FINAL INNOVATIONS REPORT – ADDRESSING THE NEEDS OF SOCIALLY ISOLATED OLDER ADULTS

Daniel Hill, BA, Curry Senior Center
Ashwin Kotwal, MD, UCSF
Carla Perissinotto, MD, UCSF

TABLE OF CONTENTS

I. BACKGROUND

Social isolation was identified by the San Francisco Mental Health Services Act Innovations (INN) Planning Committee in 2011 as the number one priority concern for older adults living in San Francisco. Mental Health Services Act (MHSA) planning efforts and the Department of Disability and Aging Services (DAS) identified barriers to socialization such as: the lack of mental health services for non-English speaking populations, the lack of mental health services for LGBT older adults, the lack of awareness of mental health services for older adults, lack of appropriate in-home interventions, stigma associated with mental health challenges resulting in the likelihood that older adults would not seek treatment. The extremely high cost of housing was also identified as a factor resulting in increased numbers of older adults living alone in Single Resident Occupancy (SRO) hotels, along with geographical challenges such as distances between the homes of older adults and the services they need to access, the navigation of hills in San Francisco, and congested city streets.

A. PURPOSE

Given the INN Planning Committee's defined priority – Social Isolation; Curry Senior Center's 'Addressing the Needs of Socially Isolated Older Adults' was established in 2015 to cultivate trusting relationships between a Peer - with lived experience of isolation or navigation through the behavioral health system of San Francisco - and an older adult currently experiencing isolation. It was the program's hope that this intervention, to reduce isolation, would ameliorate some of the mental health challenges attributed to isolation while connecting program participants to services and activities in the community.

B. HISTORY

For the past several decades, there has been a growing recognition of the association between loneliness, social isolation and physical and mental health. Concurrently substantive research (National Academy of Sciences, the American Association for Retired Persons, or AARP, the National Center for Elder Abuse, et al) has emerged on the risks, causes and prevention of loneliness and social isolation in older adults. It is important to note that while loneliness and isolation are related terms, they are distinct concepts. Loneliness refers to the subjective feeling of being alone, and social isolation relates to a quantifiable number of relationships.

It is now widely accepted that loneliness and isolation are directly linked to greater risks of a wide range of negative outcomes on physical and mental health, mortality and quality of life. The dimensions of the adverse consequences are summarized below:

1. Social isolation and loneliness increase the risk of mortality.
2. Feelings of loneliness can negatively affect both physical and mental health (particularly depression and greater risk of elder suicide).
3. Social isolation can lead to unnecessary use of emergency rooms (lack of timely access to medical care), hospitalization and premature admission to nursing homes and higher

health care costs. (Source: San Francisco Department of Adult and Aging Services, Needs Assessment of Older Adults and People with Disabilities, 2016)

4. Feelings of loneliness are linked to poorer cognitive function and faster cognitive decline.
5. Isolated adults are at higher risk of elder abuse (physical, emotional mistreatment, fiscal exploitation, neglect by others, and self-neglect).

The Department of Disability and Adult Services (DAS) of the San Francisco Human Services Agency conducts a periodic comprehensive needs assessment on older adults and people with disabilities. Data and findings from the most recent report (2016) allows us to quantify the estimates of those at risk and forecasts of future need:

- The DAS study estimates that 7,200 to 16,000 seniors experience the heightened risk of isolation in San Francisco by 2020. They live alone, report disabilities that may result in being homebound, and are low income, having income below 300% of the federal poverty level.

- Based on the estimate above, as many as 10% of all seniors living in San Francisco (161,000 or 20% of the total population in San Francisco) are at risk for social isolation and its adverse consequences. National prevalence rates of isolation and its adverse consequences is estimated at 40%.

- The size of the population at risk will only continue to increase. San Francisco is a "graying" city; growth in the number of older adults is anticipated as the Baby Boomer generation ages and seniors are living longer. It is estimated that more than 250,000, or 30% of the City's population, will be seniors by 2030. Using current rates of risk (6 to 10% of seniors), it is estimated that between 15,000 and 25,000 are at risk of loneliness and isolation while the national prevalence would increase these rates. It is possible that these rates are even an underestimate and dependent on how we measure and define loneliness and isolation.

C. PLANNING AND IMPLEMENTATION

In the months prior to hiring a Program Manager, Curry Senior Center's Consumer Advisory Panel (CAP) met monthly to discuss issues facing seniors living in the Tenderloin, such as Program updates, staff changes, feedback from limited English speaking clients, and neighborhood issues. When the initial contract was awarded to Curry Senior Center, CAP provided input on recruitment of staff, the importance of diversity, outreach strategies, and potential training needs for the Peer Outreach Specialists to be hired.

In January 2015, a Program Manager was hired who had the life experience of being an older adult, history of mental health challenges, isolation, and familiarity of community resources in the Tenderloin neighborhood and outlying areas of San Francisco. During the 2 months prior to the start of the program, the Program Manager worked on recruiting and interviewing Peer staff, designing a 2- week training for the Peers, meeting with community partners, and

cultivating new relationships with agencies providing services for older adults in the centralized neighborhoods of San Francisco.

The City and County of San Francisco's MHSA team placed a sharp focus on engaging with the community through our community program planning efforts and the team demonstrated organizational efficiency in meeting the needs of community members so that their feedback is captured and integrated into program improvement efforts through a transparent process. The program planning and implementation efforts for this program incorporate the feedback of San Francisco community members and behavioral health consumers.

D. PEER RECRUITMENT

In recruiting Peer Outreach Specialists, the program took into account that a 'new' additional income for the Peers could possibly have an impact on their Social Security Benefits, Medi-Cal, and subsidized housing which are based on individual income. As a result, eight part-time positions were created.

The Program Manager recruited Peers through frequently used employment websites such as Craigslist and Indeed. More often, the Peers were recruited through San Francisco employment agencies such as Positive Resource Center, Citywide Case Management, and Richmond Area Multi-services (RAMS). Peers recruited from RAMS were graduates of RAMS Mental Health Certificate Program which is co-sponsored by San Francisco State University.

E. OUTREACH AND PARTNERSHIPS

Recognizing the importance of collaborating with neighboring service providers, Curry Senior Center cultivated strong working relationships with The Saint Francis Living Room, The Downtown San Francisco Senior Center, The Felton Institute, and Hospitality House. The program design included two (2) Peer Outreach Specialists and a desk, phone, and computer located at each agency. Memorandums of Understanding (MOU) were established outlining the roles and the relationships between agencies which included:

- The target population of seniors 60 years of age or older residing in the Tenderloin.
- Curry Senior Center will organize a quarterly meeting with program partners.
- Each agency will attend the quarterly meeting to discuss any changes in existing services, the sharing of information and resources for seniors, and to collaborate on outreach strategies.
- Curry Senior Center will provide ongoing training and support to the Peers to deepen their knowledge and skills necessary for peer to peer services.
- Each agency will contribute to the professional development of the Peer Outreach Specialists by providing a training twice a year on one of the topics requested by the Peers.
- Each agency will identify seniors in their programs who are isolating and who may be a good fit for the Peer Outreach Program at Curry Senior Center.

- Each agency will receive a payment of $1,000.00 each quarter for participation in this partnership.
- All agencies will consult with each other as needed to determine if their referrals are appropriate for the receiving program and provide necessary support to make enrollment to the program a positive experience for the clients.

F. CHANGES TO PROGRAM DESIGN

One significant change to the program design was the work location of the Peers. The original intention was to have two Peers located at each partnering agency with a desk, a phone, and a computer. In planning, lack of space to locate the Peers at three of the four agencies became problematic. It was also considered that the team would benefit from working from one centralized location, with easier access to team support, and the flexibility of being more mobile in the community. The program became centralized at Curry Senior Center, and the Peers were given 'smart phones' allowing the team to outreach within the partnering agencies and other locations throughout the Tenderloin neighborhood.

In the original design of the program, the target population was age 60+. The Curry Health Clinic expressed the need to refer older adults 55+. This was echoed by other agencies whose participants were 55+ as well. With approval by the MHSA Program Manager, the age was lowered to 55+.

An additional change to program design included clarifying definitions of loneliness and isolation to ensure that the program and MHSA goals were met. Through a better understanding of the terms, we saw that social isolation was measurable, but the presence of accompanying loneliness was more difficult to identify. Moreover, if loneliness co-existed with isolation, did it drive some of the health consequences which concerned MHSA and DAS? We recognized the need for stronger research protocols which included structured and validated measures of loneliness and isolation. We partnered with a team at University of California San Francisco in order to better refine the program evaluation.

G. TIMELINE OF FUNDING AND EXTENSIONS

In March of 2015, Curry Senior Center was awarded a 2-year contract by the Mental Health Services Act Oversight and Accountability Commission (MHSOAC) for Addressing the Needs of Socially Isolated Older Adults. Innovations funds of $500,000 were awarded. As the program developed, increased needs were identified which resulted in 2 requests for extensions and 1 request for additional funding as detailed in the following.

1. In July of 2016, SF MHSA and Curry Senior Center requested and received a 2-year extension, $500,000 for the program based on the following justifications:

- Clients requested more time to 'connect' and engage with the Peer providers.
- The Peers needed extended training to work more effectively with clients.
- There was a need to hire a Spanish-speaking Peer to outreach to limited English speaking seniors.

- The Peers requested more time to build and maintain rapport with clients.
- More time and resources were needed to better measure outcomes and see if there had been any progress with engagement, social inclusion, and decreasing stigma for the isolated older adults.

2. In May of 2018, MHSA/SF and Curry Senior Center requested and received a final extension for 1 year, $170,250, with the following justifications:

- To use additional interventions to engage ethnically diverse populations and the most isolated seniors.
- Ability to better evaluate the impact of the program.

H. ADDITIONAL FUNDING

In October 2019, Curry's Addressing the Needs of Socially Isolated Older Adults was awarded $195,787 additional 'one-time-only' funding for the final year of its Innovation programming. The justification for this request was as follows:

- Addressing a MHSA identified need for outreach to older transgender adults, the program hired a transgender Peer to conduct outreach to transgender older adults.
- Train the Peer Outreach Specialists to strengthen core competencies in the following areas: Grief and Loss, Trauma in the senior population, Harm Reduction/Motivational Interviewing, and the aging process.
- Increase social events.
- Working with the University of California San Francisco, Division of Geriatrics to assist in an evaluation of experiences and outcomes for dissemination.

II. SUMMARY OF SERVICES

A. PROGRAM STRUCTURE

Addressing the Needs of Socially Isolated Older Adults was 100% peer-run including all Peer Outreach Specialists and Curry Senior Center's Program Manager. The Peers were defined as having the shared life experience of being older adults, histories of isolation, consumers of the Behavioral Health System, residents of the Tenderloin, or having had a history of homelessness. Through the course of the 5 years of providing services, the demographics of the team reflected the population served, at times focusing specifically on underserved populations within the Tenderloin/Civic Center older adult community. This is a highlight of the program services and reflected in the qualitative program evaluation conducted between March and June 2020.

Program Outreach: Working under the original assumption that isolated seniors were not connected to services, the team began by reaching out to seniors where seniors were known to gather in the Tenderloin; the Dining room at Curry Senior Center, The Family Service Agency Drop-In Center, the Downtown San Francisco Senior Center, the St Francis Living Room, and the Hospitality House Drop-in Centers on the 6th Street corridor and Leavenworth Street. The Program Manager presented the program to other agencies that provided 'limited basic needs', services of food, shelter, and money management in hopes of cultivating referrals.

Core Functions: At the core of Addressing the Needs of Socially Isolated Older Adults was the intention to cultivate trusting relationships. It was through these connections that participants would hopefully be inspired to seek treatment for mental health or substance use, medical attention or case management services. The Peers began with the soft approach of getting to know the seniors through home visits, accompanying them running simple errands, or connecting them to activities in the neighborhood. Strategies to reduce isolation were driven by the participants' interests, strengths, and desire to bring about change in their lives. The number of visits each client received was dependent on the client's degree of loneliness and isolation.

Since most of the program participants were found to be connected to service providers, linking clients to services for the first time in the community did not occur as much as was initially expected. Instead, one of the strengths of the peer connection was referring clients back to their service providers by suggesting, reminding, or accompanying clients to needed services. This fact was again reflected in the qualitative evaluation after interviews with peers and clients and highlighted that often in program design and dissemination, initial assumptions and plans must evolve as the needs of clients are better understood. Linkages and referrals to such services included these examples:

- **MEDICAL PROVIDERS:** Curry Senior Center Health Clinic, Tom Waddell Health Clinic, Saint Anthony's Health Clinic, or San Francisco General Hospital.
- **MENTAL HEALTH PROVIDERS:** Curry Senior Center, Westside Community Services, Central City Older Adults, Tenderloin Outpatient Clinic, South of Market Mental Health.
- Case Management: Curry Senior Center, Institute on Aging, Westside Community Services, Central City Older Adults, Episcopal Community Services/Canon Kip.
- **SUBSTANCE USE TREATMENT:** Curry Senior Center.
- **HOUSING SPECIALISTS:** Curry Senior Center, Hospitality House, Glide Memorial
- **ACTIVITIES IN THE NEIGHBORHOOD:** Congregate Meals at Curry Senior Center, Saint Anthony's, Downtown San Francisco Senior Center, The Living Room, Open House. Drop-in Centers at Curry Senior Center, Hospitality House. Community Service Programs at Curry Senior Center, Downtown San Francisco Senior Center, The Healing Well, Episcopal Community Services/Canon Kip. Local Parks; Boedecker Park, Yerba Buena Park, Jefferson Square Park, Golden Gate Park, Salesforce Transit Center Park. Free events at local museums, the public library, Yerba Buena Center for the Arts, SRO Hotel events. Coffee at local café's, walks in the city, art programs at Hospitality House.
- **PERSONAL BUSINESS:** Walgreens, grocery shopping, pharmacies for medication, representative payee check distribution, banks, dollar stores, thrift stores, library, farmers' market.

Through referrals and outreach, the Program recognized 12 barriers to socialization that were often expressed by the program participants. This finding was not apparent during the initial design phase, but proved to be a core feature linking loneliness, isolation and ultimately effectiveness of the program as evidenced in our results section below. These included:

- Body ability
- Body function
- Safety
- Financial: Participants are low income
- The climate of the neighborhood
- Mental health
- Substance use
- Proximity: How far away services were.

- Mood
- Homelessness
- Language barriers
- Cultural difference

B. CREATING EVENTS

At the start of the program, there was a core assumption that isolation was magnified by the lack of culturally appropriate activities. According to the San Francisco Department of Public Health, a great disparity in connection to services existed in the older African American community. In response, the Peers created 'Soul Food Monday.' Hosted one time per month, the event catered soul food, celebrated African American culture, and provided a raffle of prizes to primarily African American seniors. The event was open to the 55+ community and also provided another opportunity for program participants to socialize and potentially be connected to services.

In the same spirit as 'Soul Food Monday,' the peer program created 'Guitarras'; a program designed to reach out to undocumented Latino seniors whose isolation was increased due to the political climate in the United States. Held at the Cadillac Hotel in the Tenderloin once a month, Guitarras brought together Mexican Folk music, tamales, papusas and casamiento, prepared by a participant in the peer program. Eventually 'Guitarras' evolved into an open-mic for all. This intergenerational event celebrated the talents of the seniors involved in the program, residents of the Cadillac Hotel, and neighbors in the community. Both of these examples highlight the importance of knowing the population you serve and designing programs through participatory engagement of peers and clients in order to achieve success.

In 2018 Addressing the Needs of Socially Isolated Older Adults received a second grant to expand the program which included teaming up with Episcopal Community Services/Canon Kip in creating the Senior Center Marching Band. This event was held once a month as well. The event outreached to a predominantly Filipino population of seniors through music and food.

Music choices were selected by participants via YouTube. Participants were given musical percussion instruments to play along with as line dancing and circle dancing were encouraged. During the event 2-3 seniors were randomly invited to complete questionnaires which included assessments of their levels of isolation, loneliness, and depression. The seniors chosen were primarily Filipino which was a population we had not yet assessed for the prevalence of isolation and loneliness. The event usually ended with healthy snacks of fruits and nuts.

The Peers recognized that despite the success of these two social events, there was a need for smaller, more intimate opportunities for seniors to connect. 'You Can Have Your Cake and Eat it Too' and 'The Breakfast of Champions' welcomed small groups of program participants to socialize without the intimidation of large groups. Cake and tea were offered in the afternoon to discuss current events, favorite foods, desserts, and concerns facing seniors. 'The Breakfast of Champions' brought our Spanish speaking monolingual Latino clientele together for papusas and coffee. It was through these smaller events that friendships were fostered. Again, as we move into dissemination phase, this highlights the importance of continuous evaluation and tailoring of programs to the needs of the clients rather than sticking to preconceived notions of what the populations needs in order to address isolation. This means creating programs broad enough to scale, but intimate enough to include those desiring smaller, less intimidating and more culturally appropriate opportunities.

C. CLIENT SUCCESS STORY #1

A 77-year-old client was referred to the Addressing the Needs of Socially Isolated Older Adults Program in October 2015. The client was described as extremely isolated while suffering from agoraphobia with no significant relationships or connections to services.

When our Peer, Frank, knocked on the client's door, the client only opened the door 6 inches. Frank introduced himself and our program and asked if he could return to visit. The client agreed. Over the course of the first month of visits, the client would only open the door 6 inches. Frank reported the constantly drawn shades, and the elderly woman in her pajamas, anxious and alone.

In November, the client began opening the door by 12 inches and by December, she invited Frank in to visit. The client began calling Frank on the days he did not visit. Trust was being built. On occasion, Frank runs to the corner store to pick up items she needs, all the while he reminds her that someday soon they will walk there together. Frank realized that the client's mental health issues were fairly severe. We sought support and advice on how best to work with our client from our Behavioral Health Director at Curry.

In March, the client began asking Frank about getting help from a therapist. Frank referred her to Curry's MHSA Mental Health Therapist/Case Manager. Over the past two months, the client has made slow progress as the therapist has discovered a complexity of psychiatric impairments.

Frank continues to work with her. Most recently he connected the client to a female massage therapist who is elderly and provides free massages to other seniors in the neighborhood. Frank is also informing the client that Curry provides medical care through the clinic in hopes that one of our providers could possibly do house calls until the client is ready to make it to the clinic on her own or escorted by Frank.

C. CLIENT SUCCESS STORY #2

Assistant Program Manager Andres Lozano often accompanies his longtime client to coffee hour at the Le Nain Hotel for seniors in the Tenderloin. As they visited one morning, Andres noticed a gentleman sitting alone. Andres approached him and struck up conversation. The gentleman (we will call him Samuel) was monolingual Spanish Speaking and new to the Le Nain, and new to the Tenderloin. As the conversation continued, Samuel revealed he was in need of medical treatment, food, and more importantly that he was very alone and had been for several years. Andres invited Samuel to join him and his client as they were heading to Curry Senior Center where they could sign him up for meals in the Dining Room and perhaps make a medical appointment in the clinic. Within the hour Samuel was fed and signed up for his first medical appointment.

Since Andres had a full caseload, our Peer Outreach Specialist, Michael Belmontes began to work with Samuel. Michael quickly learned that Samuel had come to the US undocumented after fleeing a war where he witnessed tremendous violence and human loss. Consequently, Samuel lives with PTSD and Major Depressive Disorder. Michael began to visit regularly; Samuel was always waiting and ready at their appointed time.

In March, Michael invited Samuel to Guitarras, a monthly social event hosted by Assistant Program Manager Andres Lozano at the Cadillac Hotel. The event is an open-mic for seniors with a concentrated effort to outreach to monolingual Spanish speaking, undocumented Latino seniors who are experiencing increased isolation due to the political/immigration environment of the US. Samuel was introduced to another client who makes the tamales for the event. They discussed favorite foods, including the different ways lizard is prepared. Samuel requested a song from his home of origin and, as the music played, him singing along, his eyes filled with tears. Later he recounted the memories of his wife and family back home.

Through Michael's ongoing visits, conversations and encouragement, Samuel has been connected to a Church in the Mission, attending weekly. Samuel expressed desire to purchase a cart from which he can sell elotes (boiled corn on a stick) and sell them in

CLIENT SUCCESS STORY #2 Continued

the Mission District with other street vendors. The Church heard of this and offered the use of their kitchen where he can cook the corn. Through his work he hopes to save enough money to be reunited with his family.

Michael has also connected Sam to a local organization that teaches people to ride bikes, has connected him to Library services where he signed up for English classes and computer classes, as he was issued his first library card. The first book he checked out was 'English for Dummies'. Sam is part of a new social group the Peer Program created for monolingual Spanish speaking seniors, 'The Breakfast of Champions', meeting once a month at a local diner for breakfast. Sam visits his new friend from time to time and looks forward to her tamales at the next Guitarras.

D. PEER SUPPORT

The support of the Peers was an integral part of the success and definition of the program. The team met once a week to discuss outreach challenges, success stories, and coordination of programmatic agenda. The peers also received a 1-hour one-on-one supervision with the Program Manager to discuss individual clients' needs, along with receiving support in the peers' own professional development, wellness, and recovery.

The initial team of Peers received a two-week training. The trainings were facilitated by community partners and clinicians from the Curry Senior Center Health Clinic. Some topics included: harm reduction, de-escalation, drugs 101, physical and mental health facing older adults, cultural humility, outreach strategies, motivational interviewing, self-care, and literature on loneliness and isolation facing older adults in the world. When the program implemented the use of validated measures, Carla Perissinotto, MD, MHS, of the University of California, San Francisco, presented a training to the Peers o the relevance and prevalence of isolation and loneliness among older adults and the importance of evaluation to measure the impact of the Peers' meaningful interventions. This training enabled the Peers to see the value and significance of their work.

Ongoing, the Peers received one training per month, often on subjects per their request, once again, focused on their professional development, wellness and recovery. The program also initiated a strong relationship with Richmond Area Multi-services (RAMS). An MOU was established which encouraged the program staff to attend the Entry Level and Advanced Level Mental Health Certificate Programs along with the Leadership Academy courses offered once a month. RAMS in turn provided interns to work as Peer Outreach Specialists for 9 months. One intern was hired as a part-time Peer Outreach Specialist employed by Curry Senior Center.

III. EVALUATION METHODS

A. LEARNING QUESTIONS

1: Will using a peer to peer system effectively engage, empower, and instill protective factors for adverse mental health outcomes for socially isolated older adults living in the highly depressed neighborhood of the Tenderloin in San Francisco?

2: What kinds of support are most needed by peer supporters in their learning as mental health professionals, as well as in their recovery journey from mental health challenges?

B. OBJECTIVES

1. Understand the prevalence of loneliness and isolation.
2. Understand the factors influencing social isolation and loneliness.
3. Understand if a relationship with a peer could reduce loneliness and isolation
4. Understand the most important aspects of the peer relationship in order to disseminate and scale the program.

C. DATA COLLECTION

Our primary data collection method was quantitative using structured in-person surveys that used validated assessments of social well-being at baseline, 6, and 12 months, including loneliness (3-item UCLA loneliness scale), social interaction (10-item Duke index), self-perceived barriers to socializing (Range: 0-10 barriers), and depression (PHQ-2 screen). We also assessed participants' satisfaction with the program through self-report. We used mixed-effects linear and logistic regression to determine significant changes in assessments over time. These quantitative methods were geared toward understanding program effectiveness.

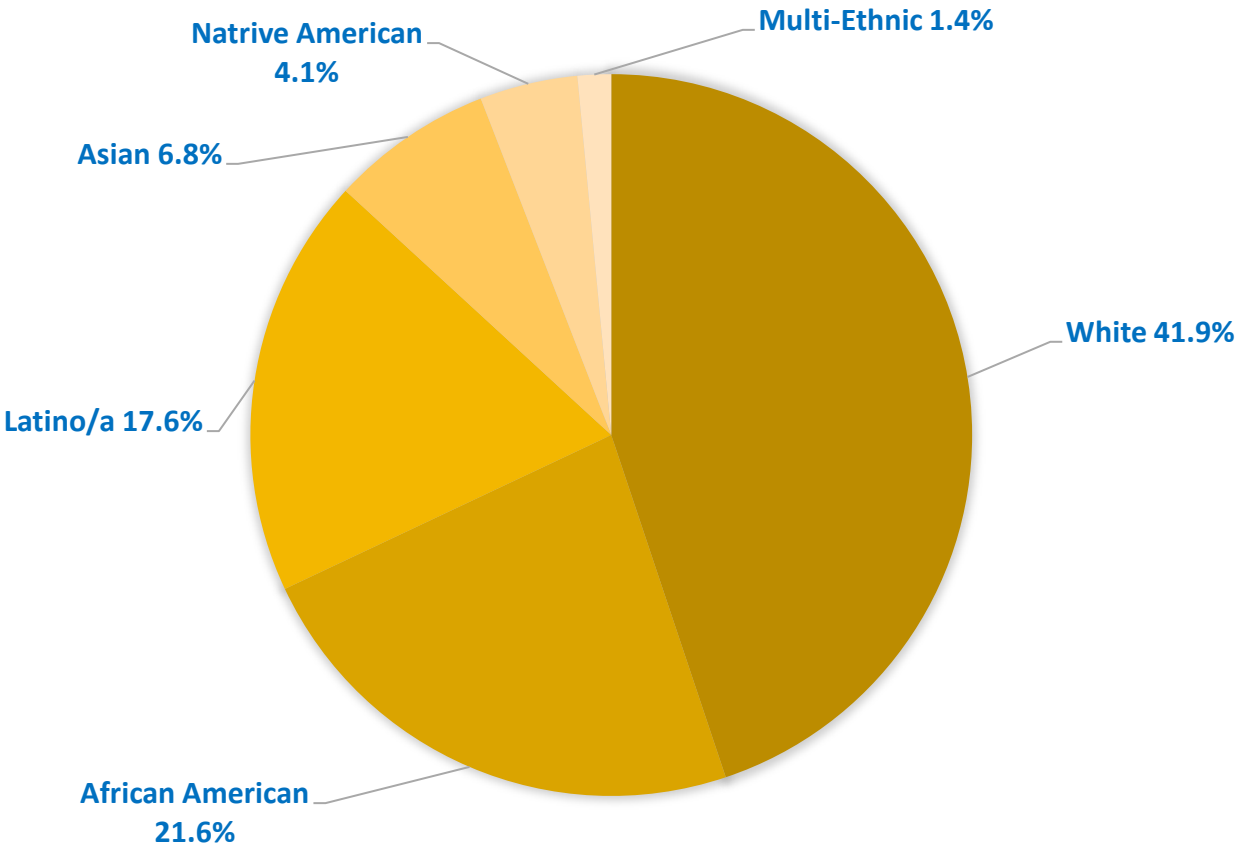
The second data collection method was qualitative and focused on the evaluation of the program in order to understand what factors will be important for dissemination. The qualitative methods were conducted in the following way. From March-June 2020, an evaluation team from UCSF conducted in-depth, semi-structured qualitative interviews with a sample of clients (n=15) and peers (n=6) to assess their experiences in the program. Interviews were conducted by telephone, audio-recorded and transcribed for analysis. Five of the client interviews were conducted in Spanish; the remaining 16 interviews in English. The inclusion of qualitative analysis ensured that the stakeholders (peers and clients) contributed to the program evaluation. In addition, in the quantitative analysis (surveys), participants and interviewers were also able to add any comments and observations that arose during the survey period.

D. PARTICIPANT DEMOGRAPHICS

Descriptive Statistics Summary: (Appendix Tables 1 – 2)

- Participant age ranged 58 – 96 years old
- Participants were visited over 12 months
    - The average participant had 54 points of contact
    - The average time spent per contact was 74 minutes
- 63% of participants were male
- 15% of participants were LGBTQ
- 86% of participants lived alone
- 76% of participants were unmarried/unpartnered

Participant Ethnicities consisted of:



Participants experienced the following medical conditions, with some participants experiencing multiple conditions:

Depression
55.4%

Anxiety
43.2%

Hypertension
32.4%

Diabetes
29.7%

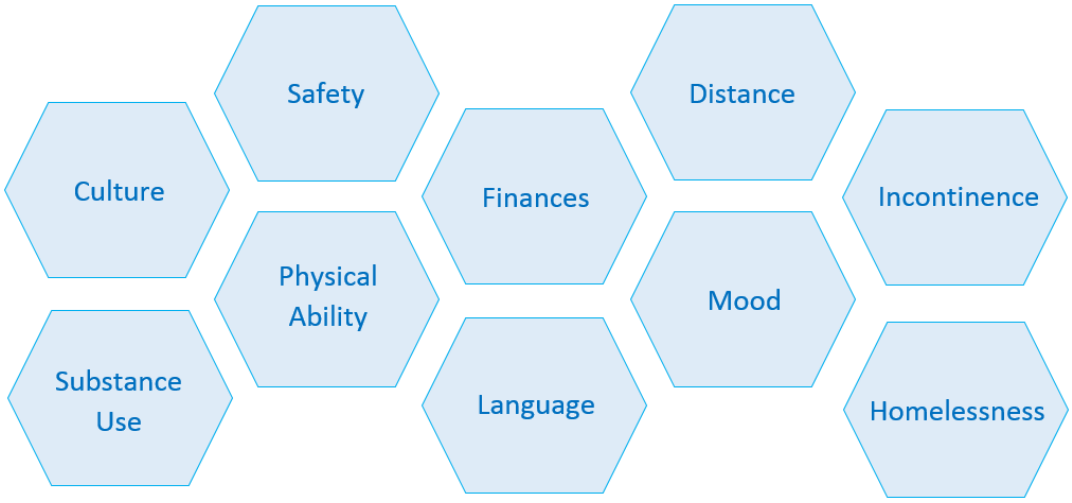
Cancer
18.9%

Heart Disease
14.9%

Lung Disease
10.8%

Prior Stroke
9.5%

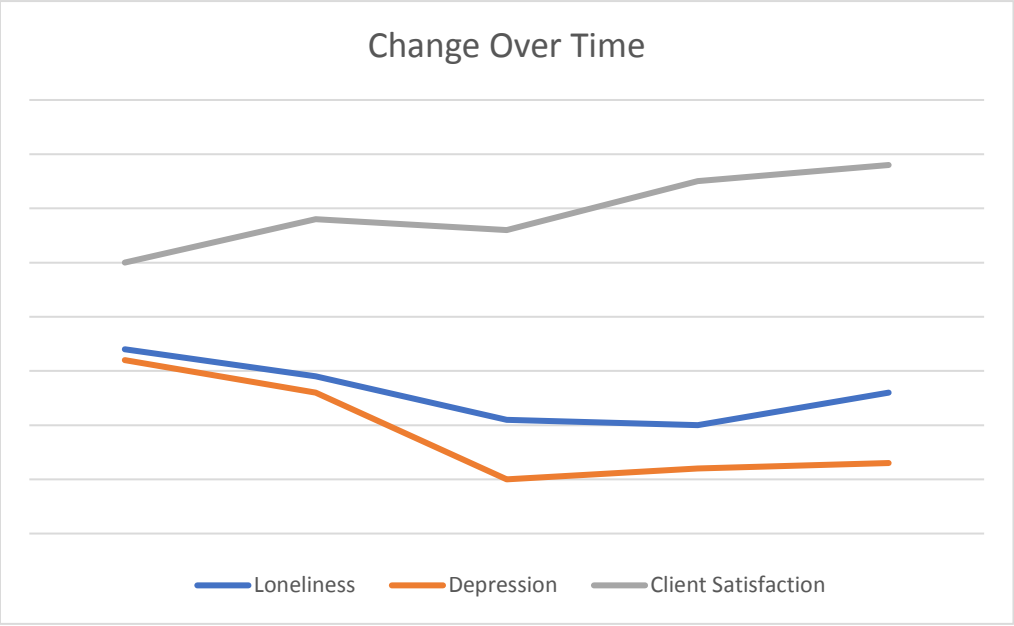
Participants faced the following barriers to socialization:



E. OUTCOMES

(Appendix Table 3 and Table 4, figures 1-4)**:**

- From baseline to 12 months, **fewer participants reported loneliness** (92% to 64%, p=0.006).
- From baseline to 12 months, there was **also reduced depression** (40% to 15%, p=0.07) and **fewer barriers to socializing** (4.0 barriers to 2.4 barriers, p<0.001), with the largest change in reports of poor mood as a barrier (57% to 25%, p<0.001).
- Over 12 months, the program's success was dependent on the length of the relationship between clients and peers and engagement in activities. Though MHSA had a goal of connecting to services, Table 3 demonstrates that improvement in loneliness was more likely related to engagement in OTHER activities. This is also expressed in the qualitative data (Table 5).
- Over the 12-month period, changes in social isolation were variable and not necessarily overall improved (figure 4). This is because the **Duke Scale, may not have ultimately been the best scale to use** and it did not actually match the goal of the program. Ultimately, the programming seems to have had a greater effect on loneliness rather than helping clients form new relationships or the relationships asked about in the Duke Scale.
- Over the 12 month period, participants had **high rates of satisfaction with their peer** (96% reported being extremely satisfied), 100% felt welcomed by the program, and 100% stated they would recommend the program to others, and participants felt that their culture was respected, showing the cultural appropriateness of the program.



F. QUALITATIVE EVALUATION

The Qualitative evaluation helped us determine which activities and elements of the project contributed to the above successful outcomes.

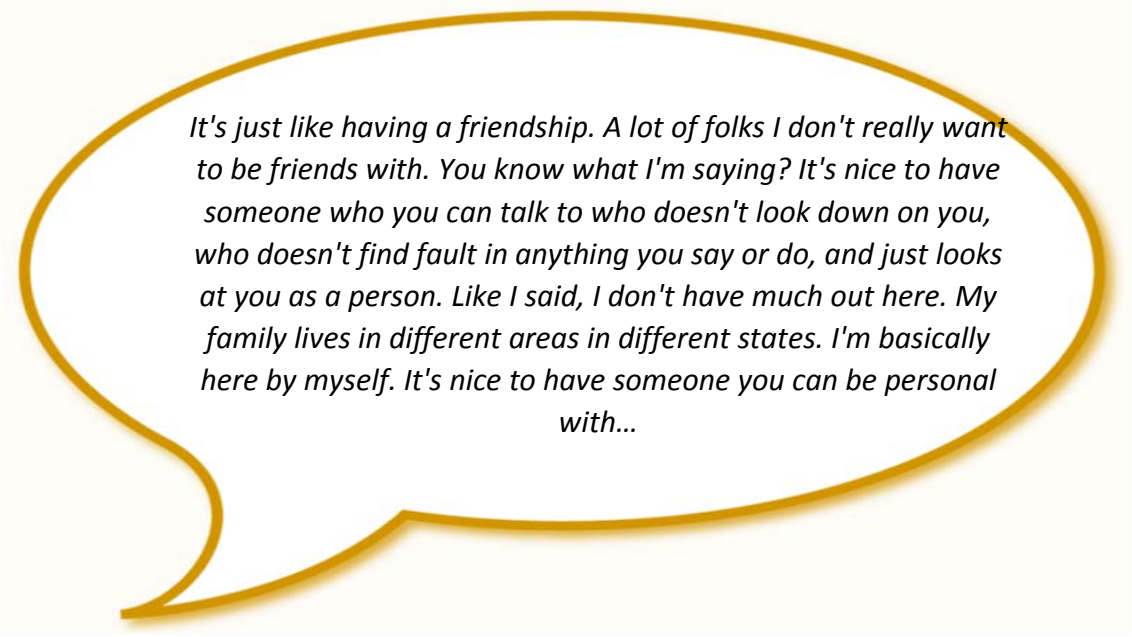
On average, the clients interviewed had been enrolled in the peer program for approximately 2 years (range: 2 months – 3 years). The interviews revealed strong endorsement of the program from both the peers and clients. Clients described two tangible benefits and supports from the peers:

- connections to medical and psychosocial services
- accompaniment on errands

Yet, they frequently underscored the **intrinsic value of having someone they felt connected to consistently checking in on them over an extended period of time**. In other words, simply knowing that someone cared about them, and would be available to listen and help was both empowering and validating. Similarly, **peers felt good about their work**, felt that they were making a difference and that the structure of the program made this possible. The peers also noted that having flexibility to meet their peers as different times and engage in different types of activities were also key successes of the program.

Additional Key themes identified and highlighted by direct quotes are as follows.

CLIENT FEEDBACK



CLIENT AND PEER FEEDBACK CONTINUED

I think you really have a chance to touch someone and to connect with them on however deep level you can. And establish a trusting relationship, which I think is very important and really heals people

I've noticed that a lot of the depression - and there's like a general feeling of frustration, anxiety, and depression - not heavy-duty. But that I've noticed in most of my clients, that's started to lift. One in particular. We went in and we fixed up her apartment, or her SRO. And I helped her do it. And we actually went down to Best Buy and we got a TV. And this was the one who was trying to quit drinking. And she just was on fire. All of a sudden, she had this interest about setting up her apartment and whatnot. So that was really good to see. She had an interest in things again.

For me, the visits are important… as I say, as for moral support. Well, sometimes I feel kind of sad, because nobody visits me. And, then he appears and I'm already happy.

IV. LESSONS LEARNED

1. Was the learning question answered? Please describe in detail.
    - **Learning Question #1:** Will using a peer to peer system effectively engage, empower, and instill protective factors for adverse mental health outcomes for socially isolated older adults living in the highly depressed neighborhood of the Tenderloin in San Francisco?

      One of the strengths of the program was that through developing trusting relationships and low-threshold program access, program participants and Peers were not confined to the structures often experienced in mental health services. This 'agenda-free' model permitted participants and Peers to share their life experiences which included navigating through both medical and mental health systems of care. The trappings of diagnosis and treatment therefore were not at the forefront of the relationship, allowing program participants and Peers to address these issues with more ease, empowerment, and familiarity. Through this 'non-clinical approach, the program witnessed reductions in reported depression and loneliness.

      Another strength of the program was the reduction in perceived barriers to socialization. The program identified 12 barriers to socialization. Of these, safety was a common concern for older adults. With Peers at their sides, older adults were more empowered to go to social activities, run essential errands, frequent congregate dining opportunities, and access medical and behavioral health service appointments. Finances was another area identified as a barrier to socialization. The program created four free, monthly events for older adults, coupled with the Peers' knowledge of a wide variety of free programs, events, and outings in San Francisco. With a trusted companion at their side, the program witnessed a reduction in this area as well. Another identified barrier was mood. The reduction in depression and loneliness correlates with the decrease in mood as being a perceived barrier to socialization. A final barrier reduction worth noting was physical ability. Being homebound and having ambulatory challenges, and vision impairment are examples of physical abilities which impaired older adults' access to socialization. The program participants who identified this area as a barrier, benefitted from the escorts and visits of the Peers.

      In the final year of the INN contract, the program identified two program participants who were willing to outreach to other isolated/lonely seniors on a volunteer basis. Due to the onset of Covid 19 at the end of the contract, the program did not realize this goal, however, looking ahead, the program hopes to empower these seniors in the role of volunteers.

- **Learning Question #2:** What kinds of support are most needed by peer supporters in their learning as mental health professionals, as well as in their recovery journey from mental health challenges?

  The Peer Outreach Specialists received ongoing support in three ways: the weekly team meeting, the one-on-one supervision with the Program Manager, and monthly trainings in professional development, wellness, and recovery.

  The weekly team meeting provided the Peers with the opportunity to share success stories and challenges they were facing in the work they were doing with their program participants. This venue provided each Peer with professional development support from their colleagues and Program Manager. The meeting also provided the Peers the opportunity to share resources and information they had garnered on their own. This information was both program participant centered or Peer focused. Although not required, there were times when the Peers self-revealed mental health/recovery challenges/successes they were experiencing.

  Each Peer met once a week with the Program Manager. The supervision provided the Peers with a more in-depth support/supervision regarding each of their program participants. The Peers were also provided the opportunity to discuss their own challenges in their recovery or desires in professional development. The Program Manager, also a Peer, would encourage, empower or assist the Peers through being a supportive ear, referring the Peer to professional services if needed, or encouraging the Peer to pursue outside avenues of learning. If the Peer was experiencing a mental health challenge, i.e.; an episode of depression, the Program Manager not only would encourage the Peer to seek support from their service provider, but also permitted the Peer to take time off if needed to take care of themselves.

  The Program developed a strong relationship with Richmond Areas Multi-Services (RAMS). Through this relationship, the Peers were encouraged to enroll in RAMS Mental Health Certificate Entry Course and Peer Specialist Mental Health Advanced Course while working as a Peer Outreach Specialist at Curry Senior Center. RAMS also provided monthly trainings through their Leadership Academy. Curry Senior Center and RAMS developed an MOU which provided the Peers priority in their enrollment in the RAMS certificate programs. In addition, Curry Senior Center provided monthly trainings which focused on the needs/community services geared towards working with older adults. The program also provided trainings based on Peer identified needs. These trainings focused on professional development, wellness, and recovery.

2. Highlights/key learnings:

- **Connection to Services** – The program originally operated under the assumption that isolated older adults were not connected to services and needed to be connected. The program discovered in the first year that older adults who were isolating were already receiving/linked to a variety of services; primary care providers, case managers, therapists and support groups. The strength the Peers brought to their relationship with the program participants was through suggesting/encouraging that they contact their providers, helping make appointments to see their providers, or escorting participants to appointments.
- **Relationship Building** – Through interviews conducted with program participants, it was revealed that the participants needed more time than 6 months to develop trust in the relationship with their Peer.
- **Culturally Relevant Events** – The need for culturally relevant special events to bring older adults together was identified. Open to anyone 55+, these events provided opportunity for program participants to get out into the community, while at the same time, gave the Peers opportunities to outreach to potential program participants.
- **Increasing the Diversity of the Peers** – As referrals were generated to the program, specific needs were identified. Spanish and Cantonese speaking Peers were hired, LGBT Peers with familiarity with HIV/AIDS services were recruited, and a transgender older adult was hired to outreach to the transgender population. Female Peers were difficult to recruit to work in the Tenderloin because of safety. The need for female peers was constant as women often preferred a female Peer to work with.
- **Initial Contact** – Through participant interviews and Peer focus groups, the first initial meeting was reported as being the most challenging. The Peers used active listening approaches and asked open ended questions to help move through the initial awkwardness.
- **Peer Caseloads** – How often Peer Outreach Specialists met with the program participants was dependent on the need of the individual combined with the number of participants each Peer was seeing. The caseload was also dependent on the number of hours each Peer worked each week. In the beginning, each Peer worked 12 hours per week. As the Program developed the Peers worked anywhere from 12/hrs. per week to 37.5/hrs. per week. The program was also sensitive to the Peers' work ability, always maintaining a conversation regarding caseload capacity.
- **Measuring Impact** – The first 2 years the program used an in-house isolation scale created by the Program Manager. At the end of the 2nd year, the program partnered with the University of California San Francisco (UCSF). A robust questionnaire (attached) was developed and administered at baseline, 6 and 12 months and every 6 months thereafter. The questionnaire included the Duke Isolation Scale, The UCLA Loneliness Scale, the PHQ-2 Depression Screen, and perceived barriers to socialization.

- **Peer Income** – Hiring Peers involved having a discussion on how the 'new income' would impact their Social Security Benefits and subsidized housing. Peers were encouraged to speak to employment specialists at agencies available in San Francisco, or to make appointments with the Social Security Administration. Regarding subsidized housing, the Peers were encouraged to speak with the Property Managers of the buildings where they lived to understand the impact a 'new income' would have on their rents.
- **Training** – The need for repeated trainings in the areas of grief and loss, trauma in older adults, the aging process on body and mind, and motivational interviewing were identified. These core competencies assisted the Peers in the relationships they cultivated, but also as older adults, they themselves integrated the learning into their own aging process.

3. Recommended significant changes:
    - Would ensure that relationships can be longitudinal and flexible enough to allow clients and peers to develop the relationship that is best for them to accomplish the program participant's goal of increasing socialization.
    - Expand capacity to outreach to the Filipino, Chinese, Southeast Asian, and HIV/AIDS older adult communities.
    - Create more culturally specific social events that meet monthly.
    - Increase access for older adults to get out of the inner-city neighborhoods. (Monthly excursions).

V. ACCOMPLISHMENTS

Diverse, socially vulnerable older adults actively participated in a novel peer-mentoring program which resulted in high satisfaction rates with the program and the peer relationship. Preliminary evidence suggests the intervention is associated with reductions in loneliness, and unexpectedly self-perceived barriers to socializing, and **depression.**

Over the course of the 5 years of this pilot project, 3 team members passed away unexpectedly, while 1 team member experienced the onset of dementia. The team was remarkable in outreaching to the families of the deceased, comforting one another through their grief, and integrating the team member with dementia into their list of regular contacts to ensure that their colleague did not experience isolation and loneliness.

VII. MOVING FORWARD AND PROJECT SUSTAINABILITY

In 2007, Curry Senior Center partnered with the University of California San Francisco, Carla Perissinotto, MD, MHS, a national expert on Isolation and Loneliness among older adults, to measure the impact and outcomes of the program. Many of the results from their research are

included in this report all suggesting that the intervention of this program was highly successful, most notably in the mental health challenges of depression and loneliness.

Client satisfaction surveys were administered annually to program participants, 96.3% of program participants, agreed or strongly agreed that they were satisfied with their peers, 100% agreed or strongly agreed that their culture and lifestyle were welcomed and respected, and 100% of program participants agreed or strongly agreed that they would recommend the program to others.

In 2019, the final year of the INN program, SF MHSA presented the program to various stakeholders in the community of San Francisco to gather feedback on the relevance and potential continuance of the program. In 2020, Curry Senior Center received confirmation from SF MHSA of continued funding for the program through the MHSA Prevention/Early Intervention (PEI) component of funding.

The program continues to receive regular referrals from service providers in San Francisco. In 2020, the program hired a transgender older adult to specifically outreach to the older transgender population of San Francisco. This facet of the program is being strongly embraced by the Transgender Community.

VIII. DISSEMINATION OF PROJECT RESULTS

MHSA/SF seeks to keep stakeholders and the broader community informed about Innovation Projects through a variety of communication strategies. This report and the results of this Innovation Project will be disseminated through various modalities including the San Francisco MHSA webpage on the SF Department of Public Health website: https://www.sfdph.org/dph/comupg/oservices/mentalHlth/MHSA/default.asp; regular communication with community groups including the MHSA Advisory Committee and the Behavioral Health Services Client Council; the monthly Behavioral Health Services Director's Report; the Behavioral Health Services Executive Team; and regular updates to all MHSA stakeholders through MHSA email distribution and other meetings. Lastly, this report will be disseminated to the Mental Health Services Oversight and Accountability Commission (MHSOAC) with the State of California.

1. National Academy of Sciences EaM. Social isolation and loneliness in older adults: Opportunities for the health care system. Washington DC: The National Academies Press; 2020.
2. Perissinotto CM, Stijacic Cenzer I, Covinsky KE. Loneliness in older persons: a predictor of functional decline and death. Arch Intern Med 2012;172:1078-83.
3. Medicare spends more on socially isolated older adults. 2017. (Accessed 11/12/2019, 2019, at https://www.aarp.org/content/dam/aarp/ppi/2017/10/medicare-spends-more-on-socially-isolated-older-adults.pdf.)

IX. APPENDIX

Table 1. Sample Characteristics of Participants in the Peer Mentoring Intervention (N=74)

Characteristics		N	%
Age	Median (Interquartile Range)	74	70 (66-76)
	Range	-	59-96
Gender	Male	43	58.1
	Female	30	40.5
Sexuality	Heterosexual/straight	56	75.7
	Gay, Lesbian, or Bisexual	13	17.6
Ethnicity	White	31	41.9
	African American	16	21.6
	Latino(a)	13	17.6
	Asian	5	6.8
	Native American	3	4.1
	Multi-ethnic	1	1.4
Primary Language	English	46	62.2
	Spanish	13	17.6
	Chinese	5	6.8
	Other, Non-English	3	4.1
	Russian	1	1.4
Education	College graduate or more	9	12.2
	Some college	21	28.4
	High school/GED	19	25.7
	<High school	15	20.3
	No formal education	3	4.1
Veteran	Yes	8	10.8

Characteristics		N	%
Medical Conditions	Depression	41	55.4
	Anxiety	32	43.2
	Hypertension	24	32.4
	Diabetes	22	29.7
	Cancer	14	18.9
	Heart disease	11	14.9
	Lung disease	8	10.8
	Prior Stroke	7	9.5
Disability Benefits	Yes	37	50.0
	No	22	29.7
	Declined answer	15	20.3
Disability Diagnosis	Mobility	36	48.6
	Vision	22	29.7
	Health condition	15	20.3
	Hearing	13	17.6
	Speech	10	13.5
	Cognitive	6	8.1
Disability in Activities of Daily Living	Bathing	22	29.7
	Dressing	12	16.2
	Incontinence	12	16.2
	Toilet	7	9.5
	Moving	7	9.5
	Eating	6	8.1

Table 2. Baseline Social Characteristics of Participants (N=74)

Characteristics		N	%
Housing	Yes	71	95.9
Live Alone	Yes	65	87.8
Married/Partnered	Yes	10	13.5
Currently working	No	2	2.7
City Programs	Mean (SD)	3.5(1.7)	
	Medical Appts	62	83.8
	Case Manager	57	77.0
	Meals on Wheels	34	45.9
	IHSS	29	39.2
	Mental Health Appt	28	37.8
	Urgent/ED Use	17	23.0
	Drop-In Centers	16	21.6
	Substance Use Tx	6	8.1
	Other	5	6.8
	Community Programs	3	4.1
Barriers to Socializing	Mean (SD)	3.8 (1.9)	
	Physical Ability	51	68.9
	Safety	47	63.5
	Financial	54	73.0
	Distance	44	59.5
	Mood	39	52.7
	Culture	15	20.3
	Incontinence	12	16.2
	Language	11	14.9
	Substance	6	8.1
	Homelessness	0	0.0
Loneliness (Range: 0-6)	High (3-6 pts)	49	66.2
	Moderate (1-2 pts)	14	18.9
	Low (0 points)	9	12.2
Duke Social Support Index (Range: 0-20 points)	High (11+ points)	39	52.7
	Moderate (6-10 pts)	18	24.3
	Low (0-5points)	17	23.0
Frequency Meeting up in last week with family/friends (Range 0-7+)	None	15	20.3
	Once	6	8.1
Frequency Talking in last week with family or friends (Range 0-7+)	None	17	23.0
	Once	9	12.2
How often can you talk about your deepest problems with family or friends?	Hardly Ever	24	32.4
	Some of the Time	25	33.8
	Most of the Time	20	27.0
Depression Screen (PHQ-2)	Positive screen	27	36.5

Table 3. Log of visits, missed connections, and connections to activities over 12 months (N=74)

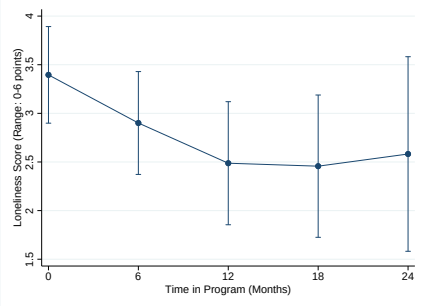
Number of visits	Median (IQR)		43 (31-97)
	Range		1-168
	Proportion (%)		
		1-5	2.7
		5-10	2.7
		11-20	9.5
		20-50	47.3
		50+	37.8
Number of missed connections	Median (IQR)		11 (5-25)
	Range		0-105
	Proportion (%)		
		0	9.5
		1-5	23.0
		5-10	20.3
		11-20	23.0
		20-50	21.6
		50+	2.7
Number of connections to activities - Median (IQR)	Medical visits		2.5 (1-5)
	Mental Health		1 (1-3)
	Substance Use Treatment		1 (1-2)
	Case Manager		1 (1-3)
	Other Medical		11 (3-43)
	Other Activity		54.5 (28-81)

Table 4. Satisfaction with program (n=55)

Questions		N	%
I am satisfied with my peer	Strongly Agree	43	79.6
	Agree	9	16.7
	Disagree	2	3.7
	Strongly Disagree	-	-
My culture and lifestyle is welcomed and treated with respect	Strongly Agree	46	83.6
	Agree	9	16.4
	Disagree	-	-
	Strongly Disagree	-	-
I would recommend the peer program to others	Strongly Agree	45	81.8
	Agree	10	18.2
	Disagree	-	-
	Strongly Disagree	-	-

Figure 1. Changes in Loneliness and Depression during the Intervention

A. Loneliness Scores over Time



B. Screen Positive for Depression over Time

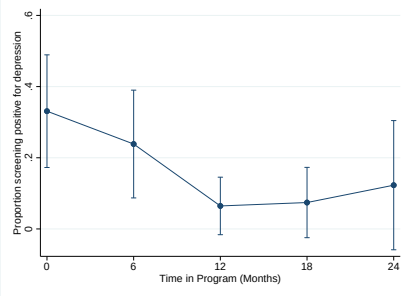
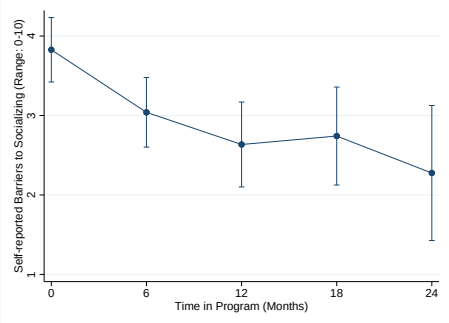


Figure 2. Changes in self-reported barriers to socializing over time during the intervention

A. Overall number of self-reported barriers to socializing over time



C. Proportion reporting mood as barrier to socializing

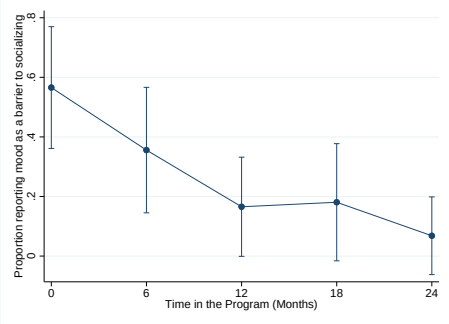


Figure 2 continued

D. Proportion reporting distance as a barrier to socializing

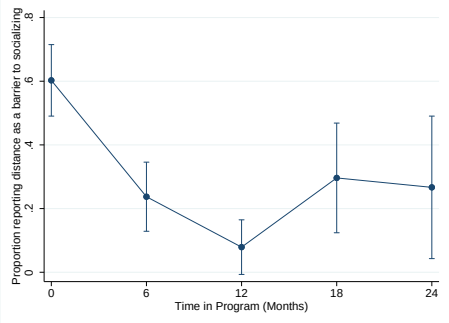
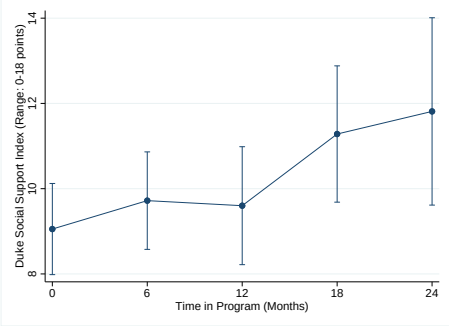


Figure 3. Social Interaction and Perceptions of Social Support over Time



Baseline Questionnaire

Baseline Questionnaire/ 6 Month Intervals

Name: _____ **ID#:** _____

Enrollment Date: ____/____/_____ **Baseline only?** Yes No

Discharge Date: ____/____/_____

Demographics:

1. **Date of birth:** ____/____/_____
2. **How did you come to the program?** (Circle one): Referral Outreach
3. **Which gender do you identify with?** (Mark one):
   - ___ Female
   - ___ Male
   - ___ Trans female (MTF)
   - ___ Trans male (FTM)
   - ___ Declined to answer
   - ___ Other: _____
4. **What was your gender at birth?** (Mark one):
   - ___ Female
   - ___ Male
   - ___ Declined to answer
   - ___ Other: _____
5. **What is your sexual orientation?** (Mark one):
   - ___ Gay/Lesbian
   - ___ Heterosexual/straight
   - ___ Bisexual
   - ___ Questioning/unsure
   - ___ Declined to answer
   - ___ Other: _____
6. **Which ethnicity do you identify with?** (Mark one):
   - ___ African American
   - ___ Latino(a)
   - ___ Native American
   - ___ Asian
   - ___ Native Hawaiian or Pacific Islander
   - ___ White
   - ___ Multi-Ethnic
   - ___ Declined to answer

If discharged, why is the client discharged from the program? (Mark one):

- ___ Non-response
- ___ Doesn't participate on a regular basis
- ___ Inability to locate
- ___ Moved out of the area
- ___ Goals met
- ___ Death
- ___ Other: _____

7. **Specify ethnicity** (Mark all that apply):

African American	
Caribbean African	
African	
Another ethnicity not listed	
African American Subtotal	
Latino(a)	
Mexican	
Central American	
South American	
Chicano/Mexican American	
Puerto Rican	
Cuban	
Another ethnicity not listed	
Latino(a) Subtotal	
Native American	
American Indian (United States)	
Alaska Native	
First Nation (Canada)	
Indigena (Mexico, Central, & South America)	
Another ethnicity not listed	
Native American Subtotal	

Asian Indian	
Chinese	
Japanese	
Korean	
Filipino	
Cambodian	
Hmong	
Laotian	
Thai	
Vietnamese	
Another ethnicity not listed	
Asian Subtotal	
Native Hawaiian or Pacific Islander	
Native Hawaiian	
Pacific Islander	
Guamanian	
Samoan	
Tongan	
Another ethnicity not listed	
Native Hawaiian or Pacific Islander Subtotal	
White	
Russian	
Other European	
Middle Eastern	
Arab/North African	
Another ethnicity not listed	
White Subtotal	
Multi-Ethnic	
Declined to answer	
ETHNICITY TOTAL **If another ethnicity is identified, please specify:**	

8. **What is your primary language?** (Mark one):

___ Chinese
___ English
___ Russian
___ Spanish
___ Tagalog
___ Vietnamese
___ Declined to answer
___ Other: _____

9. **What is the highest level of education you completed?** (Mark one):

___ Some high school (did not graduate)
___ High school graduate
___ Some college
___ College graduate
___ More than 4 years of college
___ Declined to answer
___ No formal education

Mark one:	Yes	No	Declined to answer
10. **Are you a veteran?**			
11. **Do you receive retirement benefits such as social security?**			
12. **Do you receive disability benefits?**			
12a. **If yes to 12, what type of disability do you receive benefits for?** (Specify):			

Thank you. We are going to move onto questions concerning your health.
Are you ok, or do you need a short break?

13. **Have you received a diagnosis for any of the following disabilities?**
(Mark all that apply):
___ Vision
___ Hearing
___ Speech
___ Other (Communication)
___ Learning disability
___ Cognitive disability
(excluding mental health)
___ Physical/mobility disability
___ Chronic health condition
___ None
___ Other (Not listed)

14. **Have you been diagnosed with any of the following medical conditions?**
(Mark all that apply):
___ Depression
___ Anxiety
___ Hypertension
___ Diabetes
___ Cancer
___ Chronic lung disease
___ Heart condition
___ Stroke
___ Declined to answer

15. **Do you smoke?** (Mark one): ___Yes ___ No ___ Declined to answer

16. **Is the person being enrolled, screened, or referred?** (Mark all that apply):
___ Enrolled
___ Screen only
___ Referral to X
___ Link to Y

Thank you.
The next questions are about your personal history and your ability to take care of yourself.

Questions (mark one):	**Yes**	**No**	**Declined to answer**
17. **Are you currently housed?**			
18. **Do you live alone?**			
19. **Are you married or partnered?**			
20. **Do you work for pay?**			
21. **Do you drive?**			

Activities of Daily Living: Katz ADL (Higher points = higher independence)

Activities (mark one):	**Yes** (0 pts) **Dependent**	**No** (1 pt) **Independent**	**Declined to answer**
22. **Do you have difficulty bathing?**			
23. **Do you have difficulty dressing?**			
24. **Do you have difficulty using the restroom?** (e.g. getting on and off the toilet)			
25. **Do you have difficulty moving from a chair to the bed or from the bed to a chair?**			
26. **Do you have incontinence?** (e.g. use pull-ups like Depends)			
27. **Do you have difficulty eating?** (e.g. bringing the food to your mouth)			

That is the end of the medical questions.

The next section is about services that you use and activities you are involved in. Are you ok to move on?

28. **Which of the following City Programs are you enrolled in or involved with:**
___ In-Home Support Services (IHSS)
___ Case manager
___ Meals on Wheels
___ Medical appointments
___ Urgent care or emergency room use
___ Substance use treatment
___ Mental health appointments
___ Drop-in centers
___ Scheduled center community programs (e.g. the YMCA)
___ Other: _____

28a. **If YES to "medical appointments": Are they scheduled, drop-in, or often missed?**
___ Scheduled
___ Drop-in
___ Often missed

28b. **If YES to "scheduled center community programs": Which program or programs?**

_____

_____

_____

_____

29. **Everyone has things that keep them from going out or getting together with other people. I'm going to read some types of things that keep people from going out.**

Have you ever decided not to go out with other people because of:
____Your mood or feelings or emotions?
____Your physical ability to get around?
____The safety of your neighborhood?
____Your financial situation?
____Things are too far away?
____Any kind of substance use?
____Your need to go to the restroom frequently or suddenly?

____Being homeless?
____Difficulty speaking the same language as others?
____Feeling like you are from a different culture than others?

30. I am going to read a list of activities -- things you may like to do or places you might like to go to, both in or outside the neighborhood. *(Read the frequency selections as often as necessary.)*

On a daily, weekly or monthly basis are there things you like to do, places you like to go to, in or outside the neighborhood?

Activity (mark one):	**Daily**	**Weekly**	**Monthly**	**Never**
Events at neighborhood community centers or center programs (e.g. Curry, Hospitality House, YMCA)				
Congregate meals				
Lunch with friends				
Going to the park				
Movies				
Errands/grocery shopping				
Coffee Hour at neighborhood SRO (single room occupancy)				
Hanging out at cafes				
Computer labs (in neighborhood community center)				
Farmer's market				
Exercise classes (in neighborhood community center)				
Food bank				
Obama phones				
Playing cards				
Housing searches				
Cashing checks				
Other (please specify):				

Thank you. We are close to being finished. Do you want to take a short break or move on?

The next questions are about your relationship with your family and friends and about how you have been feeling lately.

Isolation and Functional Questions:

I. **Loneliness:** UCLA 3-item Loneliness Screen. *(This scale is scored 0-9, with higher scores indicating higher degrees of loneliness.)*

Question (mark one):	Hardly ever (1)	Some of the time (2)	Often (3)
1. **How often do you feel that you lack companionship:** *Hardly ever, some of the time, or often?*			
2. **How often do you feel left out:** *Hardly ever, some of the time, or often?*			
3. **How often do you feel isolated from others:** *Hardly ever, some of the time, or often?*			

II. **Isolation:** Duke Isolation Scale. *(This scale is scored 11-33, with lower scores indicating higher degrees of loneliness)*

Question (mark one):	None	1-2 people	More than 2 people
1. **Other than members of your family, how many persons in your local area do you feel like you can depend on or feel close to?**			

Question (mark one):	None	Once	Twice	Three times	Four times	Five times	Six times	7+ times
2. **How many times in the past week did you spend time with someone who does not live with you?**								
3. **How many times in the past week did you talk with friends or relatives on the telephone?**								

4. **About how often did you go to meetings of clubs, religious meetings, or other groups that you belong to in the past week?**								

Question (mark one):	**Hardly ever**	**Some of the time**	**Most of the time**
5. **Does it seem that your family and friends (people who are important to you) understand you?**			
6. **Do you feel useful to your family and friends (people important to you)?**			
7. **Do you know what is going on with your family and friends?**			
8. **When you are talking with your family and friends, do you feel that you are being listened to?**			
9. **Do you feel that you have a definite role (place) in your family and among your friends?**			
10. **Can you talk about your deepest problems with at least some of your family and friends?**			
Question (mark one):	**Very dissatisfied**	**Somewhat dissatisfied**	**Satisfied**
11. **How satisfied are you with the kinds of relationships you have with your family and friends?**			

III. **Depression:** PHQ-2 Depression Screening. *(This scale is used as a pre-test to screen for indication for further depression screening.)*

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Question (mark one):	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. **Little interest or pleasure in doing things**				
2. **Feeling down, depressed or hopeless**				

<u>This is only for participants interested in the Peer Outreach Program:</u>

As part of this program, we are asking participants to set goals for themselves while they are in the program. The goals should be things that you might like to achieve and feel you really CAN achieve.

So what would you like to get out of the program?

The goals can be about your health, about activities you might like to take up, or maybe you would like to socialize with others more. What comes to mind for you? *(Must provide at least one; inquire thoroughly.)*

_____

_____

_____

_____

_____

_____

_____

_____

Interviewer Comments (staff use only):

_____

_____

_____

_____

_____

After completing the survey you should be able to assess if the person needs to be connected to any type of service or not. Please ask the participant if they want or need the following:

Referral (check all that apply):

___ Peer Outreach Program

___ Link to provider *(walking them to first time appointment)*

___ Referral to provider *(provided with information on services they can access)*

___ Not interested in services

Referral Form

Name:	Date:
Age:	DOB:
Address:	
Phone:	
Referring Person:	
Agency:	
Phone:	
Other Contacts:	
Notes: Medical Issues? Mental Health? Substance Use? Hx of Violence?	

Hx of suicidality?

Connection to services?

Significant relationships?

Any specific interests?

Client Satisfaction Survey

Addressing the Needs of Socially Isolated Adults

Client Staisfaction Survey ID#: _____

Date: _____

Please circle the number that best matches your opinion.	Strongly Disagree	Disagree	Agree	Strongly Agree
1. I am satisfied with my peer.	1	2	3	4
2. My culture and lifestyle is welcomed and treated with respect.	1	2	3	4
3. I would recommend the peer program to others.	1	2	3	4

Comments:

Job Postings

JOB DESCRIPTION

Title: Peer Outreach Specialist

Reports to: Senior Program Manager

Part-Time Position: 18 hours/ week

Under the supervision of the Program Manager, the Peer Outreach Specialist provides outreach to, and assessment of, isolated older adults in San Francisco's Tenderloin, Civic Center, Western Addition, SOMA, Nob Hill, and Polk Gulch neighborhoods. Therefore, we are seeking candidates with direct experience as a mental health counselor, consumer or as a family member of a mental health consumer. Candidates preferably have 2 years of experience providing peer outreach services to consumers of behavioral health along with experience in conducting mental health or behavioral health assessments. Knowledge and demonstrated history of integrating Wellness and Recovery principles in previous work is desired as well as the ability to work effectively and interact professionally with a diverse, multi-cultural, and interdisciplinary team. Living in or familiarity with San Francisco's Civic Center, Tenderloin, Nob Hill, Polk Gulch, and Western Addition neighborhoods is a plus in terms of understanding the client's environment.

Essential duties of this position

- Develop trusting relationships with socially isolated older adults.
- Advocate for and model recovery and wellness
- Create linkages to community resources, treatment services, and social activities.
- Identify traditional and non-traditional venues where socially isolated older adults may be reached.
- Learn and use effective outreach and engagement strategies to address the needs of socially isolated older adults.
- Able to facilitate groups and events.
- Must be able to travel to and from the program sites and other locations where outreach and services will be provided.
- Provide culturally sensitive behavioral health assessment.
- Engage in supervision and training and demonstrate an interest in learning new skills.
- Completion of a mental health certificate program or equivalent education, very strongly preferred.
- Ability to conduct isolation assessments and enter data into database.
- Maintain and submit accurate records, timesheets, and other program-related documentation by established deadlines

- Develop and maintain clear, open, timely, cooperative, and diplomatic communications and working relations with all staff, consumers, and partner agencies
- Serve as model of professional standards for clients.
- Perform other duties as assigned

Additional Detail About This Work.

Peer outreach services are defined as services provided by consumers, family members, and other individuals who are on their own recovery journey and have received training in how to be helpful to others who are struggling with mental health issues. Peer outreach services are customized to the needs of each individual who is served. The services include opportunities to advocate for themselves, meet their goals for recovery, make connections inside and outside of the mental health system, get a job or volunteer position, find housing, and learn skills to live well and have a meaningful role in the community.

To apply for this position, please apply online via craigslist posting or email a cover letter and resume to jessica.rosales@sfdph.org and include "Peer Outreach Specialist – [Your Name]" in the subject line. Salary is competitive with other non-profit organizations providing similar services.

You can also email a cover letter and resume to:
Curry Senior Center
315 Turk Street
San Francisco, CA 94102
Attn: Daniel Hill

For more information on Curry Senior Center, please visit us online at www.curryseniorcenter.org

Curry Senior Center is an Equal Opportunity / AA/ M/F/D/V Employer. Women and People of Color are encouraged to apply. Background and Reference Check required.

JOB DESCRIPTION

Title: Program Manager, full-time position
Reports to: Executive Director (as of April 2016)

Job Description

The Program Manager is responsible for oversight of Curry Senior Center's MHSA Innovation Project for Addressing the Needs of Socially Isolated Older Adults through peer-to-peer outreach services. The Program Manager is responsible for day-to-day supervision of peers, connecting with community partners, and participating in regular staff/peer trainings. Peer outreach services are defined as services provided by consumers, family members, and other individuals who are on their own recovery journey and have received training in how to be helpful to others who are struggling with mental health issues. Peer outreach services are customized to the needs of each individual who is served. The services include opportunities to advocate for themselves, meet their goals for recovery, make connections inside and outside of the mental health system, get a job or volunteer position, find housing, and learn skills to live well and have a meaningful role in the community.

Essential Duties and Responsibilities
- Supervise Peer Outreach Specialists
- Develop a training curriculum integrating feedback from supervisor, colleagues, community partners, and consumers
- Develop and maintain community partnerships
- Collect and analyze data and provide insight on the impacts of the program
- Ability to work collaboratively with colleagues, supervisor, supervisees, City and County officials, and community partners
- Participate in program development
- Perform other duties as assigned

Education and Experience
- BA or MA degree in psychology or related field
- 3 years of supervisory experience
- 3 years of experience working with socially isolated seniors experiencing poverty, homelessness, mental health issues, drug abuse, health problems and related issues
- 2 years community program management experience
- Working knowledge of peer-to-peer service model
- Knowledge of policies, procedures, laws and regulations relevant to a case management and behavioral health program.
- Familiarity with harm reduction and its application
- Excellent oral and written communication skills
- Demonstrate a high degree of integrity, professionalism, confidentiality and use of sound judgment in all interactions

This position offers salary competitive with other non-profit organizations providing similar services, health benefits, and paid time off.

To apply for this position, please email a cover letter and resume to adimartino@curryseniorcenter.org and include "Program Manager - [Your Name]" in the subject line.

For More Information about Curry Senior Center, please visit us online at www.curryseniorcenter.org.

Curry Senior Center is an Equal Opportunity Employer.

Photo Release

City and County of San Francisco

Department of Public Health

Barbara A. Garcia
Director of Health

CONSENT TO INTERVIEW OR PHOTOGRAPH

DATE 7.31.20

I hereby agree that I may be interviewed and/or photographed/video taped and that the interview and/or photos/videos are obtained with my full knowledge for the purposes stated below.

I further agree that the interview and/or photograph/video may be printed or publicized for public distribution.

✓ Interview ✓ Photo/video ✓ Public Distribution

_____ Other

Additional info or statement:

By signing this consent form I release the City and County of San Francisco-Department of Public Health from any and all liabilty or claims from the use and re-use of these films, photographs, or audio recordings of me and/or my child/children.

Signature of patient or legal guardian