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Evaluation of Recovery Learning Communities (RLCs): Summary Report

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Acknowledgements

This study was requested by the Massachusetts Department of Mental Health and MassHealth Behavioral Health Programs as part of their efforts to better understand how the newly funded Recovery Learning Communities (RLCs) are working. We appreciate the guidance of Suzanne Fields, Lucille Traina, and John DeLuca in shaping the goals of this evaluation.

We also appreciate the willingness of the RLCs to work collaboratively with CHPR on this evaluation and for taking the time to meet with us and organize site visits. Their openness to this evaluation and responsiveness to our requests was vital to the success of this evaluation.

It is our goal that this evaluation will provide useful information to the Department of Mental Health, MassHealth and the RLCs, and that it will serve to inform continuous quality improvement efforts at the RLCs.

Section 1: Background and Significance

Peer support for people with similar life experiences has emerged as an important strategy for helping people move through difficult situations.¹ One benefit of peer support is that people with similar experiences can generally better relate to one another and offer more authentic empathy and validation. Another benefit is that people with similar lived experiences can offer each other practical advice and suggestions for strategies that professionals may not offer or be familiar with. Peer support in mental health grew from the recognition of the benefits of shared life experience (living with a mental health condition), as well as from the benefits of peer-to-peer exchange regarding mental health treatment and recovery experiences. This movement in mental health was also shaped by the independent living movement among people with physical disabilities, which focuses on consumer centered decision making.²

The Massachusetts Department of Mental Health (DMH) has increasingly emphasized the importance of peer-to-peer support for helping persons with serious mental illness in their recovery process. Illustrating the value DMH places on peer support, in the recently issued Request for Information for Community-based Flexible Supports, the Department expressed intention to “have peer and family support services available in all DMH funded, operated and licensed services”. Nevertheless, one of the challenges to providing this peer-to-peer support statewide is the limited existing infrastructure to coordinate and ensure that peer support is provided effectively.

To build the infrastructure for peer-to-peer support for individuals with serious mental illness, DMH has funded Recovery Learning Communities (RLCs) in the Western, Metro Suburban, and Central DMH service areas. These RLCs were competitively procured in the Spring of 2007 and began operations during Summer 2007.³ Under the current procurement, these RLCs will be funded until 2011. Regionally located, these peer-operated “hubs” coordinate peer-run peer support, education, advocacy and other regional peer-run activities. By supporting and strengthening a regional peer-run network, DMH aims to promote a system that is increasingly consumer driven, where peers are more fully integrated into their community.

¹ There is a considerable body of literature on peer support in general and peer support in mental health. The brief summary provided in this paragraph draws from a literature review by S. Mead and C. McNeil, *Peer Support: What Makes it Unique?* <http://www.mentalhealthpeers.com/booksarticles.html>

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³ Since then, DMH has funded RLCs in the Southeast, Metro Boston and Northeast regions. This evaluation only examines the three originally funded.

Evaluation of Recovery Learning Communities (RLCs)

The goal of the RLCs⁴ is to provide mental health consumers with improved access to peer-run services that promote recovery. The objectives of the RLCs are to serve as hubs in their respective DMH regions to:

- 1) Provide consumers with and/or refer consumers to a wide range of peer support,
- 2) Support the providers of peer support through training, continuing education and consultation, and
- 3) Link together consumer operated services and support to create a network to facilitate communications, deliver services and coordinate advocacy.

Each RLC employs peers⁵ to perform a range of recovery promoting activities, such as offering peer support both to groups or individuals one-to-one, providing information on and referrals to various benefits and resources related to recovery, developing and operating warm lines or supporting existing warm lines, and assisting people to develop Wellness Recovery Action Plans (WRAP). RLC staff also work with mental health providers in their regions to increase awareness of and promote recovery oriented practices.

As a unique program model in the state's mental health delivery system, the implementation and operation of this first phase of RLCs provides DMH an opportunity to assess the successes, challenges, and lessons learned regarding the model. As such, DMH asked the Center for Health Policy and Research (CHPR) to evaluate the first three RLCs to help inform DMH and other stakeholders on opportunities to enhance, replicate and expand these types of peer-run initiatives. An RLC Program Diagram can be seen in Attachment A.

Section 2: Evaluation Objectives and Questions

The aims of the evaluation were a) to explore the development and implementation of the RLCs in the Western, Metro Suburban, and Central DMH service areas, and b) to assess whether the three RLCs are achieving the program goal of improving access to regional peer support and the program objectives that aim to foster ties to the community for the people with mental illness that they serve.

CHPR staff met with the DMH Central Office staff, the Community Services Directors of each DMH region (RLC Steering Committee) and staff at the three RLCs to discuss the evaluation and questions of interest. Development of the evaluation questions was guided by the RLC contract requirements and DMH's interest in knowing how the RLCs provide peer support and connect people to the community.

⁴ The RLC goal and objectives are abstracted from the RLC Request for Responses issued by DMH on 12/26/06

⁵ The term "peer" is used throughout this report to refer to people with lived mental health experience.

Evaluation of Recovery Learning Communities (RLCs)

The evaluation questions were organized using an accepted program evaluation approach of assessing the structure, process and outcomes of each RLC. Given the start up nature of the RLCs, the evaluation questions focused on exploring the processes of developing and implementing the RLCs during their first year of operation, with a lesser focus on outcomes that have resulted from their work. In addition, outcome questions focus primarily on process outcomes rather than client specific outcomes. The evaluation questions are:

Structure

1. What is the structure of each RLC?
 - What is the staffing model?
 - What agency affiliations exist, if any?
 - How do the RLCs meet the definition of a consumer-operated entity?

Process

2. How are the RLCs providing peer support?
 - What services are available?
 - Who is providing services?
 - Who is accessing services?
 - Are the availability and quantity of RLC services meeting consumer demand?
3. How are the RLCs providing training and education?
 - What topics do the RLCs provide training and education on?
 - What resources exist to provide training and education?
 - Who is the target audience for training and education initiatives?

Outcomes

4. How are the RLCs promoting community integration?
 - How do RLCs work with other health and human services agencies in their regions?
 - How do RLCs work with existing consumer-operated programs and activities in their regions?
 - How do RLCs connect their service users to the community?
5. What is the capacity of the RLC to fulfill their contractual requirements?
6. What are the lessons learned from RLC implementation and start up?

Section 3: Methods

We employed a participatory approach to this evaluation and engaged both DMH and the RLCs early on to solicit their feedback on strategies for evaluating the RLCs. To ensure that multiple perspectives were taken into consideration when reporting on findings, a range of data collection methods and sources were used. This section discusses a) data sources, b) analysis methods and c) report organization.

A. Data Sources

Internal RLC Documents

After finalizing the evaluation scope of work, we developed a Request for Information (RFI), which sought documents from the RLCs that they use internally, distribute to people who come to the RLC, and post in the community. For more information on the type of information that we requested, please see [Attachment B](#).

We conducted an initial site visit to each of the RLCs to present the RFI and answer any questions. During this visit, we also explained the overall evaluation and how primary data would be collected. Jointly with the RLC, we determined the best way to collect the necessary data and worked out a schedule of future site visits for the purpose of primary information collection (interviews, focus groups and observation).

All RLCs were very thorough and timely in their responses to the RFI. We reviewed the documentation each RLC submitted prior to conducting subsequent site visits in order to have a better understanding of how each RLC operates and to ask clarifying questions.

Site Visits

1) Interviews

Interviews were a key component of the data collection efforts of this project. We developed interview question guides for RLC staff, parent organization staff, guiding council members, and DMH contract monitors (see [Attachment C](#) for interview guides). All of the question guides were structured to gather information that would help answer the evaluation questions; however, each guide differed to capture the different role of each of the four respondent groups.

Two CHPR staff conducted the majority of the interviews, allowing for one person to lead the interview and the other person to take detailed notes; interviews were not taped. Verbal consent was secured before each interview began and participants were assured of confidentiality. Each interview took about one hour. Table 1 summarizes the types and numbers of interviews completed.

Table 1: Interview Data Collection

	Interviews Completed			
	Western	Metro	Central	Total
RLC Staff	6	3	3	12
Guiding Council Members	2	2	2	6
Parent Organization ^a	1	1	1	3
DMH Contract Monitors	1	1	1	3
Total	10	7	7	24

^a The same parent organization runs the Metro and Central RLC and only one interview was conducted that provided information on both RLCs.

2) Focus Groups

One focus group was conducted at each RLC with people who had participated in some aspect of the RLC activities. We developed a focus group question guide to seek feedback from these individuals about how they used the RLC, what they liked about their experience and what else they would like from the RLC (see [Attachment D](#)).

We provided each RLC with guidelines on how to recruit people for the focus group with the goal of including a cross-section of service users by age, gender, and type of participation in the RLC.⁶ A total of 32 people participated in the focus groups; 11 for the Western, 12 for the Metro and 9 for Central. Two CHPR staff attended each focus group - one person facilitated the discussion and the other took detailed notes. The focus groups were not taped. Verbal consent was secured before each focus group began and participants were assured of confidentiality. CHPR provided a stipend and refreshments for the participants.

3) Observation

In addition to conducting interviews with RLC staff during our site visits, we also had the opportunity to observe each RLC in action by participating in RLC programs/ activities, speaking with people who stopped by the RLC, and observing the daily routine of the RLC. These participant observations provided an important source of information on the RLC operations.

B. Analysis

During analysis, we took into consideration all data sources and the varying perspectives of interview and focus group respondents. We abstracted pertinent information from the documents provided by the RLCs, and typed the notes from the interviews, focus groups and observations. To support effective identification and analysis of themes captured in

⁶ Although the focus groups were fairly well balanced by age and gender, the range of RLC activities in which people had participated differed somewhat among the focus groups.

the interviews and focus groups, we utilized the qualitative data analysis software – Atlas-ti as a tool.

In order to answer the evaluation questions of interest, we analyzed the data collected from each RLC separately while using the following consistent framework of domains and domain elements:

- 1) *Structure*: Staffing, location, mission, defining principles and the role of the Guiding Council and Parent Organization.
- 2) *Process*: RLC methods/approach to providing peer support and training/education activities. As there was considerable overlap in responses for questions on peer support and training/education activities the two elements were combined for analysis.
- 3) *Outcomes*: As qualitatively described, RLC methods/approach for achieving community integration, the ways that peers have benefitted from the RLC, and potential areas of improvement for the RLC. (Of note, the RLCs collect and report quantitative data on outputs/outcomes to DMH monthly and hence these are not presented in this report. Attachment E lists these data elements by RLC.)
- 4) *Discussion*: As synthesized from the other domains, opportunities for improvement and general RLC fulfillment of DMH contractual requirements as specified in Section 3 of the RFR 2007-8210-RLC-01 (Attachment F). Since the focus of this evaluation was not on contract compliance, compliance with each of the RFR requirements was not assessed. Instead, our focus was on examples of contractual requirements the RLCs are meeting successfully and those that are challenging.

C. Organization of results

In the overall evaluation and final report, evaluation results are synthesized into three case studies. We chose this approach because, during data collection and analysis, it became evident that each RLC was at a different stage of development and to present findings collectively would not adequately demonstrate the individual nature of each RLC. By presenting the evaluation results in three distinct case studies in the full final report, the unique characteristics of each RLC and the factors contributing to their development are explored in more depth.

In this Summary Report, we only present findings that cut across each RLC. Section 4 of this report, Discussion of Findings Across RLCs, weaves the results from the three RLCs together in a discussion of similarities and differences among the RLCs, lessons learned, and opportunities for RLCs as a group.

We use quotes in this report to illustrate a particular point and these are presented in *italics*. Each interviewee/focus group respondent was assured of confidentiality and therefore quotes are not tied to specific individuals, but may be tied to a generic group

(e.g. focus group participant or RLC staff member) *except* in cases where a respondent could be easily identified.

Section 4: Discussion of Findings Across RLCs

This section weaves together evaluation findings from the three RLCs. The intent of this section is to provide cross-cutting themes that are relevant to each RLC and that can serve to inform the future development of the original and new RLCs. As with previous sections, themes will be presented using the structure, process, outcomes framework. But first, some literature findings on implementation stages are presented.

The University of South Florida's National Implementation Research Network (NIRM), in its *Implementation Research: A Synthesis of the Literature*⁷ provides a relevant framework for the stages of program planning, implementation and operation, which helps assess the stage of implementation of the RLCs; reasonable expectations for their structure, processes and outcomes; and expectations for their next steps:

- 1) Exploration and Adoption
A decision is made to proceed with implementing a program. Planning takes place to facilitate the installation and initial implementation of the program.
- 2) Program Installation
Resources and structural supports are put in place, staff is being hired, and policies and procedures are developed.
- 3) Initial Implementation
The program begins, staff faces a new way of doing things, and confidence in the decision to adopt the program is tested.
- 4) Full Operation
The program becomes fully operational with full staffing complements and the anticipated full level of client caseload. The community has adapted to the presence of the new program and benefits are being realized.
- 5) Innovation
Opportunities to refine and expand the program and practices are identified.
- 6) Sustainability
The program is able to retain its functional components through staffing, political and funding changes.

⁷ Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M. & Wallace, F. (2005). *Implementation Research: A Synthesis of the Literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

Currently, the RLCs are either in the “initial implementation” or “full operation” stage, although strengthening of policies and procedures is required for at least one RLC, which is associated with the program installation stage. Of note, the RLCs remained clearly in the Program Installation stage for considerably different periods of time which has resulted in their current differences in operational capacity. These differences are important to keep in mind when comparing successes and challenges among the three RLCs, as it is unrealistic to expect an RLC in the initial implementation stage to be achieving the same results of an RLC that is in full operation. Factors that contribute to a shorter Program Installation stage include stable program staff, strong leadership, and an existing network of peer run programs within the region that are already connected.

The implementation literature also suggests that “outcome evaluation should not be attempted until well after quality and participation have been maximized and documented in a process evaluation. Although outcomes data can determine the effectiveness of a program, process data determines whether a program exists in the first place.” This evaluation’s focus on RLC’s processes was in alignment with this recommendation, although the evaluation did make the step to qualitatively assess the RLC’s progress towards achieving community integration, which is one of the program’s core goals. In the near future, we recommend identification of quantitative indicators of RLC outcomes that can be feasibly collected and analyzed to continue to explore their effectiveness.

Structure

The importance of staffing to program stability

As noted, each RLC has developed at a different pace, which seems strongly associated with how stable the staff has been at the RLC. Those with more staff turnover remain at the initial implementation stage. Without a stable staff in place, it is difficult to plan and operate programs and activities. Staff stability relates directly to an RLC’s ability to offer a range of supports and activities and to connect to the community in a meaningful way. Finding qualified staff with lived experience of recovery should include other meaningful criteria for candidate selection. Being someone with lived mental health experience is key but we suggest other criteria in hiring, including prior work experience for certain roles, particularly the RLC program coordinator.

The use of mentors/coaches for program staff in the early stages of start up may facilitate a smoother transition into full program operations. Having an experienced and trusted mentor/coach available could help develop leadership skills among all staff.

Role of the Guiding Council

The Guiding Council has potential as a core source of support and guidance for the RLCs, and for serving an important purpose to help connect the RLC with other community entities. To more completely fulfill this potential, we recommend clarification of the roles and responsibilities for Guiding Council members, and the Council’s

relationship with the RLCs, is recommended. For example, the RLCs might consider the benefits and drawbacks of expanding Guiding Council membership to non-peers to bring additional diversity and perspectives to the table. With the exception of one person, all Guiding Council members across the three RLCs are peers.

Another area where clarification is recommended is whether the Guiding Council is a decision making body (as it is for some RLCs) or an advisory group (as it is for others). Finally, clarification of the role of RLC staff in relationship to the Guiding Council could be beneficial, as for some the RLC staff are intimately involved in the work of the Guiding Council, but this is not so across the board.

Process

Running programs and activities

Each RLC has a different approach to who runs their programs and activities. For some, it's mostly staff. For others, it's a mix of staff, stipended workers, volunteers, and/or consultants. All RLCs offer facilitator training, but not all require it for people to run groups. Additionally, some RLCs promote co-facilitation of most of their groups while others do not.

We conclude that it would be beneficial for all people running programs and activities to participate in a common training designed and conducted by RLC staff and to receive regular support from one another in a peer worker support group. Additionally, we suggest that the use of co-facilitation should be considered more widely, especially for larger groups and those that deal with sensitive topics. Co-facilitation reduces the burden on one person running the group and allows for the other facilitator to address individual concerns that may arise.

One of the benefits of having non-staff members run the groups is to provide peers an opportunity to develop facilitation skills in a safe environment. The opportunity for someone to initiate an idea for a group, volunteer to run this group, receive support from staff, and potentially become a stipended worker or consultant is a valuable path that can build confidence and even employment readiness.

The RLCs each have a different approach to providing peer support. Some are focused on offering traditional peer support groups, while others offer a mix of social and wellness activities. Focus group participants appreciated having both formal peer support as well as social activities where peer support can happen informally.

Some DMH requirements are readily met while others are more of a challenge

In DMH's RFR for the RLCs, several specifications for RLCs were delineated. Some of these specifications, such as providing recovery oriented services, being peer run and operated, establishing a Resource Connection Center and providing peer support, have been met by all the RLCs.

Evaluation of Recovery Learning Communities (RLCs)

The RLCs have not met the requirement to provide support and continuing education for peer specialists in their region. While most of the RLCs operate a peer worker support group, this is mostly focused on the peer workers who work directly with the RLC. As more peer specialists are trained across the state, it would be beneficial to have the RLC serve as a central support and education mechanism for these workers.

RLCs are also having challenges with providing or supporting existing peer operated warm lines. In some RLC regions, warm lines already exist and the RLC should assess their capacity and better communicate the availability of this resource to the community. In regions where warm lines do not exist, we recommend that the RLC work on developing this resource.

Different perceptions between RLCs and DMH on Implementation

There have been important discussions between the RLCs and their DMH contract manager on several issues.

Systems Advocacy – Many peer run organization see systems level advocacy as part of their role, including the RLCs. DMH’s RFR also stated that “RLC programs must partner with other DMH vendors and social services providers...to advocate for, develop and implement recovery oriented policies and practices.” Nevertheless, in the interviews with some DMH contract managers, we perceived some resistance to having the RLCs spend time on this activity. They felt that the focus of the RLCs should be service provision; consequently, the RLCs are doing little systems level advocacy work.

Location – Initially, some RLCs did not want a physical location at which they would provide services. Their early vision was that the RLCs would be out in the community making important connections and that a physical space would be unnecessary. DMH, however, insisted that each RLC have a physical location. Now, a welcoming and inviting space is seen by all as a valuable feature of an RLC. According to several respondents, a welcoming location gives peers in the community a chance to get to know what the RLC is about, build positive relationships with others, and to try different programs and activities once they feel secure with the RLC. Focus group participants also commented on the importance of having a nice place to come to. When space is less than desirable, peers feel frustrated that a more inviting space is not available.

Time for Start Up – All of the RLCs commented on the amount of time that it takes to develop a new program model. Some did not feel ready to “open” at the time required by DMH. Some RLCs wished for more start up time to conduct more community outreach and to develop a better sense of the types of program and activities that were needed. On the other hand, DMH was often concerned by the amount of time some RLCs took on start up activities and felt that services and programming needed to be in place faster.

Outcome

A focus on community integration is key to the success of the RLC

Many interviewees were asked to define community integration. The majority of responses centered on getting outside of a mental health identity, contributing to non-mental health communities and getting a better sense of one's complete self, not just the part related to mental illness. From this perspective, the RLCs are best able to promote community integration when they partner with other community groups, such as other human service providers, peer groups, wellness groups, churches, artist groups and the like. These partnerships increase the network of resources to which the RLCs can help connect peers.

The fact that the RLCs have no clinical eligibility requirements for participation in activities results in attracting a broader community of individuals. This includes those with backgrounds of domestic violence, other trauma, substance abuse, and some who don't identify at all with any lived experience at all. Having a broad range of people connected with the RLCs helps mental health consumers interact with others with many different identities in the broader community and contributes towards larger community integration for peers.

Different views on how providers are perceiving the RLCs

There is not a clear consensus on how other mental health providers perceive the RLC. Some interviewees indicated how pleased they've been with the support and enthusiasm from traditional providers. Others note how difficult it has been to make connections with provider agencies. Still others indicated that providers harbor resentment towards them feeling that DMH has given money to "soft services" while traditional providers struggle to provide mandated services.

Regardless of the view, it is clear that the RLCs could increase training of traditional providers about recovery oriented practices and peer centered services. As stated in the RFR "RLC programs must provide consultation and training to local community service providers and DMH on the consumer perspective and on recovery oriented practices". The RLCs may need additional support from DMH to engage providers and improve their receptiveness of this work.

Peers are enthusiastic about the RLCs

In the focus groups, peers cited several different ways that they have benefitted from the RLC. They all see the RLC as a promoter of hope, recovery, and wellness. Being able to receive support from fellow peers is invaluable and is different from the support they receive from traditional providers. The RLC is in a unique position to be able to connect with people who may not need or would not be open to accessing traditional DMH services.

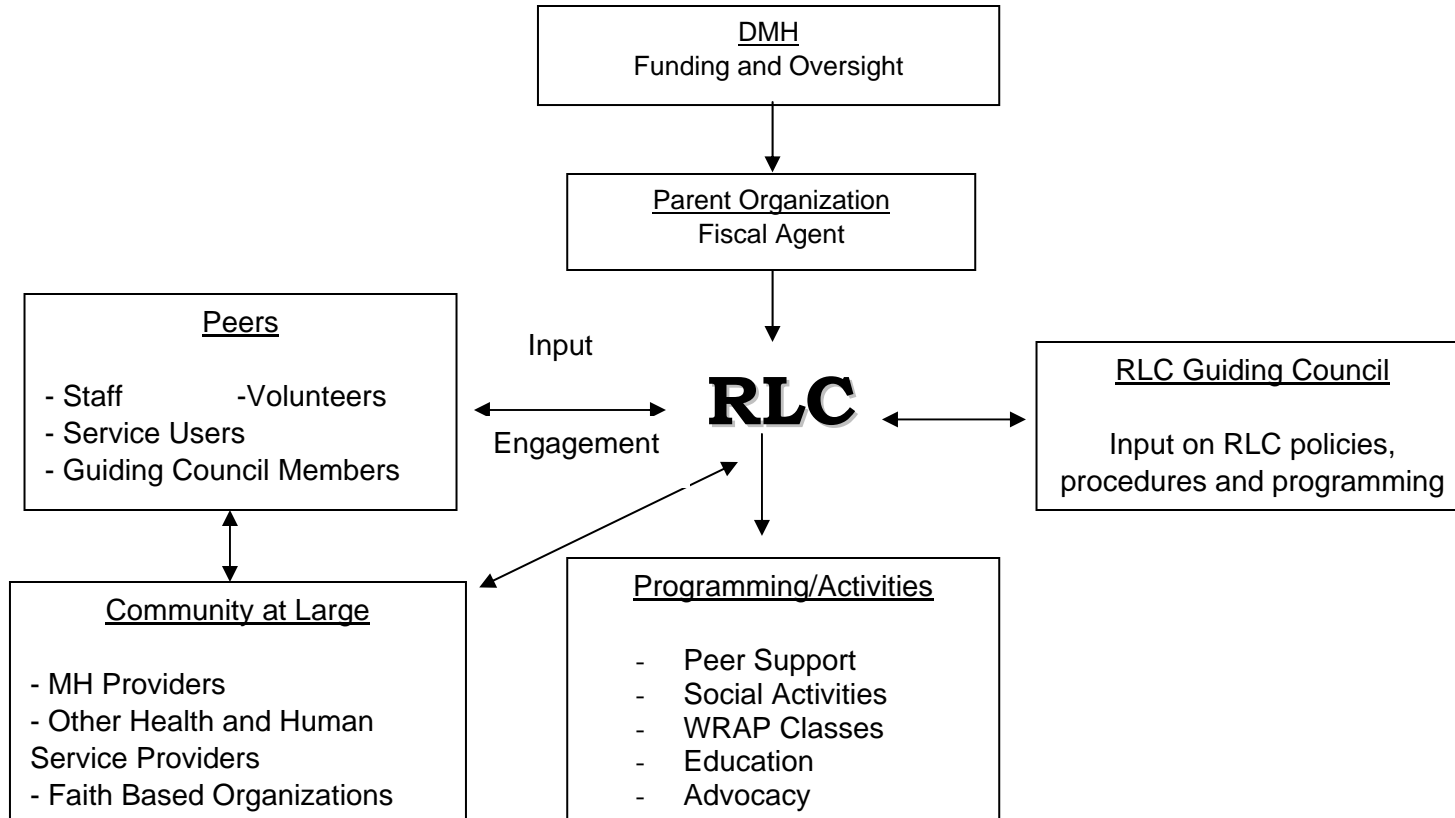
The RLCs are serving a unique and important role in transforming the community mental health system

As promoted in the President's New Freedom Commission's report *Achieving the Promise: Transforming Mental Health Care in America*, attention is needed to build infrastructure to strengthen peer-directed programs and promote a recovery orientation within the mental health service system. A lack of integration and weak infrastructure has diluted the overall power of consumer voices to transform the system and make recovery a reality. The RLCs are helping to develop this infrastructure and serve as an important mechanism for promoting these principles. With continued support from DMH and other state agencies, the RLCs will continue and strengthen their ability to serve peers in a unique and valuable way.

Attachment A
RLC Program Model Diagram

Context: Recovery Learning Communities (RLCs) are peer run programs that coordinate and provide peer-run peer support, education, advocacy and other regional peer-run activities

Goal: RLCs provide mental health consumers with improved access to peer-run services to promote recovery and community integration



Outcomes: Individual Level: Increase in community integration; Increase in feelings of hope and resiliency; Increase in meaningful activities
System Level: Increase in referrals to the RLC by traditional mental health providers; Increase in the recovery orientation of providers in the region; Increase in community awareness about mental health recovery

Attachment B

CHPR Request for Information

In order for us to better understand how your RLC works it would be helpful to review certain documentation that you may be using internally or distributing to people who come to your RLC (and in the community). We are interested in information from your RLC's start date up to the present. If documents have been updated since the start of the program, we'd be interested in seeing all versions (if available).

The following is a *wish list* and it is expected that you may not have every item:

- Organizational chart (i.e., chart that shows the number and type of staff at RLC)
- RLC Staff Job descriptions
- Board of Directors/Oversight information/role descriptions
- Outreach materials used to educate the community about the RLC
- Directories that have been developed by the RLCs (e.g., community resource lists, support groups in the region, etc)
- Information on other consumer operated programs and activities that is shared with RLC participants
- Information on other community based resources that is shared with RLC participants
- Calendars of activities/classes/groups/events
 - o Descriptions of activities/classes/groups/events
- Training manuals/materials
- Attendance/registration information for activities/classes/groups/events
- Surveys that have been conducted
- Wait lists for programs or activities (if kept by your RLC)
- Other documents that you want to share

We prefer electronic versions of these materials, but hard or paper copies will be acceptable as well. Please email or mail materials to Linda.Cabral@umassmed.edu or to Linda at 333 South St, Shrewsbury, MA 01545

Please call with any questions! 508-856-8423

**Attachment C
Interview Question Guides**

- 1) Introduction to each interview type**
- 2) RLC Parent Organization**
- 3) RLC Guiding Council Members**
- 4) RLC staff**
- 5) DMH Area Staff**

Introduction used for each interview type

Introduce self.

Summarize the goal and pertinent objectives of the evaluation:

- The goal of the evaluation is to explore how the RLCs are achieving the overall objective of improving access to regional peer support and fostering ties to the community for the people they serve.
- The evaluation will inform the development of future RLCs and aid in quality improvement initiatives. A report will go to staff at the RLCs, DMH and MassHealth and will describe the programs' successes, challenges, lessons learned, and opportunities for the future.

Assure privacy and confidentiality:

- Please know that the information you provide today will be kept private and confidential.
- We will be looking at themes across interviews, and the oral and written reports we prepare will be based on those themes and will not reference any one by name.
- To enrich our reports, we may use a few direct quotes but we will not identify the individual by name and will not use quotes if the content could readily identify the source.

Obtain verbal consent to conduct the interview.

Ask if the respondent has any questions before starting the interview and respond as appropriate.

RLC Parent Organization

1. I would like to start by asking about how your organization helped to develop the RLC.
 - a. What was your role in the RFR development process?
 - b. What was your role in deciding how the RLC would operate?
2. What do you see as the role of your organization in the current operation of the RLC?
 - a. What functions does your organization perform to support the RLC?
 - b. How often do you meet with the staff of the RLC?
 - c. In what ways, if any, is the RLC operation integrated with your organization?
 - d. What type of “oversight” does your organization provide to the RLC?
 - e. What have been the successes and challenges in the relationship between your organization and the RLC?
3. Do you envision your organization’s relationship with the RLC changing in the upcoming year? If so, how?
4. What have been the major lessons learned during the implementation and operation of the RLC?
 - a. What have been successes?
 - b. What have been challenges?
5. What about the RLC are you most proud of? What has surprised you the most?
6. Before we close today, is there anything else that you would like to add?

Thank you for the time you have taken to speak with me today.

RLC Guiding Council Members

1. I would like to start by asking about your involvement with the RLC's Guiding Council.
 - How did you get involved with the Guiding Council?
 - What role do you play on the Council?
 - How long have you been a part of it?
2. I would like to explore the role of the Guiding Council.
 - What functions did it play during the development of the RLC?
 - What functions does it currently perform in connection with the RLC?
 - How often do you meet as a group?
 - How does the Council work with the staff of the RLC?
 - What type of support does the Council provide to the RLC?
 - What has worked well and what have been challenges with the Council's work with the RLC?
3. What have been the major lessons learned during the implementation and operation of the RLC?
 - What have been successes?
 - What have been challenges?
4. What role do you see the Guiding Council playing in the future?
5. What about the RLC are you most proud of? What has surprised you the most?
6. Before we close today, is there anything else that you would like to add?

Thank you for the time you have taken to speak with me today.

RLC Staff

1. I would like to start by asking about your position in the RLC.
 - What are your responsibilities at the RLC
 - How long have you been working at the RLC?
 - In what ways do you contribute to the overall operation of the RLC?
Prompt: satisfaction with their role
2. I'd like to explore how your RLC operates.
 - What types of staff and volunteer positions do you have?
 - How successful has the RLC been in keeping staff (and volunteers)?
What approaches if any, have been used to encourage staff and volunteers to stay?
 - Please describe your RLC's relationship with your parent organization.
3. From our review of program materials, your RLC provides a variety of programs and activities.
 - How does your RLC decide what programs and activities to offer?
 - Which types of programs or activities have the best attendance? Less attendance? Do you have thoughts on why?
 - Who "leads" the programs and activities? What type of support do they get? (i.e. training materials, off-site training, etc.)
 - How do people learn about the programs and activities that your RLC offers?
 - Are certain programs and activities intended to attract (engage) certain audiences (i.e. cultural groups, age groups, diagnosis?)
 - A) Prompt for examples
4. From your perspective, how does your RLC make a difference for people with mental health conditions living in the community?
5. We would like to learn about ways that your RLC promotes community integration.
 - First of all, how would you define community integration?
 - A) Prompt for the respondent's perspective on its value for people with mental health conditions.
 - In what ways does your RLC work with other health and human services organizations in your region?
 - In what ways does your RLC work with other peer operated programs in your region?

Evaluation of Recovery Learning Communities (RLCs)

6. How familiar are you with DMH's requirements for an RLC? (Proceed if have at least some familiarity)
 - Which requirements has your RLC been successful in meeting? In what ways?
 - Which requirements has your RLC found challenging to meet? In what ways?
 - A) Prompt: Strategies to overcome difficulties
 - In what ways, if any, have DMH requirements shifted over time as the RLC evolved?
7. What have been the major lessons learned during the implementation and operation of your RLC?
 - What have been successes?
 - What have been challenges?
8. What about the RLC are you most proud of? What has surprised you the most?
9. Before we close today, is there anything else that you would like to add?

Thank you for the time you have taken to speak with me today.

DMH Area Staff

1. At a high level, what are the goals and objectives of the RLC in your DMH area? Have these evolved in any way over the past year of its existence?
2. What types of programs and activities offered by the RLC do you see as most valuable? Least valuable? Why?
3. One of the primary purposes of the RLCs according to the DMH RFR was to promote community integration.
 - From your perspective, what does community integration mean for people with mental health conditions?
 - From your perspective, what have been the successes and challenges of RLC efforts to promote community integration?
 - In what ways does the RLC work with local health and human service organizations?
 - In what ways does the RLC work with other peer operated programs?
 - What, if anything, could be changed by the RLC to better promote community integration?
4. How is the RLC doing in terms of meeting its contractual obligations?
 - What requirements have been easy for them to meet? Why?
 - What requirements have been hard for them to meet? Why?
5. What have been the major lessons learned during the implementation and operation of the RLC?
 - What have been successes?
 - What have been challenges?
6. What about the RLC are you most proud of? What has surprised you the most?
7. Before we close today, is there anything else that you would like to add?

Evaluation of Recovery Learning Communities (RLCs)

Thank you for the time you have taken to speak with me today.

Attachment D
Recovery Learning Community Evaluation Focus Group Question Guide

Introduction of CHPR staff and roles

Brief overview of the RLC Evaluation:

- Goals of the evaluation
 - To better understand the types of programs and activities services and supports that RLCs are offering people with mental health conditions
 - To better understand how RLCs are connecting people to resources and activities in their communities
- The methods for the evaluation include:
 - Discussion groups with people that participate in RLCs, such as the one we are having today
 - Interviews with RLC and DMH staff
 - Site visits at the 3 RLCs
- A report will be developed that will summarize our findings and will go to the RLCs, DMH, and MassHealth
 - No specific quotes will be tied back to you.

Ground rules for the discussion today:

- Everyone will have a chance to voice their experiences and opinions
- Respect all points of view
- One view at a time – please don't interrupt one another
- Please don't talk about today's discussion with people outside this group

Questions:

Ice Breaker

1. Our questions today will focus on several aspects of your experience with your RLC. I would like to start by asking how you found out about the RLC?
2. RLCs offer a variety of programs and activities. a) What types of programs/activities do you participate in? b) What type of information or resources do you get through the RLC?
3. Another goal of the RLC is to be peer run. a) What does being “peer run” mean to you? b) Do you think the RLC is achieving this goal? c) Is being “peer run” important to you?

Prompts:

- Who decides what kinds of activities the RLC offers?
- Who runs the activities?

4. How does the RLC help you?

Prompts:

- Connecting to programs/activities in community
- Type of resource information available.
- Connections to other health and human services organizations
- Connections to other peer run programs
- Connections to other social activities

5. One goal of the RLC is to offer services to lots of different people, including people of different racial/ethnic backgrounds, gender, age, disability and from different towns in the area. In your experience, how well is the RLC doing in meeting this goal of serving lots of different people?

Prompts

- *Racial/ethnic background*

Evaluation of Recovery Learning Communities (RLCs)

- *Gender*
- *Disabilities*
- *Age*
- *City/Town*

Evaluation of Recovery Learning Communities (RLCs)

6. What one thing do you like best about your RLC? Least about your RLC?
7. We really appreciate the responses you have given to our questions – this has been a very helpful discussion. To close, we'd like to ask you this: a) What do you think the RLC could be doing better? b)Or what would you like more of? c) Has anything surprised you?
8. Again, thank you for taking the time for this discussion. Is there anything else you would like to add before we close?

Attachment E
Recovery Learning Center RFR 2007, Section 3

Requirements for RLCs

- 3.1.1 Recovery Oriented Services
- 3.1.2 RLC programs must be operated by a consumer-run organization
- 3.1.3 RLC Services are to be delivered by consumers
- 3.1.4 New Services
- 3.1.5 Resource Connection Center
- 3.1.6 Peer Support
- 3.1.7 Support Peer Workers and Specialists and Leaders
- 3.1.8 Peer service providers and leadership advisory boards
- 3.1.9 Provide or support consumer warm lines
- 3.1.10 Encourage participation in community events
- 3.1.11 Linkages/Affiliations
- 3.1.12 Consultation and Training
- 3.1.13 Advocacy
- 3.1.14 Coordination among RLC programs
- 3.1.15 Hours of Operation
- 3.1.16 Place of Operations

3.1.17 Service Oversight

3.1.18 Culturally competent services