

The Project

Between 2019 and 2021, Westat and The Colorado Health Foundation (CHF) partnered on a study which sought to understand how individuals living in rural and frontier communities in Colorado experienced their personal recovery journeys.¹ The purpose of this study was to add to the evidence base in Colorado about how individuals living on low incomes in rural and frontier areas are experiencing recovery, and how those systems and supports could be improved to better support people on their recovery journey. This work used the Substance Abuse and Mental Health Services Administration’s (SAMHSA) 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” (SAMHSA, 2012), along with SAMHSA’s four key pillars of recovery: Health, Home, Purpose, and Community.

How Did the Evaluation Reflect Principles of Equity?

From the RFQ stage of the project, CHF incorporated a commitment to center issues of equity in both the process and outcomes of the study. The Westat team stepped into this work with that in mind, and with a recognition by both organizations of the need to shift evaluation practice and paradigms in a way that advances equity. Some considerations included:

- Being intentional in uplifting the voices of people of color and those who have traditionally had less power and privilege;
- Seeking to understand the social, cultural, and historical contextual factors that create systemic and structural barriers that limit opportunities to thrive;
- Engaging in participatory processes that share power in all phases of evaluation; and
- Discovering actionable strategies and solutions that inform program improvements, decision-making, policy formation, and social change.

The [Equitable Evaluation Initiative](#) provided a springboard for thinking about equity in this work. Using their [Equitable Evaluation Framework™](#), we reflect below upon what choices

¹ Westat. (2021). Perspectives on adult recovery in rural and frontier Colorado: A look at lived experiences, practices, and systems. Prepared for The Colorado Health Foundation by Westat. The Colorado Health Foundation.
<https://coloradohealth.org/reports/perspectives-adult-recovery-rural-and-frontier-colorado-look-lived-experiences-practices>

we made, and what we could have done differently as we tried to apply these principles to this project.

Principle #1: Evaluation and evaluative work should be in service of 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?

To start, equity was considered by CHF when they crafted the study's overarching research questions:

- **What were the recovery experiences of individuals living on low incomes in the state?** This question was designed to deliberately center the lived experience of people in recovery – reflecting that those who use systems of recovery are experts, and that they will have the most insight into what they need, how existing services work, and what needs to change.
- **How effectively do existing systems of recovery supports work in these communities?** This question was rooted in the concept that inequities are reinforced by practices, policies, etc. that are built into the ways that systems function. In order to disrupt inequity, it's critical to uncover the dynamics of systems that are creating and perpetuating those inequities. By incorporating a systems frame, our intent was to better illuminate the dynamics at play in a way that could suggest solutions or actions to improve supports for people in recovery and create more equitable practices and outcomes.

As we designed this project, we considered how to incorporate principles of equity. A few of these ways included:

- **Methods.** Our data collection was grounded in a qualitative approach which aimed to highlight unique contexts, differential outcomes, and historical and structural drivers within the system of recovery services and supports. Our initial approach was grounded in interviews and focus groups, but the COVID-19 pandemic caused a shift to virtual data collection, and provided an opportunity for us to consider more deeply how to approach people on a more 'human' level. This led us to shift towards a storytelling approach that relied on oral histories.
- **Collaboration and Engagement.** CHF and Westat attempted to engage with each other as partners in the work – each bringing ideas and perspectives – rather than a traditional "vendor-funder" relationship where the funder simply requests the deliverable and checks in occasionally on progress and budget. Additional funds

were allocated to support greater depth of engagement between the teams. The study was also structured to engage people in recovery, providers, and leaders in the recovery community in the work (described in detail below).

- **Team.** Westat 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. With an explicit focus on diversity, equity, and inclusion, team members included researchers and evaluators from historically under-represented minority groups and people with lived experience of behavioral health recovery.

What Could We Have Done Differently?

One overarching challenge was difficulty of exploring recovery journeys during a pandemic. Recovery is a deeply personal life experience. There were two main issues we encountered. Given the focus of the study was on individuals living on low incomes, the shift towards virtual data collection could potentially have created barriers to participation for those who did not have access to high-speed internet or who relied solely on cell phones in rural areas where the connections may not be particularly good. We created multiple avenues for people to participate in oral histories, but our reliance on virtual technologies may have caused us to miss hearing from certain groups of people. Second, virtual interviews were the only source of information for the study and not everyone is comfortable with that format. There are other important avenues for people to describe their recovery journeys (e.g., writing, artwork, performances and other means of creative expression, etc). Having a chance to engage participants in this way could have not only engaged different individuals but may also have broadened what they shared (as many participants focused on only more formal interactions and traditional clinical services).

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 behavioral health experiences. This meant the perspectives of individuals who did not have connections with, or access to these providers, is missing from the study.

Principle #2: Evaluative Work Should Be Designed and Implemented Commensurate With the Values Underlying Equity Work: Multi-Culturally Valid and Oriented Toward Participant Ownership.

What Did We Do?

One approach we used was designing a collaborative process designed to share power between CHF 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

collectively to think about how 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 in co-analysis of findings. The CAB was not engaged in determining the intent of the study, as that was chosen by CHF 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. As data collection began, we saw an opportunity to add community members and providers into sense-making and interpretation of the findings, and created opportunities for this to happen within the existing budget.

We also structured the data collection to capture the experiences of diverse groups of people who are in recovery (e.g., adults 18 or older with mental health and/or substance use conditions who are living on low incomes, people of color, adults with young children, people from different geographic regions – rural, mountain, frontier). 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 significant 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 and the intention to gain some understanding of how race was impacting recovery experiences, we were not able to maintain that focus. The eight counties selected for this project 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. Despite extensive efforts to outreach organizations that predominantly served communities of color, this was only successful in one of the counties with a large Hispanic population. The result was that the majority of the people recruited to participate in the study ended up being White individuals living on low incomes. Consequently, we were not able to recruit a diverse enough sample to understand how race factors into people's experience of their recovery journeys and had a limited understanding of the perspectives of people of color about the recovery system.

Additionally, we could have been more explicit from the beginning about how we engaged community organizations and stakeholders at every stage of the process. The CAB was formed early on before other decisions had been made, and the membership skewed towards people from more urban areas who sat in formal positions of power in recovery organizations. It was only later in the process that we added sense-making groups reflecting individuals from the eight counties where data collection was taking place. We could have

been more intentional in doing on the ground work to identify key stakeholders in each of the counties and including them in the process earlier and more deeply, which could also have helped ensure we had more diverse perspectives that reflected 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).

Because of the COVID-19 pandemic, rather than on-site recruitment and participant engagement we had to shift to virtual methods, and relied heavily on organizations delivering traditional clinical services to help us recruit participants. This limited our capacity for on-the-ground networking, and may have led to over-sampling of those who sought traditional behavioral health services to aid in their recovery. Additionally, we tried to recruit interviewees through less traditional organizations such as AA and other self-help groups, fitness and outdoor activities groups, among others with less success. We also did a fair amount of outreach to churches (often places where people struggling with behavioral health conditions seek support), but these were “cold calls” that may not have been received in a timely manner during the pandemic – or were not responded to, because we lacked relationships and trust with these community organization around what is often a sensitive or stigmatized topic.

Despite our attempts to use more common language in the study, we encountered several unexpected issues. We found that the term “equity” means different things to different people. In the context of this study, most people interpreted the term mostly to mean racial/ethnic equity. In the areas of Colorado that were studied it was easy for people to say, “We don’t have much [racial/ethnic] diversity here” and then consider the topic closed, despite our attempts to probe further. This complicated our desire to address the full continuum of equity issues relative to adult recovery. In addition, we found that people with substance use history were much more receptive to the term recovery than those with mental health conditions. And, talking about “recovery” may have led people to immediately jump to talking about more traditional treatment services rather than the more general concept of ‘supports’ that we were seeking to understand.

Principle #3: Evaluative Work Can and Should Answer Critical Questions about the: ways in which the historical and structural decisions have contributed to the condition to be addressed; effect of a strategy on different populations and on the underlying systemic drivers of inequity; and the ways in which cultural context is 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 developed a model to consider the key issues of recovery and equity, and how these are impacted by systematic structural inequities, biases, socio-economic and political drivers. We created

research questions that aimed to map the behavioral health system and identify dynamics that cause inequities in the context of behavioral health recovery. We interviewed providers of recovery support services in each of the counties where we were collecting stories from those in recovery, with the idea that this would help us 'see' and interpret the system from the perspectives of both those using the system and those providing services.

We engaged in a collaborative data interpretation process with CAB members and representatives from the communities to increase validity of our interpretations, with the goal of creating more accurate, 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.

What Could We Have Done Differently?

We had to trade-off between the budget and time available and the degree of engagement of the CAB and community members in sense-making and interpretation. The implication was that we had less deep and broad opportunities for engagement in sense-making than we would have liked. It also meant that the sessions were more 'input' focused rather than allowing us to engage in really deep practices such as systems or power mapping. 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.

Systems and organizational change are always difficult and challenging. During individual participant interviews, it can be easier to consider how practices and relationships might be addressed, while changing systems and policies can be seen as daunting and/or out of the purview of individuals. These topics proved more difficult to assess, and difficult to engage participants in a virtual format. We observed some findings that supported the need of better service and support connections across geographic boundaries. Perhaps on-site engagement and group interviews might have helped us more fully engage in conversations about systems, better understand opportunities to build connections, and support system changes within the existing structures. An example might be the coordination of services and supports systems that could be developed within the study area and beyond.