Establishing therapeutic and supportive relationships throughout delivery of a school-based group parenting program via telehealth: Exploring causal pathways

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Abstract

Background: Access to specialised early intervention mental health services for children, including group counselling for parents/carers, is still a challenge in non-metropolitan areas of Australia.

Aim: To gain understanding of the acceptability of a school-based targeted parenting group program delivered via telehealth by exploring the experiences of parents/carers, clinicians and school staff, and asking what works, how, why and in what circumstances.

Methods: Caregivers, clinicians and school staff involved in the delivery of a mental health program via telehealth into primary schools in two rural Local Health Districts (LHDs) in southern New South Wales (NSW) were invited to participate in interviews and/or focus group discussions. Thematic analysis of the data was conducted with reference to realist theory.

Findings: We conducted semi-structured interviews with 12 caregivers, five semi-structured interviews and two focus group discussions with school staff from six participating schools, and three focus groups with seven clinicians who delivered the intervention. We found that the intervention and micro contexts interacted to influence acceptability by initiating or enhancing cohesion among caregivers, establishing channels of communication between caregivers and teachers, and connection between caregivers and clinicians despite geographic distance. Several adaptations were made to strengthen the therapeutic alliance between caregivers and clinicians.

Conclusion: Relationships crucial to the success of delivering psychological group counselling were established. Regional community contexts can facilitate acceptability of parenting group counselling delivered into schools via telehealth.
Implementation of the program was flexible enough to allow clinicians to adjust their approach and materials to better suit the telehealth modality.

Keywords
Telehealth, group, mental health, realist, school, early intervention

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Introduction
Real-time interactive telehealth modalities have the potential to address inequities of access to mental and other allied health services experienced by regional, rural and remote communities.1–3 In Australia, and other geographically large countries, the poor retention of health workers in regional and remote areas, as well as the increased cost of delivering and seeking healthcare due to large distances and low population density further exacerbate health inequalities.4–6 Rural communities in Australia also experience unique environmental stressors such as bushfire and drought, putting them at greater risk of mental health challenges and subsequently increased need for mental health support.7 This misalignment of supply and demand could be resolved in part by routine use of telehealth.8,9

Parenting interventions are evidenced to be the most effective approach to psychosocial treatment of disruptive behavioural problems in children.10–13 However, they are out of reach for many families due to barriers of access related to distance and cost.14 Fortunately, the use of telehealth via videoconferencing or telephone to deliver these interventions is gradually increasing15 and has accelerated most recently due to the COVID-19 pandemic.16,17 Emerging evidence demonstrates that the clinical effectiveness of parental training interventions for childhood behavioural and conduct problems delivered over telehealth is comparable to in-person therapy,18 and several studies have demonstrated high participant retention and acceptability of parental training and counselling interventions delivered over telehealth among parents and carers.14,19–21

The Australian Federal Government has invested in the expansion of telecommunication infrastructure and growing the telehealth industry.6,22,23 However, adoption, scale up and sustainability of psychological healthcare services delivered via telehealth are also dependent upon acceptance by both patients and clinicians.25 Hesitance or resistance to its adoption by some clinicians has been reported to be due to concerns about compromised patient-practitioner interaction, communication style and challenges in building therapeutic alliance over distance.24 Additionally, lack of training, permanent reimbursement schemes, and established operating models that integrate service delivery via telehealth hamper its sustainability post pandemic.6,25–29

Telehealth approach to Got It!
To address the disparity in access to mental health services in communities outside of urban centres in NSW, Royal Far West, a non-government organisation (NGO) specialising in delivering paediatric health, education and disability telehealth services, in collaboration with Southern NSW and Murrumbidgee Local Health Districts (LHDs) implemented an adaptation of the targeted component of the evidence-based early intervention mental health program ‘Getting on Track in Time’ (Got It!). The Got It! program is a partnership between the NSW Ministry of Health and the Department of Education and is regularly delivered in-person in primary schools in NSW.30 The Got It! program takes a transdiagnostic and a systems approach. The program aims to intervene early in the child’s life and include those involved in the whole context of the child—namely caregivers and teachers. The program consists of a universal component delivered school wide, and a targeted program for children identified through screening using the strengths and difficulties questionnaire (SDQ) completed by teachers and parents to identify children with emerging social, emotional, or behavioural challenges, during their first three years of schooling from kindergarten to grade 2.31,32 The targeted program typically consists of child-only, child–parent/carer and parent/carer-only clinician led intervention groups, however due to the challenges of engaging early primary school-aged children with behavioural and social/emotional needs in groups via telehealth, the parent/carer-only group only was delivered in this remotely delivered program. The parent–carer group component aims to enhance parenting strengths and equip parents and carers (referred to collectively as ‘caregivers’ for the remainder of this paper) with the awareness, knowledge and skills to help mitigate and resolve social, emotional, and behavioural problems.31 The parenting program delivered via telehealth comprised the ‘Telehealth Approach to Got It!’ (TAG), which is the
focus of this study. The TAG program, in keeping with the Got It! program for caregivers and teachers, consisted of the following components: psychoeducation regarding child development, emotion coaching, zones of regulation, meta-emotions, social skills training, rewarding positive child behaviour, managing misbehaviour, brain development and attachment, family of origin, parental self-care, child-led play, rupture and repair in relationships.

We aimed to assess whether, how and why the TAG program was acceptable to caregivers in regional NSW and their clinicians located in an urban centre to inform potential scale up and transferability of the telehealth model to other settings and programs, and in response to the need for evidence-based guidelines to support adoption of telehealth services and technologies. Our study is part of a larger project assessing overall acceptability and effectiveness of the TAG program. We focused on assessing the acceptability of delivering the intervention via telehealth, as program content has been shown to be effective in previous research. We assessed the experiences of delivering a parenting program via telehealth to a group of caregivers, rather than the traditional therapeutic provider-patient dyad. A limited number of small studies suggest satisfaction and acceptability among recipients of group parenting interventions delivered via telehealth, while assessment of group parenting programs delivered via telehealth directly into schools rather than clinical or home settings is absent in the literature. This analysis comes at an opportune time when use of telehealth has increased rapidly due to the COVID-19 pandemic.

Methods

Study setting and population

The TAG program was delivered via telehealth to seven schools across Southern NSW and Murrumbidgee LHDs over three school terms in 2018 and 2019. Participating schools were identified by their LHD as potentially being able to benefit from the TAG program as they had not received Got It! due to their rural location. Additionally, the schools had the technology to facilitate telehealth, space to accommodate and capacity to set-up weekly sessions, and school staff (teachers and principal) were able to participate in up to two telehealth sessions with clinicians. The TAG program was delivered by Royal Far West (RFW) clinicians including clinical psychologists, occupational therapists, and social workers. Each telehealth session was conducted by two clinicians who delivered the parenting program to a group of 2 to 6 caregivers. All caregivers (of children who had been screened and identified as having social, emotional and/or behavioural challenges) and school staff who consented to participate in TAG were eligible and invited for interview immediately after program completion at the end of the school term. RFW clinicians were invited to take part in focus groups during intervention terms. All participants were over 18 years of age.

Data collection

Topic guides of semi-structured questions and prompts were developed to guide open-ended discussions in interviews and focus groups. Interviews were offered to caregivers at immediate and six months post-program completion and offered to schools as soon as practicable following program completion. Individual interviews with caregivers and school staff explored issues of acceptability, perceived value of the intervention and program outcomes. The interviews were conducted via teleconferencing and phone by three researchers (RH, DZ and AM) who were not known to any of the caregivers or school staff prior to the study. In line with appropriate ethical considerations, given the sensitivity of reporting family-based issues and to minimise social desirability bias, an emphasis was placed on the independence of the qualitative interviewers from clinical staff. Interviews lasted between 45 and 75 min. School staff also participated in focus group discussions to gain further insight into their experiences. Focus group discussions with clinicians aimed to gain insight into all aspects of the intervention including recruitment, arrangement of the room at the school, caregiver engagement, and technology use. All focus groups were facilitated in-person by researchers (AM and RH) and lasted between 60 and 120 min. Observational field notes were taken at the ‘clinician end’ of the telehealth connection by RH and AM during conveniently selected telehealth sessions at all participating schools. Observational field notes were taken to gather concrete observations and examples regarding the who, what, where, how and why and to create notes regarding what appears to work for whom, under what contexts and how.

The staff conducting the observations were provided with a guide and training about what to include, consider and look out for when gathering observational field notes. The observers took specific note of who was present, how they sat, who looked engaged, who participated in responses, group dynamics observed, whether participants arrived late or left early, timing and order in which events or interactions occurred, session start/end on time, technical difficulties, delays (on either end) and what happened, commentary from either end of the telehealth interaction. Associated notes from the observer contained what the observer thought was happening and why.

Analysis

Qualitative interviews and focus groups were audio recorded and transcribed verbatim by an external transcription service. Three researchers (RH, DZ and AM) all experienced in qualitative analysis read all transcripts and compared these with observational data to ensure consistency. We
followed a process of data familiarisation, identifying themes, indexing, mapping and interpretation. Data were coded inductively and deductively based on the realist theoretical framework and approach to evaluation. This framework comprises the following explanatory formula: ‘to infer a causal outcome between two events, one needs to understand the underlying mechanisms that connect them to the context in which the relationship occurs’. For this analysis, themes identified from the transcripts that related to acceptability were coded as outcomes, and themes that captured the micro contexts on which these outcomes may have been contingent were coded as contexts. Themes and categorisations were discussed and refined by the three researchers. To then explore and better understand how the intervention worked to be acceptable or not and for who and under which circumstances, two researchers (RH and DD; both trained in qualitative analysis and DD trained in realist analysis) identified mechanisms that were hypothesised to explain the relationships between outcomes and contexts. This was done through a process of concurrently examining the literature on delivery of psychological counselling in-person or via telehealth, re-reading transcripts and re-listening to recorded interviews, analytical discussions guided by first-hand experience of intervention implementation by RH and AM, email correspondence with RFW clinicians, and debate and refinement between RH and DD until saturation. From this process, the data was interpreted by mapping possible causal pathways (context-mechanism-outcome, CMO) by which the intervention may have been acceptable to caregivers and clinicians. Microsoft Excel was used to facilitate visualisation and analysis using a data matrix.

Findings

Study sample

Data were collected from a total of 38 caregivers who participated in the program at seven primary schools over three school terms. Of the 23 caregivers who completed the program, 12 took part in 14 telephone interviews. Two interviews were conducted both immediately after completion of the program and at six months post-completion, two immediately after completion only, and eight at six months post-completion. Caregivers who were interviewed were mostly female (83%) and their mean age was 41.1 years (range 26–66 years). Caregivers were either parents (83%) or grandparents (17%), and all caregivers who participated in the program were living in the same household as the child. The highest level of education completed by the caregivers was either secondary school (50%) or undergraduate degree (50%). English was most commonly the first language of the caregivers (100%). Of the 10 caregivers who responded to the question, 20% were married, 40% were living as a couple, 30% were divorced or separated and 10% were single. Ten school staff from six out of seven intervention schools participated in five semi-structured telephone interviews (two teachers, two principals and a specialised support staff) and two focus groups (four teachers and one school support staff) via phone. Seven out of ten (70%) school staff participants were female. No other demographic information was gathered for school staff. Three in-person focus groups were held with all seven clinicians who delivered the program via telehealth from the Royal Far West office in Sydney, NSW, Australia. One focus group was conducted during the first term and two during the third intervention term. Six (75%) of the clinicians were female. We also conducted field observations of 11 parent group sessions in all seven school settings.

Based on the interviews, focus group discussions and observations, we identified the following reoccurring themes, presented below as micro contexts (individual, community, school and intervention characteristics), mechanisms (‘no judgement and comradery’; ‘channels of communication’; ‘closer despite distance’) and outcome (acceptability), supported by illustrative quotations from interviews and focus groups. Detected in the data and supported by the literature is the criticality of establishing and developing positive therapeutic connections and relationships between clinicians and patients for counselling via telehealth to be acceptable at both user ends. Similarly, a feature of on-going group counselling crucial to its acceptability and effectiveness is the cohesion that develops between group counselling recipients. Thus, subheadings under each mechanism reflect our findings by each relationship type, between clinicians, caregivers and teachers. Our findings are summarised and presented in Table 1 as preliminary CMO configurations. These can inform future realist evaluation of delivery of early intervention mental health group therapy programs to caregivers in regional and remote locations via telehealth.

(No) judgement and comradery

(Caregiver–clinician). Many families, but not all, were considered by the clinicians to be ‘complex families’. Clinicians indicated this complexity (context) by reporting that over the course of delivering the program “there were risk issues every session”, “...instability within the family situation” and that “parents have their own PTSD”. Members of these families may be reluctant to openly discuss family histories out of fear of being judged by clinicians or may feel mistrust towards outsiders who are not familiar with local practices and cultures. Caregivers in our sample expressed the importance of not feeling judged in telehealth sessions and reflected that the physical distance between themselves and the clinician allowed them to speak more freely than they feel they would have in-person. Telehealth in this instance may have had the unintended positive effect of softening
reluctance to openly share information and stories (outcome), at least initially when relationships with the clinicians had not yet been established.

“... you weren’t there ... with [the clinicians’] immediate facial reaction. If that makes sense, it wasn’t as personal, you could just say, “Oh yes, this happened and that happened and this happened,” and could just let it out as if you’re on a phone call...” (caregiver22, female)

Inherent in (no) judgement, however, is the possibility of being judged. Clinicians expressed that at times the social dynamics of a small regional town (context) was a hindrance to encouraging group participants to share personal backgrounds in the group counselling format (outcome). Group therapy convened in rural areas, whether over telehealth or in-person, is more likely to accrue participants who know one another, compared to enrolling participants from a larger population base such as in a city. In this program, participants were enrolled from a school. Therefore, caregivers were even more likely to know one another. Clinicians were concerned about unpacking emotional trauma in a group setting over telehealth due to a lack of time to address individual concerns of this depth. Clinicians said that for in-person group programs it is usually possible to meet with individuals after the session ends, so to try address this need during the telehealth program, the clinicians made themselves available on email and phone to participants outside of telehealth session times.

“... always risky in a small community, they’re disclosing some things and it was mentioned to us, “Oh, you know I had my own trauma”, but then we weren’t really sure in a group situation, do we just... we were sort of like, “oh okay, it’s good that you understand the impact of trauma” but couldn’t really get into it too much.” (clinician6, female)
It was fear of judgement in a small regional community (context) that played a role in the limited uptake of the group-based therapy program by caregivers (outcome). Delivering psychological programs to groups who live in regional communities is both a strength and a challenge as families often know one another.\textsuperscript{43} It was expressed by the caregivers that challenges in engaging families to participate in the program were in part driven by concerns around judgement and privacy.

“…I think they didn’t come because they were just concerned that people would gossip behind their back. They didn’t want to have everyone knowing their business or wanting to share…It’s a pretty big subject and you’re dealing with children. They don’t want to bare their soul really.” (caregiver30, female)

However, as caregivers began to know each other, benefits of the group format began to emerge. The caregivers’ shared experience of family-based challenges (context) revealed commonality of understanding, allowing them to feel more comfortable in sharing with the group (outcome). A RFW clinician reported that in previous school-based programs aiming to support children via parenting groups found unexpectedly that “many of the parents of the kids who had the biggest range of problems were quite alienated from the school. What [the program] did in bringing those into the school was create a bit of camaraderie between those parents who had similar problems.” (clinician7, female). Similarly, the TAG program was able to connect caregivers who then found support in each other.

“It was nice to meet other people in the same situation and be able to talk freely and not be judged. On really bad days, you had someone to talk with, that you’re keeping in touch with…” (caregiver33, female)

Technical disruptions characterised by slow or interrupted internet connectivity or receiving only audio without being able to see the clinicians (context) was experienced by caregivers in some sessions. When technical problems occurred however, it was reported that caregivers experienced the unexpected positive effect of enhanced cohesion among themselves, rather than frustration over the issue; if it occurred at the beginning of the program technology failure provided additional opportunity for initiation and development of important relationships between group participants (outcome).

“…[for the whole first five to six sessions… All we saw was each other… We knew [clinicians’] voices, we just didn’t see them. And no, it was fine because we listened to them and we could hear them, but we interacted with each other… I just found it was really great and I think that’s why we bonded because all we saw was each other.” (caregiver30, female)

It was also reported by a caregiver that as time went on, the friendships they had developed while attending the program resulted in the time taken for resolution of technical issues to be filled with “a little bit of humour” (caregiver13, female), rather than complaints or impatience.

**Channels of communication**

(Caregiver–teacher). While caregivers were the primary recipients of the mental health sessions provided over tel-health, teachers play an important role in supporting a school aged child’s development.\textsuperscript{44} Consequently, they play an important part in a program such as TAG, working closely with caregivers and clinicians to support improvements in children’s social, emotional and behavioural well-being. As is part of the Got It! program, the TAG program offered two sessions with clinicians to teachers of children identified to be at risk of social, emotional and behavioural challenges, to discuss support strategies for the child/ren in their class. Clinicians tailored the content delivered to teachers based on teachers’ past experiences, knowledge and exposure to social/emotional and behavioural programs, as well as tailored the content to the needs of any particular children identified as being high needs. The content mirrored that discussed in the caregiver group. Being able to closely involve teachers in an early intervention mental health program for children is an advantage of delivering the telehealth parenting intervention in schools (context). When both the teacher and caregiver(s) of a child were involved in the program, teachers reported that stronger and more effective connections between themselves and caregivers had been created. And it was because of these connections that caregivers and teachers were able to communicate about what was going on for the child at home and at school. Teachers reported that during and after attending telehealth sessions, caregivers were more willing to approach them to discuss their child (outcome).

“They’re more calm [caregivers], they’re communicating with me more about the actual needs of their child, which I think is amazing. These families are quite rigid in their thinking and they’re only doing what they know of their own life experience, but now, they’re looking at other ways to help their children and I think that’s been very beneficial. Not only to their children, but also to me as their main person at school. That’s why I think that [children’s names] are motoring along okay.” (teacher3, female)
Teachers also reported that the program was particularly helpful in allowing them to understand and support the child during their time at school (outcome).

“I have a fairly positive relationship with these families now… they feel much more comfortable in coming and volunteering information too… whereas before they didn’t communicate that sort of stuff to me at all. If I’ve got the information, I know I can set them up for a better day… so that’s been another big improvement here, and improvement in school and home communication.”

(teacher3, female)

This new channel of communication between teacher and caregiver was influential in initiating creation of a support network needed to assist families (outcome). Whilst teacher involvement in the program was flagged by interviewees as important, not all children involved in the program had a teacher who was participating along with their caregiver. Uptake of the program by teachers was low as teachers’ annual extracurricular schedules were often full prior to notification of the TAG program.

Those teachers who participated in the TAG program shared what strategies they learned and how they implemented these into the classroom.

“It’s certainly being part of the project has heightened my awareness of what their [classroom children] needs are, so I probably pre-empt, and am more proactive that the boys themselves are quite happy within themselves.”

(teacher focus group)

For me, it was just having some strategies. I tried lots of things and it just wasn’t working, but having another set of eyes on it, and ensuring I haven’t avoided trying things because I didn’t have the energy. Now I’m ready to start that energy. You have that energy pumped into trying things. I remember writing on my notes, “this is an experiment.” We only said, just treat this as an experiment. It might work, it might not.

Teachers reported using the behaviour checklist (with antecedent, behaviour and consequence) introduced during the TAG program, and said they found it was a useful way to reflect and clarify the antecedent challenges prior to child behaviours and using this tool helped teachers plan a path forward. Teachers also reported that they were now more often rewarding positive behaviour rather than managing bad behaviour and this was a key shift after the TAG program.

(Clinicians—school and local clinical staff). As clinicians were not physically in the same room as caregivers (context), clinicians noted that they were not present for casual debriefs and chats with caregivers after program sessions as would typically occur in an in-person program. Clinicians expressed that they were missing potentially valuable feedback about how caregivers were responding to or feeling about each session. Clinicians felt this compromised their ability to prepare for the next session. To mitigate this, clinicians suggested creating a formal connection between themselves and staff present locally such as a LHD clinician or a teacher who could be in regular contact with families involved in the program and could provide greater insight into families, if needed by the telehealth clinicians. A RFW clinician suggested feedback from someone on the ground would be helpful, “… [parent/carer name] was really a bit sensitive after the session last week…. “Yes, everybody was a bit overwhelmed by about all that” or “that was a lot of information”, then we would then know the next week” (clinician6, female). The recommendation for a feedback loop highlights challenges in delivering a psychological service over telehealth and offers a solution that would allow clinicians to gain a more complete picture of how caregivers were feeling, reacting and progressing through the program, which would in turn inform and improve their delivery of the program.

Closer despite distance

(Caregiver–clinician). It is known that interaction via telehealth (facilitated by videoconferencing) requires different approaches to developing relationships and therapeutic connection compared to in-person therapy.24 For this reason and in response to clinician feedback, for the third intervention term, three adaptations were made to how the program was delivered. The aim was to mitigate the ‘distance’ between caregivers and clinicians and improve connection and rapport, make delivery of program content easier for clinicians and aid the learning process for caregivers (outcomes). This involved changes to the caregiver recruitment process and introduction of additional program tools and materials, as detailed below.

Adaptation 1: In response to strong feedback from clinicians, a hybrid telehealth model was introduced into intervention term 3. The aim of the hybrid model was to improve the recruitment process by establishing early rapport, initiating an in-person connection with families that would then be developed via telehealth, and establishing relationships with key school staff. Establishing early relationships with families is critical for engagement in mental health programs, particularly when aiming to support families with complex histories.4,13 In intervention term 3, RFW clinicians travelled from Sydney to two rural schools to conduct in-person recruitment and enrolment by way of one-to-one meetings with caregivers, subsequent to the initial screening process led by LHD Got It! program staff. During these sessions, clinicians informed caregivers about the objectives of the program, what it could offer...
them, completed risk assessments (e.g. child protection issues), and aimed to understand both the challenges that caregivers wanted to address as well as determining whether the program was suitable for each caregiver. Caregivers reported that the hybrid model was successful in enabling early familiarity and rapport between themselves and the clinicians.

“I think that was actually a very valuable thing because then you already knew the person that you’re chatting to. I think there was actually more time. It gave me more time (to focus on program content). She actually knew us a bit as well. It wasn’t just paperwork; it was face-to-face, and I think that was valuable.” (caregiver34, female)

Meeting the school principal and/or key liaison staff member and establishing relationships with them early on was essential in later being able to effectively manage risk issues that arose during group sessions. Risk issues which were present during this program included child protection concerns, relationship problems, and the caregiver’s own mental health needs. Meeting the school principal and/or key liaison staff member to establish relationships helped to provide background information on any potential risk issues which may arise. Having an established relationship with local staff ensured avenues existed for in-person assistance for any group dynamic challenges. Technological challenges were the most common of the anticipated risks. Local staff helped to alleviate these quickly to reduce lost session time. Additionally, the hybrid model was beneficial in that it gave clinicians the opportunity to view the set-up of rooms in which sessions would be held.

Adaptation 2: An interactive pack for the Emotion Regulation session was mailed to participating schools prior to commencement of the program. The pack consisted of: bubbles, chalk, straws, balloons, paper plates, table tennis balls, theraputty and Bear Cards. The purpose of these items was to ensure clinicians and caregivers had the same learning tools and program materials at the same time to enhance connection and learning via telehealth. The Bear Cards became particularly important in the telehealth program, as they enhanced emotional vocabulary and the process of learning to recognise a child’s emotions usually taught by demonstration of body language through role play, a technique that is not well suited to telehealth. Both the clinicians and caregivers had Bear Cards on either end of the telehealth connection, and they were found to successfully assist in identifying and explaining emotions. Clinicians reported that participants were able to elaborate on answers to complex questions with greater ease and that quieter caregivers were prompted to contribute more when using the Bear Cards. Caregivers reported that the Bear Cards were one of the most useful tools throughout the program.

“I liked the Bear Cards …just knowing that there is more than one emotion that can happen at one time. I found that the most useful… As you know, normally naming your emotions or naming how you feel is important. For kids, they can’t name, and they can’t express those emotions. That’s where that helped me. It’s more like taking a step back for me and going what’s actually going on emotionally rather than reacting.” (caregiver15, female)

Adaptation 3: To increase connection and build rapport between caregivers and clinicians, Royal Far West introduced a morning tea break to the telehealth program timetable. Tea, coffee and biscuits were sent to participating schools in intervention term 3 and were set-up at the back of the telehealth session room by school staff. Caregivers could then help themselves during the break. Importantly, clinicians took their tea break at the same time. They joined in the break by bringing their beverages back to the video screen where they chatted informally with the group of caregivers. The tea and coffee break acted to connect caregivers and clinicians, and “the biscuits [were] a success” (clinician4, female) because caregivers and clinicians were both participating in the same activity at the same time and could see each other doing so. The break also highlights the importance of informal interaction, to build rapport and connection, which is often lacking in telehealth programs but possible to build in as was done in this case.

Facilitator: “It’s so funny that like you said with the [regulation] packs, everyone blowing a balloon while you’re blowing a balloon, that, I guess is like mirroring.”

Participant: “It was the same as with the [lollies].”

(clinician6, female)

Discussion

This study provides insights into how the TAG program, the group parenting component of an early intervention mental health program delivered over telehealth to families in rural schools, was acceptable to caregivers, clinicians, and teachers. Our findings suggest that its delivery into rural communities and school contexts, facilitated supportive relationships and environments in which caregivers felt free to speak openly, created new channels of communication between caregivers and teachers, and promoted successful therapeutic relationships between caregivers and clinicians despite the distance between them. Importantly, our findings contribute new data to the knowledge gap regarding delivery of group therapy over telehealth. We also describe the adaptations made by clinicians to enhance ‘telehealth connection’ and ultimately...
acceptability of the program in a telehealth format for caregivers, clinicians and teachers.

In terms of relationships between caregivers, the dynamics of groups made up of participants from small regional communities may have initially made caregivers feel less comfortable to talk openly about home life, and clinicians wary of probing too deeply into personal histories which may have hindered their ability to understand problems. These findings are supported by previous research. However, we found that fear of being judged reduced and group cohesion increased as participants began to get to know each other and bonded over common experiences. The ability of group therapy to create supportive and comfortable environments among those who share experiences of hardship is well established. We found that a similarly supportive environment could be created when a mental health program is delivered to a group via telehealth. Informal interactions played an important role in the development of rapport between caregivers, and periods of technical disruption unexpectedly created additional opportunities for these valuable interactions. Interestingly, our findings did not reveal any of the negative effects of technical disruptions that have been reported in previous studies assessing telehealth, such as disengagement and compromised rapport between provider and patient. This may be due to the one-on-one format of previous interventions, whereas the TAG group format meant that participants had other people to interact with while technical problems were being resolved.

As the proverb goes, ‘it takes a village to raise a child’, and programs which aim to intervene early in a child’s behavioural and emotional development are likely to benefit from adoption of a developmental system approach by involving key figures in a child’s life such as parents or carers, and teachers. This highlights the important role teachers play in the TAG program. Our analysis found that caregivers established new channels of communication with teachers that enabled an exchange of information about a child’s progress that was particularly helpful for teachers and brought caregivers closer to the school community. Further, when a child’s teacher was also involved in the program it became possible to create a support network composed of clinicians, caregivers and teachers and other school support staff. Delivering the telehealth program into schools was effective in encouraging its acceptability among caregivers and teachers alike, and measures should be taken to increase teacher participation. Challenges experienced when seeking to have teacher participation was teachers having the time to participate, teachers understanding what the program was about, how the program was or was not like previous training they may have received and how the program might support their role.

In line with existing evidence, we found that feeling free of judgement, and subsequent building of trust, rapport and therapeutic alliance are crucial for acceptability and effectiveness of early intervention parenting group counseling and are possible to achieve via telehealth. Development of connection between caregivers and clinicians, which Draberek et al. term ‘telepresence’, was aided by several adaptations introduced by RFW and their clinicians, responding to the complexity of interacting over distance via telehealth, in particular, a hybrid program model. Meeting with caregivers in-person prior to commencing the program allowed clinicians to gather important information regarding family circumstances and community dynamics. Understanding community culture is vital for clinicians who provide psychological health services via telehealth, including into schools, due to the importance of cultural cues and expectations which may be difficult to detect over telehealth.

The successful adaptations to the implementation of TAG highlight the importance of flexibility during program implementation. Explained by community health scientist Penny Hawe, this flexibility has the potential to increase effectiveness and reach of interventions as it allows adaptation of an intervention to different contexts during scale up. Other research has discussed the importance of engagement felt by clinicians in being able to adapt delivery (while adhering to therapeutic protocols) to the needs of patients receiving therapy as an important factor in their acceptance of delivering therapy via telehealth. As there are known barriers to adoption of telehealth by clinicians, it is important as telehealth services become more widespread due to the COVID-19 pandemic that implementation guidelines include adaptive flexibility as clinicians need to adjust to new modes of delivery.

The strengths of this study include our use of clear and traceable documentation, reflexive data, data collection triangulation, researcher triangulation and observation and deep engagement with the program’s implementation. This program took place in rural areas of NSW, Australia. The findings may not be representative of all rural communities. Further limitations of this study include that data were gathered from caregivers who completed the program (23/38; 61%), such that the scope of findings is limited to participants who may have had more positive experiences and impressions than those who did not complete the program or who declined to be interviewed. This rate of completion of a parenting program is in keeping with the literature regarding attendance rates for in-person parenting programs where about half of parents typically complete in-person parenting programs at Child and Youth Mental Health Services (CAMHS), other literature reports between 30% and 60% drop-out from in-person parenting programs, less is known about attrition rates from group programs delivered to caregivers over telehealth. Two key barriers to participation and/or program completion which were hypothesised to remain include: recognizing need for early-intervention and believing the
program may have value and having the time to participate in a program which took place mostly during working day-time hours (a particular challenge for working parents as well as those with children still at home/pre-school age). Telehealth and the group format may have been other barriers to participation. To improve uptake, providing babysitting for younger children during the sessions, providing letters to workplaces for caregiver leave if feasible, running the program during the lunch-time hour, and providing further information on the program may help. A further limitation is the small number of school staff who were able to engage in interviews and focus groups. This prevented saturation of themes for school staff. The findings are limited to characteristics of communities to which study participants belong, which may differ to those of other regional, rural, or more remote areas of Australia. The sample of school staff and clinicians was small. Additionally, to assess acceptability of telehealth among clinicians in more depth, it is necessary to address additional aspects of their work beyond those included in our findings; using telehealth technologies to delivery healthcare services may create opportunities for developing new care pathways, however they require training, and may disrupt existing team interaction and workflows in ways that can prove to be more complex than initially anticipated.

Conclusions

Delivery of school-based parenting programs via telehealth aims to increase equity in access to early intervention mental health programs for children and build brighter futures in regional, rural, and remote areas. As it is likely that mental health services will increasingly be delivered remotely, understanding how to achieve, enhance and sustain acceptability of telehealth service delivery is crucial in continuing to innovate and improve delivery of these programs. Our findings have informed on-going use of telehealth for implementation of components of the Got It! program, by one participating LHD prior to and during the COVID-19 pandemic. Our findings may further inform clinicians’ strategies, future guidelines for delivery of mental health services to groups of caregivers via telehealth videoconferencing, and future research, including realist evaluation, into modes of delivering Got It! and other similar programs. Assessment of delivery of mental health services via telehealth is essential to ensuring sustainability of its increased use beyond the COVID-19 pandemic.

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Contributors: AM, HC, MM, LW, KS, SD, DM, JD and KB researched literature, consulted with partner organisations and conceived the study. RH, AM, DZ and MM were involved in the collection of data. AM, RH and DD led the analysis, and all authors contributed. DD wrote the manuscript. All authors reviewed and edited the manuscript and approved of the final version.

Declaration of conflicting interests: Royal Far West delivers specialist paediatric and allied health care for children in rural and remote Australia in-person and through real-time telehealth. Royal Far West provided in-kind resources and time towards this project.

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