the independence, income, and resources to participate in society.
- **Community**—Having relationships and social networks that provide support, friendship, love, and hope.

Exhibit IV-1. Behavioral health equity and recovery model



Source: Model by Jones, C. & Daniels, A. (2021), adapted from SAMHSA’s Four Dimensions of Recovery.

Impacting this is the role structural inequities, biases, stigma, and socioeconomic and political drivers play in recovery and how community-driven recovery solutions can address those drivers. Community-driven recovery solutions can include nonclinical services and supports as well as other social determinants of health. Central to this approach is a focus on social, physical, economic, service, and political/policy environmental factors.

Both providers and people with lived experience tended to view recovery as a journey or process, and many also expressed discontent with use of the term “recovery.” For a number of people with lived experience, there was a reluctance to speak of “recovery” due to a lack of agreement on what it means, and differences in beliefs about the often-chronic nature of behavioral health conditions. “Recovery” as a term was more well-recognized and accepted by people living with substance use conditions than by those living with other mental health conditions.

Most providers acknowledged that the landscape of recovery is shifting to coordinate with a broader definition of the term. Most shared their commitment to meeting clients where they are and providing individually tailored services. Many expressed a belief that their organizations are supporting – or striving to support – multiple client-driven paths to recovery. This denotes a paradigm shift away from traditional “one size fits all” approaches to treatment. Many described taking a “holistic” approach to treatment. Other organizations espoused a single philosophy (e.g., abstinence-only) to which they were committed.

For the most part, providers’ perspective on recovery and wellness seemed consistent with the organizations they represented. However, providers frequently suggested that their perspectives or implemented approaches may differ from other providers in their communities (e.g., abstinence-based v. harm reduction).

So recovery to us means connecting people to resources depending on where they’re at in their use and recovery trajectory... And so we’re just open to whatever that and whatever they need.... So it’s not all or nothing. It’s wherever the client is... And so I think as a whole, we’re saying wherever you are in your recovery we will help you. And if you’re still using one substance, but not another, that does not mean you’re not working on recovery.
[Provider]

Being in recovery is a self-designated term... It looks like life having its regular ups and downs, but continuing to move in an upward gradual thing... recovery just means the functioning of your life continuing to improve with peaks and valleys obviously, but generally on an upward trajectory... Upward, meaning more stable, more happy, more secure. [Provider with lived experience, SU]

It just depends on where they’re at in their journey.... people got really wrapped around the words, like are you in recovery, have you recovered, disease forever, what does that look like? We’re not about getting really wrapped around the words of what we are. [Provider with lived experience, SU]

As mentioned previously, time after time, individuals with lived experience noted that recovery was an ongoing process, not an end point. The recovery journey needs to be actively supported by ongoing awareness of when challenges occur and activities to overcome those challenges.

Recovery, I define as progress, not perfection, and chasing your recovery as hard as you chased your drug addiction. [Person with lived experience, co-occurring conditions]

Influence of Home, Health, Purpose, and Community

We asked both people with lived experience and providers of behavioral health services to discuss and reflect on if and how the dimensions of Home, Health, Purpose, and Community influence the recovery journey. For most, these factors resonated and were understood as important elements in advancing recovery.



Home: A stable and safe place to live

Providers shared that their communities offer limited available housing, including homeless shelters, and that they believed there to be a growing homeless population. In some of the counties that have ski resorts, houses, and land are routinely purchased for vacation homes, driving properties values up and making it impossible for those who

live there year-round to afford a house. There is also a lack of sober-living homes and shelters. Beyond these ongoing housing challenges, the COVID-19 pandemic forced shelters to reduce their occupancy, and some are no longer allowing overnight stays. The harsh temperatures of a Colorado winter were often brought up as serious concern.

Housing is always a thing... The last time I had a direct client that we were waiting for housing assistance, the waitlist was a year and a half out. [Provider]

We don't have a shelter. We don't have any of those resources... It's really sad to say, but they're kind of on their own. Like we can help get paperwork started for housing, but everybody knows how long housing takes... They can travel counties, but then they're far away from all of their resources, their family generally, their therapists who they've been seeing or just their support system. [Provider with lived experience, co-occurring conditions]

People with lived experience cited the importance of a stable residence. Having a “roof over your head” even if at times that was sober-living housing or rehab treatment was seen as especially important. People described a range of strategies to achieve housing solutions, such as stitching jobs together, getting on Medicaid, or finding support from partners or friends with financial stability. However, many housing solutions were temporary, and minor changes could result in housing instability.

I do think that housing has a lot to do with healing and safety and by having a partner that is able to provide enough that ... I know that I won't be homeless or something is good. [Person with lived experience, SU]



Health: Overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being

According to many providers, the challenges and delays associated with obtaining publicly funded insurance (e.g., Medicaid); limitations of insurance coverage; and limitations on what insurance providers accept caused delays in connecting clients with needed treatment services.

[A] 6- to 9-month wait, and Medicaid doesn't cover strictly substance abuse; they have to get in under the mental health umbrella to be able to get into inpatient treatment. For it to be paid for by Medicaid. Other than that ... Parole is going to have to pay for it. Probation's going to have to pay for it. They're going to have to be involved in the justice system to be able to get into rehab. [Provider with lived experience, SU]

Not all insurance companies will pay for substance abuse services. In Colorado, Medicaid was going to start paying for residential services this past fiscal year in July, however, with everything with COVID it's been pushed off to at least January or July of next year. [Provider]

Because many of the providers interviewed are located in and/or serving rural underserved areas, certain modalities of treatment services and/or other needed resources are often limited and/or unevenly distributed across service areas. Some talk about how this is improving, but others' perspectives seemed bleaker. Most counties included in this study reported lacking the full continuum of care (e.g., detox, inpatient, intensive outpatient, counseling, peer support). For many, needed services were either hours away or had lengthy waiting lists.

It's extremely limited... People do not have good treatment options here. They don't. [Provider]

But remember that being in these rural and underserved areas of the state, our programs don't have hundreds and hundreds and hundreds of participants. ... There was just this vacuum need for substance use agencies... a vacuum need for mental health agencies. ... They don't have a crisis walk-in center; don't believe they have detox. [Provider]

So we have one methadone clinic that serves our six counties... AA and NA are more abstinence-based and so it's even more difficult... There are... inpatient treatment centers around the state... booked far in advance. There aren't many programs that will take women and children. So what do you do with the children while you're in a 6-month inpatient facility, with a 2- to 4-hour drive away... rural issues. [Provider]

Treatment staff turnover was reported as a challenge for a few communities, disrupting established provider-client relationships as well as deterring the development of new ones. Several people with lived experience also expressed concern over the frequent staff turnover while they were receiving treatment. They also commented that the staff don't always seem to

understand the complexities of addiction, and that treatment is not set up to fit what the person receiving services needs. For example, sessions are scheduled at regular intervals, which may not be when a person needs them, or a treatment session ends when time is up, even if an important topic is under discussion. Treatment is often provided only during traditional 9-5 weekday hours, a barrier for individuals with employment or other obligations during these times.

Also, a lot of turnaround through the adults, which is really hard in our community because a lot of people don't like change, especially in that situation, and so that was a really, really big gap in treatment with people... when you're building a relationship of spewing out crazy personal things, more personal than physical health, and then all of a sudden they're gone, and they're like, "We'll schedule you with someone else." That is so hard because so many people have so many broken relationships, so that just solidifies that. Every time you build trust in someone, they are potentially going to leave. [Provider with lived experience, co-occurring conditions]

But keeping therapists is hard here. So somebody gets comfortable with somebody and then they're gone in 2 weeks and they went through five therapists... I think some of it has to do with money because of course, we're smaller communities and we're rural communities. So the pay isn't great anywhere, I don't think. And then also a lot of people move to bigger cities. There's nothing here and people don't necessarily want to smell cow poop all the time. [Provider with lived experience, co-occurring conditions]

People with lived experience noted similar issues with accessing treatment. All experienced at least one of the following challenges to getting the treatment they felt they needed:

- Lacking access to health insurance;
- Having insurance that does not cover mental health or (especially) substance use treatment (or severely limits that coverage); or
- Having access to health insurance coverage, but unable to find treatment they were happy with in their community, or local providers who accepted their insurance coverage. Several individuals were receiving virtual therapy from outside their home communities, while some had not found counseling support yet at all.

While a majority of our interviewees had experienced substance use, they all saw a mental health component underlying their drug use and those discussing relapse referred to unaddressed mental health issues.



Purpose: Meaningful daily activities, such as a job, school, volunteerism, family caretaking, creative endeavors, etc., and the resources to participate in society

The providers we spoke with mostly talked about purpose with respect to their efforts to assist clients with employment.

So they won't apply for a certain job or they won't even try. And I think trying to break that barrier with them, sometimes it's a little bit tough. But a lot of them, they get really emotional when you talk to them and tell them, "Not everybody's going to see you the same way." If they see the sober you and they see how great of a person you are and the qualities you have and the potential that you have, that you can bring to a company, they're going to see that person and they're going to give you a chance. [Provider]

Yeah, so the sense of purpose piece, what comes to mind is our vocational program. So, I think that does a beautiful job at helping people realize what they're truly capable of, whereas working in a t-shirt shop or a small engine shop before. They also didn't think that they were capable of doing things. And so, I think that does a really beautiful job of training with the vocational skills, but then also giving some hands-on experience. Some of those individuals become employees. Some of those individuals realize that "Hey, I can do something when I do want to do more," and then they go on and apply for other job opportunities. [Provider]

For people with lived experience in recovery, purpose was a much talked about component of their recovery journey. Many participants shared their desire to give back to the community that had supported them and/or the desire to volunteer or start careers in mental health or substance use as ways to help others. People found purpose in different ways including taking care of an animal, creating art, and going to school.

Purpose is a big one too, because my last career, I wasn't living with any purpose or meaning. And now I have to develop that into my recovery journey or else I will go back out again. [Person with lived experience, co-occurring conditions]

The connection, the community. The sense of helping, the sense of something bigger than yourself. If you're totally alone in your recovery, you then get the chance to do closet things and hide things from no one that's looking as well as yourself. [Person with lived experience, SU]

And as far as my purpose [goes], I do help other people that suffer from mental health and addiction. And I do groups and I volunteer. So they are important pieces of my recovery. And I define that as my recovery as well. It's not just decide to quit using drugs and alcohol. And then everything went on as planned or as normal people would. I'm actively involved in that every day [as] part of my life. And I try and stay grateful for the things that I do have. [Person with lived experience, SU]

The criteria to be a peer support specialist is to have lived experiences. So you talk about the best medicine to maintain mental health and sobriety, and that's helping others. So I'm really lucky to have contact with so many people, and that's what this job really offers, me a chance to help others. [Provider with lived experience, SU]



Community: Relationships and social networks that provide support, friendship, love, and hope

In the provider group, COVID-19 was identified as a barrier to service delivery with a major effect on connection with clients. Several also commented that the pandemic pushed their organizations to try new ways of work like tele-health and opening groups to remote access, which provided new

opportunities for more people to participate in services.

I think when COVID hit, a lot of things became available that never would have been even thought about or offered previously. So like that technology piece, it's been huge, and I hope that's something that we can continue to offer long-term. [Provider with lived experience, SU]

Community was something most participants shared as important to their recovery. People with lived experience often commented on the effectiveness of, and the sense of connection derived from, Alcoholic Anonymous and the 12-step program, though some did comment that if AA wasn't a fit for them there isn't much else available. Some individuals noted that they didn't always find that recovery supports needed to be labeled specifically with reference to "treatment" or "staying sober." While providers often spoke about the services that are available, or those that they wish were – most also shared the importance of people connecting to others in the community through groups such as AA. Positive connections with others were cited by many, including connections with people who had similar feelings, experiences and interests.

... we provide what's called recovery support services, meaning non-clinical, peer-run, peer-led services. Now, we do that in numerous different ways. Really the basis is around building your community connection of like-minded people. We work with numerous treatment centers. [Provider with lived experience, SU]

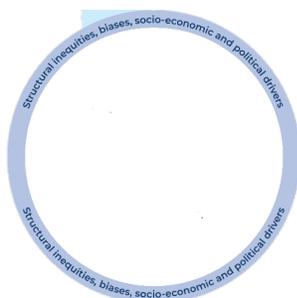
Almost everyone noted that the loss of personal interactions, group meetings and community involvement during the COVID-19 pandemic posed a challenge. But others also noted that it has provided an opportunity to slow down, to be more selective and to learn to enjoy using online tools (e.g., Zoom).

But what we've seen, what we heard from our patients is a mixture. So some of our patients complain about it. They don't like it. They want the old thing back. And some of our patients are incredibly appreciative specifically around the therapy because now instead of having to hire a babysitter and drive across town, they can literally put a movie on for the kids and go into their bedroom and attend group sessions. [Provider]

I think it's affected me most in that they don't have AA meetings going right now. So you're not able to really have that sense of community that is really, really important. [Person with lived experience]

I think that some things have definitely had to go online. I'm just getting into the recovery community here because I'm not shameful about it anymore, but everything has been outdoors, so I wonder how it will change as we go back into the colder months. Even like my schooling was supposed to be partially in person and it's no longer. [Person with lived experience]

It's not easy to talk to somebody over the computer, because they're thinking, "Well, who's in your house or is somebody else listening to what I have to say?" And then they don't open up all the way. So it kind of puts that barrier there. [Provider]



Structural Inequities, Biases, Socioeconomic and Political Drivers

When asking providers and people with lived experience about experiences related to structural inequities, most responses focused on socioeconomic barriers, with fewer references to biases and almost none related to political drivers. Many of the structural inequities that people in recovery faced related to criminal justice involvement, housing, and employment. Issues of homelessness, poverty, gender, and/or being a non-native English speaker added to the challenges that people experience on their recovery journeys.

People involved in the criminal justice system seem to have varied experiences. Often the only reason people were able to access treatment was due to being incarcerated. However, being incarcerated also comes with many problems after release including difficulties finding housing and employment. Often, there are disconnects between legal requirements and what providers may think is best for the person. For instance, clients may be required to abstain completely from substances instead of being able to use harm reduction techniques to address their substance use. The overtaxed criminal justice system is frequently unable to connect inmates with appropriate resources upon release, so they often fall into the same life circumstances that led them to become incarcerated in the first place.

We find people frustrated a lot because they're expected to do A, B, and C. And so like say, probation officer says they have to go to this class, this class, and this class. But that person does not have a job. And that class requires payment because some of the, like DUI groups and stuff like that require payment. And so then probation officer says, "Okay, well, I'll give you a voucher." Well, then there's never a voucher. So that person was ready to start their class and they were ready and willing to go. But it took a month to get the voucher figured out or to get it sent through or whatever the process may be. So then by that time that person's already given up. It's taken them a month to get it figured out it must not be that important. That person gives up, and then it's hard to wrangle the people back in, encourage them to come back. [Provider with lived experience, co-occurring]

And then, the other part, too, is people seeking recovery because they got into trouble, and they are on probation. It's expected that their recovery includes

abstinence. Which, I'm not going to fight the law, but it's not going to work for everybody. [Provider with lived experience, SU]

Several providers indicated that gender does play a role in barriers to care as well. There are few resources for women looking to go through detox or find sober-living housing. Very few places, if any, will allow children to come with their mothers. This scenario creates an often-impossible situation for women.

There's a huge deficit for women's healthy sober living, safe sober living in the state of Colorado." [Provider with lived experience, SU]

There's barely any places for women and there's really only one program for pregnant women....again the options in those rural places are slim." [Provider with lived experience, SU]

Well, I think it's different too. Like Denver, they have these women's shelters. All these different shelters that are available that offer great things. They're very integrated in their own kind of individual independent spectrum which is so important, where we don't have a lot of that here. [Provider]

Some providers indicated that they have a large Spanish-speaking client base and that a lack of ready access to services offered in Spanish can interfere with individuals' ability to participate. Whether or not enough bilingual staff were available to assist with Spanish-speaking clients varied by location. Most providers had enough by bilingual staff to meet Spanish-speaking client needs. However, others struggled with not only staffing but also with providing useful Spanish language resources.

We do encounter language barriers every so often. It's hard again being in rural Colorado because either you're finding this magical unicorn of an employee who's credentialed who also speaks another language which never happens, or you utilize the language line and you're trying to navigate through that. [Provider]

There is a huge lack of resources for Spanish-speaking individuals specifically, even though we have a very large population here. It's really interesting. We tried to put together a couple of resource pages and one specific to just Spanish speaking. And there's really nothing. People can find a form translated, but that's about it. There's one organization. I can't even remember the name of it, but it's basically one lady that tries to help everybody that reaches out to them for whatever variety of needs. So yeah, that's a huge gap. [Provider]

Moreover, being able to assist people with behavioral health conditions who were undocumented posed a different set of challenges. Fear often prevented people from accessing services that they may need.

Sometimes I do think it can be a barrier for our folks that are undocumented to be afraid of, one, sometimes the language barrier but two, just to be a little bit afraid that they might get turned into ICE or something. Of course, we would never do that, but I think there's a fear in the community that, that could

happen. And so we see a lot less undocumented folks. We're trying to manage that. We're trying to manage that through outreach and by making all of our things in Spanish more available. But yeah, I think that's one population that might feel a barrier. [Provider]

Very few providers felt that existing services were culturally responsive to the needs of immigrant populations in their communities. For example, immigrants from French-speaking countries in Africa had difficulty accessing behavioral health services and supports.

And then the second cultural piece being that we have a large number of Spanish speakers, an immigrant community. Also an immigrant community from Africa as well here, but very few providers that identify culturally with that community. And so there's just a gap there. [Provider]

Several of the counties in the study either had Native American populations or bordered tribal lands. However, due to factors such as racial biases and stereotypes, lack of trust, and lack of cultural responsiveness and culturally diverse providers, Native American people with behavioral health conditions were hesitant to access services.

Yeah. There are two Native American tribes surrounding [County name]....And I want to be sensitive when I speak to this, but I think that just historically, the relationship between modern Western civilization and Native American tribes, there's a lack of trust. [Provider]

I think that there is a, there's like an idea around this area, because we have a lot of Native Americans ... And we all live together in our small little corner over here. I think there's like a [stereotype] that they are lazy, that they all have alcohol problems. And then culturally, for any of the Natives to come out and be like, I have an issue, I need help people are like, whatever, you'll just be drunk again tomorrow. I think that there is definitely some racial issues in serving our Native American population. [Provider]

The issue in serving the Native American population is whenever somebody goes in for treatment and wants services, they want to see somebody like them. They don't necessarily want to get treatment from me. And so that's hard because we don't have treatment providers that are Native Americans. We don't have people alike serving people alike. That's not fair. I mean, because as soon as they see me, they're like, oh, here comes "judgy-Judy." I don't blame them at all. [Provider]

A few providers shared that working with people who are deaf is a difficult problem as there are no local sign language interpreters. One provider did share that they have been able to use a video phone-based system where a provider speaks into the phone, and a sign language interpreter signs the information via video.

Every once in a while, we come across an issue of the deaf community not being able to get services because nobody does sign language. [Provider]

Occasionally we have a few people that come in and are needing services, who English is not their primary language. I really work hard to get them connected with an interpreter and get interpreting services for that. Actually, sign language is harder for us because there are no sign language interpreters in our area. [Provider]

All providers shared that lower socioeconomic status is one of the largest barriers to people receiving care. Some counties shared that there are not enough providers who take Medicaid and others who were dismayed that if people made just a little too much money, they were not eligible for Medicaid which was the only way they would be able to afford services.

And I know we all know the struggle with Medicaid. You pretty much have to be very poor to utilize it [Provider with lived experience, SU]

This place is so poor... I realized I'd never seen poverty until I came here. And [this area], there are miles and miles and miles of just nothing, just scrub brush, but people are camped out there under the scrub brush. [Provider]

Obviously, the lower income status, the more barriers they're going to have. ... But yeah, socioeconomic is the biggest barrier, I think. [Provider]

Lack of availability for people with low income to get support. We're starting to find some places that Medicaid will pay for, for long-term treatment and that kind of stuff. But these are 6 months to 2-year programs. If you have money you can spend the \$25,000 and get into a good program in 30 days. So money has a lot to do with it, and the ability to actually go get some help. [Provider with lived experience, SU]

As previously mentioned, lack of available housing has created several challenges and increased inequities for people with behavioral health conditions in rural areas. Limited available housing, including homeless shelters, and a growing homeless population was mentioned by several providers as a barrier to treatment and recovery.

We have a growing homeless population and absolutely no homeless shelters, programs or anything for the homeless people... we are not open at night... So we can't offer a place for somebody to sleep... [people are sleeping] Under the bridge, outside in abandoned buildings, wherever they can. [Provider]

It's super tourism and so I think some of those things, fundamentally, I think, places don't want that to be a huge awareness that there's a homeless population here. And those things like this is a vacation land and so people want it to be looking in a certain way. [Provider]

Well, we look at what the circumstance is. So, many of them are homeless here. We have a huge homeless population. And it seems like the majority of them have co-occurring things going on, and the addiction. And so again, you can't work with anybody until they're detoxed, and so they have to, if they need to be detoxed, and they have to agree to that. And then, come back, and then they have that conversation again. But you got to help them establish their basic

hierarchy of needs. They have to have a place to sleep, and they have to have food. And here, it's way below freezing at night already, and they have to have shelter, food, clothing. [Provider]

Community-Driven Recovery Solutions (Formal and Informal Services and Supports)

A persistent pitfall in evaluating recovery support systems is restricting the scope of the evaluation to clinical treatment practices and services. Yet we know, and research increasingly demonstrates, that recovery does not simply happen within the confines of treatment – and sometimes happens entirely outside that realm (Ashford et al., 2019). Recovery is impacted both positively and negatively by the conditions in which people are born, grow, live, work, and age that shape health.

The system of recovery supports participants describe in this study includes independent yet interdependent components of a single, holistic system of recovery that includes both clinical and community-based assets. Participants in the study clearly saw a role for clinical services in their recovery, but only in a much larger community context where their basic needs were met, and their activities of daily living provided supports that sustained them. The recovery system of supports encompasses all these factors. Both persons with lived experience and providers gave feedback on how effectively this multifaceted recovery system was working within their communities.

People with lived experience and providers noted that for a recovery journey to begin, some aspects of **basic needs had to be met**. The clinical providers have limited control over access to some of these resources. While several providers and people with lived experience noted that their counselors helped them get in touch with basic support services, like applying for assistance, housing or other supports, access to these services is generally managed by yet other systems of control. Medicare; Medicaid; Social Security Disability Insurance; and other income, housing, or employment supports are controlled by disparate systems. Additionally, comments from both people with lived experience and providers indicated that this segment of the recovery system was not functioning effectively for those being served.

People with lived experience provided a wealth of detail on the community-based supports that sustained and enriched their recovery journey. Many of these supports have been discussed previously in viewing people's experiences of the four dimensions of health, home, community, and purpose. These supports are varied, including family and significant others, friends, volunteer work, educational pursuits, recreational and outdoor activities, and employment. Interestingly, most people with lived experience seem to be negotiating these community supports on their own - that is, without support from the formal "treatment" system or other institutional support, or sometimes with engaged family and community members participating.

Providers of treatment services are often **limited in the services they can offer people with lived experience**, and the causes of those limitations vary. Some providers do not elect to offer an array of services; for example, an abstinence-based program will not offer harm reduction services. Similarly, the criminal justice system may control entry into certain outpatient or

residential treatment for substance use, so that a community provider cannot access these services for a participant living in the community. The most common limitations are that the services are simply not available in the community or are too expensive or are dependent on supports that are not accessible. For example, one provider highlighted a major gap in the continuum of treatment services available in the rural areas served by her organization:

So people have to leave to get inpatient treatment. This is a whole another issue, but how that inpatient treatment gets paid for? What happens during that inpatient treatment process? And what happens when people are released? If there aren't the community resources there, if there isn't connection to those resources even before people leave treatment, that's an issue. We have one detox center where people are kept for 3, 5, 7 days, and then sent back out... And those are just rural issues. We'd love to have an inpatient treatment program here. How does that get paid for? [Provider]

Another provider similarly describes **major gaps and lack of resources** in the treatment continuum for those seeking mental health services:

We're very much lacking in resources here. This is like... back woods, rural, very rural, we don't have many resources at all, and we have an extremely high suicide epidemic rate. It's critical here... We really don't have big agencies or entities to turn to. And similarly, there are zero back to the housing, there are no inpatient, no residential, no half-way houses, no safe houses, no nothing. We have developed at the hospital one safe room. It's called a comfort room, where if somebody's having a freak-out and should not go to jail, they're not, criminally they'd be detained, don't throw me in a padded room either, but I need a safe room with a couch and somebody to come check on me and just to be there. Because we can't be treating suicidal people like criminals or else I'm never going to call for help. [Provider with lived experience, co-occurring conditions]

People with lived experience noted similar limitations, mentioning the difficulty of finding services within their community. Several individuals were receiving virtual therapy from outside their home communities, and some had not found counseling support yet at all. Another person with lived experience noted how difficult it was to find a good counselor, and that could be a deterrent to staying in or achieving recovery. A provider talked about the importance of building a relationship with a trusted provider, only to have that person leave and need to start again from scratch. One participant who was attending court-mandated outpatient treatment was critical of the imposed and rigid format of services. Others noted “you have to move forward with it even if you don't like it. You can't give up.”

Another important aspect of the functioning of the recovery supports is **how well collaboration and communication occur within the system**. The provider commentary points out that communication between traditional clinical services providers and agencies that control access to resources central to meeting basic needs (income, housing, insurance [Medicare, Medicaid, etc.]) is challenging, although several pointed to the willingness of individual service providers to work together to address short-term emergency needs of specific individuals. Even within

the treatment community itself, communication is seen as functioning unevenly, with positive and negative commentary:

We actually have different providers here in this community, which they have done great things. We also have the family resource center... And the youth center that helps our youth who are... or whose families are in recovery... We have great, great resources here in the community... It's really nice to see everybody work together. We all get referrals from everyone. We send out referrals to everyone. So we definitely work as a community to help individuals with a recovery process. [Provider]

(While) there's lots of cross-organizational collaboration I think we have a long ways to go, and it hasn't been at the top of the priority list to create a community that's conducive to recovery.... There's lots of funding behind crisis resources and making therapy more accessible. [Provider]

Unfortunately, in these areas, I feel there's a lot of disconnect. So agencies don't always work well together. There's not a lot of communication... We find people frustrated a lot. [Provider with lived experience, co-occurring conditions]

While transportation was listed as a serious barrier to services by both providers and people with lived experience, there was one way in which the COVID-19 pandemic resulted in useful innovation that addresses this issue. Since groups and sessions could no longer be conducted in person, many sites switched to **virtual platforms** such as Zoom for these functions. While some people with lived experience note they miss the companionship of in-person meetings, they and others comment that it is a great convenience not to have to spend so much time in travel or solving transportation dilemmas.

V. How Effectively Do Systems of Recovery Supports Work Within Communities?

One of the main goals for this study was to understand how effectively systems of recovery supports work within communities. To that end, we discussed with providers and people with lived experience what recovery supports are available in their communities. We used that information to examine conditions for systems change and how these conditions are currently playing out as either facilitators or barriers to successful recovery journeys.

Commentary from providers and people with lived experience highlighted the extent to which various recovery supports were available in their communities. Table V-1 shows the different elements of the system of formal and informal services and supports and their availability in rural and frontier communities.

Table V-1. Availability of system services and supports

System component	Accessibility/Availability
Shelter	Frequently inaccessible
Housing	Frequently inaccessible
Substance use/co-occurring outpatient treatment	Frequently inaccessible
Substance use detox treatment	Residential frequently inaccessible; other fairly accessible but limited duration/utility
Income supports	Fairly inaccessible
Health insurance	Fairly inaccessible
Mental health outpatient treatment	Somewhat accessible
Linguistically/culturally responsive services and supports	Linguistic supports somewhat accessible; both linguistic and cultural considerations would benefit from further study and organizational and system supports
Peer support	Fairly accessible (12-step), could benefit from expansion of diverse options
Healthy living programs	Self-directed, could benefit from increased organizational and system supports and greater visibility
Work/education/volunteer activities	Self-directed, could benefit from increased organizational and system supports
Family/significant other supports	Self-directed, could benefit from increased organizational and system supports

Certain services were regarded as key to their recovery by some individuals interviewed but viewed as having little value by others. A service may be available and delivered in an excellent manner, but if that service does not correspond to what an individual is experiencing and/or what an individual is seeking – no matter how well-delivered and potentially helpful that service is – it will not be effective and will often be rejected. Given the highly-individual nature of recovery, this is expected – but it also highlights the importance of making a variety of recovery services and supports available.

Where gaps or lacks are identified by people with recovery experience or the providers who support them, this can be a clue to disconnects and stumbling blocks, including investment of resources in particular services at the expense of others.

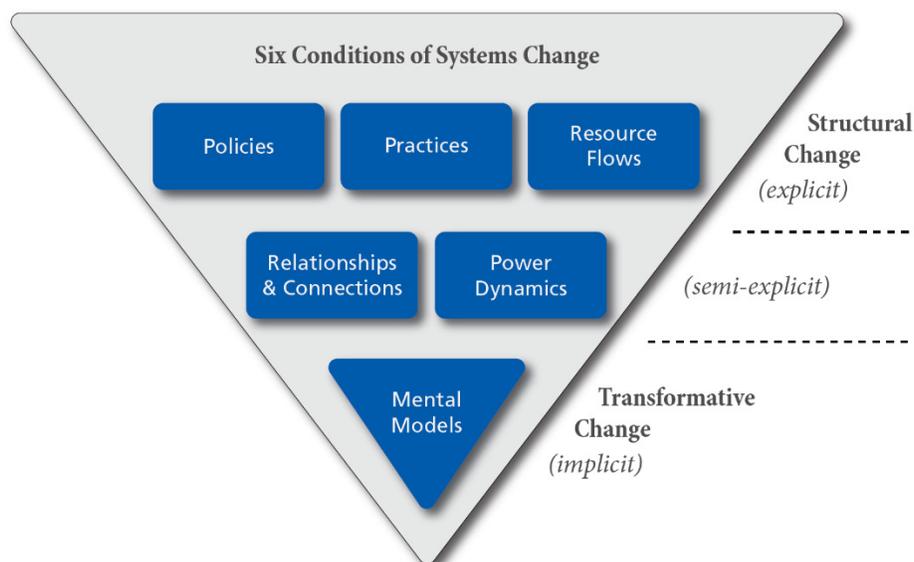
Overall, there was a substantial gap between aspiration and reality of what recovery supports are available in rural communities. Providers' expressed commitment to adopting a client-focused approach with multiple treatment options matched to each individual's goals and preferences was found to be at odds with the access to services that actually exist in the counties studied. This gap between aspirations and realities – many due to an actual lack of services and resources, and others resulting from impeded access, inequities, and lack of information and coordination – stands as a major barrier to achieving and sustaining recovery for individual residents and the counties at large. Without a truly accessible range of services, individuals' recovery is impeded, and many people will not be as successful in recovery as they have the potential to be.

Moreover, the individual nature of recovery and the shift to a focus on self-determination and choice in pathways to recovery highlights the need for community involvement in service delivery and decision-making. Literature points to the importance of consistent and meaningful involvement of people in recovery in identifying and determining what services and resources are needed, funded, implemented, and evaluated (Chinman et al., 2014; Daniels, et al., 2012).

Opportunities for Systems Change in Behavioral Health Recovery

Systems change seeks to understand how the different service systems – such as mental health authorities, substance use authorities, providers, social service agencies, and safety net organizations – are working together to support individuals in recovery. Systems and organizational change create a shift in the way that an agency makes decisions about policies, programs, and the allocation of its resources – and, ultimately, in the way it delivers supports and services to its citizens (Fixsen, Naoom, Blasé et al., 2005). Figure V-1 shows the FSG Six Conditions of Systems Change model (Kania et al., 2018).

Figure V-1. Six conditions of systems change



Whether the change is intended to be structural or transformative, the following conditions play an important role:

- **Policies:** Government, institutional and organizational rules, regulations, and priorities that guide the entity's own and others' actions.
- **Practices:** Espoused activities of institutions, coalitions, networks, and other entities targeted to improving social and environmental progress. Also, within the entity, the procedures, guidelines, or informal shared habits that comprise their work.
- **Resource Flows:** How money, people, knowledge, information, and other assets such as infrastructure are allocated and distributed.
- **Relationships & Connections:** Quality of connections and communication occurring among actors in the system, especially among those with differing histories and viewpoints.
- **Power Dynamics:** The distribution of decision-making power, authority, and both formal and informal influence among individuals and organizations.
- **Mental Models:** Habits of thought—deeply held beliefs and assumptions and taken-for-granted ways of operating that influence how we think, what we do, and how we talk.

This systems change model is helpful in understanding where the behavioral health recovery system has opportunities for change and growth. It can help us understand how the system looks in light of the recovery experiences of people served by these systems.

Table V-2 highlights SAMHSA's four dimensions of recovery (Health, Home, Community, and Purpose) and categorizes factors and conditions described by those interviewed within the context of the Six Conditions of Systems Change (Policies, Practices, Resource Flows, Relationships & Connections, Power Dynamics, and Mental Models). The table is designed to offer an overarching summary of the current situational factors in the counties studied and offer a detailed window into major themes expressed, to inform future actions.

Table V-2. Factors/conditions within the system that inhibit or support different dimensions of recovery

Systems conditions	Recovery dimensions			
	Home	Health	Purpose	Community
Policies	<ul style="list-style-type: none"> Long waitlists for affordable housing Limited shelter capacity, made worse due to COVID-19 No overnight stays due to COVID-19 	<ul style="list-style-type: none"> Focus on keeping people in community rather than inpatient settings Corrections system determines outpatient or residential treatment for substance use 	<ul style="list-style-type: none"> Legal/regulatory barriers to employment related to past criminal justice involvement Medicaid eligibility/Social Security Disability Income restrictions 	
Practices	<p><i>Housing supports</i> <i>Shelters</i> <i>Residential rehabilitation</i> <i>Independent community living</i></p>	<ul style="list-style-type: none"> Focus on crisis and short-term services, vs. prevention and early intervention <p><i>Crisis services</i> <i>Emergency rooms</i> <i>Law enforcement engagement</i> <i>Abstinence-based programs</i> <i>Harm reduction services</i></p>	<p><i>Supported employment</i></p>	<ul style="list-style-type: none"> Virtually-available peer support programs <p><i>Recovery centers outside of clinical settings</i></p>
Resource Flow	<ul style="list-style-type: none"> Limited availability of affordable housing Lack of sober-living homes and shelters Lack of supported housing for women, pregnant women, and/or women with children Lack of reliable, accessible transportation 	<ul style="list-style-type: none"> Lack of insurance coverage 	<ul style="list-style-type: none"> Need to stitch together multiple jobs to afford housing Uneven knowledge about available services and supports Increased dissemination of resources/services information via social media 	

Table V-2. Factors/conditions within the system that inhibit or support different dimensions of recovery (continued)

Systems conditions	Recovery dimensions			
	Home	Health	Purpose	Community
Resource Flow	<p>  Medicaid eligibility provides access to services</p> <p> People forced to return to dysfunctional living situations due to lack of housing options</p>			
Relationships & Connections	<p><i>Housing support from partners or friends with financial stability</i></p>	<p> High turnover of providers</p> <p><i>Connectivity among service providers, and between service providers and resources</i></p>	<p> Increased dissemination of resources/services information via social media</p> <p> Lack of connectivity between service providers and resources not specifically focused on recovering individuals</p>	<p><i>Volunteer work</i> <i>Educational pursuits</i> <i>Recreational and outdoor activities</i></p>
Power Dynamics		<p><i>Individualized, recovery-oriented services vs. provider control of services to be received</i></p> <p><i>Appointments based on agency/provider schedule vs. person's needs</i></p>		

Table V-2. Factors/conditions within the system that inhibit or support different dimensions of recovery (continued)

Systems conditions	Recovery dimensions			
	Home	Health	Purpose	Community
Mental Models	<i>Sobriety-first models vs. housing-first models</i>	— Resistance to harm reduction services Punitive paternalism*	+ Focus on self-determination and choice + Giving back as important to recovery + Community providers' commitment to working together — Local resident stigma about individuals' ability to recover	<i>Rural and resort communities having substance use culture ("party atmosphere")</i> <i>Desire for community support not labeled as "recovery support"</i>

* Punitive paternalism describes an approach that focuses on treating behavioral health conditions as a moral failing by the patient, with symptoms treated as an acute problem that can be fixed by others.

Most factors are associated with a plus sign, a minus sign, or both. The signs indicate whether the factor was generally found to support (+) or inhibit (-) the recovery process. Where variable experiences exist, those factors carry both a plus and a minus sign. Factors listed in italics are not associated with either a plus or minus due to significant variations across communities regarding availability, support, and importance.

VI. Considerations About Systems of Behavioral Health Recovery for Individuals Living on Low Incomes in Rural and Frontier Communities

The implications for this study are based on two models for recovery and large-scale systems change as described above. Each of these contribute to a clearer picture of the opportunities and conclusions that can be drawn from the study.

The **Behavioral Health Equity and Recovery Model** (Jones & Daniels, 2021) integrates the four SAMHSA recovery dimensions (Health, Home, Purpose, and Community) as the interface between individual experience and the social and system of care determinants that impact individual wellness and health outcomes. In addition, this approach recognizes the vital factors of community driven recovery solutions and the impacts of structural inequities, biases, and socioeconomic and political drivers. From the experiences of people in recovery from behavioral health condition and the providers who support them, we learned how the recovery journey varies with each person and what the touchpoints are in that journey process. No recovery journey is without barriers or facilitators. However, it is essential that particular attention be paid to the structural inequities that are impacting the recovery process and the role of community driven solutions to help overcome those challenges and facilitate opportunities for success.

The **Six Conditions of Systems Change Model** addresses the different levels of change that are possible (Figure V-1). These include explicit structural change, semi-explicit change, and implicit transformative change. The operational components of this process of systems change include: Policies, Practices, Resource Flows, Relationships & Connections, Power Dynamics, and Mental Models. This framework can be used to better understand the experiences of the people with lived experience and providers included in this study and the opportunities to improve the systems of care in which they work. In virtually every case, directly affecting change in the availability of the recovery component is a matter of impacting Policies, Practices, and Resource Flows, while overall functioning could be improved with better communication, shifts in Power Dynamics and changes in habitual thought (Mental Models), along with what aspect of the FSG System Change model impacts/is impacted by the level of availability. This yields a quick profile of where change needs to occur to redress the challenges to the availability of the component.

Together these models provide a framework to detail the experiences of individuals in recovery, identify systems strengths and challenges, and consider structural supports and barriers to change.

In Table VI-1, we offer targeted observations and key questions to help stakeholders focus on opportunities to improve adult behavioral health systems, including both formal and informal supports. While not an exhaustive listing, these are offered as starting points for communities and providers to consider in thinking through what solutions and approaches would work best in their own context. In any solution, it is critical to center the experiences of people with lived experience in recovery, and to consider how inequities may be exacerbated or improved through a given solution (CFE Research, 2020). In particular, it is vital to consider racial inequities, including the ways in which solutions need to be culturally responsive and how they are cocreated with those experiencing racial inequity in order to meet their needs. Equitable

solutions should always involve considerations about how to share power more deeply and authentically with those in recovery – recognizing the unique expertise they bring around the recovery process, systems of support, and potential solutions – and, in particular, sharing power over decisions about how recovery programs and systems are designed and implemented.

Table VI-1. Observations and key questions

Systems change component	For consideration
Policies, Resource Flows	<p>Regional services planning often focuses on high-level discussions and does not always lead to meaningful and/or timely action.</p> <p>Some types of supports seemed to have significant gaps, such as services that incorporate harm reduction practices and programs that support pregnant or parenting women.</p> <p>Given what is currently available around recovery, what kinds of services and supports are missing? Who is being most impacted by these gaps, and what inequities might that be reinforcing?</p> <p>How can regions engage in creative and equitable planning process that pay attention to services within a region, identify duplication and gaps, and redistribute or search for resources to ensure improved availability and quality of services?</p> <p>What would it look like for a region to have a variety of services that allow people to choose a path to recovery that best meets their needs?</p> <p>What policies (formal and informal) might exist locally that serve as barriers to the kind of recovery system envisioned by the community? What could be done to change these policies to create a community that is more recovery-friendly?</p>
Policies, Relationships & Connections	<p>In general, there was an appetite for local collaboration between recovery providers, and for addressing local fragmentation of services (including in-kind and material resources). But some counties were experiencing a lack of collaboration, or current collaboration was centered around addressing individual situations and crisis management.</p> <p>What kinds of collaboration between service providers would make the biggest difference for this community? What would it take for us to take a step in that direction?</p> <p>What would it take for providers to engage with each other in ways that meet the needs of people in recovery? What are key barriers, and what would it take to create transformational change?</p> <p>If we leveraged the experience of both local providers and those in recovery, what would we discover in this community about new opportunities to collaborate, or ideas about how to address fragmentation and gaps?</p>

Table VI-1. Observations and key questions (continued)

Systems change component	For consideration
Mental Models, Resource Flows	<p>There was little evidence of organized partnerships with people in recovery around co-creating community supports and resources to support a variety of personal recovery strategies, and to deal with barriers to accessing those supports and resources.</p> <p>How can communities implement diverse and creative solutions to make local residents aware of available supports and resources and how they can access them?</p> <p>What would it look like for a community (or service provider) to authentically share power with those in recovery to co-create how that community (or service provider) supports recovery through services, supports, and policies?</p> <p>What might it take in our community to shift power over recovery services, so that people in recovery have a greater ability to make decisions about what recovery supports exist, and how recovery is supported?</p>
Practices	<p>Technology has increasingly been used for behavioral health services delivery and communications during the COVID-19 pandemic to assure continuity of service delivery and maintain contact.</p> <p>What have we discovered about how technology can best be leveraged to expand access to recovery supports (e.g., group and individual treatment, education, peer supports, etc.)?</p> <p>What do we now know about delivering behavioral health services through technology? What of this do we want to maintain as we go forward, and what do we want to let go of to create space for these new ways of working?</p> <p>What would it take to prioritize creating virtual recovery services that draw on the expertise of those with lived experience to serve as program designers, implementers, and peer support workers?</p>
Relationships & Connections, Power Dynamics	<p>Many individuals access behavioral health services in connection with their involvement in the criminal justice system.</p> <p>In what ways are communities engaging with those who are/have been justice-involved in order to understand what is working for them around recovery, what is not, and how supports and services need to change to better support their recovery process?</p> <p>How can community stakeholders advance dialogues with those in recovery to shift community practices that lead those with behavioral health conditions to experience unnecessary engagement with the criminal justice system?</p>

Table VI-1. Observations and key questions (continued)

Systems change component	For consideration
Practices	<p>There is a disconnect between available services and desired services. For example, there are individuals mandated to receive outpatient therapy from the courts who do not want it (with self-reported disappointing outcomes), while many individuals in the community seeking outpatient therapy cannot access these services.</p> <p>What would it take to create local systems of recovery that can provide recovery services in ways that those in recovery want?</p> <p>What are ways communities can meaningfully understand what services are desired - from the perspectives of both people with lived experience and the providers who support them - and use that to inform what is available and how that is delivered?</p> <p>How can communities ensure that available resources are targeted toward services desired by those in recovery?</p>
Power Dynamics, Mental Models	<p>Communities seeking to address behavioral health conditions tend to focus on expanding traditional/existing treatment services, resources to correct deficits, and community problems. Such a focus supports an overall view of people in recovery as unstable and incapable vs. advancing the reality of recovery and possibility that exists in every community.</p> <p>What would it take for those in recovery to feel welcomed, understood, and accepted within the community, instead of stigmatized? What community narratives, practices, or policies would need to change?</p> <p>What actions would ensure that people in recovery lead the work of conceptualizing and implementing a new vision for the future of how recovery is thought about and supported in communities?</p> <p>How can communities help facilitate people in recovery stepping into their power - whether that's about publicly describing their journeys and experiences, participating in decisions about resources or policies that impact recovery, or providers engaging those in recovery as experts to inform programmatic shifts and improvements?</p>

The Colorado Health Foundation embarked on this study to better understand how individuals living on low incomes in rural and frontier areas of Colorado experienced their recovery journeys. This report showcases those experiences, considers the relationship of experiences to practices and resources, and puts a spotlight on opportunities for systems change. Along with providing important data, key questions have been raised here to inform future dialogue and action, among them:

What would it look like to truly support recovery in our communities?

What would it take?

How do we move forward?

What strengths can we build on?

How do we work equitably to share power and accountability?

There is the opportunity to craft a better future around behavioral health recovery in Colorado. In every community there are steps that could be taken to create systems of recovery that are designed and implemented in partnership with people in recovery, and which are focused on ensuring that people in recovery can achieve health and wellness, lead self-directed lives, and reach their individual goals.

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Appendix A
Data Collection Protocols

Appendix B
Screeners for Inclusion for Adults in Recovery Study

Appendix C
How Did We Engage in Equitable Evaluation?

Appendix D
Key Definitions of Terms Used in This Report

Appendix A

Data Collection Protocols

Understanding the Experience of Coloradans in Recovery Provider Interview Protocol

Introduction

Hi and thank you for being here today. My name is [state your name], and I'm here with my colleague [state her/his name] who will be taking notes. We are from Westat, a national research company dedicated to improving outcomes in health and social policy.

We are partnering with The Colorado Health Foundation to better understand the experiences of adults in Colorado who live with and are recovering from mental health or substance use conditions.

Confidentiality/Informed Consent

Before we begin, I would like to review a few items. As we stated in the recruitment email for this interview:

- This interview will last about 1 hour.
- Your participation in this interview is voluntary. If at any time during the discussion, you do not want to answer any of the questions we are asking for any reason, you are free not to answer them, and you have the right to stop the interview at any time.
- There are no right or wrong answers. All your comments and thoughts are important to us.
- We would like to use a voice recorder (no video) to record our conversation, so that we can listen to the recording in case our notes are incomplete. You can still participate if you are not okay with having your voice recorded during this interview, we would just take notes during the interview.
- All of your answers will be kept confidential and your name or the name of your organization will not be associated with your comments or identified directly in any reports or presentations.
- The recruitment email has contact information for someone that you can call if you have any questions later.
- No written consent will be collected. Interviewer will ask for verbal consent before starting interview.
- You will receive a \$50 gift card as an expression of appreciation for your time.

Do you agree to continue with the interview?

[OBTAIN VERBAL CONSENT TO RECORD SESSION]**[IF CONSENT IS GIVEN TO RECORD, THEN SAY WHILE RECORDING]:**

Okay, just for confirmation, you have agreed to participate in this interview and have agreed to allow this session to be recorded. You understand that your responses will be kept confidential, you can refuse to answer any questions, and you can stop the interview at any time. Is that correct? Do you have any questions before we begin?

Background

As I stated earlier, we are partnering with The Colorado Health Foundation to better understand the experiences of adults in Colorado who live with and are recovering from mental health or substance use conditions. We think one of the best ways to do that is to listen and learn from the experiences of people like yourself. We want to hear your perspectives and experiences with services/supports available to help people in their journeys toward wellness and recovery, what you think is working, and what is not working well. This interview will help us to identify systemic barriers and obstacles that impact pathways to wellness and recovery for Coloradans.

We would like to begin with a few questions to help us know more about your work and your role in [insert name of organization].

1. Briefly, what is the mission/goal of [insert name of organization]?
2. What is your current role/position in [insert name of organization] and what are your main responsibilities?
 - How does your role/position relate to supporting people who live with and are recovering from mental health and substance use conditions?

Concepts of Recovery and Wellness

Next, we'd like to hear your personal thoughts about concepts of recovery and wellness, as a service provider and someone familiar with people living with mental health and/or substance use conditions in [county]. **[Optional:** *When I use the term "recovery," I am using it to refer to people's experiences in addressing their mental health and substance use conditions and building healthy lives, or their interactions with systems that impact their wellness and recovery.*]

3. How do you think about recovery in your organization?
 - Probe for terms used to describe current situation, length of time in relationship to definition of recovery, role of treatment in defining where they are
 - Probe: What do you think recovery from mental health and substance use conditions looks like, over time? When you think about a person working on recovery and building a healthy life, what types of feelings or ideas come to mind?
 - Probe: Do you think that your individual definition of recovery is the same as your organization's definition? The same as most other service providers in [county]? (If no, probe on differences.)

4. Building a healthy life may involve a person’s mental and physical health, their housing, their sense of purpose and community, and similar factors. Tell us more about how you believe your program/organization supports people in building healthy lives in these or other ways.
5. Tell me more about if and/or how you believe other programs or organizations in [country] support people in building healthy lives.

Experiences of Program Participants

Now we’d like to focus on what you hear from the people you serve in your program/organization. We will also talk with service recipients themselves but are interested in your viewpoint as a service provider, as well.

6. What do you hear from people living with mental health or substance use conditions about how well the services and supports in this community meet their needs?
 - Probe: How well do services and supports in your community provide the opportunity for people to choose their own paths to recovery? (i.e., can people pursue sobriety, harm reduction, medically-supported vs. not recovery)
7. What do program participants say gets in the way of identifying and accessing support they need? What do you observe about these barriers?
 - Probe on particular groups of people (e.g. people of color, people coming out of incarceration, young adults, people with English as a second language, etc.) who experience these challenges more than others
 - Probe: As a provider, what do you think would help address these challenges [*refer to responses from previous question*]?

Observations and Insights

We’d like to hear some observations and insights from your perspective as a service provider.

8. In general, how would you describe the relationships and connections between organizations and service providers for people with mental health and substance use needs in your community? [*relates to relationships & connections*]
 - Probe on making a hand-off, providing resources, or even linkage to other resources
 - Probe on how people learn about different resources and organizations
 - Probe on quality of connections and communication

9. To what extent are individuals working on their wellness and recovery included in creating, informing, or overseeing the supports and services around recovery within your organization? In this community? *[relates to power dynamics; practices]*
 - Please give me a few examples.
 - Probe on if and how program participants' own recovery and wellness goals are used as the basis of treatment or service plans
 - Probe on opportunities for shared decision-making, shared power, and shared authority
 - Probe on policies and practices in place
10. How well-supported (funded) are services supporting recovery and wellness within [county]? *[relates to resource flow]*
 - Probe on how they believe their specific geographic area compares to other parts of Colorado
11. From your personal perspective, where are the biggest barriers impacting the recovery journeys of the people you work with? How do inequities in the system show up?
 - Probe on ways in which system or administrative requirements (policies and practices) lead to disconnects between the ways services and supports are made available
 - Probe on provider observations about the beliefs of those in power [legislators, administrators, key community stakeholders] about the ability of people to recover, where resources are directed, etc.
12. What would you like to see done differently in [county] to support individuals in their recovery journeys?
13. What do you think is important for the public to know about recovery from mental health and substance use conditions?

That concludes our questions. Is there anything else you would like to share with us that you think would be important for us to understand about the experiences of individuals working on recovery and wellness?

Thank you very much for meeting with us today! We really appreciate your time!

Understanding the Experience of Coloradans in Recovery Peer Support Specialist Interview Protocol

Introduction

Hi and thank you for being here today. My name is [state your name], and I'm here with my colleague [state her/his name] who will be taking notes. We are from Westat, a national research company dedicated to improving outcomes in health and social policy.

We are partnering with The Colorado Health Foundation to better understand the experiences of adults in Colorado who live with and are recovering from mental health or substance use conditions.

Confidentiality/Informed Consent

Before we begin, I would like to review a few items. As we stated in the recruitment email for this interview:

- This interview will last about 1 hour.
- Your participation in this interview is voluntary. If at any time during the discussion, you do not want to answer any of the questions we are asking for any reason, you are free not to answer them, and you have the right to stop the interview at any time.
- There are no right or wrong answers. All your comments and thoughts are important to us.
- We would like to use a voice recorder (no video) to record our conversation, so that we can listen to the recording in case our notes are incomplete. You can still participate if you are not okay with having your voice recorded during this interview, we would just take notes during the interview.
- All of your answers will be kept confidential and your name or the name of your organization will not be associated with your comments or identified directly in any reports or presentations.
- The recruitment email has contact information for someone that you can call if you have any questions later.
- No written consent will be collected. Interviewer will ask for verbal consent before starting interview.
- You will receive a \$50 gift card as an expression of appreciation for your time.

Do you agree to continue with the interview?

[OBTAIN VERBAL CONSENT TO RECORD SESSION]

[IF CONSENT IS GIVEN TO RECORD, THEN SAY WHILE RECORDING]:

Okay, just for confirmation, you have agreed to participate in this interview and have agreed to allow this session to be recorded. You understand that your responses will be kept confidential, you can refuse to answer any questions, and you can stop the interview at any time. Is that correct? Do you have any questions before we begin?

Background

As I stated earlier, we are partnering with The Colorado Health Foundation to better understand the experiences of adults in Colorado who live with and are recovering from mental health or substance use conditions. We think one of the best ways to do that is to listen and learn from the experiences of people like yourself. We want to hear your perspectives and experiences with services/supports available to help people in their journeys toward wellness and recovery, what you think is working, and what is not working well. This interview will help us to identify systemic barriers and obstacles that impact pathways to wellness and recovery for Coloradans.

We would like to begin with a few questions about your background and role in [insert name of organization].

1. Briefly, what is the mission/ goal of [insert name of organization]?
2. What is your current role/ position in [insert name of organization] and what are your main responsibilities?
 - Within the organization, how do you support people who live with and are recovering from mental health and substance use conditions?

Concepts of Recovery and Wellness

Next, we'd like to hear your personal thoughts about the concept of recovery, as someone familiar with people living with mental health and/or substance use conditions in [**name of county**]. [**Optional:** *When I use the term "recovery," I am using it to refer to people's experiences in addressing their mental health and substance use conditions and building healthy lives, or their interactions with systems that impact their wellness and recovery.*]

3. What do recovery and wellness mean to you?
 - Probe for terms used to describe current situation, length of time in relationship to definition of recovery, role of treatment in defining where they are
 - Probe: What do you think recovery from mental health and substance use conditions looks like, over time?
 - Probe: When you think about a person working on recovery, what types of feelings or ideas come to mind?
 - Probe: Do you think that your individual definition of recovery is the same as your organization's definition? The same as most other service providers in [**county**]? (If no, probe on differences.)

4. Recovery and building a healthy life may involve a person's mental and physical health, their housing, their sense of purpose and community, and similar factors. What factors do you believe lead to recovery?
5. What services and supports have helped you maintain your own recovery journey?
 - Probe on useful policies or practices of organizations/agencies, affordability, etc.

Experiences of Program Participants

Now we'd like to focus on what you hear from the peers you serve in your program/organization.

6. In general, how would you describe the relationships and connections between organizations and service providers for people with mental health and substance use needs in your community? *[relates to relationships & connections]*
 - Probe on making a hand-off, providing resources, or even linkage to other resources
 - Probe on how people learn about different resources and organizations
 - Probe on quality of connections and communication
7. What are some of the challenges that the peers you serve have in identifying and accessing support they need?
 - Probe on particular groups of people (e.g. people of color, people coming out of incarceration, young adults, people with English as a second language, etc.) who experience these challenges more than others
 - Probe on how they do or do not support cultural, financial, spiritual, physiological and social needs
8. What recommendations do you have to address these challenges *[refer to responses from previous question]*?
9. To what extent are individuals working on their wellness and recovery included in creating, informing, or overseeing the supports and services around recovery within your organization? In this community? *[relates to power dynamics; practices]*
 - Please give me a few examples.
 - Probe on if and how program participants' own recovery and wellness goals are used as the basis of treatment or service plans
 - Probe on opportunities for shared decisionmaking, shared power, and shared authority
 - Probe on policies and practices in place
10. From your perspective as a peer support specialist, where are the biggest systemic barriers in the recovery journey for most people?
 - Probe on points at which the system is not making a hand-off, providing resources, or even linkage to things that cause people to stumble in reaching recovery

- Probe on ways in which system or administrative requirements lead to disconnects between the ways services and supports are made available
- Probe on if and how program participants' own recovery goals are used as the basis of treatment or service plans
- Probe on observations about the beliefs of those in power [legislators, administrators, key community stakeholders] about the ability of people to recover, where resources are directed, etc.

Observations and Insights

We'd like to hear some final observations and insights from your perspective as a peer support specialist.

11. How well-supported (funded) are services supporting recovery and wellness within [county]? *[relates to resource flow]*
 - Probe on how they believe their specific geographic area compares to other parts of Colorado
12. What are the biggest issues that impact your ability to serve people working on recovery and wellness?
 - Probe on social problems that groups of people working on wellness and recovery experience in the county
 - Probe on who are some of the groups of people whose behavioral health needs go unaddressed by the formal behavioral health system
13. What types of peer support services are provided by local service systems – both in your organization and elsewhere?
14. How well supported (funded) are peer support services and recovery-based services within the local systems of care?
 - Probe on how their specific geographic area compares to other parts of Colorado
15. What would you like to see done differently to support peers in their recovery journeys?
16. What can you tell us about successes related to recovery and wellness in this community?
17. What do you think is important for the public to know about recovery from mental health and substance use conditions?

That concludes our questions. Is there anything else you would like to share with us that you think would be important for us to understand about the experiences of individuals working on recovery and wellness?

Thank you very much for meeting with us today! We really appreciate your time!

Understanding the Experience of Coloradans in Recovery Oral Histories Participant Orientation

We are working with The Colorado Health Foundation to understand the experiences of Coloradans living with mental health and/or substance use conditions. As a part of this project, we are collecting oral histories, or life stories, from people who have dealt with mental health and/or substance use. We are interested in the story of your life experiences and the opportunities and challenges you experienced because of mental health or substance use. Your oral history will be confidential. The oral history will be audio recorded but will not be connected to your name.

Telling Your Own Personal Story

Each oral history recording will be about 45 minutes long and will use Zoom. There are three ways for you to give your recorded story.

1. We will give you a set of questions that will guide you through the opportunity to tell your own unique story.
2. You can ask a family member, friend, or someone else to ask you the questions that we provide and help guide you through your own story.
3. We can provide a research staff member who can ask you the questions to help you to tell your own story.

The questions that we will be asked for the oral history stories include:

- What has your experience been with behavioral health (mental health and/or substance use) conditions?
- What challenges have you needed to overcome?
- What services and supports (both formal and informal) have helped you get to where you are now?
- What does wellness look like to you?
- How has the current COVID pandemic impacted your well-being?
- What do you see as your next steps in your journey to well-being?
- What would you like people to understand about recovery from mental health or substance conditions?

We are interested in your unique story and experiences. We hope that you can discuss your own personal journey and the challenges and opportunities that you have faced along the way. This may include obstacles; how you overcame challenges; people that have been helpful; services that helped or did not work for you, and whatever else you feel is important. Because recording the time limit is 45 minutes, please be clear and try to tell your complete story by answering the questions provided.

If you have questions or need help getting ready for your oral history, please contact us by email at adultrecovery@westat.com or call our toll-free line at 1-855-968-2702. And, if at any time during your oral history recording you need to pause or stop, this is certainly allowed. Thank you for participating and we appreciate your willingness to share your story.

Appendix B

Screeners for Inclusion for Adults in Recovery Study

1. **Verify age:** Are you over the age of 18?
 - Yes → CONTINUE
 - No → THANK AND END

2. How did you hear about the study?

3. What is your County of residence?
 - Gunnison County → CONTINUE
 - Routt County → CONTINUE
 - Larimer County → CONTINUE
 - Alamosa County → CONTINUE
 - Summit County → CONTINUE
 - Prowers County → CONTINUE
 - Montezuma County → CONTINUE
 - Logan County → CONTINUE
 - Any other county not listed above → THANK AND END

4. Are you comfortable speaking in a group setting, individual setting, or both?
 - Individual Setting → CONTINUE
 - Group Setting → CONTINUE
 - Both → CONTINUE
 - No → THANK AND END

5. Do you identify with having a substance use and/or mental health condition?
 - Yes → CONTINUE
 - No → THANK AND END

6. Are you willing and able to speak about your personal experience with mental health and/or substance use conditions?
 - Yes → CONTINUE
 - No → THANK AND END

7. Do you currently have a behavioral health provider?
- Yes → CONTINUE
 - No → THANK AND END
8. What is your gender?
- Male
 - Female
 - I identify as: _____
9. Are you Hispanic or Latino(a)?
- Yes
 - No
 - Don't know
 - Prefer not to say
10. Which of the following describe your race (Select all that apply)?
- White
 - Black or African American
 - American Indian or Alaska Native
 - Asian
 - Native Hawaiian or other Pacific Islander
 - Other (specify): _____
 - Don't know
 - Prefer not to say
11. What is the total number of people living in your household your total household income?
- Total number of people in household: _____
 - Total household income, check box that applies:
 - Less than \$15,000
 - \$15,000 to \$24,999
 - \$25,000 to \$34,999
 - \$35,000 to \$49,999
 - \$50,000 to \$64,999
 - Above \$65,000.

12. Do you have any children who are 6 years old or younger?

Yes

No

How many? _____

13. What is your native language?

English

Spanish

Other, please specify: _____

Thank you so much for answering my questions. We will be contacting you if we would like to be part of the Adults in Recovery Study. Lastly, please let us know if you know anyone that would be interested in being part of the study.

Appendix C

How Did We Engage in Equitable Evaluation?

In the field of evaluation, there is a current need to shift the evaluation paradigm and to engage in evaluation practices that work towards advancing equity. To this end we must:

- Be intentional in uplifting the voices of people of color and those who have traditionally had less power and privilege;
- Seek to understand the social, cultural, and historical contextual factors that create systemic and structural barriers that limit opportunities to thrive;
- Engage in a participatory process that shares power in all phases of evaluation; and
- Discover actionable strategies and solutions that inform program improvements, decision-making, policy formation, and social change.

Using the Principles of Equitable Evaluation,¹ we reflect upon how the Adult Recovery in Colorado project engaged in applying these principles. Considerations of equity in the evaluation process were present from the beginning, and we were cognizant throughout of the tradeoffs we made as we attempted to work within the intent and budget of the project. This summary examines – for each principle – what choices we made, and what we could have done differently, in order to create an evaluative process that was in service of equity.

Evaluation Work Is in Service of and Contributes to Equity

Production, consumption, and management of evaluation and evaluative work should hold at its core a responsibility to advance progress towards equity.

What Did We Do?

The goal of this study was to understand the experiences of individuals with behavioral health conditions (both mental health and substance use) living in rural and frontier areas in Colorado, with a focus on individuals living on low-income. To that end, we **developed an approach grounded in behavioral health recovery principles and equity practices** that brings a systems perspective to examining how adults who are in recovery from mental health and/or substance use conditions are navigating their journey. Our **qualitative approach aimed to highlighted unique contexts, differential outcomes, and historical and structural drivers** within the system of recovery services and supports. We engaged with The Colorado Health Foundation and its stakeholders in a **collaborative approach that sought to allow individuals and communities** to shape and guide future efforts.

We **assembled a diverse research team** that combined behavioral health knowledge and equitable evaluation practices with the management and logistics skills needed to effectively execute the study requirements. With an explicit focus on diversity, equity, and inclusion, team

¹ Center for Evaluation Innovation, Institute for Foundation and Donor Learning, Dorothy A Johnson Center for Philanthropy, Luminare Group. (2017). Equitable evaluation framing paper. <https://www.equitableeval.org/framework>.

members included researchers and evaluators from historically underrepresented minority groups and people with lived experience of behavioral health recovery.

What Could We Have Done Differently?

Due to the COVID-19 pandemic, we had to modify our data collection methods from in-person to virtual. The move to a virtual platform may have created barriers to participation for low-income individuals who did not have access to high-speed internet or who relied solely on cellphones in rural areas where the connections may not be particularly good. Thus, we may have missed out on opportunities to hear from participants across the low-income spectrum. Additionally, due to Institutional Review Board (IRB) requirements, participants for the oral histories had to have access to behavioral health or primary care providers to ensure that they would have adequate support in case they experienced distress from discussing their mental health and substance use experiences. Therefore, the perspectives of individuals who may not have had behavioral health or primary care providers is missing from the analysis. Finally, the core team of researchers could have benefited from having someone who has lived experience of behavioral health challenges and is from one of the targeted communities as part of the research team.

Evaluative Work Should Be Designed and Implemented In a Way That Is Commensurate With the Values Underlying Equity Work

It should be multi-culturally valid and oriented toward participant ownership.

What Did We Do?

First, we **engaged in a collaborative process of shared power** with The Colorado Health Foundation and key community stakeholders (e.g., local behavioral health coalitions, providers of recovery services, law enforcement, work entry centers, advocates) to facilitate active, equitable participation throughout the evaluation process. This included working together to embed equity within the evaluation framework, evaluation processes, and reporting and dissemination. We **created a Community Advisory Board (CAB)** to serve in an advisory capacity so that they could provide their deep experience – lived, professional, etc. – to provide new insights and perspectives to influence our thinking and understanding in the study. CAB members provided input on the study design, data collection processes and tools, and participated on co-analysis of findings. The CAB was not engaged in determining the intent of the study, as that was chosen by The Colorado Health Foundation based on previous input from community about the need for more rigorous evidence about perspectives of people in recovery. CAB members were compensated for the time they spent preparing for and participating in a set of advisory and sense-making meetings.

Second, we attempted to **capture the experiences of diverse groups of people** (e.g., adults 18 or older with mental health and/or substance use conditions who are living on low income, people of color, adults with young children, people from different geographic regions – rural,

mountain, frontier) who are in recovery. Using qualitative methods such as interviews and oral histories, we **worked with community stakeholders** to identify appropriate participants who could share their experiences around what recovery looks like for them, the availability of services and supports that fit their social and cultural needs, and challenges to engaging in services and supports. Given that several of these counties had Spanish-speaking populations, we ensured that data collection tools and consents were available in both English and Spanish.

What Could We Have Done Differently?

Although we began this work with a race-conscious approach, we were not able to maintain that focus. The eight selected counties (Gunnison, Routt, Larimer, Alamosa, Summit, Prowers, Montezuma, and Logan) ranged from 48.2 percent - 89.5 percent White, with 6.5 percent - 18.9 percent of the residents at or below the Federal Poverty Level. Therefore, the majority of the people recruited to participate in the study were White individuals living on low incomes. Our efforts to outreach organizations that predominantly served communities of color were only successful in Alamosa County, which has a large Hispanic population. Consequently, we were not able to recruit a diverse enough sample to understand how race factors into people's experience of their recovery journey.

Additionally, we could have been more explicit on how we empowered community organizations/stakeholders at every stage of the process. For example, the CAB did not have members from the eight targeted counties represented. We could have been more intentional in doing "on the ground" work to identify key stakeholders in each of the counties. By empowering community members to be more invested in the process, we might have had more opportunities to outreach more diverse individuals who embody the various experiences of adults in recovery (e.g., from diverse backgrounds, speak a primary language other than English, or are from a group that has historically had less power or privilege).

Evaluative Work Can and Should Answer Critical Questions

Effect of a strategy on different populations and on the underlying systemic drivers of inequity, and the ways in which history and cultural context are tangled up in the structural conditions and the change initiative itself.

What Did We Do?

In this study, we **applied a systems perspective to understanding the dynamics of how services and supports are structured and functioning** to support recovery. We created research questions that aimed to map the behavioral health system and identify root causes of inequities in the context of behavioral health recovery. Moreover, we **engaged in a collaborative data interpretation** process with CAB members and representatives from the communities to increase support for the findings and create more robust stakeholder participation, which aimed to result in more meaningful and useful findings. We were attentive to how patterns emerged from the data that highlight the different pathways that define how people navigate behavioral health systems and recovery supports, as well as how they would prefer to navigate systems

and supports. We examined how experiences reinforce each other (or not), what the processes of change and resiliency building are, and how these factors combine to create or influence systems change. As we engaged in the analysis process, we remained sensitive to the types of structural dynamics and complexities that influence (either positively or negatively) the inequities that exist in the behavioral health system. Based on our analysis, we produced a summary report that highlighted common challenges and emerging best practices and emphasized how different services and supports contributed to changes in system conditions and behavior.

What Could We Have Done Differently?

We created a process that aimed to understand the inequities that exist as part of the recovery journey and framed questions to identify racial inequities. However, respondents were unable to fully respond to those questions or to discuss structural and system barriers that lead to disproportionate opportunities for people of color or historically marginalized groups. If we had been able to engage more participants of color, we might have been able to uncover more information on how historical and cultural context influences systemic drivers of inequities.

Furthermore, with more time and resources, we might have been able to engage in practices such as systems mapping and power mapping with CAB and community members to really understand the systemic drivers of inequity. The power map would have allowed us to uncover who holds the power that influences policies and outcomes, who was engaged and empowered in the decision-making process, and who was missing. A systems map would have allowed us to outline the boundaries of the behavioral health system of formal and informal supports to better understand the nonclinical services and supports that are important to the recovery journey.

Appendix D

Key Definitions of Terms Used in This Report

Oral history

For the purpose of this study, oral history refers to an audio recorded account of participants' personal experiences and recollections related to their recovery from mental health and/or substance use conditions.

Peer support

Peer support is a form of shared interaction in which participants seek to use their personal experience to both help others and gain additional reinforcement for their own life circumstances. Peer support occurs in both individual and group settings. Usually, participants are not paid to participate in this process.

Peer Specialist

A Peer Specialist, sometimes referred to as a peer support specialist, peer coach, or peer support provider, is an individual in recovery from a behavioral health condition(s) who provides peer support services to individuals seeking to achieve and/or maintain their recovery from those conditions. For the purposes of this study, the term "Peer Specialist" is used to describe this role.

Person with lived experience

Within the behavioral health field, this term is used to refer to someone who has experienced a mental health and/or substance use condition firsthand. In addition to "person with lived experience," we also use the terms "recovering individuals," "recovering adults," and occasionally "consumers" to indicate that a person has experience with a behavioral health condition.

Provider

Providers are professionally trained individuals who offer health care services to patients or clients. This includes doctors, nurses, social workers, psychologists, case managers, and others. Providers are generally paid for their services.

Recovery

Recovery means different things to different people. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Most participants in this study saw recovery as a journey rather than a destination, and a process filled with ups and downs that is moving them closer to the lives they want to live.