PEARLS FREQUENTLY ASKED QUESTIONS

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Overview

What is PEARLS?
PEARLS stands for the “Program to Encourage Active, Rewarding Lives.” PEARLS is a brief, community-based depression-care management program. The program is participant-driven, empowering people through behavioral techniques to actively manage depression. PEARLS has been shown to significantly improve participants’ depressive symptoms and quality of life.

How is PEARLS different from other depression programs?
PEARLS teaches people skills to actively manage overwhelming problems that contribute to their depression, focusing on the here and now. The participant drives the program – selecting what problems they would like to address, defining reasonable goals, identifying possible solutions and weighing the pros and cons of each solution, and coming up with a feasible action plan. PEARLS was designed to be delivered at home, or in another accessible place for the participant. Some people do PEARLS and then engage in other traditional therapies, or do PEARLS in addition to other programs.

Who are the target populations for PEARLS?
The two PEARLS randomized controlled trials included frail, homebound elders with multiple chronic conditions and all-age adults with epilepsy, many of whom were low-income, and 25-40% identified as a racial/ethnic minority. In a later study of underserved elder populations, and through our work providing technical assistance to PEARLS providers, we learned that PEARLS is successful with other populations, such as veterans and vet spouses/widows, immigrants and refugees, elders with limited mobility, and elders in rural settings.
What we have learned about working with some of these elder populations through research and technical assistance activities:
• **Low-literacy**: coach reads worksheets aloud and may have a caregiver help them fill out worksheets, as long as they are not doing it for them.
• **Mild cognitive impairment** may not be grounds for exclusion. If participant is still able to answer PHQ-9 and come up with goals, engage caregivers to assist with activities but makes sure they are not doing the activity for them.
• **Vet and vet spouses**: Aging and Disability Services has been implementing PEARLS and has shown much success with this population. Recruitment and mental health stigma may be a barrier, but we encourage building a strong rapport with vets.
• **Racial/ethnic minorities**: PEARLS has been implemented through agencies that focus on minority populations and has been successful. A person from the same or similar cultural background as a PEARLS coach is helpful, or at least a community representative that can build a bridge to the coach and the participant.
• **Rural populations** tend to have less transportation options and can be more isolated.
• **Substance abuse populations** can successfully make it through PEARLS, especially if the participant is also seeking treatment and has the use under control. Participants that are able to remain sober during sessions and able to complete goals can be successful. PEARLS can be a good outlet to refer participant to seek help.
• **Mental illness:** PEARLS has been beneficial to those with bipolar or other mental illnesses if they are stable and on medication so that they are able to focus during the session and complete goals.

• **LGBTQ populations** have benefited from PEARLS, especially those who may be isolated. Loss of a partner, no adult children, and increased stigma around LGBTQ are potential issues that they face.

**Where has PEARLS been implemented?**
PEARLS was designed to be delivered outside of traditional mental health settings, such as at area agencies on aging, senior centers, community centers, other community-based organizations, and through epilepsy foundations. PEARLS has also been implemented at community mental health agencies. To date, PEARLS has been implemented in over 50 sites across 18 states. You can find a list and map of current program providers at the Evidence-Based Leadership Council’s program map: [http://www.eblcprograms.org/evidence-based/map-of-programs/](http://www.eblcprograms.org/evidence-based/map-of-programs/)

**How is fidelity to the program maintained?**
We have developed a brief self-report fidelity instrument (20 items) that counselors or supervisors can complete; follow the following link for a 2015 research article for more information about the development and testing of the tool, as well as a link to the PEARLS Fidelity Instrument: [http://journal.frontiersin.org/article/10.3389/fpubh.2014.00200/abstract](http://journal.frontiersin.org/article/10.3389/fpubh.2014.00200/abstract)

The PEARLS Toolkit/implementation manual includes a counselor self-assessment as well as a checklist to help counselors remember key components of sessions. Please contact Lesley Steinman at [lesles@uw.edu](mailto:lesles@uw.edu) or 206-654-9837 with any questions about fidelity and balancing fidelity with program adaptations.

**How has PEARLS been recognized by national evidence-based registries?**
PEARLS has been evaluated and included in several national clearinghouses for evidence-based programs:

  o Administration for Community Living’s (ACL) Aging and Disability Evidence-Based Programs and Practices (ADEPP): [http://www.acl.gov/Programs/CDAP/OPE/ADEPP.aspx](http://www.acl.gov/Programs/CDAP/OPE/ADEPP.aspx)
  o The Centers for Disease Control and Prevention have included the PEARLS Program in its publication *Addressing Depression in Older Adults: Selected Evidenced-Based Programs*

In addition, PEARLS received the 2011 Archstone Award for Excellence in Program Innovation: [http://www.archstone.org/usr_doc/Archstone2011Program.pdf](http://www.archstone.org/usr_doc/Archstone2011Program.pdf)
What are some benefits and challenges of seeing older adults in the home (the PEARLS model)?

- In a place where participants are comfortable
- It allows you to see the person in their home environment and get a more holistic picture (e.g. photos of their grandchildren, bare cupboards, fall risks, possible hoarding). Also understand better what existing supports they have available.
- They don’t have to go anywhere (minimized access challenges)
- They feel more in control
- No stigma of going to therapists’ office
- Though homebound, will be able to start connect to the outside world via their PEARLS counselor.
- Challenges include travel time required by counselor limiting number of clients that can be seen daily; some clients are reluctant to have counselor enter home(e.g. clients with hoarding issues or family members who feel threatened by client working on issues with counselor); some home settings are difficult or unsafe (e.g. homes with pest infestations or extreme uncleanliness, cigarette smoke/odor)

Do you have to do all of the legs of the PEARLS stool during each session?
No – while we encourage and teach PST and behavioral activation (social, physical and pleasant events scheduling) at each PEARLS session, it is OK if only PST or BA is worked on during each session given other circumstances (e.g. some clients are resistant to doing PST because this type of approach to problem-solving is not something that they are familiar with or does not resonate with their worldview; some clients are feeling ill so may prefer to just work on PST and not plan a physical activity for that week).

The clinical supervision (the floor of the PEARLS stool) is required as it provides regular support for the PEARLS counselor, timely responses to questions about eligibility, what to do if a participant is ill or needs to pause the program, and how to work with participants who are not improving their PHQ-9 scores after several sessions.

Research

Where can I find out more about PEARLS research?
PEARLS has been published in several peer-reviewed manuscripts in scientific journals which can be found on the research findings section of our website.

How many studies make up the PEARLS evidence-base?
There were two Randomized Controlled Trials that demonstrated PEARLS effectiveness – one with older adults with minor depression or persistent depressive disorder, and one with all-age adults with epilepsy and most with major depression.
There have been several studies conducted to date to better understand how PEARLS is being implemented. These studies include a study to examine implementation barriers, which resulted in a pilot study with medically trained interpreters with Russian- and Somali-speaking older adults and an examination of facilitators and barriers to reaching underserved communities, and a study to develop and assess a self-report fidelity instrument.

Who was included in the research studies?
Subtext: how do I know that this program will work for my population...Latinos, rural communities, LGBT, people who are very frail and sick, etc.?

The two PEARLS randomized controlled trials included frail, homebound elders with 4 – 5 multiple chronic conditions and all-age adults with co-occurring epilepsy. For both studies, the majority of participants were low income. 25% in the epilepsy study and 42% in the study with older adults identified as a racial/ethnic minority. In a later study of underserved elder populations and through our work providing technical assistance to PEARLS providers, we learned that PEARLS has been successful with other populations, such as veterans and vet spouses/widows, immigrants and refugees, elders with limited mobility, and elders in rural settings.

To be clear, PEARLS did not work for everyone in the original RCTs and may not work for all of your clients. For example, in the first PEARLS RCT with older adults, only half of PEARLS participants experienced a significant response (50% of more reduction between their pre- and post PHQ-9).

Training
Where can I find PEARLS materials?
All of the forms and other materials that you need to do PEARLS are available for free download on the PEARLS program website: http://www.pearlsprogram.org/Training/PEARLS-Toolkit.aspx. Materials are available in Word so that you can customize them for your agency (e.g. put your agency’s logo and photo of your PEARLS counselor on the PEARLS program flyer).

Who can be a PEARLS counselor?
The PEARLS counselor is the heart of PEARLS, as this individual works directly with participants to implement the program. In the original research studies, PEARLS counselors were Master’s level social workers and nurses. In practice, PEARLS has been successfully delivered by case managers, marriage and family therapists and other counselors, psychologists, social workers, and nurses with bachelor’s or master’s level training. Many PEARLS counselors will also be case managers; however, it is recommended that a counselor does not deliver PEARLS to the same participant(s) he or she case manages as PEARLS is more structured than traditional case management and requires that the participant “drives.” PEARLS counselors are sometimes referred to as “coaches” to reduce stigma associated with counseling or therapy.
Implementation

What is the typical caseload?
The average PEARLS caseload depends on how much PEARLS counselor full time equivalent (FTE) you have and whether your counselors are wearing other hats such as providing case management services or other therapies. A ballpark estimate is 15-20 participants for a half-time PEARLS counselor and 30-40 participants for a full-time counselor. Note that some participants are being seen during weekly sessions while others are in monthly sessions and/or follow-up calls, which allows them to have a bigger caseload. Other factors to consider include how geographically dispersed your population is / how much time will need to be spent getting to and from appointments.

Caseload sizes also vary between programs. Some programs span across a large geographic area, which increases the amount of time for transportation to/from home. Not all the counselors who are in those areas are able carry a full caseload. Some programs have full time counselors that carry a 25-50 person caseload. However, another program may have a few part-time counselors that work a total of 30 hours per week and each counselor has an average of 10-12 active cases.

A tip for maintaining your caseload is to build ample time for outreach, recruitment, screening, data entry, and supervision.

Funding source may dictate caseload size. Some grants or levy-funded program aims to recruit a certain amount of participants per month, quarter, or year.

How do I measure outcomes?
The PEARLS Toolkit includes several outcome measures. More detail can be found in the PEARLS Toolkit:

- **9-item Patient Healthcare Questionnaire (PHQ-9):** The PHQ-9 is a brief validated measure of depression severity. It includes nine questions that measure symptoms of clinical depression (e.g., low energy, lack of appetite, depressed mood). It is administered at each in-person PEARLS session and provides a way to monitor each participant’s progress throughout the program, as well as educate the participant about their depression symptoms. Outcomes include:
  - remission (no longer meets criteria for major or minor depression)
  - response (≥ 50% drop between baseline and final PHQ-9 score)
  - significant change (≥ 5 point drop between baseline and final total PHQ-9 score)

  These outcomes can be aggregated for your entire PEARLS population on a regular basis (e.g., mean change in PHQ-9 score for all completers in quarterly reports; % of participants that met remission in an annual report to funder).

- **Baseline/Final PEARLS Questionnaire:** This questionnaire includes measures for self-rated health, physical activity, social activity, and pleasant activities.
• **Participant satisfaction:** A participant satisfaction questionnaire is provided in the PEARLS Toolkit. In addition, we encourage agencies to gather testimonials from participants to use for program evaluation and marketing.

**How do I measure how well my PEARLS program is being implemented?**
In addition to outcomes, it is important to measure process measures to assess how well the program is being implemented. Process measures include looking at the percentages of people that move through the program (e.g. referrals, enrollees, completers and dropouts). Other process measures include whether key program components are in place, such as regular clinical supervision meetings. The RE-AIM framework (Glasgow et al., 2003) is one model for evaluating program implementation, examining program reach, effectiveness, adoption, implementation, and maintenance). Learn more in Appendix D: Implementation Plan of the PEARLS Toolkit.

**What are my data tracking options?**
1. PEARLS online data entry system (ODES) is now available. Features include tracking referrals and participants, process and outcome reports, and download forms in Word and PDF format. PEARLS teamed up with Sound Generations (formerly Senior Services) of King County and ODES is built on Salesforce’s secure cloud platform that is widely used in the healthcare and financial industries and government agencies. The cost is $200 per year/per single user License, which can be purchased through Sound Generations by contacting: Meghan Thompson
   Sound Generations
   2208 Second Ave, Ste. 100
   Seattle, WA 98121
   Email: meghant@soundgenerations.org
   Phone: 206.268.6701

2. PEARLS survey data excel sheet included in training manual can track baseline and final information per individual. Participation Report excel tracks how many people based on participation such as referred, active cases, and completed.

3. Some PEARLS sites have developed their own excel sheet or use their existing data system such as ReferNET or PeerPlace database.

**Tips for Administering the PHQ-9:**
We recommend having the counselor read the PHQ-9 as stated on the form to maintain fidelity. It may be easiest to phrase the question as a Yes/No and then have them point at a handout that displays the scale (not at all, several days, more than half the days, nearly every day). We recommend that counselors administer the test it at the beginning of the session. However, participants may have a burning desire to talk about particular things so it is okay to catch up a bit and then administer the PHQ-9.
PHQ-9 scores may fluctuate both ways—e.g., some participants may start with a very high score and drop significantly after the 1st sessions, while others may increase after the first session. In some cases the fluctuation in scores may be impacted by how comfortable the participant is answering the questions, whether they believe that their score is tied to receipt of services, increased awareness about depression, and how immediately they perceive a benefit from someone visiting their home.

The phrase “PHQ-9” may not mean anything to the participant. Some counselors refer to the PHQ-9 as the “9 questions” that they ask at the beginning of each PEARLS session. As participants get more comfortable doing the PHQ-9 and talking about depression, the PHQ-9 becomes a tool for teaching participants about their symptoms of depression and how to monitor them.

More tips about administering the PHQ-9 can be found in the PEARLS Toolkit in the section on PEARLS Sessions.

The Mental Health Training Network also offers a free, self-paced online training on the PHQ-2 and PHQ-9 that is geared towards working with older adults at: https://mentalhealthtrainingnetwork.org/PHQ

What if my participant’s PHQ-9 results are stagnant?
Consult with your supervisor about how they are doing with their Problem-Solving Treatment and Behavioral Activation. Work together to examine other things that could be impacting the participant’s depression.

It may be that the participant is working on problems and activities that are not central issues to their depression. Try to explore deeper problems that they may want to work on.

At times the total PHQ-9 score stays the same but there are some improvements in some of the questions and some decreases in other questions. Other times, their score stays the same but they have made positive changes in their lives.

Remember to point out participant’s successes, even if they are small.

How do I handle inappropriate behavior or issues in the environment?
If a participant is being inappropriate towards the counselor, set firm boundaries around type of language or behavior that is not OK. It may be appropriate for other staff to accompany the counselor on initial visits if they are uncomfortable.

Look into participant’s history and assess potential safety and other issues. They may need to be referred to other therapy resources such as mental health or substance abuse.
Some isolated adults may have bedbug or insect issues. Counselors should bring minimal things such as their own chair and spray down their stuff with alcohol. You could also try to meet elsewhere that is close by and private.

Is PEARLS available in other languages?
The original PEARLS research studies were conducted with English-speaking populations. We have conducted a small pilot study with Somali- and Russian-speaking older adults using an English-speaking PEARLS counselor and medically trained interpreters and found similar improvements in depression outcomes as in the original PEARLS studies. In practice, PEARLS has been successfully implemented with Chinese, Vietnamese, Korean, Filipino, Russian, and Latino elders using either bilingual and bicultural PEARLS counselors or trained interpreters. The PHQ-9 has been translated and used in PEARLS programs in Somali, Russian, Spanish and Chinese. Please contact Lesley Steinman at lesles@uw.edu for a copy of these instruments. You can also download the PHQ-9 in over 80 languages at: http://www.phqscreeners.com/overview.aspx. We recommend reviewing these translated versions with native speakers from your community to ensure that the language is appropriate.

Repeating sessions/Pausing sessions
Setbacks can create scheduling issues or disrupt frequency of sessions. When a trauma happens in the middle of PEARLS sessions, work with your clinical supervisor to possibly meet the participant more frequently to get on top of the new problem or setback.

It is OK to pause PEARLS sessions for 1-2 months if participant is away, in hospital, etc. When resuming sessions, you may need to meet more frequently at first to get participant back on track. 8 session total is still the amount of sessions you are aiming for.

After setback, resume weekly sessions initially to reinforce skills even if the participant is further along in the program.

If caseload permits, it is okay to repeat PEARLS program a second time. If the participant is requesting to go through the program a third time, there may be other underlying issues that need to be addressed outside of PEARLS. Some participants enjoy having a visitor. Many communities offer free services for friendly visits.

Can you do other therapies with PEARLS?
With the original PEARLS research, the focus is on two evidence-based treatments - Problem-Solving Treatment and Behavioral Activation. We encourage PEARLS counselors to stay focused on delivering these two treatments during PEARLS session. If you do other treatments during PEARLS sessions, you can never be sure that you are giving someone an adequate dose of any psychotherapy (and the evidence-base requires a certain dose of PST and BA). It is OK to do other psychotherapies a) after their PEARLS sessions have ended or b) while PEARLS is in progress, from another counselor separate from the PEARLS counselor at another time as the PEARLS sessions.
Recruitment & Screening

How are participants recruited?

In most settings, the counselor will be responsible for some or most of the recruiting of participants for PEARLS.

- Measure depression
  - Case managers use different depression scales (such as CES-D, PHQ-2, etc). If a case manager identifies participants that may benefit from PEARLS, they can refer them a PEARLS counselor who could provide more information and further screening.
- Cultivate and foster community relationships. Connect with case managers, social workers, medical providers, law enforcement, and emergency services to build a referral base.
- Create and distribute flyers about PEARLS
- Send introductory letter once a participant is referred for PEARLS

Community-Based Partners

Building relationships with community-based agencies that serve older adults and isolated populations is key to successful recruitment. Begin networking by attending local health and aging events in your community.

- Senior Centers
- Religious Institutions
- Clinics
- Assisted Living Facilities
- Senior Housing
- Programs that deliver meals to homes, such as Meals on Wheels
- Media sources such as newspapers and radio

Reference Base

Connect with these agencies, organizations, and programs to encourage referrals.

- Housing Authorities
- Adult Protective Agencies
- Area Agency on Aging
- Veterans Health Administration
- Rehabilitative Units
- Substance Abuse Programs
- Emergency responders such as Firefighters, 911, Police Depts., EMTs who tend to receive many non-emergent phone calls
- Neurologist, Primary Care Physicians, Geriatric Physicians, Nurses, Social Workers
- Hair Stylists
- Family members
- Transportation assistance

Activities
Putting on events can bring awareness to depression and the PEARLS program.

- **Hold a presentation** for agencies and community partners about depression, aging, isolation, and PEARLS. Provide CEUs and food.
- **Hold a presentation** for potential participants on *wellness education, feeling better, minor depression* where they could enter to win a gift card to a grocery store or Walmart if they complete PHQ-2 and contact information.
- **Hold a training** for first-contact-people on how to screen and administer depression tests such as PHQ-2, PHQ-9.
- May is both Mental Health Month and Older Adults Month, which provides a nice opportunity to **promote** PEARLS in your community.

**Making Contact**

When you to make contact, it is important to be delicate in the way that the program is discussed.

- When receiving a referral, **contact** the participant via phone or in-person as soon as possible. Calls may take 5-20 minutes. Information in this call could include:
  - The program helps teach skills to address issues that may be making them feel unpleasant, with the goal of improving their health and well-being.
  - Who the program is for - seniors in home, many with health issues and family issues, cannot do what they used to do, partner to help do new things.
  - What the program is not - it is not a younger person coming in and telling you what to do.
  - Tell them that the second session they will do the problem-solving worksheet using goals from you to help you figure out what to work on to help you feel better, and what can you do to help impact that.
  - What to expect before the first PEARLS session. Mention that there is a lot of paperwork during the first session so they are not caught off guard but that they will help them complete the paperwork
  - 75% of participants do not know that they are depressed or anxious. Approach the initial call as if they do not know. It’s more important for them to get their foot in the door vs. convincing them that they are depressed.

**Materials**

Distribute materials to agencies, community organizations, and potential participants.

- Make sure your materials are sensitive to wording such as *depression, mental health, or counseling*. Given stigma, use words like *wellness care manager, mood, emotion, feel better, and problem-solving treatment*

- Provide brochures, fliers, PEARLS instruments (PHQ-2 and the Feel Bad/Do Less chart), and PowerPoints.

**Spread the word!**

Publish an article about PEARLS in their community online or print. Contact local radio stations. See full list of press stories on our website [here](#).

**Share success stories**
These stories and quotes are free to share.

- "I would always leave our meetings with a feeling of hope." – PEARLS participator Barbara Myerson
- “I never used to laugh like this” – PEARLS participator Chuck Lazenby
- "As you well know, illness and depression walk hand in hand for persons like me who have no family or real friends to cheer my darkened corner. Life holds little joy.... I have to create order out of chaos and happiness out of almost continual sorrow. It is not easy being alone and struggling to find validation in a youth-worshiping society ... [Carl] left no stone unturned when it came to looking for tools to assist me in solving my predicaments, and he would always leave me with a feeling that my situation was somehow brighter. He truly helped me to discover ways to maintain better control of my life." - PEARLS participator Lacey Gannon, in a letter she wrote to the City of Seattle in appreciation for the program and Carl Kaiser’s counseling services.

- Share digital stories use photos and audio to create an audiovisual that the program uses to bring stories to life during presentations about PEARLS. Digital storytelling is a fairly simple and affordable technology to use.
  
  http://vimeo.com/60012522
  http://vimeo.com/59960748

Tips

- Do not use the words depression, mental health, or counseling. Given stigma, use words like wellness care manager, mood, emotion, feel better, and problem-solving treatment.
- Frame PEARLS in a way that is stigma free such as something to help them bounce back after the loss of a spouse, broken hip, etc.; it is free, they should give it a try!
- It is important to communicate eligibility criteria for PEARLS and have sufficient capacity for processing referrals/enrolling new participants so that you get appropriate referrals and do not discourage future referrals.
- Practice Motivational Interviewing
  
  o Motivational Interviewing (MI) is a goal-directed, participant-centered counseling style for eliciting behavioral change by helping participants to explore and resolve ambivalence. See more info here. Free manual available here.

- Multiple contacts. PEARLS programs have learned to try and try again with this population. It may take mailing information 3 times, making multiple phone calls, and visiting a potential participant in-person.
- Connect with those people and agencies who make contact with isolated seniors the most. Consult with community centers that understand those populations.
- Build time for continual recruitment and nurture relationships around the community. Some PEARLS programs hold monthly meetings with PEARLS counselors and local agencies to talk about recruitment.
- Encourage PEARLS graduates to reach out to their friends who may benefit from program.
Tips on recruiting hard-to-reach populations:

- Connect with community representatives to learn how best to connect with potential participants. For example, religious centers, veteran administration, cultural centers, neighborhood resources, etc.
- It is okay to use forms that have been translated and reviewed by members of the native country. If you already have forms, please share with us so we can share with other sites.
- Take the time to get to know their story and be careful about generalizing
- Spend sufficient time to engage the participant during the initial meeting. Allow for up to a half hour of chatting to get to know the vet and build trust. Some sites encourage the referral source person to be present at the first 3 sessions to help build rapport and trust between PEARLS counselor and participant
- Respond quickly when a potential participant is interested, ideally within a day or two.
- Be aware that some cultures may be apprehensive about paperwork/signing documents if had negative experiences with immigration or other systems.
- Understand that some populations may have low literacy/education.
- Frame PEARLS that it can connect participants to services that will help them be more independent and a friendly visitor comes to the home.
- Re-word the PEARLS to something that suits your agency better such as “Positive Solutions” or “Project UPLIFT.”
- When working with African-American elders, it has been key to make sure materials are appropriate in terms of literacy, culturally, pictures, and spiritual backgrounds

I’d like to develop marketing materials for PEARLS. Do you have any samples available?

Brochures/Flyers:

- Uplift 120312.pdf
- positive solutions program newsletter.pdf
- PEARLS flyer_073012.pdf
- PEARLS.pdf
- PEARLS Spring Brochure.pdf
- PEARLS Mar 2015 Brochure.pub
Eligibility

Who is PEARLS appropriate for?

- PEARLS is designed for older adults and all-age adults with epilepsy with minor depression or persistent depressive disorder. This intervention was designed to be implemented at home as some older adults are socially isolated. Participants need to be able to read, write, as well as able and willing to engage in social, physical, and pleasant activities. These activates can be minor and easy to accomplish.
- Original research excluded those with a cognitive impairment, psychosis, schizophrenia, bipolar disorder, substance abuse or alcoholism. This isn’t to say that PEARLS wouldn’t be effective for these people. PEARLS has been used in addition to receiving other mental health or substance abuse services and on medication.

Bipolar

A good question to ask, “Is the person able to function well enough to attend sessions and do the problem solving exercises? Are they currently taking medication?” If so, PEARLS may work for them.

It is important to assess current functioning. A person may have bipolar but have not had a manic episode in years or perhaps the diagnosis may be incorrect.

Assess how comfortable the PEARLS counselor is with seeing certain participants.

Even if they are appropriate for PEARLS, you may want to encourage that they participate in additional mental health programs.

Mood Fluctuations

It is important to assess how often the person’s mood cycles. If they fluctuate from depression to normal mood to manic within a year, there is a good chance that even before PEARLS is completed their natural course of illness will cycle them out of depression. If this is that case, PEARLS may not be a good program for them.

If their mood fluctuates less frequently, ask them for more information. Most people with manic depression spend most of the time in depression (e.g., ‘I’ve been depressed for a year w/o a recent history of mania’)

Mild Cognitive Impairment

A mild cognitive impairment may not be full grounds for exclusion. If the participant is able to remain present in sessions but completing goals is difficult, engage caregivers to assist with activities as long as they are not doing the activity for them.
Participants may have low-blood sugar or medication issues. Re-administer the following week to determine if it was a short-term. Exclude the participant only if they are too impaired to focus during sessions and complete their goals. Also, look to see if there is a history of impairment, if so, PEARLS may not be appropriate for them.

If the participant is unable to write or verbally communicate, PEARLS may not be appropriate for them.

Administer the MOCA to pick up signs of mild cognitive impairment. 26 or above is “normal” less than a score of 20 may be too impaired for PEARLS. The Mini-Cog is another assessment tool to assess severity of cognitive impairment.

**Suicide Ideation**

Go through your agency’s systematic protocol for assessing suicide risk such as SOQIC lethality tool to assess suicide risk. Also, the PEARLS toolkit provides a sample Protocol for Handling Participant Statement of Self-Harm.

As a counselor it is important to consult with your supervisor and attend trainings on assessing suicide risk and mental health. Having a written down plan is key for counselors to follow and so that everyone is on the same page.

If suicide comes up, try asking less intrusive questions, e.g. having ‘thoughts about not wanting to be around’, ‘feel like you want to disappear’. Try to build rapport with participant, then hone in on the standard suicide-risk questions (e.g., whether they have a plan, a weapon, means to carry out the plan, etc.) a difference between participants that express not wanting to live vs. wanting to die.

FYI: PEARLS is not set up to be available 24-7/for crisis intervention. However, PEARLS can be used as auxiliary treatment if another MH provider is in place, it is OK for PEARLS to be an adjunct to treatment.

**Anxiety**

Anxiety is not grounds for exclusion as depression and anxiety typically co-occur. Although the PEARLS study did not measure anxiety as an independent outcome, the participant may want to address anxiety as one of their “problems” to work on during PST. If the participant begins to solve problems, their anxiety may decrease or become more manageable.

**Alcoholism**

Alcoholic behavior doesn’t always qualify the person to be excluded from the program, but they do need to be able to be present and keep appointments. If the person is intoxicated or doesn’t keep appointments, consider dis-enrolling. You may be able to influence their sobriety by educating the participant about the interaction between alcohol and depression. It is also important to assess your experience and training on chemical dependency.
Tips for evaluating consumption:
- Some older adults tend to minimize use or don’t count beer or wine as alcohol so you need to ask about these specifically.
- There are free effective screening tools for older adults and substance use at SAMHSA’s website.

Major Depressive Disorder (MDD)
If the participant is taking anti-depressants, they may still benefit from PEARLS. In Seattle/King County, the protocol for working with participants with MDD is that the participant will need to be taking antidepressants or is willing to consider starting antidepressants. If they do not show any improvement in their depressive symptoms after 3 PEARLS sessions, they will be referred to other services.

MDD/Supervision
It is important to have a clinical supervisor who can address changes to antidepressants for participants with MDD as this issue will come up more frequently than with participants with minor depression. It is also important for supervisors to educate counselors on MDD if they are not coming from a mental health background.

MDD/Suicide
Sometimes participants with MDD have more suicidal ideation. The agency needs to properly train the counselor on assessing suicide risk and having a suicide protocol in place.

PTSD
Most people with PTSD have depression as part of a spectrum of symptoms. Other PTSD symptoms include nightmares, hyper arousal, and substance abuse. PEARLS may be appropriate for treating depression in people with PTSD as long as their other PTSD symptoms are managed. Keep in mind that there is no existing evidence for PEARLS treating PTSD so programs cannot bill PEARLS as a PTSD program.

Schizophrenia
Some people with schizophrenia have neurocognitive problems that directly affect executive function (the ability to handle complex problems and execute solutions and strategies, carry out multiple steps in a particular order and particular way). Inability to cope and difficulties with executive functioning may exacerbate psychosis, in which the stress from problem solving treatment within PEARLS may exacerbate schizophrenia or make it more difficult to complete.

However, there are two key issues to address which are, “is the schizophrenia an active problem?” and “is the schizophrenia diagnosis accurate?” If schizophrenia is not an active problem and they are able to participate in sessions, PEARLS may benefit their depression.
Clinical Supervision

Who can be a PEARLS clinical supervisor?

The original PEARLS studies used a psychiatrist as the clinical supervisor for PEARLS. In addition to psychiatrists, current PEARLS programs use licensed clinical social workers, geriatricians or other primary care providers, and psychiatric nurse practitioners as clinical supervisors. It can be challenging to obtain psychiatrist’s services due to limited funding and/or availability. Ideas for connecting with psychiatrists include contacting an academic medical center or university who has training as part of their mission. Clinical supervision can be done over the phone or Skype so the clinical supervisor is not required to be local.

Key characteristics of a clinical supervisor include a knowledge of the PEARLS model particularly problem-solving treatment, and knowledge of the types of medications that older adults take both for depression and for other chronic conditions. It is okay to have two people providing clinical supervision if needed to fill this expertise—for example, we know of some programs that use clinical social workers or psychologists for the PEARLS supervision and meet less frequently with a primary care provider.

Clinical supervision is beneficial during challenging cases, stagnant PHQ-9 scores, and behavioral issues.

Frequency

- 90 minute sessions 1x/month for small caseload
- 90 minute sessions 2x/month when case load picks up
- It may be helpful to have more than one clinical supervisor depending on their availability

Candidates

- Geriatrician
- Geriatric Psychiatrist
- Clinical Social Worker MSW/LCSW with a background in aging
- Psychiatric Nurse Practitioner

Good clinical supervisor attributes

- Knowledge of depression and other common medications/medical conditions for older adults
- Knowledge of the PEARLS model (participant driven, problem-solving treatment, and behavioral activation
- Ability to address cultural issues
- Ability to not stray away from PEARLS techniques

Supervision sessions
• When programs first start, supervisors can use the session to review training materials and practice PEARLS techniques with the counselor.
• After caseload picks up, discuss any issues that may have come up, review case presentations, look into comorbidity and medication affects, and review participant worksheets

Reimbursement
• A contracts is helpful in order to establish supervision goals, hours, rates, and makes clear that PEARLS clinical cases are not part of the supervisor’s clinical responsibility
• Look into funding between AAA and county agencies that work with older adults
• Rates may vary locally from $150-200/hour

PEARLS Stories
Where can I find PEARLS participant testimonials?
http://www.pearlspogram.org/Stories/Participants.aspx
• "I would always leave our meetings with a feeling of hope." – PEARLS participator Barbara Myerson
• “I never used to laugh like this” – PEARLS participator Chuck Lazenby
• "As you well know, illness and depression walk hand in hand for persons like me who have no family or real friends to cheer my darkened corner. Life holds little joy…. I have to create order out of chaos and happiness out of almost continual sorrow. It is not easy being alone and struggling to find validation in a youth-worshipping society ... [Carl] left no stone unturned when it came to looking for tools to assist me in solving my predicaments, and he would always leave me with a feeling that my situation was somehow brighter. He truly helped me to discover ways to maintain better control of my life." PEARLS participator Lacey Gannon, in a letter she wrote to the City of Seattle in appreciation for the program and Carl Kaiser’s counseling services.
http://community.seattletimes.nwsource.com/archive/?date=20020128&slug=sad28m
• "It makes you start thinking, maybe there is hope. Maybe there is something going for you." http://community.seattletimes.nwsource.com/archive/?date=20040406&slug=webdepression06
• "I'm back doing the things I like to do,"
Digital Stories

“PEARLS: for Seniors with Minor Depression” by Senior Solutions
PEARLS counselors explain how the program works and their training experience. PEARLS participants talk about their experiences with depression and the successes of the program. 
https://www.youtube.com/watch?v=PQmTtkhyvZY

PEARLS: Program to Encourage Active, Rewarding Lives
Lori talks about the difficulties of being a female veteran and how PEARLS can help. http://vimeo.com/59960748

PEARLS – a Digital Story
Veteran talks about his experience in Vietnam, his loses in life, reaching out for help. 
http://vimeo.com/60012522

Sample News Stories and Brochures/Flyers:
Brochures/Flyers:
Uplift 120312.pdf positive solutions program newsletter_PEARLS.pdf
PEARLS flyer_073012.pdf

Sample News Stories:
PEARLS Helps End Depression for Seattle.pdf
PEARLS Tackling Depression in Community-Based Settings.pdf
Billing & Finance

What are the costs to implement PEARLS and funding options?

Some opportunities for possible funding for the PEARLS Program include:

- The SAMHSA-sponsored Community Mental Health Services Block Grant Program
  This funding is allocated by the state Mental Health Division through a grant application process for programs specifically designated to provide for services not covered by the Medicaid program. The PEARLS Program fits this definition, which means that organizations can apply for this funding by working with the mental health regional support networks of their geographical locations.

- Special funding allocations from within Area Agencies on Aging budgets and Case Study: In one urban Area Agency on Aging (AAA), the PEARLS Program has been sustained with funds allocated directly from the AAA discretionary budget as authorized by its advisory council at a funding rate of $20,000 per year. This helps support services from two half-time PEARLS counselors and their ongoing psychiatric supervision.

- Private, independent small grant funding.

Costs for PEARLS

This varies depending on how much your staff time costs to deliver the intervention (factoring in time for recruitment, transportation and supervision) and how much the clinical supervisor’s time costs. A general estimate is $1350 or a $150 unit rate for 9 sessions (8 in-person sessions + 1 screening and follow up). This is based on the unit rate that the state Medicaid waiver uses in WA as well as what we've learned from several other programs. It is twice what was estimated from the original RCT study ($630). Start-up costs include approximately $500-$1500/person for training.

Time Estimates for delivering PEARLS (beyond the 6-8 client in-home session):

- clinical supervision: 1 - 4 hours per month (per counselor/not per client - each client is usually only covered a few times during supervision)
- program supervision: 1 - 4 hours per month (per counselor - many programs meet with a program manager and other counselors on a regular basis)
- travel: per client. this is where it is tricky to estimate as based on distance btw counselor and client and how frequently they are meeting (e.g. may be 4 hrs in first month of weekly visits then 1 hr per month once less frequent)
• paperwork: 15-30 min per client per session (depends whether entering into a data management system)
• recruitment: this is more per counselor (or program in some cases) then per client. Can be 1-4 hrs per week on presentations, meetings with clinics/CBOs, etc. Depends a lot on whether you already have relationships with referrants.
• screening: the estimate our state uses is 1 hr/potential client (not all clients screen in - you can estimate the screening out rates from your PEARLS programs thus far, and we can discuss on Feb national TA call too)

Potential funding sources:
• Grants
• OAA funding
• Tax Levies
• Direct Bill
• Medicaid Waiver, see example

When providing information for funders and grant applications, include as much evidence as possible. PEARLS is included in SAMHSA’s National Registry for Evidence-based Programs and Practices, which continually reviews and rates the quality of PEARLS research and dissemination. Also see the PEARLS website section on research findings.