It Could Be a Pearl to You: Exploring Recruitment and Retention of the Program to Encourage Active, Rewarding Lives (PEARLS) With Hard-to-Reach Populations

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Purpose of the Study: We partnered with 3 social service organizations to identify hard-to-reach populations, barriers to reach, and strategies for improving recruitment and retention for Program to Encourage Active, Rewarding Lives (PEARLS), a home-based depression-care management program for elders.

Design and Methods: We conducted semistructured interviews with staff and former PEARLS participants. All interviews were transcribed verbatim and thematically analyzed.

Results: Veterans, African Americans, Filipino men, other immigrants and English-language learners, old-older adults, rural communities, and people with limited education were identified as hard to reach. The themes of trust, cultural appropriateness, meet them where they are, and framing and reframing, cut across barriers to participation in PEARLS and approaches for overcoming these barriers.

Implications: Research findings will be used to inform technical assistance activities with PEARLS providers, changes to PEARLS program and training materials, and future PEARLS research activities.

Key Words: Mental health, Implementation, Reach, Recruitment, Retention, Underserved

Late-life depression is often considered a normal part of aging, attributed to other medical conditions or social and financial hardships in an older person’s life (Lebowitz et al., 1997). When depression is recognized, up to one in two older adults do not receive effective treatment (Harman, Edlund, & Fortney, 2004; Young, Klap, Sherbourne, & Wells, 2001). Barriers to treatment include stigma associated with a depression diagnosis and traditional mental health treatment, poor management of antidepressants, and limited access to effective care (Unützer et al., 2002).
Ineffectively treated depression in older adults is associated with increased morbidity and mortality, as well as decreased function and quality of life (Frederick et al., 2007; Penninx et al., 1998).

In 2000–2003, the University of Washington Health Promotion Research Center (HPREC) developed the Program to Encourage Active, Rewarding Lives (PEARLS) with the local area agency on aging and a consortium of senior centers. We aimed to create a program to (a) systematically identify depression among community-dwelling older adults; and (b) work with these elders to effectively manage and decrease their depression through a home-based depression-care management model. PEARLS has demonstrated effectiveness in two randomized controlled trials: one with 138 frail, low-income, homebound older adults with an average of four to five comorbid chronic conditions (Ciechanowski et al., 2004) and one with 80 all-aged adults with epilepsy (Ciechanowski et al., 2010). PEARLS participants in each study demonstrated statistically significant improvement in depressive symptoms compared with participants receiving usual care.

PEARLS empowers participants by teaching behavioral techniques to better manage and cope with their lives. PEARLS is participant-driven: Clients choose problems they would like to address and action plans for working between sessions. A PEARLS counselor guides, teaches, and supports the client. The brief program is six to eight 1-hr sessions tapered from weekly to monthly over a 5-month period. PEARLS is designed for delivery through nontraditional mental health settings, reaching clients through existing aging service networks such as Area Agencies on Aging, senior centers, and community-based agencies that serve specific communities (e.g., recent Asian immigrants). Successful recruitment strategies have included other programs at the agency (e.g., meals on wheels, case management) or at partner agencies (e.g., presentations at senior housing sites). PEARLS recruitment stages typically include screening to identify depression, contact by the referrer to briefly describe PEARLS and invite to participate, and meeting with the PEARLS counselor (by phone or in-person) to assess eligibility, describe program in detail, and obtain consent.

Despite evidence of effectiveness, adoption of PEARLS has been limited. There are currently over 40 PEARLS programs across 14 states, most initiated during the last several years. Overall recruitment rates of frail, homebound elders typically range from 10% to 20% and retention rates at 50%. PEARLS program providers report (anecdotally) that these figures are much lower for hard-to-reach populations. Over the last decade, it has been increasingly noted that successful translation of evidence-based interventions into everyday practice has been slow (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). The public health field has commented it takes an average of 17 years for knowledge generated in randomized controlled trials to be incorporated into routine clinical practice (Green, Otoson, García, & Hiatt, 2009; Institute of Medicine, 2001). Clearly, successful implementation of evidence-based programs in community-based settings is not determined solely by their availability (Segre, McCabe, Stasik, O'Hara, & Arndt, 2012).

Our current research focuses on improving the dissemination and implementation of PEARLS. RE-AIM (Reach, Effectiveness, Adoption, Implementation fidelity, and Maintenance) framework of Glasgow, Lichtenstein, & Marcus (2003) is one model for conducting translational research; in addition to examining whether PEARLS is still effective at treating depression, RE-AIM focuses on other domains essential for determining public health impact. For instance, “reach” refers to evaluating the participation rate of the target population. Moving beyond numbers treated, attention is paid to the representativeness of participants. Reaching all older adults, particularly underserved populations, is a key issue for PEARLS implementation that was recently identified in focus groups with staff from our local area agency on aging (Steinman, Cristofalo, & Snowden, 2012). This issue has also been raised by other PEARLS providers around the country in monthly technical assistance calls.

We recently partnered with several local community-based organizations to improve PEARLS program reach, focusing on the recruitment and retention of populations that were underserved by PEARLS. This paper describes an exploratory study to identify the barriers to participation among hard-to-reach populations and strategies for overcoming these barriers. In this study, “hard-to-reach” refers to older adults that agencies have struggled to recruit into or retain in their PEARLS programs.

Methods
Design
A qualitative design was chosen given the lack of empirical data on how to best reach older adult populations currently underserved by PEARLS. Interpretive methodology is appropriate as this research is interested in the way that people currently describe and think about these hard-to-reach communities (Lincoln & Guba, 1985). We conducted interviews to provide data to analyze for describing populations that are hard-to-reach by local PEARLS programs, barriers to reach, and recommended approaches for best reaching these communities.
Sample and Setting

HPRC partnered with three PEARLS provider agencies in the Seattle-King County area to recruit participants. HPRC partners with communities to conduct prevention research that promotes healthy aging and is incorporated into community practice. These community-based, non-profit agencies included a senior services center for first-generation, low-income, immigrant elders, a social service program for African-American older adults, and an association of senior centers. Stratified purposive sampling (Patton, 2001) was used to identify three participant groups: staff delivering the PEARLS intervention (“PEARLS counselors”), staff tasked with recruiting PEARLS participants (“PEARLS referrers”), and former participants in the PEARLS program (“PEARLS participants”). PEARLS program managers at each partner agency identified potential participants and made an initial introduction via phone or e-mail. Interested participants were contacted by HPRC by phone to describe study purpose and procedures and formally invite them to participate in the study. Study procedures were reviewed by the UW Institutional Review Board.

Data Collection

Primary data sources included single and group semistructured interviews. Semistructured interviews are useful for providing consistent, comparable data while allowing participants to express their points of view in their own terms (Bernard, 1988). We created an interview guide with questions to identify which populations were hard to reach, why these populations were challenging to reach, and possible strategies for improving reach. The guide included probes to expand “reach” to include recruitment and retention. Informants selected their preferred format for the interviews: in-person or over the phone. Each received $20 for participation. Interviews were conducted by two trained research coordinators (L. Steinman, K. Hammerback). All interviews were audio-recorded with subjects’ permission and transcribed.

Analytic Methods

We employed thematic content analysis, a research method used to analyze text data with attention to the content or contextual meaning of the text (Hsieh & Shannon, 2005). In thematic content analysis, the researcher examines language intensely for the purpose of classifying large amounts of text into categories (or themes and subthemes) that represent similar meanings (Weber, 1990; Vaismoradi, Turunen, & Bondas, 2013). This approach focuses on analyzing both the explicit content of a text, as well as that which can be interpreted from the text (Graneheim & Lundman, 2004). Two members of the research team analyzed the data. Transcripts were read several times to become familiar with the data, and then each transcript was coded during data reduction using deductive codes based on our research questions and the interview guide (e.g., barriers for reaching hard-to-reach populations). These initial codes were broken down into more specific inductive codes (e.g., mistrust) during data complication. Each researcher independently collated the codes into potential themes, coming together to review themes and include them in the final analysis if both agreed on the precision of at least several examples of textual evidence. When disagreements about the inclusion of a theme arose, researchers presented their supporting textual passages and reasoning and discussed until they reached consensus to include, discard, or rename the theme. An initial summary of themes was shared with study informants to check that our organizing of the data was credible. Themes were collapsed during the production of this manuscript to present the story of the data as it relates to our research questions. No qualitative analysis software was used.

Enhancing Methodological Rigor

Qualitative studies can be evaluated by the trustworthiness of the findings, which include criteria of credibility, dependability, and transferability (Lincoln & Guba, 1985; Murphy, 2006). In this study, we aimed to enhance “credibility” by purposefully selecting participants with diverse experiences to increase the likelihood of answering our research questions from a variety of angles (Denzin & Lincoln, 1994). We stopped collecting data at 34 informants when we reached theoretical saturation of the data, and preliminary data analysis yielded no new information. In addition, we shared an initial summary of themes with study informants. Although there is some debate about the appropriateness of member checking (Patton, 1987), the intent of using this method was to confirm whether our themes were appropriate and not to force one single reality (Graneheim & Lundman, 2004). “Dependability” asks whether the process of the study is consistent and reasonably stable over time and across researchers and methods (Lincoln & Guba, 1985; Sandelowski, 1993). We included multiple research investigators to foster dialogue and provide a context in which researchers’ often hidden beliefs, and values, perspectives, and assumptions can be revealed and contested (Miles & Huberman, 1994). “Transferability” asks whether the research findings are transferable to other contexts and whether they have any larger import (Malterud, 2001). We have provided detailed information on sampling, data collection, and analysis for the reader to assess whether
our findings are transferable to other settings (Graneheim & Lundman, 2004).

Results

Details about the interviews and informants are provided in Table 1. Our key research questions were as follows:

(a) What populations are hard-to-reach with PEARLS?

(2) What are barriers for reaching these populations? and

(3) What are approaches for improving recruitment and retention? Several themes emerged from our analyses that encompass barriers and strategies for these populations: trust, cultural appropriateness, meet them where they are, and framing and reframing. Details on each theme are described subsequently. Although themes are described individually, they are interconnected.

Hard-to-Reach Populations

Veterans, African-American men and women, Filipino men, other immigrant and English-language learning communities, very old older adults (defined by informants as age 75 and older), rural communities, and people with limited income and/or education are identified as hard-to-reach older adult populations by the PEARLS counselors, former program participants, and staff tasked with referring people to PEARLS. Other hard-to-reach populations include recent retirees, people living in assisted living and retirement communities, the Lesbian, Gay, Bisexual, Transgender (LGBT) community, and caregivers. These categories are not mutually exclusive as many older adults identify with more than one of these communities.

So I’d say the hard to reach people are the people who have nothing. Or have very little. Limited income, education, you name it.

Female PEARLS counselor, delivering PEARLS for 2 years, 1:1 phone IW

Veterans of course. That’s the hardest group to reach.

Female PEARLS referrer, manager at social service agency for 17 years, 1:1 in-person IW

The elderly elderly. All older adults are hard but this group has particular challenges.

Male PEARLS referrer, front-line staff at community-based organization for 11 years, 1:1 in-person IW

Table 1. About the Interviews and Informants

| Interviews were conducted from January through March 2011. |
| There were 34 informants: 24 1:1 interviews and 3 group interviews (10 informants). Informants were members of and/or worked with hard-to-reach communities: |
| 9 referrers: program managers and front-line staff from 11 organizations |
| 11 PEARLS counselors: from three local PEARLS programs |
| 14 former PEARLS clients: participated in PEARLS between 2008 and 2011 |
| PEARLS clients were aged 50 or older. Most referrers and counselors were middle-aged; 29% of clients and 18% of counselors were male, all referrers were female. |
| All of the group interviews and six of the 1:1 interviews were conducted in-person; the remaining 1:1 interviews were completed over the phone. |
| Interviews lasted 30–90 min. |
| We stopped collecting data at 34 informants when we reached theoretical saturation of the data, and preliminary data analysis yielded no new information. |
Partnering with trusted organizations and leaders who serve hard-to-reach communities was identified as a key approach for reaching underserved elders. These organizations might include healthcare and social service agencies; veterans organizations; community and senior centers; fire districts; spiritual and religious organizations; barbershops; sandlots; education facilities; and senior housing units.

Well, if my rabbi, my imam, my pastor told me about this program, it must be OK if I continue. I mean, there’s almost a stamp of approval.

**Former PEARLS client, male, in-person 1:1 IW**

Some organizations may be more receptive to serve as a channel to PEARLS if they have identified depression as an issue with their clients. Referrers should also have other options in place for addressing depression as the PEARLS model may not be acceptable to everyone. Things to consider when working with organizations include credibility with your target population, finding an appropriate time and place for conducting recruitment, and having a private setting for introducing PEARLS.

You have to make sure the agency serves the folks you are trying to serve. So, some veterans organizations are not places where spouses go. And some older adults don’t see themselves as “seniors”, so don’t go to senior centers.

**PEARLS counselor, 3 years, in-person group IW**

In addition, many PEARLS referrers and former program participants described ideal qualities of a PEARLS counselor. Although PEARLS is a client-driven program, it was clear that having a caring, trusted, helpful person is an important ingredient to keeping clients enrolled in the program.

You can tell that they care. And that I noticed in him, he never talked down and was always talking on an equal basis, not like to a child.

**Former PEARLS client, male, in-person 1:1 IW**

It was that extra arm for me to lean on, when I needed someone to lean on. When I couldn’t turn to former friends or former family members, or family members. And it’s good to know that you can go to places like PEARLS and other places for help. To keep me from drinking, or picking up a weapon and harming someone, then being locked away, with no freedom.

**Former PEARLS client, male, phone 1:1 IW**

**Cultural Appropriateness**

Another prevailing theme was cultural appropriateness. In this case “culture” describes both membership in hard-to-reach populations (e.g., by ethnicity, veteran status) and shared values, traditions, norms, customs, history, experiences. Informants shared how PEARLS client-driven, problem-solving approach may not fit with what the client is looking for, and/or it may not resonate with their cultural worldview. Informants were mixed about whether the PEARLS counselor should be a member of the target community, with advantages relating to trust and rapport and challenges related to privacy.

This program is one which is driven by the client themselves. Where they wanna just pretty much talk . . . They just wanna share their life, not work on changing or actually making a plan about how they wanna do things.

**Female PEARLS counselor, delivering PEARLS for three years, in-person group IW**

Some of the veterans I’ve talked to don’t feel PEARLS really measures up. It’s like, I’ve been to war, I fought to save this country and now you want me to sit down and look at putting things into perspective like that, and they just didn’t see the value is doing things like that.

**Former PEARLS client, male, in-person 1:1 IW**

To some recent immigrants, a program like PEARLS may feel like it is prying into their inwards.

**Male PEARLS counselor, delivering PEARLS for 2 years, in-person group IW**

Furthermore, another belief shared by many hard-to-reach populations is stigma about depression. Depression may be equated with more severe mental health issues or feelings of shame, embarrassment, and weakness. Stigma impacted whether a potential PEARLS client would even discuss being depressed, let alone enroll in, or stay in the program. Values and norms around privacy and not discussing feelings create further challenges for reaching older adults. Within this stigma frame, the PEARLS program may be viewed as intrusive or inappropriate.

Reaching those over seventy-five is hard because of the stigma of mental health, because they came from a generation where people with mental health issues were institutionalized, they were put in a basement, they weren’t talked about.

**Female PEARLS referrer, manager of a senior center for 10 years, 1:1 in-person IW**

Depression is not a word that is talked about. Men do not like to have that [their depression] put on the table.

**Male PEARLS counselor, delivering PEARLS for 2 years, in-person and group IW**

Informants from all three groups endorsed sharing stories of former clients to help illustrate what PEARLS is (and isn’t) and communicate that the program is culturally appropriate and relevant. Ideally, former program participants could facilitate recruiting members of their communities; otherwise, stories could be shared through other in-person channels.
Well, it could be a pearl to you. If it was demonstrated and you could talk to someone who participated in it.

Former PEARLS client, male, phone 1:1 IW

You need to talk about what PEARLS is, with some real great stories about people who really can articulate, in a real positive way, what it did for them. You know?

Female PEARLS referrer, manager of social services agency for 21 years, in-person 1:1 IW

I think the best way to reach people is through people.

Former PEARLS client, male, phone 1:1 IW

In addition to sharing stories in-person, using a range of media that reach hard-to-reach populations was encouraged, including community radio and newspapers, agency newsletters, flyers, and brochures. Diverse media may be helpful for reaching children and families of hard-to-reach elders and can also address various levels of access and comfort (e.g., not everyone has a computer, oral materials may be preferred due to cultural norms or low literacy).

And you have to meet them on their level. If they are intelligent, you have to speak to them intelligently, if they aren’t well learned, you have to speak to them on their level.

Former PEARLS client, male, phone 1:1 IW

Advertising in the local little papers we have. They’re small, but they reach the local people who live here. Which is why I think that advertising in the little local papers would reach people that aren’t ordinarily getting the bigger papers or getting out to other places to read about it.

Former PEARLS client, female, in-person 1:1 IW

Meet Them Where They Are

Informants described the importance of meeting PEARLS clients where the client’s are, where and how outreach is done and sessions are held, and considering client’s motivation, readiness to change, beliefs about depression, and what else is going on in their lives. Potential PEARLS participants may be physically, socially, or linguistically isolated. Informants described how physical isolation can result from mobility and functional impairments, or lack of access to transportation. Doubts about existing social service systems may further isolate elders. Isolation can contribute to these older adults being more vulnerable and/or disconnected from needed health and social services.

In my rural catchment area, elders are hard to reach because they might not even hear about our program. So, them finding out about me, me coming out, is the first step I guess. And those people may go to less doctors appointments because of the getting transportation that far out, and then they choose to hermit themselves.

Female PEARLS referrer, case manager at a social service agency, in-person 1:1 IW

Many of our client [Filipino elders] are isolated from services they need because they do not speak English, or there are no interpreters or staff who speak Tagalog. Some rely solely on their adult children [to communicate with English-speakers], who are gone at work all day.

Female PEARLS counselor, delivering PEARLS for 2 years, 1:1 group IW

Hard-to-reach communities may also face myriad challenges in addition to depression, including financial problems, other chronic illnesses, and meeting basic social needs such as housing, income, immigration status, and food security. Dealing with other issues may make depression seem less important to staff tasks and recruiting PEARLS participants, making a PEARLS referral less of a priority. Other comorbid health issues may make it challenging for clients to engage in PEARLS. Because a lot of them have a lot of health issues even though they meet the criteria for PEARLS. I think because of they’re sick, because of that, they can’t really grab hold to what’s possible for them. Because I believe PEARLS would be great for a lot of these folks, but I don’t think they’re able to because they have pain.

Things like pain get in the way.

Female PEARLS referrer, manager of a social service agency for 20 years, in-person 1:1 IW

Informants commented on the significance of adjusting and being flexible with clients once enrolled when considering session content, timing, and location. It is important to balance client’s immediate needs with overall PEARLS program goals in order to keep clients engaged. Giving clients a few minutes to vent at the beginning of each session is essential for building rapport and making them feel heard. A skilled PEARLS counselor can do the PEARLS program components while hearing the client’s current situation by encouraging the client to work on one of these issues in a problem-solving session or to make an action plan for doing something physical, social, or pleasant to help cope with the situation. In addition, timing adjustments include tapering the sessions more gradually, particularly if new issues arise during the monthly sessions in which case extending the follow-up calls or holding periodic “booster sessions” was recommended. Meeting people where they are most comfortable may also involve meeting outside their home.

A lot of our patients are comfortable coming here and so if a PEARLS social worker or nurse would come here to us, then the patients would be more likely to attend
as opposed to me telling them to go to the senior center. And so, you need to hit them in a place where they are comfortable.

Female PEARLS referrer, director of an outpatient specialty clinic, phone 1:1 IW

You already know that depression is a hard one for people to grapple with. And once you get their interest, you gotta stay with them closely, otherwise, they’re out of it. So if something’s come up and you need to let them vent for a few minutes to start the session, so be it. That may become the problem they want to work on that day, or you can brainstorm activities to help them feel better even if they can’t do anything about what’s going on.

Female PEARLS counselor, delivering PEARLS for two years, in-person group IW

Furthermore, it often takes time to recruit members of hard-to-reach communities. Histories of mistrust, cultural norms around relationship building and slower time frames, stigma about depression, the novelty of the PEARLS approach, and unstable lives mean that members of these communities may not initially enroll in PEARLS after just one or two introductions to the program. Informants urge referrers to be persistent and take the time to build the relationship with potential clients. As one former PEARLS participant shared,

Unless that person is ready to talk, you know, you can talk until you are blue and purple in the face, but that person, you just have to keep going after. You know, keep putting it out there, saying this is here for you and we are able to help you get through this.”

Former PEARLS participant, male, phone 1:1 IW

Framing and Reframing

PEARLS can be seen as too rigid in regard to the focus and timings of the sessions. For some referrers and counselors, the PEARLS model can appear inflexible as the problem-solving and behavioral activation steps do not leave a lot of time for attending to other pressing needs in a client’s life. Clients may also get bored or disengage when the PEARLS sessions begin to meet less frequently (sessions taper from weekly to monthly). As one referrer shared,

People get used to you coming, and they look forward to that. And then when the time spreads out . . . all of a sudden they’re busy. You get there, and they’re not there. And then the next month you try to engage them again, they don’t call you back.

Female PEARLS referrer, manager at social service agency for 17 years, in-person 1:1 IW

Participants also talked about how PEARLS can be hard to describe. The PEARLS model is viewed as different from traditional mental health counseling, and can be challenging to try and illustrate to a potential client during limited time available.

And they are reluctant to go in for anything. They say, ‘the PEARLS program, what is that?’ To blindfold yourself and cross I-5 . . . they are reluctant to do this.

Former PEARLS client, male, phone 1:1 IW

During a first meeting or a meeting where you are giving people a lot of different information or a lot of different referrals, or a lot of resources, saying ‘oh, by the way, here’s another one’ can make it hard for a person to understand what PEARLS is ‘cause it might just be more information than a person can take in.

Female PEARLS referrer, case manager at social service agency for 5 years, in-person 1:1 IW

Many referrers and counselors were unsure of what changes could be made to PEARLS since it is an “evidence-based program (EBP).” The language around EBPs stresses fidelity to the original program model, which is often interpreted to mean that no adaptations can be made. In order to reach underserved populations, that understanding needs to be reframed as the nuances and specific needs these communities necessitate that no one cut and dry approach will work. As one participant shared:

We gotta stop counting numbers and make numbers count.

Former PEARLS client, male, phone 1:1 IW

Informants from all three groups also stressed the importance of focusing on PEARLS as a problem-solving and life skills program. Using language such as “getting unstuck” and “blue” or “sad” instead of depression can be used to get potential participants’ attention without scaring them away. If depression is not a cultural norm, it may particularly helpful to frame the discussion around recognizable symptoms (e.g., loss of energy, changes in eating and sleeping patterns) and around problem-solving as many elders can identify issues in their lives. PEARLS can help clients both address the pressing issues in their lives that they have control over and cope with those things that cannot be changed.

PEARLS is about looking at or exploring the possibility of learning to do the same old thing in a different or new way. So indeed, some conditions, including health conditions, life conditions, are not going to change over time. But the person can explore, how can I cope with this differently?, to contend with this condition differently, is kinda the opportunity

Male PEARLS counselor, delivering PEARLS for two years, in-person group IW
Discussion
This study aimed to describe populations that are hard-to-reach with an EBP for late-life depression (PEARLS), barriers for reaching these communities, and possible approaches for overcoming these obstacles. Our findings are similar to recent work that identifies obstacles and solutions for better reaching underserved older adult communities in research and practice. Barriers to research participation include past scientific misconduct, mistrust, and perceived imbalance of risks and benefits; beliefs that the disease is a normal part of aging, stigma about the disease, and isolation; and lack of access (Pietrzak, Johnson, Goldstein, Malley, & Southwick, 2009; Shellman & Mokel, 2010; Stahl & Vasquez, 2004; Williams, Meisel, Williams, & Morris, 2011). This study identified the additional challenges such as barriers to the intervention itself (e.g., hard to describe, too rigid, not acceptable) and other pressing issues in clients’ lives. Recent research on how to improve outreach and recruitment of racial/ethnic minority elders and older veterans recommends education with potential participants and their caregivers, providers, and community leaders; consistent, tailored, and branded media; developing a network of community collaborators; use of altruistic and culturally congruent staff; open, regular communication with providers and outreach organizations; and one-on-one, face-to-face interaction and recruitment (Corbie-Smith, Thomas, Williams, & Moody-Ayers, 1999; Dhanani, et al., 2002; Ejiogu et al., 2011; Flanagan & Hancock, 2010; Mendez-Luck et al., 2011; UyBico, Pavel, & Gross, 2007; Welsh, Ballard, Nash, Raiford, & Harrell, 1994; Williams et al., 2011). Many of these strategies were identified for PEARLS in this study, as well allocating sufficient time for recruitment, reframing how the program is described, and sharing client stories. Specific approaches for retaining clients in PEARLS included being attentive to counselor (interventionist) attributes and meeting the clients where they are.

We specifically undertook this study based on feedback from PEARLS providers that ineffectively reaching underserved populations was an important barrier to implementation. This barrier conflicts with agency goals to serve all older adults by helping them to live independently. Recommended approaches for improving recruitment and retention and addressing underlying challenges will be used to inform future technical assistance, training, and research activities. For example, we recently edited the implementation manual for PEARLS and the PEARLS training for program interventionists and administrators to include a discussion around possible implementation barriers and approaches for overcoming obstacles. We also began an inventory of culturally specific recruitment materials and testimonials to share among PEARLS program providers. We have fostered several partnerships and platforms for making changes for future PEARLS implementation, including monthly technical assistance conference calls with PEARLS providers and biannual in-person meetings with local PEARLS providers, trainers, and researchers.

This study furthers the growing research base on translating EBP. The use of qualitative methodology captured the unique perspectives of people throughout the continuum of EBP implementation: referrers, counselors, and program participants. It is clear that an “if you build it, they will come” philosophy is not sufficient for reaching hard-to-reach communities. Even though PEARLS was developed with community-based agencies that serve these communities, a broad range of partners are needed to really engage isolated elders where they are most comfortable (e.g., places of worship). The emphasis on reaching hard-to-reach populations needs to be on the agencies and staff aiming to recruit and retain these communities. That is, these communities are “hard to reach” because of agencies approaches for reaching them and beliefs that need to be addressed (e.g., mistrust, stigma), not because of significant issues within the group itself (Murphy, 2006).

A recent process evaluation of 12 community-based organizations implementing evidence-based chronic disease prevention intervention programs found that adaptation is a natural element of implementing evidence-based interventions (Carvalho et al., 2013). EBPs can successfully balance fidelity with adaptations for specific populations while maintaining program effectiveness. The Stay Safe, Stay Active fall prevention program was recently translated into community practice and able to achieve positive outcomes while making modifications to implementation (e.g., modifying the frequency and duration of the classes; Shubert, Altpeter, & Busby-Whitehead, 2011). Not all adaptations are created equal as some changes are acceptable, whereas others may undermine program effectiveness, such as changing the theoretical approach (O’Connor, Small, & Cooney, 2007). As PEARLS providers make adaptations to reach underserved populations, the RE-AIM framework can be utilized to document appropriate modifications while monitoring program outcomes (Glasgow et al., 2003).

This study included several limitations. The mix of data collection approaches (in-person, telephone, group, individual) might have affected the data that were collected and/or biased the results; for example, data collected in a group setting may be subject to groupthink. Likewise, the sample characteristics might also have biased the results. For transparency, we have identified what type of interview was conducted in the Results section along with sample characteristics. Participants in this study were a
self-selected sample of PEARLS referrers, counselors, and former program participants who were motivated to talk with researchers about their experience with and ideas for better reaching hard-to-reach populations. These participants may not be directly comparable with other people who recruit for, deliver, or participate in PEARLS. Finally, this study did not examine specific success rates of implementation for hard-to-reach populations, or it did not ask where the most effective recruitment has been done to date with these populations. Follow-up research can test the recommended strategies that were described in this paper to identify which were successful/not successful with each hard-to-reach community and to flesh out the approaches in more detail. McHenry and colleagues (2012) provide a detailed template for developing a specific recruitment plan for underserved elders to address specific barriers and utilize recommended strategies.

In summary, this study took the first step for improving screening and treatment of depression in underserved communities by identifying specific populations, barriers to reach, and approaches for recruiting hard-to-reach communities into PEARLS and keeping them engaged in the program once enrolled. These findings will be used to inform future PEARLS research and technical assistance activities and the larger public health focus on translational research.

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**References**


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