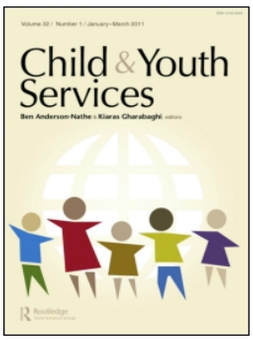

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Successful recruitment strategies for prevention programs targeting children of parents with mental health challenges: An international study

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ABSTRACT

Research substantiates children of parents with mental disorders including substance abuse face increased risk for emotional and behavioral problems. Although evidence suggests that support programs for children enhance resiliency, recruiting children to these groups remains problematic. This study identifies successful recruitment strategies for prevention programs for children of parental mental illness. The participants were recruited from an international network of researchers. E-mail invitations requested that researchers forward a web-based questionnaire to five colleagues with recruitment experience. Forty-five individuals from nine countries practicing in mental health responded. Descriptive statistics and qualitative content analysis techniques were used. Results: Schools, adult, and youth mental health services were recruitment sources. Nine themes were identified: Relationships, diversified information output, logistics, program consistency, family involvement, recruitment through adults, stigma, recruiting locations, social media. Recruitment barriers were: stigma, inadequate knowledge about parental mental illness and limited time. Transportation to programming was an essential component of successful recruitment.

KEYWORDS

children; parental mental illness; parental substance abuse; co-occurring disorders; recruitment; support groups; psycho education; families

Parental mental illness and substance abuse can have significant long-term effects on the development and socioemotional well-being of children (Rutter, 2006; Velleman, 2004). Children affected by parental mental health disorders may have more school problems (Hjern, Berg, Rostila & Vinnerljung, 2013; Straussner, 2011), difficulties with attention or self-regulation, and emotional/behavioral problems (Nicholson, Albert, Gershenson, Williams, & Biebel, 2009; Lam & O'Farell, 2011). They may

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have an increased risk for acquiring a mental health diagnosis (Weitzman, Rosenthal, & Liu, 2011). Many experience family violence and child protective services involvement (Nicholson et al., 2009). They may be more isolated from the community (Cogan, Riddell, & Mayes,2005).

Children of parents with mental disorders may also experience "parentification," or parent–child role reversal (Aldridge, 2006). At the least the children often become young carers on an intermittent basis as the parent moves in and out of crisis (Charles, Stainton, & Marshall, 2012). Children may continue to harbor resentment towards the parent (Foster, 2010). They may experience negative emotions including shame, depressed mood and fear of conflicts, loneliness, as well as feelings of abandonment, anger or envy of peers (Knutsson-Medin, Edlund, & Ramklint, 2007). Lifetime self-harm and suicide rates tend to be higher for children who have a parent with a mental illness (Ferguson, 2011; Weitzman et al., 2011). Velleman (2004) notes that comorbid parent psychopathology of mental illness (especially mood disorders) plus substance abuse is common and the combination of parental disorders often exacerbates children's developmental risks.

When children face multiple risks, it may be necessary to increase the likelihood of resiliency by decreasing adversity and increasing protective factors (Werner, 2000). An increased understanding of mental health challenges as well as social support enhance coping and promotes resiliency in children (Mordoch, 2010; Skerfving, Johansson, & Elgàn, 2014). In the context of exposure to significant adversity, resilience is both the capacity of individuals to navigate their way to the psychological, social, cultural, and physical resources that sustain their well-being, and their capacity to negotiate for these resources to be provided in culturally meaningful ways (Ungar, 2011). When children receive accurate information about their parents' illness, they are less likely to blame themselves for the parental symptoms (Cooklin, 2008). Children who understand the biological and environmental antecedents of parental mental illness are more likely to demonstrate increased self-efficacy (Bourke, 1998), as well as improved adjustment and functioning (Beardslee, Solantaus, Morgan, Gladstone, & Kowalenko, 2012; Wuhib, 2007). In fact, the literature shows understanding mental illness is one of the keys to resiliency (Beardslee, Gladstone, Wright, & Cooper, 2003; Riebschleger, 2004). Family communication about mental health challenges can be an additional protective factor (Greeff, Vansteenweggen, & Ide, 2006).

Prevention

Two decades of family-focused practice and support programs demonstrate that they may help children of a parent with mental health challenges develop resiliency (Beardslee, Versage, Van de Velde, Swatling, & Hoke, 2002; Tolan, Szapocnik & Sambrano, 2007). A recent meta-analysis of thirteen randomized controlled trials of preventative interventions for the children of parents with mental illness found, that the risk of developing the same mental illness as the parent was decreased by 40% by the

intervention. (Siegenthaler, Munder & Egger, 2012). Studies were conducted in the United States (9), Canada (2), United Kingdom (1), and Finland (1).

In Finland studies evaluating the effectiveness of these family-based interventions found that they successfully decreased children's maladaptive behaviors and symptoms of anxiety and hyperactivity; they also improved social behavior in the children of parents with mental illness (Solantaus, Paavonene, Toikka, & Punamaki, 2010). In studies conducted in the United States family based interventions were associated with significant improvements in family social support and a decline in the need for services (Nicholson et al., 2009; Tolan et al., 2007).

Researchers in Australia and United States have taken another approach targeting the children themselves in an effort to promote resilience through mental health literacy, social connectedness, and coping strategies (Fraser & Pakenham, 2009). Psychoeducational programs increased children's mental health knowledge and empathy towards their parent (Grové, Reupert, & Mayberry, 2013; Riebschleger, Tableman, Rudder, Onaga, & Whalen, 2009). Program participation reportedly improved children's functioning (e.g., behavior, attitudes, self-esteem) (Orel, Groves, & Shannon, 2003). Peer support approaches connect target children with their peers in order to increase support, increase mental-health knowledge, promote strategies to deal with stigma, and encourage healthy attitudes, communication, leadership, and empowerment (Foster, McPhee, Fethney, & McCloughen, 2004; Pitman, & Matthey, 2004; Hayman, 2009). Individual experiences are normalized through the process of sharing with similar peers and evaluation of these programs found increased participant self-esteem, problem-focused coping, social support and improved connections with family (Goodyear, Cuff, Mayberry, & Reupert, 2009). Other, less researched approaches include online interventions and bibliotherapy (Reupert et al., 2012).

The struggle to recruit and retain participants

Despite the benefits to the children and successful outcomes of prevention programs, many researchers and practitioners around the world identify that they face recruitment challenges.. Some of the barriers to recruiting to prevention programs in general, include the fear of being judged (Blitz, Kida, Gresham, & Bronstein, 2013); the need to focus on immediate pressures rather than prevention, (Byrnes, Miller, Aalborg, & Keagy, 2012); feelings of distrust, fear of mistreatment, and/or exploitation (Blitz et al., 2013; Heinrichs, Bertram, Kuschel, & Hahlweg, 2005; Yancy, Ortega, & Kumanyika, 2006). Other reported barriers include a lack of time and/or competing interests (Cooney, Small, & O'Connor, 2007), as well as differences in cultural backgrounds between participants and program staff (Yancy et al., 2006). In addition, children are a vulnerable group and the practices put into place to protect them can make recruitment efforts challenging (Duncan, Strycker, & Duncan, 2002). The requirement of parental consent for an adolescent's participation in substance abuse related programs can inhibit participation (McCormick et al., 1999). In addition, the more sessions that are required, the less

likely parents are to attend (Heinrichs et al., 2005). Individuals with lower socioeconomic status are more difficult to recruit than those with higher SES (Yancy et al, 2006). Hooven, Walsh, Willgerodt, and Salazar (2011) recommend using a cross-system approach that includes recruiting across community, organization, family, and youth. In summary, there appears to be a need for more information about successful recruitment strategies that may overcome these program access challenges for high risk youth of parents with mental illness, substance abuse, and co-occurring disorders.

The aims

There is a paucity of research about recruitment to prevention programs specific to families living with parental mental health challenges. To address this gap, the aim of this study was to examine successful recruitment strategies for programs that target children of mentally ill parents and their families. It makes sense to also include substance abuse in this study given the frequent co-occurrence of substance abuse and mood disorders; similar developmental risks for children of parents with mental illness and/or substance abuse; and particularly elevated risks for children who have a parent with co-occurring disorders (National AIA Resource Center, 2012; SAMHSA, 2011). This study was initiated during network meetings of "the Prato research group," a group of international researchers in de area of parental mental illness who held their first research meetings at the Monash University campus in Prato, Italy in December 2013. The aim of this network is to develop international research collaborations/partnerships in the area of parental mental health disorders. The authors are members of this network and researchers from six different countries (Netherlands, USA, Australia, Canada, Norway, and Sweden).

The research question was, "What are successful recruitment strategies for prevention programs for children of a parent with mental illness substance abuse and co-occurring disorders?"

Method

Participants

Study participants were health and human services professionals with experience recruiting children with a parent with a mental illness and/or substance abuse disorder into prevention programs. The participants were drawn from an international network of researchers from the field of parental mental health disorders, known as "the Prato research group."

Subject invitations were sent out by e-mail, with the request to forward an invitation to participate in a survey to five colleagues who had experience with recruitment. The participants were asked to respond to a web-based questionnaire and the

Table 1. In Which Organizations Do the Participants Work ($N = 45$)?

Organization	Response	%
Adult mental health service (and addiction)	13	29
Child and youth mental health service	8	18
Child and adult mental health care	3	7
NGO mental health care/adult for children	4	9
University (clinic)	4	9
Family center	3	7
Child protection	2	4
Family association for mental health	2	4
Public health service	2	4
Social service	2	4
National Alliance on Mental Illness (USA)	1	2.5
National Institute for Health and Welfare	1	2.5

link to the survey was in the e-mail. A total of 45 individuals responded. The participants, 70% of whom were mental health care or child mental health care providers (see Table 1) are representatives from nine countries: Norway (12), Canada (8), Australia (6), Netherlands (6), Finland (3), Sweden (3), the United States (3), Denmark (2), and Italy (2). The participants worked in programs with parents with mental disorders (including some parents with substance abuse and co-occurring disorders). Most worked with groups for children between 6–12 years (71%) and a combination of parent and child groups (51%) (Table 2).

The programs were offered mainly within mental health services, in the community, school and social services with a mean of eight children per group (range 2–16) and offered six times per year (range 6–45).

Table 2. Type of Program and Setting ($N = 45$).

Type	Response	%
For children		
Groups for children 6–12 y	32	71
Groups for adolescents 12–18 y	21	47
Group for young people 19–23 y	4	9
Online chat or course 16–23 y	7	16
Other (Parent groups, school projects)	8	18
For parents		
Parents group	15	33
Combination of child and parent groups	23	51
Whole family group	5	11
Family meeting/parents meeting	4	8
Other (Parenting workshop, online course for parents, teacher group)	5	11
Setting		
School	12	26
Community/neighborhood setting	24	53
Mental health services	26	57
Social services	9	20
University	3	7
Other (NGOs, family home, library, family center)	6	8

Measures

A self-designed questionnaire (developed by the authors) was used. The survey contained 18 structured and open-ended questions which generated text data. Questions centered on (1) demographics (i.e., organizational affiliations, country); (2) programs (i.e., type, target group, delivery site), (3) recruitment strategies (i.e., number of child participants, number of groups, recruitment locations, methods, via which agencies); and (4) successful recruitment strategies and barriers (i.e., effective recruitment techniques, barrier types, recommendations).

The questionnaires were completed anonymously and confidentially, if participants could choose to not leave their name and/or organization details at the beginning of the questionnaire. Participants completed the questionnaire through the electronic survey medium, Qualtrics.

Data analyses

All quantitative data were analyzed with SPSS (Version 21). Descriptive analyses were used to explore the demographic details of the participants.

A qualitative content analysis of qualitative data was developed from participants' written comments to the survey instrument questions. A content analysis approach was used to guide analysis of the data to answer the research question (Creswell, 2007). Qualtrics was used, to aggregate the raw data by question. Data were sorted into themes, subthemes, and aligning text content initially using Microsoft cut and paste followed by NVIVO data entry. An experienced qualitative researcher and two trained social work doctoral students used a constant comparison method within iterative scans of the data (Padgett, 2008). Each read the data independently and developed a draft list of main themes of the data based on frequency and intensity of the content aligning with the research question. Then researchers met to share their ideas about main themes using first cycle and then second cycle data coding procedures (Saldaña, 2013). The group established coding rules and procedures for linking data to specific themes and subthemes. They continued to randomly select text data to independently match data excerpts to data themes and subthemes followed by comparison discussion of coding until inter rater reliability reached 70% or higher. A search for divergent data was conducted to further ensure trustworthiness of findings (Padgett, 2008).

Results

There were three main arenas for recruitment: schools, adult mental health services, and youth mental health services. The most common approach was through professional connections. The use of materials such as flyers or posters in schools or health care systems was also a common strategy. Less than half of the participants in this study stated they use the Internet to recruit participants (see Table 3). The

Table 3. Recruitment Arenas and Strategies ($N = 43–44$).

	Schools	Adult mh	Youth mh
Flyers/posters	71%	85%	72%
Internet	47%	41%	28%
Collaboration staff	100%	91%	92%
Part of routine	–	47%	40%

quantitative results of this survey identified barriers to successful prevention program recruitment (see Table 4). The main barrier seemed to be the stigma related to mental illness. 82% of the participants stated that stigma connected to mental illness caused reluctance to participate in prevention programs. Furthermore, lack of time was considered an important hindering factor for busy families. Participants also suggested that a lack of accurate knowledge about parental mental illness hindered program recruitment.

The analyses of the text data yielded nine main themes. They are: (1) direct relationships, (2) diversified information output, (3) logistics, (4) consistency of program, (5) family involvement, (6) recruitment primarily through adults, (7) stigma, (8) recruiting locations, and (9) social media. Each of the themes provided information about respondent-identified successful recruitment strategies and barriers to recruitment. The online version of this manuscript includes a table that provides additional data and more quotes per theme. Themes one through eight were reported by more than half of the survey participants. Theme nine (social media) was drawn from the reports of about six participants; social media was included herein as some of the professionals considered it a strong recruiting tool for the present, and especially, the future of prevention program implementation: see appendix for supplemental text data.

Theme one: direct relationships

Most participants repeatedly emphasized the need for direct relationships that connected people who could collaborate to generate referrals to the prevention programs. They stressed the need for face-to-face interactions with a broad array of colleagues from the host organization, mental health services, health care services,

Table 4. Barriers to Successful Prevention Program Recruitment ($N = 39$).

Barriers	Response	%
Fear of sharing information	18	46
Concerns about privacy	17	44
Mental illness stigma	32	82
Lack of accurate knowledge about parental mental illness	21	54
Lack of time for busy families	19	49
Difficult to find right person in organizations	10	26
Difficulties to talk with patients about parenting	16	41
Cultural/language aspects	7	18
Need consent of both parents/guardians	7	18
Practical barriers (Getting to locations, costs of programs etc.)	16	41
Not aware of whether adult has child	5	13

schools, child welfare, family services, and the like. One noted successful recruitment takes place, "when professional workers of the Mental Health Center are involved in recruitment." They cited the limitations of e-mail and flyers for developing the "trusted relationships" needed to obtain referrals to prevention groups for the children and families. Similarly, they wrote about the need for a direct relationship with parents: "The only successful strategy was when we knew [parents] and they knew us; and we could give them information directly and all the time about the group."

Theme two: diversified information output

Most of the survey participants said engaging in successful recruitment involves using diverse strategies for providing information about the program to potential referral sources. They highlighted specific strategies for face-to-face contact, use of active outreach, word of mouth, traditional advertising, and the use of digital resources such as websites and e-mail. They suggested that personally delivered information was a critical part of effective recruiting. They recommended "active, rather than passive, information sharing" and "constant outreach" to youth, professionals, and parents. Some of their ideas for outreach included distributing "repeated flyers," sponsoring program "information meetings," "attending staff meetings," having a "pre-program interview with parents," and "participation in fairs." Numerous participants said that "word of mouth—from one trusted person to another" was important. They reported using traditional advertising directed toward "local and targeted media" such as newspapers, flyers, and brochures. They also used digital methods such as organizational and program websites, as well as e-mail communication, to connect with "professional networks." The participants encouraged using a combination of these methods with an ongoing program recruitment plan.

Theme three: logistics

All of the participants described the need to overcome logistical challenges associated with a need for resources, including time, funding, and transportation. They said effective recruiting to prevention programs required "definitely investing the time to meet and speak with groups in school and clinicians who are referral sources. This can be a huge investment of time— generally not accounted for in the budget." The said that they needed to "dedicate time for promotion" consistently and well before beginning the prevention program. One recommended beginning, "half a year before the date of starting the group." They explained that it can take time for families and parents to consent to being involved and/or allowing their children to be involved in the program (e.g., "You need extra time to convince them to come"). The survey participants also said that time can be a challenge for recruitment and retention for everyone, including busy family members.

The participants were concerned about funding challenges associated with program recruitment implementation. One said:

> In our community, we have one program with stable funding, and a consistent provider who works well with individual families. We have not been successful in running groups as the funds are small to sustain a consistent provider, which creates a barrier to building relationships and the running of the program.

Some noted that there is no funding for engaging in the many interactions with others needed to build a referral base for the program. They recommended these activities be done by a consistent provider who "understands and believes in the program" and who "has knowledge of the population served." The participants said they need "MONEY to advertise and pay group therapists." One suggested that planners "Build the cost into the budget to allow for as much recruitment time as session time! The rapport building with professionals and families is the only way I've found to insure follow through and attendance."

Many survey participants cited the need for access to transportation to programs especially for children's prevention programs. One voiced, "Transport is the biggest barrier." They noted having to rely on parents for bringing their children to the groups.

Several participants noted that it is important to have a large enough services area so as be able to offer multiple groups for children of particular age groups. Participants explained, "It is also difficult for small places to make groups for children. We don't have enough children of the same age." Others mentioned that serving children of different ages can challenge recruiting numbers for program delivery.

Theme four: consistency of program

Nearly half of the prevention program professionals expressed a need for individual perseverance in engaging in "sustained relationship building and outreach for recruitment of children and families." This was described as the need for a "regular program" that is sustained over time.

Participants also strongly emphasized that the need for *program* perseverance, namely, to "deliver the program regularly" in order to "develop …a positive reputation for the program being delivered." Consistent "running of the program" seemed to be associated with routine integration of the program into an organizational environment and/or a human services system of care. For example, they described keeping intake workers "well informed of when groups are available so they [will] consider the group as part of the intake planning." Similarly, they said that referring professionals can "integrate conversations with children into routine practice from the onset at intake." They also articulated that increased cooperation among services systems professionals yielded credibility to the program followed by a "better overview of families in need and [the] services available, [Prevention] groups can be one of them [services available]." They suggested referral to the program be considered within routine organizational meetings for "discussion of cases," within "ordinary treatment session[s]" for parents, and "staff meetings just ahead of the referral information going out." One interesting recommendation was to create "permanent cross-institutional recruitment teams [that] meet 2–4 times each year." Recruitment

teams could be part of an enduring program that is "run …consistently at the same time, same day and same place on an ongoing basis."

Theme five: family involvement

Most of the participants recommended family involvement within program development, including recruitment activities. Participants agreed that parents needed to be involved in order to recruit children. They said that children also needed to be involved in making decisions about their participation in the program and they recommended talking about the activities of the program as "Children are more likely to engage in an activity." They stressed that children needed to understand confidentiality policies in advance as "The children are scared that the program leader will share information with their parents." Most of all, they said the program itself needed to be "interesting, engaging, and enticing to children." Those prevention experts promoting "whole family" as an intervention" said that the broader program scope "makes mental health a family issue [and facilitates recruitment]." Family programs needed to consider adding "childcare for families participating in the program with younger children."

Theme six: recruitment primarily through adults

The majority of the participants pointed out repeatedly that recruitment of children and others to prevention programs happens primarily through contacts with adults, namely, parents and professionals. A respondent explained, "We only recruit children by talking to adults." Parents were described as "gatekeepers" who must "buy in" to their child attending a prevention program. They said that some parents facilitate recruitment as "Parents are happy for their child to be involved without them." Others seemed to portray parents less as recruiting gatekeepers and more as barriers when they described some parents who "have difficulties in understanding …the impacts their difficulties can have on children and [children's] need for a group." Participants noted that some parents "worry about what the child will be told," "do not want their children to know about their mental illness," or may be "ambivalent" about children's participation. They noted that "[parents] do not know what the children will do with the information or whether it could affect a custody situation." Recruitment of parents into parent and family groups can be affected when parents "do not always want to come together in a group setting or [to] share information about themselves." They recommended taking the time to work with parents and to address any concerns that the parents express.

The adult services professionals who served as potential referral sources for prevention programs were similarly viewed as both helpful and not helpful to recruitment. Collaboration with the professionals was viewed as a key strategy for referrals to prevention services. However, some professionals were said to "experience difficulties [talking] with parents about parenting." Participants said the professionals may fear "crossing [the client's] privacy." Professionals also may not be "aware if a

parent has a mental illness." Even if they are aware, they may fear that "the client already has enough to worry about." The prevention professionals recommended coaching professionals in how to talk to parents about mental illness and parenting. They also recommended education for professionals about children, parent, and family needs when a parent has a mental illness and/or substance abuse disorder.

Theme seven: stigma

Nearly all survey participants frequently referred to stigma as a barrier to prevention program recruitment. They mentioned parental guilt and shame associated with mental illness and substance abuse. Some explained that they avoided using the words "mental illness" in written program materials:

> I think with some of the barriers we have tried to address [stigma] in the word content of our flyers, using "mental health concern" instead of "mental illness." We are finding more and more that the term mental illness makes people uncomfortable. I think more awareness of mental illness and mental health is needed for the public to break down stigma.

The participants strongly stressed the need for an "information campaign" for "fighting stigma."

Theme eight: recruiting locations

Recruitment locations were identified by many participants as impacting recruitment. Many said that schools make the best recruitment location for children's programs; for example, "Holding programs at schools …has been successful for our support groups and the children are already there." Another seemed to agree, "Screening and selecting [participants] via schools worked better for me than through adult mental health." According to participants, when schools are the location for prevention services, "makes it about the health of the child and a service of the school." They recommended working with "school wellbeing teams," teachers, school counselors, school social workers, and school nurses. They also said infrastructure support was important, such as "Using an established person in the school with support from administration worked best."

While schools were recommended by participants as excellent locations for recruitment, mental health services organizations were identified as the most frequent source of referrals for prevention programs for children who have a parent with a mental illness and their families. The participants recommended recruiting from adult and child mental health services, although adult mental health services were mentioned more frequently. They cited advantages of mental health professionals' access to parents diagnosed with mental health disorders.

Other respondent-identified locations for referrals were community health care organizations. Survey participants said they received prevention group referrals

from general practitioners community health nurses, and children's health services providers. The participants listed numerous other community based services organizations that could be referral sources, such as "family social services," a "family agency," "child welfare," a mental health advocacy agency, or an organization described simply as a "partnering agency." Prevention services experts who responded to the survey said, "Groups that are placed at family agencies [have] less stigma. It is easier [for participants] to attend."

Theme nine: social media

In this study, social media is defined as interactive communications among large numbers of people though the use of Internet websites. Some participants indicated they were using social media such as blogs, Twitter, Facebook, and other web formats. For example, participants said they engaged in "recruitment from a specific COPMI [children of a parent with mental illness] blog and "Facebook for organizations." Some participants reported success when using "Snowballing in the social media (So my post is shared)." One claimed, "Social media and Internet platforms generate the most responses by participants."

Implications and recommendations

The data seems to support Cooney et al.'s (2011) obstacles to participation in the form of competing demands on families, lack of accessibility via public transportation since theme three "Logistics" were identified as a major consideration in recruiting and retaining prevention program participants. Similarly, the theme seven "stigma" content herein coupled with an 82% barrier identified in the survey quantitative data seem to align with the barrier of "fear of fear of being judged" and "mistrust" reported by Blitz et al. (2013) and Cooney et al., (2007). It should be noted that Cooney and colleagues, as well as the survey respondents in this study, noted that engaging children in prevention programs meant working with adults, especially parents.

The findings portray successful recruitment as an enduring and ongoing labor-intensive process of personal contacts with professionals and families who may be part of a broad services area. There is a need to ensure the population area from which potential participants are drawn uses a multi-agency, team approach for accessing enough youth of particular age groups. Survey participants connect with services organization professionals and potential program participants through personal invitations and active outreach. This finding aligns with Hooven et al.'s (2011) recommendations for constant outreach at multiple system levels, including youth, families, organizations, and communities. Consistent with both the work of Hooven et al. (2011) findings of this study show that involvement of youth and families are important for successful recruitment for prevention programs.

When there is an ongoing program with consistent staffing, referrals to the program may come from word of mouth, particularly from those who have participated

in the prevention programs or their family members. The survey respondents in this study seemed to emphasize a new construct of a need for advance and ongoing administrative planning and support for consistent operation of the program. For example, they said that those who take on the task of building and maintaining a prevention program can benefit from allotting sufficient time for regular promotion of the program though connections within their own agency and with professionals and family members associated with other community organizations. Administrators or planners of prevention programs should build in staff time for ongoing outreach activities and consider this to be part of the program cost. Recruitment activities are enriched by using newspapers, flyers, brochures, e-mails, websites, and other digital methods to supplement their face-to-face connections. Transportation is an essential resource that should be built into the program. Whole family programs are likely to need onsite child care resources. It is critical to involve parents, children, and families in recruitment processes. Parents are gatekeepers for obtaining consent for children's participation and they may have questions and/or concerns that need to be addressed. Children and youth need to agree to participate and are likely to be interested in programs with activities. One new finding of this study previously unreported in the prevention program methods literature seems to be that over half of the professionals reported that a lack of knowledge about parental mental illness served as a barrier to recruitment. Mental health professionals require encouragement to learn how to talk to the parents about their parenting and may need education on family needs and program responses to those needs.

If the preventions service programs are primarily targeted to children, schools can be a location for services referrals and/or program delivery. However, the participants in this study said that mental health agencies are the most common source of referrals. This also was confirmed by the quantitative data. Other sources include health care providers, family services agencies, child welfare professionals, and mental health advocacy agencies. Social media is beginning to be used for recruitment with some reported success. It seems likely that social media will play a stronger role in the future of prevention services programs.

Perhaps social media can also be used to provide accurate information about mental health stigma. This seems to be an emerging new concept that did not seem to be showing up yet in the prevention recruitment peer-reviewed literature on programs for children who have a parent with mental health challenges. This study also highlighted the power of mental illness stigma as by far the greatest barrier to successful recruitment of children of a parent with a mental illness and their families to prevention services programs. Anti-stigma programs are greatly needed.

Limitations

The sampling was purposive and not randomly assigned. Survey participants were drawn from the professional networks of an international research group ("the Prato research group"). Further information on specific programs, participants' work roles

and experience levels with prevention program recruitment would provide additional context to develop understanding of the nuances associated with recruitment. However, an exploratory study with a purposive sample is appropriate for a new knowledge area (Creswell, 2007). This provides support for this study, since it is among the first to address strategies for successful recruitment to prevention programs for a unique population, children of a parent with mental health challenges. Future research should use more rigorous designs and larger samples.

In conclusion prevention programs for these children and their families are greatly needed to build child and family resiliency. Program delivery will require knowledge about how to recruit and retain future program participants. Using the practical recommendations in this study shall serve as identified in this study will make a beginning contribution to the successful entry of the children into future prevention programs.

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Appendix. Themes of Successful Recruitment Strategies for Prevention Services.

Theme Subtheme Selected supplemental text data
1. Direct relationships
1A. Collaboration & Connections
"Working collaboratively with ideal organizations and the health service …we have succeeded in recruiting for groups since 2002 …We have a binding agreement." "Simply e-mailing or delivering and posting the information is not enough …Meeting in person and pursuing potential referrals with home visits is by far the most successful strategy I have experienced." "A flyer, poster, or ad on its own will not be successful. You need to meet people …face to face and provide information about the benefits of the program, details about the content, and details about the referral." "Build collaborative partnerships with other workers and services that come in contact with children [for referrals]"
1B. Referrals
"[Referrals through the nurse]. Through relationships. [For example] The nurse or social worker who knows the family and our Child and Family Group." "Referrals from Children's Aid Services" Referrals from GP." "Other partner agencies." "Child and adult MH centers" "Face to face meetings. Speaking with referral sources."
2. Diversified information output
2A. Delivered personally
"Invite families directly by telephone and meeting[s]." "Personal invitations" "Open door …invitation to an informal presentations; both families and professionals are invited.
2B. Active outreach
"Educational workshops for professionals" "Be active in outreach." "Information meetings"
2C. Word of mouth
"Word of mouth from mental health care workers" "Use the persons that have joined the group themselves to inform others."
2D. Traditional advertising
"Media – local and targeted" "Local newspapers" "Brochure" "Flyers"
2E. Digital methods - websites, e-mail
"Regular e-mail reminders" "Email professional networks" "Internet. E-mail." "Website" "News on the Internet" "Web pages"

(*Continued*)

Continued

Theme Subtheme Selected supplemental text data
3. Logistics
3A. Time
[Professionals need] "TIME to visit relevant places for recruitment in person (health care, child protection, different teams in hospital, social services, etc." [Family]. " It will take time. These families do not participate after seeing a poster at the store or in the paper. Some of them need information several times and to meet us and get to know us. They need to feel safe. It takes some time to join this group." "Barriers in therapists, parents, children and youth time, and other 'have to' tasks"
3B. Funding
[Need] "funding and a consistent provider." [Need for many groups by children's age]. " …and we have few resources to manage different groups." "It is helpful to be able to pay the school social workers for the extra work involved in the recruitment of children. Also involves a lot of coordination with parents and school administrators."
3D. Transportation
"Children lack transportation or means to attend groups." [Barrier] "Transportation" "Children need to be transported by parents."
3E. Population Size
[Organization barrier]. "*You must have a big enough area* to recruit from." [Organization barrier]. "COPMI can have different ages and this makes it more difficult to create uniform groups for ages."
4. Consistency of program
4A. Perseverance
"Be patient." "Do not give up."
4B. Regular program operations
"We recruit adults and children in two adult mental health centers directly after the first interview." "[Use] recruitment teams" "Operating the program frequently enough so it is top of mind for intake suggestions"
5. Family involvement
5A. Parent involvement
"My experience is that some parents want more involvement in the groups to get knowledge and to be secure about what their children are told/learned." "I think it is absolutely necessary to involve parents, especially with the youngest children."
5B. Child involvement
"Children want to know that the program will not be boring." "Children have to be reached with a message that is focused not only on COPMI, but on the common needs of the children."
5C. Family – parent, child, others
"Meeting with family prior to group start to build relationship and increase comfort …." "Offering intervention with …parents' and children's groups" [Need to arrange]"babysitting for other children who are not attending."
6. Recruit primarily through adults
6A. Parent gatekeepers & need for parental buy-in
"For children …recruiting has to be done by talking to the parents." "Sometimes it can be hard to reach the children as their parents are the gatekeepers."
6B. Professionals
[Professional facilitator] "*Regularly [provide] information* to those who meet the adults" [such as parents with substance abuse and mental illness" [Professional facilitator]. "*Share ideas about how to reach the parents and children*. Especially for therapists, they experience *difficulties to talk* with parents about parenting. By *discussing this together* with the adult mental health professional, and facilitate them to talk about parenting with their patient."

(*Continued*)

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Theme Subtheme Selected supplemental text data
7. Stigma
7A. Stigma as a barrier to recruitment
"There can be a barrier of guilt as well as stigma on the part of parents …I have found most often even if the parent is keen and has initiated the referral, there has not been a conversation at home about the mental health challenges." "When parents are drinking, parent involvement is a challenge. This may be because of fear of stigma (to be claimed to be 'bad parents')."
8. Recruiting locations
8A. Schools are best recruitment location
"A flyer to share is the best especially for teachers and school counselors to give to the parents and families. "Screening and selecting children via schools." [Successful recruitment strategy]. "Holding [the] program in the schools."
8B. Mental health agencies are most frequent location
"We recruit adults and children in two mental health centers." "In our program it is easier to recruit adults than children because we work in a mental health center for adults. We offer more specialized adults' treatment. "The community psychiatric team knew the mothers and fathers. Some of them also saw the children, and together with the family center, a group for parents and children was made.
8C. Community health sites
"Personal contact with patient [within] health care" "Community health care for children and youth"
8D. Other organizational sites
Recruitment from family social services "NAMI newsletter"
9. Social media
9A. Blogs, Twitter, Facebook
"Website blog" "Our person in charge of social media posts on Twitter and Facebook."