# Elders' Storytelling Project - INN-04
# County of Santa Clara
# Behavioral Health Services
# Santa Clara Valley Health and Hospital System

## Final Evaluation Report

## February 2, 2016

***Submitted to***

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# Executive Summary

**Background:** The goals of the Storytelling Innovation Project (INN-04) were to: 1) use the technique of life review and storytelling (reminiscence) and incorporate other innovative service components to help restore participating elders to a position of social connectedness with family, friends, caregivers and community; and 2) Improve the quality of services and outcomes for isolated older adults, sixty (60) years of age and older who are predisposed to mental health issues or have unrecognized mental health symptoms, particularly those from underserved ethnic communities (Spanish and Vietnamese-speaking). Two providers were selected to implement INN-04: Gardner Family Care Corporation (GFCC) who developed a program called *Miradas al Pasado* (Views of the Past) for Spanish-speaking elders; and Asian Americans for Community Involvement (AACI) who developed the *Healing Legacies* program for Vietnamese-speaking elders. This report covers the period starting January 1, 2013 and ending January 7, 2016. The program was implemented in six month cycles.

**Intervention:** The intervention program involved Outreach, Recruitment, and Screening for eligibility. Client *Assessment* was done during the first two-hour home visit. Peer Specialists conducted an assessment of the older adult's quality of life, and collected pre-intervention data using standardized assessment tools for depressive symptoms, loneliness, cognitive impairment, and life satisfaction. Program staff met with family members and/or caregivers, built rapport with the older adult and explained the program, including roles of staff and the family. *Implementation of the Storytelling intervention* consisted of the following: Peer Specialists conducted 10 - 12-weekly home visits to facilitate the older adult's storytelling. In the last few weeks of the program, staff explored, identified, and utilized artistic methods to document the older clients' oral stories as keepsakes for sharing with family, friends and community. *Assessment of Storytelling Intervention Outcomes* was conducted by Peer Specialists using the same measures as the initial assessment. A *community event* was organized at the end of each 12 week treatment implementation cycle to provide clients an opportunity to present their artistic productions to the community. A final survey *Assessment of Overall Intervention Outcomes* was conducted.

**Evaluation methods:** The following measures were used by the service providers to establish baseline data and collect post intervention measures on clients: Demographic data on clients; the Patient Health Questionnaire (PHQ-9)*;* the Geriatric Depression Scale (GDS-15)*;* the Short Portable Mental Status Questionnaire (SPMSQ)*;* Short Loneliness Scale; Satisfaction with Life Scale (SWLS); Treatment Satisfaction (Post-test only). The Final Project Outcome Survey Instrument was administered via telephone by staff from Santa Clara County's Ethnic and Cultural Communities Advisory Committee (ECCAC) to capture data necessary to answer the various Process Questions identified in the Learning Objectives for the project.

**Key Findings:**
A summary of the results and conclusions for each Learning Objective identified by the project are presented below:

***Process Question 1: How does the utilization of a community worker with cultural competence contribute to the senior's comfort level in expressing his personal memories?***

Having a community worker with cultural competence contributed to the seniors' comfort in expressing their personal memories. Clients were overwhelmingly positive in their responses on feeling like their cultural traditions were understood and that their worker communicated well with them. While the majority concurred that having a worker of a similar cultural background was helpful for building rapport and facilitating the story telling process, the responses were somewhat mixed when asked if they would be just as comfortable sharing their stories with a worker from another cultural background, suggesting that perhaps more acculturated clients, or those more fluent in English could feel comfortable with workers of other cultural backgrounds. Furthermore, these findings may also reflect the expansion of the target population to include non-Hispanic and non-Vietnamese clients, thus reducing the "cultural fit" between peer specialists and clients. Qualitative data indicate that specific counselor characteristics such as the counselor's character, professional competence, and relational skills helped enhance the storytelling experience. However, it is also important to note that these results on the cultural competence process question are based on responses of fewer than 50% of clients who completed the intervention.

***Process Question 2: How does the inclusion of a family member throughout the activity affect the relationship between the senior and the family member at the conclusion of the activity?***
Including a family member in the Storytelling process positively influenced the relationship between the senior and the family member(s). Provider agencies indicated that slightly less than half of all participants had one or more family members participate in the Storytelling intervention. Reasons for lack of family participation included not having any family around, or family members being at work all day which precluded their participation in the Storytelling intervention. However, when clients were asked if the intervention resulted in improvement is relationships with family/friends, 76% of AACI's clients and 44% of Gardner's clients responded affirmatively. The qualitative data provide some context to these findings. That is, the storytelling intervention lead to improvement in family relationships through improved communication and shared understanding of the client's life story. When no changes in family relationships were noted it was because the relationships were already positive or no family members were available, or just simply that there had been no change.

***Process Question 3: How does the exercise of capturing the seniors' life stories through some expressive arts medium and presenting them to the larger community contribute to preserving personal and collective history?***
About 50% of all clients presented their stories or artwork at one of 6 community events held by each provider agency, and several clients attended subsequent community events to support their peers. For AACI, many clients presented their story at several community events, which may have enhanced their experience of feeling more connected with the community. Similarly, for Gardner, there were six stories that were used again for the Teatro Vision community event. The majority of clients who attended a community event or presented their story or artwork spoke very positively about the experience, especially focusing on the improved connection with their community, listening to others' life experiences, and sharing their own. The structure and format of the community events (client presentations and inviting the larger community to attend) greatly enhanced the preservation of personal and collective histories as clients enjoyed sharing

their stories and listening to others' experiences, as did the attendees (family members and the general public).

***Process Question 4: What are the seniors' perceptions of the Storytelling program?*** *(This question was added in consultation with service providers and the Project Lead staff).*
The Storytelling program was well received by the seniors and their families. Sixty-eight percent of the sample had a score of 6 on the Treatment Satisfaction Scale indicating the greatest satisfaction with treatment. Qualitative comments on reasons for recommending the program to others reflected appreciation of the reminiscence activity, reduction in isolation, and improvement in mood for clients.

***Outcome Question 1: How many seniors engage in this program?***
The providers were successful in engaging ethnic minority seniors of Vietnamese or Mexican origin that were the target population for this project. Client recruitment was done through outreach in non-mental health settings such as senior centers, wellness fairs and other community events, and senior housing. A total of 206 clients were enrolled in the intervention with 165 clients completing the intervention and the post-test measurements. The overall attrition rate was 12% and could be attributed to a variety of reasons such as: clients were no longer interested in participating; did not like answering the eligibility and evaluation questions; serious illness in client or family; and needing a higher level of mental health care. There were 16 cases that were still open at the time of this report. The combined demographic data on clients indicates that the clients were older (mean age = 75 years), female (62%), the majority of clients are Vietnamese or Hispanic (Mexican), who had limited English proficiency, self-described as having poor to fair ability to speak, read, or write in English. Although a few clients were native born the majority have lived in the US for varying lengths of time. About a quarter of the clients lived alone, and the majority from both agencies lived with either a spouse or with a spouse and adult children. Program implementation data indicates that, on average, clients were seen for 11 to 12 sessions and the average time spent on each completed case was 25 to 27 hours.

***Outcome Question 2: How does the program affect the seniors' quality of life and daily functioning?***
The Storytelling program was successful in improving the seniors' quality of life and daily functioning as assessed through statistically significant improvement in post-test scores on depressive symptoms, loneliness, and life satisfaction. When the results are examined separately by provider agency, for AACI the post intervention scores on all four outcome variables show statistically significant improvement. Interestingly, although not a focus of the intervention, the SPMSQ scores appear to show statistically significant improvement ($p < .05$) at post –test, which may possibly be related to reduction in depressive symptoms, or simply an anomaly in the data. For Gardner, the two depression measures (PHQ-9 and the GDS-15) as well as the loneliness and life satisfaction measures show statistically significant improvement. There was no change in the SPMSQ scores. However, Gardner also had clients who ended the intervention showing higher depression scores. Possible reasons for this finding were explored with providers and include: critical incidents such as the departure of a visiting family member, the death of a family member, exacerbation of illness in the client or family member.

Client responses indicated that the two areas with the most perceived improvement were mood, and relationships with family and friends –which are the two domains specifically targeted by the program.
Finally, the intervention, was successful in producing clinically significant change scores in depression (5 or more points) as measured by the PHQ-9 for approximately a third of all clients in the program (32%) and successful in producing smaller change in depression scores (1 – 4 points) for over half of all clients (54%). A small number of clients either experienced no change or had worse scores on the PHQ-9 at post-test.

**Lessons Learned**
**Challenges:** A few of the challenges encountered during the implementation of INN-04, the Storytelling project were:

- **Recruitment of clients into the program**. For example, it was difficult to reach out to isolated seniors in institutions due to a lack of gatekeepers who could connect these seniors to the Storytelling program.
- **Several delays were experienced in the process of data collection by the ECCAC staff** which resulted in a smaller sample size available to answer the process questions related to the impact of the cultural competence of the community worker, and the preservation of personal and collective history through presentation to the larger community.
- **Issues related to Translation of Instruments.** Supervisors from both provider agencies noted discrepancies in translations which may lead to misinterpretation by clients. It was helpful to periodically examine the data to better understand how clients were interpreting the questions and making necessary adjustments to the survey items to clarify the content and meaning of the words.
- **Issues related to Community Events**.
    - Because resources for translating the life stories into English were unavailable the community events were restricted to members of their respective ethnic communities. The language issues also impacted the participation of family members as the grandchildren are often not bilingual and cannot read the stories in Vietnamese or Spanish.
    - About half the sample did not participate in the community events. Reasons for declining the opportunity to present their story included not wanting to make their personal lives public, or not feeling like they had something special to share, especially in the case of women participants.
    - Transportation to community events remains a perennial problem for seniors. Although Gardner provided vouchers for clients to come to the events, this mechanism was not always successful in bringing the seniors out to the community events.
- **Staff Turnover**. Both provider agencies experienced some staff turnover which resulted in the supervisors and other staff needing to devote time to orient new hires to the work of the Storytelling project.

**Recommendations and Implications for future projects**

- Careful attention should be given to screening and eligibility criteria to ensure that clients are appropriate for the intervention, and possible modifications to the intervention may be considered for clients with serious health conditions (who may benefit from a shorter or more focused intervention) to better suit their needs. Similarly, for clients with mild depressive symptoms, reduced number of treatment sessions or a group treatment format could be considered particularly if the goal is to reduce isolation. These alterations to the program would then need to be evaluated to determine whether they are still producing the intended program outcomes.

- Given that the PHQ-9 was suitable for this population and allowed an examination of both statistically and clinically significant change, using only the PHQ-9 for assessing depression may be justified in order to further reduce the burden of completing the assessment tools.

- Providers could also consider alternative ways to engage family members in the intervention – especially for those family members who work and are unavailable to participate in the intervention process.

- If the community presentation is maintained as part of the overall intervention, more consideration needs to be given to methods for increasing client and community participation in these events.

- Ongoing monitoring and evaluation of data proved to be an excellent mechanism for ensuring that translations were accurately capturing information as intended, and more attention was being given to obtaining complete post-intervention data from clients.

# Introduction

## Project Overview

(Period covering January 1, 2013 – January 7, 2016)
Older adults are susceptible to mental illness due to isolation that leads to extreme loneliness, and the multiple stressors that they face. They may have unrecognized mental health symptoms which place them at risk of developing mental health disorders, most commonly depression and anxiety. Physical and emotional isolation can trigger or compound initial minor symptoms of anxiety and depression, and may lead to very serious conditions if not addressed.

The public mental health system struggles to engage elders into treatment, particularly at early stage of service need. Experienced culturally proficient clinicians may base the outpatient model treatment on the culture of the elder client, but most elders will not seek the current service models and may resist the suggestion by those around them. More significantly, isolated elders probably will not receive the attention from those around them that can help them receive the treatment they need. The main barriers to engagement in treatment are that:

- Elders may not define emotional problems as a treatable mental illness.
- Information about mental health treatment for elders is unavailable.
- Outpatient treatment is "foreign" to most elders' health seeking practices.

Two-thirds of Santa Clara County residents are immigrants or first born. The mental health system provides services throughout the county in the language of the client served. In addition, education about mental illness and the benefit of mental health treatment is offered to the community. However cultural issues still pose an urgent barrier to treatment access.

Depression is the most prevalent disorder among elders (60+) who receive services from the County's public mental health system. In 2003, 42.1% of this group received treatment for depression, which was their primary clinical diagnosis. The Elder's Storytelling Project was developed to engage elders who are physically or emotionally isolated and who are experiencing emerging or unmitigated symptoms of depression, some with cognitive decline.

The aim of this Innovation Project (INN-04) was to improve the quality of services and outcomes for isolated older adults, sixty (60) years of age and older who are predisposed to mental health issues or have unrecognized mental health symptoms, particularly those from underserved ethnic communities (Spanish and Vietnamese-speaking). This project had two goals:

1. To use the technique of life review and storytelling (reminiscence), while engaging natural support systems to help restore participating elders to a position of social connectedness with family, friends, caregivers and community. These storytelling techniques will bridge generational gaps and will incorporate other innovative service components.

2. To increase the quality of mental health services, including better outcomes, for isolated older adults who are predisposed to emerging mental health issues, or who have unrecognized mental health symptoms.

## Service Providers

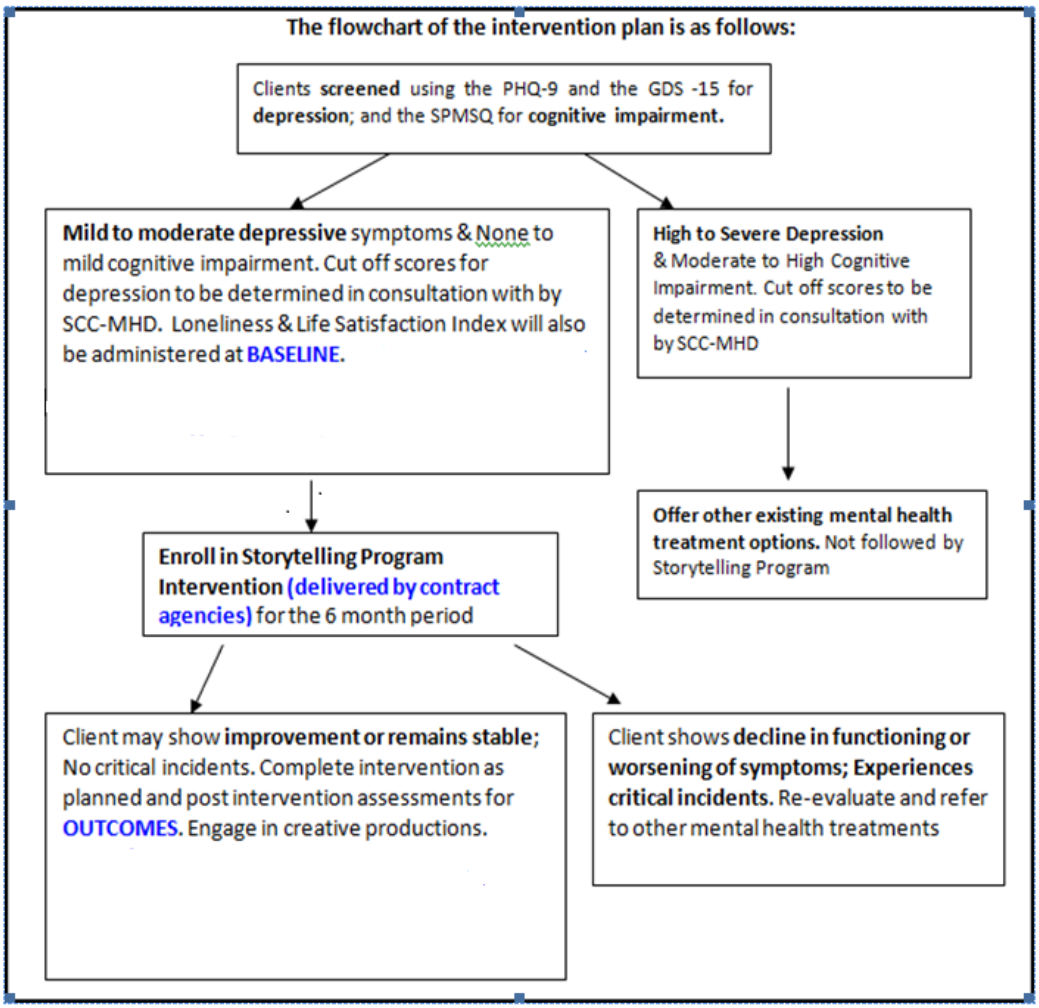
Two providers were selected to implement INN-04 – that is, use the technique of life review and storytelling (reminiscence) as a method of reducing older adults' social isolation, and depressive symptoms. The two providers were: Gardner Family Care Corporation (GFCC) who developed the storytelling intervention called *Miradas al Pasado* (views of the Past) to Spanish-speaking elders, and Asian Americans for Community Involvement (AACI) who developed a similar intervention called *Healing Legacies* to Vietnamese-speaking elders.

The overall staffing structure for the duration of the project for each agency was as follows: One half-time clinical supervisor (LCSW) and 1.5 FTE peer specialists (Bachelor's degree level) who conducted outreach; screened for eligibility; conducted the intervention and pre and post-test assessments; and planned and executed the community events.

## Eligibility Criteria & Service Delivery Process

Figure 1 provides an overview of the Screening and Intervention process used by the service provider agencies to determine eligibility for the program and for service delivery. Clients selected to participate in the program needed to have mild to moderate scores on depression on either of the following depression scales: the Patient Health Questionnaire (PHQ-9) and the Short Geriatric Depression Scale (GDS-15). The cut off scores for eligibility on the PHQ-9 is a score of 5 to 14 (mild to moderate depression). The cut off score for the GDS-15 is 5 to 11 (mild to moderate depression). Because clinical staff from both programs noted that clients might be reluctant to openly admit to depressive symptoms, it was decided that clinical judgment about the presence of depressive symptoms would also be used in cases where there was some doubt about the accuracy of the client's responses on the two depression scales. Additionally, clients were also screened for cognitive impairment using the Short Portable Mental Status Questionnaire (SPMSQ). The cut off score on the SPMSQ was set at 6, (mild to moderate cognitive impairment).

**Figure 1: Flowchart of the Screening and Intervention process**




## Storytelling Program Implementation & Intervention Description

The intervention program involved the following elements:

1) *Outreach* for recruitment of seniors for the intervention.
2) *Screening for Eligibility* for the intervention and *Assessment* of clients.
    a. During the first two-hour home visit, Peer Specialists conducted an assessment of the older adult's quality of life, and conducted pre-intervention data collection using standardized assessment tools for depressive symptoms, loneliness, and life satisfaction. In addition, program staff met with family members and/or caregivers, built rapport with the older adult and explained the program, including roles of staff and the family.
3) *Implementation of the Storytelling intervention* which consisted of the following activities:

a. Peer Specialists conducted 10 - 12-weekly home visits with the older adult in which they facilitated the older adult's storytelling activities.
b. The staff made every reasonable effort to promote involvement of family and/or caregivers in the initial assessment and the 12-week storytelling processes.
c. In the last few weeks of the program Provider staff explored, identified, and utilized artistic methods to document the older adult clients' oral stories as keepsakes for sharing with family, friends and community.

4) *Assessment of Storytelling Intervention Outcomes* by Peer Specialists using the same measures to assess change in depressive symptoms, loneliness, and life satisfaction. Satisfaction with treatment was also assessed.

5) *Organizing a community event* at the end of each treatment implementation cycle to provide clients an opportunity to present their artistic productions to the community.

6) *Assessment of Overall Intervention Outcomes* conducted by staff from Santa Clara County's Ethnic and Cultural Communities Advisory Council (ECCAC).

## Program Implementation Cycles

The complete intervention (steps 1 through 5) were implemented in six-month cycles for a total of six cycles (January 1, 2013 to December 31, 2015). Ongoing evaluations of data from each cycle were conducted and shared with provider agencies, the SCC Department of Mental Health Project staff and the Learning Advisory Committee. These ongoing interim evaluations were instrumental in helping the providers make small modifications to recruitment procedures, and to data collection measures early on to ensure the successful implementation of the project.
*See Appendix A for a more detailed description of the Project Implementation as described by the Service Providers.*

# Evaluation Logistics & Methods

## Institutional Review Board approvals

Approval of the entire data collection protocol was obtained for each year of the project from the Health Services Institutional Review Board of the Santa Clara Valley Health & Hospital System. Similar approval and renewals were obtained from the San Jose State University Institutional Review Board.
*See Appendix B for IRB approval letters from 2015 – 2016 (the last year of the project).*

## Data Collection - Methods

***Assessment Instruments***
The Storytelling intervention is based on Life Review/Reminiscence interventions which are evidence-supported treatments for the enhancement of psychological well-being among elders. Thus, the measures used to assess treatment outcomes for the Storytelling intervention included those typically used in previous intervention studies to enable a comparison of outcomes between this project and other studies in the literature.[1] The following measures were used by the service providers to establish baseline data and collect post intervention measures on clients:

1. Demographic data on clients – ethnicity, age, gender, living arrangement, level of English proficiency, and length of stay in the U.S.
2. The Patient Health Questionnaire (PHQ-9). *(Range: 0 – 27). Higher scores = greater depression. The cut off scores for eligibility on the PHQ-9 is a score of 5 to 14 (mild to moderate depression).*
3. The Geriatric Depression Scale (GDS-15). *(Range: 0 – 15). Higher scores = greater depression. The cut off score for the GDS-15 is 5 to 11 (mild to moderate depression).*
4. The Short Portable Mental Status Questionnaire (SPMSQ). *(Range: 0 -10) Eligibility criteria excluded severe cognitive impairment, thus cut off score is 6 errors or lower.*
5. Short Loneliness Scale. *(Range = 3 – 9). Higher scores = greater loneliness.*
6. Satisfaction with Life Scale (SWLS) *(Range = 5 – 35). Higher scores = greater life satisfaction.*
7. Treatment Satisfaction (Post-test only) *(Range = 6 – 24). Lower scores = greater treatment satisfaction.*
8. Another survey instrument called the Final Project Outcome Survey Instrument was created in consultation with service providers and the Project Lead to capture data necessary to answer the various Process Questions identified in the Learning Objectives for the project.

[1] Bohlmeijer, E., Roemer, M., Cuijpers, P., & Smit, F. (2007). The effects of reminiscence on psychological well-being in older adults: A meta-analysis. *Aging & Mental Health, 11*(3), 291-300.

### *Translations*

The translation of all instruments (except for the PHQ-9 for which translations were readily available) in Spanish and Vietnamese were done by Santa Clara County's preferred contractors and the translated instruments were edited by Service Provider agency supervisors to ensure comprehension and increase ease of response for clients. The open-ended responses in the Final Project Outcome Survey Instrument were translated into English by the ECCAC interviewers. *See Appendix C for English versions of all data collection instruments.*

### *Training for data collection*

Separate training sessions were conducted by the evaluator with Service Provider staff and with the ECCAC interviewers to ensure consistency in data collection processes over time and across provider agencies. Table 1 outlines the data collection instruments used for obtaining needed information to answer the different process and outcome questions for this project.

**Table 1: Data Collection Instruments used in this Project**

| Purpose of Data Collection | Data Collection Instruments |
|---|---|
| Process Question 1:<br>*How does the utilization of a community worker with cultural competence contribute to the senior's comfort level in expressing his personal memories?* | 1) Final Project Outcome Survey Instrument (4 quantitative and 1 qualitative questions on cultural competence of the worker) |
| Process Question 2.<br>*How does the inclusion of a family member throughout the activity affect the relationship between the senior and the family member at the conclusion of the activity?* | 1) Provider data on family participation in the intervention<br>2) Post-test Survey by Peer Specialist – Question on Impact of Intervention on Family<br>3) Final Project Outcome Survey Instrument – (1 qualitative question) |
| *Process Question 3.*<br>*How does the exercise of capturing the seniors' life stories through some expressive arts medium and presenting them to the larger community contribute to preserving personal and collective history?* | 1) Final Project Outcome Survey Instrument (2 quantitative and 2 qualitative questions on impact of community event)<br>2) Qualitative summary reports from Providers after each event |
| *Additional Process Question 4: How do the seniors and others perceive the Storytelling program?* | 1) Post-test quantitative data on treatment satisfaction & Perceived Impact of Intervention<br>2) Final Project Outcome Survey Instrument – (1 qualitative question on Reasons for Recommending the program to others)<br>3) Client testimonials obtained by Service Providers |

| Purpose of Data Collection | Data Collection Instruments |
|---|---|
| *Outcome Question 1*.<br>*How many seniors engage in this program?* | 1) Quantitative data on participation, completion, and attrition from Providers<br>2) Quantitative descriptive data on: ethnicity, age, gender, living arrangement and family support situation, and length of stay in the U.S. |
| *Outcome Question 2*.<br>*How does the program affect the seniors' quality of life and daily functioning?* | 1) Pre and post-test Survey data on participants on:<br>a. Patient Health Questionnaire (PHQ-9) & Short Geriatric Depression Scale (GDS-15).<br>b. Short Loneliness Scale<br>c. Satisfaction with Life Scale (SWLS)<br>d. Short Portable Mental Status Questionnaire (SPMSQ)<br>2) Post-test quantitative data on Perceived Impact of Intervention |

## Data Processing and Analysis

The provider agencies provided de-identified client data to the evaluator in an Excel spreadsheet on a monthly basis. Evaluation reports were completed and submitted after each Implementation cycle (each 6 –month period). These reports allowed for ongoing monitoring and problem resolution of data issues. This final report combines data from all Implementation Cycles over the course of the project.

# Findings

The findings from the project evaluation are organized around the Learning Objectives that had been proposed and approved by the state's Mental Health Services Oversight and Accountability Commission (OAC).

## Learning Objectives (Process & Outcome Questions)

The learning questions included three Process Questions and two Outcome Questions. An additional process question related to clients' perceptions of the overall program was added in consultation with service providers and the Project Lead staff. The questions are listed below:

- Process Question 1: How does the utilization of a community worker with cultural competence contribute to the senior's comfort level in expressing his personal memories?
- Process Question 2: How does the inclusion of a family member throughout the activity affect the relationship between the senior and the family member at the conclusion of the activity?
- Process Question 3: How does the exercise of capturing the seniors' life stories through some expressive arts medium and presenting them to the larger community contribute to preserving personal and collective history?
- Additional Process Question 4: What are the seniors' perceptions of the Storytelling program? (This question was added in consultation with service providers and the Project Lead staff).
- Outcome Question 1: How many seniors engage in this program?
- Outcome Question 2: How does the program affect the seniors' quality of life and daily functioning?

For each question, there is a description of the sources of evaluation data, followed by a detailed presentation of the results separately for each provider agency, and a conclusion.

Table 2 provides detailed information on the total number of respondents for the two data collection instruments to provide overall context to the results presented for each Learning Question.

**Table 2: Number of respondents for Data Collection (Sample size)**

| Data Collection | AACI (n = 111) | Gardner (n = 95) |
|---|---|---|
| Total number of clients completing the Post-test interview | 92 (83%) | 73 (77%) |
| Total number of clients still active and will be closed shortly | 9 (8%) | 6 (6%) |
| Total number lost to attrition (as of 1/1/16) | 10 (9%) | 16 (17%) |
| **1) Pre and post-test Survey data for clients completing the Post-test** | | |
| | **AACI (n = 92)** | **Gardner (n = 73)** |
| Patient Health Questionnaire (PHQ-9) | 92 (100%) | 71 (97%) |
| Short Geriatric Depression Scale (GDS-15) | 92 (100%) | 66 (90%) |
| Short Loneliness Scale | 91 (99%) | 70 (96%) |
| Satisfaction with Life Scale (SWLS) | 91 (99%) | 71 (97%) |
| Short Portable Mental Status Questionnaire (SPMSQ) | 91 (99%) | 72 (99%) |
| **2) Final Project Outcome Survey Instrument** | | |
| | **AACI (n = 92)** | **Gardner (n = 73)** |
| Number and percent of clients completing post-test referred to ECCAC for final outcomes interview | 47 (51% of clients completing post-test) | 61 (83% of clients completing post-test) |
| Number of clients completing ECCAC final outcomes interview | 29 (represents 31.5% of post-test completers) | 31 (represents 42.4% of post-test completers) |

## Process Questions

***Process Question 1.*** ***How does the utilization of a community worker with cultural competence contribute to the senior's comfort level in expressing his personal memories?***

**Data Sources**: 1) Final Project Outcome Survey Instrument (4 quantitative and 1 qualitative questions on cultural competence of the worker) collected by the ECCAC interviewers. The total number of respondents for this survey were 29 for AACI (31.5% of clients completing the post-test) and 31 for Gardner (42% of clients completing the post-test).

**Results:** Tables 3a and 3b present the data by service provider agency on the questions that were asked of clients to ascertain their opinions on having culturally competent peer counselors.

**Table 3a. Client responses on Cultural Competence (CC) – AACI (n = 29)**

| **Final Project Outcome Survey Instrument:** | **Agree N (%)** | **Disagree N (%)** | **Neutral N (%)** |
|---|---|---|---|
| *CC1. My worker understood my cultural traditions* | 29 (100%) | 0 | 0 |
| *CC2. My worker communicated well with me* | 29 (100%) | 0 | 0 |
| *CC3. Having a worker who shared my cultural background helped with the process of telling my life story* | 27 (93%) | 0 | 2 (7%) |
| *CC4. I would be just as comfortable telling my story to a worker from another cultural background* | 10 (35%) | 7 (24%) | 12 (24%) |

**Table 3a. Client responses on Cultural Competence (CC) - GARDNER (n = 31)**

| **Final Project Outcome Survey Instrument:** | **Agree N (%)** | **Disagree N (%)** | **Neutral N (%)** |
|---|---|---|---|
| *CC1. My worker understood my cultural traditions* | 28 (90%) | 0 | 3 (10%) |
| *CC2. My worker communicated well with me* | 29 (94%) | 1 (3%) | 1 (3%) |
| *CC3. Having a worker who shared my cultural background helped with the process of telling my life story* | 26 (84%) | 0 | 5 (16%) |
| *CC4. I would be just as comfortable telling my story to a worker from another cultural background* | 17 (55%) | 14 (45%) | 0 |

Responses to the open-ended question soliciting additional comments on the counselor were examined and coded for themes. The main themes emerging from these responses focused on an elaboration of specific counselor characteristics such as the counselor's character, professional competence, and relational skills which helped enhance the storytelling experience. A couple of clients specifically mentioned cultural identification with the counselor, while a couple of others were puzzled by question on cultural competence. The following comments exemplify the client's experience with the counselor:

Counselor characteristics:

*"From the moment I met her I had a good experience. She was a very good woman to me and she was excellent. I explained everything and she listened and when they had a party, they invited me and I loved it. I have very good memories of her." (Gardner client).*

*"[The counselor was] patient, understood me, and encouraged me to share my feelings with others in a comfortable, relaxed environment." (AACI client).*

Cultural identification*:*

*"He was an excellent person with me, in fact he had even visited my country and we identified well with one another. He is a very fine person with me and I was very satisfied with the work he did with me." (Gardner client).*

*"Great. Understood the Vietnamese tradition." (AACI client).*

A couple of clients were puzzled about the cultural competence questions related to the peer specialist.

*"I'm just puzzled by the questions. I did not know it was culturally involved and it should not matter. These questions are puzzling. (Gardner client).*

**Conclusion:** Clients were overwhelmingly positive in their responses on feeling like their cultural traditions were understood and that their worker communicated well with them (CC1 & CC2). While the majority concurred that having a worker of a similar cultural background was helpful for building rapport and facilitating the story telling process (CC3), the responses were somewhat mixed when asked if they would be just as comfortable sharing their stories with a worker from another cultural background (CC4), suggesting that perhaps more acculturated clients, or those more fluent in English could feel more comfortable with workers of other cultural backgrounds. Furthermore, these findings may also reflect the expansion of the target population to include non-Hispanic and non-Vietnamese clients, thus reducing the "cultural fit" between peer specialists and clients. However, it is also important to note that these results on the cultural competence process question are based on responses of fewer than 50% of clients who completed the intervention. Qualitative data indicate that specific counselor characteristics such as the counselor's character, professional competence, and relational skills helped enhance the storytelling experience

***Process Question 2. How does the inclusion of a family member throughout the activity affect the relationship between the senior and the family member at the conclusion of the activity?***

**Data Sources**: 1) Provider data on family participation in the intervention; 2) Post-test Survey by Peer Specialists – Quantitative question on impact of intervention on family; 3) Final Project Outcome Survey Instrument (1 qualitative question on clients' perceived impact of program on family relationships) collected by the ECCAC interviewers.

**Results:** Tables 4a and 4b present the data by service provider agency on whether family member(s) participated in the Storytelling intervention; whether clients perceived the services received resulted in improvements in family/friend relationships.

**Table 4a: Family Participation (FP) & Perceived Impact of Program on Family Relationships - AACI**

| Survey Question | Total n | Yes | No | Unknown/ Unable to verify |
|---|---|---|---|---|
| **FP1. Provider data**: Did any family members participate in the Storytelling process? | 92 | 35 (38%) | 35 (38%) | 22 (24%) |
| **FP2. Post-test data collection survey by peer specialist**: "The services which you received resulted in improvements in Family/Friend Relationship?" | 92 | 70 (76%) | 26 (28%) | 0 |

**Table 4b: Family Participation (FP) & Perceived Impact of Program on Family Relationships - Gardner**

| Survey Question | Total n | Yes | No | Missing/ Unable to verify |
|---|---|---|---|---|
| **FP1. Provider data:** Did any family members participate in the Storytelling process? | 73 | 36 (49%) | 37 (51%) | 0 |
| **FP2. Post-test data collection survey by peer specialist:** "The services which you received resulted in improvements in Family/Friend Relationship?" | 73 | 32 (44%) | 38 (52%) | 3 (4%) |

Responses to the following open-ended question, "How did participating in "Storytelling" influence your relationship with your family?" were examined and coded for themes. Two main themes emerged from the comments - that is family relationships improved (with spouse, adult children, grandchildren, and friends); or there was no observable impact on relationships with family members - either specifically because the family was already involved, or because there was no family available. Others simply reported "no changes" without specifying the reason. The following comments exemplify the clients' responses about the impact of the intervention on family relationships:

Positive impact - Improved relationships:

"*My family loved it. Everyone is happy with what I did. My children and grandchildren saw what I did and they liked it a lot. They saw that everyone treated me very well." (Gardner client).*

*"The relationship with my daughter with whom I live has improved a lot. We now communicate much better, and she is treating me much better." (Gardner client).*

*"Great. My family/children support me. They help me to remember the stories so I could share with the group." (AACI client).*

*"Relationship in my family improved. They appreciated me more. My children and grandchildren understand me more by reading my book." (AACI client).*

No impact – Family relationships are good:

*"Well it was good, but I've always had a good relationship with my family." (Gardner client).*

"*No [change in family relationships]. Everything is good. This project brings my friends back together." (AACI client).*

No impact – no family available:

*"Well l live by myself so it didn't really help me with my family because I have lived by myself in the United States for 40 years. I am very distant from my family." (Gardner client).*

*"No. I have no family around. I don't like to tell people about my story." (AACI client).*

**Conclusion:** Data from provider agencies about family participation (FP1) indicate that less than half of all participants had one or more family members participate in the Storytelling intervention. Provider agency input on reasons for lack of family participation included not having any family around, or family members being at work all day which precluded their participation in the Storytelling intervention.

When clients were asked if the intervention resulted in improvement is relationships with family/friends (FP2), 76% of AACI's clients and 44% of Gardner's clients responded affirmatively. The qualitative data provide some context to these findings. That is, the storytelling intervention lead to improvement in family relationships through improved communication and shared understanding of the client's life story. When no changes in family relationships were noted it was because the relationships were already positive or no family members were available, or just simply that there had been no change.

It is important to note that the Provider data (FP1) and the post-test survey data on the impact of the intervention (FP2) are based on 100% of clients who completed the post-test whereas the qualitative comments on the impact of the intervention on family relationships are based on responses of fewer than 50% of clients who completed the intervention.

***<u>Process Question 3</u>. How does the exercise of capturing the seniors' life stories through some expressive arts medium and presenting them to the larger community contribute to preserving personal and collective history?***

**Data Sources**: 1) Provider data on description, numbers of participants and attendees at the community events; 2) Final Project Outcome Survey Instrument collected by the ECCAC interviewers - 2 quantitative questions on whether clients attended a community event, and whether they presented their story or other artistic work at a community event; and 2 qualitative questions on clients' perceived impact of presenting their work on their relationship with the community, and clients' perceptions related to attending a community event.
*Appendix D provides a description of the format of the community events by provider agency and pictures of clients' artistic productions displayed at the community events.*

**Results:** Table 5a presents an overview of the 6 community events held by each service provider. Tables 5b and 5c present the data by service provider agency on whether clients attended a community event; and whether they presented their story or artwork at the event.

**Table 5a Community Events held by Provider Agencies**

| | **AACI** | **Gardner** |
|---|---|---|
| **Cycle 1** Period covering January 1 – December 31, 2013) | 1. *Tully Public Library, 880 Tully Rd, San Jose on June 28, 2013.*<br>2. *Evergreen Public Library, San Jose on January 11th, 2014.*<br>• About 6 - 7 seniors presented their story at each event (total = 14)<br>• About 40-60 attendees at each event (total = 100) | 1. *Gardner Adult Day Health Center, San Jose on May 30, 2013*<br>• 7 seniors presented their art/story. 3 additional seniors attended but did not present.<br>• About 58 people attended the event. |
| **Cycle 2** (Period covering January 1 – June 30, 2014) | 3. *Tully Public Library 880 Tully Rd, San Jose, on June 5, 2014.*<br>• About 20 seniors participated in the event (6 new participants, and 14 previous participants).<br>• Total of 20 stories displayed<br>• About 80 attendees. | 2. *St. James Health Clinic, 55 Julian St., San Jose on February 27, 2014.*<br>• 8 seniors presented their art/story.<br>• About 56 attendees. |
| **Cycle 3** (Period covering July 1 – December 31, 2014) | 4. *AACI, 749 Story Rd, San Jose on February 6, 2015.*<br>• 8 new senior clients and 4 former program clients participated in the event.<br>• Total 28 stories displayed<br>• About 60-65 attendees. | 3. *MACLA, 510, S. 1st St San Jose on July 12, 2014.*<br>Theater production by Teatro Vision.<br>• Stories of 6 different clients interpreted and performed by 3 actors.<br>• About 55 attendees.<br>4. *Mayfair Community Center, 2039* |

| | AACI | Gardner |
|---|---|---|
| | | *Kammerer Ave, San Jose on January 24, 2015.*<br>• 9 seniors presented their art/story.<br>• About 40 attendees. |
| **Cycle 4** (Period covering January 1 – June 31, 2015) | 5. *AACI, 749 Story Rd, San Jose on June 6, 2015.*<br>• 7 new seniors presented their story<br>• Total 35 stories displayed<br>• About 70-80 attendees. | 5. *Biblioteca Latinoamericana, 921, S. 1st St, San Jose on July 22, 2015.*<br>• 7 seniors presented their art/story.<br>• About 20 attendees |
| **Cycle 5** (Period covering July 1, 2015 to December 31, 2015) | 6. *AACI, 749 Story Rd, San Jose on January 16, 2016.*<br>• 11 new seniors presented their story<br>• Total 46 stories displayed<br>• About 80 attendees. | 6. *Biblioteca Latinoamericana, 921, S. 1st St, San Jose on December 1, 2015.*<br>• 5 seniors presented their art/story. 3 previous participants also attended.<br>• About 25 attendees |

**Table 5b. Participation in Community Events – AACI**

| **Provider data:** | | | |
|---|---|---|---|
| Total number of community events held | 6 | | |
| Total number of clients presenting their story or artwork | 46 (50% of all clients) | | |
| Total number of attendees (all events combined) | 50+50+80+65+75+80 = 400 | | |
| | | | |
| **Final Project Outcome Survey Instrument: (n=29)** | **YES** | **NO** | **Missing** |
| Did you attend any of the community events held at __? | 21 (72%)[1] | 8 (28%)[1] | 0 |
| Did you present your story or artwork at one of the "community events"? | 14 (48%)[1] | 13 (45%)[1] | 2 (7%)[1] |
| [1] Note the % for these data are based on the number of clients responding to the final interview done by ECCAC (n =29). | | | |

**Table 5c. Participation in Community Events – Gardner**

| **Provider data:** | | | |
|---|---|---|---|
| Total number of community events held | 6 | | |
| Total number of clients presenting their story or artwork *(does not include Teatro Vision event) | 36 (49% of all clients) | | |
| Total number of attendees (all events combined) | 58+56+55+40+20+25 = 254 | | |
| | | | |
| **Final Project Outcome Survey Instrument: (n=31)** | **YES** | **NO** | **Missing** |
| Did you attend any of the community events held at __? | 15 (48%)[1] | 16 (52%)[1] | 0 |
| Did you present your story or artwork at one of the "community events"? | 13 (42%)[1] | 17 (55%)[1] | 1 (3%)[1] |
| [1] Note the % for these data are based on the number of clients responding to the final interview done by ECCAC (n = 31) | | | |

Responses to the following open-ended questions, "How did presenting your story or artwork at the Community event influence your relationship with your community? and "How did attending the community event make you feel?" were examined and coded for themes. The responses to both questions did not appear to be different and hence were combined in this analysis. The following two themes characterize the responses: Improved relationship with the community; and no changes in the relationship.

The majority of respondents who attended a community event noted experiencing an improved relationship with the community. A couple reported no change. The following comments exemplify the themes of improved connection with the community:

*"Great. I always enjoy the time talking with Vietnamese people in the community." (AACI client).*

*"Feel closer to community because we have to opportunity to share and learn from each other. Networking allows us to socialize and update with current issue in community." (AACI client).*

*"I feel very happy about the book and enjoy it a lot. I enjoy when people read my book. I feel very happy." (AACI client).*

*"I feel like it healed my shyness. I spoke with more people and made new friends. I feel like I have more will power to speak with people. (Gardner client).*

*"It felt very good and yes I do feel more connected to the community." (Gardner client).*

*"Everything was nice. I enjoyed hearing others' stories. Some bad, some good. But all of it did me a lot of good." (Gardner client).*

*"Yes of course. It is nice to communicate with other people. I have been sick for a long time but it helped me to connect with people in the community and with the counselors as well." (Gardner client).*

**Conclusion:** About 50% of all clients presented their stories or artwork at one of 6 community events held by each provider agency, and several clients attended subsequent community events to support their peers. For AACI, many clients presented their story at several community events, which may have enhanced their experience of feeling more connected with the community. Similarly, for Gardner, there were six stories that were used again for the Teatro Vision community event.

The majority of clients who attended a community event or presented their story or artwork spoke very positively about the experience, especially focusing on the improved connection with their community, listening to others' life experiences, and sharing their own. The structure and format of the community events (client presentations and inviting the larger community to attend) greatly enhanced the preservation of personal and collective histories as clients enjoyed sharing their stories and listening to others' experiences, as did the attendees (family members and the general public).

***Process Question 4*: How do the seniors perceive the Storytelling program?**

**Data Sources**: 1) Post-test quantitative data on treatment satisfaction; and 2) Final Project Outcome Survey Instrument – (1 qualitative question on Reasons for Recommending the Program to Others).

**Results:** Table 6 presents the data by service provider agency on client's Satisfaction with Treatment; and whether clients would recommend the program to others.

**Table 6. Satisfaction with Treatment**

| **AACI overall (n = 92)** | |
|---|---|
| Overall Treatment Satisfaction Scale (6 items)<br>Range: 6 – 13; (lower scores=greater satisfaction) | Mean = 6.5<br>SD= 1.41 |
| **Gardner overall (n = 68)** | |
| Overall Treatment Satisfaction Scale (6 items)<br>Range: 6 – 18; (lower scores=greater satisfaction) | Mean = 8.3<br>SD= 3.07 |

The Final Project Outcome Survey asked seniors if they would recommend the Storytelling program to others, and reasons for why they would or would not recommend the program. About 93% of both samples [AACI = 27 (93%) & Gardner = 29 (93.5%)] said they would recommend the program to others.

Responses to the following open-ended questions, "Can you tell me the reason you would or would not recommend the project?" and "Is there anything else you would like to share about the project?" were examined and coded for themes. The following themes characterize the reasons for recommending the project: Reminiscing was a good activity; Felt better by talking to someone; and Felt less isolated. The major themes characterizing additional comments about the project were: Gratitude; and the Need to Continue the project. The following comments exemplify these themes:

Reminiscing, Improving mood, Reducing isolation:

*"You learn a lot from others. You learn to get out the good memories and also the bad. We talked to other participants. It is good to get out what is causing you stress and keep going." (Gardner client).*

*"I would tell them they would feel better after doing it. You can look at negative and positive and look back and say you could've done somethings different, but it made me more aware of myself. Not so much that you are patting yourself on the back, but just a good way to see the positive… Some people seem to look at mistakes and a lot can't see the good and they are looking for just the negative. I'm glad there's a project like this. It helps people out like talking about your problems. If feels better to talk about your problems." (Gardner client).*

*"I like to introduce my friends to this type of events. We like and need to participate in community events. We have nothing much to do at home." (AACI client).*

*"Improved my life so I hope it would help others. It is mental medicine to help others who are living isolated." (AACI client).*

Gratitude & Continue to Offer the Program:

*"Very grateful. It helped me a lot." (Gardner client).*

*"The project is a very good idea and very beneficial. I hope it is offered again to others." (AACI client).*

**Conclusion:** The modal score on the Treatment Satisfaction Scale for both Service Providers was a score of 6 indicating the greatest satisfaction with treatment [n= 79 (86%) for AACI; n = 33 (49%) for Gardner]. However, there was greater variance in the responses from Gardner's clients (mean = 8.3; SD = 3.0) on the Treatment Satisfaction Scale score as compared to AACI's (mean = 6.5; SD = 1.4). It is possible that cultural issues in responding to these questions may play a role in producing these results, where Asian clients may not feel comfortable giving less than perfect responses to the peer specialist who provided the services. The results may also

reflect the possibility that this intervention was particularly suited to the needs of this Vietnamese sample. Nonetheless, the qualitative comments on reasons for recommending the program to others reflected appreciation of the reminiscence activity, reduction in isolation, and improvement in mood for clients from both programs.

## Outcome Questions

***Outcome Question 1*: How many seniors engage in this program?**

**Data Sources**: 1) Quantitative data on participation, completion, attrition and program implementation from Providers; 2) Quantitative descriptive data on: ethnicity, age, gender, living arrangement and family support situation, and length of stay in the U.S.

**Results:** Table 7a presents the data by service provider agency on numbers of clients engaged in the program, completed the program, or lost to attrition. Also included in this table are program implementation data for clients completing the intervention and the post-test, i.e., the average number of treatment sessions with each client, and the average number of hours spent on each case by the peer specialist. Table 7b provides the demographic characteristics of the clients who completed the intervention and the post-test. These data are included to provide context to client participation and program implementation.

**Table 7a: Program Participation & Implementation Data for AACI & Gardner**

| **Program Participation data – all clients** | | |
|---|---|---|
| | **AACI** | **Gardner** |
| Total number of clients enrolled in the intervention | 111 | 95 |
| Total number of clients completing the Post-test interview | 92 (83%) | 73 (77%) |
| Total number of clients lost to attrition | 10 (9%) | 16 (17%) |
| Total number of cases still active - to be closed. | 9 (8%) | 6 (6%) |
| **Program Implementation data for clients completing the post-test** | | |
| | **AACI (n = 92)** | **Gardner (n = 73)** |
| Number of Sessions for Intervention | Mean= 12<br>(SD = 2.7)<br>(Range = 5 – 23) | Mean= 11<br>(SD = 2.3)<br>(Range = 5 – 17) |
| Typical number of sessions with clients | 75% of clients had between 10 – 14 sessions | 77% of clients had between 10 – 14 sessions |
| Number of Hours spent on each case | Mean = 25.5<br>SD = 11<br>Range = 8 – 64 | Mean = 27.8<br>SD = 8.3<br>Range = 7 – 45 |

**Table 7b: Client Demographics for AACI & Gardner**

| Client Demographics | AACI (n = 92) | Gardner (n = 73) |
|---|---|---|
| Age | Range = 60 to 91;<br>Mean = 73.7; SD =8.0 | Range= 60 to 94;<br>Mean = 76.0; SD =9.5 |
| Gender | Female = 48 (52%)<br>Male = 44 (48%) | Female = 55 (75%)<br>Male = 18 (25%) |
| Ethnicity | Vietnamese = 89 (97%)<br>Other = 3 (3%) | Hispanic = 62 (85%)<br>Caucasian/Other = 9 (12%) |
| English Proficiency - Speaking | Poor = 45 (49%)<br>Fair = 34 (37%)<br>Good = 13 (14%) | Poor = 51 (70%)<br>Fair = 2 (3%)<br>Good = 6 (8%)<br>Excellent = 14 (19%) |
| English Proficiency – Writing | Poor = 46 (50%)<br>Fair = 34 (37%)<br>Good = 12 (13%) | Poor = 51 (70%)<br>Fair = 2 (3%)<br>Good = 6 (8%)<br>Excellent = 14 (19%) |
| English Proficiency - Reading | Poor = 46 (50%)<br>Fair = 33 (36%)<br>Good = 13 (14%) | Poor = 43 (59%)<br>Fair = 8 (11%)<br>Good = 10 (14%)<br>Excellent = 12 (16%) |
| Years Lived in the U.S. | Range = 3 to 64;<br>Mean = 24.4; SD = 10.9 | Range = 2 to 94;<br>Mean = 46.4; SD = 26.0 |
| Living Arrangement | Alone = 25 (27%)<br>Spouse = 27 (29%)<br>Other Family = 36 (39%)<br>Other non-Family = 4 (4%) | Alone = 20 (27%)<br>Spouse = 3 (4%)<br>Other Family = 36 (49%)<br>Other non-Family = 14 (19%) |

**Conclusion:** The results indicate that a total of 206 clients were enrolled in the intervention with 165 clients completing the intervention and the post-test measurements. Client attrition [10 cases (9%) for AACI and 16 cases (17%) for Gardner] could be attributed to a variety of reasons such as: clients were no longer interested in participating; did not like answering the eligibility and evaluation questions; serious illness in client or family; and needing a higher level of mental health care. Program implementation data indicates that, on average, clients were seen for 11 to 12 sessions and the average time spent on each completed case was 25 to 27 hours.

The combined demographic data on clients indicates that the clients were older (mean age = 75 years), female (62%), the majority of clients are Vietnamese or Hispanic (Mexican), who had limited English proficiency, self-described as having poor to fair ability to speak, read, or write

in English. Although a few clients were native born the majority have lived in the US for varying lengths of time. About a quarter of the clients lived alone, and the majority from both agencies lived with either a spouse or with a spouse and adult children.

The providers were successful in recruiting ethnic minority seniors through community outreach typically in non-mental health settings such as senior centers, wellness fairs and other community events, and senior housing.

***Outcome Question 2: How does the program affect the seniors' quality of life and daily functioning?***

**Data Sources:** 1) Pre and post-test Survey data from participants on: Patient Health Questionnaire (PHQ-9) & Short Geriatric Depression Scale (GDS-15); Short Loneliness Scale; Satisfaction with Life Scale (SWLS); Short Portable Mental Status Questionnaire (SPMSQ). 2) Post-test quantitative data on Perceived Impact of Intervention

**Results:** Tables 8a and 8b present the data by service provider agency on the change in scores in depression, loneliness, satisfaction with life, and cognitive impairment scores pre and post intervention using paired t-tests. Tables 9a and 9b present the data by service provider agency on the clients' Perceived Treatment Impact on Areas of Functioning. Table 10 provides a summary of the change scores on the PHQ-9. Existing literature on the PHQ-9 suggests that a 5 point reduction in symptoms would suggest a clinically meaningful change from one category of depression to another (Kroenke, 2012).[2] Research guidance on clinically significant change scores for the other measures – GDS-15, Loneliness, and Satisfaction with Life is not yet available in the literature.

[2] Kroenke, K. (2012). Enhancing the clinical utility of depression screening. *Canadian Medical Association Journal (CMAJ)*, February 21, 2012, 184(3). DOI:10.1503/cmaj.112004

**Table 8a: Mean Pre- and Post-test Differences in Quality of Life Variables – AACI**

| | | Mean | SD | N | Difference Mean | Difference T value | Sig |
|---|---|---|---|---|---|---|---|
| Pair 1 (range = 0 - 27) | PHQ-9 total-pre | 6.68 | 3.75 | 92 | 3.46 | 11.75 | .000 |
| | PHQ-9 total-post | 3.22 | 2.69 | 92 | | | |
| Pair 2 (range: 0 – 15) | GDS-15 total-pre | 6.50 | 1.64 | 92 | 3.26 | 19.35 | .000 |
| | GDS-15 total-post | 3.24 | 1.57 | 92 | | | |
| Pair 3 (range: 0 – 10) | SPMSQ score-pre | .58 | 1.67 | 91 | .23 | 2.22 | .029 |
| | SPMSQ score-post | .35 | 1.24 | 91 | | | |
| Pair 4 (range = 3 – 9) | Loneliness-pre | 4.86 | 1.53 | 91 | 1.14 | 8.52 | .000 |
| | Loneliness-post | 3.71 | 1.05 | 91 | | | |
| Pair 5 (range = 5 – 35) | Life Satisfaction-pre | 18.04 | 6.05 | 91 | -5.27 | -10.34 | .000 |
| | Life Satisfaction-post | 23.32 | 5.75 | 91 | | | |

**Table 8b: Mean Pre- and Post-test Differences in Quality of Life Variables – Gardner**

| | | Mean | SD | N | Difference Mean | Difference T value | Sig |
|---|---|---|---|---|---|---|---|
| Pair 1 (range = 0 - 27) | PHQ-9 total-pre | 9.76 | 3.42 | 71 | 2.97 | 5.32 | .000 |
| | PHQ-9 total-post | 6.79 | 4.43 | 71 | | | |
| Pair 2 (range: 0 – 15) | GDS-15 total- pre | 5.79 | 2.87 | 66 | 1.69 | 5.14 | .000 |
| | GDS-15 total-post | 4.09 | 2.93 | 66 | | | |
| Pair 3 (range: 0 – 10) | SPMSQ score-pre | 2.19 | 1.26 | 72 | .22 | 1.58 | .117 |
| | SPMSQ score-post | 1.97 | 1.54 | 72 | | | |
| Pair 4 (range = 3 – 9) | Loneliness-pre | 5.79 | 1.88 | 70 | 1.00 | 4.75 | .000 |
| | Loneliness-post | 4.79 | 1.65 | 70 | | | |
| Pair 5 (range = 5 – 35) | Life Satisfaction-pre | 24.04 | 6.70 | 70 | -1.87 | -3.35 | .001 |
| | Life Satisfaction-post | 25.91 | 6.24 | 70 | | | |

**Table 9a. Perceived Treatment Impact on Areas of Functioning– AACI (n = 92)**

| **Areas of Improvement Experienced** | |
|---|---|
| The services that you received resulted in improvements in any of these areas? | **YES, n (%)** |
| Education/ Gained knowledge during participation | 65 (71%) |
| Occupation/ Productive Daily Activity | 66 (72%) |
| Family/friend relationship | 70 (76%) |
| Health Condition | 67 (73%) |
| Finance | 12 (13%) |
| Overall Wellbeing/ Mood Symptoms | 66 (72%) |

**Table 9b. Perceived Treatment Impact on Areas of Functioning – Gardner (n = 73)**

| **Areas of Improvement Experienced** | |
|---|---|
| The services that you received resulted in improvements in any of these areas? | **YES, n (%)** |
| Education/ Gained knowledge during participation | 21 (29%) |
| Occupation/ Productive Daily Activity | 22 (30%) |
| Family/friend relationship | 32 (44%) |
| Health Condition | 14 (19%) |
| Finance | 4 (6%) |
| Overall Wellbeing/ Mood Symptoms | 36 (49%) |

**Table 10. Clinically significant change in PHQ-9 depression scores**

| **Agency** | **got worse** | **no change** | **Smaller change (1-4 points)** | **Clinically significant change (5+ points)** | **Missing** |
|---|---|---|---|---|---|
| **AACI (n =92)** | 2 | 1 | 64 | 25 | 0 |
| | 2.2% | 1.1% | 69.6% | 27.2% | 0.0% |
| | | | | | |
| **Gardner (n =73)** | 15 | 4 | 25 | 27 | 2 |
| | 20.5% | 5.5% | 34.2% | 37% | 2.7% |
| | | | | | |
| **Total n (%)** | 17 (10%) | 5 (3%) | 89 (54%) | 52 (32%) | 2 (1%) |

**Conclusion:** As these results indicate, when examined separately by agency, for AACI the post intervention scores on all four outcome variables show statistically significant improvement. Interestingly, although not a focus of the intervention, the SPMSQ scores appear to show statistically significant improvement ($p < .05$) at post –test, which may possibly be related to reduction in depressive symptoms, or simply an anomaly in the data. For Gardner, the two depression measures (PHQ-9 and the GDS-15) as well as the loneliness and life satisfaction measures show statistically significant improvement. No change was observed in the SPMSQ scores. However, Gardner also had clients who ended the intervention showing higher depression scores. Possible reasons for this finding were explored with providers and include: critical incidents such as the departure of a visiting family member, the death of a family member, exacerbation of illness in the client or family member.

The responses on improvement experienced in different areas for clients from both agencies indicate that the two areas with the most perceived improvement were mood, and relationships with family and friends –which are the two domains specifically targeted by the program.

Finally, the intervention, was successful in producing clinically significant change scores in depression (5 or more points) as measured by the PHQ-9 for approximately a third of all clients in the program (32%) and successful in producing smaller change in depression scores (1 – 4 points) for over half of all clients (54%). A small number of clients either experienced no change or had worse scores on the PHQ-9 at post-test. The impact of the intervention on quality of life and daily functioning is highlighted through the following comments made by clients:

> *"Yes it influenced me. Well it's because I was depressed and I stopped doing my dialysis, but after this project I started going back again." (Gardner client)*

> *"Improved (my depression), healthier life. Enjoy my life more." (AACI client)*

# Lessons Learned

## Challenges

A few of the challenges encountered during the implementation of INN-04, the Storytelling project were:

**Recruitment of clients into the program**. Both provider agencies reported some challenges to recruiting appropriate clients into the program. For example, it was difficult to reach out to isolated seniors in institutions due to a lack of gatekeepers who could connect these seniors to the Storytelling program. Recruitment challenges were addressed by conducting a significant amount of outreach in a variety of locations (senior centers, senior housing, wellness fairs, other community events, and other provider agency programs), and by expanding the scope of the original target population (Vietnamese and Spanish-speaking seniors) to include others. These efforts helped the agencies meet their targeted goals for client participation.

**Post Intervention Survey Outcome Data Collection**. Several delays were experienced in the process of data collection by the ECCAC staff which resulted in a smaller sample size available to answer the process questions related to the impact of the cultural competence of the community worker (process question 1), and to preservation of personal and collective history through presentation to the larger community (process question 3).

**Issues related to Family Participation**. The providers noted that fewer than half the participants had one or more family members participate in the storytelling intervention. Thus the majority of the sample either had no family members available to participate, or the families were too busy with work to be able to participate in the intervention.

**Issues related to Translation of Instruments.** Supervisors from both provider agencies noted discrepancies in translations which may lead to misinterpretation by clients. It was helpful to periodically examine the data to better understand how clients were interpreting the questions and making necessary adjustments to the survey items to clarify the content and meaning of the words. These early checks helped improve the data collection process.

**Issues related to Community Events**. The providers noted the following issues regarding the community events:

a) <u>English language proficiency and translation resources</u>

For AACI, all the client stories were presented in Vietnamese and there were no resources to translate these stories into English. Thus, this limited expanding the scope of the community event to include the general public and the attendees were mostly from the Vietnamese community.

For Gardner, some clients preferred to do their treatment and their stories in English whereas others were monolingual in Spanish. This also created some logistical difficulties in that monolingual Spanish or English attendees and participants could not fully access all the stories depending on the language in which they were done. Although visual art pieces were often used

by Gardner's clients, the story that the art represented was not universally accessible to all attendees and participants.

The language issues also impact the participation of family members as the grandchildren are often not bilingual and cannot read the stories in Vietnamese or Spanish.

b) Openness to Presenting One's Life Story in Public

Although 50 percent of the clients who completed the post-test presented their story at one or more events, the other half of the sample declined to participate in the presentation. Reasons for declining the opportunity to present their story included not wanting to make their personal lives public, or not feeling like they had something special to share, especially in the case of women participants.

c) Transportation to Attend Community Events:

Transportation to community events remains a perennial problem for seniors. Although Gardner provided vouchers for clients to come to the events, this mechanism was not always successful in bringing the seniors out to the community events.

**Staff Turnover**. Both provider agencies experienced some staff turnover which resulted in the supervisors and other staff needing to devote time to orient new hires to the work of the Storytelling project.

## Successes

Based on the findings on the process and outcome questions developed for this project, the successes of the Storytelling program are summarized below:

1) *The utilization of a community worker with cultural competence* appeared to contribute to the seniors' comfort in expressing their personal memories. Although the sample size of respondents to the post intervention outcome survey represented roughly a third of the sample completing the post-test, the seniors were overwhelmingly positive on feeling like their cultural traditions were understood and that their worker communicated well with them. The majority concurred that having a worker of a similar cultural background was helpful for building rapport and facilitating the story telling process. However, many of the clients also felt that they could feel comfortable with workers from other cultural backgrounds, suggesting that more acculturated, bilingual clients may be comfortable with non-ethnically matched workers. Thus, the program could be beneficial to seniors from other ethnic groups as well.

2) *The inclusion of a family member in the Storytelling process* had a positive impact on the relationship between the senior and the family member(s). Although less than half of all participants had one or more family members participate in the Storytelling intervention, when clients were asked if the intervention resulted in improvement in relationships with family/friends, 76% of AACI's clients and 44% of Gardner's clients responded affirmatively. The qualitative data suggest that the storytelling intervention lead to improvement in family

relationships through improved communication and shared understanding of the client's life story.

3) *The exercise of capturing the seniors' life stories through some expressive arts medium and presenting them to the larger community at one or more of 6 community events held by each provider agency* greatly enhanced the preservation of personal and collective histories as clients enjoyed sharing their stories and listening to others' experiences, as did the attendees (family members and the general public). About 50% of all clients presented their stories or artwork at a community event. The majority of clients who attended the community event or presented their story or artwork spoke very positively about the experience, especially focusing on the improved connection with their community, listening to others' life experiences, and sharing their own. The community events also helped seniors become more familiar with resources available in the community.

4) *The providers were successful in engaging ethnic minority seniors that were the target population for this project.* The majority of seniors were of Vietnamese or Mexican origin, with a mean age of 75 years, and limited proficiency in English. Recruitment for clients was done through community outreach – typically in non-mental health settings such as senior centers, wellness fairs and other community events, and senior housing. A total of 206 clients were enrolled in the intervention with 165 clients completing the intervention and the post-test measurements. The overall attrition rate was 12% [9% for AACI and 16% for Gardner] and could be attributed to a variety of reasons such as: clients were no longer interested in participating; did not like answering the eligibility and evaluation questions; serious illness in client or family; and needing a higher level of mental health care.

5) *The Storytelling program was successful in improving the seniors' quality of life and daily functioning* as assessed through improvement in depressive symptoms, loneliness, and life satisfaction (although Gardner's clients did not report changes in life satisfaction, their average scores were on the higher end of the scale to begin with). Furthermore, client responses on improvement experienced in different areas of functioning indicate that the two areas with the most perceived improvement were mood, and relationships with family and friends –which are the two domains specifically targeted by the program. The intervention was successful in producing clinically significant change scores in depression (5 or more points) as measured by the PHQ-9 for approximately a third of all clients in the program (32%) and successful in producing smaller change in depression scores (1 – 4 points) for over half of all clients (54%). Clients commented positively on the improvement in depression which also influenced their overall quality of life and daily functioning. Despite the stigma related to mental illness and treatment, the seniors appeared to be receptive to engaging in a storytelling treatment intervention.

6) *The Storytelling program was well received by the seniors and their families.* The modal score on the Treatment Satisfaction Scale for both Service Providers was a score of 6 indicating the greatest satisfaction with treatment (68% of the sample). The qualitative comments on reasons for recommending the program to others reflected appreciation of the reminiscence activity, reduction in isolation, and improvement in mood for clients from both

programs. The successes of the Storytelling program are highlighted by the testimonials that were gathered by peer specialists from clients both at community events and at the end of their treatment sessions:

**AACI – Healing Legacies**

*When I was first introduced to Healing Legacies, I hesitated to join because I don't want to share my life story. We are often only sharing the happiness and joyfulness and hide away the painfulness or sorrowfulness, but [AACI staff] has been patient with me and walked with me through the process to reveal my life story. I feel very happy and proud of myself for sharing the experience that has made my life richer and more meaningful. I am grateful for the program as they helped me find needed information for senior citizens." ---- Mrs. T. T. B*

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*This is my first time sharing my life story that I have kept for over 40-50 years. I have been feeling uplifted after revealing some of my painful life stories. Throughout the storytelling, Healing Legacies has helped me relieve the painful feelings that I've carried inside of me for many years. Healing Legacies is a great program that I would recommend for other seniors." ---- Mrs. D. H. N*

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*I really enjoy participating in the "Healing Legacies" program. AACI staff has helped me review, gather information, evaluate, and bring my story to life. My storybook would become an effective tool to help promote and enhance my familial relationship. My children will have the opportunity to understand more about their parents' past experiences in their near-death journey from Vietnam to America so they can learn and better themselves and their families. ------- Mr. D. V.*

---

**Gardner – Miradas al Pasado**

*"At first I wasn't sure about having someone come to my home to visit me because I have had people come before and I didn't trust them, but I am glad I began this program and I feel better about my life now. I have more energy and when I lay down to sleep I don't think about the bad things that have happened in my life. I have learned to accept my past and understand that the bad things that happened were not my fault. I have accepted them and I feel like I have much more to live for. Remembering has helped me let go of bad feelings that I have had for years." – N.D.*

*"This is a great program because it is a service where people come into your home. Seniors are not always able to drive places and are at home so it is great to have this type of service. Telling my stories has made me remember all the things I have done that I hadn't thought about in a long time and it motivates me to do more things. I think it is also great because it is offered in Spanish for those who don't speak English". – E.B.*

*"The program has helped me to see things differently. The life I have lived has been of painful and sad memories but I learned to see things in a different way and I feel happy. I have shared things that I have never said to anybody, not even my own children and I feel good about it. It was hard to remember but I feel better that I did." – O. A.*

## Recommendations and Implications for future projects

Although the attrition rates were relatively low, careful attention should be given to screening and eligibility criteria to ensure that clients are appropriate for the intervention, and possible modifications to the intervention may be considered. That is, clients with serious health conditions are more likely to not complete the intervention, and perhaps the intervention process may need to be modified (shortened or more focused) to better suit their needs. Similarly, for clients with mild depressive symptoms, reduced number of treatment sessions or a group treatment format could be considered particularly if the goal is to reduce isolation. These alterations to the program would then need to be evaluated to determine whether they are still producing the intended program outcomes.

Although the burden of pre and post- test measurements for clients was kept to the minimum, providers reported that some clients did not want to complete the assessment tools. Given that the PHQ-9 was suitable for this population and allowed an examination of both statistically and clinically significant change, using only the PHQ-9 for assessing depression may be justified in order to further reduce the burden of completing the assessment tools.

Providers could also consider alternative ways to engage family members in the intervention – especially for those family members who work and are unavailable to participate in the intervention process.

If the community presentation is maintained as part of the overall intervention, more consideration needs to be given to methods for increasing client and community participation in these events.

Ongoing monitoring and evaluation of data proved to be an excellent mechanism for ensuring that translations were accurately capturing information as intended, and more attention was being given to obtaining complete post-intervention data from clients.

Finally, the provider agencies were asked to provide a summary of their overall impressions of the Storytelling Project that may be useful for future programs. The summaries are presented below.

*Angelica Eliazar, Program Supervisor, Gardner:*

"As the program manager for the *Miradas al Pasado* storytelling program I was able to have a firsthand account of what an amazing impact this program has had on seniors and their family members. Through this program we were able to reach those individuals who would not normally seek out mental health treatment. However they had signs and symptoms that impacted their functioning. In the process of sharing their stories with a peer mentor they were able to re-

live past successes and positive feelings. Then when they created a visual piece of their choosing--be it a collage, a painting, a crocheted napkin, a papier- mâché figure or a recording of them--they were then able to re-create that experience to share it with loved ones and the community through regularly held events. Our version of the storytelling program also had a community performance where monologues of clients stories were performed by Teatro Vision. This was an emotional event for those participants who could see, not only parts of their lives on stage, but also see how the community connected and reacted to the stories as there was a guided discussion at its conclusion. The community members were able to resonate with themes and feelings which validated the experience for the elders. This program was sought out by other colleagues and amongst our clients were the parents of a staff nurse, a former mental health board member, and a Gardner staff member. Other mental health professionals also saw the value of this program and wanted their loved ones involved. As much as this was impactful for the clients we were able to serve, it also touched staff in a positive way to listen and help document the beautiful tapestries of client's lives."

*Duy Pham, Program Supervisor, AACI*

"The Healing Legacies program has created an effective learning opportunity through the powerful storytelling techniques that opens a place for seniors to reminisce about their life stories and focus on the healing process. Reminiscing is also a coping mechanism at later stages of seniors' lives when they review their stories and continue to share them with others. The program has truly illuminated their pasts, improved intergenerational dialogues and relationships, and carried rich lessons across generational members. The program has brought a great deal of relief and pleasure to the seniors that their stories have been recognized and they have created a precious legacy for their next generations. The process has not only given seniors a look back and voice to the long lost and forgotten pasts but also empowered them to overcome fear, shyness, and grief. It has given them power to change their mindsets to open up and seek help to improve their overall well-being. "

# Appendices

A: Summary Description of Project Implementation in First Cycle (July 2013)

B: IRB Approvals

C: Data Collection Instruments (English versions)

D: Description of the format of the community events by provider agency and pictures of clients' artistic productions displayed at the community events.

## Appendix A. Summary Description of Project Implementation in First Cycle

On July 15, 2013 a structured discussion group was conducted with all project staff members from both provider agencies to better understand how the projects were being implemented and to discuss and resolve any issues or challenges that needed to be modified or addressed at the end of the first cycle of project implementation.

AACI and Gardner reported on the implementation of the storytelling project among Vietnamese and Spanish speaking seniors. The agencies described their outreach and implementation strategies, and supervisors and peer mentors discussed their experiences working within the program. Providers were also asked to discuss clinical issues that arose during the storytelling sessions, the process of helping clients to create the final product, and the community event. In addition to these areas of focus, peer mentors from both AACI and Gardner raised issues of cultural and linguistic competency that impacted program implementation at all stages. Providers discussed these challenges and offered suggestions for improving outreach and implementation in future phases of the program. Below is a summary of the discussion by agency. The process described below remained essentially the same throughout the period of the project.

**Table A1. Summary Description of Storytelling Project Implementation**

| | AACI | Gardner |
|---|---|---|
| **Program Description** | This was the first phase of a storytelling program targeting Vietnamese seniors in East San Jose. The program included 2 peer mentors and 1 clinical supervisor who provided initial outreach to 93 individuals over a 6 month time period. The GDS, SPMSQ, and PHQ9 assessments were used to assess eligibility for the program and those seniors assessed with mild to moderate depression were invited to participate in the program. Peer mentors enrolled a total of 25 clients and met with them for an average of 12 sessions each to engage in the storytelling process and assist with the creation of a final product. | This was the first phase of a storytelling program targeting Spanish speaking and other underserved ethnic communities in Central and East San Jose. The program included 3 peer mentors and 1 clinical supervisor who provided initial outreach to 89 individuals over a 6 month time period. The SPMSQ and PHQ9 assessments were used to assess eligibility for the program, and those seniors assessed with mild to moderate depression were invited to participate in the program. Peer mentors enrolled a total of 19 clients and met with them for an average of 11 sessions each to complete the storytelling process and assist with the creation of a final product. Peer mentors reported meeting with potential clients for about 2 sessions before they are actually enrolled in the program. |
| **Outreach** | Outreach was conducted at community events and community centers in East San Jose. Outreach was also conducted | Initial outreach was conducted to older adults in Central and East San Jose through presentations at senior community centers |

| | AACI | Gardner |
|---|---|---|
| | through contacting other providers. Other referrals came through family members or other connections in the community.<br><br>Ideas for future outreach include going more directly to the seniors, for example focusing on residences where there is a concentration of Vietnamese seniors. | and subsidized/below market/low income housing sites. Outreach was also conducted to Valley Medical staff, APS staff, and at senior resource fairs. A Community Service Segment was also done on a Spanish language morning news TV program.<br>Outreach presentations were conducted in Spanish or English, and included information about the Storytelling Program and a reminiscence activity for attendees. Attendees were asked to complete an Interest Card for a follow-up appointment. |
| **Storytelling Process** | Peer mentors spend time talking with the clients about the program and how it can benefit them. Relationships are established over several sessions, until clients feel assured that their stories will be received nonjudgmentally.<br>Clients can share whatever they want, but if they have difficulty starting, the peer mentor provides prompts of different topics. Clients are also told that if there are things they do not want to share, they do not have to talk about them.<br>In addition to the past, clients are also encouraged to talk about what they would like to do in the future, what their challenges and hopes are, and how they can they make changes.<br>Peer mentors and clients go through the clients' pictures and souvenirs together as part of the engagement process, to help clients feel excited about the project and comfortable with the peer mentors being in their homes. | Reminiscence kits are an integral part of the storytelling program. They facilitate the fluidity of the sessions, and help to elicit memories. Visual kits include pictures, audio kits include music and sounds, texture kits are used for clients with visual impairments, and smelling kits are based on food and products such as soap, ointments, or herbs that are familiar to the general population.<br><br>The kits are adapted for every senior adult, situation and circumstance. At the start of the storytelling sessions, the client's cultural and social background is identified, and that information is used to present a kit that is relevant to the client. This can involve research by the peer mentor into the client's hometown, the history of the client's country, or the popular music and writers of the time. |
| **Progress Notes** | Regular progress notes for the clients are written for each session in addition to recording the clients' stories. If an emergency situation just happened, for example if someone just passed away, | Progress notes have the client's name, minutes worked during the session, date, and name of facilitator. The progress note is divided in three sections. One is the part related to stories which is subdivided in |

| | AACI | Gardner |
|---|---|---|
| | this is discussed as part of the storytelling, as well as documented in the client's progress note. | three sections: Personal, interpersonal and sociocultural, and if a family member or friend were present. Another section registers activities, such as use of screening tools, linkage, case management, reminiscence kits. Everything that is marked in these 2 sections must be described in a succinct manner in the note section. Then the stories are documented in a storytelling form that is given to clients after they conclude the program. |
| **Engaging Family** | Family members may become engaged if they see the final product the client has created. For example, a husband may see his wife participate in the program and the final product she created, and he may become interested in joining. | Clients are informed that their family members or friends can also participate in the program. This strengthens ties between family and friends, and family members can have input into the clients' stories (with the clients' permission). Family members can also help in the creation of the final product, and they are invited to the Community Event. |
| **Community Project** | The Community Event was conducted on June 26th 2013 at the Tully Library and was very well received. Seven clients participated and were very happy and excited to receive so much attention. Clients received an honors certificate; one client said that she had never received any certificate before. A common theme among clients is that it is very difficult for them to share their stories, but with the help of a peer who will be patient and spend time with them it becomes easier. Because the Community Event was so well received, it is hoped that more clients will consent to be in the program. | The Community Project/Event took place on May 30th 2013 at Gardner ADHC with about 35 people in attendance. Seven art pieces were displayed, and of the seven clients, five were presented with a Certificate of Completion. Peer Mentors gave a brief description of their client and their artwork and asked clients why they decided to create their art piece. The presentations of the art pieces were done in the client's primary language, and Spanish-English translation was provided.<br>The families' feedback was very positive, and family members and guests wanted to refer others to the storytelling project. |
| **Termination** | Clients do not have a clear understanding of what this means even if they are told the service/project will terminate in 14 weeks. They are okay if | Termination is difficult because clients like someone coming to talk to them, and while peer mentors can provide linkage to other services, the clients may not qualify. |

| | AACI | Gardner |
|---|---|---|
| | the meetings stop, but they are also okay if they continue.<br>Part of termination is the community event, so there is a positive experience at the end of the project where clients can share what they achieved. | The graduation and certificates are provided in part to lessen the impact of no longer being in the program. |
| **Consistency in Treatment Approach** | The team meets for weekly consultation and covers administrative and clinical issues. There are also twice monthly in-house trainings, and opportunities for outside training, especially in mental health. | For the assessment tools, a companion sheet in Spanish is used so everyone uses the same vocabulary with the clients and the same method of getting the answers. The team meets weekly to discuss issues and collaborate on finding solutions that are implemented the same way by all. The LCSW supervisor meets weekly with each individual peer mentor to discuss each case and brainstorm any issues that have arisen. |
| **Challenges** | Building trust within the community has been challenging. There are many scams targeting seniors in the Vietnamese community, so peer mentors must reassure the clients that this is a free, professional service. Outreaching to the community on a regular basis was suggested as a way to address this challenge.<br>Vietnamese clients may not have been able to bring many photographs or souvenirs with them from Vietnam. In these cases, the final product may not be easy to put together in an archival box, but could involve creating something from scratch, which might be more time-consuming. | Challenges include clarifying program criteria to service providers to ensure appropriate referrals are made, and confirming that the client has consented to the referral. Most senior/community centers do not have an on-site social worker to make a referral for clients. The reduction in services that serve seniors may also result in fewer referrals.<br>Helping the client create a polished final product can sometimes take more time than the peer mentor can spend working on the project. |
| **Social Media & Technology** | Many older Vietnamese clients use the internet to chat, read news, or download music. | Clients may not be computer literate. Staff use online tools to help with research and translation for the project and may share these tools with clients. |
| **Potential Mental Health Issues** | Within the Vietnamese community, there is a lack of knowledge about mental health issues, and there is a lot of stigma attached to having mental health problems. This may prevent clients from | Mentors are prepared to help clients deal with sadness, grief, and anger. They also make sure that by the end of the session clients have returned to a positive mood**.** If the client's mood is not stable, linkage to a |

| | AACI | Gardner |
|---|---|---|
| | sharing these issues and make it difficult for them to answer some of the questions on the screening tools that measure depression. Therefore, some clients who are appropriate for the program may not meet screening criteria. | mental health professional is provided. |
| **Cultural Competence & Use of Self** | Peer mentors for the Vietnamese community have to practice culturally and linguistically competent care. Vietnamese clients come from different backgrounds and different regions in Vietnam. North, Central, and South Vietnam each have different kinds of terms and vocabularies. If the client and the peer mentor come from different backgrounds, this can affect the assessment process, because the use of a different term can give the client a different idea of what is being asked. The issue can also be political. For example, the use of certain terms that were brought to the South following the 1975 Communist takeover can cause some clients to shut down or become angry. Peer mentors must work to build the relationship slowly and may share some of their own experiences. This way the clients can understand the mentor's background, and client and mentor can reach a better understanding of one another.<br>The assessment tools include questions about feelings and emotions to which many Vietnamese clients will find it difficult to respond. The clients can talk about symptoms, but a feeling is harder for them to talk about. Also, many of these clients are very community oriented. They engage in the community, and so they fear others will know if they say "Yes" to a question about feeling like a failure. The | With the Latino population there is stigma about mental health services, so it is important to talk with the client first and explain the program before engaging them with the assessment tools. Some clients have had positive experiences with mental health treatment, but certain words on the GDS are very pointed, and not the way that clients would usually say something. For example, clients may share a situation in which they experienced feelings of guilt, but they explain it in their own words.<br>The education level in which the questions are written might be too high for some clients who have not had a lot of formal education.<br><br>Peer mentors also need to do research into the clients' cultures and places of origin. Peer mentors who speak Spanish may be from a different country or different region than the clients they work with so they may use different words for the same thing. This becomes part of the process as the peer mentor does the research and then comes back to the client to talk about what they have learned. Gardner serves clients from various countries with different cultures which adds a another dimension of cultural humility that is necessary for staff to have when working with seniors from very different countries. |

| | AACI | Gardner |
|---|---|---|
| | importance of saving face makes it difficult for them to respond accurately to the questions. | |
| **Other issues** | Clients are also provided information and resources for other needs. | Case management needs arise during the sessions, and mentors can spend a limited amount of time helping to meet these needs. Some clients may be homeless and need more intensive case management. In those cases, referrals need to be made to appropriate programs. |

# Appendix B. IRB Approval Letters

*Dedicated to the Health Avenue, 3rd floor Of the Whole Community*

SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM

**Administration**
976 Lenzen

San Jose, California

Tel.
(408) 792-5680
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DEPARTMENT OF
ALCOHOL AND DRUG SERVICES

DATE: April 24, 2015

TO: Sadhna Diwan, Ph.D., San Jose State University

FROM: Kakoli Banerjee, Ph.D.
Chair, Health Services Institutional Review Board
Santa Clara Valley Health & Hospital System

RE: INN 4 Story Telling

On behalf of the Health Services IRB, I have reviewed the request for extension of IRB approval. The study has not been revised since the last approval dated 1/14/2014 (IRB Number 14-13). The study meets the conditions for renewal.

**Your IRB number is 15-04.**

This IRB approval is valid until April 23 2016. If this study continues beyond one year, please submit a request for an extension prior to the expiration date, indicating changes, if any, in the approved protocol.

Any change in the research project that significantly alters study procedures or risks must be submitted for review to the IRB prior to implementation of changes in the study protocol. Complications or adverse events must be reported to the IRB expeditiously.

Please also provide the IRB with reports, findings, articles and other relevant materials at the conclusion of the study.

SJSU SAN JOSÉ STATE UNIVERSITY
Office of Research
Division of
Academic Affairs
San José State University
One Washington Square
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TEL: 408-924-2272
sjsu.edu/research

To: Dr. Sadhna Diwan
School of Social Work
San Jose State University
One Washington Square
San Jose, CA 95192-0100

From: Pamela Stacks, Ph.D.
Associate Vice President
Office of Research

Pamela C Stacks

Date: May 22, 2015

The Human Subjects-Institutional Review Board has registered your study entitled:

"Evaluation of Santa Clara County's Initial Innovation Project (INN)-04: Older Adults' Story Telling (Reminiscence) Project"

This registration, which provides exempt status under Exemption Category 5 of SJSU Policy S08-7, is contingent upon the subjects participating in your research project being appropriately protected from risk. This includes the protection of the confidentiality of the subjects' identity when they participate in your research project, and with regard to all data that may be collected from the subjects. The approval includes continued monitoring of your research by the Board to assure that the subjects are being adequately and properly protected from such risks. If at any time a subject becomes injured or complains of injury, you must notify Dr. Pamela Stacks, Ph.D. immediately. Injury includes but is not limited to bodily harm, psychological trauma, and release of potentially damaging personal information. This approval for the human subject's portion of your project is in effect for one year, and data collection beyond May 22, 2016 requires an extension request.

Please also be advised that all subjects need to be fully informed and aware that their participation in your research project is voluntary. Further, a subject's participation or refusal to participate, will not affect any services that the subject is receiving or will receive at the institution in which the research is being conducted. If you have any questions, please contact me at (408) 924-2479.

Protocol #: F15056

# Appendix C: English versions of all data collection instruments.

## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

**NAME:** _____ **DATE:** _____

| Over the *last 2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)* | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way | 0 | 1 | 2 | 3 |
| **add columns:** | | + | + | |
| *(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)* | **TOTAL:** | | | |

| 10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people? | |
|---|---|
| | **Not difficult at all** _____ |
| | **Somewhat difficult** _____ |
| | **Very difficult** _____ |
| | **Extremely difficult** _____ |

## Geriatric Depression Scale (short form -15 items)

Choose the best answer for how you have felt over the past week:

1. Are you basically satisfied with your life? YES / **NO**
2. Have you dropped many of your activities and interests? **YES** / NO
3. Do you feel that your life is empty? **YES** / NO
4. Do you often get bored? **YES** / NO
5. Are you in good spirits most of the time? YES / **NO**
6. Are you afraid that something bad is going to happen to you? **YES** / NO
7. Do you feel happy most of the time? YES / **NO**
8. Do you often feel helpless? **YES** / NO
9. Do you prefer to stay at home, rather than going out and doing new things? **YES** / NO
10. Do you feel you have more problems with memory than most? **YES** / NO
11. Do you think it is wonderful to be alive now? YES / **NO**
12. Do you feel pretty worthless the way you are now? **YES** / NO
13. Do you feel full of energy? YES / **NO**
14. Do you feel that your situation is hopeless? **YES** / NO
15. Do you think that most people are better off than you are? **YES** / NO

Sheikh, J.I., & Yesavage, J.A. (1986). Geriatric Depression Scale (GDS): Recent evidence and development of a shorter version. *Clinical Gerontology: A Guide to Assessment and Intervention.* 165-173, NY: The Haworth Press.

## Three-Item Loneliness Scale

*Lead-in and questions are read to respondent*: The next questions are about how you feel about different aspects of your life. For each one, tell me how often you feel that way: Hardly ever, some of the time, or often?

| ***Question*** | ***Hardly Ever*** | ***Some of the Time*** | ***Often*** |
|---|---|---|---|
| First, how often do you feel that you lack companionship: | 1 | 2 | 3 |
| How often do you feel left out: | 1 | 2 | 3 |
| How often do you feel isolated from others? | 1 | 2 | 3 |

NOTE: the score is the sum of all items.

Hughes, M.E., Waite, L.J., Hawkley, L.C., Cacioppo, J.T. (2004). A Short Scale for Measuring Loneliness in Large Surveys: Results from Two Population-Based Studies. *Research on Aging*, 26(6), 655-672. DOI: 10.1177/0164027504268574

## Satisfaction with Life Scale

Below are five statements with which you may agree or disagree. Using the 1 – 7 scale below, indicate your agreement with each item by marking the response in the appropriate column. Please be honest in your responses.

| | **1. Strongly disagree** | **2. Disagree** | **3. Slightly disagree** | **4. Neither agree nor disagree** | **5. slightly agree** | **6. Agree** | **7. Strongly agree** |
|---|---|---|---|---|---|---|---|
| In most ways my life is close to my ideal. | | | | | | | |
| The conditions of my life are excellent. | | | | | | | |
| I am satisfied with my life. | | | | | | | |
| So far I have gotten the important things that I want in life. | | | | | | | |
| If I could live my life over, I would change almost nothing. | | | | | | | |

Pavot, W. & Diener, E. (1993). Review of the Satisfaction with Life Scale. P*sychological Assessment*, 5(2), 164-172.

## Short Portable Mental Status Questionnaire (SPMSQ)

**Instructions:** Ask questions 1 to 10 on this list and record all answers. (Ask question 4a only if the subject does not have a telephone.) All responses must be given without reference to calendar, newspaper, birth certificate, or other aid to memory. Record the total number of errors based on the answers to the 10 questions.

| **+** | **-** | **Questions** |
|---|---|---|
| | | 1. What is the date today? |
| | | 2. What day of the week is it? |
| | | 3. What is the name of this place? |
| | | 4. What is your telephone number? |
| | | 4a. What is your street address? |
| | | 5. How old are you? |
| | | 6. When were you born? |
| | | 7. Who is the president of the United States now? |
| | | 8. Who was president just before him? |
| | | 9. What was your mother's maiden name? |
| | | 10. Subtract 3 from 20 and keep subtracting 3 from each new number, all the way down. |

Pfeiffer, E. (1975). A short portable mental status questionnaire for the assessment of organic brain deficit in elderly patients. *Journal of the American Geriatrics Society*, 23: 433-41.

## Client Satisfaction with Treatment Survey

Please check the box that best describes your response to each statement below.

| | Strongly Agree | Agree | Disagree | Strongly Disagree |
|---|---|---|---|---|
| 1. It is easy for me to schedule an appointment. | | | | |
| 2. It is easy for me to cancel/reschedule my appointment. | | | | |
| 3. I received services from someone who speaks my preferred language. | | | | |
| 4. The staff was polite and treated me with respect | | | | |
| 5. The staff respected my cultural and ethnic background. | | | | |
| 6. Overall, I am satisfied with the services I received. | | | | |

The services which you received at (Asian Americans for Community Involvement OR Gardner) resulted in improvements in these areas (check all that apply)?

| | |
|---|---|
| | Gained Knowledge During Participation |
| | Productive Daily Activity |
| | Family/Friend Relationship |
| | Health Condition |
| | Finance |
| | Mood Symptoms |

Source: Asian Americans for Community Involvement (AACI).

**Final Project Outcome Survey Instrument**

I. *We would like your thoughts on your overall experience with the "Miradas al Pasado/ Healing Legacies" - Storytelling Project. Just to remind you, this is when you worked on telling your story with the counselor from Gardner/AACI, (insert peer specialist name)_____.*

For each statement below, please tell us if you agree, disagree, or are neutral/don't have any opinion.

| Cultural Competence | Agree | Disagree | Neutral |
|---|---|---|---|
| **1. My worker understood my cultural traditions** | **2** | **1** | **0** |
| **2. My worker communicated well with me** | **2** | **1** | **0** |
| **3. Having a worker who shared my cultural background helped with the process of telling my life story** | **2** | **1** | **0** |
| **4. I would be just as comfortable telling my story to a worker from another cultural background** | **2** | **1** | **0** |

**5. Do you have any other brief comments about working with your counselor?**

_____

_____

_____

## Overall Assessment of the Project

**6. How did participating in "***"Miradas al Pasado/ Healing Legacies"* **influence your feelings of depression?**

_____

_____

_____

**7. How did participating in the** *"Miradas al Pasado/ Healing Legacies"* **influence your relationship with your family?**

_____

_____

_____

## Community Connectedness

**8. Did you attend any of the community events held at _____?**

**Yes ___ No**

**9. Did you present your story or artwork at one of the "community events"?**

___ Yes ___ No. *If YES to 8 or 9,Continue to question 10 otherwise skip to 12.*

**10.** *(Ask if **YES** to question 9, otherwise go to 11)* **How did presenting your story or artwork at the Community event influence your relationship with your community?**

_____

_____

**11.** *(Ask if **NO** to question 9)* **How did attending the community event make you feel? __**

_____

_____

**12. Would you recommend the** *"Miradas al Pasado/ Healing Legacies"* **to others who might be feeling depressed?**

**___ YES ____ NO**

*For either response, ask:*

**13. Can you tell me the reason you would or would not recommend** *"Miradas al Pasado/ Healing Legacies"***?**

_____

_____

**14. Is there anything else you would like to share about** *"Miradas al Pasado/Healing Legacies"***?**

_____

_____

_____

*THANK YOU SO MUCH FOR DOING THIS INTERVIEW AND PARTICIPATING IN THE STORY TELLING PROJECT. YOUR COMMENTS WILL BE EXTREMELY USEFUL IN HELPING US IN THE FUTURE.*

## Appendix D. Format of the community events

Both provider agencies hosted community exhibition events to showcase the products developed by the clients with assistance from their peer specialists. Below are descriptions of the events as provided by each agency.

### AACI

Healing Legacies held 6 community exhibition events whose purpose was to honor seniors' life stories (their successes/challenges) by sharing or displaying their life stories with the community and to impart wisdom to the next generation. The life stories included pictures and objects that have significant impact on the seniors' lives. The format of each event was as follows:

- The AACI management team gave a welcome message and provided information about the program.
- Each senior received an honoring certificate for completing the program and shared his or her thoughts and experiences of being a participant in the program.
- The event was opened to the public after the ceremony. People who attended the event included community members, seniors, family members, and service providers.

AACI staff noted that during the events seniors were happy to share their stories with the community. They have a chance to be recognized/honored within the community. The event has connected them with other seniors in the community. They gathered and talked about life. They shared and laughed and made friends. The products created by the seniors to depict their life stories are showcased in the pictures below.


**Gardner Family Care**

Gardner held 6 community events. The format for 5 of the events was similar and included the following:

- A welcome address and introduction to the program by Gardner staff.
- Art review and recognitions. Gardner staff introduced the participants' work by providing a small synopsis of their work including the idea behind the creation of their visual piece and how it tied in to their stories. This was done in the language that the client spoke, in Spanish or in English.
- Participants who had completed the program were given a certificate of completion.
- Viewing of the Art Pieces: Time was allotted for people to look at each of the pieces and read the small description provided. This time was also to mingle, enjoy the food and the company of the participants.
- Attendees included clients, their friends and family members, and community members.

Gardner staff provided food and drinks and played traditional music. People appeared to have a very good time and stayed longer than anticipated talking to each other, laughing and sharing more stories. Participants spoke very highly of their peer specialists/mentors and of the Storytelling program stating how happy they were to have participated. The art pieces were all arranged on a table for viewing. They ranged from poster boards, to albums, to papier-mâché items. Each item was unique and represented the client's journey and talents, making it meaningful to them.

An alternative format for one community event in July 2014 was used when Gardner hosted its theater production in conjunction with Teatro Vision, in the format of monologues titled: *Maestros de la Vida.* This was a production that incorporated the stories of 6 different clients that were interpreted and performed by 3 actors in a wonderfully choreographed sketch. The bilingual (English and Spanish) production was 50 minutes long and held at a community venue, MACLA, so that the greater Latino community could come, connect and discus the stories that

were presented. After the closing curtain the actors along with the clients that they represented came up and there was a Q & A. Spontaneously clients and community members started sharing stories and connecting. Food and refreshments were provided.

Pictures of the visual pieces produced by clients are below.