The Lodge

INNOVATION PLAN ANNUAL UPDATE FY 2022-2023

Department of Behavioral Health

Introduction

The Lodge is an innovation project launched in Fresno County nearly three years ago. It was a demonstration project that sought to learn if there is a model and approach that can be used to engage individuals who are homeless or at-risk for homelessness, who are in the pre-contemplation stage of change, and thus not involved in care or minimal care.

The Lodge is an exploring model which seeks to engage persons who are unhoused and who have a Serious Mental Illness (SMI), which may include co-occurring disorders, to get them into some type of temporary lodging, address their basic needs and work to engage them in care. The Lodge is really a precursor to the Bridge Housing model, with a heavy emphasis on 24/7 peer support.

The Lodge project has been exploring a change to an existing practice in the field of mental health, including but not limited to application to a different population; by using Peer Support Specialists (trained in motivational interviewing; and other evidence-based practices to understand its effectiveness in engaging a specific population. In this case the population are individuals who are homeless or at risk of homelessness, with an emerging or chronic mental illness, and who are not engaged in the behavioral health system due to being in the pre-contemplative stage of change.

The Lodge was initially approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) in May 2020. The service agreement for the Lodge was approved in October 2020, and the Lodge began welcoming individuals in March of 2021.

On April 27, 2023, the Lodge was approved for an extension for two more years by the MHSOAC to allow for additional data, as well as testing what kind of impact a longer stay may have on the participants' engagement outcomes.

The Lodge has completed three years and at the time of this annual update is entering its fourth year (of five as approved by the MHSOAC). The Lodge services are rendered by RH Community Builders.

Background

The Lodge was initially a $4,200,000 three-year Innovation project, which seeks to understand effective methods of engagement for individuals who are homeless or at risk of homelessness, with an emerging or chronic mental illness, and who are not engaged in the mental health system due to being in the pre-contemplative stage of change. The program is examining whether meeting an individual's basic, intrinsic needs can improve engagement in care, and whether peers with similar experience can be effective facilitators of that engagement.

The program was extended for an additional two years (for a total of five years) and an additional $3,160,000 was added to the project for the additional two years of services.

- The extension will allow the program to have close to four years of data for final evaluation, rather merely 1.5 years of data to assess the effectiveness and sustainability of the program.
- Challenges with housing also delayed the transition for those who were effectively engaged in behavioral health services but risked being unhoused when entering a program. Thus, the programs length of stay was extended from 45-days to 90-days to provide time to secure housing.
- RH Community Builders has continued to provide the Lodge's services.
- This project was approved by the MHSOAC in May of 2020 and an extension was approved in April of 2023.
- The initial three-year agreement was for $4,679,216 was executed with RH Community Builders. Of this amount, $3,822,396 was from Innovations funding and $856,820 from Federal Financial Participation. In FY 2022/23, RH Community Builders generated $296,887 in Medi-Cal revenues.
- An agreement for $150,000 was executed with the California State University Fresno Foundation's Social Research Institute for the purpose of program evaluation for the initial three years. With the approved extension, the agreement with evaluator will be extended by two additional years, to ensure completion of the evaluation. This project is

led by a team of professionals and academic researchers who have worked with similar populations and social challenges.

RH Community Builder operates several housing related services (including emergency housing during COVID-19) and is keenly aware of the challenges inherent in providing housing programs for individuals experiencing homelessness and/or mental health challenges. RH Community Builders owns the space where the Lodge is being operated and thus has allowed for physical adaptions as needed to support those accessing the Lodge, including separation of space by gender, by those who identify as transgender, or need to be in less communal space.

The Lodge utilizes stages of change and Motivational Interviewing, an evidenced-based practice, as an indicator of readiness for change and assists individuals in moving toward the next steps of change. As best practice, The Lodge utilizes a housing first model based on harm reduction. The Lodge seeks to remove barriers to make it possible for individuals to have equitable access to care and services. The philosophy focuses that safe and stable housing will be the entry point to services, not the reward for entry into services. The staff are trained in Motivational Interviewing, harm reduction, and operate from a trauma-informed perspective.

Project Activities

The Lodge may serve up to 30 persons at any given time. The Lodge is located on a direct public transportation route and has living and recreational space, including space for individuals to safely keep their pets on the premises.

The Lodge's team has worked to accommodate the needs of its lodgers, including private space for those who are gender non-binary or identify as transgender.

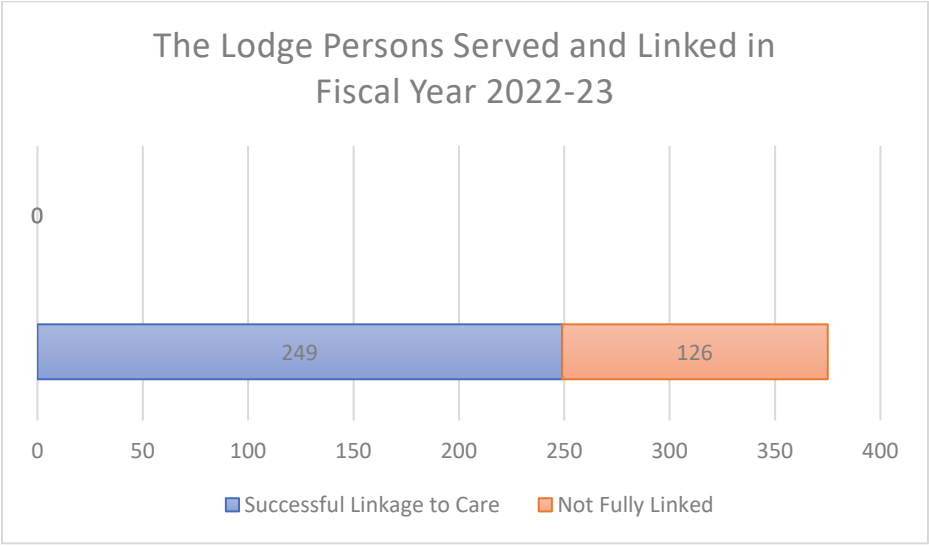
Fiscal Year (FY) 2022/2023 the Lodge hosted 375 unduplicated individuals. The duration of stay, the service needs, and linkages vary for those served at the Lodge.

Some program outcomes were measured by examining reduction in emergency room/department visits, reduction in hospitalization, and successful linkages to mental health and/or substance use disorder programs.

The program reported that it provided 2,808 services during that time period. Those services range from assessment, linkages, and psychoeducation.

The Lodge provides linkages and referrals to services based on an individual's preference and/or choice of providers. The Lodge prioritize linkages to community partners that reduce any barriers in accessing ongoing services after their stay at The Lodge. The program has developed relationships with the Fresno County Department of Behavioral Health, WestCare, TURN Behavioral Health, Comprehensive Addictions Program (CAP), Poverello House, Turning Point of Central California, Blue Sky Health and Wellness Center, various Federally qualified health care centers, the Fresno Housing Authority, local landlords (for housing) and/or local room and boards to increase access to community services and resources necessary for program participants to develop supports to a successful journey to recovery.

For reporting purpose, the Lodge records individuals served as successfully engaged when they enter into in outpatient mental health or substance use treatment. Of the 375 persons that were served, 249 (66%) successfully engaged in mental health or substance use treatment services and care. The persons served for this program are persons who are not currently in any care or services and were not in care before entering the Lodge. Also of note is that all participants are persons in a pre-contemplation stage of change when they enter the Lodge.



For this project a "successful" linkage is defined as linkage to behavioral health services (mental health and/or SUD treatment). Linkages to medical, health or housing are part of the linkages however the primary focus is on engagement and connecting individuals in need of behavioral health (mental health, substance use, or co-occurring) to care to appropriate services. A list of every type of linkage was not developed but can be tracked in the future.

The program tracked the number of unique visits to the Crisis Stabilization Unit (CSU) for each person served while in the program with a goal to reduce those visits. The goal was a 75% reduction of CSU visits by the persons served. The program had only 18 visits to the CSU, which was a reduction from the 26 visits in FY 21/22.

During FY 22/23, of the 375 individuals served, there were 78 visits to local emergency departments while at the Lodge. This was measured to be a reduction of 83% in emergency department visits based on individual's served self-reports upon entry to The Lodge.

As individual moved from the "pre-contemplative" stage and determined that they are interested in seeking mental-health services, a mental-health assessment was conducted by the Lodge within 48 hours. 100% of individuals accepted to the Lodge were offered a mental health assessment once they expressed interest in seeking mental health services. The staff uses motivational interviewing to encourage participation in a mental health assessment for placement, linkage, and advocacy in participating in ongoing services given their voice and choice of services.

In the past year, 100% of the respondents served at the Lodge reported being satisfied or very satisfied with the services in their exit survey.

The Lodge did not have any family members of persons served who decided to take part in the exit survey; however, out of the individuals served during this reporting period, 15% of the persons served had family member involvement during services. This was compared to the goal of having family members of those involved provide input on how they perceived the Lodges' role in assisting the person served access care.

The length of participant stay continued to be a challenge during the reporting period. Shorter length of stay has impacted engagement into mental health services as well as the cost per client as a higher turn-around of participants results in the cost of meeting initial client needs such as hygiene items, shoes, and clothing.

The overall average length of stay has been 17-days for the term of the program. Most participants remain for the 45-day allowable term, a few have been extended, and some depart earlier with a successful linkage or voluntarily opt to depart. In the coming year the Lodge can provide lodging for persons for up to 90-days, this is an increase from the previous 45-days. This change will be assessed to see if it increases engagement, and also more successful linkage as access to housing and other shelter has been reported as a barrier to transition out of the Lodge.

The Lodge was initially designed to have a LVN on staff, however the project learned that an LVN would need to work under a license of a physical or a physician's assistance, both which were not included in the plan nor budgeted for. As such the position is going to be removed from the project and those funds will be reallocated to staffing and opportunities for additional resources such as tele-psychiatry. Aside from challenges in hiring and supporting the LVN position, the Lodge has remained continuously staffed, and when the program has experienced any vacancies, it has been successful in filling those positions almost immediately.

The program has not had challenges with the retention of its personnel; and as the cost of living, and inflation have become factors, under the new extension the budget was increased to help support wages for personnel and services.

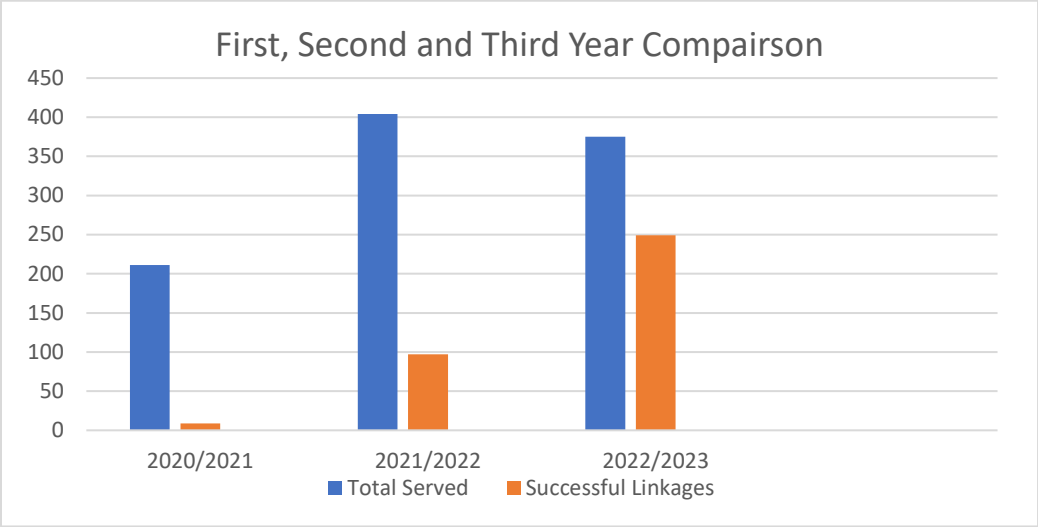
The Lodge has sought to leverage California's Payment Reform under CalAIM and is seeking to bill Medi-Cal for additional services. The project billed $296,887 in Medi-Cal services in the past year. The Medi-Cal services that were billed were primarily related to rehabilitation, followed by case management, mental health services, and then assessments.

To help maintain the fidelity of the project, the Lodge continues to receive referrals from a closed system. This restriction is to ensure the pilot and research are referring and servicing a population with specific needs. To ensure the program does not reject persons in need and is able to assess

the impact of the model, milieu, and interventions, it is important for the pilot to work with the specific target population.

The Lodge continues to receive referrals from the Emergency Departments, the Department of Behavioral Health, Crisis Intervention Teams (CIT), and the Crisis Stabilization Unit.

New Bridge Housing, that will be provided by RH Community Builders will provide additional housing and shelter options for those who do not meet the Lodge's criteria.



The Lodge has faced some challenges for linkages based on the capacity for some services/resources, especially with housing, and the fact that the previous timeline allowed for persons served to fully obtain and engage in mental health and substance use disorder programs is too short for some. In the coming year the length of stay has been expanded to 90-days to help improve linkages. The Lodge has not reached the mark of 85% of total individuals that fully obtain and engage in mental health and substance use disorder programs within the 45-day timeframe. However, it has reached as high of 66% success in that timeframe, and with the extended time to 90-days should see an increase in the percentage of persons who are linked successfully.

Some programmatic milestones to note in FY 2022/23 include, the program tracked the number of unique visits to the Crisis Stabilization Unit (CSU) for each person served while in the program

with a goal to reduce those visits. The goal was a 75% reduction of CSU visits by the persons served. The program had 18 visits to the CSU (out of 375 persons).

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Next Steps

Psychiatric Advanced Directives (PADs) – In the coming year the Lodge's participants will be engaged in the next phases of the PADs development. The Lodge and its participants are planned to be a population that can be supported with the development of PADs. PADs are a part of a different multi-county MHSA INN plan in progress. As part of that plan, it is the intent of Fresno County to work with the Lodge for PADs development and implementation. The Department hopes that the development and obtaining of a PAD will serve as an empowerment tool for individuals served by The Lodge that increases and leads to further engagement of services. It is also a part of an empowerment tool for those who have not been involved in care.

These processes for PADs will likely not be implemented before the end of this INN project, but as the PADs moves into the second phase, the Lodge and its participants will be able to have an active role in the implementation of PADs.

Peer Certification - The Department continues to work RH Community Builders on trainings, as well as scholarship and other opportunities for the project's peer staff to become certified. It is the goal that in the future more programs within the system of care will employ Certified Peers,

and to reach that goal more opportunities to develop peers will be made including things like training and certification opportunities.

Referrals - In the coming year, the Department will work with the Lodge to explore opportunities to accept referrals from other justice sources for individuals that meet the project's parameters. These may include referrals for some individuals under supervision by the probation department, as well as those released from jail. The anticipated creation of the new Mobile Crisis Response services may also be an option for referrals. In addition to the planned Bridge Housing programs in Fresno County that is modeled similarly to the Lodge could be a viable option to engage persons who are unhoused and not engaged in care that may enter CARE Court. The Lodge was developed to examine some models or approaches to engage persons whom the State's new CARE Court program seeks to serve. The Lodge may still provide needed temporary lodging and engagement until such time as an individual can successfully be linked to services in our system of care.

Data collection and reporting - A potential goal for the program which can be measured and used to assess its effectiveness could be tracking the percentage of persons served by the Lodge who are receiving entitlement benefits, such as CalFresh, General Relief, and SSI from intake to discharge. The program's desired outcome would be to increase the percentage of individuals who are receiving at least one entitlement program benefit during their stay, which can increase their resources and opportunity for a successful outcome.

Sustainability

The program, at this time, and with two full years of data, has limited the ability to assess the effectiveness of the model, or the understanding of which aspects of the program may be effective in resulting in a more than 50% successful completion. The continued work and evaluation are anticipated to contribute to this understanding.

With a focus on sustainability, the Department needs to be able to evaluate the program based on data, which is very limited at this juncture. The Department will be exploring the opportunity to extend the Lodge beyond an Innovation Plan, and possibly be supported by the housing

component under the revision to the Mental Health Services Act, Proposition 1. In addition to possible local funding, the Lodge is working to maximize FFP/Medi-Cal through both enhanced case management services as well as specialty mental health billable services.

Evaluation

The California State University, Fresno Foundation evaluation team, also known as the Social Research Institute (SRI), completed the evaluation to date in April 2023. SRI created an executive summary, herein attached as Exhibit A, and full report evaluating services at The Lodge.

The Department will continue to monitor the evaluation data carefully in an attempt to assess the following: Does the program's model prove to be effective in engaging the target population? Does the program's interventions prove to be effective in improving engagement into care with the target populations? Lastly, the department will seek to understand if the overall program has been effective and can support other initiatives such as CARE Act participants, and other housing supports.

The SRI evaluation team continues to work with the provider to collect the necessary data. It is an on-going collaboration to ensure data is collected that can assist in effective evaluation of the project. Data analysis is being conducted on the program from the full year of services.

In the past year, 100% of the respondents served at the Lodge reported being satisfied or very satisfied with the services in their exit survey.

Budget

In the past year, the cost per person served was $4,141.23.

The budget remained the same in the last year, however the number of persons served slightly decreased as persons engaged longer for an increased number of successful linkages.

The Lodge was able to draw down FFP (Medi-Cal) funds in the amount of $296,887. It was limited to billing for limited clinical services such as assessments, etc. In the future, the project could bill for additional services under CalAIM, and with legislation allowing Certified Peers to bill for some services, the project could increase its FFP revenues to improve its sustainability.

The Project cost $1,285,579.86 in the last fiscal year, and there was a balance of $114,755 left from the allocation. These funds may not be expended by end of the project and may be subject to reversion.

The allocated budget for FY 2023/24 is $1,746,210.

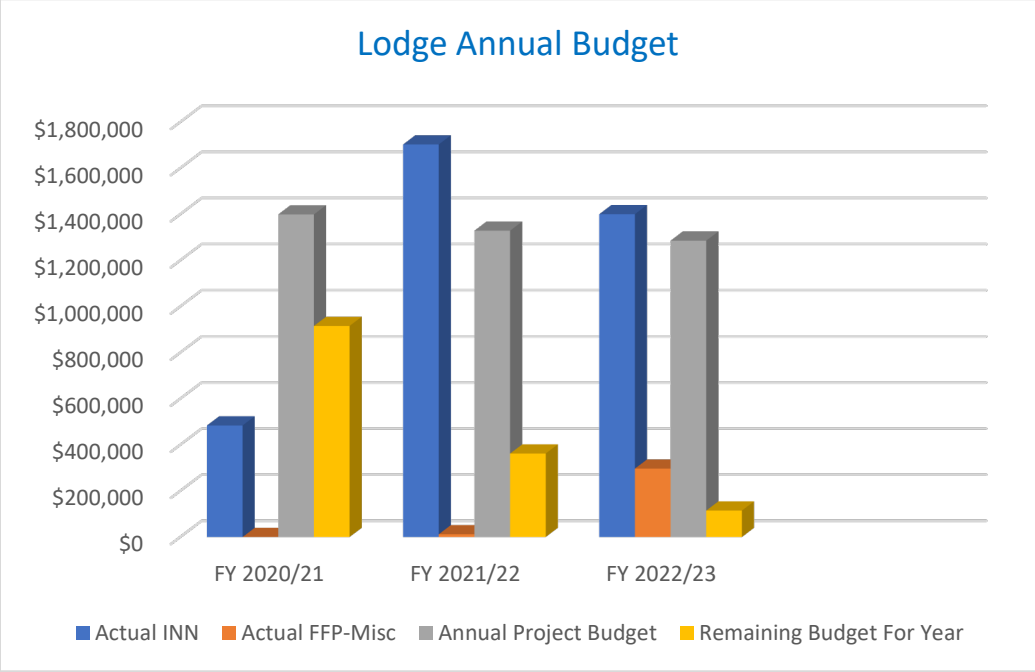

Exhibit A – SRI Evaluation Executive Summary

Executive Summary

Care Seeking within an Innovative Homeless Shelter: Combining Housing First with Peer Support to Encourage Client Progression Through Stages of Change

Analysis Conducted and Executive Summary Written by:

The Social Research Lab

California State University, Fresno

Timothy Kubal, PhD, Director

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Introduction

This report examines data collected from a homeless shelter that is employing a relatively new approach to homelessness, where clients are humanized through a “harm reduction” and “housing first” model that does not put barriers in front of the person’s access to housing. This new type of response to homelessness has been studied across North America and Europe, and studies have shown that it has clearly resulted in large percentages of homeless people being placed in what appears to be relatively-permanent housing; another potential influence of these types of programs is the benefit to the health and wellbeing of the homeless population, but studies showing the influence of a housing first model on health have been relatively limited compared to documenting its success with housing (Baxter et.al. 2019). The lodge provides an ideal location to further test and understand how a low-barrier, housing-first model might be implemented to encourage care seeking.

The Lodge, as it is commonly known, adds some additional components to the housing first model, and thus produces an experimental community that provides a unique learning opportunity. The Lodge uses motivational interviewing and an active workforce of peer support

specialists who have recently overcome homelessness. This report seeks to document the general performance of the various components of the Lodge program, and if such a program might positively influence client's care-seeking behavior.

The evaluation of this experimental program – conducted by The Social Research Lab at Fresno State University – began by partnering with relevant stakeholders to find acceptable quantitative and qualitative measurement tools from the scientific literature to measure the unique properties of this experimental homeless shelter. This report is based on the findings from the first year of data collected by the employees at the Lodge and examines data from surveys given to Lodge clients that measure four concepts: Wellbeing, Stages of Change, Peer Support, and Self-Efficacy/Self-Care. This report does not discuss motivational interviewing, because the Fresno State team did not receive the requested data on this topic.

From analyzing the survey data, we uncover three main patterns regarding each concept: frequencies, associations with client demographic characteristics, and changes over time. As an abridged version of the report, this executive summary does not include the quotations and statistics that are provided for evidence throughout the unabridged report,

and only includes the conclusions from the analyses. Before presenting the analyses, we introduce the clients, both qualitatively and quantitatively.

Introducing the Clients: Qualitative

Lodge staff completed qualitative interviews with clients, using an interview protocol from the literature that was meant to help clients describe their care-seeking behavior. These interviews help us understand how clients define the process of care-seeking, including motivation, what occurs before making a decision to seek care, what is entailed in making a decision to seek care or not, and their feelings about their own care-seeking decisions.

Motivations for care seeking include the release from pain, long term physical and mental health, general life longevity, and being there for pets, family, and educational opportunities. The situation before making a care-seeking decision was typically described as one of three types: outside intervention, emergency, or rational choice. The actual care seeking was often described as mundane follow through with prescribed appointments. Clients described several reasons for not getting help such as feeling overwhelmed, long lines, drinking, self reliance, god and prayer, lack of social support, lack of trust of the medical establishment, and a general dislike of psychiatric discussions. Regarding their feelings about their care

seeking decisions, clients described some feelings of fear, helplessness and weakness, but also relief and general positive interpretation of their decision to seek care.

Introducing the Clients: Quantitative

We received 260 valid responses on the intake survey, which is where we documented the demographics of the respondents. Tthe typical Lodge respondent is most likely to be a heterosexual, non-veteran, European male in the 26 to 59 age category, who is single and never married, with no disability, having 12 or more years of education, and having been homeless for almost all of the last three years. However, it is important to acknowledge the diversity of characteristics of the clients; each of these demographic characteristics provides an opportunity to examine outcomes for the various demographic groups. Examining demographic differences suggests small groups of people that may experience the Lodge in different ways. In the analysis later in this report, we examine these statistically significant differences in how people experienced the Lodge. Next, we next describe our analytic tools.

Introducing the Four Concepts

The four concepts used in this report include wellness, stages of change, peer support, and self care/efficacy. These four concepts emphasize the measurement of client perspectives regarding their journey through the stages of change toward care seeking and wellness. The support staff at the Lodge, and especially the peer support specialists who can mentor homeless clients and provide a model to emulate, provide invaluable support through this care seeking journey. The academic literature provides tested tools that we use in this report to measure the client's perspective in their care-seeking change process, including survey instruments to measure wellbeing, stages of change, peer support, and self-care/self-efficacy. Note that this executive summary does include an introduction to the survey tools that we used, but only the unabridged report has the listing of the actual questions that were used.

Wellbeing

Wellbeing is a common idea in the psychological literature, and there are many different measurements. Most of the survey measurements are focused on higher-level well-being such as being actualized at work, how well one's life matches their personal ideal, comparing their life to their parents and children, and other types of wellbeing that would commonly be

discussed among middle-class respondents. Similarly, many studies, even those with homeless subjects, have defined wellbeing as happiness, and satisfaction with life (Diener and Diener 2006). In contrast, in consultation with the stakeholders, we chose a survey that more closely measured Maslow's hierarchy of needs, in part because it seemed to better measure the attempts of homeless clients to secure the basic needs of daily living, and in part because the scale accurately measured the desire for housing first programs to reduce harm by prioritizing the meeting of basic needs. The scale we use has successfully shown both reliability and validity (Weger et.al.2000).

Stages of Change

The concept of stages of change provides one central concept for understanding the process of behavior change. The idea of stages of change is that we can document client movement through successive stages of self-change, beginning at resistance (pre contemplation stage), to considering change (contemplation stage), to taking change-oriented actions ("action" stage), and finally the last phase where people evaluate their efforts ("maintenance" stage).

The precontemplation stage involves a type of denial, it contains people who have not yet acknowledged that they have a problem. People

in this stage have limited awareness of their problem, and typically do not acknowledge their behaviors as particularly problematic. Clients in this stage can sometimes redefine their actions as normal or act defensively about their problems; they often seem resistant to change, and sometimes see attempts to change as more harmful than helpful. The second stage, contemplation, entails acknowledging problems, but being unsure if the problems are serious enough to warrant any lifestyle change. Clients in this stage appear to be unsure how to act; they are often willing to hear about their problems and possible solutions, but may appear indecisive about if and when to take action. In this report we use the original conceptualization that directly connects the contemplation and action stages (McConnaughy et.al 1983; McConnaughy et.al. 1989); newer research tends to add an additional stage at this point, called the preparation stage (Raihan and Cogburn 2023). We found the original conceptualization of the model more useful and so we followed the contemplation stage with the action stage. In the action stage people openly discuss and acknowledge their problems, and are willing to accept help. They do not seem indecisive, resistant, or defensive. They have taken explicit steps to change their behavior, and have been successful at change for a consistent period of time. The last stage, maintenance,

involves efforts to perpetuate the lifestyle change. This often involves awareness of weaknesses, temptations, triggers, and patterns of relapse.

The academic literature has shown the idea of stage of change to be an enduring model to understand the trajectory toward positive behavior change for most major behavioral change issues. While the initial model implies a linear progression through the stages leading to change toward a healthier lifestyle, people's lives are messier than conceptual models, and thus the empirical literature often shows people moving back and forth across the stages, instead of moving in a single linear direction (Raihan and Cogburn 2023) .

Peer Support

Peer support is a relatively new idea, and thus we could not find relevant quantitative surveys from which to draw questions. We were able to develop our own questions based on the claimed influence of peer support within published qualitative studies. This resulted in fifty questions about the influence of the peer support specialist.

Self Efficacy / Self Care

Self efficacy is a sense of empowerment that is thought to be developed through successful accomplishments; typically people with more

failures and fewer accomplishments display lower levels of self efficacy. Self-efficacy can also be seen as a cause of other desired behaviors, such as care seeking. This is where the concept of a general self efficacy becomes especially important. The traditional conceptualization of self efficacy has often been applied to understand task-specific sense of empowerment that is created as a result of successful actions in a specific domain (e.g., a specific skill or job), rather than a sense of empowerment that is more generally connected to the self and a cause of all sorts of future behavior. The general self efficacy concept that we used (Chen et.al. 2001) is especially useful to understand efficacy as a cause for other behavior; such as behavior change and care-seeking behaviors. The idea is that self efficacy could provide the general sense of personal empowerment to encourage successful efforts at behavior change.

The self-care scale (Rubio et.al. 2001) helps us understand the behaviors and beliefs that shape care seeking. The first set of questions in this scale document respondent involvement in treatment or some sort of professional care in the last three months. The second set of questions asks about the prevalence of rationalizations and excuses for not seeking care.

Frequencies

This section examines the raw frequencies in the data. These frequencies represent the survey participant answers as a whole, and show variation in responses from all respondents to questions from all four surveys: wellbeing, stages of change, peer support, and self-efficacy/self-care. In this abridged executive summary, only the summary of the findings are shown; for a more complete analysis, see the full report.

The wellbeing frequencies suggest that clients have some structural deficiencies in their life (such as lacking medical/dental care, lacking money, getting support, having a home, having transportation), a few deficiencies that are based at least partially on interpersonal relationships (getting support, enjoying sexual intimacy) and only one “psychological” deficiency (having fun). The wellbeing frequencies also suggest that clients have a strong foundation upon which to build a happy and healthy life with most respondents describing themselves as having life meaning, laughing, expressing joy, love, and sadness, and feeling good about themselves. When compared to the published literature, we see that the Lodge wellbeing average of 51% is far below published averages.

Stages of Change Frequencies

All of the highest scoring responses were statements showing the client's readiness for change. Similarly, all of the lowest-scoring responses were statements showing the client's resistance to change. Therefore, we can conclude that the stages of change frequencies show that clients have minimal resistance to change, and a general receptiveness to both receiving help and desiring change.

From placing the Lodge data into the stages of change, one can clearly see that the precontemplation stage contains the least popular responses, with all of these questions comprising the lowest percentages of all responses, suggesting that clients have mostly moved on beyond the precontemplation stage. The most common results were from the contemplation stage, with those questions comprising the top four most common responses, and seven of the top ten most common responses. These data suggest that clients are beyond precontemplation and receptive to change, but also that they have not fully taken the action steps necessary to create that change.

Both our data and the published data showed the highest percentage for the contemplation stage and were within the same range for the maintenance stage, but showed important differences: Lodge results were

lower than the published studies for contemplation and action stages, and higher than published studies on the stage of precontemplation.

Peer Support Frequencies

The average rate of positive responses across all peer support questions is 68%. These data show that the majority of clients are receiving many benefits from the peer support specialist, including for care-seeking behavior. While the questions are based on the literature, they are based on qualitative studies that describe the various characteristics that clients have identified in the peer support specialists. We were not able to find relevant survey questions on this topic, so we wrote our own questions based on the characteristics defined in the qualitative literature. Therefore, comparison data from the literature are not available for the peer support survey questions.

Self Efficacy and Self Care Frequencies

The Lodge clients had an overall average for general self efficacy of 3.7, considerably lower than the averages within the published literature. Despite low involvement in programs and groups, about half or more of respondents do report regular interaction with medical professionals. The

observation from comparing the Lodge self-care frequencies to those in the published literature is that the Lodge clients have low attitudinal barriers to care seeking, but have relatively high practical barriers that may restrict their ability to accomplish care seeking.

Associations

The previous section examined the general influence of The Lodge, but we know that the influence is not uniform across all participants. The analysis above does not show how the Lodge has an influence that varies depending on the group of participants. In the following paragraphs we examine how the program influence varies depending on client characteristics such as race, gender, education, and age. To accomplish this task, we use chi-squared statistical tests to present the statistically significant associations between each question and demographic variables. This is a comparative type of analysis that highlights the group that answers the question differently than statistically expected. If there were no differences between groups, then the answers would be evenly distributed across groups and all groups would give relatively equal answers. A statistically significant relationship means that one group is more likely than another group to answer a question differently than the statistically-even

distribution, and allows us to say, with at least 95% certainty, that the difference between how two groups answered the question is not due to chance.

Wellbeing Associations

While there seems to be a great deal of variation in answers to the wellbeing questions, each question had at least one statistically significant association with a demographic variable, and many associations with demographic variables that were not statistically significant. The patterns of statistical significance were not random. Demographic groups tended to occupy consistent positions across questions – some groups were consistently more likely to report wellness, and some groups were consistently less likely to report wellness.

When there was significance based on race, it was consistently Whites who reported greater well being compared to non-Whites. When there was significance based on gender, men consistently reported more wellness than women. When there was significance based on relationship status, non-single respondents consistently reported more wellness than single respondents. When there was significance based on children, people without children consistently reported greater wellness than people with children. When there was significance based on disability, people with

disabilities reported more wellness than people without disabilities. There were only a few demographic characteristics with mixed wellness reporting – meaning that on some questions they showed higher amounts of wellbeing, and on other questions they showed lower amounts of wellbeing; these examples include Hispanic ethnicity, age, and sexual orientation.

Stages of Change Associations

Some demographic groups were more likely to agree with statements in the pre-contemplative stage. When education was significant, people with lower education were consistently more likely to agree than people with higher education . When relationship status was significant, single people were consistently more likely than non-single people to agree. Single people are more likely than non-single people to reside in the pre contemplation stage. People with lower education are more likely than people with higher education to reside in the pre contemplation stage.

Questions in the contemplation stage are significant with a consistent set of demographic variables. When veteran status is significant, non veterans are more likely than veterans to agree. When mental troubles are significant, people with mental troubles are more likely to agree. Non-veterans and people with mental troubles are more likely than veterans and people without mental troubles to reside within the contemplation stage.

Questions in the action stage are significant with children status, race, and veteran status; those without children, non veterans, and non whites were more likely than their counterparts to reside within the action stage. There was one even more consistent pattern: The variable children status was significant with several questions in the action stage. When the variable of children status was significant, each time it was those people who did not have children that were more likely to agree. Therefore, we can be especially certain that people without children are more likely than people with children to reside in the action stage.

For the maintenance stage, significant relationships were with race, veteran status, age, disability status, education, and parental status; groups more likely than their counterpart to reside in the maintenance stage are people with children, non-whites, veterans, younger respondents, people reporting a disability, and people with lesser years of education. Groups that had multiple statistically significant positive responses were the youth, people that reported a disability, and non-Whites; we can say with extra confidence that these groups are more likely than their counterparts to reside in the maintenance stage.

Next we examine the associations between client demographic variables and each client's average score for each whole stage. The

average score for a client on a whole stage of change varied by group, including by ethnicity, having children, veteran status, education and relationship status. Single and less educated people have higher scores in the precontemplation stage. Non-Veterans have higher scores in the contemplation stage. People without children have higher scores in the action stage. People without children and people with an African ethnicity have higher scores in the maintenance stage.

Peer Support Associations

The peer support specialist received high marks from the clients, but there were differences in how different groups of clients experienced the peer support specialists; people with more education were more supportive than people without an education, people without children were more supportive than people with children, individuals with a disability were more supportive than those without; Whites were more supportive than both non-Whites and Hispanics, people without mental troubles were more supportive than people with mental troubles. By far the most common of these factors was the distinction between how Whites and non-Whites assessed the peer support specialist, which appeared significant across

most questions. We can be sure that the data is telling us that Whites appreciate the peer support specialist more than non-Whites.

Did any of the client assessments of the peer support specialist show a statistically significant relationship with the frequency of exposure to the peer support specialist?

For the most part, we can conclude that the answer is no – client assessment of the peer support specialist rarely showed a statistically significant relationship with the frequency of client exposure to the peer support specialist. Of the dozens of relationships we examined, there were only two that were significant: number of homeless days, and overall evaluation of the living environment.

Weekly exposure to the peer support specialist improved how well the client viewed the peer support specialist's influence on the client's interpretation of a better living environment. Weekly exposure to the peer support specialist also improved the client's interpretation of how well the specialist helped the client reduce the client's number of homeless days.

Self-Efficacy and Self-Care Associations

People who have been married or are married tend to agree or strongly agree that they could overcome challenges. People that reported

rationalizations and excuses for not seeking care tended to be people with a disability, young people, and non-Whites.

Changes

The previous analysis sections of this report examined the influence of the program in general, and its influence on different sub-groups. Another important measure of impact is to examine change over time. All of the surveys were administered multiple times throughout a client's stay at the Lodge. Surveys were given near the beginning and near the end of their stay at the Lodge. Asking the same questions at entry and exit allows us to examine if and how client answers changed. While we cannot scientifically prove that the difference in answers between the two times was due solely to the influence of the program, such an analysis will tell us if there are statistically significant changes, and provide strong evidence suggesting different types and levels of program influence. To accomplish this task, we conducted a scientific procedure called the Repeated Measures T-test. This procedure allows the researcher to compare results from the two surveys. Like the chi-squared test, the key statistic is the significance level, and for the t-test, a statistically significant finding is one with a significance level of .05 or below, and that means that we are at

least 95% sure that the difference in responses between the two times is not due to chance.

Wellbeing Changes

By examining the difference between respondent's answers at survey time one and survey time two, we can see that the Lodge appears to have induced some statistically significant improvements in respondent's well-being. The successful, statistically significant improvements include the following: eating well-balanced meals, expressing laughter and joy, feeling good about family, having close friendships, having a home, having people who think highly of you, having adequate transportation, laughing, learning new skills, making plans for the future, and relaxing.

Stages of Change: Changes

Almost all of the 32 stages of change scale questions have increased from time one to time two; however, only two questions showed a significant change between time one and time two. The first significant change is regarding being ready for self-improvement. The unfortunate interpretation of this finding is that over time, through participation at the Lodge, people became less ready for self-improvement. The second question that showed change is how often people work on their problems.

The unfortunate interpretation of this data is that over time at the Lodge, clients have decreased how much they are working on their problem.

We also followed the academic literature and averaged the scores within each stage for each respondent, and then examined if those averages for each stage changed between time one and time two. The pre contemplation average scores increased over time (2.1 to 2.5) and the others decreased over time: contemplation (4.2 to 3.8), action (4.0 to 3.8), and maintenance (4.07 to 3.6). While these data are suggestive (and unfortunately, again, display some trends in the wrong direction), we must be cautious; in part because we were only able to use a small sample size of 12 participants who completed surveys at both time one and time two, none of the changes in overall stage averages showed a statistically significant difference between the scores at time one and time two. Therefore, while the trends for the average stage scores appear clear, the statistics suggest otherwise.

Peer Support: Changes

By examining differences between respondent's answers at survey time one and survey time two, we can see statistically significant changes in client's attitudes about the peer support specialist. The peer support

specialist did not reduce stress, but did show improvements in several important outcomes: Helping clients control drug use, control the amount of money spent on drugs and alcohol, encouraging contact with professional services, encouraging engagement with treatment, helping interpret addiction recovery, and helping reduce the time since the last relapse.

Self-Efficacy and Self-Care: Changes

The data show no statistically significant changes over time in self-efficacy, and almost no changes over time in self-care.

Explaining Patterns with Index Variables

Relationship status and children status are the two most important demographic variables for explaining variation in the five indices: wellbeing, stages of change, peer support, and self-care/self-efficacy.

Medical Transportation as Care Seeking

The data include medical transportation logs for 75 clients. We call this “care-transport”; among the 75 clients that used care-transport over the year, the most common level of usage was once, with an overall average of 1.75 usages.

Chronically homeless are more likely than other clients to use care-transport. Those with the least education tended to be the least likely to use

care-transport. There were no index variables that showed a statistically significant correlation with care-transport. And none of the individual questions we asked in all of our surveys showed a significant relationship to transportation, except for a single question about hoping for good advice. We were able to uncover a few demographic questions that showed different usage levels of transportation by different groups of clients, but overall there was almost no indication that care-transport had an important influence. Therefore, we can conclude that the data show that there is not an important relationship between care-transport and any of the main components under study in this report: wellbeing, stages of change, peer support, and self-care/self-efficacy.

Peer Support Public Survey

An original survey was conducted by Fresno State Social Research Lab in June of 2022, with residents of the Central Valley, California (N=648), asking various opinion questions about homelessness and other social issues. One question asked if the respondent agreed with peer support specialists, more specifically, “How much do you agree or disagree with the policy of employing former homeless individuals to mentor existing homeless people.”? Findings from the public survey show that, among

residents of the Central Valley, there is a small amount of opposition to peer mentors, and a large amount of support.

Our findings from the chi squared analysis of the public survey show that most of the demographic variables showed a statistical relationship with public attitudes about the peer support specialist. This means that there are established differences of opinion about the peer support specialist between subgroups of the Central Valley population.

The regression analysis of the public opinion data showed that the only variables (listed in diminishing order of influence) that remained independently significant in their influence on attitudes about the peer support specialist were: marital status, employment status, income, and education. These four variables had an independent influence on public opinion about the peer support specialist. Therefore we would proclaim that variation in public attitudes about peer support specialists can be explained best by the combination of four demographic variables: marital status, employment status, income and education.

Suggestions

This is an exciting project and the Fresno State team is thankful for the efforts of the Lodge employees for their successes in collecting data for

this project. We did have some issues with the data collection that need improvement, which in some ways is expected in the first year of a large project. In this section of the full report, we describe these problems, and provide some suggestions for improvement. The main areas of discussion are topics of incomplete quantitative data, inconsistent quality qualitative data, and problems caused by changing the client ID number system.

References

Baxter AJ, Tweed EJ, Katikireddi SV, et al. 2019. Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomised controlled trials. J Epidemiol Community Health 73:379-387.

Diener, Robert and Ed Diener. 2006. The Subjective Well-Being of the Homeless, and Lessons for Happiness. Social Indicators Research Vol. 76, No. 2, pp. 185-205

Chen, Gilad, Gully, Stanley M., Eden, Dov. 2001. Validation of a new general self-efficacy scale. Organizational Research Methods, Vol. 4, Issue 1, pp 62-83.

McConnaughy, Eileen, DiClimente, Carlo C., Prochaska, James O., Velicer, Wayne F. 1989. Stages of change in psychotherapy: A follow-up report, Psychotherapy**:** Theory, Research, Practice, Training, Vol 26(4), pp. 494-503.

McConnaughy, Eileen, Prochaska, James O., Velicer, Wayne F. 1983. Stages of change in psychotherapy: Measurement and sample profiles. Psychotherapy: Theory, Research, and Practice, 20, pp 368-375.

Raihan, Nahrain and Mark Cogburn. 2023. “Stages of Change Theory.” National Institute of Health. https://www.ncbi.nlm.nih.gov/books/NBK556005/

Rubio, Doris McGartland, Berg-Weger, Marla**,** Tebb**,** Susan S**.,** Parnell, Lisa A. 2001. Comparing the well-being of post-caregivers to noncaregivers. American Journal of Alzheimer's Disease, Vol 16(2), pp. 97-101.

Tebb, Susan 1995. An aid to empowerment: a caregiver well-being scale. Health and Social Work, Vol. 20, Issue 2, pp 87-92.

Vanheusden, Kathleen, Mulder, Cornelis L., van der Ende, Jan, van Lenthe, Frank J., Mackenbach, Johan P., Verhulst, Frank C. 2008. Young adults face major barriers to seeking help from mental health services. Patient Education and Counseling, Vol. 73, Issue 1, pp. 97 - 104.

Weger, Marla Berg, Doris McGartland Rubio, and Susan Steiger Tebb. 2000. The Caregiver Well-Being Scale Revisited. Health & Social Work, Volume 25, Issue 4, Pp. 255–263,